
A Case Study of India

by

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ABSTRACT

THE POLITICS OF NORMATIVE POLICY FRAMES OF DEVELOPMENT:
IMPLICATIONS OF HUMAN RIGHTS FRAMING OF MATERNAL HEALTH FOR
ADVANCING REPRODUCTIVE JUSTICE

A CASE STUDY OF INDIA

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University of Guelph, 2016

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Some scholars have argued that framing preventable maternal morbidity and mortality (MMM) as human rights injustices can strategically accommodate the multifaceted gender injustices, health disparities and multidimensional poverty that collectively contribute to the issue and communicate its political and moral urgency to prompt political action. Yet, this is largely a theoretical and normative proposition lacking empirical evidence to. This study contributes to this gap. It is located in interdisciplinary theoretical debates over the discursive power of framing women’s right to maternal health as a human right to alter domestic political priority surrounding the issue and advance reproductive justice for all women. It uses a qualitative case study approach involving six-months of field research in 2012-13 in India – the largest contributor to such deaths globally and the first country to (judicially) recognize preventable MMM as human rights violations – and includes nearly sixty-five key informant interviews with state and non-state actors, ethnographic observations and extensive document analysis.

Overall, the findings demonstrate that the politics of framing preventable MMM in India is complicated by discursive and structural factors, which limit the potential of human rights frames to affect the political priority for the policy problem. The discursive factors are products
of historical, political, economic and social conditions, which arise at the intersection of domestic and global circumstances. They fragment feminist solidarity in India and complicate articulation of a holistic reproductive justice agenda. In contrast, the structural factors are related to peculiar constitutional and institutional designs, which complicate attribution of responsibility and conceptualization of state accountability for adverse maternal health outcomes that are also produced by compromised state capacity in neoliberal times. The findings point to the limitations of normative policy frames, specifically human rights frames of development, which is significant due to the renewed emphasis on the centrality of human rights in the post-MDG era. They are also consequential to the design of collective action strategies and mobilization efforts given the concurrent yet disconnected appearance of two inter-related issues in the SDG agenda – maternal mortality reduction (under SDG 3) and women’s sexual and reproductive health and rights (under SDG 5).
For Anindya
Acknowledgements

I tend to be lengthy and verbose in my written articulations and this acknowledgement is no different. A doctoral dissertation is seldom a product of sole efforts and energy of an individual and it is only fair to acknowledge all those who have made the completion of this dissertation possible.

I am indebted to International Development Research Centre of Canada (IDRC) for funding this project through its doctoral research award. I would also like to thank the staff at IDRC Asia headquarters in New Delhi. They were immensely helpful in leveraging their professional and personal networks during the initial days of field research which ‘opened many doors’ for me and allowed me to conduct fieldwork in a manner that enriched this study. This project would be impossible without the support of Ms. Jashodhara Dasgupta of Sahayog. I would also like to express my gratitude to all those who participated in this study and so generously shared their time, knowledge and reflections with me.

I am also deeply appreciative of the mentorship and support my advisor Dr. Candace Johnson provided toward my overall doctoral training as well as this specific research project. I am immensely thankful to her for introducing me to diverse and prestigious opportunities since the beginning of my doctoral education, which have been important to my intellectual and professional growth. International students, such as myself, face many barriers to successfully undertaking and completing a lengthy and expensive doctoral degree in a foreign country. Hence, I am acutely aware of the significance of her support toward my training and research. As well, her enthusiastic support and faith in my abilities to simultaneously pursue full time employment to support my family and myself while completing this dissertation has been an invaluable source of personal confidence, especially during one of the toughest and most challenging period in my life. I also owe her an immense debt for introducing me to the importance of interdisciplinary intellectual enquiry in thinking about the social problems that surround us, while at the same time firmly grounding my disciplinary training in political science. This has exposed me to a fascinating world of intellectual enquiry and sophisticated analytical possibilities, which I hope to pursue in greater depth in the future.

I am also extremely grateful to the members of my fantastic thesis advisory committee, Dr. Craig Johnson, Dr. Dennis Baker and Dr. Sharada Srinivasan, for several rounds of thoughtful and challenging comments on this rather lengthy dissertation. Their comments and questions have introduced me to analytical possibilities that I could hardly ever imagine in my limited intellectual capacity. They have taught me the significance of peer review, which can be rather lengthy and challenging process but is ultimately and quintessentially responsible for the comparatively superior quality of the final product. Additionally, I am grateful for their mentorship and their intellectual labour, which has enabled me to “speak to” diverse disciplinary audience to successfully communicate the significance and contributions of this dissertation. Furthermore, I owe a special thanks to Dr. Fiona Robinson of Carleton University for agreeing to serve as the external examiner and providing invaluable thoughts on improving my work. I am humbled by the interest and enthusiastic support she has indicated in my work, especially given her widely acknowledged intellectual and scholarly reputation.
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I would have never dared to embark on the task of obtaining a PhD without the love, support and sacrifices of my family members. My father, as an academic himself, has always been a source of inspiration and chiefly responsible for encouraging my pursuit for knowledge. But it is my mother, who has made numerous sacrifices to ensure I had the support and opportunities since the early years of high school to enable me to translate my dreams and goals into realities. Her continuous reminders of the privilege and opportunities that my generation of women (whether in India or beyond) have over her own, have also kept me grounded and determined in face of challenges.

Finally, no one has endured the brunt of this dissertation like my partner and husband Anindya Ghosh who has left no stone unturned to ensure I can pursue my dreams and do so most earnestly. His contribution to this dissertation is the most direct and significant, but also the most invisible (in the ‘classic’ manner that unpaid domestic and care giving labour often is). No amount of gratitude, whether in words and/or thoughts, will ever be adequate to acknowledge his role in completion of this dissertation, and more broadly to nearly a decade long graduate career.
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<tr>
<td>AAAQ</td>
<td>Availability, Accessibility, Acceptability, and Quality</td>
</tr>
<tr>
<td>AAY</td>
<td>Antordaya Ayodhya Yojana</td>
</tr>
<tr>
<td>ACLU</td>
<td>American Civil Liberties Union</td>
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<tr>
<td>ANM</td>
<td>Auxiliary Nurse Midwives</td>
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<tr>
<td>ARROW</td>
<td>Asian-Pacific Resource and Research Centre for Women</td>
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<tr>
<td>ASHA</td>
<td>Accredited Social Health Activist</td>
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<td>BPL</td>
<td>Below Poverty Line</td>
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<tr>
<td>CCT</td>
<td>Conditional Cash Transfer</td>
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<tr>
<td>CEDAW</td>
<td>Convention for Elimination of All forms of Discrimination Against Women</td>
</tr>
<tr>
<td>CEHAT</td>
<td>Centre for Health and Allied Themes</td>
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<tr>
<td>CHCs</td>
<td>Community Health Centres</td>
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<tr>
<td>CRR</td>
<td>Centre for Reproductive Rights</td>
</tr>
<tr>
<td>DFID</td>
<td>Department of Foreign Affairs and International Development</td>
</tr>
<tr>
<td>DHC</td>
<td>Delhi High Court</td>
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<tr>
<td>EAG</td>
<td>Empowered Action Group</td>
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<td>EmOC</td>
<td>Emergency Obstetric Care</td>
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<tr>
<td>ESCR-NET</td>
<td>Economic, Social and Cultural Rights - NET</td>
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<tr>
<td>ESR</td>
<td>Economic and Social Rights</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drug Agency</td>
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<td>FIGO</td>
<td>Federation of International Gynecologists and Obstetricians</td>
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<td>FRU</td>
<td>First Referral Unit</td>
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<tr>
<td>GoI</td>
<td>Government of India</td>
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<td>HDR</td>
<td>Human Development Report</td>
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<td>HRLN</td>
<td>Human Rights Law Network</td>
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<td>IAG</td>
<td>Inter-Agency Group</td>
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<td>ICDS</td>
<td>Integrated Child Development Scheme</td>
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<td>ICESCR</td>
<td>International Covenant of Economic, Social and Cultural Rights</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<tr>
<td>IDRC</td>
<td>International Development Research Centre</td>
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<td>IFIs</td>
<td>International Finance Institutions</td>
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<td>IGMSY</td>
<td>Indira Gandhi Matritva Surkhashya Yojana</td>
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<td>IIMMHR</td>
<td>International Initiative on Maternal Mortality and Human Rights</td>
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<tr>
<td>INC</td>
<td>Indian National Congress</td>
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<td>ITISC</td>
<td>Indian Trust for Innovation and Social Change</td>
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<tr>
<td>IUDs</td>
<td>Intra Uterine Devices</td>
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<tr>
<td>JSSK</td>
<td>Janani Sishu Suraksha Karigram</td>
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<td>JSY</td>
<td>Janani Suraksha Yojana</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MMR</td>
<td>Maternal Mortality Rate</td>
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<tr>
<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<tr>
<td>MoWCD</td>
<td>Ministry of Women and Child Development</td>
</tr>
<tr>
<td>MTP</td>
<td>Medical Termination of Pregnancy</td>
</tr>
<tr>
<td>NAC</td>
<td>National Advisory Council</td>
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<tr>
<td>NAMMHR</td>
<td>National Alliance for Maternal Mortality and Human Rights</td>
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<tr>
<td>NCT</td>
<td>National Capital Territory</td>
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<tr>
<td>NFBS</td>
<td>National Family Benefit Scheme</td>
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<td>NFHS</td>
<td>National Family Health Service</td>
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<tr>
<td>NGOs</td>
<td>Non-governmental Organizations</td>
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<td>NHP</td>
<td>National Health Policy</td>
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<td>NHSRC</td>
<td>National Health System Resource Centre</td>
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<tr>
<td>NIEO</td>
<td>New International Economic Order</td>
</tr>
<tr>
<td>NMBS</td>
<td>National Maternity Benefit Scheme</td>
</tr>
<tr>
<td>NMEW</td>
<td>National Mission for Empowerment of Women</td>
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<tr>
<td>NPC</td>
<td>National Planning Commission</td>
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<tr>
<td>NPP</td>
<td>National Population Policy</td>
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<tr>
<td>NREGA</td>
<td>National Rural Employment Guarantee Act</td>
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<tr>
<td>NRHM</td>
<td>National Rural Health Mission</td>
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<tr>
<td>NSSM</td>
<td>National Strategy for Social Marketing</td>
</tr>
<tr>
<td>ODI</td>
<td>Overseas Development Institute</td>
</tr>
<tr>
<td>OHCHR</td>
<td>Office of High Commissioner for Human Rights</td>
</tr>
<tr>
<td>PCPNDT</td>
<td>Pre-conception Pre-natal Diagnostic Test</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Centre</td>
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<tr>
<td>PHM</td>
<td>People's Health Movement</td>
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<tr>
<td>PIL</td>
<td>Public Interest Litigation</td>
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<tr>
<td>PILO</td>
<td>Public Interest Litigation Organization</td>
</tr>
<tr>
<td>PPP</td>
<td>Private Public Partnership</td>
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<tr>
<td>PUCL</td>
<td>People's Union of Civil Liberties</td>
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<tr>
<td>RBAs</td>
<td>Rights Based Approaches</td>
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<td>RCH I &amp; II</td>
<td>Reproductive and Child Health Phases I &amp; II</td>
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<td>RGI</td>
<td>Registrar General of India</td>
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<tr>
<td>RHM</td>
<td>Reproductive Health Matters</td>
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<td>SAPs</td>
<td>Structural Adjustment Programs</td>
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<td>SIDA</td>
<td>Swedish International Development Agency</td>
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<td>SMI</td>
<td>Safe Motherhood Initiative</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>SRHR</td>
<td>Sexual and Reproductive Health Rights</td>
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<tr>
<td>SSLM</td>
<td>Support Structure for Legal Mobilization</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>UDHR</td>
<td>Universal Declaration of Human Rights</td>
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<tr>
<td>UNCESCR</td>
<td>United Nations Council for Economic, Social and Cultural Rights</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNHCHR</td>
<td>United Nations High Commissioner for Human Rights</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<tr>
<td>UPA</td>
<td>United Progressive Alliance</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>WRAI</td>
<td>White Ribbon Alliance of India</td>
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PART I: INTRODUCTION & CONTEXTUAL CONSIDERATIONS
Chapter 1: Introduction

Some scholars have argued that framing preventable maternal morbidity and mortality as human rights injustices can strategically and simultaneously address the multifaceted gender injustices, health disparities, and multidimensional poverty that collectively cause adverse maternal health outcomes. It can communicate the political and moral urgency of the situation to help create the necessary political commitment and resources deserving of the policy problem (Cook 1998; Cook and Dickens 2001; Yamin and Maine 1999/2005; Freedman 2001/2002/2003/2005; Gruskin et al. 2008; Maclean 2010). Human rights frames of maternal health, they argue, can be constructed based on interpretation of norms contained in global human rights instruments, such as the Universal Declaration of Human Rights (UDHR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on Elimination of All forms of Discrimination against Women (CEDAW), the Beijing Declaration and domestic constitutional protocols (Ibid.). This claim is based on the premise that strategic framing can lend a new meaning to the policy problem and it relies on the powerful moral imperative evoked by discursive use of human rights (Schon and Rein 1994; Stone 2002; Fischer 2003; Human Development Report 2000; Fukuda-Parr 2008; Gready 2008; Darrow and Tomas 2005; Archer 2009; Gloppen and Gauri 2012). Yet, framing theorists maintain that the potential of a frame to gain public and political attention may be subject to political interpretations and that the politics of framing is complicated. The relationship between reframing, if successful, and desired social change is hardly linear (Schon and Rein 1994; Stone 2002; Fischer 2003; Joachim 2007; Hawkesworth 1994/2012; Fischer and Gottweis 2012). However, the lack of empirical studies to that effect make it difficult to ascertain the potential of normative policy frames, such as human rights frames, to communicate the political and moral urgency behind the policy.
problem and generate the necessary political commitment and resources. This study contributes to this gap. It theorizes the politics of framing preventable maternal morbidity and mortality as human rights injustices to affect political priority of the issue and advance reproductive justice\(^1\) for all women.

Global estimates indicate that nearly 300,000 women die annually from preventable complications arising from pregnancy and childbirth (UNFPA 2014). Ninety-nine percent of these preventable deaths\(^2\) occur in developing countries, where the maternal mortality ratio (MMR)\(^3\) in 2013 was fourteen times higher than in developed countries (WHO, UNICEF, UNFPA and World Bank 2012). The recognition of the severity of the problem led to the issue being featured prominently in the Millennium Development Goals (MDGs) introduced in 2000, where countries committed to reducing preventable maternal deaths by three quarters by the end of 2015 (Shiffman and Smith 2007). Concurrently, the inability of traditional public health approaches to adequately address the issue during the previous three decades led concerned scholars and practitioners globally to reconsider the appropriate paradigm to resolve the issue of maternal mortality and morbidity (AbouZahr 2003). Insufficient progress on the issue was

\(^{1}\) Reproductive Justice is understood as “the complete physical, mental, spiritual, political, social and economic well-being of women and girls, based on the full achievement and protection of women’s human rights” (SisterSong 2015). The term “reproductive justice” was originally coined in the United States by feminist activists who identified as “women of color” (Native women, African American, Asian American and such) during the 1980s who were concerned about the limited scope of activism surrounding “reproductive rights” (illegal access to abortion), perceived to be a priority concern for liberal white feminists. It was eventually also adopted by “Southern feminists” (from Global South), following the International Conference on Population Development in Cairo in 1994, where there were tensions between advancing reproductive rights (by Northern feminists) and securing overall reproductive health and wellbeing for women in developing countries. See here: [https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051](https://www.law.berkeley.edu/php-programs/courses/fileDL.php?fID=4051) (Ross, n.d.).

\(^{2}\) Maternal death is “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes” (UNFPA 2014, 4).

\(^{3}\) MMR estimates are often assumed to be conservative estimate because of problems of under-reporting and misclassification of data as well as lack of appropriate official death registry systems in many developing countries (Cook and Dickens 2001; AbouZahr 2003). Furthermore, MMR estimates do not account for maternal morbidity. As Hardee, Gay and Blanc observe, “for every woman who dies of pregnancy-related causes, an estimated 20 women experience acute or chronic morbidity” (2012.1).
attributed to the worth assigned to women’s lives in many societies, poor condition of health systems and lack of political commitment to improving women’s health, thus pointing to its political rather than “medical” nature (Maclean 2010, 10). Progress on maternal mortality reduction or MDG 5 has lagged behind the most (among the eight MDGs) (Right to Maternal Health 2015; Countdown to 2015 MNCH 2016; Yamin and Boulanger 2014). Maternal mortality reduction remains a priority focus (goal 3.1) within the “healthy lives and promote well-being” goal (Sustainable Development Goal or SDG 3) in the post-2015 Development Agenda. This study makes a timely contribution given the transition from the Millennium Development Agenda (2000-2015) to the 2030 Agenda for Sustainable Development, including the renewed emphasis on human rights (especially women’s rights) by scholars, practitioners and the development establishment (United Nation agencies, donors, international and domestic non-governmental organizations or NGOs in the Global South) that was excluded in the former round of development agenda (that is, MDGs) despite its initial prominence in the development discourse during the 1990s (OHCHR 2016; WHO 2016; Sustainable Development Knowledge Platform 2015; Eyben 2004; Hulme 2007/2009; Sen and Durano 2014).

**The Research Problem**

The conceptualization of the “right to maternal health as a human right” is somewhat abstract and ambiguous as the concept encompasses many complex elements and may be exercised unevenly depending on the country context. Evidence of varying scope of the right to health exists at many levels, such as the constitutionally protected rights at the country levels, as well as those guaranteed in international human rights instruments and ratified by many states (Yamin and Maine 1999; Freedman 2001/2005; Gruskin et al. 2008; Yamin 2009; Dasgupta 2010). Similarly, the right to reproductive and maternal health is recognized by the Convention of
the Elimination of All Forms of Discrimination against Women (CEDAW), the Beijing Declaration, and in the formal guarantees of equality granted to women by constitutions in many countries (Cook 1998; Cook and Dickens 2001; Gruskin et al. 2008). Given the abstract, normative and subjective nature of such human rights norms and the varying contextual scope of constitutional guarantees, the lack of systematic study of politics of framing women’s rights to maternal health as a human right suggests a gap in understanding whether and how such a human rights frame may lend a new meaning to the policy problem and the conditions that affect its potential to advance reproductive justice for all women.

This is a significant gap because there are scholarly debates over which rights should women’s rights to maternal health as a human right advance – the right to health and health care, the reproductive self-determination, or both. These stem from competing normative views about the source and nature of the policy problem and disagreements over appropriate policy solutions (Cook 1998; Cook and Dickens 2001; Yamin and Maine 1999; Freedman 2002/5; Gruskin et al. 2008). Framing theorists remind us that different frame preferences among actors are reflective of distinctive agendas and interests and can result in articulation of different normative claims (Stone 2002; Schon and Rein 1994; Fischer 2003; Hawkesworth 2012; Joachim 2003/2007). There may be different “meanings read into” these claims when interpreting and applying the language of rights that can pose challenges for consensus on a new frame among concerned actors and have adverse implications for framing politics and political priority setting (Stone 2002, 235; Ibid.). The causal relationship between frames, successful reframing, political priority setting and effective attainment of policy reform as desired by those initiating framing is complex. It depends on the ability of key actors in the policy discourse to delegitimize the old and hegemonic frame and persuade institutional actors (those with access to power and resources necessary to address the problem) to relinquish it to achieve consensus (frame alignment) on the
new frame with competing norms of the issue. But frame alignment need not lead to political prioritization because of various other reasons, including lack of resources, state capacity and institutional innovation, such as creation or amendment of laws and policies (Ibid.; Benford and Snow 2000; Hawkesworth 1994/2012; Fischer and Gottweis 2012).

This gap is consequential given the growing prominence of human rights in the global and various national maternal health policy discourses (such as in Brazil, Nigeria, Uganda, India, Ethiopia, Mexico, United States, Indonesia, Mali) since the mid-2000s (Hunt and Gray 2013). This has been accompanied by the creation of the Maternal Health Task Force jointly hosted by the Harvard T.H. Chan School of Public Health and Columbia University Mailman School of Public Health and International Initiative on Maternal Mortality and Human Rights (IIMMHR), both of which have been funded and supported by prominent philanthropic and corporate donors such as the MacArthur Foundation and the Bill and Melinda Gates Foundation, among others (see Deleye and Lang 2014). The Centre for Reproductive Rights (CRR), a New York based strategic reproductive rights and a legal advocacy organization with global reach is a member and strategic (non-financial) partner in the IIMMHR (IIMMHR 2009; CRR 2007). As well, evidence of concerned advocates from select countries, such as India, Brazil and Uganda lobbying governments, including using strategic litigation to seek justice for preventable maternal morbidity and mortality has also begun to appear (Dugger 2011; Kaur 2012; Cook 2013; Hunt and Gray 2013). In essence, there are emergent actors, maternal health right advocates, who are leveraging the discursive use of human rights to address maternal health injustices in varied national contexts. But the lack of empirical documentation and analysis to that end limits knowledge of the implications of their framing efforts for political priority setting for the issue in these different contexts.
Beyond the empirical gap in the core literature, there are other related theoretical debates, which also support the rationale for this study. The debates over the scope of women’s rights to maternal health as a human right relate to arguments in global maternal health policy discourse over whether policy solutions should address proximate (biomedical and health system) determinants required to manage complications and prevent untimely death or underlying (social and gendered) determinants that are linked to issues of ill health stemming from women’s secondary status and related constraints, including reproductive self-determination (Sen, George and Iyer 2005; Sen et al. 2007; Gill Pande, and Malhotra 2007; Sen 2011). The aforementioned tensions in turn cannot be completely untied from historical and feminist struggles over linking gender inequality to women’s health outcomes. Historically, efforts to gain political support for women’s health by framing it as a women’s rights issue have witnessed various challenges from political, conservative and religious segments (globally and locally), leading to emergence of competing frames of women’s health in the policy discourse (Rance 1997; Berer 2007).

Conversely, the appearance of ‘reduction of maternal mortality’ in the Millennium Development Goals (MDGs) led some scholars to view the issue as a depoliticized remnant of the struggle to secure political commitment to the more contentious goal of women’s sexual and reproductive health and rights (Fraser 2005; Eyben 2004; Fathalla 2006; Painter 2004/5; Antrobus 2005; Sen and Mukherjee 2014). Yet, some have embraced the separation of the issue from the politically and morally polarizing shadow of women’s sexual and reproductive health and rights; this separation, they maintain, has allowed for a re-focus on the lack of political prioritization and resources for functioning health systems in developing countries, which is key to managing obstetric complications and preventing maternal deaths (Yamin and Maine 1999; Freedman 2001/2002/2003 a/2003 b/2005). Ultimately, this debate embodies struggles over the appropriate structural barriers to eliminate in order to improve maternal health outcomes and/or reduce
preventable maternal deaths. But it is deeply linked to tensions within feminist politics over the maternal and the tricky political terrains women’s health advocates must navigate to uphold the rights of pregnant and parturient women without solely reducing them to mothers.

The strength of the human rights framework, according to development theorists, exists in creating political and social benchmarks to assess the processes and outcomes of development even though its potential to create transformative change (such as improved maternal health outcomes) in practice remains contested (Robinson 2005; Alston 2007; Gready 2008; Archer 2009; Marks 2003; Darrow and Tomas 2005; Hulme 2007/2009). But there are debates over whether human rights and MDGs are complementary, which has implications for holding states accountable to their MDG commitments (made in 2000). These are also significant for using human rights to hold states accountable for adverse maternal health outcomes (Alston 2005, 2007; Schmidt-Traub 2009; Carmona 2009; Cecchini and Notti 2011; Redondo 2009; Hulme 2007, 2009; Nelson 2007; Eyben 2004). Human rights advocates call for greater state action and support in an era of growing neo-liberal reforms and shrinking role of state especially in provision of social welfare, which is seen as paradoxical (Cornwall and Nyamu-Musembi 2004; Fukuda-Parr 2008; Hulme 2007/2009; Nelson and Dorsey 2008). Characteristics of the human rights framework – such as indivisibility and inter-relatedness of various human rights – have

4 This thesis adopts a dual definition of “development”. It believes that development is both a practical project and an idea. First (from a practical perspective), development is understood as “making a better life for everyone” (Peet and Hartwick 2009, 1). In this sense, the minimum and basic requirements for human survival should include safe and sustainable access to food, water, housing, and healthcare. Second, (i.e. development as an idea), it draws from Sen’s (1999) definition of development as “the process of expanding human freedoms” (Ibid., 36) and believes that a broader understanding of development has to account for considerations of how such freedoms (social, political, economic, cultural, religious and so forth) can be available / made available to individuals. The means of achieving this development (as explained here) could widely vary as would be evident from the existence of diverse ideological and practical perspectives in the contemporary discourse surrounding development. This thesis recognizes the importance of “means” but it is also equally concerned with the “end” that these means achieve. In this regard, the thesis is of the opinion that the “end” must constitute fair share of economic, political, human, and social developments. Any one of these, alone, is not sufficient and only when a fair balance between these various kinds of development is established, can true “development” be achieved.
been of particular appeal to maternal health right advocates because of their ability to draw
political attention to the multidimensional nature (gender inequality, poverty, health disparities
and social inequities) of this complex problem (Yamin and Maine 1999; Cook and Dickens 2001;
Freedman 2001/2005). But development theorists warn of the limitations of such a framing
approach for governments who are faced with competing priorities and limited resources in
are likely to have implications for the discursive potential of human rights to advance state
accountability for preventable maternal morbidity and mortality.

Crucially, feminist development theorists have cautioned against the appropriation of the
normative language of human rights by various actors to situate women’s rights (‘women’s rights
are human rights’) – the state and/or the development establishment – to pursue political agendas,
which need not necessarily advance women’s needs and interests (Howard 1995; Molyneux and
Razavi 2003; Cornwall and Molyneux 2006; Gideon 2006; Bradshaw 2006; Rai 2008; Alvarez
1999/2009; Hartcourt 2013). Specifically, they point to various status-quo factors with dubious
impact on progress of women’s rights and question the potential of dominant notions of
development to serve women’s needs and interests. These include: instrumentalization of
women’s rights in development, reduction of rights claiming to economically efficient
transactions (pre-negotiated set of claims and entitlements as opposed to status-quo arrived
through continuously evolving political contestation), institutionalization of feminist demands by
the state (through gender mainstreaming) and NGO-ization of feminist movements (Ibid.). These

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5 Instrumentalizing is understood as implying a superficial subscription to conceptions of “women’s issues” and
gender equality, which supports (and fits with) the logic of status-quo economic growth models rather than consider
alternatives that require radical restructuring of political economy of development. It reveals the ways the logic of
the dominant conception of development has viewed (and supported) women’s needs and interests in relation to
sustaining and/or advancing the development status quo, rather than paying attention to “women’s issues” because
they are deserving of attention in their own right.
are potentially consequential to the examination of whether and how women’s rights to maternal health framed as human rights might serve women’s needs and interests.

Additionally, there are also concerns over the tendency of human rights language to universalize and essentialize all women without recognizing the differences within and different (reproductive) needs and interests among women from diverse backgrounds (Toyo 2006; Molyneux 2007; Win 2007; Cornwall, Harrison and Whitehead 2007). This is likely to have implications for what ought to be claims within the scope of women’s rights to maternal health as a human right in a given socio-political and cultural context. To prevent these differences from polarizing the discourse over reproductive choice and rights and constraining the advancement of a feminist agenda, some feminist scholars have proposed the frame of reproductive justice and argued that it must be framed/contextualized in the language of women’s (secondary and unequal) gender and (inequitable) social citizenship rights and status (Ross 2004; see also Repo 2015). Citizenship rights are defined as rights and obligations held by an individual by virtue of membership in a political community (Lister 1997; Yuval-Davis 1997). Citizenship rights are also less homogenizing (unlike human rights) and more attentive to differences within, such as identity-based differences (class, caste, race, ethnicity, religion and such), that can determine varying access to (or not) health and welfare services (Johnson 2009/2014; Hankivsky 2012; Sen and Ostlin 2011).

Additionally, proponents of the citizenship frame cite the lack of substantive equality enjoyed by women in the family, community and the state in many developing countries, despite the formal recognition of their equal status in the constitutions and laws of many states (Goetz 2007; Kapur 2007; Mukhopadhyay and Singh 2007; George, Iyer and Sen 2005; Cornwall and Molyneux 2006). The citizenship perspective reveals the contested nature of rights actualization and contends that policies accompanying women’s rights to maternal health as human rights must
be able to accommodate varying and dynamic conceptions (that is, active citizenship) of the heterogeneity of women’s needs and interests, depending on the given characteristics of specific sites of power struggle (Mukhopadhyay 2003; Goetz 2007). Such a way of framing women’s rights helps to reveal (and collapse) the various structural (state, economy, society, family) barriers facing some women that prevent them from equally exercising their rights, in private and public spheres of their lives. However, the lack of theorization of the politics of framing women’s rights to maternal health as a human right provides for an incomplete understanding of how such frames are designed and their potential to alter political priority for the policy problem to advance reproductive justice for all women. This constitutes a significant knowledge gap. This study contributes to filling this gap.

Global Politics of Framing Women’s Rights to Maternal Health

This section reviews the evolution of the various frames (“safe motherhood”, “sexual and reproductive health”, “sexual and reproductive health and rights”, and “health disadvantage”) used to frame women’s health by concerned advocates from mid-1980s until 2000. The discussion demonstrates that none of these frames individually captures the entire complexity of the actual problem, and are selectively inclusive of the range of factors that contribute to maternal morbidity and mortality. Effectively, this is telling of the distinct nature of the policy problem at hand, one that framing theorists have characterized as an “intractable policy controversy”, a policy problem which cannot simply be resolved by appealing to facts and reflects lack of discursive consensus on the origin and nature of the problem and hence, appropriate solutions (Schon and Rein 1994, 4; Fischer 2003; Hawkesworth 1994/2012).

From “Maternal and Child Health” (Pre-1985) to “Safe Motherhood” (1987)
Preventable maternal deaths have not always been framed as human rights violations. Their inception as a human rights injustice is the product of a carefully-crafted historical and global struggle by women’s health advocates to seek the political commitment and resources appropriate to address the issue without reducing the policy focus on women’s health to exclusively maternal dimensions of women’s lives.

Throughout the 1970s and early 1980s, policy focus on pregnant and parturient women was maintained in relation to the consequences of maternal ill-health for neonatal and child health, leading to programs framed as maternal and child health (MCH) with an emphasis on the natal. However, this changed in 1985 following the first-ever publication of worldwide annual maternal death estimations. Based on a review of several studies offering primary data collected from more than 60 countries (the majority from developing countries) in early 1980s, WHO and UNFPA estimated the annual global maternal death rate to be 500,000 maternal deaths. This was followed by a high profile publication in The Lancet, which argued that attention to maternal health issues, as part of maternal and child health programs were hardly adequate and comparable to the heightened focus (and resource allocation) on child health (AbouZahr 2003). The massive expansion of child health programs at the national level was reflective of a trend of “focusing social policy efforts on reinvesting in (deserving) children” rather than mothers who were considered adults and therefore in charge of their “own actions and mediat[ion] of the consequences of adversity with individual, familial or community resources” (Johnson and Das 2014, 121). This led to creation of the Safe Motherhood Initiative (SMI) by the WHO in collaboration with UN Agencies in 1987. The policy agenda within SMI was heavily technical in

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7 The underreporting and misclassification of maternal deaths caused by unsafe abortion suggests that this might actually be a conservative estimate.
nature, primarily focusing on biomedical interventions\(^8\) or proximate determinants of maternal health outcomes (Shiffman and Smith 2007). Arguably, these were useful to quickly detect and treat complications (Paxton, Maine Freedman, Fry and Lobis 2005; Campbell and Graham 2006; Ronsman and Graham 2006). However, these policy interventions were perceived to be excessively medicalized and ignored root causes such as social and gendered determinants which recognized pre-existing conditions and health vulnerabilities that were known to influence incidences of obstetric complications as well as access to health services (Sen et al. 2007).

The SMI was heavily criticized by women’s health advocates who viewed it as implicitly equating (and reducing) women’s health to maternal health, merely one dimension of women’s lives. Its creation was considered a strategy to exclude the more politically contentious issue of women’s sexual and reproductive health (SRH) needs and rights from policy agendas (Maine and Rosenfield 1999). As Rance noted: “The naming of a programme such as Safe Motherhood is more than a matter of political convenience. Rather, it is an ideological statement, which constructs women as mothers, who deserve protection and safety only as such” (1997, 11). A full range of sexual and reproductive health services, including access to contraception and family planning education (as well as post-abortion care), has been considered to be an important indication of the extent of maternal morbidity and mortality in a given society. This is because of the ability of these measures to prevent unwanted and teen pregnancies, allow birth spacing, and protect women’s sexual health (Fraser 2005; Ronsman and Graham 2006; Campbell and Graham 2006; Berer 2007).

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*From “Safe Motherhood” to “Sexual and Reproductive Health and Rights” (1994)*

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\(^8\) Such as emergency obstetric care (EmOC), mandatory presence of skilled birth attendance, dissemination of iron tablets (to treat anemia), ante-natal and post-natal care.
In response to the SMI women’s health advocates launched a call for situating Safe Motherhood in the broader context of reproductive health at the fifth International Women and Health Meeting in Costa Rica in 1988 (Ravindran and Berer 2000). However, reproductive health services in developing countries were narrowly constructed to mean family planning services. This peculiar policy focus was tied to concerns of overpopulation and implications for development and the world economy (for both poor and rich countries). Women’s health advocates were therefore committed to raising awareness about investing in the overall health of women and girls (and not simply safe motherhood or family planning). This momentum was carried forward to the International Conference on Population and Development (ICPD) held in Cairo in 1994. Following much transnational activism, women’s health advocates were able to generate consensus at Cairo among participants (including states) on investing in women and girls as a whole (including their health) by pointing to ways overall improvement in status of women was connected to corresponding fertility decline in many industrialized countries. This constituted a watershed moment in the global women’s health movement because the right to sexual and reproductive health came to be framed as a fundamental human right, which allowed advocacy for comprehensive sexual and reproductive health services (including recognition of “reproductive rights” and ethical approaches to family planning, as opposed to coercive population control policies that disproportionately targeted women) considered crucial to improving maternal health outcomes (a subset of reproductive health outcomes) (Roseman and Reichenbach 2010). Additionally, ICPD emphasized the need for “forward looking strategies” for improving women’s health including reduction of maternal deaths by 2000 (Ravindran and Berer 2000).

Despite the transformative reproductive rights agenda adopted at ICPD in 1994 and the gender equality agenda adopted at Beijing in 1995, the challenge to the ‘sexual and reproductive
health rights as human right’ frame arose from conservative and religious alliances over the contentious topic of access to safe and legal abortion. Approximately 13 percent of global maternal deaths are caused by unsafe abortions (Campbell and Graham 2006). 9 Contrary to conservative and religious advocates’ accusations which highlight the physical (and the more contested emotional and spiritual) risks to women’s health from abortion, public health and medical practitioners argue that it is complications (particularly untreated infection) arising from unsafe abortion and lack of post-abortion care that chiefly contribute to a woman’s ill-health and possible death (Ronsman and Graham 2006). Especially, poor women are most adversely affected by lack of access to safe and legal abortion because of their inability to pay for expensive but illicitly available medical abortion (Rance 1997)10. But locating reduction of maternal deaths within sexual and reproductive health and rights was seen as a “Trojan Horse” for securing access to legal abortion (Abou Zahr 2003, 18). This led to fragmentation within donor commitments (due to domestic political pressure, such as in the United States and Japan) and ambivalence toward women’s reproductive health among governments in developing countries (Ibid.; Eyben 2004; Chappell 2000/2006).

Return to “Reduction of Maternal Mortality” at the Millennium Summit (2000)

At the Copenhagen Social Summit11 held six months after the Beijing Conference (Eyben 2004), this conservative opposition led to the formulation of an agenda, which focused on

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9 The underreporting and misclassification of maternal deaths caused by unsafe abortion suggests that this might actually be a conservative estimate.

10 For example, even where access to medical abortion is legally guaranteed (such as in India), women often have to secure a second medical opinion and permission from male partners or family members to be able to undergo an abortion (Jejeebhoy, Zavier, and Kalyanwala 2010, 26).

11 Both the Beijing Declaration and the Social Summit in Copenhagen were held in 1995, six months apart from each other but the agenda pursued at each of these UN conferences was somewhat distinct. The Beijing Declaration pursued a more transformative agenda because it had witnessed historical engagement from the International
comparatively less politically polarizing gender issues. The focus on *reduction of maternal mortality* replaced the earlier emphasis on women’s sexual and reproductive health and rights endorsed by states, which would also feature in the agenda of Millennium Summit\(^\text{12}\) later in 2000 (and be codified as the fifth MDG). Many states present at the Copenhagen Summit were wary of the impact of a more transformative agenda on their domestic policy\(^\text{13}\). As well, the lack of political commitment to a more transformative gender equality agenda largely led to overlooking (perhaps deliberately) the call for augmented support for reproductive health services, since the health system infrastructure necessary to support such services could only be made possible through government intervention.

De-coupling maternal health outcomes from the women’s sexual and reproductive health and rights as human rights frame was seen to undermine women’s “agency and empowerment and pay insufficient attention to vulnerable groups” (Fraser 2005, 41). Consequently, considerations for the ways unequal power relations shaped women’s health and access to health care, whether in the public or private sphere, were sidelined. But perhaps this was not surprising. The recognition of women’s rights as human rights is a political claim and therefore not identical

\(^{12}\) The initial millennium development goal (MDG) of maternal mortality reduction did not include a scaling up of access to sexual and reproductive health services. Only after untiring efforts of women’s rights advocates, a second goal (i.e. 5b) of universal access to reproductive health services was included in 2008. Albeit, this was at the reluctance of states, which was often reflected in their negligence to live up to the commitment in practice (Shaw and Cooke 2012). Women Deliver, a coalition of civil society organizations working to improve maternal health worldwide report that MDG 5b has been “the most off-track of all MDGs” (n.d.) and the official website of MDG hosted by the UN observes “official development assistance for reproductive health care and family planning remains low” indicating the negligible change in the political priority attached to the role of reproductive health services in preventing maternal deaths (2014).

\(^{13}\) These efforts were further championed by a Vatican led Conservative Coalition that had already begun to form in response to the growing prominence of the International Women’s Movement and the victories the movement had had at Cairo and at Beijing. Chappell (2006) has pointed to the formation of this alliance as “a very loosely structured transnational conservative patriarchal network” which leveraged (and continued to do so until date) its collective strength and allies within governments of both rich and poor countries to counter the agenda pursued by women’s rights advocates.
to the more technical (and economically motivated) task of “integrating women into development”, which is how the MDGs came to be viewed by many feminists (Howard 1995, 301; Kabeer 2003/2006; Cornwall and Nyamu-Musembi 2006). The latter denotes nominal subscription to making development more inclusive for women. Essentially, women’s reproductive and maternal labor is construed as a “development priority/goal” for its instrumental benefits (healthy mother = healthy children, family and nation) to national (economic) interests (see Yamin and Boulanger 2013).

Right to Maternal Health as a Human Right: The “Argumentative Turn”14

The narrow and depoliticized focus by donors and governments of developing countries on the maternal dimensions of women’s health beginning in 1995 at the Copenhagen Social Summit excluded other equally important dimensions of women’s health and lives. It undermined the earlier victories (namely, ICPD and Beijing Declaration) achieved by women’s health advocates where they had been able to locate adverse women’s health outcomes to the unequal social status of women and lack of respect and fulfillment of women’s rights despite equal recognition (constitutional and human rights). The possibility of using a human rights approach was first discussed at the Safe Motherhood Technical Consultation held in Colombo, Sri Lanka in 1997. This was symbolic because MMR in Sri Lanka had declined from 1500 deaths in 1940-45 to less than 70 deaths in 1980-85, which was attributed to the government’s “historical emphasis on meeting the basic needs of its population in the areas of infrastructure, health and education as well as relatively high status of women in society” (Starrs and IAG-SMI 1997, 8). The technical consultation’s aim was to mobilize financial and political support for the interventions required to

14 This phrase has been borrowed from the title of The Argumentative Turn in Policy Analysis and Planning co-authored by Frank Fischer and John Forester (1993).
allow women to go through pregnancy and childbirth safely (Ibid., 7). The goal was to frame preventable maternal deaths as a matter of “social justice” and “health disadvantage” to “address the causes of poor maternal health through their political, health and legal systems” (Ibid., 9). Professor Rebecca Cook of the University of Toronto’s Faculty of Law argued during her presentation (in Sri Lanka) that constructing maternal morbidity and mortality as human rights violations offered the opportunity to shed light on

“Women’s multiple disempowerments not just during pregnancy and childbirth but from their own births as a cumulative injustice that societies are obligated to remedy. The recharacterization of maternal mortality from a health disadvantage to a social injustice places governments under a legal obligation to remedy an injustice” (as quoted in Starr 1997, 9; emphasis added).

The opportunity to do this in practice, Cook argued, arose from various constitutional promises made at the national level and international human rights treaties (mentioned earlier) ratified by governments. This view was endorsed by international health agencies, such as WHO, UNICEF and UNFPA (Starr 1997). There were four main categories of rights that were identified as central to the notion of “human rights relating to safe motherhood”. These included: 1) “Rights relating to life, liberty and security of the person”; 2) “Rights relating to foundation of families and of family life”; 3) “Rights relating to the highest attainable standard of health and the benefits of scientific progress, including to health information and education”; and 4) “Rights relating to equality and non-discrimination on grounds such as sex, marital status, race, age and class” (Ibid., 9). Furthermore, the two main goals in translating the human rights concepts relating to safe motherhood in practice, would be to lobby governments to “offer effective preventive and curative services to reduce maternal mortality” and “protecting women’s right to make and act on
decisions about their own reproductive health, free from coercion or violence, and based on full information” (Ibid., 10). Therefore, lobby efforts surrounding safe motherhood and human rights would encompass a collective focus on a comprehensive range of sexual and reproductive health services (preventive dimension), improvement of health system infrastructure (curative dimension), enabling women’s reproductive autonomy and overall agency (Ibid.; Gruskin et al. 2008). That is, the human rights frame would be employed to collapse the distinction between proximate determinants (bio-medical and health systems) and underlying determinants (gender and social inequalities) mentioned earlier.

Effectively, the construction of the ‘right to maternal health as a human right’ symbolized efforts by women’s health advocates to leverage the opportunities presented by normative diffusion of “maternal mortality reduction” as global development priority to re-politicize the issue. It constituted attempts to engineer a discursive shift in the hope of securing political and resource commitment, one that would involve re-interpreting the scope of the issue (reduction of maternal mortality) by using the normative language contained in constitutional promises and global human rights guarantees ratified by governments.

**A Note on Definitions: Maternal Health vs. Reproductive Health**

The World Health Organization (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO 2011a). Within the broader context of health, WHO defines maternal health as “the health of women during pregnancy, childbirth and the postpartum period” (WHO 2011). Maternal health is a tricky term to define, largely because of the various debates that exist among scholars, practitioners and policy makers about the difference between “maternal health” and women’s sexual and reproductive health. Sexual and reproductive health is defined by WHO as “people [being] able
to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so” (WHO 2011). Further, this implicitly includes the “right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant” (WHO 2011; emphasis added).

Despite the “official” existence of two separate terms, maternal health and sexual and reproductive health are not mutually exclusive in practice. Maternal health is directly and/or indirectly an outcome of the sexual and reproductive health care and choices available to a woman (and to some extent her male partner). The two concepts, therefore, cannot be treated so distinctively; maternal health may be understood as a sub-set of sexual and reproductive health. Hence, this study adopts WHO’s definition of maternal health as it is; but it recognizes that women’s “sexual and reproductive health” is a key determinant of her “maternal health” and therefore cannot be entirely isolated from it15.

That said, the distinction between the terms becomes tricky when one considers the role of safe abortion care and its moral and political considerations in relation to women’s health. Safe abortion care is understood as central to essential reproductive health services but may not be viewed similarly in case of maternal health depending on whether “maternal” is applied to state

15 Furthermore, there is a debate among scholars whether the human right framing of “right to Maternal Health” and the human right framing of “Maternal Mortality” are one and the same primarily because of the distinct connotations (see Johnson and Das 2014). The latter is understood more as “Right to Maternal Survival” (or Right to surviving pregnancy) whereas the former “Right to Maternal Health” is a much broader expression in scope encompassing pre- and post-natal outcomes, neo-natal outcomes and a woman’s overall health outcomes. This will be further explored in the empirical findings in this dissertation. Unless specifically mentioned, “maternal health” or “right to maternal health” will be used throughout this document to refer to both connotations (maternal mortality as well as the broader scope of the term “maternal health”).
of pregnancy and/or childbirth (essentially, carrying the fetus to term). The complexities arising from inclusion/exclusion of access to safe abortion in maternal health policy have already been discussed in great detail earlier in this chapter. The study does not make a value judgment on this issue. Rather it highlights, as and where applicable, the tensions that emerge on this point, both in the existing literature and in the empirical findings.

**Research Questions**

The purpose of this study is to explore the potential of normative policy frames, such as human rights frames of maternal health, to affect political priority surrounding maternal morbidity and mortality and advance reproductive justice for all women. Specifically, the study examines the ways in which the discursive use of human rights to frame preventable maternal morbidity and mortality can add new meaning to the policy problem to secure the political commitment and resources necessary to address the problem. To that end, the research questions guiding this study are:

**How does framing preventable maternal morbidity and mortality as human rights injustices affect political priority surrounding the policy problem? Is it able to create necessary political commitment and resources to advance reproductive justice for all women? What does this reveal about the potential of normative policy frames, such as human rights frames, to advance development outcomes?**

In developing a response to the above research questions, a further set of sub-questions has been designed. These are:

1) What are the political dimensions of using human rights to claim accountability for maternal health?
2) What conditions affect concerned actors’ ability to mobilize political support for advancing reproductive justice?

3) How do concerned actors frame maternal morbidity and mortality as human rights injustices to affect political priority for the policy problem?

4) How does state recognition of preventable maternal morbidity and mortality as violations of human rights help generate the political priority for the policy problem?

**Rationale for Case Selection**

This research used India as its country case study. There were five main reasons behind this selection. First, India alone contributes to 17 percent of total global maternal deaths per year and is the leading contributor to preventable maternal deaths worldwide. This is significant especially in comparison to other middle-income countries, including neighbors such as China, Sri Lanka, Nepal and to some extent Bangladesh (WHO, UNICEF, UNFPA and World Bank 2012: 1; UNFPA 2014). The maternal mortality estimation inter-agency group’s records indicate a total of 50,000 maternal deaths in India in 2013\(^{16}\). According to the World Health Organization (WHO), the MMR in India in 2013 was 190, a decline since 2005-2009 when MMR was 220 (2015). As early as 2011, studies had begun to warn that India will not be able to meet the MDG 5 target (national MMR of less than 100 deaths per 100,000 live births), which was subsequently confirmed in the year 2015 (Chatterjee and Paily 2011; Balrajan et al. 2011; UN India Country Team 2015). However, there were also wide disparities in state-specific MMRs, which have been

\(^{16}\) Both these estimations draw upon the Registrar General of India (RGI)’s records, which are considered conservative estimates because of misclassification and underreporting of maternal deaths as well as due to an institutional culture of target oriented maternal mortality reduction (hence possibly under-recording of deaths due to lack of maternal death audit). For example, in 2009 the RGI indicated the national MMR to be 212 per 100,000 live births, when Indian Institute of Population Sciences (2010) estimated this figure to be in range of 325-350 whereas UNDP figures stood at 450 per 100,000 live births. This may also be telling of the difficulties in recording and counting deaths in general, especially in developing countries.
primarily linked to women’s social status, levels of economic development and condition of the health system, social hierarchy and poverty in different states. For example, states such as Kerala and Tamil Nadu (both with well performing health system, comparatively more gender-equal societies, and lower levels of poverty) indicated a MMR of slightly below 100 and had already achieved MDG targets while Assam, India’s “most maternal death prone state” recorded a MMR of 390, much higher than national average (Press Information Bureau, MoHFW 2014). Further, one study revealed that cost of childbirth (maternal health care expenditures) in India was US$ 9.5, 24.7 and 104.3 for birth at home, in a public facility, and in a private facility respectively, pointing to the disparities in economic access to maternal health care. More specifically, 51 percent of households incurred maternal expenditures of “more than 40% of household ‘capacity to pay’” indicating the substantial household economic burden of pregnancy and childbirth (Bonu, Bhusan, Rani and Anderson 2009, 445). In sum, the nature and extent of maternal morbidity and mortality in India were uncharacteristic for the levels of economic growth and development the country had achieved, suggesting that the policy problem had a political dimension to it, rather than being purely a medical coincident (MacLean 2010).

Second, maternal mortality reduction had never been a priority concern in the health policy agenda in India and was largely overshadowed by the historical focus on family planning and population control (Narayanan 2011; Mukherjee 2002). However, this changed following the Millennium Declaration in 2000 (Shiffman and Ved 2007). In 2005, the Government of India (GoI or henceforth, the Union or Central Government\textsuperscript{17}) created the National Rural Health

\textsuperscript{17} Please note that the terms Central Government and State Governments (to refer to sub-national units) are generally used in popular and official discourse. However, in referring to ministries at the Central Government level, the term Union is also employed in legal and official documents – such as Union Ministry of Health and Family Welfare or the Union (meaning the Central Government as a whole). Additionally, the terms Centre-State are used to referred to the Central-State Government relationship. In writing this dissertation, when the term “state” as in a political entity needs to be used, the researcher has used the term “sub-national authority/unit” to refer to a/the State Government.
Mission (NRHM), an autonomous health agency, under the auspicious of Union Ministry of Health and Family Welfare (MoHFW). It further established the Janani Suraksha Yojna (JSY), NRHM’s flagship public health program and a conditional cash transfer (CCT) program to incentivize women to give birth at formal health care facilities (Vora et al. 2009). This political commitment and resource allocation, accompanied by institutional innovation was encouraging and the first ever of its kind in decades since the systematic underfunding of public health sector beginning in the 1980s (Baru 2002; Qadeer 2005a; Shiffman 2007; Balrajan et al. 2011).

However, the design of JSY attracted a lot of criticism from scholars and practitioners alike. The most conspicuous ones pertained to the bio-medical and technical design of policy interventions and the dilapidated nature of public health systems which made it difficult to actualize the nature of policy promises made by the government (Sethuraman and Duvvury 2007; Vora et al. 2009; Sri B and Khanna 2012; Gaitonde and Shukla 2012; Gautham 2010). Other important criticisms included insensitivity to needs and interests of pregnant and parturient women and lack of consideration of underlying determinants (gendered and social factors) of maternal health outcomes (Qadeer 2005a; Lingam and Yellamananchilli 2011; Gopichandran and Chetlapalli 2012; Dasgupta 2011). These criticisms were also articulated by Paul Hunt, the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (hence forth, Special Rapporteur), who undertook a two-week long official country visit to India in 2007 (the only country visit to-date on maternal mortality). The Special Rapporteur focused on a range of issues surrounding (financing, range of reproductive health services, legislative framework, health system accountability to name a few) maternal mortality and submitted a report to the UNHCHR. The report was discussed in 2010\(^\text{18}\) at the 14\(^{\text{th}}\) General

\(^{18}\) Hunt’s tenure ended in 2008 and was followed by Anand Grover, an Indian national and a senior advocate in
Assembly Meeting of UNHCHR and described India’s case as “shocking”, especially as a middle-income country. The report maintained: “There is a yawning gulf between India’s commendable maternal mortality policies and their urgent, focused, sustained, systematic and effective implementation. For the most part, maternal mortality reduction is still not a priority in India …” (Hunt 2010, 2). It recommended using a “right-to-health approach to maternal mortality” and provided several recommendations to improve the state of the health system (although it did not speak to any gender concerns) (Ibid., 5-6). In sum, even though some political commitment and resources had been allocated by the Central Government to the policy problem, these were seen as largely inadequate to truly address the problem. This revealed concerns about the nature and extent of political priority attached to the problem, including recommendations for using a human rights approach to change the status-quo which fit with the scope and purpose of this study.

Third, India has had a history of multi-decade spanning feminist health activism born in late 1970s in response to government’s coercive family planning policies for reasons of population stabilization (Mukherjee 2002; Narayanan 2011). Indian activists were very active through transnational feminist networks in influencing outcomes at UN Conferences and intergovernmental meetings (in ICPD in Cairo in 1994 and Beijing Declaration in 1995). They used these events as political opportunities to re-frame domestic debates over ethical approaches to family planning, reproductive choice and women’s bodily autonomy. Symbolic and political success, as some have argued, was achieved with the creation of the National Population Policy (NPP) in 2000. The NPP recognized the historical and misplaced burden of family planning on women alone (in practice) (Sarojini and Murthy 2005; Qadeer 2002/2005b; Sen and Iyer 2002).
It chose to do away with target-based approaches to family planning that had come to embody the hegemonic conception of women’s health by the Union MoHFW for over forty years. However, there was evidence to suggest that access to maternity benefit schemes created post-2005 (such as aforementioned CCT program) continued to be tied to number of pregnancies and/or live-births women had had especially in high fertility states of Northern and Central India (Rao 2008; Agrawal 2009; Narayanan 2011). There was also evidence of Central Government encouraged and state government led sterilization drives focused exclusively on women in some states, which offered financial incentive to male partners and other family members (parents-in-law) who would often cajole women into seeking sterilization operations (Agrawal 2009; Narayanan 2011; CEHAT 2013; MacAskill 2013; Uppal 2013). Hence, the political promises contained in NPP about ethical and gender sensitive approaches to family planning were largely rhetorical and had not materialized evenly across states. This pointed to a complex relationship between maternal health and family planning politics (and by extension politics of reproductive health and choice/rights) rooted in history. Consequently, it also spoke to likely discursive challenges in articulating a human right to maternal health without navigating the difficult terrain of politics of reproductive choice and rights in the domestic context. The growing complexity of articulation of reproductive choice and rights and fissures within the women’s health movement had been underscored sporadically in the scholarly literature emerging from India at various points during the 2000s but it had not been systematically studied (Mukherjee 2002; John 2008/2012; Narayanan 2011; Qadeer 2005).

Fourth, preliminary scoping activities (online research and a field trip in January-February, 2012) revealed that there were several regional (spanning multiple states) coalitions and/or alliances of maternal health NGOs in India. These were loosely-formed collectives of largely domestic NGOs (but also included a few international NGOs), who claimed to view
preventable maternal morbidity and mortality as human rights injustices and identified as groups working on maternal health from a “human right-based approach”. Nearly all of them were being funded by the Chicago-based John D and Catherine T MacArthur Foundation, a prominent philanthropic donor in the reproductive health sector with decades of presence in India. The coalitions were created at different points in time. Some were entirely indigenous in origin while others were founded as national chapters of global networks but were led and established by Indian women’s health advocates (NAMMHR n.d.; CommonHealth 2014; Sri B and Khanna 2012; Dasgupta 2011; Motihar and Gogoi 2009). For example, a national chapter of International Initiative for Maternal Mortality and Human Rights (IIMMHR) was created in 2008 based out of New Delhi, which came to be recognized as the National Alliance for Maternal Mortality and Human Rights (NAMMHR). Select members of leadership of NAMMHR’s steering committee were also founding members of the IIMMHR in 2007. NAMMHR was a coalition of individuals and member organizations working on maternal mortality in different Indian states. Other coalitions included CommonHealth or The Coalition for Maternal-Neonatal Health and Safe Abortion (CommonHealth) coordinated from Mumbai (created in 2006) and White Ribbon Alliance for Safe Motherhood (WRAI) coordinated from New Delhi (created in 1999). These coalitions strategized and lobbied the Central and State Governments collectively, even though their member organization functioned in diverse sub-national contexts. Their contextual realities were characterized by 1) widely varying levels of MMR; 2) varying levels of economic development and health system capacity; 3) different levels of poverty; 4) diverse socio-political peculiarities related to women’s health and social status (surrounding education, fertility rates, child marriage, sex-selection and so forth) with distinct implications for maternal health outcomes; and 5) different levels of social hierarchy, particularly social identity-based (caste, tribe and religion) discrimination. These diversities presented an interesting empirical
opportunity to examine and compare the ways these maternal health and human rights advocacy coalitions and their member organizations were designing and using human rights frames in varying intra-country context (but under the same policy framework designed, introduced and funded by the Centre) to alter political priority surrounding the issue.

Finally, in a historic development in a public interest litigation (PIL) case (in two consolidated petitions) in 2010, an Indian High Court (specifically, the Delhi High Court) delivered a landmark judgment recognizing that preventable maternal morbidity and mortality were violations of human rights. PILs were developed in India during the late 1970s and 1980s following a series of verdicts provided by the Indian Supreme Court whose objective was to “promote and vindicate public interest[,] which demands that violations of constitutional or legal rights of large number of people who are poor, ignorant or in a socially or economically disadvantaged position should not go unnoticed and unredressed.” The Supreme Court observed that a “right without a remedy is a legal conundrum of a most grotesque kind,” and declared itself legally and constitutionally obligated to create a system that allowed common citizens to seek remedy in case of violations of their fundamental rights (Sood 2006: 837-8).

The judgment in the Delhi High Court case drew upon both domestic constitutional protocol and international human rights instruments and was considered the first ever declarations of its type at the country level (ESCR-NET CaseLaw Database 2011; CRR 2011; The Guardian 2011; WHO 2010; UNHCHR 2011). This state recognition, by the judiciary, of preventable maternal morbidity and mortality as human rights issues was a major impetus behind undertaking this study since the recognition of a new right (or possibly re-interpretation and expansion of an existing guarantee) had the potential to affect the maternal health and human right discourse within India and globally. After all, the significance of law and courts to advance state accountability for maternal deaths had been underscored by scholars, but the absence of a
favorable judgment (at the country level) meant there could be little empirical study (Cook and Dickens 2001; Freedman 2005; Gruskin et al. 2008; Yamin 2010/2013; Hunt and Bueno de Mesquita 2011). The details of the case are provided below.

**The Delhi High Court Case**

In early 2008, a Delhi-based public interest litigation organization (PILO), the Human Rights Law Network (HRLN), filed a petition in a public interest litigation (PIL) case (W.P.(C) 8853/2008) in the Delhi High Court (or the Court) on behalf of Mrs. Laxmi Mandal, the sister of the deceased Mrs. Shanti Devi. The petition highlighted “deficiencies in the implementation of a cluster of schemes, funded by the Government of India, which were meant to reduce infant and maternal mortality” (Justice Muralidhar 2010, 2). Specifically, the petition took issue with the “systemic failure resulting in denial of benefits” to the deceased (Shanti Devi), who belonged to Scheduled Caste and the Below Poverty Line (BPL) group, during pregnancy and in the immediate aftermath of childbirth. Similarly, in 2009 HRLN again filed a second petition (W.P.(C) 107900/2009) on behalf of Jaitun whose daughter Fatema, a poor, Muslim, homeless woman suffering from epilepsy, gave birth under a tree because she was denied admission into a Municipal Corporation of Delhi (MCD) owned maternity home. Prior to giving birth, Fatema Begum had approached the hospital authorities with questions about vaccination and access to fully publicly subsidized benefit schemes for BPL group to which she belonged but was denied access to such entitlements. Fatima Begum’s mother was also turned away when she approached the authorities enquiring about various schemes that offered nutritional, health check-ups, or financial assistance to parturient women and newborn children. At the time of the filing of the petition three months after Fatema Begum had given birth, she was still struggling with ill health and inability to feed (breast feed or purchase milk) her child.
Additionally, HRLN was supported by MacArthur Foundation through funding and New York-based Centre for Reproductive Rights (CRR) for non-monetary strategic advice. It constituted the first in series of court cases (ongoing at the time of field research in 2012-13) undertaken by HRLN as part of its strategy to hold the state legally accountable for preventable maternal morbidity and mortality. The CRR is also a member of the IIMMHR and funded by the MacArthur Foundation for its activities in the United States and abroad, according to its annual reports (from 2006 onwards) available on its website (CRR 2013).

The defendants in the cases were the Central Government of India (the Union) and the State Governments of Haryana and the National Capital Territory (NCT) of Delhi (ESCR CaseLaw Database 2010). Both petitions “concern[ed] the right to maternal health for urban poor women, focusing specifically on the government’s failure to ensure that pregnant women are able to access essential services and entitlements guaranteed under government benefit schemes, including the National Maternity Benefit Scheme (NMBS), the Janani Suraksha Yojna (JSY), the National Family Benefit Scheme (NFBS), the Integrated Child Development Scheme (ICDS), and the Antyodaya Anna Yojana (AAY)” (CRR 2011, 17). Further, they shed light on multiple violations – including, denial of essential life-saving care, Central Government promised benefit schemes, access to health care facilities, discrimination and lack of institutional capacity to provide essential health care.

The Court concluded that the defendants in the case were in violation of two critical “survival rights” guaranteed by Article 21 of the Indian Constitution which protected the right to life and consequently the rights to health care and the right to food. It also observed that all of these rights were “interrelated and indivisible and emphasized that the lack of effective implementation of health and nutrition schemes essentially creates a denial of the right to life” (Justice Muralidhar, Delhi High Court 2010, 3). Additionally, it highlighted that as signatories to
the UDHR, the CEDAW, the ICESCR and the Beijing Declaration – all of which recognize special care and protection for women during pregnancy and immediately after childbirth – the Central Government had failed to live up to its international legal commitments (Ibid.). The failure to uphold constitutional obligations was recognized by the Court under the judicially-recognized right to health (interpreted in an earlier Supreme Court verdict based on its links to explicitly protected ‘right to life, liberty and security’, Article 21 of the Indian Constitution). In the verdict issued in both cases, the Court recognized:

“Denial of maternal healthcare is a violation of fundamental constitutional and human rights. Justice Muralidhhar emphasized that the Indian Government is obligated to ensure maternal health services under the judicially-recognized constitutional rights to health and reproductive rights as well as under its international legal commitments, citing the Universal Declaration of Human Rights and the Convention on the Elimination of All Forms of Discrimination Against Women, as well as the International Covenant on Economic, Social, and Cultural Rights and General Comment 14 issued by the Committee on Economic, Social and Cultural Rights” (CRR 2011, 17; emphasis added).

Furthermore, during the proceedings in the Court it was revealed that the Central Government sponsored schemes of JSY and NMBS\(^1\) were not made available to the impoverished mothers. The reason cited for this denial was that Shanti Devi already had two children (although four pregnancies) and use of benefit schemes on her part would be in direct conflict with the Central Government’s efforts and larger goal to promote family planning in

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\(^1\) Both these schemes are co-sponsored by the states (sub-national) and the Union. JSY integrates fixed amount cash schemes with delivery and post-delivery care through Accredited Social Health Activists (ASHA) who work as Auxiliary Nurse Midwives (ANM) and are co-supervised by a medical officer i.e. a doctor. Cash assistance in High Performing States (8 states in India, Haryana, Rajasthan, Madhya Pradesh, Uttar Pradesh, Bihar, Jharkhand, Chhattisgarh and Orissa with the worst social development indicators) is limited to two births per mother during the delivery / immediately after, provided she is able to present proof of eligibility. The NMBS on the other hand provides fixed amount cash assistance to pregnant women as a form of social security. JSY and NMBS are independent schemes that any eligible pregnant mother can avail of. To clear the confusion, in 2007 Supreme Court of India in the People’s Union of Civil Liberties (PUCL) case against the Central and the State governments directed that all below poverty line (BPL) women will continue to receive the NMBS benefit “irrespective of the number of children and the age of the woman” (Justice Muralidharan of Delhi High Court quoting from the Supreme Court PUCL Nov 20, 2007 Case while presenting judgment on W.P. (c) nos. 8853 of 2008 and 10700 of 2009, p. 7).
accordance with the existing two-child norm promoted for population stabilization. The adjudicator in the Delhi High Court case highlighted that the Union MoHFW had previously presented a similar argument before the Supreme Court of India in 2007 during the hearing of the People’s Union for Civil Liberties (PUCL)\textsuperscript{20} case but was turned down and ordered to continue to administer the relevant schemes (JSY and NMBS) accordingly. The Union MoHFW had filed a petition of amendment but this was pending at the time of the Delhi High Court hearing and no judgment had been provided by the Supreme Court in this matter. This left the administration of JSY and NMBS to stand as initially established. Hence, the Court concluded that the Central Government was in direct violation of its own policies in this case (Justice Muralidhar, Delhi High Court 2010, 6-7). Indeed, this confirmed the deep links between the politics of maternal health and family planning in India with implications for articulation of corresponding rights and liberties.

Moreover, in its verdict the Court ordered individual relief and monetary compensation to both Shanti Devi and Fatima Begum (and their children and spouse), the majority of which were tasked to the State Governments. But the Court also directed the Central Government to take a numerous steps aimed at generally improving program design, policy implementation and administration of maternal health care entitlements. Further, it also ordered the Central Government to issue clarification to all state governments regarding the administration of applicable benefit schemes to all BPL pregnant women (or lactating mothers) irrespective of number of children (Justice Muralidhar 2010).

The Court verdict is particularly significant because the Indian Constitution does not

\textsuperscript{20} PUCL vs. Union of India (Writ. Petition no.196/2001) was a decision delivered by the Supreme Court of India on Nov. 28, 2001 where the Court recognized the interrelatedness of benefit schemes targeting maternal health, child health and development, and various food schemes. Essentially, the Court declared that the right to food was implicit in ensuring the rights to health and life of the mother and newborn / child.
explicitly recognize a ‘right to health’ which “has been shaped by international law, its constitutional mandate, and judicial interpretation” (Grover, Misra and Rangarajan 2014, 423). It is therefore silent on health (and health care) rights and entitlements suggesting the varied scope of interpretation possible depending on human rights frame of maternal health injustices, with implications for affecting political priority (including systemic reforms) for the policy problem. The Indian government’s spending in the health sectors is less than 2 percent of annual GDP, which does not meet the recommended guidelines (minimum 5 percent) of the International Commission for Macroeconomic and Health hosted by WHO (Balrajan et al. 2011). But more importantly, the Indian health system is mixed in nature with public and private health care services and facilities. Even though the private sector provides a greater share of health care, it largely remains unregulated without substantive legislation, regulation and oversight mechanisms. Efforts to regulate it have hardly featured as political and legislative priorities due to opposition from powerful professional medical, corporate health care and pharmaceutical lobbies (Gadre 2015; Nandraj 2015). Grover, Misra and Rangarajan (2014) remind that “there is a conspicuous lack of a body of laws establishing rights, duties, and available remedies between recipients of services and service providers and health care workers” (432). But beyond these contextual ambiguities over specific state obligations for health and health care, socio-legal theorists have argued that use of courts to generate policy and social reform in a long term and sustainable manner is far from straightforward and given. Various factors may stand to affect the ability (or the lack of) courts to affect (directly and/or indirectly) progressive policy and social reform (Rosenberg 1991; Epp 1998; McCann 1994; Scheingold 2004; Sarat and Scheingold 2006). Experts on use of courts to advance economic and social rights in the Indian context also concur with this claim (Baxi 1988; Epp 1998; Desai and Muralidhar 2000; Rajagopal 2007; Sood 2008; Parmar and Wahi 2011; Grover, Misra and Rangarajan 2014).
These realities raise important questions about the political will and state capacity to implement existing policies and recognize the rights they have already bestowed on their citizens through domestic and international protocols. These will be likely significant in examining whether state recognition, specifically through the court and judicialization, of preventable maternal morbidity and mortality as violations of human rights can help generate the political commitment and resources necessary to resolve the policy problem. The findings of this study stand to be of consequence beyond India, since this historic judgment forms a significant incident that has the potential to alter global debates concerning maternal health and human rights (including maternal health policies).

Structure of the Dissertation

Hereafter the dissertation is organized in eight chapters. Chapter 2, the remaining chapter in the introductory part of the dissertation, provides an overview of the context in which the politics of framing preventable maternal morbidity and mortality as human rights injustices takes place in India. It outlines five major contextual factors and argues that the intersection of these will be significant in determining the politics of framing women’s rights to maternal health as a human right in India. These factors are: history (evolution of reproductive health politics and policy); policy (status-quo maternal health policy design and competing norms); institutional (poor and weak health system capacity and governance); legal and constitutional (judicial receptiveness amidst constitutional silence on state obligation to health and lack of minimum guarantees in judicially interpreted right to health); and citizenship and feminist activism (identity politics and related fragmentations within women’s movements).
The second part of the dissertation comprises of two chapters. Chapter 3 provides an expanded discussion over debates and gaps in the core (maternal health and human rights) and related literature outlined earlier in this chapter. Examining the theoretical debates against the Indian realities (discussed in Chapter 2) points to various difficulties likely to be associated with articulating a human right to maternal health, contrary to very clear and distinct (existing) normative and theoretical conceptions in the literature. Likewise, in locating the contextual realities outlined in chapter 2 against the debates in the related literature (MDGs and human rights; women’s rights as human rights in development, and women’s rights, citizenship, and reproductive justice), the chapter argues that the politics of framing women’s rights to maternal health as a human right is unlikely to affect the political priority for the issue and secure the necessary political commitment and resources (as maintained in existing literature). This may be due to lack of state capacity and lack of political will but also because of lack of solidarity within the women’s health movement and disagreement over a single conception of reproductive needs and interests. These, both individually and collectively, have implications for human rights articulations of women’s rights to maternal health. The progressive judgment in the Delhi High Court case may suggest otherwise. But based on review of debates in the literature (on judicialization of rights, including health rights in developing country context) the chapter argues that there may be challenges associated with justiciability of rights, and (judicial) lack of control over resources, which are likely to limit the potential of state recognition (through judicialization) of preventable maternal morbidity and mortality as human rights violations to affect the political priority for the issue. The court case may help advance individual access to justice which the constitutional provision of PIL is meant to do, but it is less likely to generate systemic reform that can address maternal health disparity among the wider population.
The analytical and methodological considerations relevant to this study are outlined in chapter 4. The concepts used for analysis are selectively drawn from the framing literature, in critical policy studies and social movements literatures. Frames or policy positions are outcomes of frame sponsors’ beliefs and perceptions of the problem and their interests and organizational agenda. The process of framing is complex and dependent on the dynamic interaction between the policy forum and framing strategy used by frame sponsors and the mobilization resources available to them. However, reframing need not necessarily result in change in political priority which is dependent on various other conditions and resource constraints (Schon and Rein 1994). This is further complemented by use of an analytical framework proposed by Gloppen (2011) to study litigation as a specific framing strategy. This framework simply divides the litigation into four stages – claims formation, adjudication, implementation and social outcomes and equity – and factors associated with each stage are helpful to analyze the Delhi High Court case and also map the findings against the framing literature. The second part of the chapter presents a full methodological overview, the methodological considerations which define the scope of the research, describe the research design (including the nature of empirical data and approach to data collection), the method of analysis and indicate the methodological limitations of the study. The study draws on sixty-two key informant interviews with state and non-state actors, extensive legal, policy, program and advocacy documents, and observation of national and regional state-civil society consultations organized by Indian maternal health and human rights advocacy coalitions. Included in here is also a note on researcher’s positionality which framing theorists have argued is important to doing frame analysis (Schon and Rein 1994).

The findings and discussion of the study are presented in part three, which consists of chapters 5 to 8. Each of these chapters, in turn, corresponds to the research sub-questions outlined earlier and are organized in that sequence. Chapter 5 theorizes the political dimensions of using
human rights to claim accountability for maternal health. Two main themes are included in this chapter: the politics of generating human rights consciousness among maternal health policy recipients and the politics of conceptualizing accountability, including attribution of responsibility. Both have implications for the politics of framing and claiming women’s right to maternal health as a human right. In contrast, chapter 6 theorizes the struggle for reproductive justice in post-liberalization India (defined as the period when maternal mortality first began to appear in the policy agenda in late 1990s until the completion of the field research in early 2013). Three main themes emerge here: the politics of feminist engagement with the health system as a state institution, including the challenge of instilling the attitudinal shift from a welfare-based perspective to a rights-based perspective; the internal politics of feminist mobilization for maternal health including the fragmentation caused by articulation of claims of human right to maternal health; and theorization of possible ways of discourse reconstruction to avoid politicization of human rights and overcome methodological challenges in operationalizing them. Collectively chapter 5 and 6 theorize the “overwhelming complex reality” of the context in which the politics of framing women’s rights to maternal health unfolds in India, which is hypothesized earlier in chapter 2 but has not been empirically documented (Schon and Rein 1994, 26).

Having theorized the context, chapters 7 and 8 examine the framing dynamics as designed by Indian maternal health and human rights frame sponsors. Chapter 7 focuses on comparing the human rights frames of women’s rights to maternal health as employed by three maternal health and human rights advocacy coalitions in India. It also compares the framing strategies they use and the policy forums or political opportunity structures they engaged with and why. As well, it documents sources of frame dispute between these coalitions and analyzes their underlying reasons. Collectively, this chapter focuses on the policy positions and various lobbying strategies used by the three coalitions who are located in different contextual realities (defined as a
combination of various gender empowerment measures, condition of health system infrastructure, and prevalence of social identity-based discrimination). In contrast, chapter 8 lends itself to the study of the Delhi High Court case. It explores the broader socio-political dynamics behind the court case and in the aftermath of the judgment which affected the implementation of the judgment. As well, it analyzes the politics of using strategic litigation to advance women’s rights to maternal health as a human right in India, including the scope of the newly interpreted and recognized right in the judgment and its potential consequences for affecting political priority for maternal morbidity and mortality. The findings of this chapter are organized into four sections – claims formation, adjudication, implementation, and socio-political dynamics of implementation.

Chapter 9, in last part of the dissertation, sums up the implications of human rights framing maternal health for advancing reproductive justice for all women. It begins by providing an overview of the study before presenting a summary of the findings. The contributions of the study are highlighted next along with research gaps. The chapter concludes by identifying recent and important changes in global development and human rights politics and in Indian health and health care (including reproductive health) politics which further underscore the continued relevance of the findings and contributions of this study.

The Argument

The politics of framing preventable maternal morbidity and mortality in India is complicated by discursive and structural factors that limit the potential of human rights frames (of women’s rights to maternal health) to affect the political priority for the policy problem. The discursive factors are products of historical, political, economic and social conditions, which arise at the intersection of domestic and global circumstances. They fragment feminist solidarity in India and complicate articulation of a holistic reproductive justice agenda. In contrast, the
structural factors are related to peculiar constitutional and institutional designs, which complicate attribution of responsibility and conceptualization of state accountability for adverse maternal health outcomes that are also produced by compromised state capacity in neoliberal times.

The discursive factors include challenges of demystifying the abstract notion of human rights and generating right consciousness among poor and marginalized pregnant and parturient women, who are deprived of citizenship guarantees to health and health care. This is due to a constitutional silence on state obligations for health (including absence of related minimum guarantees) that also leads to lack of socio-political consciousness of health and wellbeing among women. This is heightened by their weaker gender and social status. As a result, indigenous articulations (that is, vernacular expressions) of human rights to maternal health conform to the norms of the policy frame, which is narrowly defined and predominantly biomedical in scope. Thus, the human rights frames are unable to make the normative leap required to communicate a radically alternative, politically powerful and morally imperative possibility that can be sufficient to alter public and political attention to the issue. Concurrently, the human rights discourse of women’s rights to maternal health is further complicated by politicization of maternal health care policy entitlements by the state, which is made conditional for some women upon fulfilling difficult citizenship obligations – such as supporting the state’s population stabilization agenda by submitting to state regulation (sometimes through incentives, other times through coercion) of their reproductive liberties. This tricky juxtaposition of guarantees of maternal health entitlements with simultaneous constraints on other reproductive liberties presents an additional obstacle for frame sponsors. It further intensifies the discourse and polarizes pro-choice advocates between two ends – pro-natal and anti-natal – of an already contentious and fragmented policy discourse over reproductive choice and rights. The vernacular women’s human rights discourse grows more problematic as global factors – such as politicization of human rights
discourse by the development establishment and global aid politics – divide different women’s groups within the women’s health and broader women’s movement. This undermines feminist solidarity and also leads to frame disputes. The result is a haphazard and highly fragmented discourse overall, which is unable to underscore the ultimate struggle for reproductive self-determination and gender injustices existing beneath the layer of contextual complexity. This compromises the ability of concerned frame sponsors to use human rights to advance women’s rights to maternal health. Frame sponsors can benefit from reflecting across frames, and consolidating claims of different reproductive needs and interests of different groups of women within the reproductive justice framework.

The structural factors point to difficulties of attributing responsibility for adverse maternal health outcomes and conceptualizing where accountability lies. The former is inherent to the policy problem because its determinants are fluid and not bound to a single structure such as the family, community, health system or other elements within the state. The latter, given the constitutional ambiguity on state obligations for health, historical and political dynamics of federalism in India, and lack of institutional / policy specific grievance redressal mechanisms point to absence of legislative and executive accountability. Under the circumstances, courts are the only accountable authorities due to the judiciously recognized right to health. Yet, the lack of clearly specified minimum guarantees – that is a justiciable right to health – results in individual financial compensation and relief for maternal health injustices. Even the legal arena, which recognizes preventable maternal morbidity and mortality as human rights violations limits the potential of such successful reframing from creating systemic reforms that can address maternal health disparities in the wider population. This is tied to the reluctance of courts to direct legislatures to undertake health care reforms – unlike in other related and normative cases in the Indian context. It is possibly an outcome of cognizance of poor state capacity (especially, health
system capacity) to deliver and lack of demand for health and health care entitlements from the wider electorate, suggesting judicial restraint and perhaps reluctance to breach the separation of power that is characteristic of democracy. It is also tied to the outcomes of the claims formation stage which lacked strategic collaboration between the human rights lawyers and maternal health right advocates due to frame disputes indicated above. Arguably, the issue of state capacity is a product of historical economic and political trajectory of development of the Indian state. Still it cannot be completely untied from the past and present global realities, which promote liberalization, privatization and deregulation of the economy, and as a result a reduced role for the state in the health sector – both public and private. It compromises the Indian state’s ability to guarantee and uphold citizens’ rights to health and health care and presents difficulties for evoking any notion of human right to health and health care (and by extension maternal health and health care). This stresses the incompatibility of human rights frames with what is largely a welfare-based system and also reveals the inherently undemocratic nature of the Indian public health system as a political and social institution.

Therefore, based on the findings in this study, normative policy frames such as human rights frames can have analytical and symbolic strengths in evaluating the process of development and its outcomes but they are limited in affecting such outcomes in practice. These limitations arise from operationalizing abstract human rights principles because discursive characteristics of the context limit the transformative potential of human rights articulations, to communicate a profoundly different, politically potent and morally urgent alternative. At the same time, activating the transformative potential of human rights-based policy frames is conditional upon greater involvement of the state in society and economy, which is fundamentally at odds with the dominant neo-liberal model of development that has been embraced by many developing countries. Insensitivity to these realities lead to politicization of
normative policy frames, such as human rights frames of development, rather than present potential for genuine empowerment.
Chapter 2: Contextual Considerations: Politics of Maternal Health in India

This chapter provides an overview of the different dimensions of the context – historical, policy, institutional (state capacity and health system governance), legal/constitutional, and citizenship and feminist activism – in which the struggle for altering political priority for maternal morbidity and mortality unfold in India. The analysis points to the complex political terrain Indian maternal health right advocates must navigate in their efforts to frame women’s rights to maternal health as human right. The conclusion highlights a set of key contextual factors that are likely to be significant to the politics of using human rights to secure political priority for maternal morbidity and mortality in India.

Historical Context

The issue of maternal mortality reduction had not always dominated the health (and women’s health) policy agenda in India. Within the scope of women’s health in India, the political priority and historic policy focus had been on family planning for purposes of population stabilization at least until the late 1990s (beginning in early 1950s) and maternal mortality reduction was largely a relegated issue (Shiffman 2007). However, it became a political priority in India in early 2000s due to the “convergence” of three domestic factors. These are in addition to the global phenomenon (as suggested by scholars) of inclusion of the issue as a priority health concern in the Millennium Development Agenda in 2000 (Shiffman 2007; Shiffman and Ved 2007). These three domestic factors included: 1) official recognition of the severity of the problem and lack of progress on the issue following the then Prime Minister’s participation at an international gathering where India failed to live up to the progress made by its immediate
neighbors (particularly, Bangladesh); 2) agreement among donors and the Indian government about appropriate interventions (investment in primary health care) to reduce maternal mortality, leading to the creation of National Rural Health Mission (NRHM); and 3) the rise to power, following general elections in 2004, of the Indian National Congress (INC) Party leading to the formation of a government with “social equity aims” (Shiffman and Ved 2007, 785). That said, the emergent political priority for maternal mortality reduction, should not be seen in isolation from the politics of family planning and population control, which gave rise to the first wave of feminist health movement in India. This is both due to continued emphasis on family planning in design of maternal health policy and its implications for the struggle for reproductive choice and rights in India – both of which are significant issues for this study.

Maternal health did not feature in policy agenda in India during post-independence years (post 1947) up until mid-1970s. During this time, the focus had been on family planning and population control. In fact, India was the first country to officially adopt a national population stabilization policy in 1952. The legalization of abortion through the creation of the Medical Termination of Pregnancy (MTP) Act as early as 1971 – with relative ease, contrary to women’s struggles for access to safe and legal abortion elsewhere – has been tied to national interest in controlling population growth (Rao 2008; Grover, Misra and Rangarajan 2014). Although family planning policies targeted both men and women simultaneously in early decades, the exclusive focus on women as shouldering the responsibility for family planning emerged in 1978, shortly after the Emergency years of 1975-77\(^1\). In the post-Emergency years, the official policy

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\(^1\) Prior to 1975, the focus of population stabilization was on men and in many cases through forced vasectomy or through disguised vasectomy procedures conducted without consent with selective populations perceived to be highly fertile (such as members of minority communities, Muslims, lower caste or Dalits, Scheduled Tribes or Adivasis). These clandestine efforts were supported by the Indian National Congress (INC), the ruling party at the Central level and led by the then Prime Minister Indira Gandhi. The uncovering of such incidences by major media investigations in many states of northern India (with high populations) led to a national outrage and shaming of the
(including promotion of the two child norm) shifted from focusing on male vasectomy to solely focusing on women as the target of state’s (coercive) family planning interventions (such as, varied forms of contraceptive including sterilization$^{22}$, non FDA approved injectable contraceptives). Here after, governing women’s reproductive health became a major pre-occupation of the state (Hartmann 1995; Jeffrey and Jeffrey 1997). This thrust continued throughout the 1980s and early 1990s to the point where women seeking pregnancy and post-abortion care were “arm-twisted into accepting methods like IUDs, pills or sterilization depending on the number of children and surviving sons, by health workers, whose career and promotions depended on the number of ‘cases; they could mobilize for family planning” (Mukherjee 2002). This was further accompanied by the state’s increased focus on vertically designed family planning interventions at the cost of a wider and horizontal focus on maintaining the quality of primary health care$^{23}$, resulting in overall decline in quality of health care available to women - a significant contributor to maternal deaths (see Parmar and Wahi 2011; Ravindran 2014). These were early signs of the policy linkages between maternal health and family planning as experienced by women in India, although this link was not really made explicit until much later (see Narayananan 2011, 42).

The enthusiastic participation of Indian women’s health advocates in global summits surrounding women’s rights, including health rights (such as ICPD in Cairo and the Beijing

$^{22}$ Sterilization or tubal ligation was promoted as a permanent method of contraception through mobile medical camps in rural and remote India where uptake of temporary contraceptive methods were very poor due to various reasons (low availability, poor access, and social taboos especially among men).

$^{23}$ There is general consensus among maternal health experts (both biomedical as well as health and gender experts) that access to a functioning primary healthcare center is critical to preventing adverse maternal health outcomes (especially those related to birthing and post-natal complications).
Summit) added fuel to a rising domestic discourse on ethical approaches to population stabilization, and by extension women’s reproductive health (Mukherjee 2002; Qadeer 2002/2005a/2005b; Narayanan 2011). The strides made by women’s health advocates at ICPD in Cairo in 1994 and at Beijing in 1995 (where a more “humane” connection was made between women’s health, development and women’s rights) also led to corresponding policy shifts on the domestic front leading to the creation of Phase I (1997/98 -2004/5) of the Reproductive and Child Health (RCH) Program or RCH I. It was in RCH I program design for the first time, that an extensive range of systematic maternal (and child) health interventions were witnessed. This is likely due to the success women’s health advocates had had both globally and in India in connecting maternal mortality to broader women’s health and status issue at Cairo (in 1994) and Beijing (in 1995) given the chronology of the facts.

*Emergence of Maternal Mortality Reduction in the National Policy Agenda and Feminist Anxieties*

However, the emergence of maternal mortality reduction as a (although not a central one initially) concern in RCH Phase I (1997-98) at least in Indian policy documents was considered “epidemiologically misplaced” by some segments of the Indian women’s health movement (Jain and Rao 2001,1301). For example, at a colloquium supported by UNFPA in New Delhi, some women’s health advocates argued that “deaths due to reproduction, high as this is, accounted for merely 2.4 percent of deaths among females in the country” (Ibid.; emphasis added). This is likely linked to “new divisions and differences” within women’s movements in India highlighted by Mary E. John who refers to the struggle women’s health advocates have had in systematically

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24 This was also corroborated by the fact that some participants highlighted this issue at multiple occasions during field research. It is reported and discussed at greater length in the empirical chapters of this dissertation.
responding to the rhetoric of reproductive choice and rights promoted by the state to support its family planning and population control agenda (2012, 556). John analyzes the differences in perspective among those who “draw upon the perspective of public health initiatives and the need for improvements in the economic in order to address women’s health needs” and other who do not view “the annexation of the rhetoric of reproductive health per se diminishes the legitimacy of addressing this sphere of women’s lives” (Ibid.).

Arguably the aforementioned difference is connected to wider concerns surrounding the state’s historically exclusive focus on women’s reproductive health because of its links to population stabilization and its perceived significance for national economic growth. Imraana Qadeer, a noted Indian population health scholar, has criticized the feminist focus on women’s reproductive health (particularly activism for reproductive choice and rights). She maintains that this is often met with narrow, bio-medical and technically packaged reproductive health policy interventions – which disguise the underlying efforts of the state to appropriate the rhetoric of reproductive choice and rights – without adequate attention to broader (public) health system issues. She reminds us that such a policy approach was never really “pro-women, … [but] it [was] only women-centred” (Qadeer 2008, 382; see also Qadeer 1998). The focus on maternal mortality, from this position, may be unacceptable to some women’s health advocates in India without attending to problems of health system reform. But others argued that the widening policy focus of population policies (family planning to reproductive health and beyond) can draw attention to “enabling conditions” and highlight issues of “social rights” that would offer women

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25 For example, Tuberculosis remains a major contributor to adverse health outcomes for women in India (India has the highest TB burden globally). This is peculiar in parts of South and South-West Asia in comparison to elsewhere in the world, where this infectious disease affects more women than men. Determinants of TB among women in South Asia, including India has been connected to various social determinants of health including gender and other forms of socio-economic inequalities.
opportunities to make *genuine* reproductive choices (Ravindran 1993; Sen et al. 1994 as quoted in John 2012, 556). From this perspective, the focus on maternal mortality reduction may be welcome since it examines the preventable and untimely nature of these deaths that require political attention (beyond the health system). Either way, this debate reveals the tensions between different segments of the Indian women’s health movement and differences in opinion over which issues ought to be considered *deserving* of political attention and why. This is likely to be significant in introducing the language of human rights to the issue of maternal health, given the different views on importance of reproductive choice and rights to maternal health outcomes (as outlined before in the introductory chapter).

*Maternal Health, Emerging Politics of Reproductive Choice & The Ghosts of Population Control*

Some hailed the creation of Reproductive and Child Health (RCH) Phase I as a “paradigm shift” due to its “Target Free Approach” (first ever in reproductive health policy interventions) (Vaidyanathan 2006 as cited in Narayanan 2011, 44). Shortly thereafter the National Population Policy (NPP) was launched in 2000. It also advocated for gender sensitive and ethical approaches to family planning in the preamble, although it still included a section called “Promotional and Motivational Measures for Adoption of Small Family Norm” highlighting several *incentivizing measures* “that could not be described as anything but target-motivated” (Narayanan 2011,45; Qadeer 2002). In fact, women’s health advocates in India pointed to the

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26 In fact, in exchange for support for ensuring legal access to abortion at Cairo, Indian women’s health advocates had negotiated endorsement for “women’s health policies … sensitive to locally significant cultural and political economic issues” with their counterparts from developed countries (Narayanan 2011, 42). Thus emerged the call for ethical approaches to family planning, collectively made by women’s health advocates from rich and poor countries, at the end of both ICPD and Beijing.
official policy document as “slightly increased flexibility in terms of methods of fertility regulation on offer and not a relaxation of population-control goal-setting itself” (Narayanan 2011, 45; Mukherjee 2002). The NPP also led to contradictory policies and practices at the state level, as its advocacy for greater decentralization in health planning and administration had a strange impact on family planning interventions at the local level. For example, policy makers abandoned an exclusive focus on family planning as the major component of reproductive health in states where fertility replacements levels in accordance with international demographic guidelines had been reached (Tamil Nadu, Kerala for example)\(^{27}\) (Agrawal 2009). In contrast, in states with “officially unacceptable” population growth rates (such as Northern and Central India), some authorities introduced controversial two-child-norm policies through the Union Ministry\(^{28, 29}\) of Panchyat Raj responsible for decentralized governance including one in eight states, which prevented individuals with more than two children from standing in local elections (Sen and Iyer 2002; Rao 2008). When challenged in the courts (including the Supreme Court), petitioners were turned down citing no conflict with fundamental rights (Bhat and Acharya 2011). Likewise, indirect methods of coercive population control continued to be pursued in these states by tying maternity benefits (including conditional cash transfer programs) to the number of live births and sometimes even the number of pregnancies (Narayanan 2011, 45).

\(^{27}\) This has been attributed to a range of reasons – historic conditions such as women’s relatively improved social status and empowerment, condition and efficiency of states health systems, welfare conditions and such - including the absence of coercive family planning measures solely targeting women in Southern States in comparison to Northern and Central States such as Uttar Pradesh, Bihar, Haryana, Rajasthan and such (Agrawal 2009).  
\(^{28}\) Some have raised the issue of state autonomy cited by the Union, arguing that it was unusual for the latter to look the other way in these specific cases despite its history of interfering in state business (Qadeer 2002/2005b).  
\(^{29}\) One study has criticized the Centre for not adopting strategies (and allocating resources), which promote education and awareness (despite promise of universal coverage of family planning education) specially to minimize social taboos that prevent family planning professionals from reaching unmarried youth or married but under-aged youth. This study also provides insights into the ways in select sub-national states, the Central Government directly funded large non-governmental organizations (under the NGO and private partnership program in NPP) working on providing family planning measures to “promote” the two child norm and medically intrusive family planning measures to women (Agrawal 2009).
Nevertheless, the promise of promotion of quality reproductive health care in NPP was undermined by the introduction shortly after 2002 of the National Health Policy (NHP) and National Strategy for Social Marketing (NSSM) by the Union Ministry of Health and Welfare, which relaxed quality control regulations (under the neoliberal policy of less intervention) on existing and new private health care providers (especially abortion clinics), thus promoting questionable methods of achieving unmet need for contraception (Qadeer 2002).

Perhaps, this is why the design of JSY (discussed below), the primary maternal health policy intervention tool, by the Union reveals the incorporation of measures to incentivize adoption of family planning methods in high fertility states. In this regard, it is difficult to ignore Mohan Rao’s (2008) observation about the likely roots of such policy design. He reminds:

“[the] widespread consensus among our [Indian] policy makers and elites, and indeed our [Indian] middle classes, that something more drastic needs to be done on the population front, that all the social ills in our country have their roots primarily in population. This calls for ‘giving teeth’ to population policy, to ‘showing political will’, takes the form of disincentives and incentives and the norm for family size” (300).

In other words, despite a shift to the maternal mortality reduction policy frame, the old and hegemonic frame with a focus on coercive family planning measures (for reasons of population stabilization) has not been completely abandoned. If anything, it continues to ‘lurk’ behind the new frame. It shows a historical tendency of the state to appropriate (women’s) reproductive health policy interventions to pursue its political agendas. The strength of the state’s (or at least in some segments of it) belief in the idea of family planning and population stabilization as integral to economic welfare of the country is revealed in its willingness to systematically discriminate (over many decades) against a segment (women of poor and disadvantaged background) of its own citizens (also see Rao 2004). Perhaps this is why Rao observes:
“Fundamentally, it [state approach to population stabilization] represents a profound misunderstanding of the relationship between population and resources. … I would also argue that they are morally compromised since they violate the principle of natural justice, creating two sets of citizenship rights on the basis of fertility” (2008, 300). Overcoming this deliberate discrimination of some citizens through systematic politicization of women’s health (and the broader health system) by the state points to the complexity of citizenship rights – gendered, economically marginalized and socially vulnerable – at stake in relation to maternal health politics in India. It remains to be seen how Indian maternal health rights advocates will draw upon the universal appeal of human rights in their framing efforts to underscore the injustices experienced by selective segments of the population.

**Policy Context**

The main biomedical causes of maternal deaths in India are hemorrhage (heavy bleeding from ruptured blood vessels), sepsis (inflammation of parts of or whole body caused by infection, also tied to poorly performed abortion\(^3\) as well), abortion, obstructed labor and hypertensive disorders, which contribute to respectively 38, 11, 8, 5 and 5 percent of deaths. Other conditions, such as anemia and indirect causes contribute to remaining 34 percent of deaths (Registrar General of India 2006). Beyond biomedical factors, economic, socio-cultural, political and financial (health care expense related) factors immensely amplify the complexity of the issue, particularly in the rural Indian context. Poverty, illiteracy, gender inequality and disempowerment play a significant role in affecting maternal health outcomes. A 2007 report on socio-economic determinants of infant and maternal mortality by the Indian Trust for Innovation

\(^3\) It is worth mentioning that in some countries of North and Sub-Saharan Africa, sepsis is also tied to infection caused by female genital mutilations.
and Social Change (ITISC) showed that lack of control over economic resources, lack of say in household decision making – particularly finance related lack of control over individual income are major contributors to infant and maternal mortality in India (13). The report indicated that economic empowerment of women improves overall financial status of women which ultimately impacts the extent and quality of care mother and child receive. Similarly, lack of education for girls and women—a product of belief in “traditional gender roles”—is also an important factor leading to gender inequality and disempowerment. The situation is further compounded by socio-cultural factors such as discrimination based on caste, class, religion, and tribe, which also impact women’s access to appropriate health care (George, Iyer and Sen 2005; Dasgupta 2011). In a nutshell, Indian women’s unequal social and economic status resulting from gender inequality in public and private spheres – that is, their unequal citizenship status – cannot be de-linked from their maternal health outcomes.

**A Critical Overview of India’s Maternal Health Policy**

The establishment of the National Rural Health Mission (NRHM), an autonomous unit under Union MoHFW in 2005 led to the creation of JSY or maternal security scheme, NRHM’s flagship public health program. The Union’s approach emphasized maternal mortality reduction (as opposed to improving overall maternal health outcomes) keeping in line with its belief that “effective care is possible by making available essential and emergency obstetric services, by

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31 On June 1, 2011 the Central Government’s Ministry of Health and Family Welfare re-launched JSY as the Janani Sishu Suraksha Karyagram (JSSK or Maternal and Child Safety Program). The JSSK was not entirely rolled out until 2013 by which time field research was completed. In 2011, it was piloted in three states only, Rajasthan Uttar Pradesh and Uttarkhand. Aside from adding a variety of neo-natal and child health safety measures, two major important changes were introduced. The first constituted making all entitlements entirely cashless (including caesarian operations, purchase of drugs and other medical necessities, emergency medical transportation), which was not the case under JSY. This was done to eliminate the out-of-pocket expenses and malpractices such as demand for user-frees from health care providers which were discouraging pregnant and parturient women from seeking institutional maternal health care. The cash incentive to women, under JSY, however remained unchanged (see Guidelines of JSSK; MoHFW 2011). [http://nrhm.gov.in/images/pdf/programmes/guidelines-for-jssk.pdf](http://nrhm.gov.in/images/pdf/programmes/guidelines-for-jssk.pdf)
way of focusing on increased institutional care, among women in Below Poverty Line [BPL] families” (MoHFW 2006b, 44). The NRHM adopted the target-based approach of MDG 5 with the goal of reducing MMR to less than 100 deaths per 100,000 live births as the primary policy objective. JSY was funded entirely through funds supported by the Union and was essentially a conditional cash transfer (CCT) program available to women in both public and accredited private health care facilities. It promised pregnant women from BPL families “benefit of cash assistance with institutional care during delivery, preceded with antenatal care and immediate post-partum care [in the aftermath of child birth]” (Ibid., 45).

India’s maternal health policy intervention focused on the “supply side” of the health care system (in fact it explicitly identified its focus as “supply side interventions” as “key policy entitlements”) and included the following provisions (Ibid.):

- Universal access to skilled birth attendants;
- Essential emergency and obstetric care (EmOC) through network of first referral units (FRU) and 24-hour Primary Healthcare Centres (PHCs);
- Improving access to EmOC services through private public partnerships (PPP);
- Access to early and safe abortion services; and
- Strengthening referral systems and emergency medical transportation.

Resources were also allocated to improving PHC infrastructures and front line health workforce [in form of Auxiliary Nurse Mid-Wives (ANMs) and Accredited Social Health Activities (ASHA) workers] (MoHFW 2009).

Nonetheless, the major strategy that was actively pursued and focused upon was the promotion of institutional births (“institutional deliveries” as termed in the policy and program documents) by creating a financial incentive for pregnant women giving birth at formal health
care facilities. To receive the sum of money (Rs 1400 or approximately USD 20) awarded under the JSY by the Central Government (administered by local health care service providers), women would have to fulfill the following requirements: 1) attend three antenatal check-ups; 2) give birth in a formal health care facility assisted by “health personnel”; and 3) return for a postnatal check up within two months of giving birth (MoHFW 2006; Vora et al. 2009). Furthermore, the initial policy design lacked any incentives or support for those opting for home birthing even though National Family Health Survey 2 (1998-99) and 3 (2005-06) prior to creation of JSY indicated that more than 60 percent of women were giving birth at home (Gupta, Joe and Rudra 2010, 20). After much struggle, maternal health right advocates were able to negotiate a cash promise (Rs 500 or approximately USD 7.5) for home birthing in eight of the 26 states with highest fertility as well as MMR (MoHFW 2006a, 3). Nonetheless, the amount of the incentive was reduced to one-third of what was provided for institutional delivery indicating an effort to “promote behavior change with pregnant women opting for deliveries at institutions” (Sri B and Khanna 2012, 5). Women have also faced difficulties in collecting the promised cash incentive and in some cases the out-of-pocket expenses have been significantly higher than the designated cash incentive (National Health System Resource Centre 2011). This is important to consider given that the JSY aimed to eliminate the financial barrier created by out-of-pocket expenses poor women had to bear to access formal health care facilities.

The underlying assumption behind creation of the JSY was that institutional birth and the basket of medical care services available at formal facilities would reduce maternal deaths and help achieve the targeted reduction (Vora et al. 2009, 192; Sahayog 2009). This is problematic because provision of health care services cannot guarantee access and utilization which are determined by social and cultural norms and practices (Ibid; Sanneving et al. 2013). A number of studies – including the results of the District Level Household and Facilities Survey-3 conducted
as part of the Reproductive and Child Health Project (2007-08) commissioned by the Union Ministry of Health and Welfare – indicate that the increase in institutional births (accompanied by uptake of the JSY scheme) has not resulted in decline in mortality rates and/or improvements in maternal health outcomes (Das 2012, 13; Randive, Diwan and De Costa 2013; Ng et al. 2014). This is attributed to the vertical nature of the program, which has generated demand without paying adequate attention to the health system’s readiness to attend to clients. Readiness in this case goes beyond simply scaling up infrastructure and resources (including human resources), which have not reached the desired level either; it also relates to quality of maternal health care (National Health System Resource Centre 2011; CEHAT 2013).

Further, the target-oriented approach (in keeping with MDG targets) of the policy has led to more and needless referrals in a system of poor FRU and absence of EMT as facilities race to reduce the number of maternal deaths logged (Sri B and Khanna 2012). Following the introduction of the JSY, the state has focused on “counting” use of formal health care facility as opposed to the ways that use of institutional care facilities has improved women’s birthing experiences and maternal and neo-natal health outcomes. An independent evaluation commissioned by the UNFPA showed the strain JSY had caused on the already weak and dilapidated public health system and the poor quality of services available to women, ranging from timely availability of care to management of beneficiary payments (UNFPA India 2009, 16).

Practices of systemic abuse of poor, vulnerable and marginalized (particularly from lower caste and tribal or Adivasis) in public facilities, particularly women, are also widespread, which reveals the ways gender and other forms of social inequalities determine their experiences of accessing and utilizing maternal health services. Such disrespectful treatment often includes a range of malpractices, including unethical and unnecessary medical/surgical interventions
without informed consent, verbal and physical abuse and violence (including “scolding”, kicking and slapping)\textsuperscript{32} by care providers in labor rooms, and demand of excessive user fees against what is supposed to be freely provided health care (Gopichandran and Chetlapalli 2012). Gender identity (coupled with other axes of identity - class, caste, race, tribe, ethnicity, religion) is a core determinant of Indian women’s maternal health outcomes (Sanneving et al. 2013). However, the narrowly defined technical focus of state policy not only overlooks but also undermines women’s agency (George, Iyer and Sen 2005). The design of JSY includes restrictive clauses such as ineligibility of women below 19 years (in keeping with the Child Marriage Act) even though 46 percent of all marriages in India are child marriages leading to early childbirth (CRR and HRLN 2013). It is not clear why women who are vulnerable to incidences of early and teenage pregnancy due to discriminatory social practices and poor enforcement of child marriage laws are excluded from accessing publicly funded maternal health care services. Women who have been married under-aged are more likely to be under-nourished and physically under-developed (due to the nexus of gender discrimination related to nutrition in natal and marital home), hence anemic and thus prone to pregnancy risks and complications (namely, higher incidence of hemorrhage and death) (Sethuraman and Duvvury 2007).

Likewise, the government’s decision to exclude women with more than two live births from access to JSY in states with high fertility rates (in accordance with the coercive population policy of “two-child norm”) – despite the Supreme Court directive to the contrary\textsuperscript{33} - has also

\textsuperscript{32} Many pregnant women also complain of physical and sexual violence by their male partners in domestic life as well.

\textsuperscript{33} PUCL or People’s Union for Civil Liberties vs. Union of India (Writ. Petition no.196/2001) was a decision delivered by the Supreme Court of India on Nov. 28, 2001 where the Court recognized the interrelatedness of benefit schemes targeting maternal health, child health and development, and various food schemes. Essentially, the Court declared that the right to food was implicit in ensuring the rights to health and life of the mother and newborn / child. In 2007 the Supreme Court of India in the PUCL case against the Central and the State governments directed that all below poverty line (BPL) women will continue to receive maternity benefits “irrespective of the number of children
been termed anti-women by critics who point to lack of women’s autonomy in sexual and reproductive health decision making (CEHAT 2013). Similar criticisms of corruption and denial of access to the National Maternity Benefit Scheme (NMBS), a nutritional scheme for pregnant women in the BPL segment have emerged. NMBS was launched in 2001 but merged with JSY in 2005. Following this development, similar restrictive criteria (legal age of 19 years, number of live childbirths, birthing in formal facilities) were being applied until a Supreme Court decision in 2007, which ordered retaining and administering the NMBS benefits without the restrictive eligibility clauses (Tripathi, Kukreja and Thomas 2013).

Similarly, the design of JSY promises access to safe & quality abortion care (an important determinant of maternal health outcomes), but this has not been met in practice. The politics of access to safe and quality abortion care is particularly complex in the Indian context despite the 1971 MTP Act, which legally guarantees women access to safe abortion care. Women may be denied access to abortion by providers in formal health care facilities (public or private) and/or asked to obtain additional medical opinion and permission of family members, which point to both systemic discrimination in health service delivery and violation of their decision to opt for abortion the MTP Act. This poses particular challenges for women who may choose not to carry the fetus to term and seek abortion care, either because they did not have access to or because they were unable to utilize quality family planning services. Due to the poor enforcement of the MTP Act and lack of regulated and safe abortion providers in rural and remote areas, women often resort to clandestine and unregulated abortion providers where the quality of service and post-abortion care may be “dubious and potentially dangerous” resulting in high “self-reported

and the age of the woman” (Justice Muralidharan of Delhi High Court quoting from the Supreme Court PUCL Nov 20, 2007 Case while presenting judgment on W.P. (c) nos. 8853 of 2008 and 10700 of 2009, p. 7).
morbidity from abortion attempts” (International Centre for Research on Women or Malhotra et al. 2003, 6; Agrawal 2008).

Other shortcomings related to faulty administration have also come to light. For instance, the JSY scheme may only be accessible to women who give birth at institutions within the jurisdiction where their pregnancy is initially registered, even though it is common social practice for women (particularly for first pregnancy and for younger women) to travel to their natal homes to give birth. Similarly, the BPL card that must be presented by women to access JSY is often hard to acquire for the poor (due to lack of other documents and difficulties in navigating a corrupt bureaucracy) and not portable beyond the specific sub-national state where it is issued. The majority of such women frequently migrate across state lines in search of temporary or seasonal work, arriving to urban and semi-urban areas where they are ineligible for welfare benefits they are entitled to (CEHAT 2013). Similarly, the increasing feminization of labour in the informal economy (accompanied by low pay and overworked conditions) can result in inadequate income to consume appropriate nutrition for self and fetus or newborn (and the rest of the family), not to mention the lack of ability to get appropriate rest and care in the final stages of pregnancy or post-pregnancy (Lingam and Yelamanchilli 2011). The launch of the Indira Gandhi Matritva Sahyog Yojana (IGMSY) in 2011 by the Ministry of Women and Child Development (MoWCD) was expected to correct this by providing funds to compensate for loss of wages and access to nutritional food (for both mothers and newborns). However, IGMSY had preconditions that excluded women with more than two-live births and those below 19 years, the most vulnerable and in need of its support. It also imposed conditions such as mandatory breast
feeding, insensitive to the reality in which women work in the informal sectors\textsuperscript{34} (Falcao and Khanuja 2015).

In a nutshell, three major concerns exist with the design and administration of JSY and other CCT programs (NMBS, IGMSY) used as maternal health care policy interventions. First, the health care service and other related benefit (such as nutrition) promised to poor and marginalized women through the launch of these policy interventions remains unfulfilled due to poor and weak state of health system. Second, the policy interventions overlook the challenges women face in accessing and utilizing those services. These challenges may stem from gender and other forms of social discrimination institutionalized in health system delivery, but cannot be disconnected from women’s inability to make decisions about their lives, bodies and health within the private sphere. Finally, access to maternal health / nutritional benefit schemes is conditional upon meeting difficult eligibility criteria that women have very little control on, especially given poor enforcement (and deliberate reluctance in case of two child norm) of laws and policies created to protect and uphold women’s rights.

\textbf{Institutional Context}

Direct causes (proximate determinants) of maternal deaths can be tackled by ensuring the presence of a range of interventions related to on-time and quality ante- and post-natal monitoring and follow up (including family planning counseling), early detection of anemia and infection and appropriate treatment, skilled attendant at birth, access to basic provisions such as

\textsuperscript{34} The food included as part of the scheme has been mostly carbohydrate, which can be cheaply sourced despite promises of quality protein rich food that is necessary to meet the nutritional requirements of lactating mothers and infant\textsuperscript{34}. Evaluation of the scheme undertaken by civil society groups also concluded that the administration of the benefit scheme was incredibly long-winded and time consuming, thus discouraging women working in daily-wage employment from accessing it (due to potential wage-loss) (Sahayog and NAMMHR 2012). [Maternity Entitlements in India]
blood transfusion, a functioning referral system (including medical transportation) and access to surgical interventions should complications arise (Sri B and Khanna 2012, 10).

**Challenges of Health System Capacity**

However, the Indian health care system suffers from inadequate infrastructure, physical, financial and human resources, which poses significant challenges for improving maternal health outcomes. Oxfam India’s briefing booklet on sexual and reproductive health issues for parliamentarians indicated (based on 2005-06 National Family Health Survey data) that the Indian public health care infrastructure was missing 20,903 sub-centres, 4803 primary health care centers (PHCs), and 2653 community health centres (CHCs) (2010, 9). Gautham (2010) reports that the Government of India’s official statistics indicate 18.8 percent vacancies in positions of PHC doctors and 51.6 percent vacancies in the positions of CHC specialists. The lack of adequately trained staff especially in rural facilities, the absence of well-functioning PHCs or the complete lack of any in some rural areas, insufficient preparedness (poor physical infrastructure) in providing basic primary care and emergency obstetric care (EmOC), lack of emergency medical transportation in highly underdeveloped areas are some of the system-wide deficiencies affecting maternal health outcomes (National Planning Commission 2008; Vora et al. 2009; ITISC 2007).

Government spending in the health sector (combination of health care and research) is approximately 1.1 percent of the annual GDP, which is amongst the lowest in the world and does not meet the WHO’s recommended level of minimum 5 percent (Balrajan et al. 2011; Sen 2012; Mukherjee 2014). Since liberalization in 1991, India has witnessed the rapid development of a largely unregulated private health care sector, which has led to major human resource drain in the public sector. Economic reforms during the 1990s also led to a reduced role of the state in the
public health sector, which has severely affected the quality of care available in public health care facilities (Baru 1999; Baru and Bisht 2010; 7-9). A 2007 study of the emerging health care market in India observed: “In 2003, fee-charging private companies accounted for 82% of India’s $30.5 billion expenditure on health care. This is an extremely high proportion by international standards. Private firms are now thought to provide about 60% of all outpatient care in India and as much as 40% of all in-patient care. It is estimated that nearly 70% of all hospitals and 40% of hospital beds in the country are in the private sector” (PWC 2007). Additionally, the imposition of user fees on below poverty line (BPL) health care seekers in private healthcare facilities - contrary to the policy of free health care for BPL population in exchange for state subsidies (on infrastructure costs, duty free equipment importing, highly subsidized land for facility construction) - is one of the chief barriers to access to health care for the disadvantaged.

The argument that creating a universal health care system would be quintessential to salvaging the state of health disparities (and particularly preventing maternal deaths) in India have been made by many (Paul and colleagues 2011; see for example The Lancet January 2011 series titled India: Towards Universal Health Coverage). Specifically, the series observed “that a failing health system is perhaps India's greatest predicament”, however, the Centre’s initial proposal to create a universal health “coverage” system (by 2030) in the twelfth five year plan met with vigorous criticism and opposition from the civil society due to 1) heavy involvement of the (currently, unregulated) private sector in the proposal designed by the National Planning 

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35 To be precise, the public health care system began to deteriorate long before financial liberalization in 1991, which could be attributed to a number of historical factors. The most important and widely acknowledged of these factors is the categorical lack of investment in public health as a social sector in the post-independence era. A second and equally critical factor was the policy approach, which focused on vertical interventions (even prior to SAPs), especially family planning and reproductive health, in comparison to establishing a functioning primary health care system. For an excellent analysis of historical factors, see Gangoli, Duggal and Shukla (2005) edited volume Review of Healthcare in India (published by Centre for Enquiry in Health and Allied Themes), available http://www.cehat.org/publications/PDF%20files/r51.pdf
Commission\textsuperscript{36} and 2) the proposition of a “managed care” model of public health-care provision such as in the United States indicating a “semi-privatization of public health facilities, along with expanded public funds being given to the private sector and commercial insurance without consideration to public health logic” (Gaitonde and Shukla 2012 n.p).

\textit{Challenges of Governing the Health Sector}

India is a constitutional federalist state and health is a state subject. Yet, India is also an example of centralized federalism where power and by extension planning, policy design and resource allocation (including distribution of donor aid) has historically rested mainly with the union/central government, although implementation is largely left to state governments (Kohli ed. 2001; Sinha 2005). Essentially, the Union mostly (with the exception of progressive states such as Tamil Nadu and Kerala that have historically performed well on health and welfare indicators) leads in health policy & planning and resource distribution (led by the National Planning Commission and the Union Ministry of Health and Family Welfare) whereas policy implementation is left to the sub-national entities. Nonetheless, as mentioned earlier, sub-national state capacity to absorb and direct resources as well as to efficiently implement policy (including undertaking research and building technical capacity) varies widely and has an undeniable impact on health outcomes. In fact, poorer states with larger populations and greater proportions of national disease burden “spend only half of more advanced states” and despite provision of

\textsuperscript{36} The National Planning Commission was established in 1950 by a “Resolution of the Government of India” and its objective was to “promote a rapid rise in the standard of living of the people by efficient exploitation of the resources of the country, increasing production and offering opportunities to all for employment in the service of the community. The Planning Commission was charged with the responsibility of making an assessment of all resources of the country, augmenting deficient resources, formulating plans for the most effective and balanced utilization of resources and determining priorities”. It produced five year plans that guided planning and policymaking in various sectors at the central and state level. However, it was dismantled toward the end of 2014 by the new government that emerged after the 2014 General Elections. It has now been replaced by the NITI Aayog (National Institution for Transforming India Policy Think Tank).
equalization grants from the Finance Commission, remain dependent on fiscal transfers from the Central Government (Mukherjee 2014, 23). This is why Mukherjee (2014) maintains that the Centre must encourage states to “prioritize expenditure on health” (23). Some scholars have attributed this historic reliance on the Union to its excessive meddling in financial and general administration of sub-national health systems (see Peters, Rao and Fryatt 2003; Pahwa and Beland 2013). They do, however, acknowledge that this is also partially linked to repeated and massive fiscal management of centrally disbursed funds in many states; as well, the inability of sub-national authorities to redistribute funds in an effective manner, which can attend to its health system infrastructure and resource challenges, beyond managing personnel wages. In a nutshell, the extent of union’s involvement in sub-national health system governance is to some extent tied to the uneven political sub-national political and economic development and the size and complexity of implementing health care for a massive population.

But at the same time, scholars remind that this centralization of power in the Union arose from creation of the Union Ministry of Health and Welfare immediately following independence (in 1947) for the very purpose of population stabilization (Peters, Rao and Fryatt 2003). A recent analysis of inter-governmental fiscal transfers pointed out that according to the 42nd amendment37,38 (1976) of the Indian Constitution the Central Government holds “major responsibilities in providing health care services” particularly in relation to “population control and family planning” (Mukherjee 2014, 17). Others have pointed to the ways centralization of

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37 The 42nd Amendment was introduced in 1976 under the leadership of Prime Minister Indira Gandhi. Due to the nature of the changes, that provided sweeping powers to the Office of Prime Minister, which suspended fundamental civil liberties and considerably reduced the power of judiciary to review any constitutional amendments made through majority vote of the Parliament, it has been called a “mini-constitution” in itself. It transformed India into a parliamentary sovereignty and made fundamental rights conditional (and suspendable during times of emergency and in “national interest” and “public interest”). See here for the amendment http://indiacode.nic.in/coiweb/amend/amend42.htm.

38 The most controversial one (reduces the power of judiciary to review constitutional validity of laws) until date and undertaken during the Emergency years (1975-77).
power (especially in relation to family planning policies) by Central Government and constant interference in health governance at sub-national level continues to undermine authority of the latter. In the post-NRHM era, this “subordinate position” of sub-national authorities has been further complicated by Central Government’s selective and varying efforts to incentivize (though fiscal transfers) the former to improve administration and management of health care systems due to historically poor and underdeveloped sub-national capacity and planning (Pahwa and Beland 2013, 1). Such incentivizing efforts have been counter-productive to India’s ability to introduce large scale health sector reforms (Ibid).

**Constitutional and Legal Context**

As indicated in the previous chapter, the Indian Constitution does not explicitly guarantee a right to health and the Indian parliament has not created comprehensive legislation on provision of health and health care. This is likely due to the directive principles on socioeconomic rights in the Constitution, which recognize that health and health care are sub-national state responsibilities, “although [they are] not enforceable by any court” (Grover, Misra and Rangarajan 2014, 431). References to health under Part IV (Directive Principles to States) of the Indian Constitution can be found in Articles 39e, 39f and 47 but these are admittedly vaguely termed39 except in case of Article 47 (“Duty of the State to raise the level of nutrition and the standard of living and to improve public health”) (Ministry of Law and Justice 2012, 19 and 21). This must be located in the complex relationship between the Union and state governments and

39 39e: “that the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength”; 39f: “that children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment” (Ministry of Law and Justice 2012, 19-21). Available from here: [http://lawmin.nic.in/olwing/coi/constenglish/Const.Pock%20Pg.Rom8Fsss%287%29.pdf](http://lawmin.nic.in/olwing/coi/constenglish/Const.Pock%20Pg.Rom8Fsss%287%29.pdf)
the distinct nature of Indian federalism discussed earlier. For example, the Central Government does not have the authority\textsuperscript{40} to create legislation governing “public health and sanitation, and hospitals and dispensaries” since those come under the authority of state governments (Grover, Misra and Rangarajan 2014, 431), which unfortunately does not have control over revenue collection and financial resource allocation overseen by the Union and the National Planning Commission (Peters, Rao and Fryatt 2003; Pahwa and Beland 2013).

Hence, there are no central/Union laws on health financing which is delegated to policy makers, the executive branch (and has been historically influenced by the National Planning Commission). The Consumer Protection Act 1986 (a central law) partially attends to “deficiency in service and medical negligence” and the Clinical Establishment (Registration and Regulation) Act 2010 has partial relevance for the private sector “by imposing minimum requirements of space and infrastructure for the effective functioning of all medical establishments” (Grover, Misra and Rangarajan 2014, 432-3). Hence, there are no legal oversight or regulation of “rights, duties, and available remedies between recipients of services and service providers and health care workers” (Ibid., 432).

\textbf{The Right to Health in India}

The Supreme Court of India has “collapsed” the distinction (in Francis Coralie Mullin vs. The Administrator, Union Territory of Delhi) between negative rights (civil and political rights) and positive rights (economic and social rights, such as the right to health and health care) in making clear connections between the two (Grover, Misra and Rangarajan 2014). The fundamental right to health was \textit{judicially interpreted} on the basis of right to life recognized in

\textsuperscript{40} Unless two or more states request Central Government to do so, but such legislation may not be binding on other states.
Article 21 of the constitution by the Supreme Court\textsuperscript{41} (Ibid.). But as Parmar and Wahi (2011) indicate, the decision of higher courts (the Supreme Court and the state high courts) has generally tended to highlight “specific minimal obligations” but not a “comprehensive definition of the core content of the right [which is] yet to be articulated” (166). This is also a reason why the higher courts in India continue to draw on international covenants such as UDHR and ICESCR (ratified by the parliament) to adjudicate health rights cases (as also seen in the Delhi High Court case)\textsuperscript{42}. This has been particularly prominent in incidences of health rights litigation given the lack of domestic health and health care legislation (Grover, Misra and Rangarajan 2014). Balakrishnan (2008), however, has argued that these efforts of Supreme Court fall short because they do not undertake extensive consideration of the norms and principles guiding the development of such international laws in interpreting and applying them to adjudication of cases that have implications for legal precedent setting.

Furthermore, the higher courts have also shown a tendency to adjudicate cases that uphold individual right to health but have not commented on systemic changes that can affect health equity for the wider population (Wahi 2012). This has ramifications for the use of legal accountability to advance human rights claims to maternal health in India and might suggest the limitations of judicialization as a framing strategy to address maternal health inequities for the broader population. Parmar and Wahi (2011) point to the “mixed record” of the Indian Supreme

\textsuperscript{41}The first incidence of this occurred in 1996 when the Supreme Court directed the government to pay compensation to the petitioner who had been denied emergency medical treatment by seven hospitals. The Supreme Court has exhibited similar behavior at various other occasions while adjudicating cases related to various dimensions of health and health care (see Parmar and Wahi 2011, 166 for a list).

\textsuperscript{42}Time and again, the Supreme Court has also collapsed the superiority of domestic laws over international laws (where comprehensive legislation is lacking and given the state’s constitutional obligation to uphold international law), especially where the two do not differ and the latter strengthens the promise of constitutional guarantees – as in the case of Vishakha vs. State of Rajasthan (1997) where the Supreme Court recognized the failure of state to create domestic laws to protect women (gender-based discrimination at work place which later paved the way for sexual harassment legislation in 2013), despite having ratified CEDAW in 1993.
Court in making health systems more responsive to the needs of the poor, which they attribute to the Court’s failure to assign heavy penalties in case of non-compliance and difficulties in implementing structural reform without “oversight mechanisms” (lack of monitoring and facilitative mechanisms) (182). Similarly, the higher courts have also had a dubious track record – likely due to the wide scope of interpretation of right to health, as opposed to well defined rights and entitlements or a patient’s charter/bill of rights – with offering verdicts, indicating conflicts between decisions from different benches and high court judges (Ibid.). The higher courts have, however recognized that the issue of “efficient and effective allocation of financial resources” in the design of health systems (especially in the public health sector) is a legislative responsibility (Grover, Misra and Rangarajan 2014, 450). The willingness of the Indian higher courts to leverage international law to adjudicate health rights litigation, yet reluctance to direct legislators to consider the need for transformative reform and oversight of the health care sector has been characterized as odd by some (Rajagopal 2007, 158-9).

This contradiction is noteworthy in relation to the famous right to food verdict (Civil Writ Petition 196 of 2001) issued by the Supreme Court of India in 2001 in a public interest litigation filed by the People’s Union of Civil Liberties (PUCL). The verdict was later legislated as the National Food Security Act (NFSA) in 2013. But the verdict allocated greater financial resources to the multi-billion dollars (per year) and massive state funded nutrition programs (one example being the existing Mid-day Meal scheme) to improve the nutritional status of school age children (Hassan 2011)\(^43\). The verdict is also significant for maternal health outcomes since it recognizes

\(^43\) In 2014-15, the program cost the Central Government (with 75 percent Centre and 25 percent state contribution) approximately INR 10,526.97 Crore or US$ 15 billion and fed 120 million children on a daily basis) (Ministry of Human Resource Development 2016)\(^43\). Some have argued that the programs created as a result of the verdict are financially unsustainable for the state, while others point to increased primary school enrollment (including enrollment of girls) as an indirect benefit of the program (Right to Food Campaign 2014; Indian Economic Association 2013).
the maternal nutrition related scheme for BPL population to also fall under its scope (GoI 2013, 12). Crucially, the verdict was accompanied by the creation of the “Office of Supreme Court Commissioners for Right to Food” established by the Supreme Court of India (along with advisers in each state). The Office of Commissioners was headed by retired senior bureaucrats who were also members of Prime Minister’s National Advisory Council. This unit was responsible for oversight and monitoring, including quality checks, surprise field visits, and sometimes unearthing the massive corruption involving politicians and private contractors in the public distribution system⁴⁴. The Commissioners’ office was also allowed to accept reports from members of civil society or concerned citizens (See official webpage of the Office of Supreme Court Commissioner 2011). But the success of this particular case has also been attributed to the exemplary nature of strategic litigation undertaken “within a broader public advocacy campaign” and repeated “follow ups” (in court) from grassroots Indian organizations (Parmar and Wahi 2011, 159). A massive coalition of interested domestic NGOs, media, academics and public intellectuals, and independent food and health activists, has come to exist and has supported the verdict in form of the “Right to Food Campaign” (Right to Food Campaign 2014; see www.righttofoodcampaign.in). In fact, the PUCL vs. Union of India (196/2001) is an ongoing case (petition first filed in 1999) with multiple court hearings and interim orders that have led to subsequent verdicts in relation to related social issues – ranging from maternity (nutrition) entitlements, rural employment guarantee, homelessness, to even social security and pension entitlements (in relation to access to the public distribution system) (Ibid.). But possibly the most noteworthy element of the case was the issue of state capacity and the ability to clearly attribute responsibility since the petition in the globally acclaimed right-to-food case pointed to huge

⁴⁴ Apparently, its periodic reports were “dreaded” by the Parliamentary sub-committee on the same issue (through personal communication with various participants during field research).
reserves (50 million tones) the government had in face of wide-spread drought in many parts of the country. Further, the petition also highlighted how the government (both Central and all the states) had failed to meet their obligations to drought affected citizens as spelt out in “famine codes” and “scarcity manuals” (Right to Food Campaign 2014; Hassan 2011). This is unfortunately, not the case in India for health and health care. In light of everything that has been discussed so far about the conditions of public and private health system in India, the issues of state capacity and the absence of clear accountability (encompassing legislating and regulating the health sector, budgetary allocations, resource augmentation, workforce enhancement, tackling challenges of structural violence) will likely present challenges for using judicialization to affect political priority for maternal health.

The Indian Higher Courts & Coercive Population Policies

The progressive and pro-poor verdict pronounced by the Supreme Court in the ‘right to food’ case, however, cannot be generalized to indicate the Court’s stance on other related policy domains. Of particular significance to this study is the Supreme Court’s position on the two-child norm promoted by various state governments, which is in direct opposition to the promises made in the National Population Policy established in 2000. In 2003, the Supreme Court defended a law promoted by the State Government of Haryana, which prevented individuals with more than two children from contesting in elections in local Panchyat Raj institutions. In fact, the three-judge bench unanimously indicated that the law was not a violation of fundamental rights and was in accordance with “national interest” (Rao 2008, 297). An earlier decision pronounced by the State High Court in Rajasthan (a state with high fertility and extremely high MMR) similarly
argued that elected officials stand to be role models for the local populations and support
government policies and (family planning) spending to curb the “menace of population
explosion” (Sarkar and Ramanathan 2002, 42 as quoted in Rao 2008, 297). Similar laws were
devised in early 2000s in at least four other states – Andhra Pradesh, Madhya Pradesh,
Chattisgarh and Orissa – all of which exhibit high fertility rates (and incidentally high MMRs).
One study undertaken to examine the consequences of introduction of these policies found that
80 percent of those excluded from contesting in local elections were Dalits, Adivasis and
members of Other Backward Classes (OBC) (Buch 2005). Moreover, few studies also recorded
very high instances of wife abandonment, refusal to recognize paternity, deliberate mistreatment
of girl children including refusal to register birth or seek immunization, forced termination of
pregnancy and especially in cases of female fetus (Ibid.; Sama 2005). This demonstrated how
judicial shortsightedness of Indian higher courts and support of the “national interest” (in relation
to state promotion of two-child norm) systematically discriminated against the already
marginalized sections of the Indian population – not only creating and perpetuating differentiated
categories of citizenship, but also undermining the gendered nature of its wider social impact.
The elite and upper class (and caste) bias of the legal system revealed in these instances is not the
only shortcoming of the Indian courts, which has also been plagued with gender (read, anti-
women) biases, even when it has tried to be progressive (at least on the surface) about gender
equality. The implications of selected cases of relevance to this study are discussed below.

Politics of Women’s Rights & the Indian Higher Courts

Additionally, the Indian higher courts have pronounced a number of verdicts relating
specifically to women’s right to health (including different dimensions of reproductive self-
determination) that are of interest to this study. These are very briefly reviewed here because they
reveal the tricky nature of judicial intervention in women’s reproductive health in India and point to the prospects and challenges of using the law to advance women’s rights.

In Suchitra Srivastava and Anr. V. Chandigarh Administration, which involved the right of a mentally disabled woman and victim of rape (in a state-run institution) to not be forced into an abortion (by the state), the Supreme Court upheld the women’s right to reproductive health. The Court concluded that “mental illness” and lack of access to sufficient resources for child rearing were inadequate grounds for the state to suggest that a woman seek termination of pregnancy. This ought to be considered a progressive verdict, especially given the historical tendency of the state to coerce poor and marginalized women into seeking abortion and sterilization services as methods of family planning. However, in producing the verdict the Court argued that “termination of pregnancy has never been recognized as a normal recourse for expecting mothers” (as cited in Grover, Misra and Rangarajan 2014, 447). Arguably, one could interpret this as assigning life to the fetus and also upholding women’s customary gender role as mothers. In other words, “the Court let slip the opportunity to untie a woman’s right to reproductive health with traditional and societal expectations” (Ibid.). A similar stance was assumed by the Supreme Court in reviewing the lack of enforcement of the Pre-Conception and Pre-Natal Diagnostic Act (PCPNDT), which was yet to be seriously implemented even five years after its coming into existence in 1994. In Vinod Soni v. Union of India (2005), the constitutionality of the PCPNDT Act was questioned in relation to right to personal liberty of a woman (and her male partner) to exercise her right to reproductive health under Article 21 of the Indian Constitution. The Court upheld the constitutionality of the PCPNDT Act (given that its initial aim was to uphold gender equality and prevent termination of the fetus based on its gender) but not by raising ethical concerns over the notion of sex-selective abortion. Rather the Court pointed to the life of a fetus and concluded that the act was meant to advance the “right to
every child to full development” (Ibid). In sum, each of these significant judgments reveals the court’s attempts to be progressive on the issue of gender equality but based on logic that is undeniably couched in traditional social and cultural norms that have been historically criticized by women’s rights advocates.

But to be fair, perhaps this also points to the wider issue that courts and legal systems as formal institutions are reflective of their societies they exist in (Kapur 2007). Hence, they may not be able to entirely escape its dominant logics that contribute to women’s secondary social status to begin with. In the Indian context, however, such legal fallacies are not simply limited to the tricky terrain of women’s reproductive-self determination as discussed above. Similar issues have arisen in relation to other cases pertaining to women’s rights, such as: (1) the issue of conceptualizing “consent” in case of rape in connection to the Supreme Court decision on Tukaram v. State of Maharashtra (1979) (Baxi, Dhagamwar, Kelkar and Sarkar 1979 in John 2008, 272); (2) the pro-family (preserving marriage as an institution) stance of the Family Court System created to address issues of family as recommended by Committee on Status of Women (Agnes 2008, 278); and (3) the challenges of defining “unwelcome signs” and “outraging the modesty of a woman” in case of sexual harassment allegations which “provide scope for reproducing and reinforcing dominant assumptions about sex, women’s sexuality and sexual practice” (Kapur 2008, 288-9).

Perhaps this is why some Indian feminist scholars and practitioners are cautiously optimistic of using courts and calls of “violation of [women’s] human rights and fundamental rights” to address the problem of gender inequality (John 2008, 262-6; Agnes 2008; Kapur 2008; Haskar 2008). Haskar (2008) writing on the violation of (individual) rights of women from historically marginalized and minority groups (Adivasi and Dalits for example) in India cautions (liberal, educated, upper and middle class) feminist advocates to not oversimplify issues and
ignore the ways collective rights of marginalized communities may have been neglected. She also emphasizes the importance of developing a nuanced understanding and awareness of issues and mobilizing outside the courts as well as the importance of a grass roots social movement to shoulder the burden of legal reforms (284). As well, she reminds of the intricacies of framing women’s rights as human rights in regards to issues where no equivalent masculine notion may exist. Drawing on Carol Smart’s words she observes:

… ‘the rhetoric of rights has become exhausted, and may even be detrimental. This is especially the case where women are demanding rights which are not intended (in an abstract sense) to create equal rights with men, but where the demand is for a “special” right (e.g. women’s right to choose) for which there has been no masculine equivalent.’ (1989, 139 as quoted in Haskar 2008, 284).

Therefore, using courts to frame women’s rights to maternal health as a human right may be accompanied by several challenges – lack of clear health and health care laws and entitlements, institutionalized gender biases, and unique (and complex) conceptualization of the right to maternal health in relation to women’s rights. Arguably, there are opportunities as well given the precedents set by the higher courts as in the ‘right to food’ case. But whether the courts can tackle and resolve the complexities that arise from a differentiated notion of womanhood and stratified citizenship (from different forms of social hierarchy) surrounding maternal morbidity and mortality, remains to be seen. This challenge is significant to this study given that the high prevalence of maternal morbidity and mortality among poor and marginalized women (as opposed to all women) in India (Sanneving et al. 2013). It is also noteworthy given that Indian women’s movement has historically failed to capture the heterogeneity of Indian women’s experiences, especially the needs and interests of marginalized women (John 2008; Menon 2008;
Sen 2012). The next section briefly delves into these issues, given their centrality to the politics of framing right to maternal health as a human right in India.

**Citizenship and Feminist Activism in India**

In developing a framework of comprehensive social determinants of maternal health in India, Sanneving and colleagues (2013) undertook an extensive review of sixty-six empirical studies (published between 1995 and 2012) of maternal and reproductive health disparities in the country. Of the five major “closely interlinked” structural determinants – economic status (class), gender, education, social status and age (adolescents) – social status (caste, tribal, religious affiliation) was found to be a significant structural predictor of access to formal health care facilities and health care providers. For example, utilization of maternal health care services (birthing in facilities, access to skilled birth attendant) was much lower among women from Dalit, Adivasi and Muslim backgrounds; similarly, availability and awareness of contraceptive choices was lowest among them although usage of sterilization services was comparatively higher than for the general female population in the same geographical regions (Ibid., 6-8). Put simply, those who are most likely to experience maternal morbidity and mortality shoulder the burden of being not simply women of weaker economic class but also of discriminated and minority sections of the society. A study commissioned by UNICEF India in sixteen districts of six states in central and Northern India – Bihar, Rajasthan, Madhya Pradesh, West Bengal, Jharkhand and Orissa – demonstrated that 61 percent of women dying in childbirth were from the lowest caste, or otherwise known as “untouchables” (2008, 6). These findings about who is most affected by adverse maternal health outcomes is essential to debates over maternal health and human rights. This is because the claim of women’s rights are human rights tends to universalize and thus, homogenize and invisibilize different notions of womanhood and women’s experiences
of pregnancy and childbirth. But maternal health disparities in India point to complex and differentiated notions of citizenship experienced by pregnant and parturient women.

The importance of social status as a major determinant of maternal health disparities is noteworthy in relation to the history of feminist mobilizations in India, many of which have a record of ignoring/under-representing the needs and interests of women from marginalized segments of the society (John 2008/2012; Menon 2008; Sen 2012). They have been dominated by issues affecting educated, urban, middle and upper class women, such as dowry, divorce and domestic violence, sexual violence, eve-teasing, non-discrimination and sexual harassment at the workplace, sex-selective abortion, concern of unregulated contraceptive injections and so on (John 2012; Sen 2012). The point being the politics of female morbidity and mortality (and by extension maternal morbidity and mortality) as experienced by poor and marginalized women (“merely 2.4 percent” of female morbidity by some feminists in Jain and Rao 2001, as highlighted earlier in this chapter) may be distinct from that experienced by their elite counterparts. Alternatively, gender, class, social status, and maternal health adversities may combine to produce distinct experiences of pregnancy and childbirth that are alien to women from comparatively elite segments of society.

Arguably, this is hypothetical given the near absence of any reference in the literature to the issue of maternal health disparities in relation to feminist activism and/or women’s movements in India. Nonetheless, it is difficult to overlook when considering criticisms laid by Dalit, Adivasi and feminists concerned with women from non-dominant social segments who have criticized Indian women’s movements for not being inclusive of their concerns (Manorama 2008; Namala 2008; Xaxa 2008; Dube 2008). For example, Manorama (2008) reminds that Dalit women are “thrice marginalized” (gender-class-caste) and “the downtrodden among the downtrodden” and as such their concerns may fail to interest feminist advocates because they are
seen to dilute (and therefore distract) women’s common concerns by raising specific concerns of Dalit women (445). Andharia and Batliwala (2008) maintain that the “agenda for [the] women’s movement at the national level is still framed by middle class women’s perspectives” (12). They also remind that “very personal matters (such as sexuality)” that dominate such agenda may not be priority concerns for Dalit and Adivasi women who “were still dealing with basic problems such as lack of access to resources” (Ibid.; emphasis added). Rege (2008) raises equally worrying issues facing Dalit and Adivasi women whose concerns may not find a home in Dalit or Adivasi movements, which aim to underscore the collective struggles of an entire population and are less receptive to the exclusionary politics facing women in their communities.

Nevertheless, these point to the challenge of using the universal language of human rights to alter political priority surrounding maternal morbidity and mortality which disproportionately affects women from communities that have been historically deprived of equal citizenship status and rights. This may take on a new meaning in the context of feminist anxieties surrounding maternal dimensions of women’s health given the history of state intervention in governing women’s reproduction. It is more, rather than less likely (in view of everything discussed so far), that the politics of framing women’s rights to maternal health as a human right will be viewed cynically by those concerned with advancing the agenda of women’s reproductive choice and rights given the ubiquitous links between reproductive and maternal health. This is of special significance with changing times (since mid 1990s) and nature of feminist struggles over health which is confronted with challenges of liberalization, globalization and internationalization of the politics of women’s health (Mukherjee 2002, Narayanan 2011, Tharu and Niranjana 1994). As John points out: “the entire problematic being covered in the name of population control – with women’s reproductive and sexual ‘choices’ now at its heart – has become one of the hardest areas for the [Indian] women’s movement to confront, where older strategies forged during the
developmental era [prior to 1991] serve feminists poorly under the present dispensation” (2012, 556). At the same time, raising the issue before courts stands to highlight many challenges, notwithstanding the various difficulties of navigating the legal system that has generally privileged the elite. The courts must simultaneously address the issues of gender equality and social inequities captured in maternal health disparities. The former has been partially guaranteed (formally through equality in the constitution) but remains to be realized substantively. The latter has been integrated into the design of state sponsored welfare schemes, such as access to maternal health and health care entitlements, promised to the BPL population in state policy (although not always actualized for various reasons).

**Conclusion**

In summary, there are five main contextual factors of likely significance to the politics of framing women’s right to maternal health as a human right in India. First, the emergence of maternal mortality reduction (albeit, as a largely bio-medical issues) in the political agenda may provide Indian maternal health right advocates a timely opportunity to use human rights to politicize the issue in order to secure political commitment and the resources that it deserves. However, despite official policy shifts, the politics of maternal health cannot be untied from the historical politics of family planning and population control – the older and hegemonic policy frame of women’s health in India. This is likely to be a challenge for framing women’s rights to maternal health as human rights, given its complex relationship to the politics of reproductive choice and rights and its particular history in the Indian context. Specifically, the challenges are likely to be on the strategizing front as well as for feminist mobilization and support, the former requiring particular attention so as to not be coopted by the state machinery to advance its own agenda.
Second, the existing policy design is dominated by a bio-medical approach and prioritizes interventions, which are insensitive to the gendered and social realities (be it female malnutrition, child marriage, freedom of decision making, reproductive self-determination, agency to oppose individual and systemic oppression and such) that determine women’s access and utilization of maternal health care services. Effectively, this reveals the ways secondary and unequal citizenship status of women despite constitutional guarantees of formal equality determine their maternal health outcomes. Given that these formal guarantees of equality and protection are currently not upheld and enforced by the state, it is not clear how a human rights frame may be useful to draw attention to these issues.

Third, the resource deficient and dysfunctional health system poses significant challenges for fulfilling promises made by the existing policy design. Collectively, the second and third issues discussed above demonstrate two ends of the spectrum of structural barriers (and likely competing goals) that maternal health right advocates must consider in designing human rights frame(s) of maternal health. However, securing the political (especially, legislative) commitment and resources to improve the health system (including oversight and regulation of the private health care sector) using a human rights frame(s) is likely a challenge due to the historically low political priority attached to health and health care.

Fourth, the traditionally low political priority attached to health is likely a result of or at the least intensified by constitutional ambiguity on state obligation for population health (and citizens’ health care rights and entitlements). Nevertheless, there is historical and legal precedence (as in the right to food case) to suggest that the Indian higher courts – should they choose – can create concrete provisions that can *grant* maternal health care rights and entitlements to Indian women (however recognized, deduced or interpreted by the court) and ensure they are fulfilled. This is likely to be dependent on maternal health right advocates’ ability
to strategize and mobilize broader civil society (and public) support to compel higher courts to act in a way that forces the Indian state to re-consider its status-quo approach to the issue. But again, it would be important to consider the ways lack of enforcement of existing fundamental rights and equalities granted to women continue to perpetuate the problem. On this, however, the Indian state (including courts) has an insufficient, and somewhat ambiguous, track record.

Finally, maternal health right advocates must strategically underscore the unequal citizenship (beyond gendered) dynamics that arise from social inequities underlying adverse maternal health outcomes. This particularly resonates with the reality that largely poor and marginalized women experience adverse maternal health outcomes. It remains to be seen whether and how this can be done by using the universal language of human rights. But being able to do this successfully will have implications for mobilizing support from women’s and other related social movements for the cause (improving maternal health and well being) that may be crucial for pressuring the state to take progressive action, be it on the policy, institutional or legal front. The next chapter examines these contextual insights against existing theoretical knowledge to outline the debates and gaps that inform this study.
PART II: THEORETICAL, ANALYTICAL & METHODOLOGICAL CONSIDERATIONS
Chapter 3: Theoretical Debates & Gaps

This chapter locates the politics of framing women’s rights to maternal health as human rights, including the use of judicialization as a framing strategy in the relevant literature.

It is divided into two parts. The first part examines the implications of debates & gaps arising at the intersection of five bodies of literature: determinants of maternal morbidity and mortality; maternal health and human rights; maternal health, Millennium Development Goals (MDGs) and human rights; women’s rights, human rights and development; and women’s rights, citizenship and reproductive justice. The debates and gaps arising at the intersection of these literature constitute the cornerstones of the study. In contrast, the second part considers existing knowledge in relation to judicialization of rights politics which is particularly relevant in theorizing the Delhi High Court case. The analysis draws on debates from two related bodies of literature that can be characterized as rights and judicialization of politics; and judicialization of social (including health) rights (developing countries). The discussion in this chapter locates the key contextual factors from the previous chapter – on historical, policy, institutional, constitutional/legal and citizenship and feminist activism dimensions of maternal health politics in India – in the existing literature and outlines likely implications for the study.


Debates Over Determinants & Policy Interventions

There is a debate over the significance of proximate and underlying determinants of maternal morbidity and mortality and a lack of consensus among key actors on appropriate policy interventions to address the problem (Maine and Rosenfield 1999; Yamin and Maine 1999;
Freedman 2001; Cook 1998/2001; Fathalla 2006; Maclean 2010; Sen 2007/201145). This is important to debates over the scope and contents of claims of ‘human right to maternal health’.

While some advocate for consideration of direct causes and proximate determinants (Maine and Rosenfield 1999; Yamin and Maine 1999), others also emphasize the importance of indirect causes and underlying determinants (Cook 1998/2001; Fathalla 2006; Maclean 2010; Sen 2007/2011). Direct causes and proximate determinants ensure health system readiness, such as provision of various emergency medical interventions that can help manage obstetric complications and prevent death. They also emphasize creation of vital registration systems and accompanying resources that can track and monitor pregnant women to address obstetric complications in a timely manner. These collectively indicate state of health system readiness (Maine and Rosenfield 1999; Yamin and Maine 1999/2005; Freedman 2001, 2002, 2003a and b, 2005).

In contrast, indirect causes and underlying determinants require addressing a multitude of factors that determine women’s status-quo health and wellbeing and access and utilization of health care services, which in turn can improve overall maternal health outcomes. These refer to women’s social status (in public and private spheres), intersecting46 social identities and poverty which determine access to resources within the household and services at health care facilities. These in turn affect health status, the decision to seek care, the quality of care received at health facilities (if at all), and utilization of health services (Cook 1998/2001; AbouZahr 2003; Fraser

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45 Please note that Prof. Gita Sen is an internationally respected, Indian (and based out of India) scholar specializing in the study of gender, health and development (an economist by profession). She has been a chair person/member of several high level international forums/groups including WHO Commissions on Social Determinants and Macroeconomic Determinants, High Level Task Force for ICPD, and the General Coordinator for Development Alternatives with Women for a New Era (DAWN). She has written on women’s health (including maternal health) in both Indian and Global Context. Here, I am referring to her work that is of global scope.

46 Maternal health outcomes are often intersectional in nature because they result from interplay of multiple identity based factors, such as race, ethnicity, caste, class, religious / tribal affiliations (George, Iyer and Sen 2005; Maclean 2010; Johnson 2014, 29-30).
For example, women’s access to resources (food and financial) within the household generally as well as during pregnancy can be gendered (that is, connected to their secondary social and familial status) which determines their health conditions (such as anemia, which is a leading contributor to hemorrhage during childbirth) and can also raise the risk of complicated pregnancies. Similarly, their decision to seek health care services is affected by their financial capability as well as previous experience with health care facilities – be it quality and/or availability of service (especially for women from socially marginalized background who have faced systematic discrimination and abuse in accessing health care services). Alternatively, women’s access to essential emergency obstetric care can also be affected by the family’s decision to seek care (be it for financial reasons, the low priority attached to women’s health or otherwise). As well, access to available and quality reproductive health services, such as abortion, contraceptives (temporary or permanent, such as sterilization or tubal ligation) and family planning counseling only partially determine utilization; this is attributed to some women’s weaker status in private and intimate relationships with male partners as well as the often hierarchical relationship between health care service provider and seeker (Ibid.).

Arguably, these two distinct sets of factors reveal the different structural barriers (health system, community, family) preventing women from achieving better maternal health outcomes. However, each recommend prioritizing a very different set of policy interventions to address maternal morbidity and mortality.

**Policy Interventions to Address Proximate Determinants of Maternal Health**

In relation to proximate determinants, the government’s ability to establish functioning (and accessible) primary health care facilities is considered important for provision of essential
reproductive health services and emergency obstetric care (EmOC) (Maine and Rosenfield 1999; Yamin and Maine 1999/2005; Freedman 2001). The health system’s inability to provide appropriate and timely interventions due to insufficient resources (financial, physical and human) can deprive women of necessary EmOC. Such weak health systems in developing countries may be the result of historically poor state capacity in administering health service, poor investment in the health sector and/or introduction of neoliberal economic policies (such as Structural Adjustment Programs or SAPs in 1980s and 1990s) by international financial institutions (IFIs). SAPs resulted in reduced state support of public health care systems and introduction of user fees, which imposed further affordability concerns for the poor. A high quality and strong primary health care system in poor and resource scarce context has been demonstrated to be a significant determinant of reduced health disparity (and reduced disease burden) for the overall population (Shi, Starfield, Politzer and Regan 2002; Starfield, Shi and Macinko 2005; WHO 2006; De Maeseneer et al. 2008).

Specifically, in relation to maternal mortality reduction, experts have expressed concerns over lack of state investment in resources and a dwindling health care workforce (accelerated by growth of a parallel and often better paid private health care sector). They maintain that policy designs, which advocate for “support for private services (through vouchers or other means)” are questionable since private health care providers are rarely committed to the goal of equitable and quality health care for the “underserved populations” (Maine 2007, 1381; Maine and Rosenfield 1999; Yamin and Maine 1999/2005; Freedman 2001/2002/2003a and b/2005). Some have also raised concerns over the burden of pregnancy and childbirth related expenses, which regularly push poor families into further poverty by increasing household and individual debts (Berer 2007; Maclean 2010). Unger and colleagues’ multi-country (developing) study showed that the failure of comprehensive primary health care, led by underfunding and collapse of public health
systems, is one of the main determinants of stalled progress on maternal mortality reduction efforts in developing countries (2009). Others support these concerns over stalled progress on maternal morbidity and mortality as well (Maine and Rosenfield 1999; Bhutta and Dewraj 2000; Shiffman and Smith 2007; Berer 2007).

More importantly, scholars who emphasize the role of well-functioning primary health care facilities – and health system more broadly – in managing the proximate determinants of maternal morbidity and mortality underscore the significance of state commitment to public investment in health and health care sector (Freedman 2001/2002/2003a/2003b/2005; Yamin and Maine 1999; Yamin 2010/2013). From this perspective, the creation of NRHM and public investment in JSY following political prioritization of maternal mortality reduction in India in 2005 would be considered partial victories. But for the potential of these initial political mobilization to be completely fulfilled, policy planning and budgetary allocations that can ultimately lead to the establishment of well-functioning primary health care centers in all corners of the country (and not just CCT programs) will be essential to ensuring improved maternal health care for all women. The implicit assumption being health system readiness (that is, provision of accessible, available and quality maternal health care) will guarantee women a safe passage through pregnancy and childbirth and allow women unwilling to carry pregnancy to term access to essential reproductive health services including safe abortion care. However, it is not clear how these will address the apathy and abuse by health care workers toward women from poor and disadvantaged background trying to access health care services – as in India’s case. The scaling up health system does not address the ways provision of care can be insufficient to ensure actual utilization (not simply uptake) of services – such as, family planning counseling and a range of contraceptive methods – by women given their minimal decision making capacity in intimate relationships about their health and body within the private spheres. Likewise, provision
of services to address anemia, such as iron tablets and nutrition schemes for pregnant women (as in the case of India), are insufficient in that they do not address issues of intra-household gender discrimination with allocation of food (and various other fronts). This is attributed to both the primary and breadwinner role of males (and therefore needing more strength and nutrition) within the household as well as social norms that lead women, including pregnant women, to address nutritional requirements of children and male household members before considering their own needs (Bentley and Griffiths 2003; Sethuraman and Duvvury 2007; also see Kabeer 1994). Moreover, it is also not clear how advocates of health system readiness would respond to systemic discrimination and power hierarchies in the health system toward women from some social segments who are coerced into submitting to health care interventions to support the state’s family planning goals and population control objectives. Such attitudes are associated with prevailing social norms about gender and social hierarchy that are institutionalized in the form of health system discriminations and have also been linked to lack of reproductive choice – globally and especially in India (Hartmann 1995; de Oliviera, Dias and Padmadas 2014).

Policy Interventions to Address Underlying Determinants of Maternal Health

Proponents of indirect or root causes maintain that health system interventions are excessively medicalized and inadequate to prevent maternal morbidity and mortality. Some critics have attributed the excessive focus of policy solutions on biomedical interventions in designing maternal health policy to medicalization of pregnancy and childbirth. Medicalization defined “as the systematic preference of the technological over the natural” (Johnson 2014, 49), is argued to be a partly a product of vertical design of health program planning in developing countries but is also a result of various socio-political factors, including but not limited to scientific (i.e. medical) advancements, organization of health care entitlements and policies (for e.g. policies that promote institution birth as ideal over other alternatives), role of key actors (such as professional medical associations) and so forth (Maclean 2010; Sen 2011; Johnson 2014; Clark 2014). For example, AbouZahr (2003) maintains that the highly visible advocacy role played by the Federation of International Gynecology and Obstetrics (FIGO) in promoting provision of better emergency medical care, at the least, has resulted in disproportionate focus on the biomedical dimensions of the problem and undermined the fact that pregnancy and childbirth are natural phenomenon and not diseases.
They point to the fallacy of such policy interventions that emphasize health system readiness and focus on “break[ing] the chain of cause and consequence near its very end” (Sen 2011, 22). Further, they argue that the excessive reliance on EmOC and health system readiness to prevent maternal morbidity and mortality is largely a short-cut approach – focusing on preventing deaths, rather than improving overall maternal health outcomes. Such short-term technical fixes, they maintain, may actually fail to deliver long-term and “sustainable” results in absence of interventions that can deal with underlying complex intersection of social and economic factors (Ravindran 1993; Sen 2011; Johnson 2014). This is because availability of qualified medical experts and health care workers does not guarantee access – and evenly – to health care for all women.

Health systems are after all social institutions and the services they provide are often accessible unevenly depending on the health care seeker’s gender, social and economic background (Iyengar et al. 2008). This should not be taken to mean an affordability issue; rather unequal access to health care services is very much a product of existence of simultaneous and complex intersection of individual identities (gender, class, race, ethnicity, religion and such) that point to wider social inequities (Sen 2011; George, Iyer and Sen 2005; Sen and Iyer 2012).

48 Prof. T.K. Sundari Ravindran, like Gita Sen, is an Indian economist specializing on issues of sexual and reproductive health rights. She is the coordinator of International Journal of Reproductive Health Matters and was a member of the UN MDG Task Force on Maternal and Child Health and Global Forum for Health Research. She has written on gender and health issues both within India and globally. Here, I am referring to the global scope of her work.

49 For example, despite the crucial role medical interventions play in high risk and obstetric complication cases, the high incidence of use of “unnecessary” medical procedures (whether diagnostic or surgical) in pregnancy and childbirth cannot be dismissed. These medical procedures could include misuse of oxytocin or intravenous infusions to artificially induce or “speed up” labour, forceful fundal pressure, unwarranted cesarean sections (or C-section), electronic fetal monitoring, epidural analgesia among others (Iyengar, Iyengar, Martinez, Dashora, and Deora 2008). The WHO (1985) recommends that standard C-section national rate should be in the range of 10 to 15 percent. However, C-section rate in Brazil is 36 percent for example, which is a combination of unusually high demand among privileged women but also due to “recommendation” of doctors in decision making because of “their expertise and authority to convince women to “choose” a caesarean section” (Johanson, Newburn and Macfarlane 2002, 892).
This is of particular relevance to India given that gender, class and social status interact to produce complex inequalities that are major determinants of maternal health disparities (Sanneving et al. 2013).

There are also other equally important concerns surrounding women’s access to health care that may arise in the private sphere which are not addressed by solely considering the proximate determinants of maternal morbidity and mortality. For example, within the scope of multi-country (developing) studies, scholars have pointed to the “status and empowerment - measured by education, employment, intimate partner violence, and reproductive health - affect women’s capacity to access and use services during pregnancy and childbirth or otherwise maintain good maternal health” (Gill, Pande and Malhotra 2007, 1350). Similarly, one study pointed to a household gender-bias (toward males) in health seeking behavior in two rural districts of Karnataka in Southern India, which exhibited very high rates of maternal mortality (Sen, Iyer and George 2007). This problem with access (and its consequence for health status) is largely related to women’s ability to make independent decisions about their health and need to seek health care. Other widely prevalent issues that determine maternal health outcomes in India, such as domestic violence during pregnancy including sexual violence as well as involvement of family members in reproductive health decision making (including decision to seek permanent contraception, abortion and so forth) have also been recorded by researchers (see Sanneving et al. 2013, 5).

Unfortunately, for women from disadvantaged backgrounds, access to available medical care may translate into medical interventions without prior discussion or consent from her or her family members indicating an abuse of power by health care providers. This trend is particularly on the rise with the growth of private practitioners and commercially provided health care, where medical “expertise” are often abused to prescribe / recommend expensive interventions because of commercial motivations. In India, the poor conditions of public health care facilities have led to a higher incidence of referrals to private facilities, where denial of care failing to undertake or pay for such medical interventions (required or not) along with request for informal payment has led to major obstacles for poor women seeking maternal health care (CEHAT 2013; NAMMHR 2014)
Maternal health outcomes therefore cannot be delinked from women’s low status in household and communities which lead to poor attention paid to their health concerns, poor investment in seeking health care for women and poor inability for women to negotiate better care for themselves. WHO has observed: “maternal mortality is an indicator of disparity and inequity between men and women and its extent a sign of women’s place in society and their access to social, health and nutritional services and to economic opportunities” (WHO 1999, n.p. as cited in Gill, Pande and Malhotra 2007, 1350). Similarly, a study conducted in six African countries by a WHO study group on female genital mutilation (FGM) and obstetric outcome concluded: “women with FGM are significantly more likely than those without FGM to have adverse obstetric outcomes” (2006, 1835). This is because such a discriminatory and unjust practice often leaves women with serious infections (Maclean 2010). Likewise, the menace of child marriage common in many developing countries (most common in South Asia, followed by Sub-Saharan Africa) may force young girls to fall victim to teenage pregnancy leading to higher risk of maternal mortality, particularly compounded by malnutrition and anemia (common especially in South Asia, a region with one of the highest maternal health disparities in the world) (see UNICEF 2008, 14; Qadeer 2005; Sanneving et al. 2013). There is also evidence to demonstrate the link between decline of maternal mortality in countries of Global North during early 20th century and reduced social and gender disparity51 (Lerberghete and de Brouwere 2001).

More recently, this link has been confirmed in case of countries such as Thailand, Malaysia,

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51 Sen’s (2011) observation is indeed corroborated by historical evidence found in a study conducted by van Lerberghe and de Brouwere (2001), which indicated that decline in maternal deaths in industrialized countries, particularly in Northern European countries, correlated with implementation of policies that tackled both structural and agency dimensions of the problem. This was particularly the case in Scandinavian countries (where MMRs had dropped to 300 by 1930s) in comparison to that in England & Wales and United States (MMRs above 400 and between 600-700 respectively in 1930s). The researchers maintain that the determinants of progressive maternal health outcomes in Northern European countries cannot be separated from the broader socio-political changes (including improvements in gender parity) that took place in early 1900s to establish socialist democracies with commitments to comparatively more socially just principles.
Cuba, and Sri Lanka none of which has been income rich but has been characterized by commitments to socially just and redistributive principles (Songane 2007).

A comprehensive strategy for addressing root causes and underlying determinants require deliberate policy interventions that go beyond ensuring health system readiness and addressing institutionalized discrimination in health service delivery. They require examining the various gender based discriminations and apathy for women’s lives and health (in private sphere), which increase their chances of overall ill health and prevent them from seeking the requisite health care. That is, there are issues of gender inequality and different forms of social inequities (beyond health disparities) that determine maternal health outcomes that need to be systematically addressed. For example, the design of JSY in the Indian context that excludes under-aged pregnant women from accessing maternity benefits likely reinforces the Indian state’s failure to enforce child marriage laws and reveals the patriarchal bias of the state (not to mention, reveal gender based discrimination in family and community and failure of laws that supposedly provide women formal guarantee of equality). Similarly, it will require reconsideration of policies that intertwine family planning and population control measures with delivery of maternal health care services since they reveal discrimination against women and especially toward those from poorest and marginalized background.

The challenge for maternal health right advocates, therefore, would be to employ the human rights framework in a manner that addresses proximate determinants in the near term while also tackling root causes (that may take time to demonstrate discernable and measurable results). Arguably, the ability of the human rights framework to underscore the interrelatedness of various rights (corresponding to the different structural barriers discussed above) associated with the multidimensional and complex nature of the problem will be of particular appeal to maternal health right advocates. But this is difficult to ascertain given the lack of empirical evidence.
Which human rights – right to health or right to reproductive self-determination or both – are advanced using human rights by maternal health rights advocates is likely conditional upon their perception and beliefs about whether the issue can be appropriately resolved by addressing (especially, prioritizing) direct causes and proximate determinants or indirect causes and underlying determinants. This is consequential – especially given the lack of empirical evidence – because there is also a theoretical debate among maternal health and human rights scholars over which set of determinants (and fundamental human rights) ought to be prioritized (or not) to outline state obligations to address adverse maternal health outcomes. The analysis below demonstrates the particular relevance of these debates for this study, especially the challenges of securing state accountability for either rights in light of distinct realities of health politics and gender politics in India.

**Maternal Health and Human Rights**

As indicated earlier, proponents of direct cause interventions suggest that it would be sufficient to prevent maternal deaths by ensuring respect and fulfillment of the *right to highest attainable standard of health*. They seek greater investment (in infrastructure, financial and human resources) in public health system by governments in developing countries to improve weak and resource poor health systems in developing countries (Freedman 2001, 2002, 2003a; 2003b; and 2005; Yamin and Maine 1999; Yamin 2010, 2013)\(^{52}\). To that end, Freedman observes: “the problem has been coverage—getting professionals with the relatively simple

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\(^{52}\) Yamin’s work is slightly distinct within this group in that her scholarship originates in the study of law and therefore, while she subscribes (i.e. her analysis stems from a public health standpoint, see Yamin and Maine 1999) to the notion of denial of human rights to health as integral to preventable maternal deaths, she is more focused on advocating for the role of legal accountability as central to the principle of applying the human rights framework i.e. the use of courts and judicial interventions to seek legal remedies (both intermediary as well as to systemic transformation) (Yamin 2010 and 2013).
anesthesia skills necessary for EmOC into the health care facilities that women can reach when they have emergency obstetric complications” (2001, 156). In the Indian context, however, the challenge for actualizing the ‘right to highest attainable standard of health’ would likely arise from constitutional ambiguity on state obligations toward population health, including health financing, regulation and oversight of public and private health sector.

Others, who perceive root causes as determinants (individually as well as in combination) of poor health outcomes (respectively anemia, teenage pregnancy, lack of reproductive autonomy or freedom to seek timely care) outline a very different scope of human rights injustices – generally multifaceted gender injustices (Cook 1998; Cook and Dickens 2001; Fraser 2005; Fathalla 2006; Shaw and Cook 2012). Fathalla (2006) has emphasized the role of secondary social status of women in the ways maternal health programs and policies (including safe abortion care) are (under)funded and its implications for the political commitment and resources deserving of the issue. His observation in this regard is in direct opposition to what Freedman (2001)’s aforementioned claim. He states: “women are not dying during pregnancy and childbirth because of conditions that are difficult to manage. They are dying because the societies in which they live did not see fit to invest what is needed to save their lives” (414). Cook and Dickens (2001) have also underscored this issue in suggesting that “many societies tolerate maternal mortality and morbidity with considerably more fatalism and equanimity than they tolerate avoidable deaths and disabilities that strike young men” (230). Other studies have also demonstrated the significance of the role of family and communities who may not consider women as worthy “investment”; this can include their individual health needs and interests and other factors that determine their overall wellbeing including access to resources (such as, nutrition and financial) and opportunities (such as economic and educational) as well as ability to make decisions (to start a family, to seek care and the type of care, in a timely manner) for
themselves within the household and at the community level (Filippi et al, 2006; Gill et al, 2007). This is why Cook and Dickens (2001) call for holding the (patriarchal) state accountable to ensuring “women’s access to political, economic, social, civil and other activities” (231) which are not simply determined by state’s economic capability (as required for health system improvements) but point to issues of political will and commitment to alleviating women’s secondary social status. From this perspective, health system interventions alone may not be sufficient in light of the broader social attitudinal reforms required to address family and community level gender injustices. That said, the Indian state’s obligations to prevent gender and other forms of social discrimination against women (both a constitutional and international legal obligation) will be quintessential to addressing barriers preventing pregnant and parturient women from achieving better health and wellbeing.

Further, scholars emphasizing the importance of addressing root causes have touched upon another crucial and strategic advantage stemming from the use of human rights, which they argue helps to expand the scope of claims associated with framing women’s rights to maternal health as human rights. They point to the indivisibility and inter-relatedness characteristics of human rights framework to link reproductive health and rights to maternal health outcomes (Fraser 2005; Shaw and Cook 2012). This symbolizes an effort to counter the lack of political commitment and resources at the end of governments to address women’s health and rights (especially sexual and reproductive health and rights which were excluded from MDGs) and outline a more expansive agenda for women’s health. They emphasize issues of reproductive self-determination including choice in reproductive health services (especially family planning and emergency contraceptive methods) and quality abortion care which donors and governments made commitments to during the 1994 ICPD at Cairo but never really upheld to the extent as promised in creation of new policies (such as the National Population Policy introduced in 2000
in India). Similar arguments, as discussed in the previous chapter, have also been made in the Indian context (John 2012, 556; Ravindran 1993; Sen et al. 1994; also see Cottingham et al. 2001).

However, advocates of proximate determinants have criticized the use of the human rights framework to advance the goal of sexual and reproductive health rights. Freedman (2001, 2005) in particular argues that it presents challenges and can sideline the issues (health sector reforms) that need to be at the heart of the debate. Her position is vested in preventing maternal deaths that are caused by resource poor and weak public health systems, which was further accelerated by neoliberal policies implemented during 1980s and 1990s. She argues that advancing an agenda of sexual and reproductive health rights stands to derail the goal of reforming health systems. This is fair and legitimate concern. For decades after decolonization health sector resources in many developing countries (as well as at donor end) were singularly directed to address family planning issues (India being a classic example as discussed in previous chapter, also see Parmar and Wahi 2011) because high female fertility and population growth were perceived to negatively affect economic development (Hartmann 1995; Ravindran 2014). Such vertical interventions – supported and promoted by IFIs as well – came at the cost of organized comprehensive primary health care service provisions (that is, horizontal approach), which resulted in poor and weak health system (unable to prevent maternal deaths) (Campbell and Graham 2006; Bhutta et al. 2008; Unger et al. 2009). A number of studies have demonstrated the adverse effects of World Bank led health sector restructuring (introduction of user fees, divestment from public health sector, introduction of private medical education) on India’s already weak and under-funded

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53 This belief stems from the Malthusian notion, which predicted that population growth rates would surpass food production in developing countries resulting in adverse impact on the state’s development agenda. However, what this notion ignored was that women’s fertility rate in developed countries had steadily declined with various societal changes, especially women’s political, economic and educational empowerment.
public health system, that begun during 1980s and continued well into the years after financial liberalization (1991) (Baru 2002; Reddy 2004 as cited in Rao 2008). As well, the Indian Ministry of Health and Family Welfare’s exclusive emphasis on vertical intervention directed to further the state’s population control objectives and its devastating consequences for overall deterioration of the health system (and victimization of poor women from Dalit and other marginalized communities) are also well documented (Rao 1994/2000; Hartmann 1995; Ravindran 1998; Rao ed. Collection 2004; Qadeer 2002/2005; Jeffrey and Jeffre 2010; Parmar and Wahi 2011). These circumstances would suggest that Freedman’s (2001, 2005) concerns are highly relevant in the Indian context. There is a significant likelihood of struggle for both health sector reform as well as advancing women’s sexual and reproductive health rights, although the nature and links between the two – whether at state’s end or at human rights advocates’ – and their implications for advancing Indian women’s human right to maternal health can only be established through empirical inquiry.

Hence, advocates of proximate determinants of maternal health have emphasized the state’s obligation to meet the clause of “progressive realization of rights”\(^{54}\) (in this case right to health, a social right) enshrined in the ICESCR\(^{55}\) (Yamin and Maine 1999; Freedman 2003a). These scholars are wary of the contentious nature of sexual and reproductive health politics and

\(^{54}\) That is, the responsibility of states to ensure resources are allocated to continuously and incrementally improving the conditions that allow individuals to exercise their human rights and as required by the ICESCR. On one hand, such a principle excludes consideration for practical limitations originating in historical conditions, such as poor and weak state capacity encountered by planners and policy makers. Even when rights advocates have been occasionally successful in bringing about much desired policy changes (i.e. in securing political commitment), resource constraints at the state level (i.e. lack of state capacity) have been a major obstacle to delivering such policy promises in practice (Nelson and Dorsey 2008; Archer 2009). On the other hand, the principle of “progressive realization” can also be abused by states reluctant to pursue egalitarian development goals for its citizens even if it had access to necessary resources. The point being “progressive realization” is a normative and relative concept without any clear articulation of the minimum threshold of resources and capability required to compel states to act on an issue (Cornwall and Nyamu-Musembi 2004a; Uvin 2004).

\(^{55}\) Ratified by many states in 1960s/70s but not complied or enforced by all. India for example ratified ICESCR in 1979.
caution against obscuring advocacy efforts in the more politically and socially charged debate over women’s sexual and reproductive rights. The focus on various public health concerns as part of MDGs (such as child and maternal mortality, HIV AIDS, and to some extent reproductive health, but not rights) was seen as a timely opportunity for renewed focus on health systems and the ways inequities in access to health care determined lack of health and wellbeing (Freedman 2005).

But advocates prioritizing root causes and proximate determinants have criticized the priority focus on health system (Cook and Dickens 2001; Sen et al. 2006, 21-24). They have argued that policy makers and technocrats have a simplistic view of factors that contribute to (and can tackle) high female fertility (central to family planning, population control and higher incidence of maternal mortality). They have pointed to the ways female fertility and maternal mortality have declined with greater empowerment through education, labor force participation, gender sensitive community health care provision and improved social status in countries of Global North (Paruzollo et al. 2010; Hogberg 2004). They also emphasized the challenges facing women whose social and familiar status are determined by their ability to reproduce (not to mention male control over women’s reproduction and sexuality) (AbouZahr 2003). Crucially, Cook and Dickens (2001) argue that resource poor states hide behind arguments of economic incapacitation required to commit to health system improvement because they prioritize other (male) concerns in budgetary allocation (such as military spending being one example). This is tied to feminist critiques over the ways the patriarchal (figuratively) constitution of the state has historically prioritized men’s concerns (state security) over women’s concerns (social security) seeing that women are more likely to be beneficiaries of social and welfare investments (Tickner 1992; Stone 2002). This suggests that the neoliberal (patriarchal) Indian state might fail to fulfill the commitment to “progressive realization of rights” in relation to right to maternal health not
solely because of economic inabilities, but also because women’s health and women themselves are considered less deserving of political attention (or at least for the right reasons). For Indian maternal health right advocates this likely constitutes a tricky challenge of designing a frame that can unequivocally incorporate claims of health and gender justice to secure the appropriate political commitment from the state for maternal morbidity and mortality.

Hypothetically speaking human rights frames of maternal morbidity and mortality ought to consider both violations of a right to health (and health care) and women’s rights in public and private spheres. To that end, Gruskin and colleagues (2008) have tried to bridge this fault line, arguing that human rights to maternal health should represent a joint agenda for advancing both women’s rights (including reproductive choice and autonomy) and the right to health. But their analysis substantiates this link based on consensus achieved between donors, developing country governments, international agency representatives, and women’s rights advocates at UN Conferences, such as the ICPD (in 1994) and the Beijing Declaration (in 1995). Whether and to what extent maternal health right advocates, in India or elsewhere, leverage the consensus on this link (to strategically and clearly underscore both claims, right to health and gender equality) in their advocacy efforts can only be confirmed by empirically examining their policy positions (or frames) of human right to maternal health.

Nevertheless, development scholars disagree over whether and to what extent a human rights frame is compatible with an MDG goal (such as maternal mortality reduction or Goal 5) (Kabeer 2006; Hulme 2010). They view the MDGs as a set of normative goals, the fulfillment of which is conditional upon actualizing alternative conceptions of development – unlike economic growth led models – that is sensitive to well being of the poor and socially vulnerable. Ultimately, status-quo development policies have partially contributed to aggravating many of the social problems evident on the MDG agenda (Ibid). The implications of these debates for this
study are discussed in the following sections.

**Maternal Health, MDGs, and Human Rights: Potentials and Pitfalls**

There are debates over whether human rights and MDGs are complementary and their consequences to hold states accountable to their MDG commitments (made in 2000). These are significant for using human rights to hold states accountable for adverse maternal health outcomes (Alston 2005, 2007; Schmidt-Traub 2009; Carmona 2009; Cecchini and Notti 2011; Redondo 2009; Hulme 2007, 2009; Nelson 2007; Eyben 2004).

Some human rights advocates point to the political consensus reached by nearly two hundred heads of states in creating the MDGs, citing this as formation of global normative standards for efforts to alleviate poverty and reduce inequality in developing countries (Schmidt-Traub 2009; Carmona 2009; Alston 2005/7). Some even go to the extent of extrapolating this consensus and endorsement as being legally binding, although how such accountability may be practiced remains unaddressed (Carmona 2009; Alston 2005/7). They maintain that MDGs and human rights are complementary because of the analytical strengths offered by the human rights framework in examining the injustices underlying a specific MDG with particular benefits for designing practical interventions. It is likely that this conceptual complementarity provides maternal health right advocates in India and elsewhere the political leverage and a timely opportunity to hold the state accountable to its MDG 5 or maternal mortality reduction commitments.

But others maintain that conceptual complementarity does not spontaneously generate similar possibilities in practice (Castellino 2009; Doyle 2009a & b). They merely suggest the *possibility* of political commitment of the state in monitoring and reporting progress on the MDGs to ensure accountability. They also argue for greater transparency in indicating how
human rights principles are adopted and integrated by policy makers in designing programmatic interventions for minorities (including women, but also vulnerable and marginalized groups) (Doyle 2009 b; Cecchini and Notti 2011). They remind that state ratification of global human rights guarantees does not necessarily result in automatic change at the grassroots level. In examining the consequences of the strides made by women’s rights activists globally during the 1990s at various inter-governmental UN conferences, Joachim has maintained that these lead to “discursive and normative” changes relatively more easily than concrete social and policy changes at the grassroots level (2003, 270). In the Indian context, this is reflected in the creation of the NPP in 2000. The latter is accompanied by the rhetoric of respect for women’s rights, reproductive choice, and ethical approaches to family planning to address challenges of high fertility but in practice the politics of coercive population control is replaced with the politics of incentives and disincentives to promote the old agenda (visible in design of maternal health benefit entitlements) as amply demonstrated through out the previous chapter. Maternal health right advocates in India may prefer to avoid politicization of maternal health using human rights (and likely focus on alternative strategies) to avoid appropriation of the language of maternal health rights by different elements of the state machinery in name of political prioritization of maternal morbidity and mortality.

Still others, point to the false dichotomy created by emergence of parallel (and unrelated) discourses on economic development and human rights within UN agencies (Redondo 2009; Hulme 2007, 2009). They point to the fact that the creation of MDGs, while partially sensitive to

56 These included the following: 1) Vienna Declaration in 1993 recognizing the indivisibility of democracy, economic development and human rights, most importantly collapsing the distinction between political and civil rights and economic, social and cultural rights; 2) International Conference on Population and Development in Cairo in 1994 recognizing women’s sexual and reproductive health and rights as human rights and integral to addressing maternal mortality; and 3) the Beijing Declaration in 1995 recognizing that women’s rights are human rights and that it can only be realized by addressing political, economic, social, and legal dimensions of gender inequality (Eyben 2004; Hulme 2007).
the historical trajectory of economic development in low-income countries and their consequences for human development and wellbeing, are nonetheless inconsiderate of the state ability to achieve the goals in light of ongoing neoliberal reforms (Nelson 2007; Hulme 2010; Nickel 2013; Brahmbhatt and Canuto 2013; Langford, Sumner, Yamin ed. 2013). This is especially consequential to fulfilling the principle of “progressive realization of rights” embedded in many global human rights guarantees, such as the ICESCR, which outline state commitment for fulfillment of right to health. This is why even when rights advocates have been occasionally successful in bringing about much desired policy changes (i.e. in securing political commitment), resource constraints at the state level (i.e. lack of state capacity) have been a major obstacle to delivering such policy promises in practice (Nelson and Dorsey 2008; Archer 2009). This remains a major challenge in the Indian context given the historically poor levels of resource commitment to health as well as growing lack of public investment in health care in the wake of the shrinking role of the state. Further, it will likely adversely affect the ability of the Delhi High Court case to create broader systemic reforms as well (particularly distributive justice).

Other scholars have questioned the growing popularity of the idea of state accountability among members of development establishment (such as UN Agencies, international and domestic CSOs) who encourage citizens to hold Southern governments responsible for conditions of poverty and deprivation even though such conditions are results of unequal political and economic hierarchies between the Global North and South (Uvin 2002; Slim 2002; Cornwall and Nyamu-Musembi 2004a; Robinson 2005; Darrow and Tomas 2005; Tsikata 2009). Given the adverse consequences of international financial institutions (IFIs) imposed donor conditionality on Southern governments (such as the World Bank led restructuring of health system in India), they maintain that conditions of poverty, social inequality, and health inequities (even when residing within state borders) are seldom outcomes of individual policy decisions made by
governments of developing countries. The extent to which human rights (directed solely at
domestic governments) can address the complexity of the ways various global forces shape
structural inequalities in the domestic context is therefore questioned by critics (Uvin 2007). This
is why Tsikata (2009) maintains: “[Human]RBAs represent another round of donor
conditionalities which continue in the tradition of protecting donors and the IFIs from having to
take equal responsibility for policy errors” (131). In other words, the poor and underdeveloped
public health sector as well as the unregulated private health care sector are byproducts of the
Indian state’s historical trajectory of development, which in turn is linked to globally dominant
notions of (neo-liberal) economic development. Such a discourse has historically undermined the
importance of social development and human well being as an indicator of overall development
status of a state. A shift to discourses on human rights and development in India must be sensitive
to these historical realities that cannot simply be undone by maternal health right advocates by
seeking (domestic) state accountability. Even if the Indian state were to make political
commitments in light of its endorsement of certain universal human rights guarantees, its
capacity to deliver on such promises in practice may be severely compromised.

In essence, the political consensus reached by governments at the Millennium Summit in
2000 followed by the creation of MDGs may be symbolic of normative guarantees but their
fulfillment is conditional upon conceptualizing and actualizing a different conception of
development. However, since a focus on human rights was categorically excluded from the
design of MDGs, despite the various strides made by human rights and women’s rights advocates
throughout the 1990s (at UN intergovernmental conferences) some have observed that the
MDGs are no different than earlier needs-based/welfare-based approaches to development that
subscribe to utilitarian values (Hulme 2007, 2009). They argue that in the absence of a marked
departure from earlier conceptions of development, the MDGs remain a depoliticized
development project * incompatible with the inherently political nature of human rights* (Nelson 2007; Fukuda-Parr 2007; Fischer 2013; Darrow 2013). In the Indian context, unless the state chooses to pursue a radically alternative project of development that prioritizes economic, social and human dimensions of development equally, maternal health right advocates are likely to *not* make much headway in using a human rights approach to hold the state accountable to reducing maternal morbidity and mortality. The state commitment to augment resources for maternal mortality reduction accompanied by policy and institutional reform (in 2005) likely reflects a more needs-based / welfare-based approach, rather than a human rights-based strategy. Crucially, Indian maternal health right advocates must successfully engineer a shift in state attitude from a needs-based to a rights-based way of thinking, designing and delivering maternal health policy and health care services. This may not be an easy task. It requires examining the ways they frame the issue and design strategies to *mobilize* state support given where status quo political and economic environment remains unconducive for fulfillment of human rights. More importantly, it may mean working with the state rather than antagonizing it (as *may* have been the case in the incidence of the Delhi High Court verdict). There is evidence in the Indian context to suggest that some civil society organizations may prefer to avoid legal confrontation with the state to escape further exclusion and antagonization, albeit in relation to rights of slum dwellers and informal squatter settlements in the city of Mumbai (see Patel and Mitlin 2009, 109).

In sum, using human rights to hold states accountable for maternal health injustices stands to face many practical challenges outlined above. But constraints at the state’s end are not the only ones maternal health right advocates need to consider. Feminist critics of human rights and development caution about a number of barriers feminist practitioners must consider in advancing women’s needs and interests. These may arise in relation to state and (selective) institutionalization of feminist demands in form of state-led gender mainstreaming, politicization
of (human) “rights-speak” by various actors to serve their agenda, changing dynamics of feminist activism in developing countries including NGOization of feminist movements (including growing reliance on international aid and donor driven agenda setting), which may further complicate progress of women’s needs and interests (Howard 1995; Elson 2002; Molyneux and Razavi 2003; Sen 2005; Cornwall and Molyneux 2006; Gideon 2006; Bradshaw 2006). The following section reviews these debates and outlines their likely significance for this study.

**Women’s Rights, Human Rights and Development**

Feminist scholars have cautioned about ways dominant notions of (economic) development may appropriate the language of human rights to advance agendas that merely instrumentalize the integration of women’s right in development instead of recognizing the ways development practice has historically excluded women and undermined the holistic achievement of their basic rights and freedoms (Howard 1995; Elson 2002; Molyneux and Razavi 2003; Sen 2005; Cornwall and Molyneux 2006; Gideon 2006; Bradshaw 2006). Development, they argue is a depoliticized project of social transformation designed to achieve better economic growth whereas advancing women’s right as human rights is a political claim that may be incompatible with status-quo conception of economic growth (Howard 1995; Elson 2002). This is why the formulation of MDG 5, i.e. maternal mortality reduction, reflected a narrow focus on women’s reproductive labor without addressing the ways multiple violations of women’s rights distract from achievement of better health and wellbeing for women – indicating an instrumentalization of women’s health, rather than an actual commitment to women’s rights. (Yamin and Boulanger 2014). Such instrumentalization, feminist scholars caution appropriates the feminist agenda dressed up as state prioritization of “women’s issues” (Cornwall and Molyneux 2006). This is further demonstrated in Howard’s observation, who maintains: “the rights of women in
development become the right of women to development, defined not by them but by the development establishment, both in their own country and without” (1995, 305). Hence, they question the extent to which introducing (and mainstreaming) human rights to the discourse of maternal mortality reduction as originally conceptualized in the context of MDGs necessarily serves women’s interests (including their maternal health interests).

The aforementioned concern is significant because the creation and conceptualization of MDGs have never really been sensitive to the agenda of advancing women’s rights to begin with (Eyben 2004; Painter 2004/5; Hayes 2005; Johnson 2005; Barton 2005; Fraser 2005; Antrobus 2005; Sen and Mukherjee 2014). As indicated earlier (in introduction), the MDGs failed to incorporate the victories achieved by women’s rights advocates during 1990s, the progressive decade for women’s rights (Eyben 2004; Hulme 2007). This resulted in diluting the political commitments made during earlier UN conferences (indicated above), culminating in creation of narrowly defined goals, which exhibited the older “silo” approach to development that women’s rights advocates had earlier lobbied governments to move away from (Painter 2005; Johnson 2005; Hayes 2005). Perhaps the greatest “blow” was dealt to the progresses made by women’s movements globally and locally with respect to women’s health concerns (Fraser 2005; Antrobus 2005). The case in point is that concerns associated with MDGs 1-3 and 5-6 are equally and in inter-connected ways relevant to improving women’s health (including maternal health) (Yamin and Boullanger 2014), but opportunities for such conceptual synergies (the deep links between

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57 These included the following: 1) Vienna Declaration in 1993 recognizing the indivisibility of democracy, economic development and human rights, most importantly collapsing the distinction between political and civil rights (as contained in ICCPR) and economic, social and cultural rights (as contained in ICESCR); 2) International Conference on Population and Development in Cairo in 1994 recognizing women’s sexual and reproductive health and rights as human rights and integral to addressing maternal mortality; and 3) the Beijing Declaration in 1995 recognizing that women’s rights are human rights and that it can only be realized by addressing political, economic, social, and legal dimensions of gender inequality.

58 Respectively, eradicate poverty and hunger; achieve universal primary education; promote gender equality and empower women; improve maternal health; combat HIV/Aids, malaria and other diseases.
education, health, poverty and gender) were not present in the design of the Millennium Development Agenda. Hence, the ability of Indian maternal health right advocates to underscore these conceptual synergies in their human rights advocacy would be important to systematically improve maternal health outcomes, as opposed to a narrow focus on reducing maternal mortality through purely health system and biomedical interventions. However, the silo approach to design of MDGs – as many scholars have argued – also simultaneously led to fragmentation of donor funding and led to isolated activities that adversely affect overall achievement of gender equality and women’s rights (Ibid; Unterhalter and North 2011; Germain, Dixon-Muller and Sen 2009; The Lancet and London International Development Centre Commission 2010; Vandermoortele 2009; Cornwall, Harrison and Whitehead ed. 2007). This would suggest that transforming such conceptual synergies in practice – that is forming alliances with those advocating to improve other related dimensions of women’s lives, such as education, poverty and overall equality – to improve overall maternal health and wellbeing might be harder than conceived in theoretical terms. But this is imperative given the the multidimensional nature of maternal health injustices in the Indian context, which is tied to diverse forms of gender injustices, be it women’s (and girls’) access to education, employment, health care, intra-household resources, a domestic and sexual violence free environment, and overall equal status in the family, community and broader society.

Feminist scholars also remind that human rights “speak”, as popularly conceived and used by the development establishment, originate in neoliberal principles of “good governance” and “participation”, which have characterized development practice since early 1980s (Cornwall and Molyneux 2006; Gideon 2006). They maintain that human rights principles such as accountability, participation, empowerment and greater transparency can allow for more dynamic engagements and negotiation with the state missing in earlier development paradigms. But they
caution against the “moral legitimacy” that is sought by certain actors (such as donors, UN agencies, and most importantly, CSOs) in evoking such principles to advocate on behalf of the poor (Robinson 2005; Cornwall and Molyneux 2006; Mukhopadhyay 2004). For example, in questioning the enthusiasm amongst feminist NGOs and women’s movements in the Global South over “[human] rights-based development”, studies show they may not always fully comprehend this new conception (especially the distinction with human rights framework) but nonetheless subscribe to it since they associate “rights-talk” with progressive mobilization and especially because they equate such jargon with donor requirements (grant proposals and such) on which they are reliant for their existence (Mukhopadhyay 2004; Bradshaw 2006; Hames 2006; also see Molyneux and Lazar 2003; Tsikata 2007). In other words, Indian maternal health right advocates (or at least some of them) may subscribe to the agenda of human right to maternal health because of their reliance on funding provided by a donor (such as the MacArthur Foundation) who is committed to such a cause (advancing women’s rights and health). Such superficial commitment may be characterized by lack of adequate historical knowledge and appreciation of the complexity of the issue (or even how human rights can be integrated with the issue), thus compromising framing efforts to alter political priority surrounding maternal morbidity and mortality. It may also complicate issues further given the historical politics of reproductive choice and rights in India as well as related divides among feminist groups (John 2012).

Pointing to aid effective principles that came to characterize development in the aftermath of Paris Declaration (in 2005), feminist critiques also argue that the downside of directing more donor funding through states in the Global South has meant equating citizen voice to “optimizing efficiency” – typical of an economic transaction devoid of political struggle involved in claiming and negotiating rights and entitlements (Cornwall and Molyneux 2006, 1179; Mukhopadhyay
2003). More crucially, the ideological equation of accountability to an economically efficient transaction produces new problems as need/welfare-based entitlements (as opposed to rights-based entitlements that involve political struggles) of citizens and the power to realize them still lend states more powerful, since the latter is responsible for making provisions (as opposed to being accountable as duty bearers) necessary for fulfillment of such rights and entitlements (Robinson 2005; Tsikata 2007). Evidence of such instances have already emerged in many developing countries, and especially in India, where claims of entitlements of poor (be it food, health, social security, and employment guarantee) are met with conditional cash transfer programs (consider JSY for example) or a variety of short-term welfare schemes (the plethora of schemes such as JSY, NMBS, NFBS, ICDS, and AAY that were denied to “victims” in the Delhi High Court case) offered by governments which may provide intermediary relief but are hardly able to alter the status-quo in the long-term (provided they are administered as planned) (Sinha 2006; Acharya and McNamee 2009; Lingam and Yelamanchilli 2011; Prasad and Raghavendra 2012).

In contrast to the aforementioned criticisms which caution about the ways neoliberal development interests may appropriate progressive agenda for women’s rights in development, criticisms have also been directed toward feminist practitioners in Global South given their endorsement of the human rights agenda furthered by the international development community (Nyamu-Musembi 2006; Tsikata 2007; Bradshaw 2006; Mukhopadhyay 2004). This is partially attributed to the growing professionalization of women’s movements in to NGOs (that is, NGO-ization) that are dependent on donor funding (as discussed earlier) and therefore allow their agendas to be altered (and sometimes appropriated) to fit with donors (Alvarez 1999). But it is also linked to participation of feminist practitioners (be it as advocates, “experts/consultants”, or “service providers”) in selective and sometimes questionable state-led gender mainstreaming
projects that do not go far enough in formulating a radical feminist emancipatory agenda (Rai 2008). Saheli et al. point to similar concerns in the Indian context surrounding the “entry of women activists in direct government programmes” which can also add to legitimacy of such programs (2008, 184). They maintain that such presence and endorsement (even if partial) of state agenda compromises the ability of feminist advocates to hold states accountable and allow the state to control agenda setting within NGOs (particular feminist NGOs and women’s groups) leading to “co-optation” by offering the “enticement of stability and outreach to all of us through all kinds of programmes due to its awareness of loss of its own credibility among people” (Ibid., 186-187). This concern is reiterated by Rai (2008) writing in the Indian context, but she also reminds of the challenges of gender mainstreaming facing feminist advocates especially where political will is lacking. Particularly, raising issues of violation of women’s rights in the private sphere and integrating them with policy design at the bureaucratic or state machinery level requires active participation and engagement from feminist advocates (Ibid., 86-87).

In other words, feminist practitioners in developing countries are increasingly caught between donors for their survival and the state to gain a strategic entry into policy and planning discussions. In either case, assuming these various roles require feminist practitioners to embrace the difficult challenge of designing advocacy agendas that can be sensitive to women’s everyday needs, gain buy-in from donors and the state, while simultaneously advancing strategic priorities (gender equality and women’s rights) (Alvarez 2009; Hames 2006; Cornwall and Molyneux 2006; Harcourt 2013). Concurrently, feminist practitioners must continue with the grassroots work of generating consciousness among women of their formal rights (that is, turning the passive rights holders into active rights claimants) and balance this against the ways such rights can be utilized to secure important entitlements in everyday practice (Ibid.). The realities of advancing women’s (maternal health) needs and interests may be no different for maternal health
advocates in India, in which case theorists may need to reevaluate their optimism regarding the prospects of a human rights frame to alter political priority (deserving) of the issue (or at least the extent of it).

Still others remind that as women organize to mobilize for equal rights, a complex conception of “womanhood” emerges with a variety of needs, interests and priorities—sometimes complementary, other times competing or even conflicting (including anti-feminist pursuits). Feminist practitioners themselves have begun to express concern over the “differences within”, pointing to contestations within feminist movements over what ought to be claims within the scope of women’s rights in a given socio-political and cultural context (Toyo 2006; Molyneux 2007; Win 2007; Cornwall, Harrison and Whitehead 2007). As Cornwall and Molyneux observe: “Female solidarity can never be taken as given and is often difficult to secure across the full range of women’s human and reproductive rights” (2006, 1188). This is significant in the Indian context for several reasons – ranging from Indian women’s movements historic bias at privileging the concerns of urban, middle and upper class women (Sen 2012), the underrepresentation and marginalization of issues affecting Dalit and Adivasi women (Menon 2008; Manorama 2008; Rege 2008), and the differences within women’s health movement over articulating an agenda of autonomy and self-determination (Mukherjee 2002; John 2012). But this is aggravated due to the pressures generated by the liberalization and globalization as the Indian state transitions from the developmental era of national planning (pre-1991) to that of political and economic liberalization (post-1991). As Indian feminist scholars and practitioners confront this changing circumstance and its consequences, they are increasingly divided in their assessment of the opportunities and challenges facing women and how best to address them (notwithstanding their varied consequences for different groups of Indian women). As Phadke (2003), Sen (2012), John (2008/2012), Ray (2012), Rai (2008), demonstrate in their analysis,
diverse narratives embracing, seeking amelioration and out-right rejecting liberalization and
globalization located in different points on the political and ideological spectrum have emerged
within women’s movement in India. This is not withstanding the rise of women’s groups and
movements that support the conservative and religiously inclined Hindu nationalist agenda
(Ibid.). The point being, the articulation of diverse agendas outlining women’s needs and interests
– while providing for a vibrant civil society mobilization surrounding ‘women’s issues’ – makes
for a highly fragmented with possibly competing and/or conflicting goals, and complex civil
society sector where building alliances, strengthening partnerships and mounting an adequate
(feminist) resistance against the state may be very difficult for maternal health advocates
(generally, and / or using the language of “rights”).

Given the various constraints facing women’s rights advocates due to appropriation of the
language of women’s human rights by the development establishment, some feminist
philosophers have tried to draw attention to the unexplored dimensions of political and legal
equality (i.e. formal equality) achieved by women’s movements. They remind us about the gaps
in formal and substantive rights enjoyed by women, pointing to the consequences of this for
achievement of equal rights of women in public and private domain (Mukhopadhyay and Singh
2007; Patel 2006; Goetz 2003). They also argue that the strides made by women’s rights
advocates in advancing women’s legal and political rights have not been complemented by
 corresponding social change (particularly social and economic equality), which they attribute to
 various reasons: generating rights consciousness and legal literacy among women; equipping
 them with the resources to access tools of legal accountability; but most importantly, unexplored
 prospects and limitations embedded in design of constitutional rights and entitlements
(Mukhopadhyay 2004; Waylen 2006; Goetz 2007; Kapur 2007). In fact, some call for greater
attention to ways constitutional design of rights and entitlements (that is, citizenship rights and
entitlements) may shape democratic institutions (such as health systems) and its consequences for substantive equality of women (Waylen 2006). Viewing women’s rights through the lens of citizenship rights and entitlements puts the spotlight on issues of political commitment, resource allocation and state capacity, which cannot simply be addressed through universal human rights articulations.

**Women’s Rights, Citizenship and Reproductive Justice**

Opportunities to achieve reproductive justice for women in developing countries can hardly be secured through mainstream strategies, which promote women’s equality in development through traditional “gender mainstreaming” tactics (Mukhopadhyay 2003; Goetz 2007; Kapur 2007; Rai 2008; Cornwall, Harrison and Whitehead ed. 2007). The injustices arising from socially constructed gender roles assigned to women seeking “reproductive justice” entails paying more or at least equal attention to challenges surrounding women’s immediate and long-term socio-political and legal status which are simultaneously informed by their status within the state, community and family (Goetz 2007; Mukhopadhyay and Singh 2007 ed.). Reproductive Justice is understood as “the complete physical, mental, spiritual, political, social and economic well-being of women and girls, based on the full achievement and protection of women’s human rights” (SisterSong 2015). Securing reproductive justice requires a much more transformative agenda that accounts for ideas of citizenship status and rights and the law in relation to development. For example, Goetz points to gender bias that is inherent in formal, especially legal institutions which result in creation of biased rules and procedures that give rise to “limited membership rights and capabilities for women – constrained citizenship rights in the state, for instance, or circumscribed roles in the family and community” (2007, 32). Such circumstances
prevent women from sufficiently exercising their rights for the progressive achievement of their overall wellbeing.

First, locating women’s rights in their citizenship status (in the state, community and/or family), allows for circumventing the challenges posed by the human rights framework, which tend to assume universal notion of womanhood and women’s experiences and largely lends itself to violations of women’s rights in the public sphere (Gideon 2006). Access to formal legal institutions and ability to navigate them may vary widely depending on women’s socio-economic status, education, and access to basic resources. Further, legal remedies proposed by human rights advocates are unable to address the many violations of women’s rights in the private sphere (for example, reproductive self-determination in relation to contraception use, domestic and sexual violence during pregnancy). In her writings on law and gender justice, Kapur reminds us that the legal arena is expected to be “objective, external, neutral and [true]”, which fails to address gender injustices in the domestic sphere given the latter’s “constant reiteration of rights of ‘man’, [and] its focus on autonomous, liberal subjects” (2007, 117; also see Cornwall and Molyneux 2006; Tsikata 2007). Therefore, constitutional guarantees of equality are inadequate to secure reproductive justice for women, given that the violation of reproductive rights and other rights of women (including rights of girl to food and education) occur in the private sphere. Hence, for legal accountability to be used as a tool of rights-based maternal health policy, legal and constitutional reforms that can address the continued existence of gender-unequal practices –for example, child marriage, discrimination of girl child and deprivation from access to essential resources such as food, denial of essential health care services because of weaker gender and social status despite laws and policies on the contrary – would be integral. In other words, the successful recognition of maternal morbidity and mortality as human rights violations in the Delhi High Court case may have limited potential to improve practical opportunities for
reproductive justice unless it is able to address gender and social injustices underlying adverse maternal health outcomes. But even then, one would be sceptical of its likelihood to address gender injustices in the private sphere which require broader and progressive (women friendly) societal change.

Second, using the lens of citizenship rights and entitlements allows for much more dynamic and political conceptualization of the rights of a woman in question, as opposed to her positionality as a passive rights holder in the human rights framework. Feminist citizenship theorists (writing in relation to gender justice in developing country context), warn that one must carefully examine the ways “gender and other inequalities inform the law and rights agendas of different groups including well intentioned women’s groups, human rights groups, as well as state-supported projects and programs” (Kapur 2007, 164; Kabeer 2005 a; Lister 1997; Yuval-Davis 1997; Agnes 2008; Haksar 2008). They emphasize the importance of viewing women as “active participants in the gender-justice project” and not simply “victims” and this they suggest can be made possible only by creating “legal literacy strategies that are based on understanding both the strengths and limits of specific laws for women” and informing them of the contextual challenges they might face in claiming and negotiating their rights (Ibid; Goetz 2007; Mukhopadhyay and Singh 2007; see also Nyamu-Musembi 2005, 31). In other words, the formulation of rights-based maternal health policy must consider the difficult political terrains (family, community and state) women must navigate to seek reproductive justice and develop interventions that women can use to navigate the tricky politics of these contexts.

For maternal health rights advocates the challenge therefore is to “[create] citizens who demand just governance” (Mukhopadhyay 2003, 45). This is further linked to women’s empowerment, but not limited to such empowerment being understood in simple terms of political participation (share of seats in elected political institutions), participation in education
(through enrolment rates), economic participation (women’s share of labour force or income indicators), and by extension health status (as access to formal health care facilities and nominal utilization of health services) (Goetz 2007, 53; Mukhopadhyay 2003, 47; Kabeer 1999).

Empowerment is understood as a dynamic process of enabling women to exercise citizenship actively and seek accountability, as well as be informed, educated, recognized, and treated justly from this process of inclusion and participation. For achievement of true empowerment, Mukhopadhyay emphasizes the importance of “creating access to governance institutions … effecting change within these institutions to improve their ability to women’s needs and interests … and staking women’s claims to new entitlements, arising from the needs articulated by those women affected by lack of rights and influence” (2003a, 47). Naturally this translates into more meaningful participation of women in social-political, economic and legal arena to help them raise their voice, articulate their struggles, seek accountability, and carve a space for themselves in both public and private arena (Ibid., 53-54). Hence, for true reproductive justice to exist, a rights-based maternal health policy framework must go beyond creating a demand driven public health systems that merely provides necessary resources and infrastructure and situate women’s claims in the context of “inclusive citizenship” (George, Iyer and Sen 2005; Goetz and Jenkins 2004). Such a notion would recognize the “multi-dimensionality and indivisibility” of women’s rights (including the inter-linkages between the diverse spaces in which violations of their rights occur), while also recognizing the existence of “different groups of women, their different histories and the context-specific ways in which women’s rights are framed and fought for” (Mukhopadhyay 2007, 277-8). This is especially crucial because maternal morbidity and mortality, of course, most affects women from economically vulnerable and socially marginalized background, be it in India or elsewhere (George, Iyer and Sen 2005 for India; Johnson 2014). That the determinants of women’s health outcomes including maternal health
outcomes are very much intersectional in nature and produced by complex intersection of poverty and various axis of identity (race, caste, class etc.) have been explored at length by feminist scholars (Hankivsky 2012; Johnson 2009/14). In fact, Sen, Iyer and George (2007), Sen and Ostlin (2011) and Sen and Iyer (2012) have provided empirical evidence to suggest that maternal health outcomes in resource poor contexts, such as in India, cannot be untied from ways women’s status and identity interact with formal and informal social structures to access health care entitlements. If lack of control over decision-making related to her health during pregnancy and after childbirth is connected to a woman’s subservient status in the private sphere, her health outcomes are equally connected to a lack of accountability on the part of government authorities (to uphold laws and policies created to protect and fulfil women’s rights) as well as weak health systems in the public sphere (Sen and Iyer 2012). Thus, the struggle for reproductive justice of such women may be distinct from the fight for reproductive choice and rights (legal access to abortion) of more privileged women (be it in Global South or North). Human rights-based maternal health policy that can respond to demands for such reproductive justice must therefore create socio-political and legal space for much more dynamics understanding of inclusive citizenship, one that allows women (from typically excluded segments of society) engagement and participation in formulating (and continuously negotiating) the laws, rights and entitlements that can help them maximize their overall health and wellbeing.

**Part II: Rights and Judicialization of Politics**

Central to the notion of human rights is the principle of accountability. Human rights advocates, practitioners and scholars alike, ground its significance especially in the opportunities presented for legal accountability (for example in upholding rights, addressing grievances and mitigating injustices experienced by poor and vulnerable individuals). The emphasis on legal
accountability in the literature on maternal health and human rights is quite prominent (Yamin 2010/2013; Yamin et al. 2013; Hunt and Bueno De Mesquite 2010; UNHCHR 2011). For example, Yamin places great emphasis on the role of judicial remedies and grievance redressal mechanisms in advancing legal accountability for adverse maternal health outcomes. The latter she considers central to the notion of “transformative accountability” that is necessary to recognize fulfillment of women’s rights to maternal health as a human right (Yamin 2010, 96). Although, Hunt and Bueno De Mesquite speculate that the courts may be useful for strategic interventions – “such as the provision of emergency obstetric care and particular drugs” – rather than broader structural reforms needed to address maternal morbidity and mortality (2010, 14).

The discussion so far in this chapter has pointed to the various skepticisms critics articulate about the politics of individual dimensions of seeking legal accountability - particularly in terms of access to courts and necessary resources, ability to navigate legal systems, ability to underscore political complexity of rights actualization (and violation) without “deepen[ing] technicisation and depoliticisation of gender and development work”, and the court’s ability to address broader gender and social injustices (Tsikata 2009, 131; Nelson and Dorsey 2008; Gready 2008; Gledhill 2009; Cornwall and Nyami-Musembi 2004b). These are important in considering the implications of Delhi High Court verdict in altering political priority of maternal morbidity and mortality in India. However, the structural dimensions of using legal accountability to create broader systemic and social reform and reduce maternal health injustices among the wider population are yet to be addressed. These are examined below.

Judicialization, that is “reliance on courts and judicial means for addressing core moral predicaments, public policy questions, and political controversies” (Hirshl 2011, 254), depending on the strength of the legal system, can play an important role in recognition of new rights or expansion / reinterpretation of the scope of existing ones. It can also guarantee new entitlements
based on new interpretations of constitutional norms and/or state commitments to international treaties and agreements. Yet, as legal scholars often argue, the use of courts to generate social reform in a long term and sustainable manner is far from straightforward and given (Baxi 1985; Rosenberg 1991; McCann 1994; Epp 1998; Scheingold 2004; Sarat and Scheingold 2006). A number of important factors shape the ability (or the lack of) of judicialization to affect (directly and/or indirectly) progressive social reform. To this end, there are both theoretical - although, generated largely by socio-legal theorists in the American context - and empirical evidence [through emerging but growing scholarship on legal mobilization for economic and social rights (ESR), including health rights, in the developing country context] that is particularly analytically relevant for this study.

Writing within the American context, Gerald Rosenberg has argued that it is “[a] normative belief in the courts as the guardian of fundamental rights and liberties” that mobilizes

59 Social reform, here, is defined as “the altering of structured inequalities and power relations in society in ways that reduce the weight of morally irrelevant circumstances, such as socio-economic status/class” (Gloppen 2009, 466). Also see Gloppen’s chapter “Courts and Social Transformation: An Analytical Framework”, in Gargarella et al. 2006 for a more elaborate discussion.

60 Much of the literature on the debate over the role of courts in generating and shaping social reform has taken place in the American context (or at least in the “Anglo-American” context). Perhaps, it is safe to say that the literature is dominated by American examples and theorizations by American scholars. Certain distinctiveness of the American context, a heightened social consciousness of rights, the historical legacy of the drafting of the Constitution, the legacy of the civil rights movement, the struggle over gay and reproductive rights and so forth, may be responsible for such a phenomenon (see Scheingold 2004 and McCann 2006). One, thus has to be cautious in applying theoretical breakthroughs from the American context elsewhere, particularly resource poor developing country contexts. Nonetheless, the rich body of theoretical work cannot simply be overlooked, for two reasons. First, the literature is itself underscoring the importance of diverse specificities (political, contextual, economic, social etc. although not cultural) and second, scholars belonging to the fairly new but growing literature on judicialization of economic and social rights (ESR) in the developing country context have also drawn from the American literature (see Gargella, Roux and Domingo 2006 ed.; Langford 2008; Gauri and Brinks 2008; Gloppen 2005, 2006, 2008, 2009; Yamin and Gloppen 2011 ed. vol.; Gauri and Gloppen 2012; Yamin 2014). More critically, emergence of previously non-existing but cross-cutting factors - the rising awareness and activism surrounding ESR (albeit more common among scholars and activists than general citizens), a vibrant transnational debate surrounding human rights and development following failure of decades-long welfare based approached to poverty reduction, consideration of opportunity structures found domestically but also growing transnational activism, and rising instances of success of using constitutional courts and public interest/social action litigation across many countries of the developing world - despite contextual/country-specific distinctiveness (local political economy, local-global links, institutional organization of state, historical specificities) provide strong rationale for considering how careful amalgamation of existing theorization about the role of judicialization in social transformation and lessons from analysis of empirical
advocates of an issue to seek legal support (1991, 3). Rosenberg maintains that successful judicialization does not spontaneously provoke social policy reforms unless such a proposal has support from other branches of government. This is attributed to a number of limitations of the judicial branch – lack of control over financial resources, lack of “implementation power”, and inability to affect “bureaucratic inertia” (Ibid.). Writing specifically in relation to human rights and development, this sentiment is corroborated by Nelson and Dorsey who suggest that judicialization can create political agency for advocates of a certain issue but it is not predestined to do this (2008, 182). To what extent political agency can be directed through sophisticated mobilization to garner support for real change depends on many factors such as “ample legal precedent for change”, “support for change from substantial numbers” in executive branches of government and “support of citizens” (Rosenberg 1991, 36). Rosenberg’s views are also supported by Indian socio-legal and human rights theorist Upendra Baxi whose work (following the creation of public interest litigation (PIL) provision by the Indian Supreme Court) warned against hopes of institutional reform and social transformation led by courts (1988, 2002).

Therefore, the Delhi High Court verdict may provide political leverage to maternal health right advocates in India depending on the nature and extent of social mobilization surrounding the issue outside the court room. Arguably the right to food case discussed in the previous chapter demonstrates the potential for change when judicial intervention is sought and supported through such mobilization. It may even serve as precedent setting both in terms of resource allocation as well as providing monitoring and oversight in terms of enforcement and implementation. However, this is at best a possibility especially given that the Indian higher courts have never

cases from countries in Latin America, South Asia and Africa can offer useful analytical concepts for this research (see Gauri 2009; Gloppen 2009; Yamin and Gloppen 2011 ed. collection.; Yamin 2014 edited vol. in Journal of Health and Human Rights).
sought to undertake or even “direct” the legislature to consider health sector reforms (Grover, Misra and Rangarajan 2014; Rajagopal 2007; Parmar and Wahi 2011).

The importance of availability of legal opportunity structures (LOS) – that exist due to systemic design in some legal systems (such as the constitutional provision of public interest litigation or PIL in India) – is also significant for the likelihood of using judicialization to address fundamental rights violation (Hilson 2002). For example, Gloppen (2011) has demonstrated that higher incidence of judicialization of social rights in some countries of Global South is directly tied to having “access to highest courts in public interest cases” (20). India is noted as one of the countries, in her comparative examination of six countries from three different continents (Ibid.). Similarly, importance of legal opportunity (LO), which refers to prospects of “judicial receptiveness” is also equally crucial for judicialization of rights (Ibid.; Andersen 2005 and Vanhala 2011). LO stands to shape social movements by offering them opportunity to use strategic litigation as a tool of advancing their advocacy goals. The Indian judiciary is known globally for its “activism” (for example, the creation of PIL as a constitutional provision) as well as the history of generally progressive and pro-poor verdicts (for example, the right to food case) (Cassels 1989; Epp 1998; Brinks and Gauri 2008; Robinson 2009; Gauri and Gloppen 2012). Hence, collectively the LOS and LO present ample motivation for using legal accountability to address maternal health injustices. The Delhi High Court verdict is likely an outcome of these realities.

Yet, the easier access to LOS and presence of LO must be reconciled with the complexity of claiming individuals rights using legal procedures which are nearly unachievable without a
solid “support structure for legal mobilization” (SSLM) ⁶¹(Epp 1998, 3). This has implications for individual access to courts (and justice), especially since the Indian legal system requires petitioners to file through lawyers (Baxi 1988; Gloppen 2011). But it is equally significant given the historically weak and poor state of SSLM in India, which have also been tied to weak enforcement power of judiciary (Epp 1998). In fact, Epp maintains that the “weak and fragmented” nature of Indian interest groups, the general tendency of Indian lawyers to practice alone (which prevents formation of strong legal organizations), and most importantly, the lack of public or other sources of funding to support legal aid organizations (even the limited number that exist) are responsible for the lack of growth of strong support for legal mobilization (unlike in the American context) (1998, 95). The potential for practical change signaled by the progressive verdict in the Delhi High Court case will likely be conditional upon the ability of the Indian legal aid organization to mobilize broader support for the former. In fact, the presence of funding from MacArthur Foundation and strategic support from CRR may partially address the challenges facing Indian legal aid organizations such as HRLN. But the issue of “weak and fragmented” interest group may still exist, especially given the political dynamics of women’s movements and particularly the fragmentation within women’s health movement discussed earlier. In examining the SSLM in various cases related to women’s rights (between 1977 and 1997) in the Supreme Court in India, Epp maintained: “there is little evidence that women’s organizations provided any significant financial or legal support or coordination of legal strategies” (1998, 106). This was confirmed by Sood (2008) as well in underscoring the importance of strategic mobilization in advancing gender justice through the Supreme Court of

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⁶¹ As evidenced by comparative examination of empirical cases in United States, Canada, England and India (Epp 1998).
India\(^{62}\). Hence, this would suggest that the true potential (beyond symbolic and legal victory) for Delhi High Court verdict may remain unfulfilled unless it received wider support for groups and individuals working on the issue of maternal health and human rights.

Others caution about the rights culture that is pervasive of public and political life in some societies (for example, American and Indian) and the excessive emphasis placed on legal rights due to the political symbolism of law and the added (perceived) legitimacy it brings to a claim of legal rights (Scheingold 2004; Sarat and Scheingold 2006; Epp 1998). Political activists and “cause lawyers” (i.e. activist lawyers) are attributed with further politicizing law without adequate appreciation for the role of litigation as part of a broader political strategy (Meyer and Boutcher 2007). So litigation is frequently used as a stand-alone tool, rather as a part of a broader framing strategy for social reform (Boutcher 2013a). Scheingold warn about the importance of distinguishing the use of rights language to achieve political ends and engaging with the system with a view to creating transformative systemic change (which will allow for alternative conceptions of rights in question) (2004). The latter he maintains, alike Rosenberg (1991), also requires paying closer attention to the legal system’s enforcing and implementation powers. This would reinforce the earlier argument about the likely limited potential of Delhi High Court verdict to create systemic reforms, beyond providing some sense of individual justice (which is important but not adequate). It also remains to be seen whether HRLN and the lawyers supporting the petitioner in the Delhi High Court case can be referred to as “cause lawyers” and the implications of this phenomenon for the politics of maternal health right in India.

\(^{62}\) Although Sood (2008) highlights concerns surrounding the patriarchal values and cultural beliefs (about women’s social status and their gender roles) that feature prominently in some judicial verdicts advanced in prominent cases involving women’s rights – consistent with that discussed in the previous chapter.
Nevertheless, some have taken a less definitive and direct view of the role of law in creating social reform, which is not driven by the “structural perspective” that dominates the study of law, but is rooted in “cultural studies” (McCann 1994; see Blum 1995). McCann’s thesis concerns the influence of legal mobilization, successful or not in its outcome, in shaping social mobilization and the impact of such mobilization in turn on generating long term transformation. McCann maintains that provoking claims of legal rights can create new opportunities and spaces for political debates otherwise unavailable. In other words, such view of the role of law in promoting social reform acknowledges the subtle ways in which claims of powerless can be underscored and that the law is not simply a tool available to dominant groups. The Delhi High Court verdict, therefore, has the potential to provide an alternative political venue to the issue of maternal morbidity and mortality, especially its political nature (related to rights violation). This can be substantial since there have been historical challenges in drawing appropriate attention from women’s and other social movements (John 2012). Even its emergence in the policy agenda has been largely bio-medical and technical in nature (Sri B and Khanna 2012). To this end, McCann also maintains that “law is contingent, and how it matters for social movements varies with the context and character of struggle” (2006, 17) suggesting the need to closely study the broader socio-political context in which the issue in question and legal mobilization surrounding it unfolds. Perhaps then Rosenberg’s disclaimer – despite his initial skepticism - requires careful consideration. Rosenberg asserts that sometimes courts might instigate major social reform, By inspiring individuals to act or persuading them to examine and change their opinions. Court decisions … may be powerful symbols, resources for change [,] … may affect the intellectual climate, the kinds of ideas that are discussed. … by giving salience to issues, [and] in effect placing them on political agenda. … [Court decisions] keep them [i.e. the issues] in public eye when other political institutions wish to bury them (1991, 8).
The Delhi High Court verdict therefore is of immense importance in likely restructuring the discourse on maternal health and human rights in India. A systematic examination of the verdict and its implications for reform can advance knowledge of the potential of human rights frame (and specifically using strategic litigation and judicialization) to alter political priority surrounding maternal morbidity and mortality, which can be of significance elsewhere given the wide prevalence of the problem elsewhere in developing countries. However, Delhi High Court case is not an isolated event within the broader context of judicialization of social rights in developing countries (Gloppen 2005; Gargarella et al. 2006; Langford 2008; Robinson 2009; Gauri 2009; Kahane 2009; Gauri and Gloppen 2012; Prado 2013; Cook 2013; Yamin 2014 ed.; Flood and Gross 2014 ed.). It is in line with the growing prominence of legal mobilization, especially strategic litigation, as a tool of social activism in wake of the debates over development, increased awareness of benefits of social rights (both analytically but also in practice) to discourse on poverty at the national (or local) levels. But more importantly, it is possibly a result of increased responsiveness of courts in newer democracies to address concerns of the poor (Gloppen 2005; Gargarella et al. 2006; Brinks and Gauri 2008). This has raised a number of peculiar issues – such as justiciability of social rights, role of judiciary in addressing social welfare issues in developing democracies, and the ability of courts to successfully enforce and implement social reforms (including the extent of such reforms) – which are of particular interest to this study, particularly the Delhi High Court case. These are further examined below.

Judicialization of Social (including Health) Rights (Developing Countries)

A primary concern with judicialization of social rights in developing countries has been the issue of justiciability (whether the court has judicial authority to “hear” an issue) of claims of
social entitlements, such as health, housing, food, education and so forth (Langford 2008; Gauri 2009; Kahane 2009; Parmar and Wahi 2011). Claims to social entitlements as fundamental rights are explicated to varying extent in different national constitutions as shown by Langford (2008) in analyzing nearly two thousand instances of judicial and quasi-judicial decisions on social rights jurisprudence across sixteen developing countries. Where they are largely vague, such as in India’s case with right to health, rights claimants (petitioners and lawyers) face the challenge of articulating the scope of rights violations. As well, there is likely to be ambiguity in outlining the scope of state obligations. Langford (2008) maintains the importance of international human rights law on legal mobilization at the country level and allowing practice to inform theory, thus shifting the debate further – from simply assessing “justiciability” to the extent of it. This is exactly the concern articulated by Kahane (2009) who points to the importance of “context” in assessing justiciability and suggesting implications for using strategic litigation to advance social rights (as fundamental rights). As indicated earlier, the Supreme Court of India has “read in” (interpreted) justiciability of right to health based on its implicit link to right to life. Further, it has also established a precedent of outlining the extent of justiciability in the right to food case although this has not been the case for health. Therefore, the adjudicator in the Delhi High Court case faces the challenge of assessing the “justiciability” of claims to maternal health care entitlements and the extent of state obligations. This becomes particularly problematic given the limited scope of the Indian maternal health policy design, especially if the court set outs to decide what “ought” to be minimum guarantees, which can make for a complex exercise given the various competing policy norms, discussed earlier in chapter 2 (see Policy Context). Ultimately, the framing of the petition outlining the violations is likely to determine this to a great extent, which reinforces the centrality of the frame held by the actor of the issue and is integral to the inquiry in this study.
Some have argued that social rights jurisprudence is indispensable particularly in poor countries where legislators and policy makers fail to address the fundamental concerns (with regards to survival) of the poor (Gauri and Gloppen 2012; Robinson 2009; Gauri 2009). This is because social rights litigation is viewed to offer an “alternative ‘decentralized’ means for holding decisions makers at different levels to account for their constitutional rights obligations as they set priorities and distribute resources in legislation, policies, and administrative decisions” but caution against taking a monolithic approach to understanding this process and its outcomes (Gauri and Gloppen 2012, 13). Albeit, concerns have been voiced in case of appointed judiciary in interfering with the policy making process – or otherwise, judicial overreach - that is typically a preoccupation of the representative branch of a democratic government (Desai and Muralidhar 2000; Gauri 2009). This is because few studies have indicated that those belonging to more privileged segment of the society stand to gain more frequently from such judicialization (through social action litigation) than the marginalized and downtrodden (Gauri 2009). Consider for example, the frequent incidences of medical negligence court cases in India filed generally under the PIL provision but to pursue private interests of comparatively more well off (see Grover, Misra and Rangarajan 2014). But Gauri (2009) maintains that such judicial overreach cannot be equated with breaching the condition of “separation of power” between different branches of government. Citing the case of Indian Supreme Court and its expansion of the scope of interpretation of “right to life” provision, Robinson (2009) argues that while this is not desirable (and can be problematic), it is a necessary (and lesser) evil in conditions where

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63 This is of relevance to the Indian context, particularly given the debates over judicial appointments in India. Judges in India are appointed through a collegium of judges of highest courts without any participation from other branches of government Economic and Political Weekly Editorial, 2013). One hand the collegium system is seen to lack transparency with largely no judges lacking public accountability. On the other hand, “the increasing prominence of the court in all spheres of national life” has become of symbolic of “how the senior judiciary has to shoulder responsibility while the executive misuses power” that is widely reflective of the dismal state of public policy and governance (consider health system governance) in the country (Ibid., 9).
representative branches are unresponsive to the concerns of the socially underprivileged64 (see also Ely 1980 making similar argument in the American context). The importance of this issue in the Indian context, where social hierarchy and discrimination is rampant in daily practices of formal institutions cannot be dismissed. Gargarella (2011) reminds that courts cannot be judged on enforceability alone, but also on the opportunities it creates for participation of the marginalized in the policy making process by promoting deliberations (as opposed to formulating policy) between non-judicial branches of government and the poor should also be acknowledged and examined carefully. More recent examination of empirical cases have shown that courts have responded to this criticism by using “creative forms of jurisprudence”, taking a less deliberative and more facilitative approach to policy making by directing governments to include previously excluded stakeholders in consultation process (the famous Grootboom housing rights case in South Africa) or declaring the policy status-quo as unconstitutional forcing “political authorities” to undertake necessary follow-up measures, such as review and revision (in case of Colombian Constitutional Court) (Gauri and Gloppen 2012; 14; also see Yamin 2014). In the Indian case, the Office of Supreme Court Commissioners (with its extensive apparatus of monitoring and oversight) created in the right to food case in Union vs. PUCL (2001) by the court is a relevant example. But the role of the grassroots right to food campaign comprised of other interested actors outside the formal legal institution, such as media, academics and individual experts, civil society actors cannot be ignored.

Possibly, the most significant concern with the judicialization of social rights, however, is the ability of courts to successfully implement reform and ensure such reform is both equitable (in its redistributive effect) and sustainable (most critically in terms of drain on government purse

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64 Robinson also maintains that similar examples are available elsewhere (Thailand, Iran and Bangladesh) and are reflective of the growing significance of “rise of rule through good governance principles via courts” (2).
or worse shifting resources from another critical area, rather than augmenting overall resources) (Epp 2003; Gloppen 2006, 2009; Gauri and Brinks 2008; Shankar and Mehta 2008; Yamin and Gloppen 2011; Brinks and Gauri 2012). This is likely the most significant challenge in assessing the potential of Delhi High Court verdict on altering political priority of maternal health, especially securing the resources necessary to improve maternal health and wellbeing. Here, the literature has advanced beyond the weak court / strong right (United States) and vice-versa (Canada and Great Britain) explanation provided for the role of court in interpreting constitutional entitlements to social welfare (Tushnet 2008; see also Dixon 2007). There is a widespread acknowledgement of the complexity of assessing and measuring “success” (despite a pro-poor verdict), let alone successful implementation. There is considerable debate between Gauri and Brinks (2008), Gloppen (2009), and Brinks and Gauri (2012) on the best methods to study “impact assessment”. These could include estimating the total direct and indirect beneficiary through use of multiplier method based on court documents (Gauri and Brinks 2008), studying the “scale”, “magnitude of gain”, “policy impact (causation problems and process indicators)”, “costs” and extent of redistribution (and shifting away from other areas) of resources (Gloppen 2009). Still others assess the “potential distributive impact” of outcomes of social rights litigation and find that such impact is widely variable depending on the country context and type of cases (individual provision vs. individual obligation vs. precedent setting case, abstract review case or regulation addressing case) (Brinks and Gauri 2012). Mastda, Rakner, and Ferraz (2011)’s research shows that in studying impact of litigation across countries on litigants, it is important to assess such impact individually on health policy, health budget, and access and distribution of health services. This is especially so, to form a clear idea of type and extent of any supposed “transformation”. Similarly, many of the studies reviewed here endorse the view that “NGOs and social movements” play a role in the extent of impact through their involvement and
are mostly likely to be involved, as expected, when the case stands to benefit a group over an individual (Yamin 2011, 2014; Roseman and Gloppen 2011; O’Connell 2014; Sabae 2014). A close examination of the judicial remedies offered in the Delhi High Court and their likely consequences – short, medium and longer term – is therefore critical to evaluating the potential of human rights to alter political priority surrounding the issue.

Barring enforceability, Roseman and Gloppen (2011) highlight the growing role of transnational actors, ranging from international NGOs to private actors (such as pharmaceutical companies), who are directly or indirectly (strategic role) involved in the judicialization of health rights in low and middle income countries. They stress the importance of studying “types of” actors and “forms of influence” as well as how such actors “drive” litigation in domestic context. Donor funding (by MacArthur Foundation) and strategic support from CRR were evident in the Delhi High Court case (in supporting HRLN). The CRR has received prominent mention in Roseman and Gloppen’s work as “undertaking pioneering, precedent-setting litigation around social rights” in many countries of the Global South (2011, 252). Its role in providing research and strategic support in another previous reproductive health right case in India has also been recorded by Parmar and Wahi (2011, 171) although the authors do not delve into deeper analysis of nature of involvement in such role (or its implications). However, the role of donors is noted to be largely catalytic in nature. Roseman and Gloppen maintain: “transnational donors provide funding for litigation does not mean that they provide the impetus to litigate. The recipient institution may still generate the initiative, with the transnational donor serving as facilitator” (253; emphasis added). It is difficult to assess the validity of this without empirical investigation, especially in light of existing evidence offered by feminist critiques of human rights and development who have demonstrated the significant role donors and international NGOs can play
in setting the advocacy agenda of domestic NGOs – globally as well as in India (Alvarez 1999; Nyamu-Musembi 2006; Tsikata 2007; Bradshaw 2006; Mukhopadhyay 2004; see Saheli et al. 2008; Rai 2008; John 2012 for India). This trend is particularly concerning given that domestic NGOs have subscribed (sometimes nominally) to the rights agenda and at times without completely internalizing its implications for various reasons (Bradshaw 2006; Molyneux and Razavi 2003; Cornwall and Molyneux 2006). The role of donor and other transnational actors in the Delhi High Court case and its implications are worth a systematic study, especially given the significance of their support for poorly funded and maintained nature of legal aid organizations (SSLM as Epp 1998 puts it), such as the HRLN.

Still others point to the various complexities of creating health sector reform in resource poor contexts with vast gender and social hierarchy (O’Connell 2014; Yamin 2011/2014; Flood and Gross 2014). One study regarding the judicialization of reproductive rights in the Inter-American System (both the commission and the court) and its impact at the country level attributes the failure to provoke necessary systemic transformation to the lack of direction on “sufficient structural remedies” in the verdict (O’Connell 2014). This, the author suggests, can be remedied by “requir[ing] incorporation of non-repetition remedies in the form of legislation, education, and training that seeks to remodel existing social and cultural practices that hinder women’s enjoyment of their reproductive rights” (Ibid., 116). This resonates strongly with the Indian context although would be a significant challenge to overcome, even for the courts. Yamin (2011) reminds that the impact of judicialization is contingent upon the role of physicians in providing health care and the asymmetrical power hierarchies that shape physician - rights claimants’ relationships. She also maintains “true evaluations of contributions to justice in health requires assessments of judicial interventions regarding social determinants” (2011, 337). More recently, scholars have cautioned that judicialization may be more successful in reducing
disparities in seeking health care and medical care than it can in addressing broader issues related to social determinants of health (Yamin 2014; Flood and Gross 2014). These would be critical concerns for Indian maternal health advocates given earlier discussions about the various power hierarchies and unequal citizenship dynamics central to maternal health injustices. For the Delhi High Court verdict, this would mean limited potential in affecting political priority surrounding maternal morbidity and mortality, such that deeper issues of underlying gender and social injustices can be addressed.

**Conclusion**

The emphasis on strategically framing maternal morbidity and mortality as human rights violations stems from the ability of the human rights frame to suggest the morally unacceptable (especially given the preventable nature) and politically urgent nature of the issue, to elevate its status in public consciousness and to transform the political commitment historically assigned (or not) to the issue (Yamin and Maine 1999; Yamin 2010; Freedman 2001/2005; Cook 1998; Cook and Dickens 2001; MacLean 2010; Fraser 2005; Fathalla 2006). This is due to the ability of strategic framing to lend a new meaning to an issue or policy problem although the potential of a frame to acquire public and political attention may be subject to political interpretation and contextual constraints, especially resource constraints (Schon and Rein 1994; Stone 2002; Fischer 2003; Hawkesworth 2012; Snow and Benford 1988). The theoretical debates reviewed in this chapter alert to the various possibilities – of both the interpretive complexities and contextual constraints – that can limit the potential of human rights frame to deliver on its conceptual promise. Many questions remain unanswered despite the growing prominence of human rights in the maternal health (and development) discourse, including in the post-2015 Development era: How does reframing preventable maternal morbidity and mortality as human rights injustices
affect political priority for the policy problem? Is it able to create the necessary political commitment and resources to advance reproductive justice for all women? Finally, what does this reveal about the potential of normative policy frames, such as human rights frames, to advance development outcomes? The next chapter outlines the analytical and methodological considerations employed in this study to develop responses to these questions.
Chapter 4: Analytical and Methodological Considerations

This study examines the potential of normative policy frames, specifically human rights frames of women’s rights to maternal health, to advance development outcomes, such as reproductive justice for all women. Specifically, it explores how reframing maternal morbidity and mortality as human rights injustices affects political priority for the policy problem and whether this is able to create necessary political commitment and resources to advance reproductive justice for all women. To support these objectives, the first part of this chapter outlines the concepts used to analyze the empirical findings of the study. The second part of this chapter presents the methodological considerations and contains information about research design (including sources of empirical evidence and data collection instruments), method of analysis, and methodological limitations.

Part I: Analytical Considerations

It is worth clarifying upfront that this study does not use a single given analytical framework per say. Rather, the first part of this section selectively employs concepts from the analytical toolbox of issue/strategic framing literature widely used in critical policy studies and social movements literature to describe the various factors considered in undertaking frame analysis. These include: framing as a phenomenon, frames (including its different aspects and various kinds of frames), role of political opportunity structures and mobilization resources, dynamics of framing strategies, and the collective implications of all of the above for the politics of reframing (Schon and Rein 1994; Stone 1989/2002; Fischer 2003; Rein 2009; Snow and Benford 1988; Benford 1993; Benford and Snow 2000; McAdam et al. 1996; Joachim 2003/2007). In contrast, the second part uses a conceptual framework proposed by Gloppen
(2011; see also Gloppen 2006/2008; Yamin 2014) to conduct comparative analysis of health rights litigation in developing countries. This is used to examine the findings related to the Delhi High Court case. Here, the litigation process is divided into four simple stages – claim formation, adjudication, implementation and social outcomes and equity – and factors relevant to these stages are employed to examine the outcomes of the Delhi High Court case (Gloppen 2011). The variables used to study the different stages of litigation are closely aligned with that described in the previous section. For example, careful study of claims formation can give insights into the frame (including frame design) of the policy problem held by the actor(s) driving the litigation process. At the same time, claims formation in itself is an outcome of the legal opportunity (LO) and legal opportunity structures (LOS) available to actors (Gloppen 2011). These links are made progressively explicit in the second part of the section.

The focus of this study is on the political priority deserving of the issue surrounding the policy problem (maternal morbidity and mortality). This is distinct from agenda setting in that the latter involves the politics of issue ascendance on the public and/or policy agenda (Kingdon 2002). In contrast, generation of political priority deserving of the issue – that is, second-level agenda setting – concerns reframing the issue, which may already be on policy agenda to emphasize a different attribute(s)65 of the policy problem. For example, the status-quo frame of the Indian maternal health policy privileges the biomedical and technical dimensions of women’s health. The resulting policy design emphasizes interventions to address proximate determinants of maternal health and incentivizes women to use formal health care facilities. But emphasizing a different attribute of the policy problem will entail prioritizing factors which dis-incentivize

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65 This concept has received comparatively more systematic attention in media studies, where scholars distinguish between the role of media in “first-level” agenda setting as emergence of issues in public agenda from “second-level” agenda setting as reframing through shifting news cycles to deliberately alter how such issues are perceived by the public (see McCombs and Evatt 1995; Lopez-Escobar et al. 1998; Balmas and Sheafer 2010).
women from accessing health care facilities or being denied care at such facilities due to discrimination, abuse, and neglect by health care providers. Such a frame ought to promote respectful maternal health care, as opposed to simply institutional (medical) maternal health care. Accomplishing the former will require more than allocation of material resources and will involve systemic attitudinal change which is near impossible without political commitment. This is of course one example of possible frames of women’s (human) right to maternal health. As the findings of this study (especially chapter 7) will show, there can be several such frames depending on sub-national variations in contextual factors.

This distinction between first-level and second level agenda setting is at the heart of the study because maternal mortality reduction has already featured on the global development agenda (2000-2015 in Millennium Development Agenda and continues to feature on the Sustainable Development Agenda) and domestic policy agenda in India (since 2005) (Shiffman 2007; Shiffman and Smith 2007; Shiffman and Ved 2007). But as discussed in detail earlier, this issue ascendance has been largely framed in biomedical and technical terms (that is, the policy frame). This, maternal health right advocates have argued, is insufficient to address the political nature of the problem (MacLean 2010; Cook and Dickens 1998/2001; Freedman 2001/2005; Fathalla 2006; Fraser 2005). The human rights frame is, therefore, proposed as the alternative to generate the political attention (and material resources) deserving of the issue (Ibid.).

**Conceptual Considerations in Frame Analysis**

*Frame analysis* is a social constructivist tool of analysis, which is used to study collective action strategies integral to the politics of social change (including policy reform) (Schon and Rein 1994; Fischer 2003; Stone 1989/2002; Johnson 2009; Rein 2009; Snow and Benford 1988; Benford 1993; Benford and Snow 2000; McAdam et al. 1996). The fundamental assumption
behind the social constructivist approach is that “human actors actively construct their social worlds” (Fischer 2003, 49). In other words, there is no single given objective reality; rather, there are multiple social realities which are deliberate products of individual’s “motives, intention, goals, purposes, values and experiences” (Ibid., 53). Frame analysis involves studying the frame and the different elements of the framing process (political opportunity structures, mobilization resources, framing strategies) which collectively determine the dynamics and outcomes of reframing.

**Frames as Policy Positions**

A frame is defined as “underlying structures of belief, perception, and appreciation” that determine policy positions of actors involved in a policy discourse (Schon and Rein 1994, 23). Frames determine policy positions of actors and conflicts in frames or policy positions held by different actors generally give rise to policy controversies. The latter are distinct from policy disagreements in that, they are disputes that cannot simply be resolved by appealing to facts (Schon and Rein 1994, 23). Schon and Rein (1994) use the term intractable policy controversy to refer to difficult, complex and contentious nature of issues with conflicting frames. For example, whether abortion should be legal, including under what conditions is a case in point. Similarly, whether maternal mortality ought to be deserving of political attention (and the extent of it) from the Indian state, given that it constitutes a “small” proportion of incidence of female mortality while selectively emphasizing maternal dimensions of women’s health (see chapter 2), can be termed an intractable policy controversy in this study.

There are generally two aspects to a frame, the diagnostic and the prognostic. The first specifies what is wrong with the situation and “[attributes] blame or causality” (Joachim 2007, 20). This generally involves assigning responsibility to a system (that is a “structural condition”),
rather than an individual, to underscore the systemic rather than sporadic and accidental nature of the undesirable outcomes by frame sponsor(s). This is reinforced in the construction of role of the state as central to preventing maternal deaths, even though such deaths may seem random occurrences (in time and space) and one off cases. In contrast, the *prognostic* aspect articulates what can be done to change/fix the status quo. This can take on varied forms depending on the nature of diagnostic aspect, ranging from technical interventions, resource allocation/re-distribution, and research and/or awareness generation to other solutions (Ibid., 20-21). For example, scholars who argue that maternal deaths are result of poor and weak health systems (diagnostic), generally call for improving the condition of health systems by allocating greater resources, improving infrastructure, training (or re-training) health care work force, to name a few (prognostic). However, scholars who argue that maternal deaths occur because women are unable to decide for themselves when, how and what type of maternal health care to seek (diagnostic), usually draw attention to women’s lack of reproductive autonomy and are likely to highlight the importance of broader social reform including programs for awareness generation (social, among male partners), attitude change (among family members, community), enforcement of laws upholding women’s equality (prognostic).

Theoretically, diagnostic and prognostic framing may seem simple and straightforward. But in practice, they are not especially where human rights injustices are concerned (Schon and Rein 1994, 35; Stone 2002; Benford and Snow 2000; Benford 1993). This is especially problematic given the popularity of injustice frames among civil society actors, which allow them to (construct and) emphasize the moral imperatives underlying the problem and make significant normative leaps. Such frames work by persuading important actors, particularly government, to act by “naming and shaming” them. Injustice frames tend to amplify victimization, yet offer only ambiguous solutions. Also, activists often misplace blame or struggle to rightly place blame
because “consensus on the source of the problem does not follow automatically from agreement regarding the nature of the problem” (Benford and Snow 2000, 616; Benford 1993). That is, even if frame sponsors agree on the existence of a human rights injustice, the substantive constitution (the diagnosis) of the latter may vary widely depending on the frame sponsor. Consequently, frame sponsors also differ on how such injustices may be best remedied (the prognosis) and using which specific mobilization strategies (Schon and Rein 1994, 35). Rights are “a vehicle for telling stories about what society means and what it stands for” and this story and vision is inherently subjective (Stone 2002, 353). This is noteworthy given the complex issue characteristic of maternal health injustices, and likely accentuated given the contextual intricacies in India discussed earlier.

Frames can also be of two types – rhetorical and action. Rhetorical frames constitute of stories that are meant to argue and convince a policy position to actors in a given policy discourse. They dominate policy debate dimensions of a policy discourse. In contrast, action frames communicate the actions that frame sponsors believe need to be done in practice to implement reforms resulting from reframing (Schon and Rein 1994, 32). They are prominent in policy practice dimensions of the policy discourse. Stories of women having to physically walk difficult geographical terrains in advanced stages of pregnancy (rhetorical frame) may be used by concerned actors to underscore the importance of functioning and accessible primary health centers (and emergency medical transportation) in rural and remote areas of the country (action frame). Action frames, therefore, may be aligned with prognostic aspects of a frame. Furthermore, in some situations there may be hardly any distinction between rhetorical and action frames. Conversely they may be very distinct even while emerging from the same policy position. Consider for example rhetorical frames that criticize CCT programs used by the Indian government to address inequities in maternal health care access versus corresponding action
frames that demand institutional accountability for the entitlements promised through that CCT program (see Dasgupta 2011; Shri B and Khanna 2012).

Policy frames – that is action frames of policy problems reflected in official policy design supported by the government – can also have some peculiar characteristics. Such frames tend to “hitch on to a dominant frames and its conventional metaphors” (Schon and Rein 1994, 33) as is clear in the Indian maternal health policy design which very closely emulates biomedical and technical interventions (institutional birth, skilled birth attendant, emergency obstetric care and such) that have prominently and historically featured in the maternal health policy discourse (including in professional medical associations such as International Federation of Gynecology and Obstetrics and international technical agencies, such as WHO, UNFPA, UNICEF). This adds to the legitimacy of the policy frame (Ibid.), even though there may be entirely different intentions behind the introduction of the policy – perhaps, pursuing comparatively less coercive family planning policies than before by restricting access to maternal health care to women of certain age and with certain number of childbirths.

A second characteristic of policy frames, especially in case of poverty and welfare, is for institutional actors to attribute the existence of the problem to “resource scarcity” – lack of resources and lack of organizational collaboration and coordination to maximize limited resources (Rein 2009). This claim is intended to pursue other actors in the policy discourse that the problematic outcome is not “intended”; rather it is a passive process “that no one intended and no one wanted, but no one noticed or was capable of altering” However, even this type of framing is not entirely unintended but rather an outcome of strategic “categorization” of a certain
segment of a population— in this case women from marginalized social background (Ibid., 975). It reflects the beliefs and perceptions institutional actors may have about the intended beneficiaries of the policy and how policy frames are designed to respond to their (perceived) needs and interests and the extent of resources they deserve. For instance, benefit schemes such as JSY indicate government efforts to allocate resources — even in a resource poor context (that is the underfunded public health system) — that incentivize women to approach the health system, without significantly reforming the attitude of deep seated social hierarchy that characterizes health service delivery among the service provider and the service recipient. Denial of maternal health care at formal health facilities therefore is attributed to random individual service provider’s behavior, even though such incidences are reflective of systemic culture especially in many parts of Northern India (Dasgupta 2011; Gopichandran and Chetlapalli 2012; Dasgupta 2015). Akhil Gupta (2012) has pointed to the contradictions in the “violence of poverty in India” (6), which are characterized by seemingly benevolent policy design addressing the needs of the generally poor women and children belonging to low caste and Adivasi communities who are collectively “essential” to India’s democratic and pluralist polity, but inherently unequal citizens. Such policy design and implementation are accompanied by an attitude of apathy and inactivity from civil servants. Gupta points to the underlying paradox characterized by chaotic yet extremely organized institutional practices yielding seemingly capricious outcomes. Such “ambiguity of ends” (i.e. capricious outcomes) in case of “problematic policies” should not be understood as simply given (or originating spontaneously). These may be outcomes of deliberate framing (and policy design and institutional practices) that have implications for the politics of

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66 This is somewhat similar to Schneider and Ingram (1993) and Ingram, Schneider and De Leon (2007)’s proposed framework in critical policy studies, which examines the “social construction of target population” by politicians and policy makers and its implications for design and delivery of public policy.
maternal health disparities in India. This is why the importance of considering various axes of identity and especially caste – that is different dimensions of citizenship – in designing inclusive social policy and state institutions that are led by the privileged administrative class (of an overwhelmingly Hindu, male, upper class and caste) segment of the population, has been underscored (de Haan 2008).

A third important characteristic of policy frames is that it is often challenging to separate “real and potential shifts of frame” (Schon and Rein 1994, 35). That is whether, the adoption of the new frame by institutional actors is emblematic of rhetorical or real commitment to reform sought by frame sponsors. This is apparent in the Indian context with the creation of NPP (in 2002) which made promises for promoting ethical approaches to family planning and respect for women’s reproductive choice but elements (limiting access to health care based on number of children/pregnancy) countering such promises featured prominently in maternal health policy design (launched in 2005) in India. Framing theorists describe this as lack of “complete delegitimization” of old frames – sometimes referred to as metacultural frames that are outcomes of broader context, even beyond institutions (for example, the need to curb population by any or all means to achieve “sustainable” economic development) – which has implications for frame sponsors looking to initiate reframing. That is, old frames may not completely disappear from the main policy discourse and can constrain a frame sponsor’s ability to create real change, beyond discursive shifts, through naming and framing.

**Framing Process**

Naming and framing (or frame construction) is a process by which actors relevant to an issue “perceive problems, manage preferences, formulate solutions, settle disputes, and come to compromises” (Fischer 2003, 144). That is framing is a deliberate process, that selectively
highlights certain dimension of the problem while setting aside (but not necessarily undermining) others. By doing so an “overwhelmingly complex reality” is re-organized and constructed into a comparatively simpler “problematic situation” such that frame sponsors (that is, concerned actors initiating framing) can specify solutions appropriate for resolving the problem. Framing can also deliberately shift the issue domain in which the problem resides (Rein 2009), which is of specific significance to the policy problem in question that is multidimensional in nature (has gender, health, social, political and bio-medical dimensions). However, the challenge before frame sponsors is to construct the problem in a manner that makes the solution seem “graceful, compelling, even obvious” to ensure maximum resonance with other actors in the policy discourse understood as “verbal exchange, or dialogue, about policy issues” between actors participating in the policy process (Schon and Rein 1994, 26 and 31). Thus, framing often involves making “normative leaps” from what the situation “is” to persuade other actors (especially, politicians and policy makers with power and resources) to consider what it “ought” to be (Ibid., 26). This helps to transform (at least, discursively) the very nature of the problematic situation. The discursive shift from viewing maternal mortality as a public health issue to a human rights violation constitutes one such reframing effort, which emphasizes that women are entitled to safe pregnancy and childbirth experiences (and by extension, reproductive justice) (Cooks and Dickens 2001; Yamin and Maine 1999; Freedman 2001).

**The Role of Political Opportunity Structures and Mobilization Resources in Framing**

A frame sponsor’s ability to mobilize political support, including choice of mobilization strategies, is also shaped by the political opportunity structure in which frame sponsors exist and the mobilization resources (also called, mobilization structures) available to them (Benford and Snow 2000; Joachim 2007; Schon and Rein 1994). Political opportunity structure (POS) is
understood as the broader institutional framework that can present prospects/constraints, which affect the ability of frame sponsors to mobilize political support for their cause (McAdam et al. 1996). Institution is conceptualized as a system of formal political structures bound by the laws, norms and policies that guide the rules of engagement between the various actors (state and non-state) participating in it. POS can have rigid, formal and structural dimensions and normative aspects, which offer strategic and symbolic entry points (that is, access to institutions) to frame sponsors to influence the actors internal to the system to bring about political and social change. While POSs can privilege the access of certain frame sponsors, they can also exclude others (Ibid.; Joachim 2007). The ascendance of maternal mortality reduction in the Millennium Development Agenda and subsequently in the Indian government’s policy agenda is a case in point (Shiffman and Smith 2007). It may provide both symbolic and strategic entry points to maternal health advocates because of the domestic and global attention the issue received and the agency (example, NRHM) and policy/program (example, JSY) creation that followed. However, it is likely to exclude those not engaged with (and/or not in agreement with) the issue of maternal health as defined by the narrow scope of the policy. At the same time, in a context where legal opportunity structure (a type of POS) such as the constitutional provision of PIL already exists, the right to food case may also signal legal opportunity (a type of political opportunity) to other civil society groups (for example, maternal health groups). The latter may see a window of opportunity in leveraging the same political and legal conditions to make headway, especially where judicially interpreted right to health has already come to exist (Grover, Mishra and Rangarajan 2014).

At the same time, political opportunity structures are bound by rules and procedures that can constrain a frame sponsor’s ability to mobilize (Joachim 2007). For instance, different political institutions or policy forums or venues (legislature, courts, other branches of
government) have their own characteristics, which determine the type of political discourse they can accommodate and the ability of frame sponsors to mobilize political support (including, the extent of it) (Schon and Rein 1994, 33). In simpler terms, the dimensions of policy problem that can be articulated before the court may not be underscored before a different branch of the government. In essence, the POS chosen by (and/or available to) the frame sponsor, which is closely aligned with the actor’s interests and agenda, will determine the frame or policy position. Alternatively, the frame sponsor’s ability to mobilize for broader change upon successful framing will be determined by the power and resources (for example, material resources) that characterize the chosen policy forum. Courts may not have control over the public purse but legislatures do (Rosenberg 1991).

Frame sponsors also rely on mobilization resources available to them to undertake reframing. The latter is defined as the “organizational resources and networks” used by frame sponsors to engage in collective action (Joachim 2007, 32). Mobilization resources enable frame sponsors to initiate and undertake framing to change the normative dimensions of the structures in which they exist. Specifically, they allow frame sponsors to present their frames as legitimate by making calculated choices, such as selectively engaging with information and facts, to maneuver POS. Therefore, mobilization resources emphasize the individual actor and agency dimensions of frame sponsors and complement structural explanations offered through analysis of POS (McAdam et al. 1996). There may be varied forms of mobilization resources, including financial resources, access to information (especially information at the grassroots level), organizational capacity, and knowledge and expertise (see McCarthy and Zald 1977). The knowledge and expertise claimed by frame sponsors can take many forms, scientific expertise, testimonial knowledge (provided by rights-claimants selectively chosen/supported by frame sponsors), and procedural knowledge. Knowledge and expertise have special relevance for civil
society actors because they help establish credibility and also add to the legitimacy of the frames sponsored by them. Procedural knowledge, however, requires special mention because it is particularly influential in policy forum that is political opportunity structure, selection.

Procedural knowledge pertains to know-how of the political institutions and their internal processes that frame sponsors purposefully select (or not) to undertake framing and is particularly relevant to this study, which is concerned with second-level agenda setting (McAdam et al. 1996; see also Kingdon 2002). It may come to exist as a combination of various factors – length of expertise and familiarity with the political context and institutions, deep awareness of institutional behavior surrounding a specific policy problem, and increasing professionalization of NGOs and concentration of expertise (movements for social changes being organized into professional entities). Further, it aids the framing process as frame sponsors leverage institutional norms and rules to make headway instead of always being constrained by them (Ibid.). It can constitute knowledge of how to draft proposals or policy design (or court petitions for example) reforms to generate greatest buy-in from institutional actors, when to introduce them, identify institutional allies to support them, foresee and likely fend off opposition. Procedural knowledge of frame sponsors is constantly evolving and improves vastly, becoming progressively deliberate, as they go through different stages of framing. By this logic, the contextual considerations outlined in chapter 2, about the historical and evolving nature of the policy problem, understanding of institutional and systemic issues, knowledge of opportunities and challenges presented by different political institutions is likely to be significant in determining how frame sponsors design frames and select mobilization strategies. That said, greater skill and knowledge among frame sponsors can also be a cause for lack of consensus among relevant actors (other frame sponsors, or even institutional actors), intensifying frame conflict and contributing to frame dispute (Joachim 2007).
Framing Strategies as Sources of Frame Conflicts

In a policy discourse, characterized by an intractable policy controversy, two or more frame sponsors may generally struggle to exert influence on the process of policy design. Their struggles are emblematic of competition over “social meaning of an issue domain” where the meaning communicates both what is wrong (or unacceptable and needs fixing) and how it is to be fixed. In other words, the frame or policy position identified by a frame sponsor in an intractable policy controversy will predetermine the strategy that can be used to pursue reframing (Schon and Rein 1994, 29). This is particularly relevant to the issue of generating consensus on ways to mobilize among frame sponsors. Frame sponsors in an intractable policy controversy are often divided over the meaning (of the issue) to be communicated and how, because they hold different views on which frame and strategy of mobilization can achieve “greatest potential power to effect change” (Benford 1993, 679). This is evident in the scholarly debate among Indian experts, Imraana Qadeer, Gita Sen and T.K. Sundari Ravindran over official policy approach to women’s health. Qadeer (1998) is critical of narrow policy focus on reproductive dimensions, especially family planning, while Sen (1994) and Ravindran (1993) have argued that such a focus can be strategically used to gain an entry into policy discussions over the condition of health system, critical to enabling reproductive choice for women. This fundamental difference cannot be sorted by simply appealing to facts and it results from a fundamentally different view on how a problematic situation can be addressed and to what end. As well, it is consequential to differences in mobilization strategies (Benford 1993; Joachim 2007). Qadeer’s policy position is more likely to call for an overhaul of existing official policy, where as Sen and Ravindran’s is more likely to work with the government pushing for incremental change.

The existence of multiple frames or policy positions in a policy discourse results in
emergence of diverse issue definitions (also known as problem definitions) and differences over possible solutions (Schon and Rein 1994; Fischer 2003). More importantly, each set of definition and solution (including suggested policy intervention), only attends to a particular dimension of the policy problem and is unable to address the full scope of its complexities (Ibid.; Benford and Snow 2000). Health in Global Health discourse, for example, have been framed by different actors as development, human rights, global public good, security and commodity – each with attention to different diagnostic and prognostic dimensions and corresponding policy responses (Labonte 2008). The polarization on possible solutions between different frame sponsors is further accentuated in case of intractable policy controversies, as different frame sponsors empathize with different causal factors of a problem and attach varying levels of priority to such factors (Johnson 2009). This is evident in scholarly debates surrounding maternal health and human rights, where those advocating for women’s right to health care have criticized the strategic use of human rights to advance claims of women’s reproductive rights, and expressed concerns over dilution (sidelining the issue of maternal deaths) and possible hijacking of human right “speak” (in form of “reproductive choice”) by the state to pursue questionable political agendas (Freedman 2001, 2005; Yamin and Maine 2005). While they acknowledge the significance of advocating for women’s right to sexual and reproductive health, they do not see it as critical to preventing maternal deaths (as Freedman has often argued).

The existence of two or more distinct frames or policy positions to explain the same problem also emerges from differences in frame sponsors’ interests/agendas (Schon and Rein 1994, 29; Joachim 2007, 23). To be precise, interests/agendas may influence frame construction, and frames may be used to promote and preserve frame sponsor’s interests/agendas. But frames and interests are “logically independent” concepts that are not linked in a rigidly defined “deterministic” manner (Schon and Rein 1994, 29). For example, American socio-legal theorists
have demonstrated that litigation is the bread and butter of American PILOs and “cause lawyers”, must litigate and propose appropriate frames (for example, emphasizing formal equality in law) – despite knowledge of limited gains through courts for a particular social cause and even in isolation from broader social mobilization – as else, they “risk looking irrelevant” (Boutcher 2013a, n.p.; Boutcher 2013b; Meyer and Boutcher 2007). Similarly, feminist critiques of human rights and development point out that women’s rights groups and organizations in developing countries may adopt the language of human rights and introduce it into their program, even when they nominally subscribe to such ideas, because of donor requirements on which they rely for sustenance (Bradshaw 2006; Hames 2006; Molyneux and Lazar 2003; Tsikata 2007). Others have shown that women’s rights advocates – while remaining dependent on donor aid – have grown to be more sophisticated (and organized as professionals) in their strategizing to secure a seat on the official policy making table. Their frames or policy positions and framing strategies may be deliberately designed to resonate with policy makers (without completely succumbing to policy makers’ positions), although by being at the policy table they are able to incrementally pressure the government into making more transformative change (Alvarez 1999/2009; Rai 2008).

But then again, the frames of frame sponsors who choose to work with policy makers to create incremental change may be in competition with those seeking transformative change and wishing to challenge state officials. This presents challenges for maintaining a singular frame given the constantly evolving and dynamics nature of the framing process within a master frame (for example, maternal health and human rights or women’s rights as human rights) in a mobilization characterized by multiple organizations (or coalition or networks) is particularly challenging because of the existence of competing narratives that aim to advance individual frame sponsor’s agenda (McAdam et al 1996; Snow and Benford 1988). This is perhaps the
thorniest issue for women’s rights advocates today – whether to work within the status-quo or eliminate it (and how) entirely – as demonstrated earlier in reviewing the debates over resisting the appropriation of human rights speak in mainstreaming gender into state institutions, generally as well as in India (Rai 2008; Cornwall and Molyneux 2006; John 2008/2012; Sen 2012). This can also lead to diffusion and dilution of key message, adversely affecting the issue under consideration (McAdam et al. 1996; Snow and Benford 1988).

**Summary of Key Variables, Reframing and Implication for Political Priority**

In summary, actors in a policy discourse hold different (1) beliefs and perceptions of their surrounding reality, (2) have different interests and agendas, and (3) have access to different political opportunity structures and mobilization resources. The frames or policy positions (independent variable) they have in a policy discourse and the framing strategies (independent variable) they use to mobilize political support for their cause is an outcome of dynamic interaction of the three aforementioned characteristics of actors. This dynamic interaction can unfold in multiple ways. Each frame or policy position underscores and overlooks certain diagnostic and prognostic dimensions of the policy problem. So no frame can truly capture the complexity of the entire policy problem. Frames also determine framing or mobilization strategies, which have their own strengths and limitations. Framing strategies, in turn, are distinctive to the policy forums in which they are operationalized. Different policy forums have different rules of engagement, which results in distinctive discourses that frame sponsors must conform to (and this affects the contents of the frame they sponsor).

Likewise, framing undertaken in different policy forums may have different outcomes for altering political priority (dependent variable), including the nature and extent of political commitment and access to resources available accompanying such commitment. Frame disputes
in a policy discourse can arise from various coexisting factors. This is because consensus on existence of a problem does not lead to consensus on the nature of the problem, contributing factors, solutions, ways to resolve, and the policy forums to use to achieve the greatest leverage.

Altering political priority attached to a policy problem requires reframing the problem, unless the policy controversy is resolved without reframing (because of other circumstantial and spontaneous changes from within the system). Reframing generally requires actors in a policy discourse to undertake frame reflection, which is the process by which different actors (including state actors) in a policy discourse consider ways to resolve the policy controversies that arise in the policy making process and move beyond policy stalemate. Frame reflection is challenging because it requires an actor to step out her own reality to consider the positions of other actors and frame sponsors in the policy discourse. Simply put, those resisting the human rights frame of maternal health will be required to critically examine the policy position of those advocating for it. Alternatively, those sponsoring the human rights frame would be required to reflect on the policy position of actors supporting the dominant biomedical frame. Admittedly this grows complex, especially when the multiple realities, their characteristics and actor’s subjectivities are concerned (not counting practical considerations such as lack of infinite resources to address all problems before policy makers), which is why frame reflection can actually “reinforce stalemate or antagonism” (Schon and Rein 1994; 39). That is frame disputes can antagonize possible allies, which can dampen the prospect for altering political priority. But they are not predestined to do so.

A second possibility is that problematic policies may be successfully reframed, despite “the extraordinary durability of metacultural frames and frame conflicts” because of paradigm shifts in dominant positions and “world views” (Ibid.). One could argue that the creation of the Millennium Development Agenda, where world leaders for the first time committed to
addressing social and welfare dimensions of poverty (and not just economic growth) in developing countries was one such instance that contributed to the creation of a normative vision of global social development. This political consensus inspired the idea of plausibility of state accountability against normative guarantees (corresponding to MDGs) for some scholars (Schmidt-Traub 2009; Carmona 2009; Alston 2005/2007). Arguably paradigm shifts are unpredictable phenomena, although they can set the stage for further frame reflection as demonstrated in the above example.

A third possibility with reframing is when the problematic situation entirely changes, that is “the policy pendulum swings from one unworkable extreme to another”, which forces policy makers to reevaluate their position (Ibid., 40). Under the circumstances, the old policy frame may lose its dominance and the new frame that emerges prominently in the policy discourse may not entirely address the new situation (since the status-quo has changed from when it was initially designed). This is when policy makers may choose the favorable elements of each one to propose a comparatively more acceptable solution.

In other words, there is no linear relationship between frame reflection, reframing and solutions for intractable policy controversies. Frame reflection, even if it is undertaken by actors may not lead to reframing. Although reframing – that occurs spontaneously – may set the stage for frame reflection. Reframing, as well, may not lead to resolution of policy problems. Actors in a policy discourse can overcome these challenges (partially) through various means – some deliberate, others more spontaneous (Schon and Rein 1994, 43-57). These can include: learning to communicate across different paradigms (see Kuhn 1962), establishing rules of discourse

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67 Admittedly, this was the result of many decades of advocacy by civil society actors and the UN establishment but the greater focus on economic and social rights as human rights (and not just civil and political rights) was precipitated by end of Cold War (see Donnelly 2011).
setting that equally apply to all participants (see Habermas 1984), use of arbitrators and
negotiators (see Forester 1989), readjusting expectations about ends based on means available
(see Lindbolm 1991), incremental institutional change that is not entirely deliberate (see March
and Olsen 1989), and a “bias towards hope” (see Hirschman 1971) which emphasizes “that
societal development and institutional reform may be deliberately pursued through the exercise of
human reason” (Schon and Rein 1994, 55).

**Conceptual Considerations in Analysis of Litigation as a Framing Strategy**

The analytical concepts outlined in this section pertain to the study of litigation, which is
*a* framing or framing strategy used to reframe maternal morbidity and mortality as a human rights
injustice with the ultimate goal to alter political priority surrounding the issue. They will be
specifically employed to study the Delhi High Court case, from inception to outcome. These
variables emerge directly from the judicialization of rights (including health rights in developing
country context) literature reviewed in the previous chapter. For analysis purposes, the entire
process of litigation is divided into four stages — claims formation, adjudication,
implementation and social outcomes and equity (Gloppen 2011, 29).

*Claims formation* constitutes the first stage of litigation. *This is the stage of frame
construction and its output provides insight into the frame or policy position held by the frame
sponsor*. The key actor in this stage is the litigant. The role of the litigant is also the most
significant in this stage because after the claim enters the court system the litigant is no longer the
sole and most important influencer in the process. The litigant can be an individual, a group or an

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68 It is important to note that in reality it is difficulty to completely separate events and consequences in these four
stages, since actions taken in one stage may have consequences felt in other stages. Hence, some overlap between
stages may exist.
organization that seeks to represent either or both of the former (such as a public interest litigation organization or PILO in the Delhi High Court case). The litigants, their background, their concerns, the intervention and remedies (that is, “prospective gains”) they seek from the courts, including the decision (that is, the preference) to secure these through litigation (as opposed to other alternatives with different time and resource implications) determine the scope and nature of claims underscored in the petition (Gloppen 2011, 31). As well, the litigant may also be supported by non-legal actors who influence the process of claims formation (by virtue of their knowledge and expertise), such as actors or groups engaged in broader social mobilization surrounding the issue. The latter’s motivations may influence the claims articulated (or not) in the petition since they will aim to strategically maximize the gains from litigation.

Furthermore, the opportunity structures, especially legal opportunity structures (LOS) – a type of political opportunity structure - may also be an important determinant in this stage since it allows the litigant access to courts (the policy forum). For example, the constitutional provision of public interest litigation (PIL) in India has been widely used (including in right to food and previous health rights litigation) by civil society actors to advance social justice causes (and to varying extent) (Gauri 2009). Accessibility of courts is an important determinant of litigation because some legal systems have simplified the procedures to approach courts (Gloppen 2011). This is pertinent in case of PILs in India, where rules have been relaxed such that ordinary citizens (including third party) from anywhere in the country can approach (directly or through formal letter or petition) courts, including the Supreme Court, to initiate a case (Sood 2006, 837-8). The fact that this simplifies and minimizes burden of approaching courts for litigants should
therefore be considered in initiating claims\textsuperscript{69}. As well, assessment of legal opportunities (LOs), such as judicial activism and tendency to pronounce pro-poor verdict (generally, but not in case of two child norm and coercive population policies or women’s rights) prominent in India may influence reflection on opportunities and challenges of using litigation as a tool of strategic framing. That is, confidence in courts and/or legal system may motivate (or not) the decision to approach courts and the design of claims. Wider consideration of the capacity of state (in the historical, political, economic and social context) and the potential of litigation to “activate this capacity” can also stand to be consequential in decision to litigate (Gloppen 2011, 31).

Availability of mobilizing resources is equally important in decision to litigate and design of claims. For example, “financial resources, legal skills, relevant information, and/or organizational capacity or external resources ranging from global to local, that can mobilize and link to legal service organization, activist networks, social movements, patient organizations, medical companies, media, political decision makers and/or donors” (Gloppen 2011, 31) will determine the likelihood of approaching courts and the nature of claims. This is because they underscore varying extent of resources and opportunities available to litigants during the litigation and in the aftermath of the verdict. That said, following the dynamics of framing, not all the abovementioned actors share a common agenda and gain/lose similarly from litigating, which in itself may be a driver (or not) of decision to litigate (Gloppen 2008).

\textsuperscript{69} Please note that Gloppen (2008, 2011) includes this factor in the adjudication stage since she is proposing a framework for comparative analysis of health rights litigation in several countries. Her rationale being that in some legal systems, a court can decide whether or not it wishes to “hear” a case. However, I prefer to include it in claims-formation since the Delhi High Court case is a PIL case. The ease of accessing the court through PIL case (as opposed other types of law suit) therefore, in my opinion, should be considered as an extension of the legal opportunity structure available to actors wishing to use litigation as a framing strategy. Gloppen, in fact, acknowledge the ease with which litigants can approach (and have done so) the court for fundamental rights cases (including health rights) in India, as opposed to other countries (see 2011, 33).
Claims formation culminates into the claims contained in the petition presented before the court. The claims can be further disaggregated into five elements: (1) the “substantive focus” (what interventions are sought, individual remedies or changes in structural conditions that can affect a wider population); (2) “their scope” (is the focus on individual, collective or public interest); (3) “their aim” (are they designed to address gaps in policy design or inconsistencies between design and implementation); (4) “their legal basis” (do the claims ensue from status-quo rights and accompanying entitlements – be it related to health or other issue dimensions of maternal health – specified in the constitution, other domestic legislation, or international law); and (5) their factual basis (how is credibility of interventions sought asserted, through expert and scientific analysis and/or published findings) (Gloppen 2011, 32).

The second stage in analysis of the litigation process focuses on the **adjudication stage**. This stage involves the “presentation of arguments in the case” and the adjudication process (Ibid.). The former is “simplif[ied] by considering arguments presented in the case as part of the claim and belonging to the claims-formation stage” (Ibid.). In the remaining adjudication process, the court takes center-stage. The nature of the court (Supreme or Constitutional Court, Higher/lower court) can affect the adjudication process especially since cases concerning fundamental rights can be “heard” only by certain courts. For example, in India cases that leverage the constitutional provision of PIL can only be heard through Supreme Court and the High Courts (cite). The role of judges (be it individual or a bench) in the adjudication phase is critical and the “their professional, personal and ideological backgrounds” can have ramifications for outcomes of this phase (Ibid., 33).

The most important output of the adjudication stage is the judgment. Judges may support, fully or partially the claims made by the petitioner before the court or entirely reject them (Ibid., 34). This outcome cannot be untied from the “legal basis of the judgment”, including how judges
may apply and/or conceptualize fundamental rights in question (Ibid). This, similar to that in claims formation stage, can be assessed against the domestic, constitutional and international legal protocols (those ratified by the state) used (including nature of interpretation) to base the judgment upon. Whether and to what extent these rights (included in the claim) are justiciable can have implications for the judgment; especially where justiciability is vague the likelihood of scope of interpretation (based on implicit links to other constitutional rights and guarantees) is relatively greater than where they are more clearly specified. Consequently, judges as key institutional actors hold much power and can establish minimum guarantees based on norms outlined in international protocol. *A comparison of the rights upheld and/or newly interpreted and recognized in the judgment and those furthered in the claim outlined by the petition can give insights into whether the latter’s frame resonated (and to what extent) with the institutional actors central to that policy forum.* Cases involving health rights can also involve use of “technical expertise” – introduced by litigants and/or sought by the court itself – and the ways this is drawn upon in the judgment can also provide insights into how and which elements of professional/scientific expertise is underscored by the judgment, and finally in the new frame recognized at that specific policy forum (Ibid).

Finally, it is important to examine the court-provided orders and remedies. These may implicate state actors and/or “private actors”, which are consequential in mixed health care system (such as in India). Such orders and remedies may also apply differently to individuals immediately involved in the court case (that is the claimant) versus a wider population (including those similarly placed as the claimant or the entire population). They may define “immediate and concrete entitlements to particular [maternal] health service or … “only” establish a duty on the part of the authority to address [maternal] health need in terms of general policy” (Gloppen 2011, 35). If it is the latter, the court can take a “soft” approach – that is suggest and underscore the
ongoing violation of certain fundamental rights and hope something is done by other branches of the state to address it - or take a stricter approach outlining remedies, including directing other branches of the government to consider reforms. In the latter case, the court may also stay involved in various capacities (direct “supervisory” or through creation of intermediary oversight bodies) and/or suggest a timeline by which it wishes to see changes installed along with timely updates from authorities (similar to the right to food case in India). These measures are significant for the wider implications of litigation and can directly or indirectly (based on the nature of the measure) play into altering political priority attached to the issue (Ibid.).

The third stage of litigation is the implementation stage. The contents of the judgment may directly/indirectly specify authorities responsible for upholding court orders and offering remedies. The most critical considerations in determining outcomes of the implementation stage are whether, how and to what extent the responsible authorities comply with the court order (Gloppen 2011, 35-36). This is significant for examining whether, how and to what extent reframing is able to affect political priority and by extension the political commitment and resources necessary to resolve the policy problem. Nevertheless, compliance is difficult to evaluate because it may be subjective to define (especially in case of “soft” order and directions of broader reform) and its nature and extent may by time-sensitive, especially in resource poor context. Generally, it can reside within two extremes – “blatant disregard to full implementation” (Ibid., 36). Monitoring mechanisms, such as oversight bodies, created in the adjudication stage can play important role in ensuring and measuring compliance. Their role can be complemented and/or replaced (where such bodies do not exist) by civil society actors and media in examining the nature and extent of compliance with court order (taking into account their likely bias). The ability of litigants to follow up and take legal steps, in case of lack of compliance, is also
important to consider since it offers direct insights into access to justice, beyond access to courts (Ibid.).

However, lack of or poor compliance should not be viewed as failure of litigation to create change since the latter may come about in the longer term without immediate and obvious systemic changes (through frame reflection and reframing over considerable period of time). By the same logic, judgments that do not assert a “hard” approach to their court orders and remedies should not be disregarded as they can lead to change without reframing or frame reflection. That is, there may be other factors (related to “social and political dynamics”) that play a role in the process, which can be difficult to isolate. In either case, the verdict can “provide impetus and serve as leverage for health policy reform or institutional changes to the health system” (Ibid., 36). This reinforces the complex nature of frame reflection, reframing and policy change. Last, but not least, judgments can set precedents articulating both normative and legal thresholds for fundamental rights violations. To understand this sub-phase better, it may be useful to study “who supports or draws legitimacy from the judgment?” Which actors use the verdict and how and if actors previously absent from the litigation process leverage the verdict, as well.

The judgment can also add to the social and political dynamics beyond the life of the court case and the verdict. This marks the final stage, which focuses on the broader social outcomes and equity – the impact of the litigation process. This is the most difficult stage to study because of the (subjective and) normative implications of such assessment as well as the centrality of time to it – be it in terms of length of time passed since the verdict, time taken to implement, time required to actualize effects of implementation, and/or the segment of the population that likely benefit from the changes over time. There may be far reaching implications of litigation surrounding fundamental rights that can have an impact on whether and how certain public services are made available to the population as well as whether a “judgment changes procedures
and decision-making processes” (Ibid., 37). As well, there may be “symbolic effects” about how related issues are conceptualized and articulated in public and political life (Ibid).

**Part II: Methodological Considerations**

The methodological approach of this study draws on interpretivist qualitative approaches and post-colonial feminist thought. The interpretivist approach is grounded in the belief that “we live in a social world characterized by the possibilities of multiple interpretations” that need to be made sense of (or interpreted) (Yanow 2000, 5). It is consequential given the inherently abstract, aspirational and normative characteristics of human rights, the practical politics of which is conditional upon interpretation (Stone 2002). Moreover, post-colonial feminist thinking is understood as moving beyond the liberal notions of simply demanding rights (and formal legal equality) for women from the state and also recognizing that there is no universal and monolithic analytical category of ‘woman/women’ to advance knowledge and scholarship about ‘radical’ (read, post-liberal) feminist praxis (Mohanty 1988). The marriage between the interpretivist and post-colonial feminist epistemological approaches is, therefore, highly complementary as both underscore the significance of specificity and nuance (be it structural and/or discursive) and are averse to proposals of grand theories and generalizations – either “valorizing or dismissing” as Dhamoon (2009) cautions - often attempted by scholars working in positivist and post-positivist traditions (14).

In studying the politics of social change, interpretivist approaches emphasize the importance of drawing “attention to underlying social assumptions [behind different realities] and their less obvious implications for contemporary life” (Fischer 2003, 49). Such an epistemological approach is particularly relevant for the study at hand because the politics of interpretation is essential to framing preventable maternal morbidity and mortality as human
rights injustices, especially to communicate the related moral and political imperative.

Additionally, from the interpretivist standpoint, development (or more specifically, achievement of reproductive justice) is hardly a “rational” project; rather, it is a political project because “development planning and implementation are better understood as sites of struggle in which competing interests vie for power” (Hawkesworth 2012, 138). This is why the study does not assume that introducing human rights to the discourse of development (including maternal health/death) intuitively leads to raising moral and political imperatives that provoke questions of power and reveal the ways established power hierarchies systematically discriminate, marginalize, and sometimes exploit the poor and vulnerable, thus depriving them from enjoying the benefits of development.

On the contrary, if the politics of framing is inherently about meaning making through active and deliberate construction of social reality, then following the interpretive approach there is no single ontological account of how frame sponsors interpret human rights norms and principles and use them to construct alternative discourses of development. Rather, there may be multiple and often co-existing realities of development (and specifically, notions of reproductive justice) stemming from different perspectives about the ways human rights ought to be/can be/is actually interpreted by different frame sponsors based on their contextual and discursive positionality and power to navigate these (Fischer 2003). Following this idea and in the post-colonial feminist tradition, the study problematizes the universalizing politics of human rights and its implications for the politics of reproductive justice, and development more broadly (along with the construction of different categories of the maternal subject/citizen by key actors – including frame sponsors – in the discourse). It, therefore, pays particular attention to “processes of meaning-making operationalized by the state and other members of the society… and diverse interrelated processes of meaning making that constitute differences between and among social
groups” (Dhamoon 2009, 15). Such an analytical approach is a deliberate strategy and stems from the logic of difficulties in achieving “female solidarity … across the full range of women’s human and reproductive rights” as documented in the critical feminist approaches to development literature (Cornwall and Molyneux 2006, 1188). This has been discussed and analyzed in relation to the global and Indian politics of framing women’s right to maternal health in earlier chapters.

This study tries to uncover the perspectives and positionalities of the various frame sponsors and situate them in the ‘authority’ and ‘knowledge claims’ made by such frame sponsors. The significance of the interpretive approach is further reinforced by the fact that the prerogative of framing development (and preventable maternal deaths) as a human rights issue is a concern of those who claim to represent the poor and marginalized, rather than the ‘oppressed’ themselves. Consequently, it is equally important to problematize the context, both the structure and the discourse and unearth the subjectivities in being able to nuance potential gains (especially, for whom) from reframing. Such a task can be achieved through frame reflection, which is perpetually about “creat[ing] different portrayals of the battle – who is affected, how they are affected, and what is at stake” (Stone 2012, 36).

One can argue that it is the very nature of frame reflection, that requires the researcher to be sensitive to a post-colonial feminist approach and not privilege any one positionality or any one explanation behind the choice of frame and framing strategy used by the frame sponsors to advance their advocacy objectives (and their resultant implications). This approach allows the study to recognize and distinguish the multiple “Subalterns” – be it the constituency (of maternal subject/citizen) frame sponsors claim to represent, or the frame sponsors themselves in relation to the local and global hegemonic discourses of maternal health politics – and their location in separate but intersecting structural and discursive contexts of power hierarchies, which determine her/their agency and have implications for the politics of “can the subaltern speak” (including, to
what extent and how) (Spivak 1988, 66). Additionally, if the strength and usefulness of the human rights framework exists in its ability to be applied to different contexts, then a grand and generalizable theory is best avoided. After all, as Dhamoon reminds: “the very nature of deconstructive work is that it enables specificity and contextualization rather than universal or complete knowledge” (2009, 17).

This study, therefore, takes a cautious approach to ‘reading’ the data. It selectively draws on diverse feminist theoretical lens – intersectionality (Crenshaw 1991); gender, development and inclusive citizenship (Mukhopadhyay 2003; Cornwall and Molyneux 2006); (feminist) legal theory (Kapur 2007); and reproductive justice in relation to mobilization experiences of women of color (Ross 2004) – to take an eclectic analytical approach. This approach aids the researcher to respectively emphasize the different factors that collectively determine the politics of human rights framing of maternal health/death in India and have implications for identity based politics for democratization and inclusive development (including social development), politics of ‘rights’ actualization, and the politics of feminist collective action. It is also an approach, which is sensitive to both the interdisciplinary origins of the study and the researcher’s own collaborative doctoral training in political science and international development studies.

The type of data required to undertake frame analysis is largely descriptive in nature. It involves examination of words, texts, rich narratives generated through conversations with research respondents and first hand observations. This is best achieved through use of qualitative methods to undertake social enquiry (Schwartz-Shea and Yanow 2012). Hence, this exploratory study uses a qualitative, case study approach to data collection.
Research Design

At the onset, it is important to define the scope of the research design. Data collection for this study was limited to the level of Central Government of India (or the Union). The reasons cited below are indicated in the scholarly literature and were also confirmed through observation and insights acquired from a preliminary field research trip (from January to February 2012) undertaken before the launch of the primary field research activities.

First, the JSY scheme i.e. the principle policy instrument used by the state to address maternal mortality reduction, was conceptualized, designed and directly funded by the Central Government through the creation of the autonomous National Rural Health Mission (JSY being its flagship program) in 2005 (MoHFW 2006b). In fact, the creation of the National Health Systems Resource Centre (NHSRC)\(^7\), shortly after, was designed to provide the technical support structure (staffed primarily by retired bureaucrats and expert technocrats/planners from sub-national states with well performing health indicators, such as Tamil Nadu and Kerala) under the Union level to lead health system capacity building in under-developed states (especially in the Empowered Action Group or EAG states, which also incidentally had the highest MMRs) and facilitate implementation and health care service delivery. Second and as already indicated earlier, the Union has a history of leading (and controlling) health programs such as family planning and reproductive health that are directly linked to national population control objectives (for excellent analysis of this, see Narayanan 2011). In fact, a number of scholars have attributed the decline in public health system to the Union’s zealous and exclusive focus on promoting vertical design of reproductive health and family planning programs at the cost of focus on

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\(^7\) NHSRC houses technocrats who are responsible for assessing health service delivery at the state level, providing requisite resources and training as well as evaluating state level health service delivery. It is led by former state bureaucrats and includes technocrats such as medical and health system specialists.
comprehensive primary health care (Parmar and Wahi 2011; Ravindran 2014), including linking such planning and execution to the state’s neoliberal agenda (Qadeer 2005b).

Third, the judgment in the Delhi High Court case directed the Union Ministry of Health and Welfare (MoHFW) to issue a clarification to all state governments regarding the administration of applicable benefit schemes to all BPL pregnant women and lactating mothers irrespective of number of children and/or age (ESCR-NET CaseLaw Database 2010). Due to expansion of the “locus-standi”\textsuperscript{71} clause of PIL and consequent relaxation of the jurisdiction element, the Union is legally and constitutionally responsible for “communicating” verdicts in PIL cases to sub-national states (Sood 2006, 25-26). While sub-national states cannot be legally forced by the central government to comply (and drafting of new legislation can only begin if two or more sub-national units are supportive), they are likely to comply or else be left out on resources and funding (Ibid.). Fourth, the court petition indicated denial of essential health care and nutritional services and entitlements under schemes such as the National Maternity Benefit Scheme (NMBS), the Janani Suraksha Yojna (JSY), the National Family Benefit Scheme (NFBS), the Integrated Child Development Scheme (ICDS), and the Antyodaya Anna Yojana (AAY), all of which are designed and funded by the Union (Office of Supreme Court Commissioners 2011). The judgment also indicated (“soft” approach) to the responsible authority (who host the benefit schemes) – the central government – had failed to establish grievance redressal mechanisms for delivery of public services of such massive proportion (in terms of funds dedicated) and the need to consider creation of monitoring and oversight mechanisms, including periodic review (Justice Muralidharan 2010). Fifth, central-sub national political and

\textsuperscript{71} Locus-standi principle refers to the fact that only the aggrieved party can approach the courts. The design of PIL in section 32 of the Indian Constitution gives a third party to approach the court (the Supreme Court or any of the 21 High Courts) on behalf of the aggrieved (need not be legal representative and/or a lawyer) if the nature of the violation involved a fundamental right and its preservation was therefore in wider public interest.
governing dynamics are complex in India (as indicated earlier in chapter 2). Power and by extension planning, policy design, and resource allocation have historically rested mainly with the Central Government although implementation is largely left to sub-national governments (Kohli ed. 2001; Rao and Singh 2004; Saxena 2012). The effects of this have been particularly acute for health care administration and reform in India (Pahwa and Beland 2013). Selected progressive states, depending on regional politics, may negotiate resources and implementation plans with the Union, but the poor and underdeveloped ones continue to heavily rely on the Union (Saxena 2012).

**Empirical Evidence & Data Collection Instruments**

This section outlines the source and type of empirical evidence along with the data collection instruments used in the study. Three specific types of data collection tools were used – *key informant interviews, document analysis, and observations of state-civil society consultations*. The rationales for using these along with the type of data generated is discussed below. Details about specific research respondents and their affiliations is provided in the next sub-section.

Key informant interviews with human rights frame sponsors (that is, maternal health right advocates) involved in the policy discourse were important sources of empirical data to gather information about the maternal health and human rights frames or policy positions. This helped to uncover what the actors saw as the problematic situation, the factors that they attributed to as causing the problem (ideational, material and structural), the ways they thought the problem could be resolved and the conditions they wanted to see remedied. They were also probed for what in their views specifically constituted “(human rights) injustice” in relation to the policy problem, which fundamental rights they considered violated as a result, and how they proposed to
remedy these. These key informant interviews were further supplemented with information synthesized from documents produced and published by frame sponsors which discussed the policy problem, underscored the injustices, outlined frame sponsors’ claims and indicated the practical solutions sought from the state. This involved advocacy documents such as pamphlets, brochures, booklets, newsletters available in hardcopy and/or websites, research reports, academic journal articles/commentary produced and/or published by the maternal health and human rights coalitions, the litigating organization (HRLN), its lawyers and investigators. This process of document analysis also helped to examine whether different rhetorical and action frames were used by frame sponsors, as could often be the case with intractable policy controversy.

Key informant interviews with frame sponsors were also vital source of information to understand the framing process, especially the political opportunity structures and mobilization resources available to frame sponsors. Questions such as, how did frame sponsors engage with the state, which points of interventions (individual or systemic and levels of policy process) did they use and why, what were their preferred strategies and policy forums and why, what opportunities and obstacles did they face in using these strategies and more broadly, and how did they assess their progress and what were the basis of such assessment (that is the concrete dimensions of change) were helpful in gaining information about the framing process and its implications for the policy process. The frame sponsors were also probed for resources and tools they had available at their disposal and/or the ones they would have liked to acquire to further their goals but were unable to secure. Observation of strategic planning and capacity building sessions among members of collectives or organizations sponsoring frames helped to identify information on knowledge and expertise claims and supplement what could not be acquired (or only partially acquired) through direct interviews.
To uncover the interests and agendas of frame sponsors direct enquiry through key informant interviews with frame sponsors – about goals, sources of funding and resources and activities envisioned to support such goals – were conducted. To minimize bias, this empirical data was supplemented with other sources of information, such as key informant interviews with individual actors (academics, issue experts) who were not frame sponsors but well informed about the issue history, policy problem and the policy discourse. The researcher also studied publicly available annual reports of civil society organizations and/or those submitted to funding agencies (donors) outlining activities, funds allocation and usage, self-assessment of performance and strategic goals provided insights into interests and agendas that were not explicitly spelled out in verbal conversation. Finally, key informant interviews with decision makers within donor agencies, such as grant officials and issue experts, were also conducted since they were also able to comment on interests, agendas, strategies and activities of maternal health NGOs and human rights coalitions from whom they regularly received funding applications.

Additional knowledge about the local socio-political dynamics related to the policy discourse was obtained through both primary and secondary sources (academic and grey literature). Primary sources included media reports on the policy discourse, in-depth interviews with journalists, academics and independent researchers, social commentators and others working on related issues (public health issues, nutrition and food security issues, development issues).

The maternal health policy overview presented earlier in Chapter 2 already provided a summary of various elements and competing norms based on review of official policy documents and peer reviewed literature. But formulating an in-depth understanding of policy frames present in the status-quo policy discourse was also important to understand the diagnostic and prognostic aspects of the problem as internalized by institutional actors. Therefore, key informant interviews
were conducted with institutional actors to accomplish this. This also aided in understanding the
dynamics of frame reflection and prospects and challenges of reframing from the perspective of
institutional actors. It also helped to reveal differences in the institutional policy frame and
individual frames held by some institutional actors who underscored different (and/or additional)
diagnostic and prognostic elements than those captured in the former. These differences were
outcomes of their functions, expertise and insights, and individual beliefs and perceptions.

Likewise, observing formal and informal meetings between institutional actors and frame
sponsors (such as state-civil society consultations) also provided insights into the strategic use of
political opportunity structures and the broader framing process. The researcher observed (not
actively participate) three state-civil society consultations on maternal health policy and
programs. These provided opportunities to witness and observe interactions between state and
civil society actors (officials from the Ministry of Health and Welfare and NRHM were present)
in a fairly natural and realistic setting. These included 1) the NAMMHR organized *Monitoring
the pilot phase of the Indira Gandhi Matritva Sahyog Yojana (IGMSY) from an Equity &
Accountability Perspective* on September 19, 2012; 2) *Using Maternal Death Reviews to prevent
Mortality & Morbidity in India* on October 8-9, 2012; and 3) the Asian-pacific Resource &
Research Centre for Women (ARROW) and WHO South Asia led regional dialogue on
Advancing *Accountability: Raising the Issue of Maternal Deaths in South Asia* on October 15,
2012. All three consultations were held in New Delhi. The researcher also observed a capacity
building session (as a precursor to state-civil society dialogue) organized by NAMMHR on
October 8, 2012 in New Delhi where organizational members from nearly eight states with very
high rates of MMR presented situational analysis of the problem in their home state (hard copies
of these presentations were also collected).
In regards to litigation as a framing strategy, empirical information necessary to understand the various elements of the claims formation stage was gathered through key informant interviews with the lawyers involved in drafting the claims, those associated with the litigation process and more broadly civil society actors participating in the policy discourse. The study of the petition and supporting documents (such as the court appointed expert maternal death audit report) submitted to the court was also equally crucial and useful for frame analysis.

A systematic study (including comparison against the claims indicated in the petition) of the judgment and orders and remedies offered by the court was indispensable source of empirical information to study the adjudication stage\textsuperscript{72}. Aside from studying and comparing the legal basis of adjudication to the judicially interpreted right to health case (that is the original 1996 case), the nature and scope (redistributive effect) of remedies and court ordered actions (creation of monitoring and oversight mechanism) was compared to those indicated in the famous right to food case (Gauri and Gloppen 2012). Legal basis of adjudication also provided insights into extent of frame resonance and alignment between frame sponsor (HRLN) and the institutional actor (the adjudicator). While key informant interview with the presiding judge would have been a critical source of information, this was not possible due to the “ongoing” nature of the court case (see methodological limitations later in this chapter). Indian practitioners and scholars of public interest and constitutional law (specializing in women’s rights, economic and social rights, and the right to food case) were useful sources of historical information on courts’ behavior (in terms of its supervising and monitoring role) in similar cases.

\textsuperscript{72} Transcripts of court deliberation for the Delhi High Court case were not available (publicly) because the case was technically still an open case and ongoing because of the response from state authorities involved in the court case. They could be accessed under the Right to Information Act by filing an official appeal to the Registrar General of the Delhi High Court, which involved a wait period of 120 days (officially). Audio and video transcripts are not available for High Court proceedings in India.
Collection of information on the implementation stage – particularly examining compliance – was challenging. The implementation stage provided information into implications of successful reframing and frame alignment with the institution (the Delhi High Court). Some information was available from litigating lawyers and reports published by them but due to the absence of any court appointed monitoring or oversight agency, no further information was available (because the judgment reflected a “soft” approach). Key informant interviews with litigating lawyers, state and civil society actors and issue experts were also used to study broader socio-political implications of the judgment (because of particular developments) at the implementation stage. The researcher also obtained and analyzed access to affidavits, counter-affidavits, and contempt of court orders.

Studying social outcomes and equity of reframing caused by litigation was difficult given the short duration between pronouncement of the verdict and field research. Very little information was available because of lack of any direct and observable developments in the immediate aftermath of the judgment (as confirmed by litigants). Key informant interviewees were asked about yardsticks of positive change (or at least steps toward), awareness of any indirect changes and about their expectations regarding the judgment’s to affect status-quo situation surrounding maternal health politics (including the policy discourse) (Gloppen 2011). Interestingly, almost all interviewees (barring a few) spoke about the judgment and its social outcomes and implications for maternal health disparity in relation to that of the right to food case. That is, they spontaneously made contextually situated normative comparisons. Additionally, the researcher also tracked whether, how, to what end and by whom the judgment was being used in the aftermath of the verdict, especially given this was the first instance (Gloppen 2011).
Selection of Research Respondents

Selection of research respondents was primarily based on actors identified as important to maternal health and human rights policy discourse in India. The research was guided primarily by a purposive sampling method i.e. deliberate selection of individual, populations or groups for the specific information they can provide pertaining to this research (Scheyvens and Storey 2003, 43). Where necessary, snowballing sampling techniques (i.e. recruitment of future respondents through chain-referral of appropriate acquaintances of already recruited respondents) was also used to identify research respondents. Further information about type of actors and reasons for selection is provided below.

State Actors: Maternal health outcomes, as indicated earlier, are affected by health equity, gender equality and poverty (broadly speaking). Keeping this in mind, senior (and also recently retired) government officials and bureaucrats from National Rural Health Mission (NRHM, the autonomous Union health agency), Ministry of Health and Family Welfare (MoHFW) and Ministry of Women and Child Development (MoWCD) at the Union level were invited to participate in the research. Both ministries jointly administer many of the Central Government funded benefit schemes available to pregnant and parturient women. Additionally, senior members such as planner and advisors of National Planning Commission of India and the National Advisory Council (chaired by the Prime Minister) with access to information about high level thinking and planning in the area of family health and welfare were also included in the study. Many of these individuals were also part of the High Level Expert Group on Gender
(HLEG) formed by the Union MoHFW to advise the latter on creation of universal health system. The activities of this group were ongoing during the field research in 2012.

Furthermore, interviews were also conducted with select members of the National Mission for Empowerment of Women (NMEW) and with technocrats and a technical consultant (recruited at a civil society consultation) belonging to the National Health System Resource Centre (NHSRC). The NMEW advises government on all policy matters concerning women and the NHSRC has been assigned the task of improving health system capacity. The latter has also undertaken series of reviews of maternal health policy and program for the Government of India immediately prior to this research. Technocrats with NHSRC were recruited from cadre of bureaucrats (in progressive sub-national states) and were responsible for frequent field visits to particularly under-performing sub-national states for oversight and monitoring of health system infrastructure, training front line health and medical work force, and liaising with community based civil society partners and women’s groups. Their insights provided particular leverage given their comparative perspective into the diversity (not just progressive vs. regressive, but also between under-performing sub-national units) of contextual realities (and politics) and the issue of institutional capacity.

Civil Society Actors: As outlined earlier, this study collected data from 3 maternal health and human rights advocacy coalitions (NAMMHR, CommonHealth, WRAI) and the HRLN, the PILO involved in the Delhi High Court case. Key informant interviews were conducted with the coordinators or executive directors of their secretariat and steering committee members of the coalitions. These coalitions or advocacy networks are further comprised of NGOs who work on maternal health and exist in different sub-national context. They were the main resource and

74 The National Human Rights Commission was initially considered but ultimately excluded for its practically defunct organizational and political position and lack of association with issues of economic and social rights.
capacity building NGOs on maternal health in these states offering support to individuals and smaller organizations working at the grassroots level. Within the practical constraints of time and resources, this research collected data from 16 major domestic maternal health NGOs with activities in 15 sub-national states. Key informant interviews were conducted with their senior officials. The list included (with sub-national states indicated in parenthesis): Sahayog and Health Watch Forum (in Uttar Pradesh); Centre for Health and Social Justice (in Uttar Pradesh, Delhi); Health Watch Forum (in Bihar); Child in Need Institute and Association for Social and Health Advancement (in West Bengal); Society for Development Action (in Orissa); Academy for Nursing Studies & Women’s Empowerment Research Studies (in Andhra Pradesh); Rural Women’s Social Education Centre (in Tamil Nadu); Centre for Enquiry in Health and Allied Themes and Support for Advocacy and Training to Health Initiatives (in Maharashtra); SAHAJ Society for Health Alternatives (in Gujarat and Madhya Pradesh); Centre for Health Education, Training and Nutrition Awareness (in Gujarat, Daman and Diu, Rajasthan); Action Research and Training for Health (in Rajasthan); Ekjut (in Jharkhand and Orissa); and SAMA (in Madhya Pradesh). These NGOs function in different sub-national states with distinct contextual opportunities and challenges (as outline in chapter 2). Their participation in the study allowed it to gain rich and comparative insights about opportunities and challenges of using human rights frames to discuss the policy issue in different sub-national contexts based on their experiences of engaging with institutional actors functioning under the identical institutional policy frame (since JSY was a Central Government policy and NRHM a central autonomous agency).

Key informant interviews with senior officials of selected international NGOs working on maternal health and human rights, such as Oxfam India, Family Planning Association of India

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75 The Republic of India has a total of 29 sub-national states and 7 Union Territories (city states under direct Union rule).
(branch of International Planned Parenthood Foundation) and Action Aid India were also conducted. Their representatives regularly participated in state-civil society consultations on maternal health and human rights and supported the domestic NGOs by providing resources (both financial and strategic).

A number of independent individuals (social activists) with long ties to the public health activism (such as the People’s Health Movement or Jan Swasthya Abhiyan), women’s movement (including Dalit activists) and human rights (particularly economic and social rights and PIL) activism also participated in the study. They provided information on the contemporary landscape of social and political struggles for health, women’s rights (including fragmentation within) and wider social activism in India and NGOization of social movements in India. As well, included in this group were few “retired” women’s rights activists who had participated in the women’s and women’s health movement between late 1970s until late 1990s but were no longer active members. They offered their perspective on the ways the struggle for women’s rights, especially women’s right to health, had historically evolved in the Indian context.

A number of academics and journalists also participated in the study. Academics included those with a background in public health (community health / social medicine, health ethics and health economics), socio-legal and constitutional issues, and human rights in the Indian context. They were consulted to gain insights in the sociopolitical dynamics of the context and help situate the court case and the post-judgment developments in the broader and historical politics of development, health and women’s rights in India. The researcher was able to identity two senior journalists who had previously reported (and/or written opinion columns on gender, health and development, including maternal health) in a number of popular national English dailies (The Hindu, The Indian Express, The Hindustan Times). Speaking to journalists who were engaged with the issue specifically, and the reporting of development issues (in an era of
corporate owned media, consumer culture, and celebrity news dominated media) broadly was helpful in understanding the extent of media and public awareness and interest on the issue (especially, since the literature on judicialization identifies these as important conditions for determining political priority setting beyond court judgment).

**Donors and International Organizations:** Senior officials of select bilateral aid agencies (DFID and SIDA) and philanthropic organizations (the MacArthur Foundation and the Ford Foundation) that fund and support the activities of many Indian NGOs (especially feminist NGOs) working on human rights and maternal health (but also diverse women’s issues in general) were also part of the study. WHO and UNFPA – who are keys stakeholders in the global debates and activities surrounding maternal mortality – were also included in the study although the researcher was only able to recruit those who were part of the coalitions/alliances and responded favorably to request for interview. Representatives of the office of United Nations appointed Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (or Special Rapporteur on right to health) also participated in the research. They provided insights into the policy discourse and shared their thoughts on the politics of political priority surrounding maternal health and human rights.

A total of 62 individuals directly participated in the research. A breakdown by type of participant is provided in Figure 1 below.

76 Not all bilateral aid agencies work from a human rights perspective and of those who do not all are present or wield the same level of influence in India. For example, United State Agency for International Development (USAID) has had a substantial presence in Indian health sector (sometimes in cooperation with the Bill Gates Foundation and the Clinton Foundation) but does not (categorically) work from a human rights perspective. United Kingdom’s Department for International Development (DFID) both works from a rights perspective and also has a significant presence in India (although not specifically in maternal health). Swedish International Development Agency (SIDA) on the other hand, works from a human rights-perspective in the maternal health sector but has significantly reduced its size and scale of operations due to the declining ratio of its funding in comparison to India’s growing GDP. It largely supports academic research with scholars from elite Indian universities and works through a two-employee team out of the Swedish Embassy in New Delhi. The insights from initial field trip revealed that given India’s status as an “emerging economy” since mid 1990s, many bilateral aid agencies do not wield the same level of power and influence they used to earlier. For this research, DFID was a key participant.
Figure 1: Total Number of Research Respondents by Target Profile
Schedule of Field Activities

Field activities for this study were undertaken in two phases. The first phase constituted a short trip to India from January until February of 2012 immediately following the development of the proposal. This trip was used to contact HRLN, which represented the petitioner in the specific court case, meet selected members of National Planning Commission, and identify key civil society actors working on maternal health and human rights issues. It also provided an opportunity to conduct site visits (in semi-urban and rural areas) to observe local / community (public) health care facilities and meet with selected community based organizations and learn about their maternal health programs and advocacy efforts. As well, the researcher also participated in a ten-day academic workshop on “Health and Human Rights” organized annually by the University of Mumbai and Centre for Enquiry in Health and Allied Themes (CEHAT) and focusing especially on the politics of health and health care in India (including its gender and social justice dimensions). This provided greater insight into the empirical context.

The second phase of the research was between August and December 2012 and involved conducting the key informant interviews, collecting documents and observing state-civil society dialogues. A small number of respondents who were physically unavailable to meet with the researcher during this time were later interviewed through Skype between January and April 2013. The key informant interviews lasted approximately sixty to ninety minutes long. Document collection also continued during these stage through active electronic communication with the civil society respondents.

Language of Interviews
All interviews for this study were conducted in English. In rare occasions respondents have used a specific Hindi word/terminology during interviews. Such words have been used in quotes with appropriate English translation indicated in parenthesis. As well, the various state-civil society consultation forums were also conducted in English. The researcher also possesses native fluency and many years of formal training in Hindi.

Assessing Trustworthiness

A number of practices were put in place during the field research to ensure credibility, applicability or transferability, consistency or dependability and neutrality of the empirical data, which work together to affect the trustworthiness of the data (Yanow 2013; Golafshani 2003, 601; Lincoln & Guba 1985; Thomas 2006). The following precautionary measures were undertaken during field research:

- Selection and recruitment of research respondents identified through rigorous literature review, collaboration with local research partner (SAHAYOG, as per funding agency’s requirement), and an initial scoping / fact finding trip;
- Continuous review and modification of sample design as availability of new facts and data pointed to new and relevant actors;
- Generating data through multiple sources (document analysis, interviews, participant observation, literature review);
- Collecting and documenting information about respondents’ professional training, background, association with the issue and related experiences. Efforts were also made at uncovering normative and empirical assumptions by introducing general conversation-starters (or wrap-ups) on topics such as history and politics of development, development specifically in the Indian context, mobilization surrounding women’s health in India, the
feminist movement, the right to health movement in India and so forth. These might not always be explicitly identified in the research findings (except where applicable) but have also been useful in analysis.

- Cross-referencing of data gathered through interviews with documented evidence and peer-reviewed literature;
- Culmination of field research only upon attending sample sufficiency through emergence of recurring themes and data saturation.

**Method of Analysis**

This study used an inductive and iterative approach to data analysis, which was conducted solely by the researcher. As well, it also employed both manifest (literal and explicit) and latent content analysis techniques to examine the data. This was undertaken keeping in mind the highly open-ended and exploratory nature of the study. Manifest analysis allowed to develop descriptive categories (what is said or done by respondents) whereas latent analysis technique was used to explain the rationales (why and how) behind the knowledge shared by the respondents (as well as critically examine it).

The first round of analysis of interview data involved close reading – sometimes multiple times – of the raw data, which was then organized in different word files under identical (or at least) similar interview question themes (key issues in maternal health politics in India, origins of human rights advocacy for maternal health, dynamics of human rights advocacy for maternal health, thoughts and perception of opportunities and challenges facing human rights advocacy for maternal health, knowledge and awareness of Delhi High Court case). This categorization was largely based on manifest (that is, literal and explicit) content analysis technique. This process helped to identify and cross-refer emerging themes (big themes, for instance “challenges in
articulating human right to maternal health”, “politics of feminist engagement with the health system”) within and across respondent target profiles. This was important for both initial data triangulation and achieving consistent explanation in tracing historical, political and policy shifts (an example being, in developing narrative descriptions of evolution of reproductive health policy discourse within India). These big categories were then cross-referenced with the theoretical literature and analytical concepts to develop clear connections between theory, analytical concepts and empirical data. These big themes were coded using Microsoft Excel and further segregated into sub-themes (under “challenges in articulating human right to maternal health” accompanied by sub-themes “challenges with generating rights consciousness”, “conceptualizing accountability for maternal health/death”, “attributing responsibility for maternal health/death”) during second round of analysis along with frequency of their mention. The third round of analysis involved examining the emergent nuances within thick descriptions in the narratives organized under the sub-themes developed in the previous round. For example, “challenges with generating rights consciousness” had several nuances related to the following issues: education and empowerment levels of rights claimants, challenges of demystifying abstract human rights, lack of indigenous expression equivalent to “reproductive rights”, lack of political consciousness about health and wellbeing, discursive complexities due to existence of other parallel and competing articulation of reproductive choice and rights. In reporting the findings, the study takes a deliberate approach to incorporating the narratives articulated by respondents – both to privilege their own explanations and also to support the inferences drawn by the researcher from those narratives.
Methodological Limitations

As outlined before, this study has deliberately limited the scope of research design to the level of Central Government. However, policy frames applied at highest levels of government may be transformed at the street level during implementation (Schon and Rein 1994, 35).

Arguably, this study does not seek to evaluate implementation of human rights-based maternal health policy. Nevertheless, the transformation of policy frame that may occur between the stages of policy design (or even before, at the conceptualization of problem definition stage) and implementation can undercut the potential of successful reframing achieved by frame sponsors. Hence, future studies in this area (especially those studying implementation of human rights-based maternal health policy) would benefit from considering the ways institutional norms about maternal health and human rights diffuse through various levels of government (especially where health service delivery is deeply steeped in politics of gender and social hierarchy).

A second methodological limitation of the study was that the field research was carried out shortly after the court judgment was pronounced (2 years after). As indicated earlier, the significance of time in studying the last two stages of litigation – implementation and social outcomes and equity – should not be underestimated. This limits the potential of the study to develop a deeper understanding of whether, how and under what conditions maternal health advocates are able to leverage the incidence of the court case and the judgment in the longer term to affect political priority surrounding the policy problem.

Due to the ongoing nature of the court case (at the time of field research), it was not possible to interview key informants, such as legal representatives of the state, officials who appeared before the court and the presiding judge. This limitation was partially mitigated by interviewing other very senior government officials with the NRHM and the MoHFW (including
the recently retired Health Secretary who had extensive experience and insights into the government’s perspective on judicialization and PILs (in relation to health and health care), and were privy to major policy and institutional reform discussions. That said, it is difficult to foresee the ways in which information collected through direct interviews with state actors engaged in the court case would have changed the insights offered by this study. A few state and non-state actors argued that the executive branch’s decision to appeal the Delhi High Court’s verdict to Supreme Court was not solely a result of support for population stabilization policies. They argued that such action could also be tied to bureaucratic lethargy and apathy and political opposition to the courts. The certainty of this is difficult to assert without direct conversation with those involved at the state’s end.

This study employs predominantly qualitative methodology, especially techniques such as key informant interviews, document analysis, observation of state-civil society interaction which are heavily researcher dependent (for data collection, interpretation and analysis) and therefore, inherently subjective. The researcher’s positionality, as framing theorists and interpretivist scholars widely acknowledge, cannot be separated from data collection and analysis process (Schon and Rein 1994; Stone 2002; Fischer and Forester 1993; Fischer 2003; Yanow 2013). The researcher is a woman, born and raised in India but has lived in the North American diaspora for nearly sixteen years. The researcher’s interest in this specific study was purely by accident, although the researcher had a broad interest in gender and development as a student of political science and international development studies. Additionally, she considers herself a “late

77 This respondent has waived confidentiality rights.
78 The researcher feels this allows her greater freedom, choice and mobility as a woman. She is also involved in various social and academic networks supporting feminist and social justice goals. She identifies as “pro-choice” and questions (personally and politically) the romanticization of pregnancy and motherhood evident in many cultures and societies. The researcher also has a complex relationship with her country of birth, India. She has long avoided studying India as a scholar because of convoluted feelings of patriotism and loyalty (revealed mostly in form of political criticism) which she believes may bias her work.
bloomer” to feminist and social justice struggles and only recently has become involved in various grassroots feminist activities among women of color in her hometown (Edmonton, Canada). Framing theorists also remind that human beings can be reflexive and reasonably consider alternative positions (that is frame reflection) on a given issue and that they need not be irrational (Schon and Rein 1994). This has been the researcher’s approach as well (beyond ensuring measures of assessing trustworthiness of data indicated earlier). This is also why the researcher prefers to use narratives (as opposed to provide comprehensive summary of empirical findings), although long, from her conversations with research respondents to demonstrate her method of interpretation and analysis.
PART III: FINDINGS & DISCUSSION
Chapter 5: Politics of Claiming Accountability for Maternal Health

The findings reported in this chapter theorize the political dimensions of using human rights to claim accountability for maternal health/death. Specifically, the notion of using human rights to claim accountability is understood as an outcome of two complementary phenomena - generating rights consciousness to turn passive rights holders into active rights claimants and holding responsible duty bearers accountable for injustices. The findings discussed in this chapter pertain to two broad themes: (1) the challenges of generating human rights consciousness about maternal health, including discursive complexities related to the “technical” nature of health and lack of political consciousness of health and wellbeing; and (2) the political complexities of attributing responsibility (including conceptualizing where accountability lies) in a resource-poor context characterized by constitutional silence on state obligations for health, peculiar political dynamics of federalism in India, and lack of concern for female morbidity due to weaker social status of women. This chapter contributes to the literature on maternal health and human rights by empirically documenting factors that influence the practical politics of using human rights to claim accountability for preventable maternal morbidity and mortality. The data sources for the findings reported in this chapter are key informant interviews conducted with state actors and civil society actors. The rest of the chapter is organized into three sections, the first two of which take after the themes 1 and 2 outlined above. The conclusion provides a summary findings and theoretical implications.
Politics of Generating Rights Consciousness

With regards to the politics of translating human rights into practice, Indian maternal health right advocates participating in this research unanimously (albeit, to varying extent) outlined two inter-related issues – complexities surrounding “demystifying” philosophical and abstract notions of human rights and entitlements, including specific challenges related to “health”, and turning passive rights holders into active rights claimants. Additionally, at least four of them referred to the challenges of creating rights consciousness surrounding the broader notion of “reproductive and sexual health rights” while also battling anti-feminist attitudes toward the notion of maternal death/health.

All maternal health advocates underscored the inherently abstract nature of “rights” that were difficult for women at the community level to understand and internalize. This was partly attributed to lack of internal consciousness of one’s worth as a human being that resulted from being poor and marginalized to begin with. It was further intensified in case of women given the lower worth generally assigned to them by families and societies. So instead of starting from a point of vague and abstract conceptualization of rights (that is taking a top-down approach), maternal health advocates began from the point of concrete “entitlements” (that is a bottom-up) promised in the government’s maternal health policy design. One participant from Gujarat observed:

See the whole rights thing, I do feel it takes a lot more basic work because the rights language can be absorbed at the *basti* [squatter settlements] level. I would say that a way to look at a maternal death is a violation of a woman’s right to life but women themselves at the *basti* level have not internalized the value of their lives. So to say this [i.e. right to health] is sort of far out in their own sense of reality … what some of us have learnt over the years is that begin with tangible entitlements, like the JSY, the IGMSY, and the JSSK. Begin with concrete entitlements which are there in black and white and if you do not get it then it is a violation of your right because the government has promised this. If they do not give it to you, then aapke adhikaro ka hanan ho raha hain [i.e. your rights are being...
violated]. About rights, you cannot start in a rhetorical way. You have to build the rights discourse from very concrete work around entitlements (CSO#21; emphasis added).

CSO#21’s comments point toward the practical realities of formulation of women’s rights to maternal health and the complementary and integrated nature of negative rights (“maternal death is a violation of a woman’s right to life”) and positive rights (“tangible entitlements, like the JSY, the IGMSY and the JSSK”).

A maternal health advocate from Uttar Pradesh, which is one of the EAG states (a group of socioeconomically backward states) in India and particularly infamous for its rigid caste structure also spoke about the importance of adopting the “entitlement-route” to informing and educating women about their rights. She also stressed the significance of knowledge of these basic entitlements that empower women to demand them from health care providers and negotiate their rights. She observed:

You see rights-based approach consists of different angles. One angle is the angle of the rights holder, how do you turn the rights holder who is a passive person into a rights claimant, which is an active role. We have been working on that. Given that our initial documentation and analysis indicated that the women who use public health services are extremely disempowered, so our focus was first to turn them into active rights claimants, who are aware, know their entitlements, can articulate them and are organized enough to claim them. They should be able to talk to any official and be able to negotiate with their health providers. So we have done that. Without this part the other pieces cannot fall into place (CSO#2).

Such negotiations were inherently made possible through collectivization as otherwise an individual woman could be undermined by individual male or masculine (female doctors and health workers of higher caste) health care service providers. On one hand this revealed the politics of collective mobilization – so central to feminist mobilization – for rights claiming as experienced by women individually disempowered (to varying extent) by poverty, lack of
education and social marginalization. On the other hand, the method of formulation discussed by CSO#21, #2 and several others maternal health advocates from different sixteen different states in India, and especially the socioeconomically backward states immediately lend themselves to the proximate determinants of maternal health outcomes, thus excluding claims surrounding underlying determinants and by extension “reproductive and sexual health rights”. Hence, the outcome of generating rights consciousness through the bottom-up approach of educating women about their entitlements is inherently bound by those specified in the policy frame. Where the policy frame privileges a particular dimension of the policy problem, the articulation of maternal health entitlements also follow the same pattern. Perhaps this is why women’s health and/or reproductive health advocates take issue with the conceptualization of the problem as “maternal mortality reduction” (Fraser 2005; Yamin and Boulanger 2013) since it defines the discursive boundaries of which elements of the problem can or cannot be underscored. At the same time this points to the challenges of framing where the efforts of frame sponsors are limited to largely playing by the rules and norms of the political opportunities (such as, the introduction of maternal health schemes by the government) they use to engage with the state.

In contrast, one participant – a scholar and advisor to CommonHealth, a maternal health and human rights coalition working in Southern states with better functioning health systems and relatively better gender empowerment indicators (education, fertility rates, MMRs, gender empowerment measures) – discussed efforts (underway in Kerala and Tamil Nadu) to navigate the terrain of rights-consciousness by introducing and reorienting women to the notion of “safe birth/delivery”. She observed that community based research studies on perception of “safety of delivery” with grassroots women in rural regions revealed various dimensions of pregnancy and childbirth – abuse free and dignity in relationship with health care service provider, family support, social and employment security for women working in informal sector - that go well
beyond the bio-medical and technical dimensions that have traditionally dominated the maternal health discourse (including the issue of “institutional delivery” prominent in the official maternal health policy and program design). The participant observed:

At CommonHealth, we have been trying to look at this discourse and move the discourse from language of institutional deliveries to safe births and the fact that we ultimately want childbirth to be safe wherever it takes place. We have tried to develop this idea further with the help from people belonging to all levels such as academia, civil society and from grass roots agencies as to what the “safe birth” or “safe delivery” actually means and what should be the various steps to provide safe birth or safe delivery. And interestingly this whole thing has panned a whole range of kind of dimensions from very medical health care kind of dimensions to women’s rights, the whole idea of this thing *an experience where there better be no violence, the idea of having support from both the family and the system to issues like maternity benefit at their work*. It gives us a whole range of dimensions on what “safe delivery” means to women. We are trying to break the indicators and see in certain states if the births are taking place at institutions or at home are actually safe when you define safety from the perspective of these various women’s issues; so that’s something we have been doing (AC#10).

Arguably, such articulations may not be concerned with a “right to reproductive and sexual health”, but they illuminate other dimensions of female autonomy and point to the opportunities that can arise from maternal health advocates’ efforts to use human rights language to shift the direction of the discourse.

Beyond the challenges of creating human rights consciousness among poor and marginalized women, several maternal health advocates spoke to the peculiar challenges involved in “demystifying the human right to health”. They argued that health was difficult to conceptualize as a tangible asset to own and/or have access to, unlike land or food. It was difficult to separate health from medicine, which is why health discourses had been historically dominated by technocrats and could easily become incomprehensible for common people. It could also preclude participation of broader community in defining what health and health care rights and entitlements should constitute. Where social determinants of health – such as gender,
class, and caste – were concerned attributing accountability could become even more difficult. A participant from Maharashtra observed:

> It is easier to talk about land rights, forest rights, food rights … but there is nothing tangible for health, nothing that you can possess or own. How do you own health? The whole idea of rights in health is dubious because health resources are never going to be in the hands of the people as such. There is a particular complexity in the health system, which precludes extreme community participation. Even with education, people have decided to educate their children, they have set up alternative ways but that is very difficult in health care. You are talking about people having entitlements and it gets even more complex with social determinants of health. Because where do you put the blame? Why certain outcomes happened? Where did it take place? It has always been difficult to frame human rights movement around health. If you try to do it, you will play more and more into hands of technocrats because they are the ones who will define what health is (CSO#22).

However, on probing whether the prominence of technical dimensions of maternal health in the discourse on maternal health and human rights undermined the transformative potential of human rights frame to create broader political and social change (beyond securing policy entitlements), several respondents disagreed with this assumption. They argued that the human rights frame provided civil society actors and non-technocrats an opportunity to intervene in the discourse and practice (including generating a political space for certain dialogues with state as the duty bearer) that would otherwise be entirely appropriated by technical specialists. Nevertheless, it is important to consider the power maternal health right advocates as intermediaries between duty bearers and rights claimants have in interpreting and articulating rights. One participant’s explanation of the aforementioned phenomena juxtaposed with claims of knowledge and expertise that allows maternal head advocates to assert certain legitimacy in interpreting needs of rights claimants and claiming to speak on their behalf:

> It is a kind of strategy. How do you create a set of entitlements, which are mutually agreeable to the citizens and the state? So if a woman comes to a health centre, she should get A, B, and C. But by no definition will that A, B, and C constitute a right. It is very
fragmented notion of a right. In the current scenario, the individuality of no one is recognized then what language do you use to construct the debate? Then you take an extreme position, start out with an extreme demand and that is the strategy [with human rights] that you adopt. Otherwise, the danger for civil society is that if one just says that one wants efficient and quality care, then that one loses out to technocrats. *For civil society players as non-specialists, the way to get entry into the discussion is to talk about rights because as far as rights is considered we are the experts. It is appropriate and the way to go; despite recognizing the absurdity of it, I would never say give it up!* It creates its own space for a certain kind of voice, which should not be done away with (CSO#22; emphasizes added).

Perhaps the dilemma of actualizing the aspirational prospects of human rights for the most disempowered is that it requires intermediaries to intervene to further the agency of the rights claimants on whose behalf the former claims to speak. In turn, this provides the intermediary a “moral legitimacy” often sought by civil society actors in claiming to speak for the poor (Cornwall and Molyneux 2006; Mukhopadhyay 2004).

Furthermore, with regards to cultivating rights consciousness four respondents spoke about the struggle to advance the more political conception of “reproductive health rights” (interchangeably used with “reproductive rights”). This emerged largely upon probing which was necessary to reconcile the gap revealed in some key informant interviews where respondents passionately spoke about strides made at ICPD in Cairo in 1994 over women’s reproductive and sexual health and rights. Yet in practice they had embraced the maternal health right agenda, sometimes criticized for being narrowly focused, depoliticized, and technical. On being asked to reflect on this issue, respondents indicated that the concept of “reproductive rights” or “reproductive health rights” was alien to the Indian context and there were difficulties in arriving at a comprehensive local translation. One participant noted:

*Post ICPD in 1994, when the concept of reproductive rights first came to India, it was really an alien concept. If you think of it, it is hard to translate the term in local languages and the conceptualization is quite abstract and unusual for locals. Further there are*
problems in interpreting and applying it. In the Indian context, women’s health activists tried to frame it as ‘lack of options and choices in contraception, lack of decision-making power (CSO#15).

Another participant indicated:

Give me one translation of “reproductive rights” in your native tongue, that you can use before your middle class and educated female family members and friends, and they will get it without breaking it down further! (CSO#23, emphasis participant's)

To navigate the interpretive intricacies of reproductive rights in the Indian context, these respondents referred to using the human rights framework as a guiding philosophy that is accepted and respected globally, rather than strictly adhering to the human rights jargon. They highlighted the importance of “adapting the framework” and its principles to the local context to reflect the “grassroots reality” particularly given the vast difference between how human rights are conceptualized philosophically and how rights claimants may internalize and exercise them.

One participant observed:

See if I read Lynn Freedman’s work, I subscribe to her work. I also feel some of this discourse is aspirational and I feel that it is up to people like us because we play a very important in-between role, between the grassroots reality and between the conceptual frameworks. The conceptual frameworks are set, some of us are trying to adapt them for application to grass root. Now what is applicable under what conditions is our contribution to figure out what’s realistically possible or how does it modify … that’s why I was telling you go meet these young women and ask them what do they understand by rights. How do they apply and live by those rights discourse on a day-to-day basis? I think it’s the whole translation from there to here … and how is it translated, and how much can be translated? This whole thing of understanding of rights or how people understand rights. So there is a need for indigenous documentation, the bottom up … I think it’s really important (CSO#21; emphasis added).

In other words, the notion of “reproductive rights” (or “reproductive health rights”) as conceptualized by women’s health advocates participating in ICPD in 1994 was non-indigenous
to the Indian context. “Reproductive rights” for women’s health advocates from richer and
developed Northern countries (for example, United States) participating in ICPD could be
equated with preserving and/or securing access to legal and safe abortion. But in the Indian
context access to abortion (the MTP Act of 1971) was legalized with the goal of promoting
family planning. Furthermore, it was subsequently promoted to support the two-child norm
(hence, the problem of sex-selection and missing daughters) because the state had failed to raise
social awareness about temporary contraception and address unmet need (not to mention, female
autonomy in choice and use of contraception). To that end, CSO# 15’s and #21’s
aforementioned words reinforce Mukhopadhyay’s (2007) observations about the importance of
locating the struggle for reproductive justice in notions of inclusive citizenship, which recognizes
the existence of “different groups of women, their different histories and the context-specific
ways in which women’s rights are framed and fought for” (277-8).

Nevertheless, the abstract yet moral and aspirational nature of human rights also points to
its limitations and strengths. Its abstractness is inherently subject to interpretation, yet its moral
and aspirational nature also allows interpreters to make “normative leaps” and transform the
discourse (Schon and Rein 1994, 26). Both, however, are conditional upon the actor(s) that
interprets, which lend her immense power in the process. How the actor chooses to interpret and
what she includes or excludes in that interpretation is inherently tied to her normative beliefs and
assumptions about the problematic situation. On one hand this sustains the power hierarchy
between the interpreter and the individual(s) whose needs and interests are interpreted. On the
other hand, it can generate a divide in context characterized by multiple interpreters (that is frame
sponsors), thus sustaining and perpetuating frame conflict. This is evident in the words of one
participant who pointed to the ways the debate over “reproductive health” versus “maternal
health” pitted pro-natalists and anti-natalists feminists in India against each other. She spoke passionately in regards to this concern:

So you know how this debate began … if you see the second wave feminist health movement in Europe and America in 1960s and 1970s, it was essentially about a kind of an attempt to break the whole role of women as a mother and of course the “pill” was a major issue then, control over the body etc. The context in India was very different but the politics was there. So this kind of a general critic that we are reducing women’s health to maternal health is not something I agree with. There was another critic, certain articles suggesting that the clubbing of maternal and child health sidelines the women, which is true to some extent.

If you take reproductive rights as a concept, it is fairly new. Reproductive health, when [in early 1990s] I entered the field had sort of come into currency, but reproductive rights was a fairly new concept. I am not saying one is true and other is not, but there is a focus on both things. You have to understand it in the context of who drives this movement. The feminist movement depends so much on experience and maternal death is not an experience for women who were part of the feminist movement. I don’t need to justify my claim as to why I am saying this. There is a class issue in here. There’s really been an effort to reconstruct maternal health as a human rights issue which we have been fighting for 20 years and certainly you bring in the politics of maternal death, it takes a little bit of discourse construction. That has taken place. Today, most [traditional] feminist groups will not recognize the contradictions in their position twenty years ago because over a period of time history also gets visualized and rewritten (CSO#22; emphasis added).

This divide underscored by the participant certainly speaks to the complex notion of “womanhood” that many feminist scholars have referred to in analyzing emergence of “differences within” needs, interests and priorities with regards to mobilization for women’s rights (Toyo 2006; Molyneux 2007; Win 2007; Cornwall, Harrison and Whitehead 2007). It confirms what Indian feminist scholar Mary E. John (2008/2012) has speculated (based on scholarly debates) about the splits forming in the women’s health camp in analyzing the evolving politics of women’s movement from late 1990s onward – that is, transitioning from the post-ICPD phase in 1994 where domestic policy focus on maternal mortality begun to feature in the
Reproductive and Child Health program (introduced in 1998) and provision of maternal health care was simultaneously tied to promotion of family planning.

The findings presented so far reveal the different dimension of interpretive politics involved in translating human rights in practice, which are of consequence to the politics of rights claiming. However, there is another side to this challenge, which constitutes the structural dimensions of rights claiming that exposes the complexities of attributing responsibility in a system devoid of laws and policies to ensure accountability. This is discussed below.

**The Search for Accountability**

Perhaps it would be wise to begin by quoting one state official (and warning the reader) who observed, “Accountability in health sector is a messy topic in India” (SA#7). Questions exploring conceptualization of accountability (including different forms of accountability) and attribution of responsibility yielded diverse responses from maternal health right advocates and state actors. Three specific themes emerged with regards to accountability – (1) the diverse implications of the lack of constitutional articulation of health and health care rights and entitlements and significant legislation for conceptualizing state accountability; (2) the consequences of political dynamics of a constitutionally federated state with an excessively unified central government for assigning accountability; and (3) the barriers to implementing and inculcating a culture of accountability (especially individual and community) in a health system and context characterized by historical and deep gender and social hierarchies.

All research respondents spoke unanimously about the challenges of conceptualizing accountability of health system that arose from the lack of explicit articulation of health and health care rights and entitlements in the Indian constitution. Furthermore, all three bureaucrats spoke of their reservations surrounding “rights-talk” in a context devoid of any mechanism of
monitoring and oversight of health care service delivery, including quality of health care. Two of
the respondents pinpointed to a specific time in Indian politics – the election of the Congress
(INC) Party as the governing authority in the Centre in 2004 – that gave birth to the notion of
rights in social welfare sectors, including health rights. But all bureaucrats and planner/advisors
highlighted concerns generated as a result of this manufactured shift (which they called
“rhetorical”), which was not accompanied by corresponding legislation to equip the executive
branch to enforce delivery of quality health services. As one bureaucrat, previously health
secretary of two different sub-national states, observed:

The issue of rights never really came in until much later. The rights-entitlement business
started in 2004 with Mrs. Gandhi [Sonia Gandhi, President of the Indian National
Congress Party] putting together the NAC [National Advisory Council] and so forth, such
as the right to food act, right to information act, right to education act, right to
employment [that is, NREGA]. Now they want right to health but we are resisting it. Our
argument is that, they should create a right by way of legislation then they are forced to
design [health sector] budget and also not eliminate funds whenever they want. The
budget is not currently designed that way because there is no constitutional provision that
says the government must provide health care. So it is important to bring pressure on to
the system to do its due diligence.

But see unlike right to education or information, right to health is more complex in a
country like ours where there are limited resources. Where do you draw the line on
quality? Can we recognize right to pregnancy but not right to immunization? Right to
health care encompasses from cancer to diarrhea. Where is the supply side to provide such
expensive service? You create a right to health but you cannot create a right to health
care, so you cannot neatly put it down as you can for education. Minor cases can also
become complicated cases. So the complexity of health is so huge. How do you create
this right? Right to what? The HLEG [High Level Expert Group for Universal Health
Coverage] on health defined health as everything, primary, secondary, tertiary, which is
all levels of health care. This is impossible! Where is the money? Where are the
resources? Where are the supplies? Where are the doctors, nurses, where is the supply
side? The point is in health, immediately people will go to the court and file lawsuits.
Government cannot be providing cancer treatment now. It is not possible to provide!
(SA#8)
All six bureaucrats and planner/advisors spoke about this rhetorical shift, including the role played by courts in perpetuating a sense of hope among civil society actors (through the right to food case), which was difficult to realize in practice. In fact, they pointed out that this discursive shift was disconnected from the historical reality of underfunding public health system as well as the adverse consequences of social sector spending cuts provoked by World Bank and IMF recommended changes to the Indian government immediately before (starting in mid-1980s) and after economic liberalization in 1991. This is a point many development theorists have raised in underscoring the unfairness of perpetuating a notion of state accountability by proponents of human rights that is directed entirely toward the domestic government in the Global South. Lack of recognition that domestic conditions of poverty and inequality cannot be delinked from the politics of IFI conditionalities that dominated economic development (and liberalization) of countries of Global South during 1980s and 1990s undermines the ability of Southern states to make progress on human rights, such as right to health (Uvin 2002; Slim 2002; Cornwall and Nyamu-Musembi 2004a; Robinson 2005; Darrow and Tomas 2005; Tsikata 2009). To that end, the respondents underscored its significance to reservations held by senior bureaucrats over “human rights-speak”. As one of them observed:

If you know the World Bank and IMF history in India, you will know that all funding was withdrawn from the social sector. Social sector was seen as expenditure and not as a sector worthy of investment. So this understanding of the context, the vocabulary [investment versus expenditure] and the language of the events are very important. It will help you understand why a government servant shirks away from the word “right”. Because of late, with the executive and the legislative system in crisis, the courts have stepped in to fill that void to do executive decision-making (SA#3).

State actors unanimously cited the issue of crisis of governance in health sector as a source of concern that was also connected to the legislative reluctance to undertake health sector reforms. This coupled with the constitutional silence on health, they argued, had grave implications for
“taming the ultimate beast” (that is regulating the private health care sector), which they maintained was quintessential to any debate over rights and accountability. In fact, a number of development theorists have argued that the course of neoliberal reforms that many Southern states had followed since they began integrating into the global economy, led by IFI conditionalities in 1980s, would prove it difficult for them to realize the commitment to improving human and social development made as part of the MDGs. (Nelson 2007; Hulme 2010; Nickel 2013; Brahmbhatt and Canuto 2013; Langford, Sumner, Yamin ed. 2013). One senior technocrat with the National Health System Resource Centre (NHSRC) spoke to this challenge describing the range of systemic problem that had arose in absence of regulations. The respondent observed:

Private sector lobbies are so strong; how would you control the prices? They will turn around and say what I ask you to pay. The way the health system has developed, in a chaotic unplanned fashion and the state is so weak, even a soft state is also an understatement. Do we have any control on any of these hospitals? The kind of scams going on in insurance industry … when health is such an imperfect market, and the asymmetry of information is so high, how would you know whether the doctor should do the surgery or not? What right, what punishment, and what accountability can bring in? How would you know if the doctor was doing it for profit or because it was in patient’s interest? (SA#4).

Nonetheless, nearly all civil society actors and especially the academics observed the significance of historical conditions that have led to the dilapidated condition of the Indian health system such as lack of investment in health sector in post independence period, which resonated with the fact that health care spending as proportion of GDP had never really rose beyond 2-3 percent of GDP (stayed around 1.5% before creation of NRHM in 2005) (Balraj et al. 2011; Sen 2012; Mukherjee 2014).

Furthermore, all ten state actors were of the sentiment that the inability to ensure
“minimum guarantees of service and quality standard in delivery of health care services” had led to the burgeoning phenomena of litigations that had come to characterize governance of the health system. They also speculated that the coming into existence of judicially interpreted right to health was a significant contributor to this because it was the only form of state accountability available under the circumstances. But they maintained that the failure to complement this judicial recognition with appropriate legislation and regulation had led to abuse of the opportunity presented by it. This confirms the caution earmarked surrounding justiciability and the extent of it (with regards to scope of violation and scope of state obligation) raised by socio-legal theorists who point to the downsides of using international laws and norms to interpret and establish fundamental rights in the domestic context (Langford 2008; Kahane 2009). In fact, all state actors pointed to abuse of such a right to further private interests and the prominence of contradictory verdicts and orders, which had paralyzed health system administration in India. The former Union Health Secretary further recounted the steady growth of judicial interventions in health sector governance since late 1980s, which the participant argued, was connected to the parallel rise of the private health care sector. She observed: “My boss in 1992 went to the court and said these are all the orders, please tell me which one I should prioritize because there are so many contradictory orders” (SA#7). These issues of dubious track record and the contradictory orders have been raised by Indian legal theorists, as has been the issue of poor enforcement, failure to assign heavy penalty and the excessive reliance on individual compensation (Parmar and Wahi 2011; Grover, Misra, and Rangarajan 2014). All six bureaucrats and planners expressed concerns with using the courts as an avenue to seek legal accountability because of the poor enforcement and the courts’ tendency to hand out individual compensation, which undermined opportunities for systemic reform. As a senior planner observed:
The absence of a distinct proclamation of right to health care along with clear articulation of entitlements to follow indicated subjective and ambiguous interpretation by the courts, contradictory verdicts, abuse of PIL for private interests and tertiary care related cases. Most importantly there is a lack of enforceability of minimum guarantees of service and quality standards in delivery of health care services, whether in the [Indian] public or private [health care] facilities (SA#1).

There was a deep sense of concern among bureaucrats and one senior planner with the National Planning Commission over this excessive involvement of the courts in health sector governance especially since the courts had not directed (some said “were not able to direct”) the legislature to undertake significant reforms. This is an issue Rajagopal (2007) has also observed in his study of adjudication of health rights litigation in India. A technocrat hinted that even the judiciary was wary of “excessive meddling” in reforming the health sector. In fact, a senior technocrat with the NRHM observed:

It makes you wonder, why despite so many court cases and the continuously growing burden of litigation surrounding the private health care sector, there has been no effort by the courts to suggest (in general or to the legislature in specific) that there needs to be some kind of oversight of the private health sector (SA#3).

This sentiment was also shared by almost all maternal health right advocates and academics who believed that even the judiciary, despite being activist, was cautious about the type of verdicts it handed out in health rights litigation cases and careful of what this meant for the state’s (economic) development ambitions. But this was attributed less to judicial overreach and concerns with undermining democracy and more to judiciary being wary of resources available to the state and its capacity to undertake reform.

Another challenge in conceptualizing accountability for health in the Indian context was also attributed by all respondents to the historical and political dynamics of Centre-state relations in India. This political dynamics, respondents (especially state actors) argued, was significant for
both planning and budgetary accountability since it allowed for “creative forms of buck-passing” (SA#5). As the former Union Health Secretary observed: “The constitution also has in the 7th schedule the distinction between the state and the Centre which I believe is the root cause of most confusion and abjection of responsibility” (SA#7). All three technocrats and three planners spoke at great length on this issue, although they were divided on how should the burden of responsibility (about capacity building, resource allocation, policy design, research, drug pricing and regulation) be distributed. All agreed on some form of shared responsibility given the reality that there were substantial disparities between capacities of sub-national states and that the Centre tightly controlled financial resource allocation. For example, those who cited poor state capacity as a source of heavy reliance on the Centre also acknowledged that some state governments would regularly absolve themselves of responsibility by citing poor capacity (even when the Centre had released necessary funds). Others indicated that the Centre ought to have a responsibility to ensure that the funds were appropriately reallocated at the state and district levels. However, all six technocrats and planners acknowledged that there was a greater role to be played by state level officials in policy and program design, which was dominated by central government and the National Planning Commission since independence. One planner recounted her observation of the nervous attitude of state government officials who appeared before the central health officials and planning commission authorities during the annual planning and resource allocation meetings. She described exchanges with state officials who had mentioned to her that they were treated as “school children” appearing before the “headmaster” to justify their actions and plans, even when constitutionally they were not required to. Without greater involvement from state level officials in policy and program design, assigning them any form of responsibility for poor implementation was considered unfair by all six respondents. Consider for example, an observation by a technocrat:
States are grateful for things like guidelines, protocols, technical know-hows, assistance on a day-to-day basis when we roll out the program, do the training, provide the manuals. For all these they are grateful to the center. To the point that for some states, if you do not send them or provide them with the material, training, they do not do anything because there is inequity in capacity of states and this inequity is tremendous. Addressing that is a first step and the central government can play a huge role in dealing with the inequity because here the center is not seen as interfering with the implementation. Capacity building is a fairly non-threatening process in that sense. But when it comes to policies, states are resentful. There has been more flexibility in the last 7-10 years. We have seen central government being far more open … the center is more flexible in its financing … instead of giving 45 lakhs for IUCs [intrauterine contraceptives] it will give states a 2.5 crore for spending as the state sees fit. I think states have far more flexibility than they did before. Things are less centralized. In some areas where we do wish that states would get their act together in promoting quality for example, (some states are better than others and I must say there is progress, but slow …) (SA#1).

A senior Commissioner with the NRHM made a similar observation as above. But he also underscored the disparities that existed in the capacity of officials (as individuals) between state (especially socioeconomically backward) and Central level pointing to the resulting tensions (personality and ego clashes) that existed between officials and how this undermined collaboration. He observed:

Yes, there is a difference among officials at the Central and state levels because of differences in training and resources but also because the best of the lot … and politically shrewd dominate senior official positions at the Central level. It is a vicious cycle … they [state officials] and their states do not have capacity so their ideas are not part of policy design but this also means they do not have ownership … they are implementing someone else’s [Centre’s] policy so they do not show initiative … hence poor state capacity! After all, if state capacity is weak in health, then that is a result of overall weakness in state governance which means training of [state] governing officials is also no where near that at the Central level” (SA#10)

Several maternal health right advocates confirmed this observation. Where sub-national state capacity was stronger, it was attributed to “bureaucratic entrepreneurialism”, such as in Tamil Nadu and Kerala. One maternal health right advocate from Tamil Nadu underscored the ability of
sub-national state to “protect” the health system against economic reforms supported by the Union and international agencies and also corroborated this “resentment” among states indicated by SA#1 earlier. The participant observed:

I was part of a common review mission of the NRHM which is the usual review process built into it and I went to Uttar Pradesh [in the north] as part of that mission. So I was able to talk to the state government officials and there did seem to be a lot of “resentment” of how the Centre was seen as pushing and interfering in something which is essentially a state subject just because the center was actually funding a large part of the program. So there was some element of that in Uttar Pradesh but I wouldn’t be able to say much beyond that. Tamil Nadu is, I think, again historically distinct because it has a very strong bureaucracy here and it is also seen as a state where things are functioning well and actually showing results which has led to the state resisting any central pressure; and they have done this with not just the Centre but even with the World Bank as far as health is considered as far as neoliberal health sector reforms are concerned … they totally put their foot down to something which was seen as unacceptable, for e.g. user fees in public health care system. The bureaucracy here said absolutely no user fees! So Tamil Nadu has a history of doing what it wants to do. Therefore, I do not see such dynamics here where the Centre is seen as thrusting things on the state (CSO#19).

This observation is critical since the bureaucratic culture (particularly the tendency of bureaucrats to undertake recurring field visits described by some as “being in touch with ground realities”) of Tamil Nadu was attributed by all respondents unanimously to the vast improvements made in health system. There is also evidence to suggest that this bureaucratic culture (including within Southern Indian states with shared history) is directly responsible for reducing maternal mortality and achieving the MDG-5 target well before the deadline (Smith 2009).

In contrast, in the Northern and Central states where reliance on the central government was high, maternal health right advocates indicated that the Centre-state dynamics often acted as a negative force (“buck passing”) in hindering meaningful dialogue between civil society actors and state to improve accountability of health system. Two respondents referred to creative strategies they had developed to “invent” legislative accountability where no such clear
precedence existed. In other words, to secure attention and commitment from executive officials, the Parliamentary Health and Family Welfare Committee (which would have a say in appropriations for health) was approached. One of the participant observed:

At the constitutional level, health is a state subject. But it is all being designed at the Centre - the whole population programs of 1980s, the reproductive health program of 1990s and now NRHM. The Centre claims to do this through consultation with state but finally the Centre’s decision and design stands. Money is also allocated from Centre accordingly. So health implementation is not entirely in the hands of the state (although it is supposed to be), because it is tied to the budget, which is also tied to the central level of planning and design. When you point out that something has gone wrong at the Union level, they respond by providing technical support and money but shirk responsibility for implementation. When we approach the state government it says it is just following orders from the Centre … so there’s basically an absence of accountability even at that level. And with maternal mortality, we have really faced it … this is our major challenge.

To counter this we used a different tactic. When the Bharwani [in sub-national state of Madhya Pradesh in Central India] death report came up in January 2011, we gave it to the parliamentary standing committee on Health and Family Welfare. We took it to the legislative oversight. In our covering letter, we mentioned even what Paul Hunt [the then UN Special Rapporteur for Right to Health] has recommended is not happening … this state has completely failed in fulfilling its obligations. So then they asked what Paul Hunt had said and we fed them back the Paul Hunt report. They immediately asked the Union ministry: “you haven’t told us about this report, what have you done on this? … Please give us an update!” Because we got the parliamentarians involved and the legislature can always ask the executive for accountability, they were able to get the ministry officials running around. But until then the ministry officials had done absolutely nothing! Then ministry had to cook up a response, which was bunch of ‘b.s.’ … but at least they had to be actually answerable for what they had done on the Paul Hunt recommendations.

On the Bharwani thing, they asked the ministry for an action update saying “You have given money for maternal health programs now you tell us why have so many maternal deaths of tribal women have happened in Bharwani?” So the union ministry had to send their personnel, the Assistant Commissioner of NRHM nationally himself had to run to Bharwani and make a report; even he saw that civil society organizations had reported correctly the problems. So what we did there was to bypass the Centre-state constant passing of blame game. So for us legislative accountability is quite important. Because the national level officials went, so the state level officials also became alert and cautious and had to take action and put forward a compliance report etc. The whole thing received
a lot of attention. So when we went back six months later, the whole state level NRHM team sat down with the civil society team …12 officers including the mission director sat with us! This is unheard of! It was a two-hour meeting and point-by-point they told us what they had done and what they had not done. We were telling them that ground feedback has not changed yet, so they told us how they plan to tackle those issues. But that was only because it became a national stink! We have to constantly think of new ways to approach and get around the state-centre thing. We also approached National Human Rights Commission but it did not work, that organization is so useless!” (CSO#2)

This triggered a trickle down moment in accountability, although respondents maintained that this was one-off. At the time of field research in latter half of 2012, maternal health right advocates from the most adversely affected states were still working to develop and strengthen this relationship further. Nevertheless, it is noteworthy that the creation of NRHM – the first systematic publicly funded effort to address health system improvements – as a result of the Centre’s efforts to address maternal and child mortality reduction (both associated with MDG Goal) created the political opportunity for the abovementioned innovative mechanism of accountability. It provided some maternal health advocates (frame sponsors) a potentially new opportunity structure (legislative accountability) leading to institutional innovation, admittedly incremental, which cannot be untied from the optimism shared by scholars who emphasize the complementarity of human rights and MDGs (Carmona 2009; Alston 2005/7).

In response to what could/should a system of accountability look like, three bureaucrats highlighted the opportunities that could be afforded by proclamation of a right to health care and its potential contribution to improving the overall health system. Particularly, they believed there was a role for the courts to play since they perceived the legislative arm of the government did not have political inclination to spontaneously undertake health sector reforms. They highlighted the ability of a “good judgment” to provoke legislative action surrounding a range of issues, related to service guarantee and accountability measures. Such opportunities could include (1)
creation of a patient’s bill or charter of rights; (2) monitoring and oversight for quality service provision (at both public and private health care facilities); and (3) implementation of mandatory qualifying entrance exam\textsuperscript{79} for prospective medical candidates and national exit exams for all graduates to qualify for license registration. The Deputy Commissioner, Maternal Health, for the Union Ministry of Health and Family Welfare explained:

If such a right were to exist and flesh out rights and entitlements, the state [that is, the executive branch] and civil society could work together to create frameworks for practical implementation and court could be the ultimate enforcing actor. It would be accompanied by a process in place to actualize a human right and be particularly useful in reforming the private health care sector … because it creates an obligation for the state [that is, the legislative arm] to then rethink the purposeful underfunding of the public health sector and financial resource allocation in the Union budgetary process. We can link mechanisms of accountability at the Panchayat level [village council] with the decentralized system of governance because the average person cannot approach the court. Let’s not have the average person go round and round with courts, but let him approach his local Panchayat, his village health and sanitation committee [which currently exists under NRHM framework, but is not enforced and legislated], who are all located in the community and have a vested interest (both electorally but also in general) in ensuring things are working (SA#6).

A senior technocrat from the National Health System Resource Centre (NHSRC) iterated similar thoughts and elaborated further to that effect:

We know that civil society groups have been doing public hearing and community-based monitoring, but we also know from senior level state [sub-national level] bureaucrats that people are scared to come forward to discuss the continued absence of senior medical officials from health care facilities, or the lack of response from hospital and community health centers, the demand for user fees and bribes. One way to ensure greater systemic accountability would be to enforce punitive measures and compensation on senior officials in-charge, just like we have done in the Right to Information Act, which can only be done if we have the legislature’s backing. The system needs a shake-up, so there needs to be a chain of accountability. I would even recommend creating confidential system of

\textsuperscript{79} Since the establishment of private medical education system in India (as a result of a Supreme Court judgment) there has been a massive growth of private medical colleges. Many of these, which are much more expensive than public medical colleges requiring mandatory entrance exams, admit students without any entrance exam.
complaints, for both general public but also staff so that official hierarchy is not abused to shift blames to those working with limited resources at the lower most levels of the system (SA#9).

However, while articulating similar thoughts on the above issue in addition to reiterating the importance of implementation of sensitization training (both gender but also quality and ethical practices in service provision), the former Union Health Secretary was skeptical of reform. The participant observed that influential lobbies in health sector would try to block such reform and likely have political support for their objectives:

As long as you have representatives of corporate hospital chains, the pharma industry and insurance companies sitting in meetings of National Planning Commission, that’s not going to happen. That I can tell you for sure! We will continue to get half-baked ideas of universal health coverage / insurance and biometric identity cards (emphasis respondents’ own) (SA#7).

However, at least six maternal health advocates took issue with the approach to accountability – especially, those likely to be shaped by punitive measures – articulated by many state officials. They argued that in a context where the system was dysfunctional, creating punitive accountability mechanisms would undermine the logic of systemic accountability and its potential to make progressive systemic change. They offered the example of unnecessary referrals by sub-centres and PHCs to eliminate the need to log maternal deaths (to meet MDG targets). Additionally, they also raised the issue of accountability in case of individual health care service provides in a context, which was characterized by deep social stratification and not prone to a culture of accountability [that is “civil servants as accountable to citizens” (CSO#13)]. Three respondents from states with highest MMRs, pointed to issues such as denial of care, lack of respectful care and dignity (including medical intervention without consent), physical and verbal abuse at health care facilities, social discrimination and corruption (such as demand for user-fees)
which they argued were products of historical factors such as gender and other forms of social hierarchy. They maintained that accountability for these issues needed to be distinguished from that of lack of availability of quality care due to weak human resource or infrastructure issues.

One participant observed:

Accountability is a culture and it does not happen with one report or one judgment. I think accountability is something that is fostered by constant rights claiming and the duty bearers being compelled to respond. It’s a culture that you have to develop and that’s not there … it may be there in Tamil Nadu or Kerala, but areas where maternal mortality is worse, these are not areas where people feel accountable to the poor, to the rural people, and least of all to women. That is not the way our society functions … people don’t see themselves accountable to a dirty woman in a dirty sari come in labour to your institutions … one does not automatically think ‘Oh, I have to be accountable to this person, she’s my client’ … no you don’t think that … you are filled with disgust ‘ah, she is dirty, she is having too many children, too late, she may not be able to bribe me enough’ … there is no response which is respectful and that is a culture in our country for the poor and low-caste who try to use government services.

I am not saying from the Uttar Pradesh experience alone. I have seen this in Madhya Pradesh, in Jharkhand and everywhere where maternal mortality is high because there is no culture of accountability. When you compare Goa, Tamil Nadu, and Kerala [i.e. all Southern states] to these states, there are two things, which are different: one is extremely high literacy, and women are literate in high percentages. So the likelihood of a woman coming who will never be able to write an application and complaint against you is very low. The second thing is that the social hierarchy between the service provider and the user is not as extreme [i.e. in terms of caste hierarchy] as it is in the states of the northern and central India. This is a function of poverty, caste, feudalism hangover, gender, whatever you decide to call it … it’s a complex combination of factors” (CSO#2).

On the issue of individual accountability, the notion of power dynamics between medical and health care specialists and women seeking care also emerged as a recurring theme. At least eight maternal health advocates touched on the challenge of holding duty bearers accountable where great asymmetry of information existed between health care providers and seekers. They emphasized the lack of consciousness (let alone, respect) for women’s autonomy in deciding about their health. This was attributed to the narrow understanding of health as a disease-free
condition and the public tendency to rely on such professionals as “ultimate experts” with unlimited power, which could undermine women’s own articulation of needs and preferences with respect to health care. Seeking information about why certain diagnostic tests were being recommended, what was the rational behind the prognosis was particularly difficult to navigate for poor and marginalized women (including their family members). One participant, a medical doctor and maternal health right advocate from West Bengal with many years of experience working with civil society groups, noted:

Health is very technical. People do not talk about health as a right. Also, there is too much power among doctors who see women as passive beneficiaries, ‘we know the best for them’ which is a mental and attitudinal block. Women’s own understanding and expressed needs regarding health has always been missing from the discourse. Women’s right to health, deciding about health care, seeking health care, is unheard of. There is extremely limited understanding of women’s autonomy in making decisions about health. The culture of quality health care does not enter the conception for medical authority. I did not go for OBGYN specialization, because of my own experience of observing how women were treated by health care providers even in very prestigious health care institutions (CSO#7).

Still others, all six technocrats and planners and the former Union Health Secretary, underscored the importance of holding communities accountable to preventable maternal deaths. They underscored the need to “sensitize” (about gender and social discrimination) communities and the importance of broader social change. All seven respondents raised concerns about gender discrimination in the domestic arena, which had direct impact on health status of pregnant women and could not be solely dealt through policy interventions. Some respondents acknowledged the role of state in promoting norms, policies and laws that legally ended discrimination of women (inheritance law, dowry prevention law, domestic violence law, equal access to education) but expressed frustration at poor enforcement that continued to affect women’s social and
consequently health status. This concern resonates with maternal health and human rights scholars emphasizing the significance of underlying determinants of maternal health outcomes and the failure of the state to protect women (Sen, Iyer and George 2007; Cook 1998; Cook and Dickens 2001; Fraser 2005; Fathalla 2006). As well, it points to the differences in formal legal equality and substantive equality raised by feminist citizenship theorists such as Kapoor (2007), Agnes (2008) and Haskar (2008). Hence, the respondents stressed the importance of societal attitudes and behavior change that was needed, be it in ensuring enforcement or provoking change within the domestic arena. The notion of community accountability, as raised by these respondents, speaks directly to the concerns highlighted by Fathalla (2006) and Cook and Dickens (2001) about women’s weaker social status and societal tendency to “tolerate maternal mortality and morbidity with considerably more fatalism and equanimity than they tolerate avoidable deaths and disabilities that strike young men” (230). These state actors spoke about the lower worth attributed to women’s lives by societies, which normalize adverse maternal health outcomes instead of viewing them as a social problem.

At the end of the day, as a society we have accepted that women die in childbirth. They have done so for decades and centuries. So neither the poor people nor the politicians perceive maternal deaths as unusual or worthy of attention. Women’s lives are attributed such low value that no one figures that this could be a systemic problem, and not a natural consequence. I think there is a funny dichotomy here. Sometimes, yes, these are individual rights, but I as a policy maker cannot fulfill them acting alone. There is a larger system that one functions in. In India particularly, community perceptions of rights are not necessarily based on norms of justice. There is a big tension in traditional societies such as ours in terms of how social norms have come to be, how they do not represent the broader interest of the whole people and how they are floated as acceptable and appropriate. In case of women, society often perpetuates norms of the women as the home maker, care giver, reproducer and so forth which are violations of individual rights and claims but acceptable because the society that perpetuates these norms is embedded in social, cultural and religious traditions. (SA#9; emphasis added)
In speaking about challenges of changing the community mindset, a technocrat indicated the difficulties frontline health workers faced in evoking certain conversations about child marriage and early pregnancy, contraception use and spacing of pregnancy that could result in community gatekeepers (generally male) restricting women’s access to health services. Likewise, another technocrat provided an example of lack of sensitivity (and absence of concern) among community and family members to the ways unhygienic health facilities contributed to poor health care facilities for use of pregnant and parturient women (and could cause them infections). But instead, they emphasized the importance of women’s attires in preserving and honoring tradition. He observed:

In fact, I would be appalled to visit a few of these places. It is high risk to take a pregnant woman to these facilities for delivery because of the poor condition of the facilities. But it is also the Indian man whose mentality is very funny. The man would take his wife to a health care facility, keeping her ‘ghungat on’ [keeping married women’s head cover in place] and worry about protecting his pride and honor and not tolerate any glances from other men, but he never considers the dirty, filthy conditions of the care facilities. I find that funny. Why cannot they get agitated and protest and get the workers to get their act together and clean the facility? (SA#2)

A senior advisor with the National Advisory Council made a similar observation as above although he simultaneously attributed responsibility to civil society actors indicating that the latter had a role to play in changing community’s awareness that maternal death was not inevitable. Such deaths could be prevented and the community had a role in doing so. He observed:

The community just has not recognized the kind of care the pregnant women needs. That change cannot be legally enforced. Courts can do very little about it. The government (executive and legislative branch) has to do something about it but there are limitations in changing social norms, changing attitudes … it is a very slow process. The government’s role can be of limited success. Law has a role in the society. It helps but it has to be complimented in meaningful ways by the action of the society and that is where the NGOs have a role to play, on trying to say that what conditions can be made available to
improve the experiences of pregnant women (SA#1).

Few women’s health scholars agreed with this assessment of holding the family and community accountable for maternal deaths. One respondent took issue with the specific logic of only holding states accountable for violation of women’s fundamental rights (to health). Additionally, she also criticized approaches used by some maternal health right advocates who advocated for welfare schemes and entitlements to compensate for lack of a well founded welfare state that could promote just and inclusive development which was a broader political struggle. She urged the need to consider broader political and economic factors that would ensure an environment where piecemeal welfare schemes need not be the state response to the needs and interests of poor citizens. She observed:

Let me say this … I am not very comfortable with only demanding human rights from the state. I think there are various stakeholders and you have to make demands on your family and community. Let me give you an example. Women are anemic. From a right-based perspective, we demand that food should be distributed for pregnant women under the ICDS scheme. I think that’s pathetic! Because we should be demanding a right to decent livelihood that gives us adequate food to eat and not these piece meal things. So when people integrate rights-based perspective they need to think this way. The poor do not have employment and then we get National Rural Employment Guarantee Act. What! We need a development strategy that generates employment not takes it away. Unless those macro things are looked into, I am afraid rights-based does not go far enough (AC#10).

Maternal health right advocates and two academics, however, viewed the attribution of responsibility to community by state actors as an escapist strategy. They agreed that transformative social change took a long time but underscored the role of the state in public education and generating awareness citing that it had a role to play in social attitude change. Few academics argued that the lack of concerns for women’s health among community and family may be a reason for low public awareness and therefore, social and political concern for maternal
morbidity and mortality. One academic specializing in public health ethics argued that assigning accountability for maternal death was especially difficult because the woman who had died could not speak for herself or articulate her grievances. Moreover, due to the lack of systematic maternal death audit and the various stakeholders (health officials, medical officials, relatives) involved in blame shifting, it was particularly difficult to pinpoint the responsible party and hold it accountable. This respondent observed:

With maternal death, the woman is dead, so the contestation for around who speaks for her is very difficult. So do you believe the relatives? The human rights activists? The state officials? Or the health people? So it is a war of various narratives and difficult to articulate the rights. The health system is so opaque you will never get to the bottom of it. It is difficult to frame the issue as rights (AC# 6).

However, the aforementioned respondents acknowledged that community and state accountability were the two sides of the same coin and reinforced each other. The community did not seek state accountability for maternal health/death because it considered women dispensable which led to the issue being a lower political priority for the state. In contrast, the state did not enforce laws that uphold and protect women’s rights resulting in weaker status of women in the household and community and ultimately leading to normalization and invisibilization of their deaths in pregnancy and childbirth.

**Conclusion**

In summary, using human rights to claim accountability for maternal health/death has two critical political dimensions, which represent the individual agency and the structural dimensions of claiming accountability for maternal health.

First, the need to generate maternal health rights consciousness among the most disempowered is inherently constrained by the rules and norms of the political opportunity
structures (the official maternal health policy and implementing institutions) available and sometimes preferred because of mobilization resources (specific knowledge and expertise) of the intermediary, that is maternal health right advocates (Benford and Snow 2000; Schon and Rein 1994). The intermediary, is able, where contextual realities (such as education levels of rights claimants and their social and political consciousness) permit, to expand the articulation of claims associated with human right to maternal health, but these may not involve claims to reproductive and sexual health as imagined by Cook and Dickens (2001) and Fraser (2005). This is because the discursive context is constrained to maternal aspects of women’s lives. Nevertheless, such articulations can reveal other dimensions of female autonomy (such as birthing preferences, maternity support and social security, child care) that claims of sexual and reproductive health and rights do not generally underscore. Concurrently, there are indigenous (that is, vernacular) complexities of translating “reproductive rights” that arise in the context of linguistic, historical and normative dimensions of the context. Either way, they have implications for the pro/anti natal divide among pro-choice feminist scholars and practitioners.

That said, the inherently abstract nature of human rights and the need to demystify them in practice lends a lot of power to intermediaries such as civil society actors who claim to speak for the passive rights holders. Introducing the language of human rights to the discourse of maternal health, therefore, offers such intermediaries a political space to claim legitimacy and assert their authority. This confirms the caution - about legitimacy claims made by civil society actors to promote their interests – as highlighted by feminist development theorists (Cornwall and Molyneux 2006). However, such intermediaries are critical to expanding the discursive scope of “health” which would otherwise be dominated by technocrats given the difficulties in ridding it of its technical and biomedical dimensions from popular and public imagination.

Second, the role of state (including institutional and individual), community and family
are emphasized (to varying extent) with relation to using human rights to claim accountability for maternal health. These speak to public and private, proximate and underlying determinants, and health disparity, gender inequality and social inequity dimensions of maternal health injustices emphasized by different groups of maternal health scholars (Maine and Rosenfield 1999; Yamin and Maine 1999/2005; Freedman 2001/2005; Cook 1998/2001; George, Iyer and Sen 2005; Fathalla 2006; Sen 2011). Still, conceptualizing accountability in practice reveals several complexities. This is largely because of the constitutional silence on health rights and entitlements, including the lack of specification of minimum guarantees but it is compounded by difficulties of stipulating the state obligations for health due to the historical and political dynamics of federalism. It is further challenging to operationalize accountability due to the historical factors associated with liberalization and deregulation of the Indian economy which have led to unfavorable political and economic conditions. That is, there are constitutional and institutional design issues and adverse economic and political environment that make it problematic for specifying state obligations to health. Collectively, these limit the political opportunity structures (with significant power and resources) available to maternal health right advocates, have implications for framing dynamics and affect political priority deserving of the policy problem. This may have been partially mitigated by the creation of the relatively recent establishment of NRHM (transformed into the National Health Mission since 2014 with an urban component as well) which offers the latter a political opportunity to push for incremental change.

There are also challenges concerning individual duty bearers, which may be unique to the health sector given that health care service delivery is inherently characterized by an asymmetrical notion of power. Such power is further perpetuated through combination of class, gender and other social hierarchies (especially caste, religion) between care providers and seekers, which pose barriers to women’s own articulation of health care needs and preferences
before medical and health care authority. Barring this, conceptualizing notion of individual accountability may also be problematic and counter-productive in resource-poor weak health systems where it is difficult to isolate individual and systemic contributors to adverse health outcomes. Nonetheless, the importance of holding the community and family accountable was also mentioned by small number of respondents in relation to underlying determinants of maternal health outcomes and failure to demand state accountability by perpetuating normalization and invisibilization of preventable maternal deaths. This is also a product of lack of concern for female morbidity and mortality, internalization as a result of social conditions stemming from deeply held beliefs about women’s weaker gender status – as argued earlier by Cook (1998).

The political dimension of using human rights to claim accountability for maternal health have implications for maternal health rights and entitlements specified by maternal health right advocates (frame sponsors), the political opportunity structures available to them and mobilization strategies used to undertake framing. The following chapter turns to locate the politics of using human rights to claim accountability for maternal morbidity and mortality in the broader context of struggle for reproductive justice in India. It examines two complementary issues, the politics of feminist engagement with the health system and the politics of feminist health mobilization. Collectively these present further challenges and opportunities for maternal health right advocates which have an impact on the politics of framing preventable maternal morbidity and mortality as human rights injustices, (be it using lobbying or strategic litigation). The findings reported in chapter 5 (this chapter) and 6 (the next chapter), in turn, constitute the “overwhelmingly complex reality” which is re-organized and constructed (that is, framed) into comparatively simpler “problematic situation” by frame sponsors such that they can specify
solutions appropriate for resolving the problem – studied in chapters 7 and 8 (Schon and Rein 1994, 26).
Chapter 6: Struggle for Reproductive Justice in Post-liberalization India

This chapter explores the evolving struggle for reproductive justice in post-liberalization India, defined as approximately the period between late 1990s (particularly post 1997-98) when maternal mortality began to receive political attention in the Indian health policy agenda until the completion of the field research in April 2013. Specifically, it explores three main themes.

The first theme lends itself to explaining the challenges maternal health right advocates face in engaging with the public health system as a state institution. These challenges are outcomes of convergence of two distinct encounters, gender sensitizing the health system and reorienting a welfare based health system to a rights-based one. In contrast, the second theme lend itself to respectively the origins of social mobilization for maternal health and human rights and its relational dynamics to the broader women’s health and the health movement in India. The findings included here point to tensions between these mobilizations originating in historical, (domestic) political, and development (including development activism and aid politics) context and marginalization of claims to maternal health by the women’s health movement. Yet, they also point to the ways the state politicizes maternal health to advance its political agenda of family planning and population control, which are ultimately reproductive health and choice/rights issues. Collectively, the findings and discussion in this chapter explain the conditions that affect the potential of maternal health right advocates’ to mobilize political support for advancing reproductive justice.

The third and final theme highlights some alternative suggestions for reconstruction of the human rights discourse surrounding women’s reproductive needs/interests and in India. These emerged from key informant interviews with some academics and issue specialists. These
suggestions may minimize fragmentation and strengthen collectivization (at least promote complementarity instead of competition and conflict) within the women’s health movement and women’s movement, improve strategic collaboration, and generate greater buy-in from the state (or at least avoid co-optation).

The empirical data included in this section are drawn primarily from the key informant interviews. The chapter makes a number of empirical and theoretical contributions to the literature on maternal health and human rights, while also confirming a number of theoretical issues raised by human rights and development theorists, including feminist theorists.

**Politics of Feminist Engagement with the Health System**

In enquiring about the politics of engaging with the health system (as a state institution) on issues of women’s health and access to health care, specifically using the language of human rights, all maternal health right advocates spoke (to varying extent) to the challenges of engaging with health officials and policy makers and persuading them of the significance of the notion of human rights (and rights in general). This was identified by them as the most pressing concern facing their ongoing advocacy efforts. These conversations offered insights into the challenges maternal health right advocates faced in persuading health officials and policy makers to reflect on and consider the human rights frame with the ultimate goal of convincing them of its significance – that is frame alignment.

**Feminist Human Rights Discourse and the Health System**

First, all respondents struggled to account for tactics they used to systematically engage with health officials and policy makers in sensitizing them to the notion of human rights (and rights more broadly). In fact, the researcher could recall more than half of the respondents
stumbling on this question, which was attributed to a need for reflection and careful consideration. In six different interviews, respondents explicitly characterized the question as requiring introspection and self-evaluation. Four respondents (from Gujarat, Andhra Pradesh, Bihar and Uttar Pradesh) specified that this was a “painful question” (often followed by a long pause before further conversation) because they believed they had failed to conceptualize strategies that would help them to systematically sensitize the health system (especially powerful senior health bureaucrats) to women’s health care needs and interests. For instance, in commenting on strategies to engage with the health system as an individual, one respondent observed: “But when it comes to success seen as access to government, there is very little. I don’t know how to say it but I think there’s very little. I wouldn’t consider our efforts successful. I can even say not at all. We are still in the same stage, may be moved 2 percent or 5 percent, may be not …” (CSO#17). Very similar responses were articulated by the three other respondents as well.

Appealing to and working with individual health officials and policy makers sensitive and willing to consider the importance of human rights framework (especially the notion of women’s rights) seemed to be the most common strategy used by all maternal health right advocates. The respondents very clearly indicated a preference for health officials and policy makers who were “[willing] to entertain the idea of rights, at least at the conceptual level” (CSO#18). Another respondent from a relatively well performing health system made a similar comment underscoring the importance of engaging with the “larger system” which she felt was missing from civil society end. She spoke of having used the approach of engaging with officials and policy makers at the individual level or at the community level through public hearings but recognized that the individual engagement and community engagement formed two different ends on the spectrum of engagement. She noted:
It is something that we have to actually imbibe within and it has to reflect in our work and that kind of change is something that does not happen easily. It is something we need to start working on and I agree that we are not working enough on that. If you really ask me, I don’t think as civil society we are actually engaging with the larger system trying to build the rights perspective. Either we work with the individual people and use their “good opuses” to actually push our agenda or in more open forum when they [community members] stand up and ask questions … within these two extremes (CSO#19).

Furthermore, nearly all respondents complained explicitly about the patriarchal bias inherent in the health system and among institutional actors who were mostly males. One maternal health right advocate from Gujarat observed that not every senior officer of the health system was equally willing and considerate of the human rights framework. In indicating the importance of individual bureaucratic receptiveness and attitude toward human rights language, she indicated:

> It depends … it is not a homogeneous situation. When you are talking to the state, there are some people who are discerning and understand but others do not and will not be able to. We had a very dynamic Health Secretary and Health Commissioner. With these two people one could talk like I am talking to you and they would appreciate and understand. They would also sort of try and put in programs and schemes, would understand issues relating to women’s wider health. So it just depends. It’s all very, very person specific but by and large it’s very bureaucratic, patriarchal system where they espouse the language of women’s rights and gender justice but they don’t really understand it (CSO#21).

On the issue of aversion toward human rights language among health officials and policy makers, there were hardly any differences among the experiences of maternal health right advocates based on the sub-national states and condition of health system they worked in. For instance, one respondent from Tamil Nadu, a southern state observed that the general attitude among state actors was welfare-centric. In fact, this participant indicated that because of the relatively well performing nature of the health system in Tamil Nadu it was difficult to raise discussion of rights to specific kinds of health care services, which would be dismissed by health officials and policy makers citing the better performance of the overall health system. She explained:
If you actually place the maternal health care service discussion within the context of rights and how it interplays with rights, I would say rights are nowhere in the program. It is a benevolent state that has decided to invest in the social sector, a benevolent bureaucracy but it is not because people are asking for it or because the bureaucracy or the political class believes in the program being human rights-based. For example, if you look at abortion services in Tamil Nadu, while safe abortion has to be one of the largest component of maternal health, safe abortion services is nowhere in the picture when we talk about maternal health in Tamil Nadu. Anemia is rampant, domestic violence is a big problem and data shows this but really there is no investment in those. When you actually talk to bureaucrats, say something about [human] rights language … their response usually is ‘well, you need rights in a situation where things are not functioning, but in a situation where things are functioning, why do you need to talk about rights?’ So that’s the kind of response! (CSO#19).

CSO#19’s comments also point to the limited understanding of rights among health officials and policy makers (in this case, at the sub-national level) who believed that discussion of human rights was only relevant in systems which could not meet basic needs of the health care seekers. This stood out because two respondents, senior health bureaucrats at the Central Government level, had argued that rights (to health and health care) could only be discussed in developed country context where health system was functioning and could offer minimum guarantees of health care service provision. For instance, one respondent had said:

Rights, what rights, you can talk about rights in Canada and England where they have established systems that has the funding, resources, infrastructure which can make sure citizens’ right to health care is upheld. But in India, where we have absolutely nothing, how will we ensure rights?” (SA#7).

These, two diametrically opposite views on where, when, how, and under what conditions human rights were applicable, pointed to widely varying understanding and attitude toward rights among different institutional actors. They could of course be escapist strategies in both cases, arguing to preserve the status-quo. But they pointed to the challenges maternal health right advocates faced in persuading these different institutional actors to undertake frame reflection. Partially, this
challenge speaks to that raised by some human rights scholars who point to the barriers of sustaining a rights discourse in a system that is fundamentally embedded in needs- and welfare-based development thinking (Hulme 2007, 2009). Perhaps this is why they have argued that unless, there is a marked departure in how development (in this case maternal health wellbeing) is conceptualized, the political discourse on right to maternal health as a human right is likely to be incompatible with the depoliticized notion of development (as provision of welfare, rather than a fundamental right) (Nelson 2007; Fukuda-Parr 2007; Darrow 2003; Fischer 2013).

Furthermore, feminist scholars have warned that unless the state (and by extension, the health system) changed its need- and welfare-based approach, adding the language of human rights to welfare entitlements would generate new problem where the ability to access them would attribute more power to the state (and institutional actors) that controlled the design of policies and resources allocated to the programs (Cormwall and Molyneux 2006; Robinson 2005; Tsikata 2007). This was captured in the words of another maternal health right advocate (from Maharashtra) who in pointing to the difference between policy and program documents, underscored the importance of recognizing that the latter was inherently technical in nature. Therefore, reframing such technical health care interventions in the language of human rights was a challenge, let alone the challenge of sensitizing largely male health officials and policy makers to the notion of women’s health care needs and interests. It could be thought of as a double burden in reframing – the challenge of converging women’s rights and right to health care that maternal health advocates were required to navigate. The respondent explained:

In public health, there is no notion of rights. It is still a welfare or technical intervention approach. To a district health officer or a health secretary at the state level, the whole notion that women have rights is strange … they may not be opposed to the idea in theory, but they really don’t know what it means in practice. See a policy document can look very different from how a program document looks. Look at JSY or any of these schemes for institutional delivery, of basically techno-managerial kind of intervention …
it is very difficult for them to visualize what it may entail or mean for them to engage with women as a collective. It does not make sense to them (CSO#22).

CSO#22’s observations were reiterated by at least three other maternal health right advocates. They pointed to the distinction between the official policy (JSY) promising the benefit and entitlement of access to free and quality maternal health care at a formal facility and at that being translated at the community level as assured access to X number of pre and post-natal check ups, Y number of immunization visits, Z number of blood tests. These references also pointed to the difficult task of frame alignment with health officials and policy makers. Such a process would involve sensitizing health officials and policy makers to the human rights frame at one level (say the Central Government level) and ensure that such a frame would consistently diffuse to other levels of the institution (sub-national, district, community). But diffusion of norms and ideas were seldom consistent through out the institution and frame alignment at the highest levels of a state institution did not guarantee the same at the street levels (Schon and Rein 1994). Convincing very senior bureaucrats of the significance of a rights-based approach could result in change in policy design but whether it would have the desired impact at the street level could not be said for certain. Assuming that the differences in attitude towards human rights as indicated by respondents were reflective of diverse range of systemic attitude toward human rights (be it toward health or women and/or both), they would likely require use of different sensitization strategies (and design of a multipronged approach to sensitize the system at various levels).

*Health System, Civil Society “Participation” and Feminist Dilemmas*
Second, two maternal health right advocates from the state of Uttar Pradesh underscored the importance of political context, particularly a specific historical moment, where their interactions with the health system over maternal health and human rights were distinct from their general overall experience. In case of Uttar Pradesh (UP), two of the respondents pointed to the incidence of the NRHM scam in the state (first exposed in late 2011) which involved corruption among health officials and politicians in the scale of millions of dollars. The scam eventually led to the fall of the sub-national government. Following the arrival of the newly elected government in February 2012 and mindful of the corruption issue, the freshly appointed senior health officials and policy makers were particularly receptive to maternal health NGOs and their human rights ideas. In other words, this political change allowed for a new window of opportunity for maternal health right advocates to engage with health officials and policy makers although it also made it very clear to them that there was a very specific political agenda behind the support they had received. Apparently, as an EAG state and due to the historic nature of this corruption incidence, there was internal pressure from highest levels of the Central Government on the UP Government to demonstrate results and endorsement of civil society groups. In explaining the circumstances, the respondent observed:

So whether the government will give priority to a rights-based approach or not, is really a matter of political context. In this case, the political context is that the new government is very wary of what has just happened before. They are also thieves but cannot dare to start with stealing because of what has happened immediately before. So it is not just the political formation or their political ideology, it is also the political moment. They have come at a moment when the health scam has really hit the ceiling so they are extremely aware and alert and careful of who the officer they put in charge is and that officer

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80 At that time the governing party in the Central Government was the Indian National Congress Party and senior leaders of the party, including party president Mrs. Sonia Gandhi and her son and party vice-president Mr. Rahul Gandhi were constituent members from UP. In fact, the Nehru-Gandhi family that had traditionally ruled India for many decades had a very stronghold in UP and would generally contest for parliamentary elections from there. With a General Election approaching in 2014, it was very likely that the exposure of the health fund scam in UP would have been problematic for the Central Government.
happens to be a person who is pro-poor, pro-people, pro-accountability and pro-rights. So the official has a completely different approach and actually values our work. We organize this women’s samayalan [gathering at public forum] every year on May 20 because that’s the day we commemorate … it is a day of action and observation … it is an internationally celebrated day for women’s health and we have been doing this for many years. On this day annually we bring in our village women to Lucknow to speak directly with the media and policy actors. So this year, this guy arrives before anyone else has come! He says there is some internal training going on but he does not go for the training. He spends two and a half hours at our event, [and] he listens to all the presentations. This is absolutely unprecedented in our history that a government official has arrived before people and then he stays until the end of all the presentations, gives the speech and goes. In the past we have struggled to get even junior officials come for 20 minutes. Suddenly we are a priority. Suddenly, for district level plans for NRHM, we get told that it needs inputs from development partners. He says that we have to show that there is high NGO participation in district level plans because central government is repeatedly enquiring about the role of civil society in this. Until now civil society was kept out because the previous government was busy syphoning off funds, now he calls meetings and asks us to work with district officials to make district-specific plans (CSO#2, emphasis added).

In other words, the support for human rights demands made by maternal health advocates was essentially an appropriation of the language of human rights to gain legitimacy among public. Feminist scholars have cautioned about such politicization while also pointing out the opportunities such engagements present, ultimately pointing to the dilemmas of feminist engagement with the state (Nyamu-Musembi 2006; Bradshaw 2006; Rai 2008). Such a dilemma was evident in narrative of the second respondent from the same state where the respondent revealed the ways this window of opportunity of engagement with the state had given rise to other challenges. As this maternal health NGO received an opportunity to influence the state (maternal health) agenda, it comprised their ability to protect their independence in setting their own organizational agenda. In its zeal to demonstrate civil society “participation”, the senior official was selectively partnering with CSO#2’ organization (a maternal health NGO) and encouraging them to consider development proposals related to an entirely different sector (while also sidelining the original NGO X which had created and submitted this proposal). Effectively
this official was contributing to tension between the two organizations, which was hardly short of cooptation. The respondent narrated:

But there are challenges here as well. We suddenly find that another of the development partners, called X has given a proposal to work with the youth. We find that the chief medical officer has taken X’s document, changed the organization’s name everywhere and replaced it with ours and submitted that. So we were like we did not do this. This is not our proposal for district activity! Why are you doing this? The NRHM mission director lands in [Y region] where this is happening for a meeting. There is a discussion where we inform him that this is not our proposal but he says ‘no, no, whatever has to be done here, has to be done by your organization’ and then he walks off. So it is kind of getting awkward as well but this mission director has decided that whatever has to be done anywhere in the state has to be done by us. If there’s a chance that we can do it, then we should be the organization doing it. I am just giving this as an example of how extreme this is becoming. Even though this is not our proposal and this is not what we wish to do. The other NGO is asking us ‘hey what happened, we had put this in, how come you are coming in?’ But this has become the atmosphere and it is very awkward because we have to sort this out with that other NGO. None of this has actually translated into the approval of the proposal but this is just an illustration (CSO#16).

Saheli et al. have pointed to similar concerns in the Indian context surrounding the “entry of women activists in direct government programmes” (as was the case above) which they maintain enhances legitimacy of such programs (2008, 184). In fact, they have observed that such close engagement compromises the ability of feminist advocates to hold the state accountable, which may try to lure such women’s groups with opportunities for influencing the state when the latter actually stands to benefit from the legitimacy such groups bring it because it is “aware of loss of its own credibility among people” (Ibid., 186-187).
Yet, where genuine political will was missing feminist advocates must leverage strategic opportunities to gain entry into policy and planning discussions (Rai 2008). This was the third challenge all maternal health right advocates explicitly underlined, pointing to the need to sustain engagement with the state (as opposed to disengage to escape cooptation) even if that only led to incremental change. In speaking to selective institutionalization of feminist demands (such as narrowly defined maternal mortality reduction), one respondent indicated that she and some fellow advocates who had received invitations to technical resource group on maternal health were considering using such an opportunity to slowly expand the scope of the conversation and underline gender and social considerations (including women’s birthing preferences) that should be integral to policies on maternal death audit. She observed:

We [the respondent and fellow maternal health right advocates] are deliberating over the idea of making inroads into the system through these accessible individuals and then to sort of try and get these government resolutions passed, these schemes passed which would then institutionalize some of the things we are working towards. For example, four of us are on the technical resource group of maternal health unit. So this whole idea of maternal death reviews should not just be clinical, medical audits but needs to have the social and gender elements as well. The monitoring tool we advocate for incorporates women’s definition of safe delivery along with the technical aspects. We are trying to introduce some of these things in the institutional framework so that it becomes part of future plan (CSO#21).

This observation underscores the various roles (maternal health right advocate, technical resource for the state) that feminist practitioners must embrace in designing advocacy agendas that can be sensitive to women’s everyday needs, gain buy-in from the state and simultaneously advance strategic gender priorities (Alvarez 2009; Hames 2006; Hartcourt 2013).

In regards to selective institutionalization of feminist demands involving women’s health, nearly all maternal health advocates underscored the complexities that had come to exist surrounding women’s access to abortion. They complained that the issue of sex-selection had
received disproportionate state attention [because it was a “middle class”, “national image”,
“globally shaming” issue (CSO#23, #15, #12, #2)] to the point where failure to enforce the
PCPNDT Act was resulting in greater state regulation of access to abortion (that is the MTP Act).
According to them, the poor enforcement of PCPNDT Act that was supposed to health care
providers from declaring the sex of the fetus to parents and family members was largely due to
the dismal condition of the de-regulated private health care sector (especially individual and
small and medium size private health care providers). But instead of identifying ways that could
improve the enforcement of PCPNDT Act\(^{81}\), some state governments were trying to “police”
women’s access to abortion under the MTP Act, including proposing various ways that would
limit right to privacy and violate right to confidentiality of the abortion seeker. The
announcement of the 2011 (940 females in overall population for 1000 males) census results,
some argued, had made the situation particularly worse because a comparison with the 2001
results (933 females for every 1000 males) indicated marginal improvement pointing to the poor
enforcement of the 1994 PCPNDT Act, seventeen years since it was first created. One maternal
health right advocate from Maharashtra with an overall sex ratio of 925 females according to
2011 Census results (922 in 2001) spoke at length about the creative strategies maternal health
right advocates (and pro-choice advocates) had had to adopt by involving the Mumbai High
Court (against policing of abortion facilities), lobbying the Central Government to get involved
with the Maharashtra State Government (the state had very strong decentralized health
governance). In her narration, this respondent noted:

> With this whole declining sex ratio, the response in Maharashtra has been bizarre. This
has been happening since the release of the 2011 census data. They have come up with all
kinds of proposals saying that abortion up to only 20 weeks should be allowed because

\(^{81}\) The PCPNDT Act criminalizes service providers who reveal the sex of the fetus to its parents.
that is when sex selection of the fetus becomes possible. So they are tampering with the law. They want to recommend and make changes in the existing MTP Act. Then they said feticide is a murder, which means all abortions are murder. Then some district municipal corporations sent out some circulations saying that every abortion that a provider provides should get a sanction from the [health] commissioner. Ridiculous!

Latest in this whole line of events is that police officers have been appointed in the state at the district level to monitor the implementation of MTP and PCPNDT Act when both the laws have no role in raising awareness against sex-selection. The health department has come up with guidelines for what the police officers should do because they are not supposed to enter any MTP providing facility and ask for records because they are confidential. You see all of this is happening at the state level with no participation or interference from the Union level, these recommendations have to go to the Union because MTP is a centrally issued law. Had it not been so, I am sure they would have already done away with the MTP law. Many of us had to lobby the Centre. We put in a dispute at the state level but the state authorities did not respond to us and forwarded those to the Centre. So the Centre had to take it up finally and the MTP act has not been done away with! But this appointment of the police is done at the state level. The center cannot interfere unless we go to court now and say that what the Government of Maharashtra has done is a contravention of the law. So there is a social situation [sex-selection and declining sex ratio] like that and then state intervention is allowed because health is a state subject. So essentially state-central dynamics is fragmented, we don’t know which state has what kind of people who are active with what perspective and there’s leeway for this kind of kneejerk reactions which continues (CSO#23).

Respondent CSO#23’s concerns were indeed telling of the various challenges maternal health advocates faced in an environment of growing complications surrounding reproductive choice and rights. Another respondent underscored the paradox in this situation, arguing that regulation would be insufficient to address women’s issues unless there were changes in the social fabric in which the enforcers of such regulation resided (CSO#14). This issue arose during conversation with two health bureaucrats and a senior health planner. SA#7, SA#4 and SA# 6, all pointed out that within the Central and state ministries of health and welfare, the issue of sex-selection was a “hot button” issue. They also used terms such as “national interest”, “middle class interest”, “global image”, “international naming and shaming” to underline the political emphasis on the
declining child sex ratio. One of the respondent, a very senior retired Union Health Secretary indicated that sex-selection was top of the government’s gender agenda because it indicated a negative image and dampened “India’s global ambitions” (SA#7). Another respondent, a senior bureaucrat with Ministry of Women and Child Development made a similar point but in a subtler manner. This respondent who was head of a unit overseeing gender empowerment policies (vague reference is deliberate) indicated that there were concerns within the government about the country’s social development indicators, which had not kept up with its economic development achievements. The respondent explicitly raised the issue of “declining child sex ratio” as the “burning issue” and noted that it was a “huge priority” related to women’s health (SA#6). This left the researcher baffled because while the issue of declining sex ratio was certainly a gender justice issue, whether it could be viewed as a women’s health issue was unclear. It left the researcher wondering whether the construction of the declining sex-ratio issue as a women’s health priority reflected a deeper misplaced focus on the abortion dimensions of the problem as opposed to the issue of the lesser worth assigned to women and girls (Notes Nov 9, 2012). Perhaps this was telling of the state’s hastiness and lack of adequate comprehension of how these delicate issues (sex-selection, declining sex ratio, sex-selective abortion, women’s health) were interconnected. For instance, prior to holding this interview, the researcher had spent an hour casually conversing with the respondent’s executive assistant as she waited for the respondent to arrive in office. During her conversations with this individual, the researcher inquired whether the various girl child initiatives the unit was also supporting (aside from few maternity benefit schemes) also included a focus on raising awareness about child marriage. The individual indicated that the program put in place involved raising awareness about the value of girl child and celebrating the birth of a girl child among families, including providing cash benefits in villages in five states (with lowest declining sex ratios). Furthermore, he indicated that
there was already a Prohibition of Child Marriage Act (2006) which law and enforcement were responsible for. This again left the researcher surprised since her assumption was that undervaluing of girl children was what (partially) led to their early marriages (as opposed to investing resources in their upbringing and education). Arguably, this was an anecdotal and one-off experience. Nonetheless, both SA#6 and this respondent’s executive assistant’s attitudes were telling, to some extent, of selective attention and silo approach to gender, women’s health and related rights issues at least among some segments of the state. More importantly, the broader and underlying issue on state’s part was applying quick-fix approaches to address issues of gender injustice, which were products of long historical and social conditioning and would likely require more invested and long-term strategies to produce discernible results. In sight of these dynamics, maternal health and human rights scholars should take a cautious optimist approach to demanding state accountability using the language of women’s rights and/or human rights. Such language may be selectively appropriated (such as the rights of the girl child) to further agendas which do little to actually change gendered social norms and improve women’s social status, but certainly instrumentalize political commitment to women’s issues for other less apparent state agenda (Cornwall and Molyneux 2006; Howard 1995).

**Feminist Engagement and State Reprisal**

Two maternal health right advocates from WRAI, who did extensive work in the sub-national state of Orissa, highlighted some of the resistance and reprisal they had begun to receive from the sub-national state Officials. One respondent noted that use of media to publicize gaps in the health system had led them to receive wary phone calls from sub-national level NRHM officials, who had been further pressured by their Central counterpart in Delhi. The respondent observed:
WRAI is very vocal, present in media, and has been quoted in the parliament. See we work with journalists and recently in Orissa, within a month the journalist (of a national English daily) filed four reports back to back, which got the Chief Minister of Orissa’s attention. He sent those clipping to health secretary asking why was there discrepancy in the assessment provided by ministry saying everything was great yet these cases of maternal death were taking place. The health secretary forwarded it to the managing director of NRMH [commissioner at the Central Government level] and our Orissa Secretariat got a call saying ‘why are you doing this? Why are you getting us into trouble?’ (CSO#1).

This was noteworthy because no other maternal health right advocate had mentioned such experiences of receiving direct calls from state officials, but this could also be because the use of media advocacy was not so prominent among organizational members of NAMMHR or CommonHealth, the other two maternal health and human right coalitions. The National Coordinator of WRAI indicated that some of the organizations of the coalition were also facing funding shortage for their community level training and capacity building work. The respondent was somewhat ambiguous but she seemed to attribute this to the “kind of [accountability] work” these organizations did and connected it to political concerns (at the state’s end) with this peculiar nature of work. This respondent observed:

See we do a lot of training and capacity building work teaching communities how to do verbal autopsy which is very technical work agreeably but necessary for local accountability work. But the money to do this is drying up. Why do you think we do not have funding for this? Well, it is because of the kind of work we do. We are out there giving out data, recording people’s grievances, saying 70 percent of health facilities do not have x, y, and z … we never had a fund crunch until four years back! (CSO#11).

The coordinator also narrated further concerns the work of few of WRAI’s member organization had faced in Orissa and Rajasthan (both EAG states with MMR higher than national average). She underlined the risks of retribution (from health officials) women faced in participating in
community level hearings regarding the state of health system. Moreover, she also underscored the difficulty of holding an authority responsible in case of systemic violence.

Our biggest challenge has been to prevent reprisal in our social accountability work! In a public hearing if a woman is saying that a public official has taken a bribe, she is not safe from reprisal. Tomorrow, the ASHA will be sidelined, and the woman may be denied services. So those are the dangers of rights-based approach work. That is a challenge we are still grappling with. How do we secure ourselves? Today, we [as an organization] do not have any money to do accountability work, because it is some sort of reprisal too (CSO#11).

Given the very few and sporadic mention of the issue of state reprisal involving specifically maternal health, it was difficult to perceive whether this was a systemic issue (or could become one with time, seeing that WRAI had been around the longest). Nevertheless, this issue ultimately spoke to the power hierarchy between the state and civil society and that there were limits to which the state was willing to tolerate criticism from the civil society.

Some respondents (thirteen civil society actors of different profiles), however, made general references to the shrinking civil society space in India arguing that the state was becoming more vigilant. The arrest of Dr. Binayak Sen, a pediatrician, public health specialist and human rights activist (who had a record of providing health care to Adivasi population for more than thirty years) in late 2010 was mentioned to varying extent by these respondents. They generally described the situation as closing of space for political dissent (especially human rights work) and attributed this to a shift in political culture. One human rights scholar referred to increased state surveillance of human rights activist and observed:

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82 Sen was the national Vice-President of the People’s Union of Civil Liberties (PUCL) and had been raising awareness about multiple hunger, malnutrition and poverty related deaths in several Eastern states (Chattisgarh, Bihar) that had witnessed resurgence of Naxalite mobilization over the past decade. He was arrested on charges of sedition in 2010 and sentenced to life imprisonment by the Raipur Sessions Court in Chattisgarh, however in April 2011, the Supreme Court of India granted him bail citing no incidences of sedition were found. Sen’s appeal before the Chattisgarh High Court is still pending (Vyawahare 2012). See here: http://indiablogs.nytimes.com/2012/12/10/a-conversation-with-human-rights-activist-dr-binayak-sen/?_r=0
Funding for anything related to human rights is getting more and more difficult. State surveillance is increasing for people working on human rights, which is another dampener.

[State surveillance in what form?] Anyone working on human rights issues, does get monitored to some extent. Say Binayak Sen. He has been working for 30 years, no one bothered for 25 years and suddenly he gets picked up. He had come here. I had invited him. We had not advertised, it was supposed to be a small group meeting …the CBI [Central Bureau of Investigation], intelligence people were here, especially considering that there was no publicity. It was just me talking to him and a few people in the department. So his phone was tapped and they were here. They didn’t even make an attempt to hide themselves. So probably … I am not saying it is happening extensively, but there is a certain fear about issues related to human rights. So there is a decline, there’s a major problem that needs to be dealt with (AC#11).

Respondents who raised the issue of shrinking civil society space and greater state surveillance, attributed these to the growing culture of “neo-liberalism” in India, arguing that the forces of liberalization, privatization and deregulation had led the state to abandon the poor masses and advance the interests of the few rich and elite. They found it difficult to pinpoint exactly when the state vigilance over civil society activism had started gathering momentum. This is an issue (state surveillance, reprisal to some extent) that the literature (on using right-based approach to demand state accountability for under-development) is yet to address. Arguably, the issue of antagonizing the state, making it difficult to collaborate on development projects is underscored in the literature to some extent, but nearly not to the point where the state assumes a vigilante position (Fukuda Parr-2007/2009; Nelson 2007).

But whether such a reaction on the part of state was entirely out of order and unforeseen, given the inherently political nature of the struggle for human rights, needed to be considered. To that effect, one respondent a public health specialist from a public health research think-tank highlighted the importance of considering whether the use of a right framework by various maternal health groups was counterintuitive to addressing the actual problems that needed to be overcome to improve the condition of the health system. She maintained that the confrontational
relationship between maternal health groups and the government that had resulted from using a “rights framework” was preventing necessary collaboration. Such collaboration, she argued, was quintessential for improving health system capacity and maternal health groups were well positioned to complement government efforts. Moreover, she contended that by making government official defensive, maternal health right advocates were losing their allies who were probably equally frustrated with the system. Specifically, this respondent observed that perhaps maternal health right advocates needed to reconsider some of the advocacy strategies they were using to engage with the health officials and policy makers publicly. She observed:

How does an NGO build the research to create acceptance within the government, how much involvement has it had with key players to make sure that they are part of your initiative early on? How much did it engage with the government while you were working on the initiative? Sometimes it can have technical consultancy and invite government officials to those, but they may not come … it has to create some bile especially for difficult issues. There is an art to disseminating community level findings such that the NGO can get buy in. And this is not advocacy. Disseminating results in a forum is not advocacy! Then of course the person who comes from government side will never buy the research because they were not involved with it from the beginning. Having the one-on-one interface with the government directly and keeping them appraised of research developments early on would be beneficial. If the NGO calls them to a large forum where it has controversial results, it will put them on defensive. It may be better to first share them in a smaller forum, get the buy-in and engagement and then move to a more public forum. Honestly speaking, the findings the NGO has, most people at the government end who object to it openly would agree to it behind the curtain. Because they know. There is nothing new, the findings are not rocket science. The meta data speaks to the poor conditions, no matter how good or bad your methodology or quality of data (AC#7).

While acknowledging that programs, such as the JSY, were political tools used by governments to further its electoral agenda, the respondent maintained that civil society groups had a role to play in working with government to improve overall health system governance. She emphasized the importance of partnership between civil society and government, stressing the need to realize that in terms of health system capacity (and general state capacity) the government was nowhere
near where it should be in being able to deliver the necessary public services. Failure to do so, the respondent observed, would inevitably lead to politicization of public service provision in a way that would hardly benefit the population that civil society groups claimed to represent.

The bottom line is that many more civil society organizations need to interact with the government because the government does not have that level of caliber yet [to function independently]. In absence of that, the easy thing for the government is to come up with a CCT. Now almost for everything the government has a scheme, that has just become a mantra for the government. This is the convenient thing to do. And the government think it buys it votes, so it’s a convenient political vote bank strategy! So the government runs from that level of energy. But we as advocacy or research organizations have to do much more to recognize that is what governments do. That is how the government is in a pluralistic democracy. Unless the quality of governance improves, that’s what we have to deal with. So meanwhile, is it better if we do not engage, stand outside and shout or should we go inside and improve? And improve meaning, really work through the government. There are very few organizations who are working with the government to improve government health services. I am really talking about improving the government set up and fundamentally providing quality health services. We used to have examples where the government gave up a rural hospital in Jhagaria to the civil society to run and show it how it can be done, but you just do not see as much of that anymore (AC#7).

It was noteworthy, that six of the ten state actors (all three technocrats, two planners, and one bureaucrat) who participated in this study had also underscored the importance of civil society groups working with government to improve the delivery of health care provision. To varying extent, they maintained very similar sentiments as AC#7 above. In fact, one planner and a technocrat (formerly a Health Secretary of a sub-national state) said that most bureaucrats generally have a similar impression about the poor state of affairs of the health sector but would not explicitly acknowledge it, at least not to outsiders (SA#4, SA#3). They also argued that some maternal health right advocates were viewed as smug and not appreciative of the everyday realities of governing the diverse and complex population as vast as India’s. While this could be evidence of bitter feelings toward civil society group and an effort to undermine their legitimacy, one bureaucrat with NRHM (SA#5) did not believe the state could fully withdraw from public
service (which was the fear SA#5 and other state officials presumed most maternal health right advocates had). SA#5 maintained that the state did not have the choice to withdraw because unlike other developing countries where donors were the main caretakers of social sectors, this was not the case in India (donors she argued constituted may be 10 percent of the sector). This SA#5 attributed to the internal logic of India’s democracy. Gupta (2012) has underscored this point, arguing that seemingly benevolent state policies (such as JSY) are designed to address the needs of the poor, generally Dalits and Adivasis, especially women and girls. This is because they were collectively “essential” to India’s democratic and pluralist polity (as also argued by AC#7) even if they witnessed an attitude of apathy and inactivity from civil servants. In fact, SA#5 maintained that creation of the National Health Mission (announced in 2013), which would host both the National Urban Health Mission (NUHM) and NRHM, was an opportunity that civil society groups should seize by working with the government to ensure the mission became a permanent government unit and had a lasting impact on health system improvement in India.

In exploring the evolving struggle for reproductive justice in post-liberalization India, the results and discussion presented until now point to the politics of feminist engagement with the state. Specifically, they reveal the challenges maternal health right advocates face in promoting gender sensitive health and health care policies and services using the language of human rights. But the politics of feminist engagement with the state on this specific issue only reveals one dimension of the struggle to mobilize political support for reproductive justice in post-liberalization India. The other dimension of this struggle is tied to the internal politics of feminist mobilization for health in India, including associated challenges that arise in the context of human rights advocacy.
Maternal Health, Human Rights and Politics of Feminist Activism

Enquiries about what factors led to the emergence of maternal health and human rights advocacy led to two different kinds of responses. Some viewed the emergence of maternal health and human rights advocacy as a convenient marriage of global conditions, the incorporation of maternal mortality reduction in Millennium Development Agenda and subsequent shift in donor priorities accompanied by growing popularity of human rights in neoliberal economic development discourse. But others pointed to domestic conditions, which suggested that emergence of maternal health, and human rights advocacy was a locally grounded counter-mobilization to politicization of maternal health by the state. It could be a struggle for human rights-based claim to maternal health that failed to gain recognition in earlier waves of reproductive choice/right movements in India. The findings and discussions included below will demonstrate that the source of the differences over these two explanations stemmed from different frames held by actors of what constituted struggle for reproductive justice, both the substance and nature of it. In doing so, it will provide insights into the contemporary state of feminist mobilization (henceforth, mobilization) surrounding women’s health in India and the fragmentation within the broader movement in response to complex intersection of global and local factors. The dynamics of this fragmentation is consequential to women’s health advocates ability to mobilize political support for advancing reproductive justice in India.

Emergence of Maternal Health and Human Rights Advocacy: A Product of Global Factors?

According to sixteen civil society respondents (five maternal health right advocates, eight academics, two former women’s rights activists and one health activist), maternal health and human rights advocacy in India was driven largely by global factors, chiefly the creation of the
MDGs (maternal mortality reduction being Goal 5), which altered donor priorities for aid
distribution and influenced organizational agenda setting within many Indian NGOs. However,
this did not explain how human rights came to be entrenched into the discourse on maternal
health, since MDGs had categorically excluded a focus on human right despite hard won political
commitments to women’s rights during the UN Human Rights Conferences held through out
1990s (Eyben 2004; Hulme 2007).

On probing further, eight academics and three activists maintained that maternal health
and human rights advocacy was a convenient marriage between globally designed development
norms and growing popularity of human rights speak in the development discourse led by
international agencies, donors, international and domestic NGOs. They categorized the entire
exercise of maternal health and human rights advocacy as neoliberal cooptation of human rights
language with (selective) institutionalization of the feminist health agenda by pointing to the
exclusion of the more politically and morally controversial sexual and reproductive health and
rights from the MDG agenda. One feminist health scholar underscored:

Have you considered why the focus on maternal health? Why not other women’s health
issues? Is there a neoliberal purpose to this? Why focus on reproductive labour? How is
this attached to Millennium Development Goals and a certain view of economic
development and development in general? (AC#4)

AC#4’s views on how incorporation of maternal mortality reduction as goal 5 of the MDGs was
reflective of an attitude of Instrumentalizing women’s health for purposes of neoliberal economic
development were very closely aligned with that advanced by Yamin and Boulanger (2014). As
well, the view that women’s rights were excluded from the MDGs, as articulated by AC#4 and
ten other respondents, was already established in the scholarly literature (Eyben 2004; Hayes
Likewise, the arguments about cooptation of human rights language by donors to support good governance agenda in developing countries and the growing popularity of human rights speak in the discourses of the development establishment (especially UN agencies and NGOs) had been indicated in the existing literature (Cornwall and Molyneux 2006; Gideon 2006; Robinson 2005; Bradshaw 2006; Hames 2006). One former women’s rights activist and two maternal health right advocates observed that concepts such as “human rights”, “rights-based work”, “accountability work” had become popular “buzzwords” in the development discourse and were being used by civil society groups to justify their work (gain legitimacy and sound credible) without fully reflecting on them. One respondent categorized these as “rhetorical jargons” and maintained that such uses were mostly rhetoric. This respondent observed:

When it comes to rights, whether it is ICPD, or MDG, or our own national policy, most of it is rhetoric. Tell me something, line up five people and ask them to describe what is a rights-based approach. Do we know? Each one has its own definition! Most of the time people are just taking cover under a buzzword. Now the other related word is ‘accountability’! The whole world is using the word, because it is the sexiest new kid on the block! But when you ask what do you mean by accountability you get very different answers. I personally think this whole rights-based approach is a much-abused phrase like ‘gender mainstreaming’. The whole world is doing it! The social sector has a tendency to sound good, this is part of that. See the only way we can say that we are actually doing rights-based work is if we can interview women to understand if we are building their agency, then we can say that this is rights-based approach. Rights are a jargon in the field, which does not translate into anything! People do a three-day training and say “we have empowered women” and that to me is the most patronizing thing to say! I don’t know if the work we do is empowering women to advance their agency … (CSO#11).

CSO#11’s speculation that notions such as human rights and accountability were being adopted by various interests to support their political agendas was substantiated by a human rights scholar who maintained that human rights was the “social justice face of neoliberalism” (AC#8). At least three different academics (human rights, and two public and women’s health specialists) used similar phrases (some combination of social justice and neoliberalism) to attribute to interests
that were supposedly appropriating the language of human rights. One of these academics explained that introduction of human rights speaks, led by donor aid, in the maternal health discourse was simply a “neoliberal” strategy to coopt a more emancipatory agenda of broader gender, health and social injustice as experienced by poor and marginalized women. This respondent attributed this phenomenon to the growing incidence of NGOization or professionalization of civil society groups and social movements in India. The transformation of social and women’s movements into NGOs doing “development work” funded by donors was raised by all eight academics as the “popular trend” in development. This, they argued, had led these NGOs to subscribe to the views of the donor and “take on whatever projects” the donor viewed as important. One respondent observed: “I feel this rights-based work on maternal health] is happening because of MDGs and funding” (AC#7). Another respondent observed:

You know NGOization is a kind of professional entity in India. Not everyone does grassroots work. They set up their NGOs in capitals and cities and they get international funding to do rights work because for neoliberalism to grow, it is very important that it should have a face of justice and social security and [the human] rights movement gives that face and we forget that actually it is class and caste that is struggling, that we need to focus on (AC#11).

AC#11’s reference to the significance of “class” and “caste” and how the notion of human rights tended to essentialize everything as a gender or women’s concern was noteworthy. It indicated an implicit cognizance of drawbacks of the human rights framework, but at the same time a concern for its politicization for “neoliberalism to grow”. Few maternal health right advocates, however, were extremely cognizant (that is, most were but few explicitly spoke about it) of the politics of reliance on donor aid for NGOs. CSO#17 had made recurring mentions of the issue of survival struggles and reliance on funds. This respondent observed:

[For] maternal health NGOs working in India, survival is a very very big issue … we may get funding and be asked to do a lot of work but do we actually want to do that, even if it
is outside our interest, capacity and expertise? If yes, then we are losing our focus and working only to survive. But if we want to work for an issue, survival has to be minimal and NGO turn over is very very high … staff attrition rates are very high (CSO#17).

CSO#17’s comments pointed to the larger issue of how two concurrent phenomena – growing professionalization of women’s movements in developing countries and reliance on donor aid to support the existence of such professional entities – had led to endorsement of the human rights agenda that had gained much popularity within the international development community. Effectively, this reality allowed donors and international actors of the development establishment to influence the agenda setting process within local maternal health NGOs and groups (Nyamu-Musembi 2006; Bradshaw 2006; Mukhopadhyay 2003b). The need to endorse and adopt the human rights speak, however of a “buzzword” concept it might be, was also implicitly evident in CSO#11’s comments cited previously, where the respondent referred to the importance of establishing legitimacy as she maintained “The social sector had a tendency to sound good”. Such a comment could be viewed as “tendency to sound good” to ensure access to funding and resources to eliminate the struggle for survival. Bradshaw (2006) in her study with some feminist groups in Nicaragua using human rights language found that such endorsement was equated with progressive mobilization (such as those conveyed by “tendency to sound good”) and as requirement to secure donor support.

But NGOization alone is insufficient to explain the emergence of maternal health and human rights, as thirteen other maternal health advocates argued. In the alternative explanation formulated based on interviews with these respondents, a number of local factors emerged which suggested that the emergence of maternal health and human rights advocacy were more locally grounded. However, their intersection with global factors (discussed above) should not be overlooked because it generated a new political space. It gave birth to a new discourse of
women’s rights to maternal health. Some scholars have emphasized the importance of differentiating “between the discourse of rights in development from right-based movements for equality, development, and self determination” (Mukhopadhyay and Meer 2008, 11). This is because the latter are part of struggles for rights of those socially excluded and discriminated against (Batliwala 2007). This distinction is central to understanding the alternative explanation on emergence of maternal health and human rights advocacy in India. That said, the fragmentation caused by the creation of this new discourse has implications for future of struggle for reproductive justice in India, especially the ability of feminist mobilization surrounding women’s health to mount an effective resistance against the state.

**Emergence of Maternal Health and Human Rights Advocacy: Between Global and Local Politics?**

The emergence of a new discourse on maternal health and human rights, accompanied by a simultaneous collectivization (most conspicuously embodied in NAMMHR), occurred largely because of domestic policy shifts involving women’s health that took place between 2000 and 2005. This inference was drawn based on chronological reconstruction of narratives from the thirteen key informant interviews with maternal health advocates over the policy changes that took place in the aftermath of the ICPD in 1994 until the creation of the JSY in 2005. The validity of this chronology could be confirmed based on debates and hypothesis outlined in the comparative literature (see “historical context” and “feminist activism context” in Chapter 2).

According to three respondents, within India the issue of maternal mortality was never an issue that was adopted by the feminist health movement that begun in 1980s. This movement articulated claims of autonomy over women’s bodies in response to state coercion and regulation
of reproductive behavior directed *solely* toward women 83 (following the declaration of Emergency in mid 1970s when the policy focus shifted from men to women). Furthermore, the issue also never featured in the broader political struggles of the feminist movement that was pre-occupied with “more fundamental struggles surrounding breaking gendered social norms” (CSO#23) such as equal inheritance rights, dowry and domestic violence, child marriage and sexual violence. Moreover, CSO#15 observed that there were underlying tensions surrounding the notion of motherhood that many Indian feminists (both activists and scholars) struggled with because of official policy focus on reproductive dimensions of women’s health. In other words, a focus on motherhood among feminists who jointed the women’s health movement in 1980s was equal to being coopted by the state. Hence, the issue of maternal morbidity and mortality was relegated to the sidelines. This ideological position is consistent with the criticism directed at the Safe Motherhood Initiative in the aftermath of its creation (in 1987) by many feminist practitioners and scholars (Maine and Rosenfield 1999; Rance 1997).

Two respondents, a maternal health advocate and a human rights scholar also reminded that this relegation of maternal morbidity and mortality could be due to the lack of empathy among some feminist practitioners (from previous waves of feminist health movement) toward women dying in childbirth. Readers might remember CSO#22’s comments included in Chapter 5 where the respondent observed: “The feminist movement depends so much on experience and

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83 This included forced sterilization (such as the quinacrine sterilization scandal) of poor and disempowered women but it also affected women of all backgrounds because of the aggressive state promotion of family planning directed toward women (be it abortion legalization, surgical interventions, tubectomy, contraceptive pills, injectable contraceptives and so forth) be it in form of communication and awareness campaigns or the design of reproductive health services, strategic coupling of certain surgical intervention methods with pregnancy services and so forth. Essentially, the burden of family planning was offloaded on women despite the challenges women faced in navigating intimate relationships, family and community in asserting their reproductive autonomy. See Rachel Simon-Kumar’s ‘Marketing Reproduction: Ideology and Population Policy in India’ (2006) and Mohan Rao edited collection *The unheard scream: Reproductive Health and Women’s Lives in India* (2004), both published by Zubaan. For a more historical account and evolution of women’s health policy since pre-colonial times in India see Sarah Hodges edited collection *Reproductive Health in India: History, Politics, Controversies* (2006) published by Orient Longman Private Limited.
maternal death is not an experience for women who were part of the feminist movement”. A similar conclusion was pointed out by another respondent, a human rights scholar who participated in previous wave of feminist health movement: “Because for people like me and the kind of socio-economic background we come from, there’s very little chance of us dying from pregnancy. I take it for granted that it is not the issue. But if I had a maid, she might [consider it an issue]” (AC#11). In elaborating on this further, CSO#22 pointed to the prominence of issues of involving reproductive technology that had come to dominate the feminist health movement, which the respondent argued was reflective of reproductive experiences of women of certain socio-economic class that many of the members of the contemporary feminist health movement came from. To that effect, the respondent recalled instances during early 1990s when her efforts to raise awareness about maternal mortality was dismissed by some “senior scholars” who pointed to the insignificant proportion of women who died from childbirth (relative to other causes of female mortality). The respondent observed:

The peculiarity is that maternal health was never a big issue in the feminist political agenda in India. Additionally, the origin of the feminist health movement in India is from urban educated middle class women. For them, maternal health is not a lively issue because socially and developmentally it does not affect them. Then you have the obsession with technology, if you see all the issues they [the contemporary feminist health movement] have picked up like surrogacy, sex-selective abortion, artificial insemination, assisted reproductive technologies, so there is a real obsession with technology which is in keeping with their class background and concerns they have as women. In fact, I remember giving a presentation in early 1990s when I began my career, on maternal health, when several senior scholars shot me down and said ‘do you know only two percent women die from childbirth as opposed to 15 percent who die from TB and other diseases?’ This is what we saw in early to late 1990s. The argument I made at that time is not the proportion of women dying, but that maternal mortality is symptomatic of various other gender inequalities and health sector problems over and above the fact that it is the death of a woman who has a life in front of her. It was seen as a minor issue and entangled in the politics of family planning. So demographers and public health people had more interest in the issue than feminists, human right activists and leftist groups (CSO#22; emphasis respondent’s own).
CSO#22’s recollection of the tensions between feminist health advocates over whether maternal morbidity and mortality was worthy of attention from the state and feminists, speaks to the incidence of debates at a UNFPA led colloquium in New Delhi in the aftermath of maternal mortality reduction interventions being introduced in Reproductive and Child Health Phase 1 in late 1997/98 (discussed in Chapter 2, “Historical Context”). At the same time, the emphasis that maternal deaths were actually a combined outcome of both gender inequalities and health system related factors but were seen to be couched in politics of family planning was in line with John’s (2012) speculation of the “new divisions and differences” within women’s health movement in India struggling to respond (and articulate reproductive choice and rights) to the growing complexity of gender and reproductive health politics in India.

A former member of the People’s Health Movement in India corroborated CSO#22’s comments that the issue of maternal morbidity and mortality drew interest from public health specialists because it was seen to be a result of failure of the health system. This position was consistent with those who recognized the gender inequalities behind maternal health outcomes, but viewed it primarily as an outcome of failure of health system (Freedman 2001/2005; Yamin and Maine 1999; Maine and Yamin 2005). This respondent explained that the agenda of the PHM was informed by the 1978 Alma Ata Declaration which promoted right to health as a fundamental human right, which was inherently bio-medical and technical in nature and had had a likely rub-off effect on the global and Indian maternal health policy discourse as well. This observation made sense given that one of the scholarly positions in the maternal health and human rights discourse promoted state obligation to fulfill right to highest attainable standard of health because they viewed maternal deaths as outcomes of dysfunctional primary health care systems (Ibid.; Unger et al. 2009; Yamin 2010). The respondent observed:
Even within health movement in India, the PHM which is very much public health oriented, the concerns are expressed as public health concerns. Maternal health is not a priority because in reproductive health age group, whether you like it or not maternity related mortality is not no.1 killer. That remains violence followed by TB, malaria, although violence is the number one single-cause killer. But if you think from the public health perspective, then maternal health issues arise and get represented from the systemic dimension since many maternal health care services are offered in form of JSY and as part of NRHM. But it does not become priority, so women's health is not priority of any health movement (CSO#12).

Another respondent actively engaged with the PHM confirmed CSO#12’s observation that maternal health was never a priority concern in the PHM agenda which claimed to speak for the broader health movement in India (as opposed to an issue such as maternal morbidity and mortality that affected some women). This resonated with the experiences of women from non-dominant segments of the Indian society whose issues did not find a home with the women’s movement, or the health movement and were therefore sidelined because they did not neatly fit into the dominant concerns advanced by these movements (Manorama 2008; Rege 2008; Andharia and Batiwala 2008). Likewise, some scholars in the gender, social movements and development literature have warned against taking for granted female solidarity, pointing to the complex notion of womanhood and differences within (Toyo 2006; Molyneux 2007; Win 2007; Cornwall, Harrison and Whitehead 2007).

The strides made by women’s health advocates at the ICPD Conference in Cairo in 1994 in persuading governments of developing countries to recognize the significance of respecting reproductive health and rights and promoting ethical approaches to family planning and population control led to domestic policy shifts in India, namely the introduction of the NPP in 2000. According to one respondent, at Cairo Indian women’s health delegation had
“championed”84 the coalition from Global South and its negotiations with participating countries, which was documented in the scholarly literature as well (Narayanan 2011). But the subsequent domestic policy shift (even if rhetorical), according to four maternal health right advocates, two former women’s health activists, and two academics, resulted in a loss of momentum within the Indian women’s health movement. A former women’s health activist lamented that the introduction of the NPP led to the demise of the Indian women’s health movement arguing that these were changing times and newer challenges altered the nature of activism from within (domestic changes). The respondent narrated:

You must also recognize that the [women’s health] movement [in India] has lost its momentum since there has been an ‘institutionalization’ of “gender” by the government, which is why the initial core group disappears after 2000. As the private sector has grown, there has emerged a newer problem. There have not been any new [female] leaders advocating for health causes. But I think the issues are reemerging now because as the state has reached its target [population replacement levels], the abuses are different and the activism / advocacy approach also has to change. There are newer players emerging on both sides of the spectrum. Maternal mortality is a very narrowly defined issue and the government has responded with JSY. But privatization has significantly weakened the health sector and made it harder for it to recover. Cairo and Beijing declarations have had an impact nationally. But you have to also recognize the importance of how funders conceptualize certain issues and how this might influence civil society efforts” (CSO#15; emphasis added).

A number of concurrent phenomenon occurring within India were included in CSO#15’s observation. One was the introduction of the NPP in India, in response to greater state attention to

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84 The Indian women’s health delegation had in fact agreed to support the demand for legal access to abortion advanced by Northern women’s health advocates in exchange of support for “women’s health policies … sensitive to locally significance cultural, political and economic issues” (Narayanan 2011; 45). This would be because women’s health advocates in developing countries were concerned with how the rhetoric of reproductive choice/rights were being appropriated by their governments to promote population control policies. As indicated earlier, abortion was made legal in India in 1971 because access to legal abortion was seen as critical to family planning. Many of the civil society respondents participating in this study underscored this and its very explicit connection to the ways simultaneous promotion of family planning and two-child norm with access to legal abortion in a society with son-preference had led to the problem of sex-selective abortion that began to be recognized by the government in 1990s as a concern.
gender in the aftermath of Cairo and Beijing. A second one was the growth of the unregulated private health care sector, which had begun to emerge in mid-1980s and was in full swing by the early 2000s as India neared the end of decade since its financial liberalization. In this regard, there was a general consensus among all civil society advocates who participated in this study that the growth of the unregulated private health care sector had generated new challenges for women’s health movement. Respondents argued that as opportunities for profit making for private health care sector increased – be it by virtue of easy access to sex-selection due to lack of monitoring, several incidences of clinical trials experimenting with injectable contraceptives (some supported and promoted by the government), or Supreme Court’s decision to legalize gestational surrogacy in 2002 leading to growth of the ARTs industry – newer challenges emerged for the women’s health movement. This was an entirely new era of reproductive choice/rights politics facing the Indian women’s health movement (Narayanan 2011; John 2008, 2012). But the introduction of the NPP in India also coincided with the Millennium Development Summit and incorporation of maternal mortality reduction in it, leading to the issue becoming a major donor priority. Even though at Cairo in 1994, the connection between reproductive health, health disadvantage and maternal mortality had been made, the Millennium Development Agenda did not reflect the reproductive health and rights framework (Fraser 2005; Yamin and Boulanger 2014).

According to four respondents, one former women’s health activist, two women’s health specialist and one maternal health right advocate, the introduction of a new global aid agenda designed around the MDGs was also accompanied by a growing prominence of new actors in international aid community, such as the private philanthropic donors many of whom had long history as reproductive health donors in developing countries. According to the two academics, some private philanthropic donors were not constrained by the religious and conservative forces
facing bilateral donors. As a result, they were more willing to experiment and support innovative, including “radical” projects (AC#8). This prominence of philanthropic donors in India should also be juxtaposed with the decline of influence and support of bilateral donors, unlike in some other developing nations where the latter continued to play an important role\(^85\). According to representatives of the two bilateral donors who participated in this study, the share of donor funding as a result of India’s GDP growth had become nominal and insignificant. There was also an undertone that their presence was seen as redundant by many Indian bureaucrats and politicians\(^86\). One maternal health right advocate noted:

I think it changed somewhere in the early 2000, following the MDGs. There are two things of course: one is that the field of reproductive health has become very internationalized and globalized, so many NGOs and new funding has come in. Reproductive Health is one area where a lot of funding came through independent organizations and NGOs, not through government or bilateral agencies so a large number of independent players in reproductive health which is true of HIV as well but not of TB, leprosy, and other public health problems where essentially the international aid went to government owned agencies or departments. So reproductive health field is very globalized, people build alliances across the world, so you have big NGOs meeting at ICPD meetings, so kind of a fall out of that kind of an interaction, where maternal health has come on to the agenda as a political issue (CSO#22).

\(^{85}\) Nearly all civil society respondents, including representatives of international agencies and the two participating bilateral donors (UKAid and SIDA representatives) made the same observation. In fact, key informant interviews with representatives from UKAid and SIDA indicated that there was lot of support for research (institutions and universities) on development projects in the health sector, rather than funding for capacity building and community level activism work.

\(^{86}\) Apparently, in 2010 there was a debate where a senior member of the then Governing Party (INC) at the Centre and the Union Finance Minister Mr. Pranab Mukherjee (now the President of India) had made explicit public comments about “kicking out” UKAid representatives, which led to a subsequent debate in British Parliament about the significance of British foreign aid to India. According to BBC News “India’s Finance Minister, Pranab Mukherjee, told parliament recently that India would prefer to voluntarily surrender money if Britain made a decision to cut aid. So as well as financial considerations in both countries, there is an element of national pride at stake, our correspondent says - if Britain decides to cut aid to India, Delhi may say it does not want the money anyway.” The respondent from UKAid, who was an Indian by citizenship, argued that UKAid had become a strategic extension of the British Embassy in India because of the historical and diplomatic ties and should not be seen as aid agency, at least not in India. He also joked that Britain was more interested in India than the other way. DANIDA and SIDA were also reduced to two-personnel staff working out of the Danish and Swedish embassies and were funding researchers at School of Public Health, Indian Institute of Management (Ahmedabad campus) for research on midwifery and maternal health in India. See [http://www.theguardian.com/world/2013/feb/18/uk-aid-india](http://www.theguardian.com/world/2013/feb/18/uk-aid-india) and [http://www.bbc.co.uk/news/mobile/world-south-asia-11318342](http://www.bbc.co.uk/news/mobile/world-south-asia-11318342).
This new role (as private philanthropic donors) in India had been (aggressively) taken up by Ford and MacArthur Foundation (both of which had existed for many decades in India) who, respondents pointed out, had “come to fund some really radical work around gender including doing heavy lifting on the research front as well” (CSO#15). For example, both Ford and MacArthur Foundations were major supporters of maternal health NGOs in India (especially NAMMHR and WRAI’s organizational members) doing various kinds of state accountability work. That is, several factors – loss of momentum within the Indian women’s health movement, fragmentation due to emergence of newer concerns, emergence of maternal mortality reduction as a MDG priority, growing prominence of philanthropic donors willing to fund radical projects, increasing popularity of rights speak in development discourse, and growing NGOization of women’s movement in India – aligned to create a favorable environment for emergence of maternal health and human rights advocacy. The interested frame sponsor’s had political opportunity and access to mobilization resources to support their reframing efforts, although the political opportunity structure was missing. The Union MoHFW’s RCH Phase I program included a focus on maternal mortality, but only in relation to incentivizing adoption of family planning methods by tying them with maternal health care entitlements.

**The Indian State and Politicization of Maternal Health**

The final element, the political opportunity structure, emerged with the establishment of the NRHM and creation of its flagship program the JSY in 2005 (since the link between maternal mortality reduction and health system improvements had been reinforced by global debates over the inter-linkages between health and development). The history of how the JSY came about was noteworthy for it pointed to another simultaneously occurring phenomenon, India’s changing role
in global politics. According to two maternal health right advocates, the sequence of events leading up to the creation of the JSY were as follows:

In 2005 September, the first review of MDG takes place in New York, the Prime Minister goes to New York he comes to know that Bangladesh … he sees Deborah Maine’s article on the work of NGO called Matlab in Bangladesh is doing better than India (in Maternal Health) … comes back and immediately has a meeting with Health minister and NRHM was formed. Then onwards the money really starts rolling in but what India does is policy shortcut. Instead of focusing on gradually improving 24/7 facilities, trained birth attendants, operations theaters, all you get is this sudden change. All this is suddenly in India because of the Bangladesh story! Then we get into institutional delivery, get international acclaim, global maternal health conference in India, there is a partnership [formation of Global Partnership on Maternal and Newborn Health hosted by WHO] meeting in India. UNICEF does a small sample survey, 20,000 samples and comes out with a number that 72% improvement in institutional delivery. So they get into this self-fulfilling prophecy (CSO#16).

CSO#16 and CSO#2 attributed to a similar sequence of events, and underlined that the discussions at the MDG Review Summit in New York in 2005 had hurt the national pride, especially since Bangladesh was underestimated as a smaller and weaker economic cousin. While this might have been the case, this sentiment was quite likely couched in electoral politics for the Indian National Congress led Government and in family planning politics for the Union MoHFW. This was evident in the design of the JSY which continued emphasis on connecting maternal health and related social security benefits to number of live births a woman had had, indicating to civil society actors that maternal mortality reduction had become the Trojan Horse of the Union’s aim to continue with its traditional focus on family planning (in the narrow sense of the term) and population control. From a framing perspective, the former issue could be viewed as a deliberate “categorization” of certain segments of the population who are considered deserving of welfare benefits because of their electoral significance, even when the health system simply did not have the capacity to delivery on the state’s promise – at least not at the level promised (Rein 2009). In the latter case (for the Union MoHFW), where the adoption of the new
frame (maternal mortality) by institutional actors was emblematic of real commitment to reform but without complete delegitimization of the old frame (family planning). That is, the metacultural frame of family planning had not disappeared from the policy discourse, but continued to exist in subtle ways, despite the creation of the NPP in 2000. To that effect, one former women’s health activist observed:

I was one of those who was involved in the discussions right at the beginning about the conceptualization of NRHM. The first draft which we discussed was a draft by the government where the thrust of the entire program was to be on women’s reproductive rights in the context of population and population control. So there was a very big struggle on this and we had to change that whole concept. In doing so I think there was a major achievement of women’s organizations who were involved at the time and health rights activists; we succeeded in turning the concept around in which the question of population control and what are the best ways in which to sterilize women or men, how do you make it accessible were dominant … that was a very critical aspect (CSO#14).

CSO#14’s comments were revealing of the politics of reproductive choice/rights in India, where the the struggle among women’s health advocate was that of the reverse faced by women’s health advocates globally. Whereas globally, sexual and reproductive health and right was depoliticized to maternal mortality reduction, in India different segments within the state had re-politicized it by linking the issue to that of family planning and broader political agenda (which speak to the social contract between citizens and the welfare state). Nevertheless, the persistence of the metacultural frame was evident in the design of JSY and other related benefit schemes. The access to such schemes in eight of the “high performing” EAG states (essentially state with high fertility ratio) was limited to women with two live births and/or pregnancies. In fact, measures were put in place to continue the family planning incentivization programs. The recommendation from Prime Minister’s Office was to create the cadre of female community health workers (or ASHA) would seem to make sense in light of the centrality of skilled birth attendant to safe child birth in the global maternal health policy discourse. But at the ministerial level, this notion had
undergone transformation as the creation of ASHA was viewed as an opportunity to persuade maternal health care seekers to consider family planning interventions. This was evidence of classic institutional reframing led by distorted diffusion of a policy norm from one level of government to the other. This was discussed by one maternal health right advocate:

If you look at how NRHM is formed, the common minimum program has a commitment to something that is couched in family planning and population control language, because they say we must have something sort of rigorous family planning program in 150 districts of poor performance, which then that gets raised to 219, but many of us objected to the population kind of logic. This was coming out of the ministry but from the Prime Minister’s Office (PMO) there was a conversation about getting a health assistant called the ASHA which was connected to debates around skilled / trained birth attendants and the related global discourse. When NRHM is formed, there are two concepts, one from PMO and one from ministry. Ministry one has strong family planning overtones, and the PMO one tramps! But the idea of ASHA was there because the family planning division’s concept note was full of population control; it was strongly opposed by us.

CSO#16’s comments were corroborated by many other respondents. According to seven maternal health right advocates from the various EAG states and Gujarat, the role of ASHA had transformed since its initial creation. Originally, the role was to accompany women at the community level to ensure they received the requisite maternal health care services and encouraged them to use institutional facilities for childbirth (including accompanying them to the health facility). This gradually changed as ASHAs were also “expected” to “talk women who already had couple of children into seeking permanent contraception and sterilization” (CSO#21). To that end, the ASHA was handed monthly targets to “bring women to health facilities” for sterilization operations and provided financial incentive for each women “in her care” who “registered for sterilization operations held at camps” (CSO#1). As one maternal health advocate from Bihar indicated:

ASHAs are supposed to talk women who already have couple of children into seeking permanent contraception and sterilization … she is handed monthly targets to bring women to health facilities for sterilization operations and provided financial incentive for
each women in her care who registered for sterilization operations held at camps” (CSO#9).

Another maternal health advocate from Gujarat made a similar observation, despite the state recording a decline in fertility levels:

Some of the women we have trained here from the community to become health workers have been encouraged by us to become link workers with the health department. Our whole thing is that we will train good people and let that philosophy permeate. But some of these women joined and left … they came back and the reason they offered was that they had never worked in an organization in a method, which was mindless! They said over there it was only about bringing women for contraceptive acceptance. Their supervisors did not care and told them they can fudge data but bring them, we need the names. So that thing is definitely there. There is very little understanding at the state level that when fertility rates begin to decrease there is no need to do this. Women desperately want contraceptives. They don’t have to do this coercive thing! If they just provide quality contraceptive services women will be more than happy and relieved! (CSO#21)

Several respondents noted that the launch of JSY and re-launch of other welfare schemes under the institutional framework of NRHM had been perceived by citizens from poor and marginalized background as welfare provision made available by the UPA government, thus pointing to the success of the government’s strategy to secure votes. One respondent observed:

JSY has given lot of political mileage to UPA government, the second UPA Government comes on back of NRHM, NREGA, ASHA. It has been a win-win situation for UPA. In the villages people say sarkar paisa deti hein humare bacche hone ke liye [government gives us money to have children]. See, in India, the cost of life is very low. So to make a connection that JSY has actually reduced my ability to negotiate life, that connection is very rare. You and I are making it through scientific calculation … but for the poor, 5 children are born, two do not survive, even after JSY two do not survive, except the only improvement being the money they now get from JSY. The improvement in terms of health care, that is the NRHM component, is not why they will vote; but the fact they are getting some money changes the dynamics” (CSO#16; emphasis added).

Citizenship theorists remind that rights and privileges granted to members of a political community are often accompanied by difficult obligations they must fulfill toward such community (Lister 1997; Yuval-Davis 1997). This logic is evident in the establishment of NRHM
and creation of multitude of welfare schemes including the JSY. The access to such welfare entitlements was conditional upon fulfilling difficult obligations of suspending/foregoing reproductive choice and rights to uphold the state’s objective of population stabilization. Effectively, access to maternal health care entitlements for the poor and vulnerable were made contingent upon willingness to sacrifice the privilege of reproductive choice available to other members of that political community who were not reliant on such entitlements.

*Women’s rights to maternal health in India: Birth of a Counter-Mobilization?*

In enquiring whether civil society respondents would characterize maternal health and human rights advocacy in India as evidence of collective action on maternal health in its early stages, sixteen maternal health right advocates self-identified the work of the maternal health and human rights coalitions as a “(social) movement”. The terms “social movement”, “grassroots movement”, “people’s movement” were widely used by WRAI in its published literature. Likewise, a member of NAMMHR who also identified as a member of the Indian feminist health movement of 1980s observed: “I would characterize NAMMHR as a movement … it has been only three years and it has a long way to go …” (CSO#12). One organizational member of NAMMHR had created grassroots groups with women leaders and community members called the Mahila Swasthya Adhikaar Manch (MSAM or Women’s Health Rights Forum) with chapters across the state of Uttar Pradesh and used the term “grassroots organizing” and “a unique movement” to refer to itself. Among CommonHealth members, those from sub-national states with well-functioning health systems did not use the term “movement” as per, but referred to the purpose of the coalition as “collectivization” and “aiding social mobilization”. In contrast, members of CommonHealth from states (such as Gujarat and Maharashtra) not so well functioning health system considered both NAMMHR and CommonHealth’s work to be origins
of a movement. These respondents viewed the human rights-based advocacy work surrounding maternal health to be an avenue of social change, although they hesitated to label it explicitly as such for they were highly cognizant of the very fragmented project-based ways (developed in response to funding priorities) that organizational members of the coalitions functioned.

However, four respondents including two maternal health right advocates, took issue with the maternal health and human rights advocacy being characterized as a social movement. One women’s health specialist expressed outrage on being asked whether maternal health and human rights advocacy was a new social movement within the broader feminist mobilization for women’s health in India. The respondent noted:

Why should there be social concern for maternal deaths? In whose head? The same poor people who are starving? I [as in non-poor women] am not suffering it. My kids are not dying? Why should I support a movement for maternal death reduction? Maternal mortality constitutes 2% of all female mortality! Must we look at everything from the gender category ... or is gender a way to subdue class and caste as a category? (AC#4; emphasis added)

Social inequities have been established to be major determinants of maternal health outcomes (Sanneving et al. 2013), so AC#4 and few other respondents with similar views might well be correct in outlining that maternal deaths were not only determined by gender. However, there seemed to be a lack of appreciation for the ways the various determinants combined to produce complex inequality that resulted in adverse maternal health outcomes (Johnson 2009). More importantly, however, the italicized expressions above indicated a dismissive attitude. The undertone of class privilege, in underestimating that some poor women may wish a safer child birth experience and that any mobilization involving the issue should be dismissed as cooption by funders and maternal health NGOs looking to cash-in on the opportunity presented by MDGs, was hard to miss. It pointed to a lack of solidarity and also an undertone of fear that by linking
maternal deaths to gender concerns, feminist might lose the political struggle for women’s health. Feminist scholars have cautioned against assuming female solidarity or even a single notion of women/mother-hood, underscoring the importance of recognizing the differences within (Cornwall, Harrison and Whitehead 2007). It would seem that AC#4 and others who held similar views failed to recognize this difference and the need for a political space and advocacy to articulate demands of fair and just treatment by the state (and health system). Indeed, one former women’s health activist argued that the notion of “advocacy projects” had gained stronghold among the changing women’s health movement in India and that “advocacy projects” did not represent the same level of political struggle witnessed in the first wave of feminist health movement in India (during 1980s). The respondent observed:

But within women's movement, the kind of movement I was part of in early 1980s, that character has changed! It is more and more institutionalized, so they take projects. So you don't hear the word agitation. Any meeting you sit where women's issues are getting discussed, I hear people say ‘we will do advocacy’. Do you get any sense of struggle in that term ‘advocacy’?” (CSO#12)

This judgment on CSO#12’s part on what constituted a “typical” political struggle and feminist resistance was perhaps insensitive to many other changing dynamics that had come to characterize feminist political struggle in developing countries (including India) with passing of time. Arguably, this was connected to the loss of momentum within women’s health movement in India in the post-NPP years. But as feminist scholars remind, feminist practitioners in developing countries are increasingly caught between donors for their survival and the state to gain a strategic entry in policy and planning discussions. Hence, they are constrained by having to design agendas and strategies that are sensitive to women’s everyday needs which can gain support from state and donors while also devising tactics that can advance strategic priorities (Rai 2008; Alvarez 2009; Hartcourt 2013). That is, taking to streets and organizing protest marches
that communicate agitation may not be adequate mobilization strategies in an era of institutionalization of feminist demands (even if selective). The availability of policy forums as political opportunity structures to engage with the state and undertake reframing therefore might have sparked a change in preference for strategies, which was also being influenced by access to mobilization resources (procedural knowledge, alliance building with institutional actors where possible, financial resources for research and capacity building) (Schon and Rein 1994; Joachim 2007).

According to four women’s/public health scholars, three former women’s rights activists, one health activist, one legal activist and eleven maternal health right advocates, there was a lot of confusion about the status of women’s health movement in India. They maintained, that unless they could pinpoint a cohesive movement for women’s health in India (which they could not), they could not comment on the relational dynamics of maternal health and human rights advocacy with such a movement (whether it was a fringe group within the movement, or sidelined, or a new extension and reconstruction of political discourse). One maternal health right advocate observed the lack of a single forum for women’s health struggle and pointed to its dilute nature. Here again, there was a tendency to compare with the circumstances that existed before, pointing to a lack of cognizance of how the development and social activism had changed in response to various endogenous and exogenous global and local forces. She observed:

I think the women’s [health] movement in India has lost the plot, I don’t know what they do these days. What are they unified for? Everything is Delhi centric, top down, nothing concerns grassroots voices or groups. Even with ICPD [International Conference on Population Development] review, everything is disjointed and detached. I don’t see the holistic focus on women’s health as a rights issue. No one is talking about women’s right to health. I am not aware of any national forum where these things get discussed. See, people are entering the development sector as a career rather than a cause, which has an impact on ideology and perceptions. If you see ICPD, the women’s right movement was able to bring the focus on sexual and reproductive health rights. It seems to me that the
development sector is now full of people who are running, may be not for-profit, but cost recovery clinic. The ideology is missing in that sense. I don’t think the ideology, as a piece of women’s right to health exists. I see that as a disconnect (CSO#24).

Three maternal health right advocates and one health activist, however, stressed the importance of recognizing that social movements by nature could be fragmented. Arguably, fragmentation was accelerated by NGOization and silos created due to it, but that it should not be seen as detrimental to advancing civil society efforts on women’s health. The health activist observed:

The women’s movement as such may be vibrant and takes up issues of gender based violence but if you look at the women and health movement, then there are different kinds of sub-groups. One way of looking at it is that it is completely fragmented; the other way of looking at it is that many different kinds of issues are emerging. If you look at 2007 Charter of demands, by the women and health group (it’s published by Masoom), it is extremely comprehensive and raises issues of women and health movement and it goes beyond the sexual and reproductive health to address work and occupational health. It also looks at trans-gender, at sex workers, and mental health. The 2007 charter gives you a sense of what the women and health movement is looking to do. So I wouldn’t say it’s fragmented; yes, there are different kinds of groups who have come forward and they are all looking at health rights. But, where did we have that kind of articulation before? Do we call it fragmentation or do we say that a group has joined a women and health movement? Where was the LGBTQ group earlier, as far as right to health was concerned? But today there is a certain articulation and they are demanding certain rights. You have disabled women and there are groups looking at disability and health rights of women. The women and health movement are now even looking at ARTs. Would you call that fragmentation or groups which are looking at specific issues infringing on women’s right to health? I see it as strength. You will not find a common leadership but it’s a coalition of different groups taking a lead on different issues (CSO#23).

In a nutshell, the women’s health movement in India had evolved to articulate various locally originating right to health claims of excluded and marginalized social groups. Be that as may be, the issue of maternal morbidity and mortality (or for that matter, maternal health) did not feature anywhere in the Indian Women’s Health Charter published in 2007 (which CSO#23 referred to) adopted following a National Dialogue on Women’s Health and Development (although it featured demands that if fulfilled would stand to impact maternal health outcomes).
Likewise, the issue of maternal health was only mentioned in passing by the All India Democratic Women’s Association - a major civil society collective on women’s rights issue (and especially for rights of women from minority background, such as Dalits, Adivasis, Muslims) - in its document titled *Critical Issues in Health Policy* (2007). But this mention was in relation to how focus on maternal health was used by the state to “narrow, trivialize, then neglect women’s health” which was most likely a reflection of the popular global and local critique aimed at political prioritization of maternal mortality. In other words, maternal health and human rights advocacy was still largely a peripheral group within the women’s health movement.

Neither did the issue feature in the agenda of PHM, which three former women’s health activists, two health activists, two women’s/public health specialists and two maternal health right advocates argued also had its own challenges of sustaining itself. In conversation with two members of the PHM, the respondents pointed to the challenges they had faced in keeping the struggle for social movement for health alive in India. Unlike in Latin America (especially Brazil, Costa Rica, Chile), where social movement for health had originated as early as colonial times, in India it had failed due to the inherent social hierarchy that undermined solidarity and collectivization.

But, India or South Asia, for that matter, has particularly been absent from health activism. Somehow health has never been a political issue. Even if you look at various struggles, the freedom movement, and later, how many struggles can really be identified around health? Almost none! Look at history of Europe, the sanitary movements, see Latin America, health is part of the people’s struggle. But you don’t see that happening in India. One of the things is that public health requires solidarity to survive, because it is distinct from private health. Because public health is not enough for me to work alone. I can do everything right, but still be vulnerable. So health is called a public good because

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87 Very interestingly all countries where health rights litigation has gained much prominence and litigation has resulted in some improvements in health equity for the population (see Yamin and Gloppen 2011).
it has externalities that are much beyond just what an individual can do. In India, this solidarity has been disrupted for 2000 years by a caste divided society - I will throw my garbage on the street and the lower caste will come and clean it. Not literally but that's the mentality. Hence, health becomes an individual issue and not a collective issue. Therefore, it is not a movement. That is somehow the mentality (CSO#3).

CSO#3 and #12 – both long time members of the PHM with the latter engaged in maternal health advocacy as well – also maintained that health had failed to emerge as a political issue, unlike in Britain, Canada and Scandinavian Countries (examples provided by respondents) where health and health care politics was part of the national social-political fabric. Historically, health was never a priority for the state, which was unusual given the ambition to establish a socialist welfare based centrally planned state in the immediate aftermath of independence. But several respondents stressed that health was never a concern of the Indian middle class, reminding that the state’s zeal to stabilize population for purposes of development had led officials to equate health with family planning. This had led the poor who were victims of coercive family planning measures and came to equate public health facilities with sterilization centers. In fact, they argued that the emergence of a national political discourse surrounding health, especially the universal health coverage, was an outcome of growing recognition of unaffordable health care expenses among the middle class population. This cognizance was unanimous among all sixty-two respondents who participated in this study, and especially among the ten state officials who argued that lack of political consciousness surrounding health among the Indian middle class was a reason why politicians have never paid attention to it until late 2000s. Civil society respondents, on the other hand, maintained that “the middle class had abandoned” (the term “abandoned” was argued, indirect pressures of family planning also existed for the rest of the population since it was part of the national consciousness based on the barrage of public awareness campaigns that bombarded nationalized television channels during the 1980s and 1990s and the public hoardings stressing the importance of small families by popularizing “Hum Do Humare Do” (Two of us, and two of our’s) (Rao 2004; Qadeer 2002; Mukherjee 2002).
raised was used to refer to this issue to at least once in all interviews) the public health system starting in early 1980s which allowed the state to systematically starve the public health system of resources, leaving the state no choice but to eventually turn to the private sector to operationalize universal health coverage. The point being, that there were historical challenges of raising social consciousness for maternal health concerns of some women, which did not find a home either in the women’s health movement or in the broader health movement that were in themselves weak and fragmented due to factors originating in global and local context. Arguably, these point to the political and historical complexities in which collectivization for women’s rights to maternal health was taking place in India. That said, there were still discursive challenges on the end of “human rights” that should be addressed by both maternal health right advocate and women’s health activists to ensure that the use of the idea does not hinder different women’s health groups from collaborating with each other and underscoring the ways the challenges facing them were different manifestations of a common problem (gender injustices).

Women’s Rights, Reproduction and Human Rights: Towards Discourse Reconstruction

According to five academics (women’s/public health, health system, human rights), donor preferences to selectively fund some women’s health issues while also promoting “rights-based advocacy” among those groups was further accentuating this fragmentation that was a historical and political derivative in the Indian context. It was leading to competition and conflict which prevented the formation of a collective that could mount an appropriate resistance to state policies and activities that contributed to or sustained gender injustices in health. Since the language of human rights could not be abandoned for fear of politicization, appropriation or
cooptation and the need for donor funding would not disappear at least in the near term, these respondents emphasized the vitality of cohesive and collective thinking around human rights framework. One respondent argued greater need to consider methodologies for human rights discourse construction, where different issues could be discussed on a spectrum of rights without those rights articulations competing or conflicting within themselves. The respondent observed:

Within the reproductive rights agenda, there is adolescent sexuality, reproduction, maternal health, abortion, sexually transmitted infection, HIV etc. but methodologies can be used so that we are only talking about one issue rather than these separately. I feel this is happening because of the MDGs and the funding which has a fragmented approach. Funding is there for specific issues, such as maternal health and gender equity but there is nothing else. There is some for sexually transmitted infections and HIV but then where is abortion, where is sexuality, where is adolescent reproductive health? Where is child marriage? It is sitting in forms of different pots of money and different goals so it is also leading to more fragmentation than collectivization. Fragmentation is not the issue because everyone cannot work on the same thing. But then, who is the repository that really converts this into rights-based approached for reproductive health? There is no champion organization here [on the issue in India], at least I have not found any in the last ten years that I have been working here” (AC#7).

Some critics of human rights in development have raised concerns over methodological implications pointing to the diverse definitions and strategies used by civil society groups, that lead to challenges of comparing the character of such activities and their wider outcomes including whether the adoption of rights-based approaches alone were responsible for progressive outcomes (Gready 2008; Mohan and Holland 2001). AC#7’s observation, which were also articulated by four other respondents point to some of these challenges. AC#1 raised the issue of distinguishing between evidence based advocacy that could be used to underscore violation of rights, versus rights-based advocacy. This respondent observed:

There are different efforts, but they do not add up to a systematic approach which one defines. I would like to ask these groups [maternal health NGOs] what is rights-based? What is rights-based advocacy? Within our Indian policy context, what would it mean and
I don’t mean just systematic delivery of CCTs like JSY. Then focus on specific issues that can be taken up on strategic basis, such as abortion and child marriage for next three years, something else in the following three years. So be systematic.

See the other concern is rights-based advocacy and evidence-based advocacy. So the two often do not connect because the evidence may not have been collected with a comprehensive theoretical rights framework in mind. We did an operational research study where we found that it could be provided by mid level providers and you take that to government resulting in advocating for decentralization of abortion service provision. That will help women get better access and will affect maternal mortality reduction efforts. But that is not been seen within the context of rights. The organizations who are doing that research are not conceptualizing their work within a rights-based approach.

RBA gets interpreted differently by different people … so you don’t have one kind of universe of knowledge and understanding under which all of us are operating. I may say my work is rights focused, someone else may say it is equity focused, someone else may say it is accountability focused. So we are creating different nomenclatures for one thing (AC#1).

On enquiring about possible alternatives to the human rights framework, given its various criticisms mentioned by some respondents (mainly academic or issue specialists), three scholars specializing in women’s health and public/population health argued for consideration of the equity frame. To be clear, these respondents did not argue that the state should not be held accountable by civil society for failing to prevent maternal deaths and/or improve overall maternal health outcomes. They also did not argue for abandoning the rights framework, which they maintained had its own analytical and normative strengths. But they maintained that there were several challenges associated with the human rights framework of which state intolerance for human rights (discussed in previous sub-section) was but one and likely the more extreme one. From a practical and policy design perspective, they argued that the human rights framework was rather deficient because it failed to capture the violence of poverty and structural inequality that shaped the everyday lives of the poor. One respondent, a specialist in women’s health argued:
You see equity is essentially talking about mitigating unfair inequalities. In the [human] rights framework, there is a lot of confusion about how you formulate it. I would start from the other end which is that there are inequalities and how can we look at those inequalities. Do you see them as variations across individuals or do you look at them as structural inequalities and tied to that is the whole notion of violence at the various levels of these inequalities of human lives? You cannot just talk about the poor which is completely taking them out of the structure, which perpetuates the inequalities they face. Anthropologists have written about this, the notion of violence of the state that denies and perpetuates inequalities, where they try to complement the macro with the micro instead of looking at them in isolation (AC#8).

Indeed, as indicated earlier anthropologist Akhil Gupta (2012) has raised the issue of “violence of poverty in India” (6) arguing for the need to juxtapose the macro politics of state capacity with the micro politics of practices of institutionalized structural violence. Similarly, Paul Farmer (2003) has underscored the ways adverse health outcomes of the impoverished and disempowered at the community level in poor countries cannot be untied from the collaborations between capitalist forces situated in both global and local contexts. Farmer maintains that determinants of adverse health outcomes arising from the production and reproduction of inequality by local and global actors and groups interested in capital accumulation, may seem far removed from the immediate context and therefore external to their sphere of influence. In other words, unless a major overhaul of existing state policies can be engineered to restore some sense of a genuine welfare state, a human rights framework to demand state accountability may be inadequate to advance reproductive justice (although likely beneficial for some actors who gather moral legitimacy from such rights speak).

Similar sentiment as above was articulated by two other respondents, although they assumed much more nuanced position about the shortcomings of the human rights framework, including its methodological challenges. One participant argued that the “rights framework” had greater currency as a conceptual framework, rather than one that can be easily operationalized.
This respondent, a public health specialist, maintained that the rights framework was rather an ideological statement, which was open to debate. Furthermore, it was difficult to assign indicators and monitor achievement of policy goals from a rights perspective. She observed:

I think the rights framework has conceptual merit. I do not think it has operational merit. I think conceptually everyone should understand and believe and have an ideology. Believing in equity or fairness is fine but how do you operationalize a rights framework? I think it is easier for me to operationalize an equity framework than operationalizing rights. I can define equitable access, I can even monitor it, I can have indicators, but I do not know what are my indicators for rights? Consider laws, do you believe in it, do you think it is important that the country has a law or do you believe that women have access to what is promised in the law? Laws are attitudinal statements about something. So how do you do it? If you are really going to operationalize right as access, then let’s do equitable access because it is easier to talk about. I think we need to relate them and we do not need to in opposition to each other. It does not have to be that either I talk about rights, or I talk about access. They are related. To me, rights is an overall understanding and within that there is an operational way in which access gets mediated (AC#2).

AC#2’s observations about not de-linking the rights framework and the equity framework, but rather viewing them as complementary, also received currency with another public health specialist. This respondent pointed to two specific issues connecting public health outcomes to rights and equity frameworks. First, the respondent maintained that the dominant disciplinary paradigm within public health viewed health of a population as collective but this was a shortcoming because it would essentialize the health of all members of that population (within a specific geographical boundaries) without taking into consideration how identities such as gender, class and caste affected their individual health outcomes. This would underline the importance of individual power. However, viewing individual power through the lens of individual rights popularized by the notion of universal human rights did not lend itself to the collective experiences (for example, shared economic and social experience) of a particular population that were historically determined (for example, the Dalits or Adivasis who had been
historically underprivileged although there were class and gender differences within those groups). Therefore, to capture the dynamics of differences within individual (say gender-based), that is “individual heterogeneity” and their experiences as part of a broader political community (Dalits versus Non-Dalits), a different framework – the citizenship framework - was required.

This was the second argument presented by the respondent. The respondent observed:

So when you talk about human rights, are you talking about it from a collective perspective, can you talk about it from a collective perspective? … It goes back to the entire discourse on the notions of citizenship. I feel increasingly be it universal health coverage or reproductive health care, it is increasingly the notion of human rights that is privileged. It is very important for a free market ideology to have an individualized notion of human rights …

[Interviewer: Can you elaborate further? I am not sure I understand.]

Ok. Let me use an analogy from public health. Public health is about population health, we look at collectives as aggregates of individuals, right? In the dominant paradigm, individual health affects collective health but if we look at another less dominant strand of public health, collective health brings in what I alluded to earlier. We look at populations not just as aggregates of individual but as having shared social and economic experiences. So we use concepts such as caste, class and gender and the intersections of these. But that is not there in the other viewpoint [the dominant paradigm]. Those [caste, class, and gender] just become variables. So there is no theoretical understanding of how you look at collectives and collective experiences. In classic public health teaching you say community is an aggregate of individuals living in a geographical area sharing common characteristics … that is the dominant paradigm in public health. But that is a very simplistic understanding because no community in that sense is homogeneous and if you want to look at heterogeneity you can look at individual heterogeneity … basically largely some social characters. But here we are dealing with power relations and historically how power relations have been defined. Therefore, concepts like caste, class and gender become very important. So somewhere individual rights also affect collective rights. Then you need to look at ways that social groupings actually happen and how they are negotiated with power. Then we bring in power authority as an analytical tool to understand collectivity … how do you conceptualize collectivity, what is the dominant paradigm? Citizenship, right? So that’s the internal logic (AC#3).
AC#3’s comments above are in line with a number of arguments made by citizenship theorists (including feminist theorists) who point to the gap in formal and substantive equality enjoyed by women and members of marginalized social groups (such as Dalits and Adivasis) (despite constitutional guarantees of equality). The centrality of conceptualizing adverse maternal health outcomes as reproductive injustices experienced by poor and marginalized female citizens with “limited membership rights and capabilities”, especially “constrained citizenship rights in the state, for instance or circumscribed roles in the family and community” Goetz 2007, 23) has already been underlined. To that effect, George, Iyer and Sen (2005) have underscored the significance of “inclusive citizenship” in examining the high maternal mortality among women in select communities of Koppal district in Karnataka in southern India (a state with an MMR below the national average). Arjan de Haan (2008) has underscored the importance of inclusive social policy making with respect to caste and the role of state institutions, underlining the significance of considering the deliberate role of exclusionary institutional practices in human rights-based poverty analysis. Perhaps, there is an opportunity to reconsider how the rights frame can be recast that would allow one to consider how exclusionary citizenship status plays into the politics maternal morbidity and mortality.

At the same time, while none of the above respondents explicitly pointed to the notion of reproductive justice, it was difficult to ignore how conversations with some of the respondents discussed in this section pointed to the need to consider such a framework which can accommodate reproductive choice and rights but also health and other social disadvantages (inequities) experienced by some women in relation to reproduction, such as maternal health. The reproductive justice framework, coined originally in the United States by feminist activists who identified as “women of color” (that is, the non dominant women’s groups similar to some
advocating for maternal health in India) and subsequently adopted at the 1994 ICPD Conference in Cairo, emphasized overall reproductive health and wellbeing and was (Ross/SisterSong 2000).

**Conclusion**

Based on the findings discussed in this chapter three main insights emerge about the dynamics of mobilizing political support for reproductive justice, using the human rights language, in India. The first constitutes the challenges associated with engaging with the health system as a state institution. There are primarily two barriers to be overcome by maternal health right advocates – gender sensitizing the health system and transforming its attitude from needs and/or welfare-based to rights-based. Maternal health right advocates may be able to generate rights consciousness among passive rights holders by educating them about claims to welfare entitlements. They may also use political opportunity structures such as creation of NRHM and JSY to conceptualize accountability. But such political and resource commitments at the end of the state are reflective of a needs- and/or welfare-based frame of development, rather than rights-based. Therefore, maternal health right advocates face the uphill task of influencing health officials and policy makers – and by extension, the state – to reflect on human rights frames and recognize their duty bearer role. In essence, in the given context where the policy frame is not rights-centric and the institution is not rights-based, persuading institutional actors to reflect on the rights frame is a difficult challenge to overcome. At the same time, there are several downsides of using the rights language for they stand to be appropriated and sometimes even coopted to advance state interests, which are hardly substantial to the progressive feminist health agenda. A final downside of using a right-based approach to advocacy may be antagonizing the state to the point of pushback and reprisal. It is not that the state should not be held accountable to delivering the policy promises it makes and doing so in a quality manner. Rather, the argument
is that poor health system capacity and governance may hinder effective delivery of quality service provisions. Arguably, a state, which cannot deliver on policy promises, should not be making such commitment (and certainly not politicizing them). But such an argument would lead to policy stalemate. On this front, there is room for collaboration between maternal health right advocates and the health system, albeit there are aforementioned challenges to be considered (and carefully maneuvered through). That said, it is important for maternal health right advocates to reflect on the significance of buy-in from institutional actors within the health system for making slow but incremental progress rather than being entirely excluded from influencing the process for achievement of long-term, sustainable improvements at the grassroots level (presuming that is the goal of reframing).

Second, there are numerous concerns related to discursive use of human rights that prevent solidarity formation within the women’s health and broader women’s movement in India. They are counterproductive to reforming the state and advancing the feminist agenda (including feminist health). The politicization of human rights language in the development discourse by various actors in the development establishment may sideline locally originating grassroots human rights claims as an expression of globally formulated donor driven agenda. Likewise, the politicization of human rights language in the women’s reproductive health discourse can also lead to exclusion of maternal health claims by (some) local women’s health advocates, since they are seen as pro-natal and therefore anti-feminist. But it is important to be cognizant of the ways the state can politicize maternal health claims – that may apparently seem depoliticized and narrow – to advance an anti-natal agenda because it is useful to its economic development goals. This anti-natal agenda is equally anti-feminist and oppressive. Cooptation of maternal health claims by the state can also take form of advancing other political agendas, which reveal the politicization of welfare benefits to secure support from poorest constituents who are considered
deserving because of their ability to participate in the electoral process as citizens. Additionally, the language of reproductive choice and rights is further politicized and appropriated by private interests (individual, collective, corporate) in a context characterized by prevalence of deep gender bias and deregulated health care system to pursue goals that are also essentially anti-women. This further complicates the discourse of reproductive choice and rights and articulation of a consistent message (instead, perpetuating competing and conflicting ones).

Third and final, it is necessary to consider discourse reconstruction linking women’s health and human rights given the state-civil society dynamics surrounding women’s rights, human rights, and reproduction related claims outlined above. The suggestion is not to abandon the human rights framework for it has its own strengths and significance. But to realize its shortcomings, especially from a practical perspective and its tendency to essentialize rights claimants without appreciation of their differences and experiences of inequality – both as individuals and as a collective. An alternative may be to consider the reproductive justice frame (as opposed to reproductive choice and rights) that advances the goal of overall reproductive health and wellbeing which can be sensitive to gender inequalities and inequities. There may be room for convergence of the reproductive justice and citizenship frames, since such inequalities and inequities stem from differences in and within citizenship status of women in both public and private spheres. This can allow articulation of (citizenship) rights claims embedded in the historical, political and social distinctiveness of contexts in which (unique) struggles for reproductive justice unfold. This will be necessary in light of the frame disputes that polarize the discourse and present challenges for reframing as demonstrated in the next two chapters (chapters 7 and 8), which examine and compare the specific political dynamics of different frames and framings strategies (lobbying and strategic litigation) used by maternal health right advocates in India.
Chapter 7: Comparative Analysis of Framing Dynamics of Indian Maternal Health and Human Rights Advocacy Coalitions

The findings and discussion reported in this chapter reveal the various political dimensions of the framing dynamics (comprised of contextual realities, frames, political opportunity structures and mobilization strategies, articulation of rights and injustices, and any frame disputes) of maternal health and human rights advocacy coalitions (or simply coalitions) in India. Specifically, the chapter compares the human rights frames of women’s rights to maternal health used by three prominent coalitions in India – the National Alliance for Maternal Mortality and Human Rights (NAMMHR), the Coalition for Maternal-Neonatal Health and Safe Abortion (or CommonHealth), and the White Ribbon Alliance for Safe Motherhood, India (WRAI). These coalitions constitute of many NGOs, each working independently to improve maternal health in different areas and/or state of India.

The organization of the findings takes into consideration four different factors: (1) contextual realities; (2) policy positions (including diagnostic and prognostic elements); (3) political opportunity structures and framing strategies used; and (4) articulation of rights and injustices. Contextual realities, further, take into consideration various indicators (most recent available) related to (a) gender (MMR, anemia status, female literacy rate, total fertility rate and gender empowerments measures); (b) shortfall of rural health infrastructure proportionate to population; and (c) density of social groups and history of social hierarchy, especially caste-based discrimination. Gender empowerment measure (GEM) index, produced by UNDP in 2009 takes into consideration indices of political participation and decision-making power, economic participation and decision making power and power over economic resources. A table providing
state-wise (covering the states under the three coalitions) data on these indicators is included in
the preliminary section of this chapter. Furthermore, each frame begins by providing a brief
description of the background of the coalition (time of establishment, hub of operation,
distinctive characteristics of members of steering committee). Additionally, the researcher also
reports any findings and observations about participant’s ability to reflect on other frames or any
frame disputes that emerged during the interviews.

Data sources for findings reported in this chapter are comprised of key informant
interviews conducted with the coordinator and select high-level members of steering committee
of each coalition and analysis (both content and textual) of advocacy documents such as
pamphlets, brochures, booklets, newsletter, official web resources published by these coalitions.
The chapter first presents the frames of the three coalitions, organized in chronological order
based on year of establishment. This is followed by a discussion that compares and contrasts the
three frames and examines them against the debates in the scholarly literature on maternal health
and human rights. The conclusion pinpoints the empirical and theoretical significance of the
findings to the literature.
Table 1: State-wise Summary of Key Indicators

<table>
<thead>
<tr>
<th>State/Union Territory by Geographical Area</th>
<th>Gender indicators</th>
<th>Shortfall of Health Infrastructure proportionate to population (Union MoHFW 2014)</th>
<th>Density of Social Groups (Census 2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gender indicators</td>
<td>% of Scheduled Castes or Dalits (share of total population)</td>
<td>% of Scheduled Tribes or Adivasis (share of total population)</td>
</tr>
<tr>
<td></td>
<td>MMR (2010-2012)</td>
<td>Anemia Status (% of female population of child bearing age) as per NFHS 3 (2005-06)</td>
<td>Female Literacy Rate (Census 2011)</td>
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<tr>
<td>ALL INDIA</td>
<td>178</td>
<td>55.3</td>
<td>65.4</td>
</tr>
<tr>
<td>North and Central</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Bihar</td>
<td>219</td>
<td>67.4</td>
<td>51.5</td>
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<tr>
<td>Chhattisgarh</td>
<td>230</td>
<td>57.5</td>
<td>60.2</td>
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<tr>
<td>Delhi</td>
<td>NA</td>
<td>44.3</td>
<td>80.7</td>
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<tr>
<td>Jharkhand</td>
<td>219</td>
<td>69.5</td>
<td>55.4</td>
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<td>Haryana</td>
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<td>56.1</td>
<td>65.9</td>
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<tr>
<td>Madhya Pradesh</td>
<td>230</td>
<td>56</td>
<td>59.2</td>
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<tr>
<td>Rajasthan</td>
<td>255</td>
<td>53.1</td>
<td>52.1</td>
</tr>
<tr>
<td>Uttar Pradesh (including Uttarkhand)</td>
<td>292</td>
<td>52.5</td>
<td>57.1</td>
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<tr>
<td>East</td>
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<td></td>
<td></td>
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<tr>
<td>Assam</td>
<td>328</td>
<td>69.5</td>
<td>66.2</td>
</tr>
<tr>
<td>Odisha</td>
<td>235</td>
<td>61.2</td>
<td>64</td>
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<tr>
<td>West Bengal</td>
<td>117</td>
<td>63.2</td>
<td>70.5</td>
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<tr>
<td>State/Union Territory by Geographical Area</td>
<td>Gender indicators</td>
<td>Shortfall of Health Infrastructure proportionate to population (Union MoHFW 2014)</td>
<td>Density of Social Groups (Census 2011)</td>
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<tr>
<td></td>
<td></td>
<td>Sub-centre Shortfall</td>
<td>Primary Health Centre (PHCs) Shortfall</td>
</tr>
<tr>
<td><strong>West</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Gujarat</td>
<td>122</td>
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<td>Maharashtra</td>
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<td>75.8</td>
<td>1.8</td>
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<tr>
<td><strong>South</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Andhra Pradesh</td>
<td>110</td>
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<td>Karnataka</td>
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<td>1.9</td>
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<tr>
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<tr>
<td>Tamil Nadu</td>
<td>90</td>
<td>73.4</td>
<td>1.7</td>
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Coalition 1: White Ribbon Alliance for Safe Motherhood, India (WRAI)

The WRAI is the Indian chapter of the global White Ribbon Alliance group. It was founded in New Delhi in partnership with Centre for Development and Population Activities (CEDPA) in 1999. WRAI has a strong and well-developed presence in five states in India - Madhya Pradesh (MMR: 230), Rajasthan (MMR: 255), Orissa (MMR: 235), Maharashtra (MMR: 87), and Andhra Pradesh (MMR: 110) (Registrar General of India 2013). WRAI was also the coalition with the largest individual and organizational membership (1600 community organizations) including being the only coalition to have professional lobby groups (such as Trained Nurses Association of India and more importantly the Federation of Obstetrics and Gynecologists Society of India).

Contextual Realities: It is noteworthy that the first three of the five states (mentioned above) where WRAI functions have MMRs, higher than the national average (MMR:212) (Registrar General of India 2013, 11-12). These three states are also members of the socioeconomically backward states or Empowered Action Group (EAG) of states, termed so by the Central Government because of the wide disparities in socioeconomic development in relation to the rest of the country. According to the Union MoHFW, Madhya Pradesh, Rajasthan, Orissa and Maharashtra face severe shortage of health infrastructure, especially sub-centres (first contact point with ANMs, responsible for health communication), PHCs and also lack of CHCs (a referral unit for 4 PHCs) (National Health Mission 2013). However, both Maharashtra and Andhra Pradesh have MMRs lower than national average. Andhra Pradesh is the only state that the National Health Mission reports as having a surplus of sub-centres for the proportion of
population in the state. But it also suffers from lack of PHCs and CHCs. Percentage of literate women in these states range from 48.4 to 62.9 with Maharashtra having the lowest and Andhra Pradesh the highest proportion of female literate population (the national average being 55.3%) (Census Commissioner 2011). In comparison to the national total fertility rate or TFR (2.4), the TFR in Madhya Pradesh and Rajasthan are 2.9. TFR in Maharashtra and Andhra Pradesh are 1.8, while in Orissa it is 2.1 (Ibid.). Where as the national Gender Empowerment Measure or GEM (a composite index of political and economic participation and decision making, and index of power over economic resources) is 0.497, in Madhya Pradesh, Orissa and Rajasthan it is 0.463, 0.393 and 0.442 respectively, that is lower than national GEM. In contrast, Andhra Pradesh and Maharashtra have GEMs of 0.547 and 0.516, both of which are higher than the national GEM (MoWCD 2009). Furthermore, Madhya Pradesh and Rajasthan have significant Adivasi population (respectively, 22 and 23.6 percent of entire state population), although the percentage of Adivasi population in Rajasthan was 13 percent and less than 10 percent in Orissa and Maharashtra (Ministry of Tribal Affairs 2013, 121). Similarly, the Dalit population (only Scheduled Castes and not Other Backward Classes or OBCs) as percentage of total population was highest in Andhra Pradesh (19.8) followed closely by Rajasthan (19.2), Orissa (18.9), Madhya Pradesh (17.6), and Maharashtra (13.1) (Census Commissioner 2011). It is worth mentioning that Mumbai, India’s commercial capital, and Hyderabad, one of India’s information technology hub are respectively located in Maharashtra and Andhra Pradesh which are major contributors to the high economic growth and state GDP performance.

**Policy Position:** According to the national coordinator and other long-term members of sub-national chapters of WRAI, their primary goal was to prevent maternal deaths by “ensur[ing]
government policies are reaching their target populations” (Motihar and Gogoi 2009, 20). The national coordinator observed: “government has the plans and policies to prevent [maternal and child] deaths, but what we need is their proper implementation” (CSO#11; emphasis added). According to WRAI, the cause of preventable maternal deaths rested with poor implementation of government promised policies and program, especially lack of timely provision of quality health care service (including denial). Therefore, responsibility to remedy this gap (between policy design and policy implementation) rested with local government officials, both health and medical officials in the broader community surrounding the “target population”. However, WRAI also attributed poor provision and quality of maternal health care services to lack of rights-consciousness among women seeking them. The National Coordinator of WRAI emphasized the significance of rights conscious individuals (especially, women in poor and marginalized community) as health care seekers who can “demand” their “entitlements” (quality maternal health care services) as promised in government policy (CSO#11).

**Political Opportunity Structures and Framing Strategies:** WRAI’s framing strategy included both lobbying the Central Government at the national level to affect (maternal health) policy change and working with elected representatives at the local level to improve grievance redressal practices with implications for policy implementation. WRAI had successfully lobbied the Indian government to declare a National Safe Motherhood Day (on April 11) in 2001. Most of WRAI’s engagement with the Central Government (policy makers and program planners) was through provision of technical guidance and support. For example, the alliance had provided a “compendium of evidence based best practices” to the government as a technical resource for program design in early 2000s (Motihar and Gogoi 2009, 8). As well, WRAI had successfully
advocated for policy change at the national level that allowed Auxiliary Nurse Midwives (ANMs) and nurses in India to administer emergency medical interventions (misoprostol, oxytocin, antibiotics) (Ibid.; CEDPA India 2013, 15; CSO#11). It had also worked with the health ministry at the Central level to develop technical guidelines for “Skilled Attendance at Birth for ANMs” and “Quality Assurance for healthcare facilities” (Ibid.). That is, it engaged with the Union Ministry of Health and Family Welfare and NRHM (both executive policy forums at the national level) and Member of State Legislative Assemblies or MLAs (legislative policy forum at the sub-national level). It is noteworthy that during key informant interviews with state actors – especially technocrats and bureaucrats with NRHM – respondents referred to WRAI and its national coordinator (on a first name basis). They regarded (with respect) her as a “technical specialist/expert” (emphasis added) and had relatively more knowledge of the type of WRAI’s grass roots activities than any of the other maternal health coalitions. This is most likely because WRAI had existed for nearly thirteen years, the longest in comparison to others, at the time of field research and also because of the close collaboration with Union health officials on technical elements of policy design and implementation.

As well, members (both individual and organizational) of WRAI worked extensively at the grassroots level “mobilizing communities for accountability” (Ibid., 9). This involved organizing public hearings before senior health officials and community based monitoring (“social audits” such as devising checklists for assessing health facility preparedness/ availability of services, community score cards on assessing quality of health care services) activities (CSO# 11, 12). The public hearings, according to the respondents, offered local women a collective forum to outline their individual concerns, identify services that were missing and/or not appropriately provided when they had been to those health care facilities. Additionally,
grassroots members of WRAI conducted verbal autopsies (through conversation with family members, neighbors) in case of maternal deaths (to count maternal deaths, establish a causal chain and identify the source of death that can complement a medical autopsy).

To raise awareness among women at the community level, members of WRAI underscored the importance of “demystify[ing] government procedures, policies, programs, rights and entitlements” and “work[ing] with communities around ensuring entitlements [were clearly understood]” (CEDPA and WRAI 2013, 13). This literally translated into educating local women on the number of pre and post natal check ups, iron tablets, frequency of blood tests (to check for anemia), the sum of money during institutional birth, they were entitled to. According to the national coordinator of WRAI, this approach to raising rights consciousness to therefore be able to demand such services at health care facilities was rooted in the notion of “seeking social accountability for maternal health” (CSO#11). She explained this concept as “mobilization of communities to voice their concerns and assert their right to accessible health services in the face of the social and systemic barriers undermining health” (Papp, Gogoi and Campbell 2013, 3; CSO# 11). One research participant observed:

The perfect way to build the empowered women is to expand their agency where they will take to the streets, and ask for their own rights. But in reality it does not happen! It is quite a romantic notion. So to make that happen, to push it toward this point, we need to work with intermediaries. It is really unreasonable to expect a woman to stand up and question a Chief Medical Officer or a District Magistrate. So we created this alliance as the intermediary, which leverages its strength to bring the concerned parties to the forum to facilitate a dialogue. Our main aim was to create a public place where women feel it is safe to come together and talk about their experience, express their grievances, plus they get a forum to legitimately raise questions (CSO#12; emphasis added).

Furthermore, WRAI also had the most extensive media advocacy strategy of the three coalitions studied, which was used to build/raise awareness within and beyond the community
and used as a strategy to follow up with health officials in the aftermath of public hearing organization. Other advocacy strategies of WRAI had also included generating public awareness of the issue by engaging celebrities as cause-champions and establishing a national award for government health workers. In a publication titled “Catalysing Collective Action for Saving Women’s Lives” created to celebrate its ten-year anniversary in India, WRAI claimed its “success has been the use of social mobilization to build a movement” (Motihar and Gogoi 2009, 7; emphasis added). Of the three coalitions studied during field research, WRAI had the longest and most extensive engagement with the Indian government.

The national coordinator of WRAI and a few staff members of CEDPA (the organization that hosts the secretariat of WRAI) were present in all three state-civil society consultations on maternal health (but not in the capacity building sessions for local CSOs). However, they spoke rarely except in one occasion at the ARROW and WHO South Asia organized “Accountability: Raising the Issues of Maternal Deaths in South Asia” held in New Delhi on October 15, 2012. The national coordinator mentioned to fellow respondents (maternal health advocates) during a discussion with WHO officials and UN Special Rapporteur for Right to Health, that she had received both verbal “warning” and written communication from the Union Ministry of Health and Family Welfare about WRAI being “too critical” of the government.

Articulation of Rights and Injustice(s): The only explicit human rights articulation present in WRAI’s advocacy document read: “the White Ribbon Alliance advocates for Safe Motherhood as a human right” (Motihar and Gogoi 2009, 14). This articulation (“Safe Motherhood is a Human Right”) was consistent throughout all communication material and there was no further disaggregation of this articulation into right to life, right to health, right to food, women’s rights
and such. That is, the denial of maternal health care services as promised in government policy constituted the injustice, which could be remedied by ensuring local health and medical officers (the duty bearers) were fulfilling their responsibilities when rights claimants (the local pregnant and parturient women) needed and/or wanted to access them.

**Possible Sources of Frame Dispute:** Based on researcher’s observation, members of WRAI seemed to be cordial with their counter parts from NAMMHR but there did not seem to be conversations during breaks or before and after the day-long sessions (especially since there were lengthy side-conversations between WRAI’s national coordinator and the head of the Federation of Obstetrics and Gynecologists Society of India and WHO country officials).

Barring these exchanges, references to WRAI’s activities spontaneously arose during key informant interviews with members of NAMMHR who commented on their discomfort at WRAI’s close working relationship with the government (particularly receiving financial support for technical guidance work). Upon probing, NAMMHR members expressed their concern as “not sure why they digressed into technical assistance work” (CSO#16) making a number of insinuations which may have led WRAI to commit such an act. These ranged from weakening its legitimacy by not focusing on the source of the problem (maternal death), experiencing insufficient flow of financial resources, and seeming to be “too” close to the government.

Similarly, another research participant of NAMMHR took issue with WRAI’s activities related to the government’s declaration of National Safe Motherhood Day arguing that it was essentially a “cop-out strategy that governments love to take to show symbolic support while doing nothing concrete!” (CSO#2). A similar attitude was articulated by another respondent and a member of NAMMHR, from one of the states in which WRAI existed. This respondent indicated:
If I want safe motherhood, the Government of India after a lot of advocacy declared April 11 a Safe Motherhood Day. I see that as tokenism, just to keep us quiet … give us a day so they can celebrate every year. That’s not an action that helps anybody. In fact, it, diverts those people who are looking forward and on April 11, they so some bit of some events, campaigns and rallies. So there is no real action which requires commitment from government. You see commitment required resources committed by government, such as money in terms of budget, monitoring mechanisms, and in terms of rules and regulations, procedures and processes of how it will be done. That is not there (CSO#17).

These respondent did not view this achievement, which WRAI clearly highlighted as a success including for raising public awareness, as sufficient from their perspective to have political or policy implication to improve the problematic situation. Such a declaration (of a specific commemorative day in a year) was seen as lacking political commitment accompanied by concrete resources and policy changes that could contribute to transformative reform. It was seen as easy and not transformative enough, especially given that there was some overlap in the geographical areas (Madhya Pradesh, Rajasthan, Orissa, Andhra Pradesh) where organization members of NAMMHR and WRAI functioned.

The aforementioned comments may not be stemming from purely silent professional rivalry because there were recurring references to Dalit and Adivasi issues during key informant interviews with NAMMHR members. Majority of CSOs of NAMMHR were from states of Central India – such as Uttar Pradesh, Uttarkhand, Madhya Pradesh, Chattisgarh, Jharkhand – where regions with high concentration of Dalit and Adivasi population had extremely poor maternal health outcomes (as pointed out during their power point presentations to peers for the capacity building sessions). It is not that respondents from WRAI were not cognizant of this reality (as verified through probing) but this was not spontaneously mentioned during the interviews and does not receive explicit attention in their advocacy documents (CSO#11,12). They acknowledged the significance of this to the lack of rights consciousness among poor and
marginalized women, but there were no explicit references in their mobilization strategies or exchanges with state officials to frame the issue of maternal morbidity and mortality as an issue of discrimination against certain social groups (see also Papp, Gogoi and Campbell 2013 coauthored with WRAI).

**Coalition 2: The Coalition for Maternal-Neonatal Health and Safe Abortion (CommonHealth)**

The Mumbai-based CommonHealth was founded in 2006 by a group of NGOs and individuals (mostly academics) and was active in Western and Southern states of India (i.e. Gujarat and Maharashtra in the west and Kerala, Karnataka and Tamil Nadu in the south). CommonHealth was also the only coalition of the three examined in this study, which was entirely Indian in origin (that is, not a chapter of an international network). Its steering committee had many academics (including select founding members of Development Alternatives with Women for a New Era or DAWN – a respected transnational feminist development organization with “Southern” roots) including a few who were respected scholarly voices from the Global South in the field of gender, health and development (see DAWN 2016). It is noteworthy that nearly all members of CommonHealth, including the coordinator, made numerous references to the ICPD 1994 outcomes and their subsequent dilution in incorporation in MDGs. At least 3 of the five steering committee members were involved in national and international reviews of progress on ICPD (+5, +10, + 20 years) goals.

**Contextual Realities:** According to Registrar General of India (2012), Tamil Nadu (MMR: 90), Kerala (66), Gujarat (122), Maharashtra (87) and Karnataka (144) have MMRs lower – that is
better maternal health outcomes – than the national average (178). Kerala and Tamil Nadu had already achieved their MDG related MMR goals (100) at the time field research begun in mid-2012 (RGI 2009). The overall female literacy rates are also higher in all of these states than the national rate, and vary widely ranging between a low of 68 percent (Karnataka) to a high of 92 (Kerala). Similarly, total fertility rate in all states are below that of the national rate of 2.4, with Tamil Nadu and Kerala being the lowest at 1.7 and 1.8 (Census Commissioner 2011). Gender empowerment measure, as well, are either at per with national levels (such as in Tamil Nadu with 0.498) or higher in Kerala, Karnataka and Maharashtra. Gujarat is the only one with the GEM slightly lower than national at 0.485 (MoWCD 2009). Historically women had had comparatively better social status and higher levels of education in these states (as demonstrated here) were CommonHealth functioned. Women’s movements in these regions had existed in concurrence with pre-independence trade union movements and have been shown to have an impact on maternal health outcomes in Stephanie Smith’s dissertation research (2009).

The health systems were also in comparatively better shape than those in northern and central states; particularly Kerala (with a history of a communist government) had a well-functioning system of decentralized health care governance system (the only one of its kind in India) in place with active citizen participation in community level health planning (Singh 2010). In terms of distribution of health infrastructure, Kerala had a surplus of sub-centres, PHCs and CHCs although Tamil Nadu had a slight deficiency in PHCs (lacking 45 centres). Karnataka, on the other hand, lacked 146 CHCs for its population. The remaining, Gujarat and Maharashtra, did not indicate surplus in either three of the health infrastructure categories although Gujarat performed better than Maharashtra in all three categories (that is, lower shortfall for the population size) (National Health Mission 2013). Of all the five states, Gujarat had the highest
proportion of Adivasi population – 16.5 percent – while the same ranged between 0.8 percent (Tamil Nadu) to 8.4 percent (Maharashtra). The proportion of Dalit population as percentage of entire state population ranged between, a low of 10.3 percent (Kerala) to a high of 22.8 percent (Tamil Nadu), with Karnataka at 18.4 percent which was higher than Gujarat and Maharashtra (Census Commissioner 2011).

Majority of these states were better performing socially and economically than those WRAI or NAMMHR worked in, with sub-national state governments less reliant on national government (although still implementing policies and programs designed at the national level). Further, claims of self-determination (situated in caste and vernacular language politics) in southern states of India had resulted in greater sub-national autonomy and leverage in ability to negotiate resources from the Union (in exchange for support for federal authorities). Tamil Nadu, the southernmost state with the best health systems indicators in India is known for its entrepreneurial bureaucratic culture that complemented a well-functioning welfare systems as a basic social promise to keep the claim of autonomy and self-determination alive among the general population within the state (Singh 2010). Kerala, another southern state, is one of the few Indian states had a historically matrilineal society until this was officially changed in late 1970s. Nonetheless, Kerala’s human development indicators (HDI) are comparable to that of Finland and Sweden, countries where women enjoy high levels of gender equality.

**Policy Position:** The coordinator of CommonHealth highlighted the coalition’s major concern was lack of “accountability for maternal health” – a broader conceptualization than “death” or “MMR reduction” emphasized in official policy. She clarified that the Coalition attributed responsibility to highest levels of health system – that is, policy designers - for not considering
maternal morbidity and narrowly focusing on maternal mortality. She and two other members of the CommonHealth’s steering committee argued that deaths were easier to prevent (and count) than improving maternal health outcomes and deciding how to evaluate such outcomes (that is the indices). They directed heavy criticism about the technical focus of JSY, the official maternal health policy, arguing that it revealed lack of appreciation of the complexity of the issue among policy makers. As well, they also criticized the official policy approach that incentivized women to access formal health care facilities without establishing a functioning primary health system. This was seen as a shortsighted approach. However, these accusations and attribution of responsibility seem to fit with the notion of rhetorical frame, rather than action frame. This is because all three respondents emphasized that the health system had failed (both because of infrastructure and resource issues but also deliberately) to systematically undertake maternal death review (which speaks to an action they would like to see operationalized). This was considered deliberate and was attributed to unwillingness to count deaths (at the level of health service delivery but with implicit support from high levels of the system), which would expose weaknesses in the health system and undermine apparent achievements on MDG targets. To remedy this, they emphasized the need to conduct medical and social audits to consistently expose gaps in policy and program delivery and raise awareness about quality of available maternal health care. Hence, one of the main strategic goal was “make[ing] every instance of maternal morbidity and maternal death count” (CommonHealth 2014).

Additionally, lack of inclusion of deaths due to unsafe abortion featured as a central issue in discussions about maternal morbidity and mortality with the Coordinator of CommonHealth. The JSY program design had included a promise of access to safe abortion but CommonHealth members explained that this was not fulfilled by the system (including lack of government
regulation for private and individual providers of abortion). The coordinator of CommonHealth reminded the importance of access to safe and quality abortion care (including post-abortion care) in improving maternal health outcomes. She also emphasized that this was an issue missing from the policy problem as defined by NAMMHR and WRAI. She observed:

Our key articulation includes ‘safe abortion’ which NAMMHR and WRAI do not do … our perception is that safe abortion issues become invisible and the whole Safe Motherhood issue begins to rotate surrounding ante-natal care and safe delivery. And people forget about women who are pregnant but do not want to go through with the pregnancy. That is an issue we bring focus on when working on maternal health and maternal mortality (CSO#24).

To complement this sentiment, it had urged all its organizational members conducting maternal death autopsy at the local level to “count deaths related to unsafe abortion among maternal deaths instead of just restricting the count of maternal mortality to delivery and post-delivery related deaths” (CSO#24).

Furthermore, three out of five members of CommonHealth also underscored the role of the community as duty bearer (in relation to delay in seeking maternal health care). They emphasized the various ways women’s weaker status in the broader society and inability to make decisions about seeking health care that contributed to maternal death. They spoke about needing to raise awareness about the importance of seeking timely maternal health care (and in general about women’s health) among family members and the wider community. In other words, respondents from CommonHealth attributed the causes of adverse maternal health outcomes to both state actors (at the policy design and implementation level) and the community. They were concerned with the conceptualization of policy problem (maternal death versus maternal health), the politics of counting maternal deaths, the missing attention to access to safe abortion, the overall quality of maternal health care provided by the health system – all of which unfolded in
the public sphere. As well, they were cognizant of discrimination in the private sphere – home, family and to some extent in the community – which prevented women from making decisions about seeking timely health care.

**Political Opportunity Structures and Framing Strategies:** It is noteworthy that CommonHealth members actively worked with health and medical officials and front line health work force belonging to the district level health systems, that is ranging from the sub-centre, PHCs, CHCs, sub-district or sub-divisional, to the district level. This was, according to the Coordinator, a preferred strategy because health care service providers at these levels were most likely to interact with women seeking maternal health care. Therefore, they deliberately wanted to sensitize this constituency to the health care needs and preferences of pregnant and parturient women. One member of the steering committee observed: “we work with people who are currently or in future likely to have a direct impact on implementation of policy at the state and community level” (CSO#24).

To complement its goal of seeking “accountability for maternal health” CommonHealth promoted bringing out report cards on quality of maternal health care (through community level monitoring), which were presented to health and medical officials at district level health system at regular intervals. This was accomplished through training community level social health workers who were employed on a contractual basis by the organizations that were members of CommonHealth. They were trained by the steering committee members using Central Government published manuals on minimum public health standards (equipment, infrastructure, essential medicines, number of beds, and level of cleanliness) at various levels of health system. They also regularly met with district level health and medical officials and insisted on
significance of maternal death review, including offering to organize capacity building and training workshops with front line health care work force (nominal financial remuneration for organizing expenses involved). In Tamil Nadu and Kerala, CommonHealth members had organized additional skill upgrading training for traditional midwives to offer them an opportunity to become certified skilled birth attendants (recommended by WHO as quintessential to birthing where doctors and nurses were not available). That is, CommonHealth’s mobilization strategies were less immersed in involving rights-claimants directly with duty bearers. Rather, they involved community level monitoring and one-on-one negotiations with individual officials.

It must be acknowledged that most members of CommonHealth did not have organized and sustained engagement with officials at the policy making level (barring a few select members) and this was possibly because lack of perceived need to engage at that level on a frequent basis. There were few references among steering committee members from Gujarat and Tamil Nadu about having a professional relationship with select senior level bureaucrats – at the level of state health secretary – but it was noteworthy that those relationships had come to exist through frequent (invited) participation at various high level policy consultations on gender (both at national and sub-national level). These relationships were not frequently leveraged unlike in case of WRAI and NAMMHR. Organized lobbying before parliamentarians (even sub-national state legislature) hardly seemed to be a focus of CommonHealth members.

Additionally, CommonHealth members, especially those from Kerala and Tamil Nadu observed that the creation of NRHM along with the design of JSY as its flagship program had rightly allocated the much-needed funds to address the issue of maternal mortality (although not sexual and reproductive health) and were eager to ensure that the funds were appropriately allocated where most needed. They did not view policy makers as the appropriate avenue to
create health system or maternal health service delivery reforms and were skeptical of macro
level policy changes spontaneously translating into practical reforms at the grassroots level. This
was probably also a consequence of the fact that they existed/functioned in relatively better
functioning health systems, where denial of basic maternal health care or structural violence
were not perceived to be major concerns. Even in sub-national states such as in Gujarat and
Karnataka, where health systems were relatively less high quality and efficient than in Tamil
Nadu and Kerala, the major concern was ensuring that the public facilities were well-staffed and
had necessary equipment and resources (as opposed to straight out denial of service or abuse
while in care).

It is also mention worthy that members of CommonHealth were not disengaged with
national level health bureaucracy. Several members of the steering committee were part of the
High Level Expert Group on Gender and Health (as part of consultation on transition to universal
health care), including authoring the recommendations, formed by the Union MoHFW.

Articulation of Rights and Injustices: Of all the coalitions examined in this study,
CommonHealth members spoke at greatest length of the difficulties of articulating explicit
human rights in relation to maternal health. They expressed unique challenges given how the
issue had been disconnected from the broader and more politicized agenda surrounding sexual
and reproductive health rights recognized at the ICPD at Cairo in 1994. The issue of reproductive
and sexual choice, including concerns of actualizing them in private spheres, featured very
strongly in conversations with the coordinator and one of the most active members – and a
reproductive health specialist (AC#10) – of the steering committee over what all rights
could/should be considered in articulating women’s human right to maternal health. In assessing these challenges, AC#10 observed:

For me, maternal health goes even beyond the two linkages of population policy and politics of sex-selective abortion. I am unable to talk about maternal health without locating it in the context of overall sexual and reproductive health. This is not just a jargon but in actual practice it matters. Another is overall health …how well a woman is before she got pregnant and if this pregnancy is miscarried then what are the implications for her health. This is particularly concerning for rural women because they may have reproductive tract infections and so forth which don’t get looked into. Or they may have delivery and lose a baby, which means there is pressure on them to get pregnant again and very soon. Son preference means whether or not the women can manage to have repeated pregnancies and babies again. The kind of morbidity they face is very high. Plus, the whole issue of whether or not they want the pregnancy is an issue of sexual rights. We can’t deal with these things is silos, I thought we recognized that in 1994. So if policymaking does not reflect this understanding, then it’s problematic. I do think all the links are pretty strong. Women do not get the same choice of contraceptive available to men. Spacing is not something available to women so most women believe they should have the number of children they want to have and then have sterilization” (AC#10).

In relation to articulation of human right to maternal health, two particular issues stood out in case of CommonHealth. Firstly, the advocacy message (that is, the rhetorical frame) had been framed largely around “accountability for maternal health” (emphasis added) as opposed to “maternal health right” articulated by NAMMHR. A member of the steering committee indicated that this was a deliberate strategy on CommonHealth’s part to disapprove the dissociation between rights as conceptualized in context of maternal versus reproductive and sexual health. In contrast, the action frame to complement this rhetorical frame (that is, “accountability for maternal health”) underscored systematic maternal death review including counting and assessing maternal morbidity and assessing quality of maternal health care. The participant explained:

they [i.e. NAMMHR members] are focusing on maternal health rights agenda. And many of us who are aware how that is linked to sexual and reproductive health, have focused on
trying to get one thing done, which is focusing on accountability for maternal health. I think there is a broad consensus among many of us now that let’s for the moment focus on pushing for maternal death review [MDR] that are transparent, that involve civil society organization and the community. Let’s also get the community to realize its own responsibility to contributing to maternal deaths and in preventing the whole thing. We have decided to focus on two things: bringing out report cards on quality of maternal health care and insisting on accountability for maternal death through MDR. It’s always a dilemma on how you negotiate the need to focus on something without losing sight of the big picture” (CSO#20; emphasis added).

Secondly, CommonHealth had adopted an explicit position on “sex-selection” of fetus (as opposed to “sex-selective abortion”) for two reasons. It was a deliberate strategy, the coordinator indicated, to disassociate sex-selection from abortion to protect access to safe and legal abortion while acknowledging the adverse consequences of sex-selection for the health of pregnant and parturient women. She observed: “How do you talk about the adverse health conditions women face from having multiple and repeated abortions to terminate a female fetus within short span of time, without blame being attributed to easy access to abortion?” (CSO# 24). Further, in almost all advocacy documents and activity reports (including website) CommonHealth had clarified that it “support[ed] the prevention of sex-determination through stringent implementation of the PCPNDT Act and campaigns against gender discrimination, without compromising on women’s access to safe abortion services” (Ibid.). In speaking about the peculiar discursive challenges surrounding the language of human rights, arising in debates over “sex-selective abortion” the coordinator of the CommonHealth secretariat noted:

By repeatedly placing the sex-selection issue in the abortion discourse, we completely lose the plot. In my presentations I try to talk about the 22 laws we have that promote gender equality. What is abortion? It is only one of the issues … if you can’t implement anti-dowry, anti-child marriage, paid maternal leave, equal inheritance laws, then what abortion are you talking about? If we cannot change women’s worth to make them valuable to society of course one will not want girl children. That is exactly what South Korea managed to do, to make women an economically viable proposition in the
society. See even the use of the language of feticide, it is so problematic! What would you call a male feticide? Now if you remove male and female, and it is just feticide, then you have moved over to pro-life discussions. Then you have gone down the slippery slope where you cannot have pro-choice discussions anymore. With all these conflicting issues, as far as I know, there has not yet been a national forum, which has debated out women’s issues under the forum of women’s right to health (CSO#24).

The other priority and unique to CommonHealth was a focus on at the time of field research was the claim of “respect for women’s rights in delivery care” (“delivery” as in birthing). The coalition’s position paper on “safe delivery” put the spotlight on prioritizing women’s birthing preferences (at home or institutional) – certainly a dimension of reproductive choice when understood as an extension of women’s agency in reproductive health decision making (also iterated by respondents) – as opposed to the excessively medicalized and technical bent of the Indian maternal health policy. The dimensions of safe delivery as articulated by women themselves (based on an empirical study undertaken by CommonHealth’s member organizations) encompassed issues such as “enabling environment promoting physical and emotional health of the women including nutrition, family support, social support”, “presence of birth companion”, “safe contraception and abortion services”, “autonomy and decision making of women”, “maternity benefits and welfare schemes like crèches, child care facilities” and so on (CommonHealth n.d.; Sri B and Khanna 2012, 15). These reveal a deliberate effort to expand the scope of issues by introducing the language of rights to maternal health policy discourse – as hoped for by Cook (2001) and Fraser (2005). Nonetheless, CommonHealth’s articulations were quite stark in comparison to that of WRAI, which emphasized the notion of status-quo maternal health care policy benefits as “entitlements” for rights claimants. But perhaps this was an outcome of the significant differences (albeit, with Maharashtra as the overlap state) in various dimensions of women’s social status – MMR, education, fertility rates, gender empowerment
measures – between women living in states where CommonHealth and WRAI functioned. That is, the needs and preferences of pregnant and parturient women were likely different which was understandable given the vastly different MMRs between these areas. The point being, where conditions to meet essential needs were present, perhaps there was room for negotiating preferences.

In terms of injustice, therefore, CommonHealth articulated several – some rhetorical, others more practical and action oriented – but they were comparatively broader than those conceptualized in case of WRAI. These comprised of broader reproductive and sexual health injustices, injustice in provision of quality maternal health care (including access to safe abortion), both of which contributed to adverse maternal health outcomes and a deliberate injustice in how maternal deaths were counted and reported. Perhaps the most suitable overarching rights expression that can be assigned to CommonHealth’s articulation is “women’s right to reproductive and sexual health” of which maternal health is but one component, that addresses both structural (including health system and family/community, public and private spheres) and individual agency dimensions (reproductive and sexual choice, birthing preferences, decision making power).

**Possible Sources of Frame Dispute:** The researcher did not witness the participating of members of CommonHealth at the three state-civil society consultations she attended in New Delhi. Neither were CommonHealth members present at the capacity building sessions organized by NAMMHR. The brief references to NAMMHR and WRAI by CommonHealth members have been already indicated earlier (in comments of CSO#20 and #24). Aside from these, the researcher felt there was almost a deliberate effort to speak very diplomatically about
NAMMHR’s work in particular. Given that the Coordinator and members of steering committee of CommonHealth spoke about their disapproval of dissociation of maternal and reproductive and sexual health, it is very likely that they did not entirely agree with NAMMHR’s approach.

For example, at one instance the Coordinator of CommonHealth who was an obstetrician by profession indicated the importance of sterilization camps to women in rural and remote areas where no other form of contraception was available. She indicated voluntarily participating as a medical student in such camps to provide tubal ligation surgeries to women desperately seeking them. However, she went on to observe that the term “sterilization camps” was particularly disliked by members of NAMMHR from Uttar Pradesh and Bihar (both states with fertility rates higher than national average). This is because in those North Indian states, community health workers and family members were incentivized by policy design to cajole poor and marginalized women into seeking sterilization at daylong camps (where sometimes hundreds of tubal ligation would be done by a single doctor). She observed that women’s health advocates from Uttar Pradesh and Bihar viewed such camps as synonymous to “[Nazi] Concentration Camps” and were suspicious of obstetricians and gynecologists (especially their class privilege) advocating for women’s health. Albeit, she acknowledged the gross violation of reproductive rights where women were being forced into poor quality sterilization operations, but emphasized the conditions where there was an unmet need for contraception and/or women did not have the decision making power with regards to contraception use. This pointed to tension (and arose again with respondents from NAMMHR) over the issue of reproductive choice and rights between women’s health advocates that were informed by distinct personal experiences and contextual realities.
Coalition 3: National Alliance for Maternal Mortality and Human Rights (NAMMHR)

The Delhi-based NAMMHR is the Indian chapter of the International Alliance for Maternal Mortality and Human Rights (IIMMHR). The NAMMHR secretariat is hosted by Sahayog who was the civil society partner for the researcher (a local partner is required by the International Development Research Centre, which funded this study). Sahayog is also one of the few Indian maternal health NGOs that is active internationally. The coordinator of Sahayog, also the coordinator of NAMMHR was a founding member of IIMMHR. NAMMHR was formally established in January 2010 although it had been informally functioning since 2008. Organizational members of NAMMHR were primarily from northern and central states of India - Uttar Pradesh, Uttarkhand, Bihar, Orissa, Madhya Pradesh, Rajasthan, Chhattisgarh and Jharkhand – otherwise known as the EAG states.

Contextual Realities: The MMR for all eight states, where NAMMHR members had significant presence, ranged between 219 (Bihar and Jharkhand) and 292 (Uttar Pradesh), that is significantly higher than the national MMR of 178 (Registrar General of India 2013). Female literacy rates in these states ranged between 51.5 (Bihar) and 64 (Orissa) percent of total population, where as the corresponding rate nationally was 65.4 (Census Commissioner 2011). Where as the total fertility rate nationally was 2.4, it ranged between 2.1 (Orissa) and 3.5 (Bihar) among these states. Uttar Pradesh, Rajasthan and Madhya Pradesh with TFR of 3.3, 2.9, and 2.9 respectively followed Bihar (Ibid.). In terms of GEMs, all the eight states rank lower than the national GEM (0.497), with Bihar (0.379) and Orissa (0.393) at the very bottom (MoWCD 2009). According to a report published and sponsored by National Planning Commission in
2014, seven of the EAG states feature in the top ten states with high rates of prevalence of child marriage (26). Sixty-eight percent of women in Bihar were married before the age of 18 years, followed by 57.6 percent in Rajasthan and 54.9 percent in Uttar Pradesh. That is, these states perform quite poorly on various gender indicators relative to states where CommonHealth has a presence. It is noteworthy that access to JSY and other related benefit schemes are restricted to two live births (sometimes two pregnancies, with variations across districts) and women of legal marriageable age in these states. Respondents from NAMMHR indicated that sometimes these restrictions are not officially implemented but have rather become practice imposed by health and medical officials at different levels of the health system. There were also numerous references by the coordinator and five different members of the steering committee to individual medical and health care providers discriminating and verbally and physically abusing women with more than two live births and/or pregnancies. A report produced by Human Rights Watch (HRW), which undertook a situational analysis, also made similar allegations (HRW 2009).

In terms of health system infrastructure, Bihar, Uttar Pradesh, Jharkhand, Madhya Pradesh have extremely high shortfall of sub-centres, PHCs and CHCs. For example, Uttar Pradesh has shortfall of 10,516 sub-centres, 1480 PHCs and 778 CHCs. Only Chattisgarh and Rajasthan record a surplus of sub-centres but they lack minimum number of PHCs and CHCs for the size of population. It has already been discussed earlier that these states remain heavily reliant on the Central Government for technical support in relation to resources, and program implementation. Key informant interviews with state actors, especially the three planners and the three technocrats revealed that these states had poor resource absorption and reallocation capacity and that NHSRC officials would regularly undertake state visits and monitoring activities to try to work with state officials to improve health system condition. Few technocrats
also spoke of lazy and apathetic work ethic among health work force but this should be treated carefully since all the technocrats were from Southern states with well performing health systems. They also spoke at length about “blatant corruption” at various levels of health system, including demand for user fees for free health care services promised in official policy. There were also sporadic instances of “massive corruption” in some of these states, for example the rural health fund scam of 5000 crore rupees (USD 760 million) uncovered in Uttar Pradesh in February 2012, including politically motivated murder of high level health officials, that subsequently led to fall of the governing party in the state (NDTV 2012).89

Furthermore, the proportion of Dalit population ranged anywhere between 13 percent (Chhattisgarh) to 23.2 percent (Uttar Pradesh) of total population in these states. Similarly, Chhattisgarh had the highest Adivasi population (37), followed by Orissa (23.2) and Jharkhand (20.8) percent of total state population. Many of these states, especially Bihar, Uttar Pradesh, and Rajasthan are known for being caste rigid societies (cite), where as the Adivasi population in central India (Madhya Pradesh, Jharkhand, Chhattisgarh and Orissa) are well know for being socially disadvantaged (including being categorically excluded from enjoying the benefits of wealth created by mining developments that have been achieved in these mineral rich states) (Ministry of Tribal Affairs 2013; Sharma 2015).

**Policy Position:** A central concern, according to the coordinator of NAMMHR, was the official policy approach that emphasized birthing at a formal health care facility (including incentivization that was attractive to poor women and their families), without adequate attention to the health system’s poor and weak condition. NAMMHR was also critical of the focus on

birthing alone and lack of emphasis on the continuum of care (from when women find out they are pregnant to post-partum care, beyond simply post-natal). To remedy the problematic situation, a goal of NAMMHR had been to reform the current vertical policy design and emphasize the continuum of care approach. Three members of NAMMHR’s steering committee (who participated in this study) attributed high incidence of maternal mortality to “poor health systems that fail to provide healthcare for low income communities” and considered maternal health outcomes as the “one-point indicator on the quality of primary health services” (NAMMHR n.d.). That is, preventable maternal morbidity and mortality were attributed to poor public health care system. Additionally, these respondents, including the coordinator, attributed the creation of the JSY to the Union MoHFW and politicians at the Centre (including implicitly to Prime Minister’s Office and the then ruling Congress Party). They argued that the creation of JSY as a CCT program was a “mechanism to secure votes” from poor people (CSO#16, #2). To that end, one of them went on to explicitly disagree with Shiffman and Ved’s (2007) analysis that the JSY was an outcome of support for social welfare within the Congress Party elected to govern at the Centre in 2004.

Another major advocacy goal for NAMMHR was to tackle the problem of structural violence deeply embedded in the health care system that preyed upon socially disadvantaged women. The coordinator of NAMMHR attributed this to both structural and individual factors surrounding caste-based and gender-based social hierarchy and individual health and medical officials (including front line health work force) who “dared to deny” life saving emergency care and discriminate against poor Dalit women (CSO#2). She clarified that such women were not seen worthy of any obligations from duty bearers, who were aware that poor and marginalized women were not empowered enough to voice concerns or complain. This included nurses and
female frontline health workers who would “scold them” (for getting pregnant) and “slap them around” (CSO#2). NAMMHR members were acutely cognizant of the social attitude change that would be necessary to remedy this aspect of the problematic situation.

Beyond these three priorities, a fourth advocacy priority was to shed light on the coercive population control policy and the way this was deeply intertwined with the design of maternal health care services. Respondents from NAMMHR indicated concerns over the government’s (both Central and sub-national) efforts to indirectly couple population control measures with maternal mortality reduction efforts. During state-civil society consultation, members of NAMMHR underscored the linking of eligibility for nutritional and maternity benefit schemes to women above the age of 18 years with no more than two live births and/or pregnancies. The researcher observed that these often featured prominently at domestic and regional consultations, where NAMMHR members underscored how this policy design systematically excluded those who most needed to avail of government support. To remedy this situation, NAMMHR’s advocacy documents (and key informant interview respondents) underscored the importance of making social security schemes accessible and user friendly to the targeted population. The responsibility to amend this was attributed to the Central Government.

However, members from states and regions with sizeable Adivasi population consistently underscored the significance of near absent health infrastructure (health care facilities, equipment, emergency medical transportation, doctors and health workers) during state-civil society consultations and capacity building sessions. This they attributed to lack of political concern for the Adivasi population. It is noteworthy that gender as such was not the top of mind concern for advocates (both based on conversation and their presentations at capacity building session) who participated in this study, although poverty and lack of resources were. They
acknowledge women’s weaker social status but clarified that this was distinct from the dynamics seen in non-Adivasi communities\textsuperscript{90}. They emphasized that the Adivasi population was as a whole disadvantaged socially and economically.

**Political Opportunity Structure and Framing Strategies:** NAMMHR members were trying to influence the sphere of policy and program design at the Union level, since relevant policies and programs had been conceptualized, designed, funded and implemented through the centrally sponsored NRHM. As a member of the coalition observed: “the minute we saw NRHM, we knew that it was an opportunity to start working with the government by evaluating the program from an accountability perspective” (CSO#12). They were engaged in lobbying Union MoHFW officials, NRHM Directors (both executive branch of government) and senior health advisors of the National Planning Commission. The coordinator and other steering committee members living in Delhi held both one-on-one meetings and also invited these government officials to participate in state-civil society consultations, where they highlighted gaps in policy/program design and implementation.

Based on the researcher’s observations of interactions between state officials and NAMMHR members at the consultation sessions, it seemed that the relationships were mostly individual actor-oriented (rather than systematically engaging with an institution). NAMMHR’s relationship with a very senior member and health advisor to the Planning Commission seemed largely driven by the latter’s individual interests, rather than official engagement from the Planning Commission. Similarly, the Union level ministry officials present at the consultations

\textsuperscript{90} In this regards, two of the three maternal health advocates from high-density Adivasi states were male physicians. So it is not clear whether their interpretations of gender dynamics and its implications for maternal health are different from their female maternal health advocates because of their gender.
were almost always junior-mid level officials (not even bureaucrats, but technical resource personnel) who seemed to be message bearers rather than an authority in presenting / articulating ministerial perspective. In all three consultations observed by the researcher, these were meek, young male officials, who quietly sat at one end of the table in front of a room full of various civil society actors looking to share their grievances. Even though all three consultations were held within a span of two months, each one was attended by a different official (as if the person who was free and available was sent to attend, rather than someone responsible and answerable). That is there was a lack of continuity since during question and answer (Q and A) sessions, these officials would often clarify that they were not privy to information exchanges that had happened in the previous consultation (even though the substance of the consultations were connected).

The researcher had a distinct feeling that this was not simply coincidental but a deliberate strategy by the state (that is the political entity) to escape responsibility. During one Q and A occasion, a member from one of the poorly performing Southern states yelled out “maternal health is a human right! We demand that state recognize it!” (CSO#17). This was followed by an intervention (hand gesture to calm down, request of courteous exchanges) from senior technical officials of international health agencies (WHO and UNFPA) present at the consultation to “rescue” the visibly nervous junior Union health ministry officer attending that particular session. These observations left the researcher wondering about the material and absolute power of institutional actors (in this case the executive branch) relative to that of maternal health advocates, who could persuade the former to commit to attend the state-civil society

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91 In fact, it was unclear to the researcher the reason for the presence of these representatives from international agencies who seemed to be technical resource personnel. These individuals did not directly participate in the consultations but their presence seemed to suggest that they were rather, neutral bystanders. State actors during interviews explained that international agency representatives in India supported “technical planning” but rarely disagreed with state officials or the ministry. Other non-state actors seemed to think their political influence was really non-existent (in India) and that they risked looking irrelevant by not being present at the discussion table.
consultations (on accountability for maternal health). But the latter had no control over whether they could secure the commitment of a responsible authority with the power to make decisions that could meaningfully resolve the policy problem.

Beyond lobbying executive officials, the coordinator of NAMMHR had also established a relationship with the secretary to the Parliamentary Health and Family Welfare Committee (PHFWC) and leveraged this relationship to submit briefing packages (comprised of research reports, media reports of incidences of death, results of monitoring health care services monitoring) for committee member’s review. This, the coordinator indicated, was a strategy to use parliamentarians to hold the executive branch accountable. However, she clarified that NAMMHR had not fully realized the potential of legislative lobbying because of lack of public awareness of the issue and by extension lack of political concern for what was viewed as “normal” (that is, maternal deaths). For example, NAMMHR members had never appeared individually or as a group before PHFWC. Rather, they worked through the intermediary, that is the secretary to PHFWC. To remedy the lack of public awareness and political concern, NAMMHR had begun to form a relationship with media (with national scope), based on the coordinator’s experience of building a relationship with regional vernacular media in Uttar Pradesh (which took nearly a decade).

NAMMHR member organizations were known to hold public hearing forums at periodic interval, which health officials (sometimes state only, other times both Union and state officials) were invited to attend. Often female leaders of local women’s groups presented evidence gathered at the community level about missing services, incidences of preventable deaths and grievances along with questions before officials. NAMMHR members also worked with women at community level to “empower rights holders”, specifically “turn passive individuals into
active rights claimants” (CSO#2). Emphasis had been on increasing awareness of entitlements, ensuring provision of entitlements and collectivizing to claim entitlements. The term “entitlement” was used to refer to health care service provision specified in JSY, for example number of antenatal and postnatal check ups, steps during antenatal check up such as weighing, blood pressure checks, number of blood tests to determine anemia, free iron tablets and such. To counter the denial of entitlements of individual rights-claimants, it was common at the community level (for example in Uttar Pradesh) for women to collectively arrive at health care facilities accompanied by grass roots social workers and actively seek services from health officials. Likewise, often a pregnant woman visiting the public health facility would be accompanied by local female community workers/leaders who were knowledgeable about health care entitlements under existing policy.

Beyond lobbying policymakers and parliamentarians, NAMMHR also organized training activities for its member organizations and individuals in New Delhi where public health experts and academics discussed approaches to integrating human rights concepts with accountability activities on ground (such as verbal autopsy and conducting maternal death audits). The coordinator and other members of the steering committee indicated the importance of promoting improvements in research design and data collection (including standardization) among its members, emphasizing rigor to ensure greater credibility of the evidence (of systemic and policy gaps) presented before officials.

**Articulation of Rights and Injustices:** NAMMHR’s advocacy document underscored a set of “common minimum principles” which included “gender equality, sexual and other diversity, social justice, transparency and accountability” (2010). The coordinator of NAMMHR observed
that “right to survive pregnancy and childbirth” was a fundamental right of a woman (CSO#2; emphasis added). This has an undertone of reference to “right to life” although this was never mentioned explicitly. However, under the “key issues for maternal health and human rights” on NAMMHR’s brochure (distributed at state-civil society consultations and available on the website) fifteen issues were listed (broadly summarized above). Of these only one – “nutrition and right to food” – made an explicit reference to a “right”. The remaining human rights issues could be broadly categorized – based on researcher interpretation – into advancing two types of claims: those designed to improve health system accountability and uphold right to health care (demand for grievance redressal mechanism, surveillance systems to prevent maternal mortality, regulation of private health system, allocating sufficient resources to public health sector) and others which promoted birthing preferences and access to safe and quality abortion care, that is different dimensions of reproductive choice, for the claimant (ensuring provision of continuum of care with both home and institutional delivery, incorporating access to safe abortion and post-abortion care). That said, both the issues of home delivery and abortion care hardly received mention at the three state-civil society consultations where the researcher was present. These issues were also hardly mentioned during interviews with the three respondents as opposed to the issue of structural violence and denial of health care, which arose repeatedly. Focus was on the provision of continuum of care and health and related maternity benefit schemes. This likely signals the prioritization of what was viewed by NAMMHR members as urgent needs.

Nevertheless, NAMMHR’s advocacy documents explicitly underscored that maternal health and mortality (in the areas where its members functioned) was an “issue of social inequity, as it is faced by the most marginal communities and women in vulnerable situations”
(NAMMHR n.d.; emphasis added). All three respondents from NAMMHR often used the terms “social justice” and “gender justice” to refer to the problem of maternal morbidity and mortality.

**Possible Sources of Frame Dispute:** Any noteworthy interactions and exchanges between NAMMHR and WRAI have been reported earlier. There was no opportunity to observe the interaction with CommonHealth and NAMMHR coordinators and other members, since members of CommonHealth did not attend any consultation or capacity building sessions organized by the latter.

However, it is important that while the three respondents from NAMMHR’s steering committee were extremely critical of the coercive “two child norm” provision embedded in the policy design, they hardly ever alluded to the terms “reproductive choice” or “reproductive rights”. The phrase “government regulation of citizen’s reproductive behavior is unacceptable” (or a combination of “state regulation” and “reproductive behavior”) was mentioned a few times (CSO#2, #16, #12). It was very clear to the researcher based on interview conversations with the three respondents that all were extremely knowledgeable and well versed in the global and Indian discourse on women’s right to reproductive and sexual health. Perhaps the absence of reference to reproductive choice and/or rights was deliberate to avoid state appropriation of that term to support coercive population policy agenda. Both CSO #2 and #16 were dismissive of the academic and advocacy contribution of one founding member of CommonHealth in underscoring the implicit links between maternal and reproductive health. This individual was an Indian academic who was widely regarded globally as a “population and development specialist” and a founding member of DAWN (and an influential figure in the ICPD discourse). This reinforced the researcher’s inference – that there was a deliberate effort to disassociate
human right to maternal health from the broader discourse of reproductive right. This could be because the struggle for recognition of women’s reproductive rights was central to the ICPD discourse, including the Indian discourse on family planning and population control but it did not accommodate the struggle for reproductive justice in relation to maternal morbidity and mortality (as demonstrated in the introduction and chapter 2).

**Summary of Key Characteristics of Framing Dynamics**

The table below provides a comprehensive summary of key aspects of the framing dynamics of Indian maternal health and human rights coalitions outlined thus far. For simplicity of reporting, it outlines contextual realities of the three coalitions on a relative basis (based on combined consideration of women’s social status, health system conditions and density of socially excluded groups, including historic conditions of social hierarchy). Additionally, mobilization strategies used to engage with duty bearers belonging to different policy forums (or political opportunity structures) at various levels and those used to mobilize population at the grassroots level have been separated out. This clarifies how the two complement each other.
## Table 2: Comparative Summary of Key Characteristics of Framing Dynamics

<table>
<thead>
<tr>
<th>Geographic Distribution of Coalitions</th>
<th>Contextual Reality</th>
<th>Articulation of Rights and Injustices</th>
<th>Policy Position</th>
<th>Political Opportunity Structures &amp; Mobilization Strategies (In order of priority)</th>
<th>Grassroots Mobilization Activities</th>
</tr>
</thead>
</table>
| **WRAI** (Central and South Eastern India inclusive of 3 EAG states) | Mix of poorer and average performing states | Human Right to Safe Motherhood | • Poor policy implementation  
• Gaps in technical policy design  
• Lack of rights consciousness among rights-claimants | • Close gap between policy design and implementation  
• Improve technical aspects  
• Inform and educate right-claimants about entitlements | • **District & Sub-national:** Organize public hearings with district level health/medical officials and MLAs  
• **National:** Collaborate with Union MoHFW to improve technical aspects of policy design | • Educating grassroots women on health care entitlements promised in status-quo policy design  
• Capacity building to voice concerns and demand accountability from officials in public hearings  
• Capacity building among community health workers for community level monitoring |
| **CommonHealth** (Southern and Western India including few of the best performing states in terms of health and social indicators) | Mix of best performing and few better performing states | Accountability for maternal health  
Human Right to sexual and reproductive health (SRH) - But underscore discursive complexities surrounding reproductive choice/rights | • Technical policy focus without systemic readiness  
• Policy design excludes SRH, especially safe abortion  
• Failure to undertake MDR and consider morbidity  
• Lack of respect for women’s birthing preferences  
• Lack of awareness and concern for | • Improve health care service delivery  
• Improve access to safe and quality abortion  
• Undertake medical and social audit of maternal morbidity and mortality (including those related to abortion)  
• Sensitize health system to support women’s birthing | • **District level health and NRHM officials:** hold responsible for quality of service and condition of public health facilities set by national government  
• Insist on maternal death review and offer to build capacity of frontline health workforce for social audit  
• One-on-one exchanges and negotiations  
• **Local (Front line health workforce):** Sensitize to women’s health care needs and preferences.  
• **Sub-national:** Rare one-on-one exchanges with senior bureaucrats and participation in formal civil | • Capacity building among traditional birth attendants and retrain as skilled birth attendants  
• Social audit of maternal morbidity and mortality (including collection of data on instances related to abortion complications).  
• Community based research among women to develop understanding of health care needs and preferences  
• Awareness generation and intervention with family and community on women’s health |
<table>
<thead>
<tr>
<th>NAMMHR (Northern and Central India including all 8 EAG states)</th>
<th>Mix of poorest and poor performing states</th>
<th>Right to survive pregnancy and child birth (emphasis on right to health care)</th>
<th>women’s health at the community level</th>
<th>preferences</th>
<th>society consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Policy design exclusively emphasizes institutional birth excludes continuum of care reduction of&lt;br&gt;  • Poor and weak health systems&lt;br&gt;  • Institutionalized discrimination and denial of health care&lt;br&gt;  • Other forms of structural violence by health care service provider&lt;br&gt;  • Restricting eligibility of maternal health and related benefit schemes to women above 18 years with two or less live births or pregnancies</td>
<td>• Expand scope of policy design to emphasize continuum of care&lt;br&gt;  • Improvement of health system through investment in resource and infrastructure&lt;br&gt;  • Monitoring of health care service provision&lt;br&gt;  • Creation of Grievance redressal mechanisms to address denial of care and other abuse&lt;br&gt;  • Remove</td>
<td>• National: Lobbying executive officials of senior bureaucrats of Union MoHFW, and NRHM, Health Advisors with National Planning Commission through one-on-one meeting and state-civil society consultation forums.&lt;br&gt;  • Legislative lobbying through Parliamentary Health and Family Welfare to hold executive officials accountable&lt;br&gt;  • Sub-national: Lobby state-NRHM Mission Directors to improve health system conditions&lt;br&gt;  • Local: Organize public hearings with District Magistrates and Chief Health/ Medical Officer</td>
<td>• Inform and educate women on their entitlements based on status-quo policy design and generate rights consciousness among claimants&lt;br&gt;  • Promote collective organization to support and stand in solidarity with individual women&lt;br&gt;  • Capacity building to voice concerns and demand accountability from officials in public hearings&lt;br&gt;  • Capacity building of local social/community health workers for health system monitoring&lt;br&gt;  • Capacity building of state level member organizations for systematic and standardized data collection, evidence gathering and documentation.</td>
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Discussion & Conclusion

The comparison of frames or policy positions of three maternal health and human rights advocacy coalitions indicate that these are context specific. The sociopolitical dynamics of the context determined by a combination of women’s status, condition of health system, and lived realities (and not simply density of distribution) of socially marginalized groups determine the policy positions of these coalitions. This contextual distinctiveness coupled with the frame sponsor’s assessment of causal factors and solutions to address the problematic situation determines the diagnostic and prognostic elements of their policy position. Arguably, the issues of weak health system, poor quality service delivery, and gap between policy design and implementation are common to all three frames. However, the extent of severity of these factors varies widely which likely determines the political opportunity structures selected by frame sponsors to mobilize political support.

The stronger the severity of the aforementioned factors, the greater the need to involve highest level of government (including the Central Government) possibly to generate maximum impact. Admittedly, the inclination to approach the Central Government is also determined by the strength and capacity of the sub-national health system and political institutions. Coalitions functioning in EAG states where sub-national authorities rely heavily on Central authorities (and there is a history of intervention), frame sponsors are more likely to approach the latter to influence the ultimate sphere of decision making with policy design, health infrastructure improvement and resource allocation. Hence, both WRAI and NAMMHR lobby officials at the level of Central Government although using very different mobilization strategies (technical collaboration by WRAI versus lobbying executive at collective civil society forums and legislative officials by NAMMHR). In contrast, in states where sub-national capacity such as
resource absorption and redistribution to augment health system infrastructure is relatively better, frame sponsors hardly engage with Central authorities. Rather, they focus on street level bureaucrats and front line health workforce that are more likely to influence women’s everyday experiences of accessing quality maternal health care. Either way, the aforementioned dynamics reveals that different contexts require diverse forms of political interventions, which in turn necessitate engaging with different institutional actors who are located in different political opportunity structures. As well, frame sponsors may differ on how they choose to lobby institutional actors – by collaborating and/or confronting – which in turn may shape the type of changes (consider the “technical” successes achieved by WRAI) they are able to create.

Arguably, organization of public hearings with local officials (including sometimes elected individuals) and community level monitoring feature as preferred mobilization strategies for all three coalitions. But this can be seen as an outcome of the ambiguities of conceptualizing and operationalizing state accountability for maternal health demonstrated in the previous chapter. In absence of clear rules and norms surrounding state accountability, frame sponsors are left to leverage the status-quo policy norms (that dominate the policy discourse) to conceptualize rights claimants’ entitlements, which reinforce the prominence of proximate determinants of maternal health outcomes (since that is the “jargon” of the policy design). The level of empowerment and rights consciousness of the claimants may determine the design and articulation of maternal health and health care entitlements. Likewise, frame sponsors in conditions of better contextual realities are also able to underscore the violations of women’s rights in private sphere and the role of family and community as duty bearers, while their counterparts in poorer contexts are left with hope of long term change in social attitude toward women, especially marginalized women. Whether that advances women’s needs and/or strategic
gendered interests therefore becomes a product of, once again, the context in which rights claimants are located.

Beyond the immediate politics of the frame, political opportunity structures, and framing strategies, the distinct articulation of rights and injustices by these coalitions is also a combined outcome of contextual realities and beliefs and perceptions among frame sponsors about the links between maternal health outcomes and women’s right to reproductive and sexual health. Such articulations speak to what is seen as the priority concern in a given context – preventing death, preventing adverse maternal health outcomes and/or improving overall reproductive health outcomes. The former is more closely aligned with right to life where as the latter with right to reproductive and sexual health. Perhaps these articulations can be imagined to exist at different points on a spectrum, the two ends being needs (aligned with basic survival) and preferences (aligned with choices and freedoms). Thinking about rights on a spectrum with negative and positive rights at either end is somewhat distinct from the theoretical notion of inalienability of various human rights underlined by scholars (Darrow and Tomas 2005; Archer 2009; Hickey and Mitlin 2009).

Likewise, these articulations reflect the pursuit of different principles of justice (“access” and “distributional equity” in poorly performing regions against (also) “quality” in better performing regions). That is, where the basic goal of access (to the health system and state promised health care entitlements) is met, maternal health advocates are able to advance more expansive gendered claims (such as the incorporation of birthing preferences as a dimension of reproductive choice). That said, there are tensions between these articulations especially between that advanced by CommonHealth and NAMMHR, which stem from the discursive complexities surrounding human rights. The notion of reproductive rights (including right to reproductive health) is highly contentious because it has been historically appropriated by the state (to promote
female sterilization) and individuals (to selectively terminate female fetuses) to pursue questionable agendas. Yet, it is essential to ensure women’s access to safe and quality abortion and probably even provide some women access to safe and quality permanent methods of contraception where there is an unmet need for contraception. This points to the opportunities in strategic framing of messages that can emphasize the overarching goal of reproductive justice while minimizing fragmentation among women’s health advocates. At the same time, differences over articulation of rights with corresponding differences in assessments of injustice are also a source of frame dispute. Such disputes can divide feminist movements and dampen their spirit, not to mention their ability to strategically engage with the state (Bradshaw 2006).

Possibly, one way to reconcile these differences would be to consider “conceptual connections” (Bradshaw 2006, 1329) between the different frames to propose a new frame – such as the reproductive justice frame (outlined earlier). This can accommodate (but not assimilate or essentialize) women’s “differing concerns” arising from differences in citizenship status and address concerns related to gender inequality and social inequity. It can lend analytical strength to the role of family, community and the state in contributing to gender, social and reproductive injustices. Furthermore, it can also underscore the authorities responsible for upholding the multitude of constitutional and other legal protocols in place to protect women and the socially marginalized and expose the gaps between formal legal and substantive equalities as experienced by them (Mukhopadhyay 2003; Goetz 2007). While human rights norms may evoke very powerful moral and normative sense of ongoing injustices, claims of rights and entitlements located in citizenship status can expose the violations of fundamental legal and constitutional promises of equality and non-discrimination produced by deliberate state inaction (Kapur 2007; Tsikata 2007). After all, “citizens [can] demand just governance”, “access to governance institutions”, and “claims to new entitlements” born in conditions where their rights are
undermined (Mukhopadhyay 2003, 45-47). At the same time, a citizenship frame can bring to light the ways lack of appropriate implementation of state promised health policy entitlements ultimately reveal the undemocratic nature of publicly funded health care systems (Waylen 2006). Such a strategy cannot simply be undone by excuses of resources and capacity often articulated by state officials (as demonstrated in chapter 5). If such entitlements are indeed a strategy of securing electoral support, then their underlying implications for the broken social contract between state and (some) citizens can be exposed using the citizenship frame. The citizenship frame can have constitutional and legal implications for advancing an agenda of reproductive justice (as shown in the next chapter) that the symbolic and morally imperative use of human rights norms simply does not offer.
Chapter 8: Politics of Judicialization of Maternal Health and Implications for Advancing Reproductive Justice

This chapter serves several purposes. Broadly, it explores the politics of judicialization of maternal health, leading to a successful reframing in the Delhi High Court case, and its potential to affect the political priority surrounding the policy problem. In doing so, it explains the socio-political dynamics that led to the court case and those that unfolded after the adjudication during the implementation stage. As well, it also analyzes the specific scope of the new and/or expanded right recognized by the court in the adjudication stage and the opportunities and constraints contained in it to generate policy reform that can potentially address maternal disparity in the wider population. Collectively, these help explain the implications of state recognition of maternal morbidity and mortality as violations of human rights for advancing reproductive justice for all women. The organization of the findings follow the different stages of litigation outlined in chapter 4 to analyze the different dimensions of litigation as a framing strategy – claims formation, adjudication, and implementation. Due to the short time gap (two years) between the pronouncement of the judgment and the field research for this study and other developments that happened at the implementation stage, there was not much in way of social outcomes and equity (the fourth stage in strategic litigation) evident during field research, to be reported. The analysis draws from the conceptual considerations outlined for frame analysis and litigation as a strategy of framing.

The findings are drawn from various data sources and include: (1) key informant interviews (including all the different target profiles); (2) legal documents (the original petition, the judgment, the court ordered investigative report on the maternal deaths, other related petitions regarding lack of compliance and contempt of court), related affidavits available from the website
of Office of Supreme Court Commissioner for Right to Food (including the Commissioner’s official response to a related enquiry from Delhi High Court); (3) related reports, publications and commentary produced by civil society actors involved in the Delhi high court case; and (4) related notes and observations from the state-civil society consultations.

Claims Formation

The organization of this section is categorized into two different themes. The first theme relates to the actors involved (direct and indirectly, and not involved) in the Delhi High Court case, the legal opportunity and opportunity structures available to them, their mobilization resources, their strategic goals, and choice of framing strategy including rationales behind its selection. Articulation of the claims in the petition filed before the court, including the exact nature of the violations underscored in it and their legal basis and the prayers sought from the court constitutes the second theme and corresponds to prognostic and diagnostic aspects of the frame. A brief analysis of the amicus curiae (“friend of the court” appointed to investigate the maternal deaths) report is also included under the second theme.

Actors, Interests, Opportunity Structures and Framing Strategy

The petitioners in the cases Laxmi Mandal v. Deen Dayal Harinagar Hospital and Others (W.P.(C). Nos. 8853/2008) and Jaitun v. Maternal Home, MCD Jangpura and Others (W.P.(C). Nos. 10700/2009) were Mrs. Laxmi Mandal (sister of deceased Mrs. Shanti Devi) and Jaitun (spouse of Fatima, the “victim” of maternal morbidity and near death) (ESCR_NET CaseLaw Database 2010). The main litigant on behalf of these petitioners was Human Rights Law Network (HRLN). The latter approached the families of both women based on media reports about the incidences of maternal death and near death. HRLN, on its website, described itself as “a
collective of lawyers and social activists dedicated to the use of the legal system to advance human rights in India and the sub-continent” (HRLN 2015). Furthermore, it described its diverse portfolio of work as

with human rights groups, and grass-roots development and social movements to enforce the rights of poor marginalised people and to challenge oppression, exploitation and discrimination against any group or individual on the grounds of caste, gender, disability, age, religion, language, ethnic group, sexual orientation, and health, economic or social status. HRLN provides pro bono legal services, conducts public interest litigation, engages in advocacy, conducts legal awareness programmes, investigates violations, publishes 'know your rights' materials, and participates in campaigns (2015).

HRLN was, therefore, a public interest litigation organization (PILO), “a prototypical example … like the American Civil Liberties Union”, comprised of activist lawyers or “cause lawyers” with an interest in “human rights lawyering” as referred to in the socio-legal literature (Boutcher 2013a, n.p.). It had seventeen different units dedicated to litigating (through PILs) a wide range of human rights issues92. It was born out of the “Human Rights, Social Movements and the Law” workshop conducted by the Indian Human Rights Network in 1989. Its initial goal was to focus on legal aid for the poor and the “about us” section of its website cited the creation of the constitutional provision of PIL in the aftermath of the Emergency Years (1975-77, the first PIL was filed in 1982) as an influential factor leading to its formation. Nevertheless, this section also acknowledged reasons behind HRLN’s growing involvement in cause lawyering, beyond simply provision of legal aid. It observed: “legal aid cannot have much of an impact on society as a whole. So by the late 1980s, PILs went hand in hand with building up a network and campaigns” (HRLN 2015). It is mention worthy that the organization gained prominence through the right to

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92 Including but not limited to, child rights, Dalit rights (caste issues), labor rights, prisoner’s rights, people’s health rights, sexual minority rights, disability rights, HIV/AIDS, anti-trafficking, women’s justice, refugee rights, housing and environmental rights.
food case in the Supreme Court (Union of India v. People’s Union of Civil Liberties 196/2001) in early 2000s, a judgment that ultimately gave birth to the Food Security Act in 2013.

In filing the petition in the Shanti Devi and Fatema cases, the HRLN was supported by the Chicago-based the John D. and Catherine T. MacArthur Foundation (or the MacArthur Foundation), a foreign philanthropic donor with many decades of presence in India. In fact, nearly all maternal health right advocates indicated that the former was considered a widely regarded one of the two “reproductive health donors” in India and other developing countries (such as Brazil, Uganda, Nigeria). The HRLN also received in-kind strategic support and advice from Center for Reproductive Rights (CRR), a New York based non-profit advocacy and research organization promoting women’s reproductive health and autonomy worldwide.93 A review of CRR’s annual report showed that the MacArthur Foundation was listed as a supporter and donor for its activities. It is also noteworthy that CRR was a founding member of the International Initiative on Maternal Mortality and Human Rights (IIMMHR), whose activities were also supported by MacArthur Foundation (according to the Foundation’s report to its Board of Directors). Additionally, in 2006, the CRR and HRLN jointly founded the initiative to “promote legal accountability for violations of women’s right to survive pregnancy and childbirth in India” (CRR 2010a)94. The CRR, a major grantee of the MacArthur Foundation, was also a major player in the Alyne da Silva Pimentel Teixeira (deceased) case (against state of Brazil and before the Committee on Elimination of Discrimination against Women (CEDAW) in 2007).

This case has been recognized as the first ever case of an international human right body holding

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93 The CRR does not have an office in India and the researcher’s efforts at three different occasions between July 2012 and April 2013 for an interview did not yield any response. To circumvent this issue, the research relied heavily on various material available on CRR’s website.

94 In 2008, the CRR published a report titled Maternal Mortality in India: Using International and Constitutional Law to Promote Accountability and Change, which was created “as a legal resource for Indian advocates seeking to use public interest litigation (PIL) and human rights advocacy to establish government accountability for maternal deaths and pregnancy-related morbidity” (CRR and HRLN 2011, 11)
a national government accountable in preventable maternal death case. In this case as well, the same strategy of collaborating with a local legal aid/activist organization was adopted by the CRR (Cook 2013). The CRR’s involvement arose out of its work in the designated initiative of maternal mortality reduction, as reported on its website, and its historical and extensive experience of using legal avenues to advance reproductive rights of women in many of the Global North and South, including United States, Brazil, Nepal, Peru, Hungary. It had also been involved in legal cases involving sterilization in India (Sood 2006).

Key informant interviews with senior officials of HRLN and the MacArthur Foundation’s office in Delhi indicated that the motivations behind filing the petition arose from a combination of factors. First, the interest in strategic litigation was an outcome of an initiative developed by the MacArthur Foundation to seek state accountability for preventable maternal deaths. This, according to senior officials, was a fairly new and recent initiative in India (and being tried elsewhere in Brazil, Nigeria, Uganda). This initiative promoting state accountability for dismal condition of maternal health care in India and also constituted a number of other non-legal strategies – capacity building for maternal death audits and community based public hearings – for which MacArthur Foundation had financially supported other Indian maternal health NGOs (members of NAMMHR, WRAI and select members of CommonHealth). Second, the decision to pursue state accountability resulted primarily from the donor’s belief that adverse maternal health outcomes were symptomatic of poor and weak public health system and lack of political interest in addressing it. Respondents from MacArthur Foundation indicated that the Foundation had worked in the population and reproductive health sector since early 1990s and its beliefs were a product of experiences and observations accumulated over the years. One participant explained:
You have to place the work around maternal health in the context of accountability, which is what we want, which is our goal here for maternal health. There are many different ways of seeking accountability and we support different kinds of work around accountability – better death autopsies, trying to get communities to speak up and question providers and politicians. It could be what we are supporting CHSJ [Centre for Health and Social Justice] for which is using checklist and report cards at primary health facilities, then there is the use of technology. So it is not only litigation and no one approach will get you the attention that this topic deserves. So we are locating the work on litigation in maternal health and reproductive health within a framework of greater accountability. Each strategy one has its strength and weaknesses. Certain things work and certain others do not. Within that for a long time, communities have been asking questions and NGOs on behalf of communities have been asking questions, so let’s be clear that there have been things that have been tried for a while which have not delivered the desired results (CSO#13; emphasis added).

Scholars have demonstrated the involvement of transnational actors, such as philanthropic donors and other actors (including the CRR) in spearheading initiation of strategic litigation in health in developing countries (Roseman and Gloppen 2011). But they maintain the role of donors is largely “catalytic” in nature. But this is not the case for the incidence of the Delhi High Court case, as demonstrated by the CSO#13’s comments above, where she refers very clearly to a deliberate use of litigation along with an implicit acknowledgement that other strategies have failed to yield desired extent of change (there were several gestures of frustration and impatience during the interview, including a defensive attitude). In fact, CSO#13 emphasized that the decision to use strategic litigation arose out of a strategic exercise – undertaken in the early 2000s assessing the results and sustainability of projects supported by the donor during the course of the previous decade – which indicated a lack of sustainable results and transformative change. This runs contrary to Roseman and Gloppen’s (2011) observation that “transnational donors provide funding for litigation does not mean that they provide the impetus to litigate. The recipient institution may still generate the initiative, with the transnational donor serving as facilitator” (253). During key informant interviews with two HRLN officials, they explicitly acknowledged
the generous strategic and funding support of the donor for being able to undertake strategic litigation in maternal health. They also indicated that litigation was their “bread and butter” (CSO#8), which again reinforced the point made by Epp (1998) about the weak SSLM in India, especially their weak financial capacity (one being lack of state support for legal aid unlike in United States for example). At the same time, it resonates with what Boutcher (2013a) suggests about PILOs and their need to litigate as else “these organizations risk looking irrelevant” (n.p.).

However, barring the deliberate decision to use strategic litigation, CSO#13 also emphasized the importance of series of political opportunities afforded by incorporation of maternal mortality reduction in the Millennium Development Agenda (in 2000) and the subsequent creation of JSY and NRHM in India in 2005, which indicated political commitment (although insufficient) for the issue. CSO# 13 emphasized that this indicated the issue had attention from the development community and the Indian governments, which set the groundwork for demanding state accountability. This logic was consistent with what Alston (2005/2007) Schmidt-Traub (2009) Sepulveda (2009) had argued in conceptualizing state accountability by underscoring the complementarity of human rights with consensus on MDGs among states, even though the MDGs did not explicitly refer to rights. For example, CSO#13 observed:

So going back to 2001, we took stock that frankly there was not much that had happened despite 10 years of funding on these issues. Obviously in the earlier part of 1990s, there were fewer grants but that changed in the later part. But there was not much to show in terms of leveraging impact, scale up, may be its partly because India was in a different time and space. We were working differently; NGOs had a different focus. Not to apportion blame or credit; the results were quite shocking to us because we found that beyond the little things we were funding, nothing was sustained in the ground. So we then narrowed our focus to actually looking at maternal health, reducing maternal death and morbidity and looking at young people’s sexual and reproductive rights. The reason we did that was we felt that to some extent, if we focused on maternal health, it also reflects a larger focus on improvement of health systems. We also felt some of those benefits would
trickle down to other sectors, such as women’s health (though we were not funding that). And maternal health had been kind of developed because the work had been going on for many years … and some people said nothing had happened so why are you taking up this boring subject … but there weren’t many organizations working on the issue at that time. *At that time reducing maternal mortality was not on the agenda* (CSO#13; emphasis added).

It was very clear from the above observations by the participant from MacArthur Foundation, that the donor was re-evaluating its priority (reference to strategic exercise around 2001 and also having attention of development community) in light of the MDGs, which were agreed upon by heads of countries in 2000. At the same time, the donor’s beliefs, that maternal health outcomes were indicative of state of health system, was also noteworthy. This observation was consistent with those who underscored the importance of proximate determinants of maternal morbidity and mortality and emphasized the significance of improving health system to prevent morbidity and mortality (Maine and Rosenfield 1999; Yamin and Maine 1999; Freedman 2001/2005; Maine 2007).

According to the two key informant interviewees from HRLN, the political opportunity indicated by the donor was further complemented by availability of legal opportunity (LO) and legal opportunity structures (LOS) in the Indian context. The decision to use strategic litigation was influenced by the evidence of judicial activism and pro-poor policy reform (various social and economic rights cases indicated in chapter 2) which was interpreted as a judiciary willing to intervene where other branches of state had failed. This coupled with presence of legal opportunity structure, such as the constitutional provision of PIL, which facilitated easy access to court. The fact that HRLN was already well versed in PIL and with the Indian judiciary would have simply reinforced impetus for litigation.
During a second round of interviews, and in response to whether and how HRLN’s assessment of potentially leveraging the LO and LOS fit with the criticism of judicial overreach specified by some respondents (especially given the lack of a justiciable right to health in India), one of the two respondents from HRLN observed:

I think the courts have a place to play here, especially if you look at international examples or international law in general, just in terms of the highest levels of government, highest levels of respected human beings pronouncing on these things [i.e. the verdict] in your country. I think there is significance in itself even if it does not mean anything else. Judges in India and around the world are so highly regarded and so highly respected and to have them say that a woman has a fundamental right to survive childbirth, I think that’s very important statement to be made (CSO#8, emphasis added).

There was an implicit acknowledgement in CSO#8’s words, that courts could only play limited role since Indian judiciary had a track record of poor enforcement, as indicated in the previous chapter by state actors and also by several socio-legal scholars (Epp 1998/2003; Gauri and Brinks 2008; Shankar and Mehta 2008; Yamin and Gloppen 2011; Parmar and Wahi 2011; Brinks and Gauri 2012). Yet, the participant emphasized the role of courts in addressing injustices experienced by the poor where other branches of government were not responsive. She was cognizant of the implications of judicial overreach for a democratic state but also sympathetic to the extraordinary nature of the status-quo political conditions, including the lack of explicit accountability mechanisms in health (Robinson 2009; Gauri and Gloppen 2012; Gauri 2009). The participant observed:

In terms of court actually making guidelines and policies, I am working in the status quo framework here. If people disagree with the overreach of the court, at that level it means that there needs to be an overreach to adjust the balance of power. That is exactly what the Court is set up to do in absence of legislative or executive policies that enforce basic fundamental rights for people. The court steps in there. You find the Supreme and High Court saying we are not legislators we do not want to do this. We just had a ruling in the drug pricing control and the court said we do not want to do this. But in the absence of the meaningful action [from legislature], we are going to say that you can’t raise the drug
prices past a certain level. I think people who say that court should not reach out and do this are 100 percent right. They should not have to reach over and do this but when you are at a point where there is such systematic violation of fundamental human rights, what options are you left with besides to go to the courts? Who will reluctantly step in and protect people’s fundamental rights? I am all for very dedicated and committed bench but in an ideal world we would not have to file these cases. In an ideal world the legislature would have accountability mechanisms for violating human rights for non-implementation of government schemes. But until that happens, the Indian Constitutional system mandates that the Supreme Court and other courts fill that void” (CSO#8).

One participant from HRLN also indicated that the presiding judge in the specific court case, Justice Muralidhar of the Delhi High Court, had been a prior participant in one of the many judicial colloquia organized by HRLN. This was confirmed by three different key informant interviews, including two associated with the Office of Supreme Court Commissioner for Right to Food (OSCC) who participated in these colloquia organized by HRLN. The colloquia were intended to sensitize judges to ongoing issues of economic and social rights (in accordance with ICESCR ratified by India) around the country. These colloquia sometimes involved participation of general public who would share their experiences of denial of access to various public services, such as government promised entitlement benefits. Respondents from HRLN and two other members OSCC confirmed that they “were fortunate to have Justice Muralidhar assigned to this case” because of his knowledge, expertise and sensitivity to international human rights law and his ability to navigate through a number of important international agreements and treaties, such as the CEDAW, the Beijing Declaration, the UDHR, the ICESCR and the CRC (all ratified by India) which he used to adjudicate the case (demonstrated in next section). But they confirmed that the litigants were assigned by the court system this particular judge as opposed to have a say in selecting him. Nevertheless, the significance of being assigned this particular judge could not be undermined as a possible mobilization resource available to HRLN by virtue of its
organization of judicial colloquia. It was noteworthy that this particular presiding judge was subsequently involved in initiating two “suo motu” (initiated by the court) PIL cases on maternal health (HRLN and CRR 2011).

According to respondents from HRLN, there was no involvement (in the court case or at claims formation stage) of any other civil society actors working on maternal health and human rights. This was corroborated during interviews with twenty-two key informants belonging to different Indian maternal health NGOs (including the three coordinators of the maternal health and human rights coalitions) who had no knowledge of how the court case came about. Conversations with civil society respondents, including those from HRLN, MacArthur Foundation, maternal health NGOs and activists (including legal activists and those with OSCC) pointed to a complex set of reasons for lack of involvement of maternal health right advocates in the claims formation stage of the Delhi High Court case. Four main themes emerged which led to disagreement over use of litigation as a framing strategy between HRLN and non-legal maternal health advocates.

The first concern unanimously highlighted by maternal health right advocates was the protracted nature of litigation and its resource (financial and human resources) intensive characteristics. Respondents indicated the significance of legal expertise, which was not their usual domain of professional expertise, which required them to rely on other strategic actors. Litigation was also seen as expensive and time-consuming process especially given the uncertainty of outcomes (including potential risks of adverse outcomes). In other words, these respondents believed they did not have the resources and procedural knowledge necessary to strategically use litigation, as a framing strategy to mobilize desired political support for maternal morbidity and mortality. Instead they preferred lobbying government officials, which would admittedly yield slow and incremental change but was less risky and more sustainable in the
longer term. This latter issue speaks to the lack of control over public purse among courts – in India and elsewhere – as raised by many socio-legal theorists (Baxi 1988/2002; Rosenberg 1991; Nelson and Dorsey 2008). Collectively, both the former and latter issues underscore the classic reasoning provided by framing theorists over why some actors may prefer (or not) to litigate and others not (Gloppen 2011; Schon and Rein 1994). Preferences for mobilization strategies are inherently products of political opportunity structures available to frame sponsors, mobilization resources available to them (including knowledge and expertise) and their individual interests.

A second concern underscored by all fifty-two civil society respondents – other than two respondents from HRLN - involved lack of faith in courts to address issues of systemic discrimination and structural injustice. Such injustices they argued were reflective of broader social attitude that could not be addressed through litigation and involved sensitizing the system and individual health care service providers. The pointed to the various constitutional and legal protocol which outlawed discrimination against women, against Dalits and Adivasis but were not really enforced by the state, including the courts. This speaks to the criticism outlined by feminist critiques of human rights and development, who point to the gap between formal legal equality and substantive equality as experienced by women, including the extremely poor and socially excluded citizens (Kapoor 2007; Goetz 2007; Mukhopadhyay and Singh 2007 ed.). At the same time, it is also consistent with the skepticism indicated by some socio-legal scholars over whether litigation can address issues of structural injustice characterizing health systems, including speculations in case of maternal mortality (Hunt and Bueno de Mesquita 2010; Yamin 2011). One participant from HRLN, in response to these criticisms, acknowledged the challenges but still maintained the importance of holding the system accountable for failing to uphold its promises to poor citizens. She argued: “while that is commendable and necessary goal worth
pursuing, in the mean time it is equally important to hold the system responsible for the promises it has made to poor citizens” (CSO#8).

A third reason for aversion to litigation as a framing strategy, cited by seventeen maternal health right advocates, two legal activists and all three women’s rights activists, was lack of faith in courts in relation to specifically women’s rights. The recounted the “uncomfortable relationship” between Indian women’s movement and courts, which pronounced judgments that seemed progressive on the surface but were couched in patriarchal logic. This they maintained made women’s rights activists somewhat averse to approaching the courts because it was seen as a difficult policy forum to achieve progressive judgments for women’s rights. In relation to court’s behavior and attitude to various women’s rights issues (widow burning, sexual and domestic violence, dowry deaths), one legal activist observed: “So their reception of what the women’s movement was saying came through their filter of patriarchy and a filter of paternalism” (LAS#4). This participant emphasized that the Indian women’s movement had a history of rallying and mobilizing support against judicial pronouncements, rather than leveraging judicial activism to bring about substantial change in women’s social status. LAS#4’s elaborate explanation in this context was noteworthy:

One is that the women’s movement, the second wave, from mid 1970s onwards since when we have had the status report, it has not used the court very much. It has used the law – changes, amendments, lobbying at the Parliament - because the basic legal structure itself did not and still doesn’t provide the space for dignified respectable agents so the focus was not on the courts. And the women’s movement in fact started interestingly enough … one of the core issues which fueled feminist organizing was the rape of Mathura - the famous Mathura rape case. That case did not result in a positive verdict, there was an open letter to the chief justice, which was radical for that time. It was at the parliament and in the political space that negotiations happened, not in the judicial space. So for example, take the violence against women in dowry death and domestic killings and the Sudha Goel case (Laxman vs. Delhi administration). This was a case where the victim was eight months pregnant and burnt to death. The Delhi high court was very lenient on the accused, which included the husband, the mother-in-law, and the brother-
in-law so there were huge protests and the case was appealed. The Supreme Court took it up and it was an interesting case to see how the court heard what the women’s movement had to say. It was not just what the court did but what the court thought the women’s movement was saying … the judgment ended with saying that women were divine … no one wanted divinity, we did not want to be put on a pedestal for the crows to shit on our heads … come on give us a break! But that’s how the court heard it so their reception of what the women’s movement was saying came through their filter of patriarchy and a filter of paternalism. So the court’s understanding of that was very low and this is why the activists did not use the court as the primary strategy but used law for its discourse, meaning that judicial activism was not really the domain in which women’s rights were being debated. There were cases that came up after that such as sati [widow burning at funeral of male spouse] but there too it was the legislation and action on ground that was far more superior and significant than judicial activism. For examples, the Bhavri Devi judgment that was given in sessional court proved to be something on which the women’s movement was able to rally a lot of people because the Bhavri Devi was attacked and raped because she had stood up against child marriage. This was open and known to everyone and the state could not protect her and then you have a judiciary saying high caste men would never do this to a lower caste woman … why would they touch her? It was like the most absurd judgment but after it was given, the women’s movement rallied against it. But it was not as judicial activism, it was the functioning of judiciary in its regular role as a judicial system, as judges (LAS#4).

While other respondents did not elaborate at this depth, there was a general lack of confidence in courts as being able to address the intricacies of women’s rights without patronizing women. This speaks to both the issue of confidence in courts that as been underscored by John Hart Ely (1980) and the issue of procedural knowledge underscored by framing theorists about the suitability of certain policy forums for particular discursive deliberations (McAdam et al. 1996; Joachim 2007).

But both these issues – lack of confidence in courts and procedural knowledge – received more pronounced mention among maternal health right advocates and two public health activists in relation to Indian judiciary’s dubious track record on two-child norm and coercive population policies. Selected examples of such “absurd judgments” (LAS#4) in case of women’s rights, including reproductive rights have been discussed in chapter 2. These concerns were particularly
prominent among six members of NAMMHR and also intermittently indicated by other twelve maternal health advocates who observed that the issue of maternal health was a “delicate issue” that was best not raised before courts (same choice of words used by CSO#16, LAS# 1 and #2, CSO#4). In explaining their beliefs, these eighteen respondents referred to the growing complexity of reproductive rights politics in India as the issues of family planning, maternal morbidity and mortality, child marriage and sex-selective abortion intersected in a complicated manner. Even though each issue underscored different dimensions of gender injustice, fragmentation among women’s movement over the causal factors and appropriate solutions to address these issues had made it “tricky” to discuss them before the state – and especially courts. This is because the eligibility criteria for JSY (that is, maternal health care entitlement) excluded women under 18 years (who were victims of child marriage) and women with more than two live births, especially in the EAG states (as discussed in chapter 2). It was therefore difficult to raise the issue of denial of maternal health care entitlement before the court without referring to cases where such denials involved women below legal age of marriage and/or women who had more than two children. Likewise, maternal health right advocates accused sex-selective abortion advocates for demanding greater regulation of abortion, raising fears of lack of access to legal abortion critical to maternal and reproductive health outcomes. Hence, there was a fear that approaching courts to secure women’s rights to maternal health could lead to erosion of existing hard-won rights. To that end, all four legal activists and both constitutional studies scholars mentioned that the courts were becoming more “conservative” and the assessment of risk by maternal health right advocates was very likely. This the former attributed to both “too many” cases of PILs and higher courts growing more sensitive to the issue of population stabilization (and resource distribution) repeatedly underscored by bureaucrats. They underlined that there were several counter-affidavits filed (some still waiting to be heard) by the executive branch
before the higher courts challenging selective orders in the right to food judgment in which Supreme Court upheld (in 2001) reproductive freedom and refused to let the state regulate reproductive behavior through integration of two-child norm policy. In sum, there was evidence of conflict across frames (gender injustice and reproductive injustice) among frame sponsors within the women’s movement, which had made it difficult for these actors to reflect on other’s frames (because of differences in beliefs and perceptions of the policy problem). It had made it difficult for them to recognize that the overarching concern facing them was different forms of gender injustice and had undermined solidarity within the women’s movement leading to frame disputes (Toyo 2006; Molyneux 2007; Win 2007; Cornwall, Harrison and Whitehead 2007; Schon and Rein 1994). This frame dispute had a further adverse impact among frame sponsors within the Indian maternal health and human rights discourse, which was linked to disagreement over, preferred framing strategy.

A fourth and final concern against litigation raised by all maternal health right advocates involved HRLN’s failure to consult and collaborate with them prior to undertaking litigation. This was partly attributed to disagreement over all three aforementioned reasons and partly credited to the fact that HRLN was being funded by donors specifically to litigate, as opposed locating such litigation in the broader and ongoing political struggle surrounding the issue of maternal health. At least six maternal health right advocates from the three different human rights coalitions underscored their failed attempts (at several occasion) to strategically engage with HRLN. They attributed this failure to HRLN’s single mindedness about undertaking litigation, which they viewed as “only one strategy among a continuum of advocacy strategies” (CSO#16). Further enquiries in this regard with HRLN, maternal health right advocates, and the MacArthur Foundation revealed complex tension between these actors, including frustration with HRLN’s approach of selective engagement (when searching for “interesting cases/incidences”) and lack of
sustained collaboration with grassroots collectivization on maternal health and human rights.

Two of these respondents even hinted on being denied funding to undertake advocacy activities that aimed to promote a broader approach including litigation. The coordinator of one of the coalitions (identification deliberately withheld) recalled feeling surprised when she first heard about the incidence of the court case. She maintained that members of the specific maternal health and human rights coalition were not “consulted” about the decision to approach the courts (CSO#2). Two other members of the same coalition indicated disappointment in HRLN’s approach because community health workers trained by the former were the first to document and contact media for both incidences of morbidity and mortality to media. These respondents saw the lack of acknowledgement from HRLN or consultation with members of this specific coalition as sidelining their work. CSO#2 who had “worked quite closely with HRLN for 10 years” observed:

To me it seems the court making a pronouncement, which the executive cannot fulfill, leads to an empty piece of paper. If tomorrow in X state the court was to give pronouncement to the state government, that get your act together, you know what the government is going to show in six months … hardly anything. It is going to take time as I am telling you to put this system back on its feet. And this is where I feel the HRLN’s strategy is the weakest. HRLN does not consistently engage with civil society groups working on maternal health. They do approach the groups when there is a case or when there is a report because that is something they can use to fight in the court. They do not engage in a continuous dialogue and the consultation of what should we ask as judicial remedies. That has to be grounded in what civil society organizations understand from their experience as being feasible and important. That dialogue is completely missing and that is something we are struggling to engage with them on, for at least past 3 years. And it has not worked.

We have made continued effort to engage with them, in dialogue. Even with many other issues, many other cases, there is this absence of a consultative and a collegiate process. We had worked with them around ten years ago around female sterilization operations and so we have extremely first-hand experience of how they engage with the civil society and the litigant. We have found that they have completely … even at international levels … ignored the fact that we are providing them with the key cases … it is just obliterated.
For instance, there was a case on which we worked with them in X state. It was a maternal morbidity case, and they had written about it in international publications, quoted in global conferences but they never mentioned that the case was actually documented by Y, a community based group our organization works with. The whole treatment (the saving of the life of that woman) was done because Y worked for a year with that family … nowhere, absolutely no mention. So it is not just lack of consultation and lack of engagement, it is also a lack of respect for the contribution that civil society organization are making (CSO#2, emphasis added).

On further probing about whether this was an issue of lack of acknowledge and credit attribution alone, these respondents argued that consultation was also important to ensure that the claimants and community (whose interests and experienced of injustice were being raised in the court) had a say in the decision to litigate (and its exact scope). They considered interest and support of the community imperative given that principles of inclusion and participation were so central to the notion of human rights. Few raised significance of ethical considerations in involving select community members in lengthy court battles, which could lead to psychological isolation and indirect social victimization of rights holders at the community level. One human rights scholar argued that undertaking consultation with community and individuals involved “back-breaking work and raising rights consciousness of individuals, educating them on what constitutes violations and how they take place so that individuals can recognize when a wrong is being done to them” (AC #11). But this she maintained was “… time and resource intensive; … nearly not as “sexy” as human rights activism although human rights education forms an integral part of the latter” (AC #11). She implied that such work might not be attractive to HRLN. The method of working alone, prominent in HRLN’s approach, is what some socio-legal scholars have called the “go it alone” method often used by some cause lawyers (and some PILOs) which stands to divide activists and sideline grassroots mobilization efforts (Boutcher 2013b; Meyer and Boutcher 2007). This was also corroborated by three different maternal health right advocates.
who referred to frequent enquiries from HRLN about “interesting cases/incidences”, new research and fact findings report, and contacts of possible “victims” following media reporting of incidences of maternal deaths. But these never materialized into deeper cooperation. Further enquiry, however, revealed deeper issues surrounding donor funding and competition among civil society groups pointing to larger issues at play in fragmenting advocacy efforts in the Indian maternal health and human rights camp, and leading to frame disputes.

On probing more about the CSO#2’s assessment of the reasons behind HRLN’s peculiar approach, she indicated a lack of appreciation among HRLN and the donor agency (the MacArthur Foundation) that judicialization of rights could not work in isolation from the politics of rights claiming at the grassroots level, especially as experienced by citizens.

I have no idea. We have brought this to the attention of the people who fund them but we haven’t seen any change. If anything, it has just got worse. I feel when I talk about the three pieces of rights-based approach, if the judicial activism is not drawn from rights claiming individuals which is grounded in rights claimant citizen action then the judicial pronouncement will not be used by these institutions, these networks or these women to hold the service component accountable. I feel that unless judicial action is coming from a people’s movement claiming it and unless the judicial pronouncement is again taken up by the people’s movement, to claim accountability and to put pressure on the government that piece of paper [the judgment] is worth nothing. Unfortunately, I perceive this is happening with maternal health related litigation” (CSO#2).

The concerns articulated by CSO#2 (and also supported by CSO#16 and #24) were raised by the researcher before respondents from HRLN. Both respondents (from HRLN) argued that they had received donor support because of their demonstrated track record of successfully litigating various economic and social rights cases in India (including the right to food case). They also maintained that HRLN was a one of the few PILOs with a dedicated unit (to reproductive rights)

Part of it is that we got generous support from MacArthur Foundation and we have a reproductive rights unit, which has always been exclusively devoted to this kind of work. We have the funding to enable to do this. … I think because HRLN has a reputation from all other cases. We got the MacArthur money and we have been able to establish
ourselves, as this is what we do. But I don’t know other groups who do similar work” (CSO#8).

Additional probing also indicated a lack of agreement between litigating actors (such as HRLN) and maternal health right advocates over how to approach courts. This divide, over the right time and opportunity to approach the court and the amount of groundwork necessary as a pre-requisite to pursue litigation was perceived by CSO#8 from HRLN as a contributor to tension and further fragmentation between maternal health NGOs and legal advocacy groups working on the same issue. The participant observed:

… some of them do not think the courts should be doing it, some think you should spend all this time setting the stage for litigation and then file in the lower court and have it slowly make its way up. We have seen, nothing as dramatic as infighting or splintering, but there have been conflicts between different groups working on the same issue surrounding whether or not we file to Supreme Court, High Court, or do we file at all, do we have enough facts, etc. When you have these groups working at the same issue, you obviously have the challenge of having everyone at the same page and I have seen litigation stir that pot a little bit. (CSO#8; emphasis added).

Two maternal health right advocates underscored the significance of a case “making its way up from lower courts” which allowed them to gather momentum and broader support as opposed to filing petitions directly at the High Court level (as allowed by PIL). Implicitly, such a belief could be a product of historical conditions where women’s movement had mobilized outside the courts, as cases were being heard and re-appealed at higher courts. But it could also be connected to the issue of “easier access to highest courts in public interest cases” that has been isolated as a factor leading to greater instances of judicialization of health rights noticed in some countries (India being one) (Gloppen 2011). The point being this easier access to higher courts might have undermined possible opportunities of collaboration between maternal health right advocates and HRLN and fragmenting efforts to advance state accountability for maternal health.
Furthermore, one maternal health right advocate hinted at various factors that may have led HRLN to consider the use of strategic litigation to create changed in official maternal health policy and program. The respondent specifically suggested the examples presented by the right to food case which had strong extra-legal support from various civil society stakeholders and the Pre-Conception and Pre-Natal Diagnostic Test Act (PCPNDT Act) that was initiated by very senior bureaucrats in the Central MoHFW. But the respondent underscored that these were distinct cases of homegrown social rights litigation, unlike the Delhi High Court case that had support from the CRR, a transitional actor. This respondent believed as a litigating organization the CRR (even though it had made important contributions) only partnered with other domestic litigating organizations, such as HRLN, which excluded grassroots maternal health NGOs from having any involvement in the overall litigation process.

See, currently there is a hype with litigation. PCPNDT and the right to food case are chiefly responsible for this because they have led to significant changes in government behavior. I completely agree with litigation as a strategy but I feel litigation needs to be understood in a continuum of strategy around change. What has happened is that the Right to Food has witnessed creation of a broader coalition of people, change through the Commissioner’s office, advisors to the commission itself. The right to food campaign has a much larger life around itself beyond litigation, beyond affidavits being filed and counter affidavits in the Supreme Court order. It has taken a life of its own. PCPNDT was an interesting case because Sabu George was sitting in the Ministry and doing the case, it was during Mr. Nanda’s [former Chief Secretary, Union MoHFW] time. And he supported the litigation as the health secretary so it was a collaborative litigation. But for the other cases I know, litigation is stand-alone. HRLN is slightly ‘dumadum court case lagado’ [file away petitions].

The litigation grants all go to lawyer’s groups. I have asked funders for litigation grants but they have not given. I have tried to tell them that litigation is a part of a continuum of human right approaches. But it has never happened. So when HRLN does a case, it is very sporadic. Because they are overstretched they don’t have time to do process. If they do consultation, they do not collaborate with us. I have been a little frustrated with litigation as a stand-alone strategy. Sometimes the international support for it also makes
it a little problematic … CRR litigation support is important and they have played important role in a couple of cases, even in family planning. But they tend to ally only with the litigating agency and the process of litigation. … somehow I feel on maternal health, I have tried to have conversation with HRLN on maternal health cases, asking them what are the cases they have at various locations and states … what is the state of these litigations … that we should sit down and talk it through and learn from each other … but it is not happening. Suddenly they will ask me, what can we do with this case? Give us some new data and I have responded each time with new data. But I feel we have not been able to do this strategically (CSO #16).

The lack of involvement of grassroots organization, CSO#16 also believed, had adversely affected HRLN’s ability to consult communities because of limited capacity to undertake non-legal activities. This divide was partly attributed to difficulties of overcoming a gap in communication, which framing theorists would argue might be symbolic of existence of frame conflict and inability do undertake frame reflection (Schon and Rein 1994). But it was also otherwise attributed to the donor’s preference to financially support litigating organization without recognizing the role of broader support (including the groundwork required to mobilize communities) and its impact on strategic litigation.

The researcher made further enquiries with the MacArthur Foundation, which had funded (and had continued to fund) HRLN, regarding interest from other groups in the litigation advocacy strategy. A senior official of the Foundation clarified their limited ability to support capacity building work among non-legal NGOs and instead preferred working with NGOs, which already had infrastructure and ability to take on legal advocacy. This was noteworthy both in light of Epp’s (1998) observation about the weak support structure for legal mobilization (SSLM) in India, including the lack of legal capacity among women’s rights organizations (as also indicated by the participant below). But it also raises the issue of significance of building such
capacity given the growing popularity of “rights-speak” among civil society groups in India and elsewhere. The participant explained:

[Interviewer: From a donor’s perspective, do you know of other organizations interested in exploring litigation as an advocacy strategy?

Where are the organizations, there were couple others we had funded earlier. One was looking at not maternal health, but it was looking at PCPNDT act and domestic violence, that is Lawyers Collective, but to a large extent with Indira Jai Singh [the director of Lawyers’ Collective] becoming part of government [the Assistant Solicitor General for the Central Government under the Congress party reign prior to 2014 general elections] that work has not grown. It is clear to me that there are interests but what is not clear is who is leading, what is happening there. So we have tried to fund other organizations, such as Majlis, but they are different legal group with their own work. This actually goes back several years; it was to build district level lawyers who could work on the issue of reproductive health and rights and that sort of things.

We are coming at it from a more population and reproductive health type platform. We are not a human rights organization donor. So we cannot do building capacity of lawyers to be involved in the development sector. We are not in the broad space where we are creating capacity of lawyers; we are not, we don’t have that kind of financial strength and power. We are very much on the population and reproductive health donor. Within that we can only fund organizations who already do this work; we can’t go out and fund organization to first capacity build to be able to get into this line of work. Prior to 2002, we funded work on women’s rights in general and legal work in that context; so we have had a history of engaging. I would say HRLN has benefited in terms of capacity building indirectly from our funds because one of our international grantees, CRR has worked very aggressively with all of them in HRLN. Some of the cases that got taken into court were as a result of CRR’s close cooperation with these organizations. See, a donor is a donor. We funded as many legal groups as there were in India. Some had grown and some had collapsed because of their own structures. It has nothing to do with us as such. We cannot take credit or nor can we be blamed for not having salvaged those organizations (CSO#12, emphasis added).

Furthermore, CSO#12 also hinted at having tried to promote collaboration between different domestic civil society groups working on maternal (and reproductive health) but failed due to internal fragmentation, possibly due to competition over funding and preferences for niche
competencies. This is line with what feminist scholars have pointed to as the growing phenomenon of NGO-ization of social and women’s movements that has been fueled by professionalization of such groups as well as competition over shrinking pool of donor funding (Alvarez 1999; Cornwall and Molyneux 2006). This is very explicitly captured in CSO#12’s response to the researcher’s enquiry below:

Interviewer: Why do you think there is this lack of sustained collaboration between legal activist organization and maternal health NGOs?

Because everyone has their own competency, they are so focused on what they are doing. They get grants to do different things and then let’s admit that there is a competition between different groups. It is always been the case and as much as we have tried to promote collaborative work, we cannot force it. It is obvious to me that there are factions that exist and if people do not want to collaborate, they do not collaborate. The weaknesses and fractures are very obvious to me; it is not like I do not know. But beyond putting people in touch and sitting in a meeting or two, I cannot force them to do things. They should see the value in working together; if it does not happen, it does not happen. You can be critical of it, but who in India works together. May be it is something endemic to civil society groups. It is very obvious and each one is chalking for more importance frankly. I wish there was a little better collaboration between the two but we can’t force it. They should realize that their skills complement each other’s. They are tolerant, but if they cannot come together and work together, what can we as funders do. We try to facilitate exchange but unless they want to collaborate it is really difficult for us to force them to do it. We will be happy to fund one if they form one (CSO#12; emphasis added)

CSO#12’s explicit observations above in regards to lack of collaboration between legal advocacy groups and maternal health NGOs was noteworthy. This is because socio-legal scholars have underscored that role of support from broader social mobilization in case of strategic litigation for furthering the progressive verdicts achieved through litigation. This is attributed to the crucial link between grassroots mobilization and successful implementation in the aftermath of a desired judgment (McCann 1994/2006). Likewise, Parmar and Wahi (2011) have underscored the significance of grassroots support including the role of media and social commentaries in
generating public awareness about the issue being litigated, creating political pressure and affecting implementation in case of the right to food case in India.

In conclusion, the discussion so far has revealed that the Delhi High Court case arose out of complex intersection of interests, access to different political (or legal opportunity structures), and availability of different mobilization resources. Collectively these factors determined the preference (or not) of using litigation as a framing strategy among actors who were involved (or not) in the court case. However, differences in preference of framing strategy also led to HRLN being the main actor behind the articulation of claims underscored in the petition filed before the court. The next section examines these articulations, both their diagnostic and prognostic elements, including their legal basis and the remedies sought from the court. Together, they help to decipher the frame or policy position presented before the Delhi High Court.

**Articulation of Grievances, Rights Claims, Legal Basis and Remedies Sought**

A close examination of the petition (see Appendix 1) filed by HRLN in the Delhi High Court revealed denial of multiple benefit schemes. These included the (1) Janani Surksha Yojana (JSY), (2) the National Maternity Benefit Scheme (NMBS\(^95\)), (3) the Integrated Child Development Scheme (ICDS\(^96\)), the (4) Antyodaya Anna Yojana (AAY) and (5) the National

\(^95\) The NMBS offers pregnant women a cash assistance of Rs. 500. This assistance is independent of the assistance provided to women under JSY. The Supreme Court in a verdict given on Nov 20, 2007 has already passed an order to that effect (with communication to all sub-national governments). Specifically, in that verdict the Court ordered the benefit to be administered to women at least 8-12 weeks before child birth and be administered *each time* a woman was pregnant “irrespective of number of children and the age of the woman” (as quoted in Justice Muralidharan 2010, 7).

\(^96\) The ICDS scheme has existed since 1975 and its primary objective is to improve the “nutritional and health status of children in the age group of 0-6 year” and it provides a range of services including food, immunization, regular health check-ups and referral services, among others, to the child. In 2006, upon review of reports from Chief Health Secretaries (at the sub-national level), the Supreme Court had ordered for universalization of ICDS and directed the authorities to “[extend] all ICDS services to every child under the age of 6, all pregnant women, lactating mothers, and adolescent girls” (Ibid., 8-9).
Family Benefit Scheme (NFBS\textsuperscript{97}). The denial of JSY, a maternal health entitlement was indicated to be “violation of reproductive rights of a below the poverty line (BPL) woman” (HRLN 2009; emphasis added). Furthermore, the petition described this denial as leading to “humiliation and loss of human dignity of many poor women who seek emergency obstetric care” (Ibid.). Implicit in this latter reference is violation of right to life. In contrast, the denial of NMBS constituted a violation of a 2007 Supreme Court order in 196/2001, which is the right to food case, by the Union MoHFW. The latter had filed a counter-affidavit against this order but it was waiting to be heard at the time of the death of Shanti Devi. Denial of the ICDS scheme (which provided nutrition, immunization, regular health check-ups and referral services to initially children) was a violation of a Supreme Court judgment ordering universalization of the scheme to “all pregnant women, lactating mothers and adolescent girls” (ESCR CaseLaw Database., 8-9). As well, the administration of the AAY, a nutrition scheme, was denied due to lack of documentation (the “red card”) required to access nutrition through the public distribution system. The lack of documentation resulted due to migration from one sub-national state to the other. Finally, the NFBS was a scheme that assured the family a lump sum grant upon the natural death of the “primary bread winner” and substantial contributor to the family of a household living in BPL conditions, male or female between the age of 18 and 64.

Moreover, these denials constituted violations of “different facets of the right to life under Article 21 of the Constitution” such as the right to food, right to health, “reproductive rights of the mother and the right to nutrition and medical care, of the newly born child” (ESRC Case

\textsuperscript{97} The NFBS is a scheme under the National Social Assistance Program, a flagship social assistance scheme of the Central Government in which upon the natural death of the “primary bread winner” of a household living in BPL condition, the family is provided with a lump sum grant (adjusted year to year but typically at least Rs. 10,000 as of 2012). The primary breadwinner could be male or female between the age of 18 and 64, and this individual’s earnings ought to have been a substantial contributor to the household income.
Database 2010). It also constituted a violation, by the authorities of earlier Supreme Court order (196/2001) asking officials to administer maternity benefit schemes regardless of number of live births. The petition also outlined multiple violations of health care entitlements promised to pregnant women, lactating mothers, newborn and children under Article 25 of UDHR, Article 10 and 12 of ICESCR, Articles 12 and 14 of CEDAW, and Articles 24 and 27 of Convention on the Rights of the Child or CRC (Ibid.). These articles are quoted in Appendix 1. Additionally, it indicated that Shanti Devi (in the W.P. (C) 8853/2009 case) failed to receive necessary emergency medical care from four different health care facilities since she was unable to afford user-fees sought by staff at these facilities to access benefits, which were supposed to be offered free of cost. During this entire period, Shanti Devi carried her 32-week dead fetus in her womb. One of these facilities was a private hospital which was bound by the “Delhi Directives” that required private health care facilities built on land subsidized by the government to reserve 10 percent of their beds for the BPL population and provide them with “free treatment” (Ibid.).

In case of Fatima Begum [W.P.(C) 10700/2009] who suffered from severe maternal morbidity the first four (JSY, NMBS, ICDS, AAY) of the above benefit schemes were denied. This was because her pregnancy had not been registered with the local sub-centre. The petition indicated denial of (1) reproductive rights, (2) right to health and (3) right to food. Second, Fatima Bagum was forced to give birth under a tree, outside a health facility, which contributed to high risk of infection. She was epileptic but did not receive special medical care required by pregnant women with such condition. This was categorized as denial of “right to human dignity” (HRLN 2009b). The legal basis of these claims was Article 21 of Indian Constitution (right to life, further interpreted and expanded to right to health and right to food) and International Legal Protocols such as Article 25 of UDHR, Article 10 and 12 of ICESCR, Articles 12 and 14 of CEDAW, and Articles 24 and 27. Third, the petition also indicated corrupt activities at the MCD
Maternity Home “to escape accountability” for “falsely record[ing] in their hospital records that the victim-Fatima gave birth at their medical institution”. This Maternity home had actually denied her admission when she first approached it, following which she gave birth under a tree outside the institution.

As remedies, HRLN presented the following prayers before the court. It asked for “(i) compensation to the victim for the medical negligence and humiliation and abuse from medical staff she and her family were forced to endure. (ii) Disciplinary action against the hospital staff involved (iii) full implementation of the Service Guarantees set under the National Rural Health Mission (iii) an order instructing strict implementation of the Delhi Directives regarding free bed and free treatment to all persons living below the poverty line” (HRLN 2009 a/b). The table (Table # 3) below provides a summary of the grievances, articulation of rights claims and remedies sought from the court.
<table>
<thead>
<tr>
<th>Cases</th>
<th>Grievances</th>
<th>Articulation of Claims (that is, violation of _____)</th>
<th>Remedies Sought</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shanti Devi Case (W.P.(C) 8853/2009)</td>
<td>Lack of implementation of JSY, ICDS, AAY and NFBS</td>
<td>Right to Health</td>
<td>Compensation to the victims for medical negligence and humiliation and abuse from medical staff</td>
</tr>
<tr>
<td></td>
<td>Denial of NMBS as per Supreme Court order 2007 in 196/2001</td>
<td>Right to Food</td>
<td>Disciplinary action against the hospital staff involved</td>
</tr>
<tr>
<td></td>
<td>Denial of AAY due to failure to provide eligibility documentation</td>
<td>Reproductive Rights</td>
<td>Full implementation of the Service Guarantee set under the NRHM</td>
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<tr>
<td></td>
<td>Demand for user-fees for entitlements to be provided for free</td>
<td>Delhi Directives (provision of free bed and health care in private health care facilities for individuals belonging to BPL)</td>
<td>Strict implementation of Delhi Directives regarding free bed and free treatment</td>
</tr>
<tr>
<td>Fatima Begum (W.P. (C) 10700/2009)</td>
<td>Lack of implementation of JSY, NMBS, ICDS, AAY because of lack of registration of pregnancy in the local sub-centre</td>
<td>Right to Human Dignity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Falsifying records indicating admission of victim to health care facility even though admission was denied</td>
<td>Right to Life (in Shanti Devi’s case only)</td>
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</tbody>
</table>

Based on the summary of grievances indicated in the above table, lack of access to health care by way of poor implementation and corruption leaped out to be causal factors. By extension, both systemic and individual accountability were within scope of consideration. Yet, given that Shanti Devi who died in childbirth was asked to provide user fees at all four facilities from which she was denied care and turned away, individual accountability alone would be inadequate to address this problem. That is, systemic and individual accountability were inseparable in this case. To that effect, the remedy – “disciplinary action sought against the hospital staff” –
constituted a punitive mechanism that some maternal health right advocates argued against because of its tendency to single out individuals in a system that perpetuated such practice (as demonstrated in the previous chapter). Similarly, falsifying records indicating admission of Fatima Begum to health care facility even though admission was denied (in case of Fatima Begum) spoke to a systemic practice – rather than only individual, as pointed in the petition – of manipulating logs of institutional births/ maternal deaths (to have conservative estimated for MDG 5 target). This was evident in both the scholarly literature and during interviews with maternal health right advocates (Langdon 2008; Kahane 2009). Both underscore the challenge of attribution of responsibility to appropriate parties where no specific laws (justiciable right to health) and policies exist. The overall point being that some of the remedies sought in the petition addressed the issue of individual accountability, even though such individual accountability could not be easily untied from institutionalized practice.

By the same logic, the demand for compensation for individual petitioners in both cases underline the overt tendency of seeking individual remedy (as indicated in the literature), that could have limited impact in creating systemic improvement and reducing disparities in access to maternal health care (Grover, Misra and Rangarajan 2014). As demonstrated in the previous chapter, this was an issue raised by both state officials and maternal health right advocates who underscored the absence of a justiciable right to health as perpetuating cases of individual remedy that fell short of creating systemic reform. Arguably, the petition did ask for full implementation of services “guaranteed” under NRHM – pointing to the political opportunity for systemic accountability underscored by creation of this central agency. But this overlooked that full implementation was conditional upon availability of resource and infrastructure, which the expert maternal death audit report pointed out, did not exist in the public facilities – either the sub-centre, the primary health centre or the public distribution centre which were either dysfunctional.
or closed during normal service hours – where the two petitioners lived (Prakashamma 2010). That is, while there was a theoretical service guarantee in the design of NRHM, this had not been complemented by requisite resources and budgetary allocations. This was, therefore, a missed opportunity to underscore budgetary accountability, which had resulted in denial of care, and needless referrals that led to the death of the fetus in case of Shanti Devi and extreme morbidity in Fatima’s case.

In terms of articulation of claims, what stood out was the reference to violation of reproductive right. This was meant to capture – according to the two respondents from HRLN – both the denials of NMBS and JSY. One participant explained that the denial of NMBS because the petitioners had more than two pregnancies (not just live births) constituted disregard for right to reproductive self-determination. In contrast, the denial of JSY constituted a denial of access to maternal health care. The respondents argued that both were seen as crucial to fulfilling reproductive self-determination and they did not foresee any challenges in raising these before the courts despite the delicate nature of the issue. This was distinct in comparison to the concerns articulated by almost all maternal health right advocates who pointed to the delicate nature of articulation of “reproductive rights”.

It was also noteworthy that the petition and related summaries on HRLN website repeatedly highlighted the BPL status of these women – Shanti Devi and Fatima Begum – and that Shanti Devi was from the schedule caste category. But the issue of non-discrimination of specially protected group of people (as in the Indian Constitution), an important human rights principle, was never highlighted in any of the petitions.
Adjudication

In its judgment, the court recognized the interrelatedness of the benefit schemes, which were denied to Shanti Devi and Fatima Begum. It also acknowledged the wider implications of the gaps in implementation of these schemes beyond the affected petitioners. It noted: “the petitions highlight the gaps in implementation that affect a large number of similarly placed women and children elsewhere in the country” (Justice Muralidhar 2010, 3). Further, it recognized that the denial of these schemes indicated failure to protect and enforce “the basic, fundamental and human rights to life under Article 21 of the Constitution” as a result of violation of “two inalienable survival rights that form part of the right to life” – the right to health and the right to food. Furthermore, in referring to the right to health, the court also explicitly acknowledged the violation of right to publicly funded health care in public health facilities as well as “reproductive rights of the mother” (Ibid.). In sum, the judgment recognized violation of several fundamental rights (rights to life, health, food and reproductive rights) as specified in the petitions before it. Technically speaking, this could be viewed as frame alignment since those specified by the frame sponsor were also recognized and accepted by the institutional actor.

It was noteworthy, how the presiding judge established and reinforced justiciability in the given petitions, by explicitly drawing upon the Supreme Court’s comments in 196/2001 order and arguing that

in the context of welfare state, where the central focus of these centrally sponsored schemes is the economically and socially disadvantaged sections of society, the above orders … have to be understood as preserving, protecting and enforcing different facets of the right to life under Article 21 of the Constitution (Ibid., 12; emphasis added).

The reference to the “context of welfare state” could be viewed as locating these benefits in the language of citizenship entitlement, even though the Supreme Court verdict that “read in” right to
health (in the original 1996 4 SCC 37 case) based on right to life did not specify health and health care entitlements (see Grover, Misra and Rangarajan 2014; Parmar and Wahi 2011).

Additionally, the judgment argued that this interpretation of violation of two inalienable rights (to food and health) and reproductive rights were “consistent with the international human rights law” (Ibid., 13) … “as contained in the Conventions which have been ratified by India” (Ibid. 18). But in referring to these international human rights laws, it underscored that they were not inconsistent with domestic legal norms as contained in The Protection of Human Rights Act 1993 since this act defined “human rights” as “the rights relating to life, liberty, equality and dignity of the individual guaranteed by the Constitution or embodied in the International Covenants and enforceable by courts in India” (Ibid.19; emphasis added). In other words, the judgment did not simply limit itself to drawing on international human rights protocol on the basis of state ratification. Rather, it went an additional step by locating state obligation to uphold these fundamental rights on the basis of domestic human rights instruments which would squarely put the judicial branch responsible for any violation of these rights (and weaken arguments of judicial overreach). It is noteworthy that the legal foundation of the 196/2001 right to food case does not make any reference to the 1993 Act and draws heavily on normative language of international human rights law (Right to Food in India, 2012). Neither was any reference made to the 1993 Protection of Human Rights Act in the Supreme Court judgment which first “read in” the right to health [1996 SCC (4) 37 and JT 1996 (6) 43] based on Right to life in Article 21 of the Indian Constitution (Indian Kanoon n.d.). In other words, there was a very explicit reference to citizenship rights, once again, as well as innovative adjudication beyond the legal basis indicated in the petitions. It could set a precedent for critics – both scholars and practitioners – who emphasize the tendency of Indian judiciary to adjudicate fundamental rights not specifically justiciable in the Constitution based on international laws and norms (Balakrishnan 2008).
According to the judgment, there were two interim orders issued by the court pertaining to each of the petitions. In Fatima Begum’s case, the interim order (W.P.(C) No. 10700 of 2009), dated January 8, 2010, ordered the Health Secretary for the State of National Capital Territory of Delhi and Ministry of Health of India to arrange for the eligibility documentation that would qualify the petitioner for the AAY scheme (35 Kgs of Rice) and the cash benefit of Rs. 500 under the NMBS. These were fulfilled and the court was notified on January 13, 2010 (Ibid., 30-31). In Shanti Devi’s case, the interim order (C.M. Nos. 1238 & 1239 of 2010) dated January 28, 2010, mandated that the State Government of Haryana arrange for emergency medical transportation for the newborn baby girl who needed medical observation and treatment in a neonatal unit of a well equipped medical facility. The court asked the respondent to report on fulfillment of responsibility by February 1, 2010 and a notice of fulfillment was filed to that effect on the designated date. Both these interim orders speak to the power of courts to intervene and provide temporary relief addressing individual injustices (Ibid., 23-24).

In response to inquiries from the court, the Central Government (in its affidavit dated May 26, 2010) – the financial sponsor and designer of the benefit schemes denied to the petitioners – underscored that implementation rested with the state governments. Additionally, it indicated that although periodic reviews of performance of these schemes in states existed, these specific instances were not brought to Central Government’s attention (Ibid., 32). This led the presiding judge to observe that the Central Government was being deliberately ambiguous (short of withholding what actually happened in practice) since there was a lack of “inbuilt mechanism for corrective action, restitution and compensation in the event of the failure of any beneficiary to avail of the services under the scheme” (Ibid.). This observation supported concerns underscored by many respondents, including state officials, about the absence of a grievance redressal mechanism and absence of clear accountability mechanisms (reported in previous chapter).
fact, the court indicated that the Government’s case acknowledged that the design of the schemes in question did not account for compensation. It observed referring specifically to JSY “It was not denied by learned counsel appearing for the Government of Haryana, the GNCTD as well as the Central Government that as of now there is no inbuilt component for reparations under the scheme” (Ibid., 42). This could be viewed as admission of guilt on the part of the authorities. The court went on to observe that this lack of a grievance redressal mechanism and provision of compensation was “indeed surprising” in light of the substantial expenditure incurred by the state in ensuring the provision of the JSY benefit scheme.

In referring to the denial of NMBS based on number of previous births, Justice Muralidhar of the Delhi High Court accused the Central Government of selectively upholding Supreme Court’s order (in 196/2001 dated 20th November 2007) and abusing the latter’s acknowledgements regarding the complex juxtaposition of government’s population stabilization goals and Supreme Court’s order upholding BPL pregnant women’s access to NMBS irrespective of number of child births and/or ages of the women. In 2007, the Supreme Court had ordered that “the Union of India and all State Governments would continue with the NMBS and “ensure that all BPL pregnant women get cash assistance 8 to 12 weeks prior to the delivery” (as quoted in Justice Muralidhar 2010, 38). However, in paragraph 15 of the same order, the Supreme Court had observed the following:

15. At this juncture it would be necessary to take note of certain issues which have relevance, it seems from the scheme that irrespective of number of children, the beneficiaries are given the benefit. This in a way goes against the concept of family planning which is intended to curb the population growth. Further the age of the mother is a relevant factor because women below a particular age are prohibited from legally getting married. The Union of India shall consider this aspect while considering the desirability of the continuation of the scheme in the present form. After considering the aforesaid aspects and if need be, necessary amendments may be made (as quoted in Justice Muralidhar 2010, 38).
Subsequent to the aforementioned order, the Central Government had filed an application in the Supreme Court “seeking modification of its mandatory directions” but “no order has been passed as yet by the Supreme Court”. Justice Muralidhar of the Delhi High Court observed that the Central Government had “taken shelter under paragraph 15 of the [Supreme Court] order in [196/2001] dated 20th November 2007”. It also pointed out that, the “State Governments have been instructed [by Central Government] to continue following the earlier patterns of denying cash assistance after two live births” (Ibid., 39). As well, it made remarks outlining that this was a deliberate “confusion created by the Central Government” and recognized that the rights of numerous Indian women eligible for NMBS under Supreme Court instruction were being violated. This confusion referred to by the court was denying cash assistance (Rs. 500) under NMBS because the Central Government was providing cash assistance (Rs. 1400) under JSY. The judgment underscored that these were two different schemes, created for different purposes – NMBS for ensuring BPL pregnant women had access to nutrition before childbirth and JSY for incentivizing women to give birth at formal institutions – and that the NMBS could not simply be subsumed under or assumed to be replaced by the JSY. On one hand, this incident demonstrated how even the highest court might contribute to further politicization of “delicate issue” of family planning and reproductive rights by speaking in uncertain terms and contributing to violation of said reproductive rights of many female citizens. On the other hand, it confirmed how the executive branch of the state might selectively choose to comply with the Supreme Court’s “soft” acknowledgement while disobeying its “hard” order.

Further, the Delhi High Court judgment implied references to lack of reproductive choice and autonomy among women in Indian society with respect to the number of children she conceived (and decided to carry to term). This was evident in its observation: “the logic of
depriving cash assistance beyond two live births … cannot be justified on any rational basis particularly since women in the Indian social milieu have very little choice whether she wants to have a third child or not” (Ibid., 40-41). This observation stood out because it was an indirect reference to lack autonomy in the private sphere as experienced by some women that were hardly underscored during conversations with maternal health right advocates, the focus of whose advocacy efforts rested largely on violations of women’s rights in the public sphere (barring a few from CommonHealth). Nonetheless, it suggested the power a presiding judge with a progressive attitude had that could defy expectation of women’s right advocates who complained (for good reasons) of the patriarchal bias of the court. Arguably, the lack of control over such a factor (being able to ensure that the adjudicator was of progressive nature and able to underscore pro-women rationales in adjudicating) would also point to why they might hesitate to approach the courts. Moreover, this implicit reference was telling of the difficulties of de-linking violations of women’s rights in public from that in private sphere as argued by feminist critiques of human rights (Gideon 2006). At the same time, it also acknowledged the role of community in which a woman resided and accountability for maternal morbidity and mortality in that regards.

Additionally, in its adjudication the court criticized the poor administration of the many benefit schemes for BPL pregnant and parturient women citing that these were not operationalized in a user-friendly manner. It maintained that the administration of these schemes by different ministerial units at different levels of government needed to be consolidated, such that beneficiaries could access them from single point of contact. The provision of demonstrating BPL status through eligibility cards, including in case of migration between states, was considered “onerous burden” for the “‘poor’ and ‘disadvantaged’” (Ibid. 40).

Finally, having determined that the authorities were negligent, in the “reparations and relief” section of the judgment the Court outlined a number of compensation and relief measures
(that is, “hard” orders) and many directives in regards to “shortcomings in implementation of the schemes” (mostly “soft” orders). The compensations and reliefs in both the Shanti Devi and Fatima Begum cases (Ibid., 41-46) are reported below in a tabular form (see Table 4 on next page). In both cases, the court offered different forms of monetary compensation and relief to the petitioners’ families including the children and the spouses (where the petitioner was no longer alive). Furthermore, relief obligations on the part of the state (both Central and state) were in the form of immediate monetary support as well as provision of long-term support in form of investment and educational scholarships for the living children of both petitioners.
<table>
<thead>
<tr>
<th>Case</th>
<th>Type of Compensation and Relief (USD 1= Approx. Rs. 60)</th>
<th>Responsible Authority</th>
</tr>
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<tbody>
<tr>
<td><strong>Shanti Devi’s Case (W. P. (C) 8853/2008)</strong></td>
<td>Refund Rs. 1000 (USD 16) charged to Shanti Devi’s husband for hospital admission by DDU Nursing Home</td>
<td>State of National Capital Territory of Delhi (GNCTD)</td>
</tr>
<tr>
<td>2</td>
<td>Rs. 500 (USD 8) under NMBS to be paid to Shanti Devi’s husband</td>
<td>GNCTD</td>
</tr>
<tr>
<td>3</td>
<td>Arrange for AAY eligibility card for Baby Archana (Shanti Devi’s child born in the pregnancy from which she died)</td>
<td>GNCTD</td>
</tr>
<tr>
<td>4</td>
<td>Rs. 500 under Apni Beti Apna Dhan (My Daughter, My Asset) scheme to be paid to Shanti Devi’s husband</td>
<td>GNCTD</td>
</tr>
<tr>
<td>5</td>
<td>Rs. 2500 (USD 40) of Indira Bikas Patra (government insurance scheme) in name of Baby Archana to her father</td>
<td>Government of India</td>
</tr>
<tr>
<td>6</td>
<td>Rs. 500 under the Balika Samridhi Yojana (Girl Child Development Scheme) as post-birth grant to the father of Baby Archana</td>
<td>Government of India</td>
</tr>
<tr>
<td>7</td>
<td>Ladli Scheme, annual scholarship of varying amounts under through Grade I to X (total sum of Rs. 4000 or USD 66) for Baby Archana to be handed to her father in future years.</td>
<td>State of Haryana</td>
</tr>
<tr>
<td>8</td>
<td>Rs. 10,000 (approx. USD 166) under NFBS to Shanti Devi’s husband in recognition of her status as the “primary breadwinner”</td>
<td>No clear authority specified</td>
</tr>
<tr>
<td>9</td>
<td>Rs. 2.4 Lakh (approx. USD 4000) to Shanti Devi’s family with Rs. 60,000 to be paid to Shanti Devi’s husband and Rs. 180,000 to be invested in nationalized bank in name of Shanti Devi’s two living sons and Baby Archana until they were 21 years old). Accrued interest to be deposited in another account in the same bank.</td>
<td>State of Haryana (to be complied with within four weeks)</td>
</tr>
<tr>
<td><strong>Fatima Begum’s Case (W.P. (C) 10700/2009)</strong></td>
<td>Rs. 500 (USD 8) under NMBS to be paid to Fatima Begum</td>
<td>GNCTD</td>
</tr>
<tr>
<td>2</td>
<td>Provision of AAY Card</td>
<td>GNCTD</td>
</tr>
<tr>
<td>3</td>
<td>Provision of epilepsy medication every 15 days and special check-up every two months at G.B. Pant Hospital, including arrangement of medical transportation if need be.</td>
<td>GNCTD (Maternity Home of Municipal Corporation of Delhi)</td>
</tr>
<tr>
<td>4</td>
<td>ICDS Benefits to Baby Alisha (child born of specific pregnancy) as indicated in Supreme Court order dated November 2007 in 196/2001 case</td>
<td>Government of India</td>
</tr>
<tr>
<td>5</td>
<td>Annual scholarship of varying amounts through Grade I to X (total sum of Rs. 4000 or USD 66) for Baby Alisha to be handed to Fatima Begum in future years</td>
<td>Government of India</td>
</tr>
<tr>
<td>6</td>
<td>Rs. 10,000 (USD 166) financial deposit under Ladli Scheme (investment in education for female child born to BPL families) in name of Baby Alisha</td>
<td>GNCTD (to be complied with in four weeks)</td>
</tr>
<tr>
<td>7</td>
<td>Rs. 50,000 (USD 833) compensation to Fatima Begum for denying her emergency obstetric care (in a fixed deposit in a nationalized bank for three years with accrued interest paid out in another bank account)</td>
<td>GNCTD</td>
</tr>
</tbody>
</table>
The court’s decision to award Shanti Devi’s family Rs. 10,000 (approx. USD 166) under the NFBS scheme was noteworthy since it underlined the significance of “recognizing a woman in the family who is a home maker as a ‘bread winner’ for this purpose” (Ibid., 48). Typically, NFBS was administered to BPL families in cases where the “primary bread winner” responsible for financial wellbeing of the family had died of non-natural causes. In other words, there was an effort by the court to recognize the significance of women’s (generally) unpaid domestic and caregiving labor to the overall functioning and well being of the family. Arguably this was quite progressive as well especially since the court asked that this clarification “be issued by the Central Government to the State Government” (Ibid., 48-9). But it stood to drain systemic resources (in resource-poor context) especially since women who died from childbirth would not gain from this compensation being provided to their spouse or family member. Yet, it might instigate the system to improve itself to reduce the burden of such resource drain. Perhaps this reinforced the complexity of assessing success of court judgments, let alone successful implementation (Brinks 2008; Gloppen 2009; and Brinks and Gauri 2012).

To correct the shortcomings in the implementation of the schemes, the court stressed a number of directives addressed to Central Government (Ibid., 47-50). However, the language around these directives was relatively more ambiguous in most cases than that used in outlining the reparations and relief section (except in case of directives (2) and (11)). These directives included:
Table 5: List of Directives Issued in the Delhi High Court Case Judgment

<table>
<thead>
<tr>
<th>No.</th>
<th>Directives Issued to Central Government</th>
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<tbody>
<tr>
<td>1</td>
<td>Ensure that an individual declared BPL in any one state of the country can access benefits of public health services in any other state where she relocates;</td>
</tr>
<tr>
<td>2</td>
<td>Issue immediate clarification to all the State Governments about administration of NMBS alongside that of JSY irrespective of number of childbirths and age of the woman seeking to access these schemes;</td>
</tr>
<tr>
<td>3</td>
<td>Consolidate the administration of benefit schemes by different ministerial units at different levels of government, such that beneficiaries could access them from single point of contact;</td>
</tr>
<tr>
<td>4</td>
<td>“Possibly” create monthly camps in rural and semi-urban areas to provide check-ups for women and children in absence of functioning facilities (that is, sub-centres);</td>
</tr>
<tr>
<td>5</td>
<td>Improve referral services especially to private health care facilities, including augment medical transportation;</td>
</tr>
<tr>
<td>6</td>
<td>Consider number of institutional births as proportion of total births, as opposed to reporting JSY usage statistics (without this the court argued high-performing/low-performing states could not be categorized and denial of NMBS and/or JSY in high performing states was unacceptable);</td>
</tr>
<tr>
<td>7</td>
<td>Introduce corrective measures in the administration of the schemes.</td>
</tr>
<tr>
<td>8</td>
<td>Improve monitoring mechanisms of performance of health care workers at each level and integrating them throughout the health system; in cases where beneficiary may decline to avail or fail to appear for counseling or periodic check-up, such cases be referred to the supervising officer.</td>
</tr>
<tr>
<td>9</td>
<td>Review and monitor administration of schemes such as AAY and ICDS.</td>
</tr>
<tr>
<td>10</td>
<td>“Ideally special cells” should be established within Central and State Ministries of Health for monitoring and oversight of the implementation of the schemes.</td>
</tr>
<tr>
<td>11</td>
<td>Central Government to “issue a corrective to the earlier instruction issued in October 2006 in relation to the JSY as well as instructions relating to the cash assistance under the NMBS so that is not denied to any woman irrespective of the number of live births or age. There shall be strict compliance of the orders of the Supreme Court in this regard” (Ibid., 51).</td>
</tr>
</tbody>
</table>

Finally, the court ordered the Central and the two state governments to respond to the court, “by way of compliance with respect to the above directions” within eight weeks from the date of release of the judgment (Ibid). It was noteworthy that the court did not appoint any special body or individual (for example, a Special Commissioner) to monitor the implementation of these directives. HRLN officials who were involved in the case specified that no such monitoring mechanism was included in their prayers to the court.
Nevertheless, the directives were quite extensive, and if implemented, could create some systemic reforms. They could have impact on health policy (design changes), budget (requiring greater resources to establish special cells and monitoring), to some extent access (although probably still stigmatized due to BPL status) and distribution of health services although any increase in costs would need to be analyzed against the expenditures incurred by the government in offering individual compensation and relief in various health rights litigation cases – including those that would use the judgment at hand as precedent setting (Mastda, Rakner, and Ferraz 2011; Gauri and Brinks 2008). They might not address issues of structural violence which as scholars and some maternal health right advocates had earlier argued was the shortcoming of using courts to address issues of structural injustice (Hunt and Bueno de Mesquita 2010).

Nevertheless, given the range of financial compensation and relief offered by the court to the petitioners it was difficult to overlook the likely inequitable impact this would have on redistribution of resources. The balance of justice, in that sense, was tilted toward the individual rather than the system (Epp 2003; Shankar and Mehta 2008; Gloppen 2009; Yamin and Gloppen 2011). By the same logic, one was left wondering whether the petitions in Delhi High Court case would be more appropriate as legal aid cases that underline the individual access to courts and justice so evident in the cases (Epp 1998, 95). At the same time, the decision to not provide “hard” orders for systemic reform can be assumed to be a hint of judicial reluctance to overreach as well as cognizance of state incapacitation (given the resource poor and weak health system), unlike in the right to food case where there were state reserves of grain (one of the highest in the world) (Gauri 2009; Robinson 2009; Gauri and Gloppen 2011). This is difficult to say for certain since the prayer of extra-judicial oversight mechanisms were not sought by litigations (as indicated in the claims formation stage). Nonetheless, it reveals an interesting contrast of judicial receptiveness to demands for individual justice in a dysfunctional political and health system but
an unwillingness to overreach. This is slightly outside the scope of this study, but four legal activists who participated in this study had hinted at a “conservative turn” within the judiciary following the massive expansion of state funded welfare program since the right to food judgment. They pointed to speeches by the then Supreme Court Chief Justice (before Brazilian Supreme Court Justices) and growing criticism from the executive and legislative branch (including a speech by the Prime Minister himself) urging judicial restrain (see Balakrishnan 2008).

An additional issue worth considering (but a likely stretch) is the significance of a lack of socio-political consciousness of right to health and health care among in India, which in turn can be associated with lack of corresponding citizenship guarantees. The premise for this rationale is based on the significantly weak and fragmented (ridiculed as “dying” social movements for health by some civil society respondents) social movements for health, including their historically weak nature in India (as reported before toward the end of chapter 6) and continued reference to “middle class abandonment of the public health sector” by nearly all civil society respondents as having allowed legislators to escape political responsibility for health. Perhaps, the adjudicator in the Delhi High Court case was cognizant of lack of political demand from the wider electorate who had choice of other alternatives (the private health care sector). It is possible the court “heard” the cases in question as seeking individual justice, rather than collective demand for right to maternal health (unlike in the right to food case where there was heavy criticism of state abandonment of its citizens, despite having food reserves and also clear violation of state responsibility toward citizens). This would have bearing for scholarly accusation of Indian courts as not “directing” the legislature to undertake health care reforms – as advanced by Rajagopal (2007), Parmar and Wahi (2011), Grover, Misra and Rangarajan (2014).
Implementation

The judgment on the two cases were released on June 4, 2010. Enquiries undertaken with the HRLN during the initial fact finding trip (in January of 2012) suggested that the financial compensations and reliefs to the petitioners’ families had been administered by the responsible authorities (both Central and state governments). However, no further progress had been made by the Central Government on the directives underscored in the judgment, especially directives 2 and 10 on which the court sought strict compliance (including notifying the court within a strict timeline) to uphold the Supreme Court order in 196/2001 dated November 2007, pending hearing. That is, the Central Government had not issued any order to state governments clarifying that both NMBS and JSY should be administered to all eligible pregnant women of BPL status irrespective of previous number of live childbirths or pregnancies and their ages.

On July 28, 2010, legal counsel representing the MoHFW, Government of India registered as appeal (112763/2010) in the Supreme Court of India. In this appeal, the counsel for the MoHFW urged the Supreme Court to review the Delhi High Court’s judgment dated June 4, 2010. It also sought a decision regarding the hearing pending in the 196/2001 case based on the Supreme Court’s decision dated November 20, 2007. Put simply, the legal counsel for the Union MoHFW asked the Supreme Court to reverse its initial judgment. The appeal available from the Office of Supreme Court Commissioners for Right to Food outlined four reasons for, in way of clarification, for the ministry’s stance. These were as follows:

(1) the Central Government maintained that JSY and NMBS could not both be administered to a woman since they had the same purpose and observed: “JSY which subsumes the NMBS is a very comprehensive scheme to improve maternal health and restricting the benefit to the pregnant women as per only the NMBS scheme would in effect
deprive her of the comprehensive package of assistance and services” (Office of Supreme Court Commissioner 2010, 5);

(2) it argued that JSY payments made after childbirth were meant to encourage institutional birth unlike NMBS paid before and noted: “… the payment of incentives after delivery instead of 8-12 weeks prior to delivery is meant to encourage institutional delivery and if this amount if paid before delivery, there will not be enough incentive remaining for the woman to come to the institution for delivery especially in high performing states [that is, states with poor MMR rates] where the differential between payment to the pregnant woman between home and institutional delivery is very low” (Ibid., 6);

(3) the Central Government maintained that administering NMBS and / or JSY irrespective of number of children were counter to the Government of India’s family planning goals and promotion of small family norms. To that effect, it contended: “Extending the maternity benefit irrespective of number of children goes against the concept of family planning which is intended to curb the population growth. It is necessary that women are encouraged to voluntarily adopt the small family norms. The restriction on age and number of children under JSY for home deliveries in all states and for institutional delivery in high performing states is in line with the Government of India policy to promote better maternal health by aligning with the policy of minimum age at marriage and encourage family planning” (Ibid., 7);

(4) Finally, the MoHFW for the Central Government also observed that administering the schemes (jointly or individually) to women below legal age of marriage (19 or higher years) would counter the prohibition on child marriage. This was evident in its words outlined in the petition, which read: “It is respectfully submitted that, the empirical data shows that younger women are at higher risk of maternal mortality. Therefore, the age of
the mother is a relevant factor. Besides, women below a particular age are prohibited from legally getting married” (Ibid.).

Effectively, the MoHFW of the Central Government utilized the opportunity presented by the Delhi High Court judgment in the Shanti Devi and Fatima Begum case to gain strategic advantage in pushing forward parallel political and legal agendas – as feared by maternal health right advocates interviewed in this study. The arguments outlined above by the legal counsel for the Central MoHFW revealed very clearly the inter-connectedness of maternal health and family planning politics in India, not to mention their connection with child marriage. As well, they were telling of the Counsel’s efforts at misconstruing facts and statistics to further an anti-women agenda. Arguably, this confirmed the fears articulated by maternal health right advocates about raising these issues – eligibility criteria for accessing different maternal health benefits based on number of live births and/or pregnancies and age of a woman – in a court of law. During a key informant interviews, a human rights scholar and a women’s health scholar spoke to this issue at length. They pointed to the difficulties that arose in using the “language of rights” to articulate women’s claims. Even though civil society groups working on these different issues (maternal health, family planning, child marriage) were working to advance the common goal of gender justice, their recognition of these issues took a backseat in their efforts to distinguish themselves as specific issue advocates competing for the shrinking pot of donor aid. Therefore, articulation of rights claims would not be sensitive to the reality that these issues were interrelated. In fact, they observed that those advocating for enforcement of the child marriage act would demand that the government exclude women below 18 years from accessing diverse benefit schemes at the policy and program design stage. In contrast, maternal health right advocates would point out that excluding such women from those benefits was counter-intuitive since the most vulnerable and in
need of government support were the ones who were married as children against their will and experienced early pregnancy. Nevertheless, the deliberate manipulation of these unfortunate realities - that existed because of the state’s failure to enforce laws protecting women and the reluctance of the family and community to uphold women’s rights – to further its own political agenda as evident in the 112763/2010 appeal was nothing short of state cooptation of the women’s rights agenda that Rai (2008) had cautioned against.

As with any affidavit filed in relation to the 196/2001 right to food case, the Office of Supreme Court Commissioners was tasked to advise the Supreme Court on this matter as well. In its official correspondence responding to the appeal, the Commissioners observed the completely different nature of the two schemes – NMBS being a “support” scheme and JSY being an “incentive” scheme – with distinct objectives and goals. Furthermore, it highlighted that NMBS was not intended to serve the Union’s family planning goals but rather support pregnant BPL women’s nutritional needs. It also rebutted the Union’s claims that making NMBS available to women below 19 years promoted high maternal mortality among under-aged women. The Commissioners used the empirical data submitted by the Union in its appeal to underscore the high incidence of maternal mortality among under-aged women. Specifically, it argued that the nature of the evidence should be seen as the very reason to support the continuity of the NMBS irrespective of the claimant’s age. Furthermore, in regards to the matter of family planning and overpopulation, the Commissioners drew attention to the unethical and violation of women’s right reproductive self-determination implicit in the appeal (that letting women access maternal health care entitlements irrespective of number of previous births and age would counter the state’s population stabilization goals). The Commissioners made the following observation:

It is now widely accepted that it is unethical and a violation of the rights of the women to have ‘population-control policies’ that are incentive-based and with targets. The
Government of India has also accepted this position in policy documents where it has been stated that having targets for sterilization etc. would be done away with and that benefits under other schemes etc., cannot be linked to number of children. ‘The National Population Policy, 2000, (NPP 2000) affirms the commitment of government toward voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services’ (Office of the Supreme Court Commissioners 2010, 4).

Both the November 20, 2007 and 2010 appeal had been pending at the time of finalizing this dissertation (in May 2016). While the Office of Supreme Court Commissioner’s (for right to food) counsel to the Supreme Court was encouraging, the fact that these appeals were pending hearing drew anxious remarks from some respondents, especially maternal health right advocates working in Northern and Central India who underscored the risks of adverse outcomes citing the conservative turn (supportive of limited role of judiciary and separation of power) Supreme Court had taken since the arrival of the then Chief Justice Kapadia in 2010. They underscored the challenges of claiming news rights (women’s rights) while preventing the erosion of existing rights (women’s rights), which they argued was central to feminist activism.

However, the three human rights and constitutional studies scholars and two maternal health right advocates from Southern India argued that the appeal (112763/2010) filed in the Supreme Court was rather reflective of bureaucratic inertia that characterized the governance crisis in health sector, and public sector more broadly. They maintained the appeal was a way of postponing the need to take any action which also stemmed from the cognizance that the Indian court system had a poor history of enforcement. They also argued that the executive branch’s action should seen as strategic to stall progress on the other “soft” orders or directives included in the original Delhi High Court judgment. This was because the ministry could then cite the pending appeal in the Supreme Court to tactfully ignore the directives of the Delhi High Court regarding possible systemic improvements. As one maternal health right advocate from Uttar
Pradesh, which was a state with particular concerns involving two-child norm observed:

The service component’s answerability to the judiciary is “ok, we have to go to court, send a rejoinder”. You know the government knows very well how to handle the judiciary. We have seen this in other cases also … they will just keep filing affidavit after affidavit … the affidavit is completely opposite of what is required, but nothing concrete. The judiciary ask for something, they come up with some other issue related response … they [the executive branch] are least bothered … for them it is just ringing out the judiciary until the judiciary gets tired or the litigant gets tired … so the judiciary and government accountability is not that strong as we would like to believe (CSO#2).

These speculations had merit as evident by the summary of arguments during court hearing held by the Delhi High Court in response to a second contempt petition filed by HRLN on January 11, 2013 citing lack of compliance from the authorities in the case (HRLN, 2013). The summary of arguments indicated that the legal counsel for the Central MoHFW observed: “Learned counsel for respondents no.2 and 2A submits that responses no. 2 and 2A have already made an interim application before the Supreme Court of India in the case of PUCL vs. Union of India and the outcomes of which would have a direct bearing on the present contempt petition” (New Delhi High Court 2013, 2). The presiding judge, Justice Sistani took issue with “endlessly adjourning” the case since the first contempt petition was filed by HRLN in September 2010 (once all the financial compensations and reliefs were complied with). Justice Sistani pointed to the fact that there was no interim order passed by the Supreme Court on the appeal (112763/2010) and granted the respondents “a final opportunity” to comply with the Delhi High Court judgment and report to the court within six weeks on March 7, 2013. The ministerial authorities were supposed to present themselves before the court on that latter date. However, until date no further action had been taken toward compliance of the initial order based on the case history available in the records of Delhi High Court and case updates posted on HRLN’s website or circulated through its network to which the researcher was subscribed.
Nevertheless, the executive’s response to the Delhi High Court judgment resonated with Tushnet’s (2008) theory (based on comparative constitutionalism) that executive and legislative branches of government may reject (“as long as they do so publicly”) constitutional rulings by the judiciary in extending social welfare entitlements thus allowing the constitution to be returned to the people, interpreted by their elected representative (as quoted in Jones 2008, 1). This would confirm that weak courts characteristic of some judiciaries, where the other branches of government might reject court’s interpretation of the constitution, which enhanced its ability to pronounce (and sometimes uphold) social welfare entitlements thus not taking away from the judiciary’s powers to uphold economic and social rights (Tushnet 2008). Perhaps this was also the reason why the court awarded the petitioners such wide range of compensation and relief because it treated the petitions as evidence of access to courts and justice for the individuals rather than as creating systemic reform (hence categorizing the recommendations for systemic reforms as “directives” rather than as “hard” orders). Beyond the fact that HRLN did not seek (according to the two respondents) creation of enforcement mechanisms in the two petitions (unlike that in the right to food case, 196/2001), the lack of inclusion of any extended mechanism for enforcement in Delhi High Court’s judgment could be an outcome of the court’s confidence in legislative interpretation of its constitutional ruling. The political climate since the arrival of the right to food judgment in 2001 had been accompanied by the growing number of social welfare entitlements (nutrition, maternity benefit, rural employment guarantees and pension benefits, education). These were created by the Indian parliament which beginning in 2004 was governed by the Indian National Congress Party which was leaning toward expanding social welfare (for its vast BPL electorate) – as speculated by many respondents and scholars (cite). This might have led the court to be judicious in not being explicitly directive in its judgment about systemic reforms to accompany the symbolic and legal recognitions of maternal morbidity
and mortality as violations of a woman’s fundamental human rights.

By the same logic, while there was a frame alignment between the frame sponsor and the adjudicator (that is the institutional actor) in the Delhi High Court judgment, this could not be concluded to be successful reframing leading to generation of political priority deserving of the issue – at least not as intended by the frame sponsor who desired systemic changes. In other words, the very characteristics of the policy forum (that is the court) allowed for administrative of individual justice that was accompanied by resources (financial compensation and reliefs) that the court had access to (as opposed to resources necessary for systemic reform which other branches had easier access to). The happenings in the aftermath of the pronouncement of the judgment, especially the appeal, might have stalled progress on immediate policy reform which would suggest greater symbolic and legal significance than policy implications. Nevertheless, as indicated in the judicialization of rights (including social rights) literature, lack of or poor compliance should not be viewed as failure of litigation to create change since the latter may come about in the longer term without immediate and obvious systemic changes (Gloppen 2011). In the next section, some of the other but related social and political dynamics that emerged during key informant interviews are discussed below.

**Implementation: Socio-political Dynamics Beyond Compliance**

Twenty maternal health right advocates (excluding those associated with HRLN), academics, the bilateral donors, and one participant from WHO could vaguely recall the Delhi High Court case (especially the “Shanti Devi case” as they termed it) but they had no knowledge of the scope and details of the judgment. There was knowledge of the incidence of the court case and the judgment among legal and health activists but no insight into the details of the judgment. Respondents attributed this lack of knowledge to both lack of involvement with the court case
and lack of media stories on the judgment. This was true because the case was hardly reported in
domestic media as confirmed by HRLN. Two journalists (participating in this study) that had a
track record of writing on maternal health in various national print dailies also were not aware of
the incidence of the court case. HRLN members suggested that they were still in early stages of
outlining a media advocacy strategy for their “maternal health work”. While the organization did
press releases on its website, it did not have personal connections to journalists who were
interested in this topic, which was confirmed by the two participating journalists. Generally
speaking, however, the journalists argued that there was hardly any media interest in the issue of
maternal death and indicated that they were fairly senior with their own opinion columns which
was why they could dedicate “space” for important developments on maternal mortality and other
issues arising at the intersection of gender, health, poverty and development (a review of their
columns confirmed this). Two maternal health right advocates from Northern India also
confirmed that media attention had been difficult to gather for the issue of maternal mortality. In
Uttar Pradesh, they had worked with regional Hindi media for more than five years to create a
working relationship where media had begun to take an interest and report independently
(without being briefed first by maternal health right advocates). But barring this, strategic use of
media for maternal health and human rights advocacy (excluding WRAI) seemed to be in nascent
stages. The lack of media interest in maternal health was partly attributed to the socially invisible
nature of maternal morbidity and mortality. The other reason cited by the two journalists was that
the Indian media, unlike pre-liberalization days, had grown less interested in reporting “stories”
(tracking developments in a case, investigative journalism) of poverty and development unless
there were “breaking news” items with public shock factor that would increase sell of newspapers
or get more target rating point (TRP). Nevertheless, these findings pointed to the challenges of
generating public and political support – whether for maternal health and human rights advocacy
or in a court case – for a cause when an important medium of raising public awareness and outreach was largely missing from the policy discourse. It could have significance especially in cases of lack of compliance by responsible authorities and poor enforcement.

The judgment, however, received some attention from media and other stakeholders outside India, which the HRLN members attributed to their strategic partner CRR. The United Kingdom based *The Guardian* reported it in the latter half of 2010 in its Global Development section (Bhowmick 2010). The WHO and the CRR, also made press releases following the pronouncement of the judgment (WHO 2010; CRR 2010). On one hand this likely reinforced the legitimacy of CRR as an organization which was promoting the use of law and courts to reduce maternal mortality in many developing countries. On the other hand, and seeing that several court cases on maternal mortality appeared in developing countries with high MMR (Brazil, Uganda, Nigeria), it was probably also a way to raise awareness among maternal health right advocates elsewhere and more broadly about the usefulness of a legal intervention for their advocacy. This would confirm the Roseman and Gloppen’s analysis that sometimes transnational actors, such as the CRR work with local actors to “responding to local opportunity structures” (2011, 264). This appeared to be the reality in the Delhi High Court case as well.

On enquiring about their reaction to the Delhi High Court judgment, all civil society actors and especially maternal health right advocates emphasized the symbolic significance of the judgment as a first of its kind. They also emphasized the important legal precedent the verdict helped set and its relevance to growing recognition of maternal health and human rights advocacy in the broader context of human rights advocacy in India. But this was generally followed by skeptical observations regarding the limited role of strategic litigation in creating transformative policy and practical reforms. Citing the incidence of the appeal in the Supreme Court (notified by the researcher), *all* twenty maternal health right advocates stressed the importance of community
consultation in using strategic litigation to advance advocacy goals. This was considered essential for two reasons. First, it helped to identify and build consensus on remedies and prayers sought from the court and maximize the opportunity for gains while minimizing possibilities of adverse outcomes. As one participant indicated: “it is not so much what you say in court, rather what you don’t that is important. And a good lead counsel should know that” (CSO#21). Second they stressed the role of civil society actors in ensuring enforcement and implementation (including informing and educating rights claimants about favorable judgments). To that effect, the concern surrounding lack of collaboration between HRLN and other maternal health right advocates was corroborated and acknowledged by the court appointed maternal death audit expert (also a maternal health right advocate). She acknowledged that had such collaboration existed and the judgment was strategically used by maternal health right advocates to engage with state actors, some systemic reforms could potentially be made (even though the Supreme Court hearing on the appeal was pending). It was evident in the respondents’ words that she had been reflecting on ways out-of-court mobilization could have influenced litigation during the court hearings, an issue that socio-legal scholars emphasize in success of strategic litigation (Gloppen 2011; McCann 1994/2006). The participant observed:

What we are trying now is … before we even go for a court case, we should prepare how we are going to use if we get a positive ruling. So that is more important. Here, even from my side, I did it as an academic exercise and I wanted this to happen. This was the best I could do for the judges to have enough information to take an action to take a good decision they need information. They need to know the details of the case. That was my biggest objective there. How do I use this? Of course giving this, submission of the report is one thing and getting the hearing is another thing. Between this, we did not use the case at all. But once the ruling came I started looking at how I would use this. If this is a case for writing and producing a good analysis, that is a good thing and helping others to write up cases, all that is good. But that is more of an academic exercise. But for using it for implementation, I felt that we should have thought of this before about how to do it. We should have had kind of discussion of the case with all the NGOs working on maternal health, which we did not.
[Interviewer: Why do you say that? Is that because you worked in a very small time frame?]

*I think we did not strategize well; I would not say it was entirely circumstantial.* At that time, it was urgency, do it fast. The court is waiting for us. If we give the information, they may take a good decision. But afterwards, why did we not strategize? *The lawyers’ groups have used it to some extent to take up other cases.* But the NGOs group did not take it up as strongly; may be because NGOs are working in their own little area, so little time and so little support for discussion of various issues. I think NGO fund crisis and survival issues are also responsible for why we may not have come together to take up something, which can have a positive impact. After this what I felt is, wherever we go for some litigation or for any such action, we should prepare for a good ruling from the judge based on our data and strength of the case and what are we going to do afterwards. But also, by the time one goes to court and the verdict comes, the NGO is already doing something else. And the NGO is very very limited in its scope and funds. So for them to take up something, which has happened already and to take it up on a big scale, it requires much stronger funding base and human resource base. The other thing is that we should have taken this to the NRHM and the government, we should have involved them. We should not have just limited ourselves to the health care providers but involved the government, the NRHM directors. *We should have said this is the ruling that came, this can happen in any state, you will have court cases all over the state especially now that lawyers know how to do it and be prepared, you better start doing reform as a precautionary measure.* And they are simple, most of the recommendations here are quite simple, they do not require huge funds. Of course you need more human resources, but even with the available human resources, how best to make use of them. That is a mistake of mine; I mean there is still time, we can still take it up. But I feel we missed that opportunity to inform the government and inform the NGOs that this is a tool in your hand for you to take advocacy forward. Those two areas I think we have not really done well; not us as an organization but all of us who were involved in this struggle” (CSO#17; emphasis added).

At the same time CSO#17’s comments point to the practical difficulties of forming collaboration between legal advocates and maternal health right advocates who faced distinct challenges (with mobilization resources) and had different agendas. This was in line with the observations made by feminist critics who pointed to the ways growing NGO-ization and shrinking donor funding sometimes led to working in silo (also moving from project to project supported by donor to keep
the organization floating) which hurt the ability to make transformative and sustainable progress on women’s rights (Alvarez 1999; Rai 2008).

Furthermore, CSO#17’s reference to “lawyer groups” using the Delhi High Court case judgment was regarding the thirty odd PILs that HRLN had filed in various high courts in India, including a few in the Supreme Court. In studying social rights litigation cases where poor compliance was observed, socio-legal scholars had underlined the importance of examining who drew legitimacy from the judgment (Gloppen 2011; Yamin 2011). One participant from HRLN had confirmed that there were several other cases for which petition design was underway. However, further inquiry indicated that there had been no consultation or collaboration with any maternal health NGOs or Coalitions engaged in human rights advocacy for any of these cases or petitions designed. Out of curiosity and during a discussion with one of the senior officials of HRLN about the Delhi High Court judgment, the researcher had enquired about the impetus to litigate despite the lack of compliance from the executive authorities. In response the participant observed: “we will litigate to death … some day it will bring results” (LAS#4). This attitude of perseverance and sense of hope was perhaps telling of the fact that cause lawyering was the driving force behind HRLN and helped the organization to remain relevant to judicialization of rights politics in India. Yet the researcher believed that underlying such attitude, even though HRLN officials would not explicitly acknowledge, was a concern surrounding lack of compliance and enforcement. This was evident in an article authored by a member of HRLN in an article titled “The role of litigation in ensuring women’s reproductive rights: an analysis of the Shanti Devi judgment in India” published in Reproductive Health Matters. The author of the article, Jameen Kaur (2012) observed:

99 This article was also re-published as a chapter in Maternal Mortality, Human Rights and Accountability, edited by the former Special Rapporteur for Right to Health Professor Paul Hunt and Tony Gray (2013, 19).
… it is success in the social sense which is proving the most challenging to achieve. State governments in India have yet to issue instructions to ensure the portability of schemes and entitlements, particularly for economic migrants. Central government still needs to issue clarifications to state governments to ensure that all pregnant women living below poverty level are receiving the appropriate benefits and payments. Moreover, a committed government campaign is needed to raise awareness at all levels (grassroots to government administrators responsible for maternal health care implementation) that a home-maker should be considered a primary bread-winner for the purpose of receiving benefits. One of the principal challenges that remains is people’s lack of awareness of their human rights and entitlements to begin with. This is due to lack of government outreach programmes informing communities of their rights and entitlements, and lack of accountability mechanisms within health programmes, which are not transparent, monitored or functioning effectively” (2012, 28).

Furthermore, in a jointly authored submission to CEDAW Secretariat in Geneva dated October 1, 2013 (titled Supplementary information on India, scheduled for review by the Committee on the Elimination of Discrimination against Women during its Pre-Sessional Working Group), the CRR and HRLN discussed the Delhi High Court judgment and subsequent judgments (not included in this study) that had used the former as precedent. However, they also pointed to the repeated lack of compliance by the authorities despite clear and well-formulated verdicts pronounced by the courts. In their submission they observed:

Each legally binding court order outlined specific steps for each state government including changing in government entitlement programs, improving service provision, ensuring hygiene at facilities, and taking steps to ensure staffing at public health facilities. Despite these strong decisions, India’s central government has not taken steps to hold states accountable for non-implementation of schemes or failure to adhere to Court orders (2013, 3).

It was not clear to the researcher why HRLN had failed to realize the role of working with Indian maternal health right advocates. Even though the two aforementioned verbatim were available after field research was completed, the issue of informing and educating judgments to rights claimants at the community level had arose during the two key informant interviews with HRLN.
Both officials from HRLN indicated that they were legal professionals who had limited resources and capacity to do community level activity. They viewed their role as beginning with drafting petition (when a petitioner approached them or they identified a petitioner) and ending with receiving a favorable judgment. They were very explicit that other NGOs (that is, non-legal) had the capacity who received funds for grassroots work and were “experts” in such activities were better suited to do such work. This led the researcher to believe that there were conflicts across frames held by HRLN members and other maternal health right advocates. Such conflicts arose specifically from not realizing that their work and goals were complementary, leading the researcher to conclude that there was greater opportunity for arbitration – as framing theorists had argued – preferably by the donor who had the power (by virtue of being a donor) and interest in aiding these actors with diverging views to reflect on each other’s position, expertise and strategies (Schon and Rein 1994; also see Forester 1989). Especially, if the donor did not have the distinct ability to fund capacity building needs of these two types of actors (legal and non-legal) as established earlier, perhaps the donor could consider funding and other strategies that would generate collaboration while also making more successful attempts to advance the broader advocacy goal.

Despite the challenges and pitfalls of judicialization of maternal health, almost all maternal health right advocates underscored (to varying extent) potential opportunities presented by using litigation to advance the goal of reproductive justice. There was unanimous consensus that judicialization created an alternative political space for a discourse, which was significant in its own rights especially given the lack of responsiveness of the legislative and executive branches of government. They argued that the opportunity presented by the alternative discourse could only be further leveraged through employment of media and large-scale awareness and education campaigns (they cited the right to food campaign, for instance). This could also allow
for naming and shaming the government – as done by the food rights activists – forcing different branches of government to respond. They were cognizant of the challenges they faced with the issue of preventable maternal deaths which was far more complex, in their opinion, than hunger, malnutrition and relatively more difficult to portray before the public (without oversimplifying).

Speaking to the growing prominence of “accountability work”, few maternal health right advocates hypothesized that if judicialization was approached strategically it would require a stronger collaboration between litigants and petitioners (being maternal health NGOs) in developing petitions and seeking prayers from the court. This, the respondents speculated, could lead to collectivization between the different civil society actors triggering stronger mobilization surrounding the issue. Further, these respondents noted that approaching courts required rigorous and systemic evidence gathering (documentation, maternal death audit, social autopsy, community based monitoring) and that practices of such evidence gathering could be strengthened should tendency to litigate grow. These speculations about potential opportunities stemming from judicialization were in line with scholarly standpoint about the influence of legal mobilization (including creation of new spaces for political debate) in shaping social mobilization, which in turn could generate long-term social change (McCann 1994). That said, McCann (2006) has also acknowledge that this may be contingent upon the character of the political struggle and the broader socio-political conditions in which such struggle takes place. That is, opportunities for materialization of greater collaboration and collectivization sparked by legal mobilization may be short-changed by competing interests and access to mobilization resources that perpetuate competing agendas, instead of allowing for convergence.

In contrast to civil society actors, among all ten state officials there was a slightly higher awareness of the specific court case, the sources of which were from inside the ministries (discussions with colleagues and strategic internal meetings). But according to these ten officials,
there was no knowledge of the specific scope or details of the petitions or the judgment (aside from the petitioners were turned away from the facility and needlessly referred). All three bureaucrats and the three planners underscored the importance of judicial intervention in terms of access to justice, especially for the poor. But bureaucrats particularly questioned the merit of such a strategy which provided individual compensation and could hardly improve the system. In this regards, there was a very high awareness among all three officials of the court’s tendency to award individual compensation in health rights litigation, which they maintained contributed to individual inequity and systemic disparity. The three bureaucrats observed that not all individuals who were denied health care could/would approach the courts. They also noted that in a health system with finite resources, ultimately individual compensations were creating resource redistribution that would undermine the system. All three bureaucrats also contended that health rights litigation would benefit the civil society actors, especially NGOs behind the court cases, more than they would individuals especially if such individuals were no longer living.

However, technocrats and planners (total six respondents) believed that judicialization was a potentially useful tool for health system reforms. They argued that it was important to sensitize the governance of health system at the highest levels and increase public awareness. As well, all of them maintained that it aided them to negotiate better resources and strategic interventions with other internal stakeholders such as senior bureaucrats. Furthermore, four technocrats and planners also stressed the importance of any form of intervention, whether legislative (from parliamentary oversight committee) or judicial (expert opinion, investigative audits), which required submission of explanations from autonomous government technical support agencies (such as, NHSRC). These, according to the respondents, were potential opportunities to highlight issues that had failed to capture the attention of senior bureaucrats. However, two respondents (a technocrat and a planner) cautioned that the usefulness of a court judgment relied on its contents
and nature. They mentioned that court verdicts were generally more useful to mobilize existing resources at the community level, leveraging the fear of repercussions of legal consequences among front line health workforce. But according to these two respondents, the same was not true in altering thinking at the top of the system largely because of bureaucratic inertia and power politics. In fact, all three technocrats who participated in this research spoke to the importance of looking beyond the verdict alone in judging the significance of litigation in affecting the political and legal status of a health issue. This reinforced the debates between some socio-legal scholars over the difficulty of assessing the success of social rights litigation based on compliance alone (Gloppen 2009/2011; Gauri and Brinks 2008; Brinks and Gauri 2012; Mastda, Rakner and Ferraz 2011). As well it supported the inference of both framing theorists and socio-legal scholars of the difficulty of strictly attributing change to reframing exercise since the causal relationship between reframing and change in political priority was not straight forward (Schon and Rein 1994; Rosenberg 1991; McCann 1994/2006).

Furthermore, two respondents, an advisor with National Advisory Council and another with the Planning Commission maintained that executive authorities were mindful of PIL petitions, whether such cases were present in the media and public realm or absent from them. They indicated that the growing frequency of health rights litigation were often topics of discussion at strategic sessions/meetings of senior ministry officials and that proposals for creating service guarantee acts and grievance redressal mechanisms to reduce the burden of court cases were being considered. There was an interest, the respondents argued, among senior health sector bureaucrats to improve systemic accountability. Socio-legal theorists, such as Rosenberg (1991) have argued that even if immediate reform did not materialize in case of litigation, it may influence the “the intellectual climate, the kinds of ideas that are discussed” which can change the political attention given to an issue (8). It could even force institutional actors to reconsider the
status-quo (Ibid.), which could be indicative of frame reflection and alignment or could come about with frame alignment (that is, bureaucrats might still be hesitant about rights frame, but be supporting of some incremental systemic change). Either way, this could set the stage for further frame reflection by clarifying the scope of systemic accountability and have implications for the maternal health and human rights policy discourse (Schon and Rein 1994).

Conclusion

The findings and discussion included in this chapter underscore both individual (actor-centric) and structural dimensions of using judicialization as a framing strategy to achieve the goal of framing preventable maternal morbidity and mortality as human rights injustices. The interaction of these two dimensions is dynamics in nature and has implications of using judicialization as a framing strategy to affect political priority for the policy problem.

First, the decision to litigate, that is use strategic litigation as a framing strategy, to alter political priority is an outcome of the actor’s (or frame sponsor’s) interests, access to legal opportunity and legal opportunity structure, and mobilization resources (such as expertise, knowledge, funding, strategic support from other important actors) available to the actor. Differences in interests because of access to different mobilization resources and disagreement over the suitability of the policy forum (and correspondingly framing strategy) due to lack of confidence in the policy forum (because of historical and procedural knowledge) can collectively drive a wedge between different frames sponsors (the legal and the non-legal).

Second, this divide between the legal and non-legal frame sponsors can unfavorably affect the design of the petition including the grievances highlighted before the court and the remedies sought from it. It can potentially give rise to circumstances that can erode existing hard won rights or even limit the judgment’s practical significance. This is because role of non-legal frame
sponsors is critical to ensure that the judgment is utilized to empower rights claimants and also ensure enforcement at the grassroots level. Nevertheless, the symbolic and legal significance of a favorable judgment should not be undermined in setting the stage for frame reflection and possible reframing among institutional actors that can help address the policy problem.

Third, the scope of the petition (especially the remedies sought from the court) and that of the judgment (the compensation, relief and directives) pronounced by the court are constrained by the rules and norms that dominate such a policy forum. In other words, the absence of a justiciable constitutional right to health and health care results in underscoring grievances and seeking remedies that can otherwise be addressed by ensuring a grievance redressal mechanism is included in the design of the health system and/or the specific maternal health policy. Arguably, the absence of the grievance redressal mechanism cannot be de-linked from the lack of the justiciable right to health. However, this leads to a judgment that upholds individual access to courts and justice, thus contributing to disparity but falls short of creating systemic reform that can benefit a broader population. The former can be characterized as judicial receptiveness to demand for individual justice in dysfunctional political and health system, especially given the constitutional provision of PIL in India. But for the latter, there may be a judicial reluctance to overreach and recognition of state incapacitation – unlike in other normative cases in the Indian context – which in turn is likely an outcome of lack of political (and possibly electoral) concern for health care reform.

Finally, courts as policy forums are vulnerable to institutional influences from both within and outside (other state institutions) that privilege the historically dominant family planning frame pointing to the potential risks associated with judicialization of maternal health. That said, a sensitive, willing and capable adjudicator (thus emphasizing the importance of individual actors) is able to navigate such risks which underscores the significance of the role of the
individual institutional actor in reframing process. Such an adjudicator can in fact offer an
innovative judgment which values (traditionally undermined) women’s reproductive and
caregiving role within the domestic sphere while also recognizing their lack of reproductive self-
determination in the private sphere and the injustice of the undue burden of family planning
placed on them by the state. It is also important to realize that Indian courts as policy forums (due
to the rules and norms of the forum) for reframing can have more significant impact in addressing
provision of health care services rather than addressing structural injustice or underlying
determinants of maternal health outcomes.

Nevertheless, since the potential of constraints, risks and opportunities are somewhat
inherent to courts as a policy forum, legal and non-legal maternal health and human rights frame
sponsors can benefit from working together to maximize the gains from courts (and minimize the
risks). Ultimately, their expertise and capability in reality ought to complement each other (rather
than compete and conflict). Either way, the actor behind the frame sponsors, legal and non-legal,
that may be motivating them and providing them with resources to undertake reframing can be an
arbitrator to mitigate this frame conflict (should it be interested in sustainable and transformative
results on the ground).
PART IV: CONCLUSION & CONTRIBUTION
Chapter 9: Implications of Human Rights Framing of Maternal Health for Advancing Reproductive Justice

Maternal health and human rights scholars have argued that framing preventable maternal morbidity and mortality as human rights injustices can strategically accommodate the multifaceted gender injustices, health disparities, and poverty that collectively cause adverse maternal health outcomes. They maintain it can communicate the political and moral urgency of the situation to help create the necessary political commitment (Cook 1998; Cook and Dickens 2001; Yamin and Maine 1999; Freedman 2001/2003/2005; Fraser 2005; Fathalla 2006; Maclean 2010). Human rights frames of maternal health, they have further argued, can be constructed based on interpretations of norms contained in global human rights instruments and domestic constitutional protocols (Ibid., Gruskin et al. 2008). This claim is based on the premise that strategic framing can lend a new meaning to the policy problem and it relies on the powerful moral imperative evoked by discursive use of human rights (Schon and Rein 1994; Stone 2002; Fischer 2003; Benford and Snow 1988). Yet, framing theorists also maintain that the potential of a frame to gain public and political attention may be subject to political interpretations and that successful reframing need not lead to resolution of policy problems for various reasons (Ibid.). However, the lack of empirical studies examining the construction of such frames and their potential to communicate the political and moral urgency behind the issue makes it difficult to ascertain whether, how and under what conditions are such frames likely to be effective in generating the much deserved political commitment and necessary resources. This study contributes to this gap and is guided by the following research questions: How does framing preventable maternal morbidity and mortality as human rights injustices affect political priority surrounding the policy problem? Is it able to create necessary political commitment and resources
to advance reproductive justice for all women? Finally, what does this reveal about the potential of normative policy frames, such as human rights frames, to advance development outcomes?

As the final segment of this study, this chapter provides an overview of the study and a summary of its findings. This is followed by a discussion of the contributions and research gaps.

**Overview of the Study**

This study explored the ways framing maternal morbidity and mortality as human rights injustices affected the political priority surrounding the policy problem and whether it was able to create the political commitment and resources necessary to advance reproductive justice for all women. A second objective of the study was to synthesize the implications of the findings in the above enquiries to explain the potential of normative policy frames, such as human rights frames, to advance development outcomes.

The study used India as a country case study and there were three primary rationales (beyond other secondary ones also highlighted in the introduction) behind this selection. First, India was (and remains) the single largest annual contributor to preventable maternal deaths (excluding morbidity estimates) globally (WHO, UNICEF, UNFPA and World Bank 2012). Second, there were multiple regional maternal health and human rights advocacy coalitions functioning across states with wide disparities in MMRs and varying contextual realities (such as gender empowerment measures, health system conditions, varying levels of social hierarchy), albeit under the same maternal health policy framework established and funded by the Central Government in 2005. These diversities presented an empirical opportunity for comparative findings. Third, in a historical development in a PIL case in 2010, an Indian High Court (specifically, the Delhi High Court) delivered a landmark judgment recognizing that preventable maternal morbidity and mortality were violations of human rights. The judgment drew upon both
domestic constitutional protocols and international human rights instruments and was considered the first ever declaration of its type at the country level (ESCR-NET CaseLaw Database 2010; CRR 2011; The Guardian 2011; WHO 2010; UNHCHR 2011). The judgment was particularly significant because the Indian Constitution did not explicitly outline health and health care rights and entitlements, although Supreme Court had established right to health through judicial interpretation (and as an extension of right to life). At the same time, there was a precedent of establishing fundamental rights as an extension of the constitutional right to life, such as right to food, in a PIL judgment along with orders and directives to other branches of government which had resulted in massive publicly funded welfare programs, including nutrition programs for women and children and pension and employment guarantee programs, ultimately leading to the creation of the Food Security Act in 2013. The legal developments involving maternal health and human rights were, therefore, potentially significant for maternal health right advocates in India and elsewhere. However, socio-legal scholars have observed that the potential of judicialization led reframing to generate significant policy and social reform is conditional upon the presence of many other political, social and economic factors, in the absence of which such potential may lie dormant (Baxi 1985/1988; Rosenberg 1991; McCann 1994; Epp 1998; Sarat and Scheingold 2006).

The study employed analytical concepts from the issue,strategic framing literature used in critical policy studies and social movements literature to describe the various variables that are critical to the framing process and its outcome. Specifically, it drew upon analytical variables proposed by Schon and Rein (1994) to study intractable policy controversies, which were difficult, complex and contentious issues with multiple and often conflicting frames. This was because the discourse of women’s health policy – both globally and within India – had historically been characterized by multiple, sometimes competing or conflicting frames (pro-
choice, anti-choice, pro-natal, anti-natal, biomedical, health disadvantage) leading to conflicts that could not simply be resolved by appealing to facts. Specifically, Schon and Rein (1994) have argued that the frames or policy positions held by actors in a policy discourse and the framing strategies used by them to mobilize political support for their cause is an outcome of dynamic interaction of their interests, beliefs about the policy problem, and access to political opportunity structures and mobilization resources. Altering the political priority attached to a policy problem requires reframing which is a complex cognitive process that necessitates actors to reflect on each other’s frames to achieve frame alignment. But reframing may occur without frame reflection. As well, successful reframing (or frame alignment) may not generate the desired political commitment and necessary resources because of constraints inherent to the political opportunity structures or policy forums in which frame reflection is undertaken. The analysis was further complemented by a conceptual framework proposed by Gloppen (2011) to conduct comparative analysis of health rights litigation in developing countries. This was used to examine the findings related to the strategic litigation / judicialization dimension of this study. The litigation process was simply divided into four simple stages – claim formation, adjudication, implementation, and social outcomes and equity – and dependent and independent variables related to these stages were employed to examine the outcomes of the Delhi High Court case.

Four research sub-questions structured the analysis. These included: (1) What are the political dimensions of using human rights to claim accountability for maternal health? (2) What conditions affect concerned actors’ ability to mobilize political support for advancing reproductive justice? (3) How do concerned actors frame maternal morbidity and mortality as human rights injustices to alter political priority for the policy problem? (4) How does state recognition of maternal morbidity and mortality as violation of human rights help generate the political priority for the policy problem?
The first question was relevant due to the exploratory nature of the study and lack of existing theorization of the politics of using human rights to claim accountability for maternal health, especially in light of the scholarly debates over the various structural barriers responsible for adverse maternal health outcomes. The question also allowed the study to explore the politics of claiming accountability at the end of the passive rights holders, especially examining who demands accountability, of what kind, and on behalf of whom. The ability of frame sponsors to mobilize political support for their cause could be an outcome of the opportunities and constraints present in the political opportunity structures they were embedded in since the policy discourse tended to conform to the rules and norms of these structures. Simultaneously, it was also conditional upon the dynamics of the mobilization, especially strength of solidarity, strategizing, articulation of a clear and consistent message. These themes were explored through the second research sub-question.

The third question examined and compared the frames employed by Indian maternal health and human rights advocates and the mobilization strategies used by them to alter political priority for maternal health. This provided insights into the ways their distinct interests, beliefs about the policy problem, the political opportunity structures available to them and their contextual realities (defined as a combination of gender empowerment measures, health system conditions, and history of embedded social hierarchy) influenced the design of the frames and selection of framing strategies. This was necessary given the scholarly debates over what ought to be the frame of human right to maternal health and the lack of commentary on ways state accountability for reproductive justice could be advanced. The fourth and final research sub-question allowed the study to examine the implications of frame alignment with the state, as evident in the Delhi High Court case, for generating political priority for the policy problem and advancing reproductive justice. The various stages of litigation were studied to understand what
led to the reframing opportunity, the dynamics of the reframing, the final outcome and its implications beyond the legal arena.

This exploratory, descriptive and explanatory study used a qualitative interpretivist approach, using a single case study but comparing different framing strategies (lobbying and strategic litigation) by different frame sponsors in diverse context under the same central policy design. Field research was undertaken between January and February and August and December of 2012 based out of New Delhi. The study used key informant interviews (total 62 with state and civil society actors), extensive policy/program, advocacy and legal document analysis, and observation of three state-civil society consultations. The researcher was responsible for transcription and analysis of all data, which were examined using an inductive method of analysis.

Summary of Findings

The findings of this study demonstrate that there are discursive and institutional (that is, structural) complexities associated with framing preventable maternal morbidity and mortality as human rights injustices, which fragment and muddy the politics of using human rights to claim accountability for maternal health in India. Precisely, there are issue-specific and domestic context determined complexities in articulating human rights frames of maternal health, which are unable to lend a radically alternative, politically and morally contentious meaning to the policy problem sufficient to alter its public and political perception. As well, there are constitutional design peculiarities, which do not stipulate state obligations for health care entitlements (including specifying minimum guarantees) of citizens. Even though India is a constitutional federal republic, the historical and political dynamics of federalism complicates the politics of state accountability for maternal health/death. Growing liberalization and deregulation
of the health sector accompanied by the already weak governance capacity of the health system further complicates the potential of human rights frames of maternal health to create the necessary political commitment and/or acquire the resources necessary to advance reproductive justice for all women. Barring these discursive and institutional challenges complicating the politics of framing preventable maternal morbidity and mortality as human rights injustices, there are also numerous complexities among human rights frame sponsors in the women’s health collective and the broader women’s movement. These complications are products of global and domestic factors, but they detract from the ability of successful reframing to alter political priority for maternal health/death.

Maternal morbidity and mortality is an intractable policy problem that is predisposed to frame disputes, which are further intensified in framing the policy problem as a human rights injustice. Even though there is consensus among human rights frame sponsors in India about its overall nature, there is disagreement over the contributing factors and appropriate solutions. These differences lead to formulation of policy positions which address only selective dimensions of the policy problem and are unable to fully capture the entire range of complex determinants of this multidimensional problem. Alongside, there are several indigenous complexities of designing and articulating human rights claims associated with reproductive dimensions of women’s health. Some of these arise from challenges of demystifying the notion of human rights among extremely disempowerment policy recipients (pregnant and parturient women) who also lack political consciousness of broader notion of health and wellbeing and are deprived of citizenship rights to health and health care due to constitutional silence on health. As a result, human rights articulations of maternal health borrow norms from the maternal health policy (the JSY) frame proposed and supported by the state which is largely biomedical and technical, and therefore narrow and depoliticized in nature. Albeit, there are variations in
articulation of human rights frames of maternal health at the sub-national level, which are driven by socio-political distinctiveness (product of gender empowerment measures, sub-national health system capacity, and historical nature of social hierarchy). But concerns of poor quality health care service and gaps in policy implementation tend to dominate frames of all three maternal health and human rights advocacy coalitions examined in this study. Overall, the human right frames of maternal health are mostly limited to the policy entitlements (or welfare entitlements) that are minimal and limited in their scope and therefore unable to make the normative leap required to communicate a radically alternative and politically powerful possibility. At the same time, the tendency of the state to mandate provision of such welfare entitlements to policy recipients who submit to its promotion of two-child norm and population stabilization goal through different incentives and even coercive family planning methods has politicized the maternal health policy discourse and created challenges for human rights frame sponsors. This anti-natal agenda, disguised as pro-choice, has complicated articulations of human rights to maternal health by juxtaposing guarantees of maternal health entitlements with constraints on other reproductive liberties, causing a tricky discursive terrain. Given that this political stance of the state on women’s reproductive liberties has been historically dominant, it has led to further fragmentation within the women’s health movement, especially between pro-choice advocates and pro-natal advocates. The emergence of the issue of pre-natal and pre-conception sex-selection – a product of societal son-preference and state promotion of two-child norm – has led to a thorny politics of reproductive choice and rights amongst women’s health advocates and continues to complicate the discourse of human right to maternal health. This is due to centrality of access to safe abortion (legal in India) for choosing not to carry pregnancy to term and access to legal abortion for those selecting to terminate pregnancy because of fetal sex discrimination. Both have distinct implications for maternal health outcomes. The result is a highly contentious
and fragmented policy discourse apt for frame disputes and lacking the solidarity necessary to reflect across frames and articulate a consistent message, which can underscore the ultimate struggle for reproductive self-determination and gender justice existing beneath the layers of contextual complexity.

Seeking accountability for maternal health/death is also no less messy because of difficulties of attributing responsibility and multifaceted problem of conceptualizing where obligation lies. The former is inherent to the character of the policy problem because adverse maternal health outcomes are linked to multifaceted gender injustices in private and public spheres, health disadvantages, and other social and economic injustices. This makes it difficult to isolate whether the responsible party is the family, community, the health system or other elements in the state, and who specifically within these structures. This is intensified due to the constitutional silence on state obligation for health and health care, lack of specification of minimum guarantees and separation of power, which awards jurisdiction over health to sub-national units even though historically the Centre has intervened in health governance dominating health policy making and controlling resource allocation. This has left many sub-national states with un- or under-developed health system capacity and reliant on the Centre and presents difficulties of stipulating accountability for maternal health/death. Beyond clear provisions of legislative and executive accountability for health, the right to health has been judicially interpreted as essential to the constitutional guarantee of right to life. But in absence of clearly delineated and a justiciable right to health, legal accountability is insufficient to create systemic reform and has often resulted in contradictory setting of precedent, thus discouraging confidence among state and some civil society actors in the courts as upholders of maternal health injustices. Albeit, this is not withstanding the limited ability of courts to address gender injustices in a society where women lack equal status despite formal constitutional and other legal guarantees.
These challenges in conceptualizing state accountability have been somewhat mitigated by creation of the Centrally funded health agency (the NRHM) to support the implementation of its flagship program, the maternal health policy (the JSY) also designed and funded by the Central Government. This development has offered strategic opportunity to seek executive accountability and occasionally legislative accountability due to the publicly funded nature of the NRHM and the JSY, although frame sponsors are divided over which levels (national, sub-national, street level) of executive accountability are especially useful and when (and how) to initiate reframing. This preference is dependent on socio-political distinctiveness of the sub-national context, especially the efficiency of the health system. Nevertheless, the lesser worth assigned to women’s lives in especially poorer and disempowered segments of the Indian society have also normalized and invisibilized maternal morbidity and mortality and dampened opportunities for public outcry that can generate political concern among elements of the state especially legislators. At the same time, institutional actors associated with the NRHM have poor governance capacity and limited political power due to the lack of substantial health care legislation and regulation, not to mention an institutional attitude that still reverberates a welfare-based outlook of viewing policy recipients as subjects, rather than citizens. In a nutshell, frame sponsors seeking to reframe preventable maternal morbidity and mortality as human rights injustices, are constrained by the lack of clear political opportunity structures or policy forums (which in turn have their own constraints of power and material resources) available to them to initiate reframing and seek state accountability for maternal health/death.

Collectively, the presence of the highly contentious and fragmented maternal health and human rights discourse in India and ambiguities involving attribution and conceptualization of accountability for maternal health/death has caused further polarization among frame sponsors over the appropriate framing strategies to undertake reframing. This is partly attributed to
differential access among frame sponsors to different policy forums and beliefs about the risks and rewards associated with them. It is also linked to their competing interests, organizational agendas, and access to mobilization resources (distinct skills and expertise, funding, other strategic resources). As indicated earlier, frame sponsors who view the creation of the NRHM and the JSY as providing strategic opportunities for seeking legislative and executive accountability for maternal health/death prefer lobbying, cognizant of the very slow, sporadic and incremental but sustainable change it can bring at the community level. They are also well embedded in the community, by virtue of their knowledge/experience and skills, to mobilize it using strategies such as community level monitoring to seek accountability. Moreover, they have an aversion to policy forums such as the Indian courts due to the unpredictable nature of outcomes and the lack of confidence in their abilities to uphold and enforce the rights of women (including their reproductive liberties). Also, these frame sponsors believe in improving community level capacity building, both for the rights claimants and the health system, for generation of genuine, progressive and sustainable change. Others, who are frustrated by this slow and irregular progress and galvanized by the pro-poor and reformist attitude of the activist Indian judiciary, see prospects in strategic litigation. Their past achievements add to their credibility and propensity to take risks in hope of similar rewards (as in the right to food case) as before and because of the symbolic and legal significance attached to judgments pronounced by concierges of justice. But these frame sponsors do not consult communities before claiming to speak for their rights in the court or view themselves as equipped to educate them on likelihoods of new rights they can enjoy. The difference in strategic preferences, therefore, exacerbates further disputes among human rights frame sponsors in the maternal health discourse. This study has demonstrated that such disputes are counter-productive to advancing women’s rights to maternal health for such divisiveness dampens the potential of the progressive judgment (albeit
with soft directives for systemic reform, nonetheless a window of opportunity) produced in the Delhi High Court case to create reform (or for other elements within the state to be affected by the political pressure created by threats of repeated strategic litigation).

Still, the disagreements amongst human rights frame sponsors in the maternal health policy discourse cannot be untied from the politics of aid and development, which has (to some extent) had a catalytic effect on underscoring the policy problem that has remained largely marginalized within the domestic women’s health movement in India. The ascendance of maternal mortality reduction as a priority concern in the global development agenda (also endorsed by governments) had drawn donor attention and aid resources and also generated hope for state accountability. But the desire of the donors (frustrated by failure of previous efforts to produce sustainable results) to pursue a multi-prong approach to state accountability to affect political priority for the policy problem has also fragmented such advocacy efforts. This is due to the limited capability of the donor to do capacity building for human rights advocacy work among local NGOs (both public interest litigation organization and community based groups), whose expertise (cause or human rights lawyering and lobbying) are ultimately complementary and equally necessary to advance human right to maternal health in a holistic manner – in gaining legal recognition, enforcing and monitoring its implementation. Albeit, the fragmentation between lawyers and lobbyists in the maternal health and human rights discourse is also an outcome of historical and political conditions (both within India and in many developing countries), such as growing professionalization and NGO-ization of women’s and social justice movements. This is again, to some extent, led by their reliance on donor funding, which continues to shift with the changing global development paradigms and also perpetuates silos in the development agenda. This was also evident in India in the aftermath of the creation of MDGs (in 2000), which led donors to support maternal mortality reduction in India, but not broader or
other related women’s health concerns (including sexual and reproductive health) and an all-inclusive gender equality agenda. This sidelined different groups within the women’s health and women’s movement thus adversely affecting the domestic environment for feminist collectivization and mobilization. In fact, it has raised suspicion (agreeably due to good historical and political reasons) among some women’s health advocates over the appropriation of language of human rights by development establishment to refer to women’s rights, which might hurt genuine human rights claims of pregnant and parturient women from the poorest segment of the society originating from the grassroots. This in turn has further polarized efforts to form solidarity with advocates interested in other women’s concerns (including health concerns), in an already contentious indigenous discourse of reproductive choice and rights. Such lack of solidarity can be consequential to frame alignment with the state which seems to selectively institutionalize feminist demands (and also because of a given issue’s specific relevance to its international image). Existence of such solidarity can be useful to mount an appropriate and collective resistance to the state, to persuade it to support a feminist agenda and also “name and shame” it, if need be, given its ongoing tendency to project itself as a global power of strategic significance.

**Contributions**

The findings of this study make a number of contributions to the literature on maternal health and human rights. While the empirical findings are not meant to be generalizable beyond India, the insights from this study do “speak to” the gaps and debates in the core and related literature. Overall the insights suggest the importance of accounting for the local context, although the role of global influences cannot be entirely dismissed.
First, the findings demonstrate that there are tensions over human rights framing of preventable maternal morbidity and mortality in the empirical context, similar to their theoretical counterparts. The empirical tensions, however, are less concerned about the violations of women’s rights in the private sphere underscored as highlighted by some scholars and more concentrated on demands of right to health and reproductive health and rights in the public sphere (Cook and Dickens 2001; Fathalla 2006; Fraser 2005). This is likely due to the peculiarities of politics of reproductive self-determination in the Indian context, particularly the promotion of coercive family planning measure (two-child norm) by the state, which has become ubiquitous to maternal health politics (not withstanding various other related issues). But, this focus is also in contrast to Freedman’s (2005) suggestion of detangling maternal mortality reduction from pursuing claims of reproductive health and rights for the latter can sideline advancing claims of health care essential to prevent maternal deaths. According to the findings of this study, this is easier said than done, given the historical and ongoing political priority attached to the issues of family planning and population stabilization in India. In fact, it is difficult to overlook the ways the state’s hijacking of the public health system to pursue its family planning agenda, including excessive meddling of the Central Government in sub-national health politics has left the health systems underdeveloped in many states. Such state actions have historically influenced attitude and behavior of frontline health workforce in those states toward poor and marginalized pregnant and parturient women seeking maternal health care. In other words, the politics of human rights framing of preventable maternal morbidity and mortality is unable to escape the historical and discursive characteristics of the context where right to maternal health care is intertwined with the politics of right to reproductive self-determination. A focus on sexual and reproductive health and rights was excluded from the design of the Millennium Development Agenda which led Fraser (2005) to argued that introducing the language of human rights to the discourse on
maternal mortality can allow women’s health advocates to re-politicize the narrow, technical and depoliticized notion of maternal mortality reduction. The findings of this study would caution women’s health advocates elsewhere (beyond India) about such intentions and urge them to be careful and sensitive to historical and political realities of the context.

A second take away from the findings of this study is concerned with the challenges of conceptualizing and claiming accountability for maternal health/death in India where there are neither any grievance redressal mechanisms built into the system, nor any oversight and monitoring mechanisms. The theoretical literature refers to the importance of state accountability, including health system accountability but the findings of this study demonstrate several prerequisites necessary to conceptualize and claim state and health system accountability for maternal health/death (Yamin and Maine 1999; Maine and Rosenfield 1999; Freedman 2001; Cook and Dickens 2001). The findings indicate that lack of clear constitutional delineation of state obligation for health presents challenges on several fronts – from attribution of state responsibility for resource allocation to regulation and oversight of quality health care service delivery. Additionally, contextual politics of federalism has consequences for health sector governance. The complexities of seeking accountability in mixed health care systems (where majority health care is provided by private health care sector, such as in India) without substantial legislation and regulations (for either public or private health care sector) also have implications for conceptualizing accountability for maternal health/death. But barring laws, policies, constitutional and institutional design issues, the issue of individual and systemic accountability also need to be closely considered in creating grievance redressal mechanisms. In a resource starved, weak and dilapidated health system context, these two can be difficult to distinguish and the tendency to assign blame to individual (especially the vulnerable at the bottom of the health workforce hierarchy) may be high (and tempting). In other words, creation of accountability
mechanisms should be sensitive to contextual reality (and capacity) and stress systemic reform, rather than chase punitive sanctions aimed at individuals. Nevertheless, the key take away is that constitutional protocols on health, health laws and policies, institutional design of health governance in a federalist system have implications for conceptualizing and claiming accountability for maternal health.

A third contribution of this study is theorizing the complexities of state accountability for maternal health/death, especially the two interconnected issues of political will and state capacity. Some scholars have argued that the political consensus on a common development agenda outlined at the Millennium Development Summit in 2000 speak to the existence of global normative standards to alleviate poverty and inequality (Schmidt-Traub 2009; Carmona 2009; Alston 2005/2007). But others argue that such consensus cannot be assumed to indicate firm commitment. They also criticize the former scholarly position for being insensitive to the ways historical trajectory of development in poor countries of Global South may compromise such possibilities, not to mention be unfair to such states (Redondo 2009; Hulme 2007/2009/2010; Nelson 2007; Nickel 2013; Langford, Sumner, Yamin ed. 2013). The findings of this study support this latter position. They show political reluctance (especially legislative reluctance) to legislate and regulate the health sector including the growing private health care sector and the compromised health system capacity from systematic underfunding and inadequate resources. Both are tied to India’s historical development trajectory, including the state’s decision to follow IFI recommendations for withdrawing public investment from health sector (in years leading up to economic liberalization) (Uvin 2007; Tsikata 2009). This accelerated the already underfunded and declining public health system and its implications for growing health inequities, including maternal health disparities, have been amply demonstrated by existing literature as well as this study (Ravindran 2014; Baru 2002; Reddy 2004 as cited in Rao 2008). Arguably, some would
suggest the establishment of the NRHM and creation of the JSY as evidence on the contrary. But these policy actions emerge from intentions to politicize welfare entitlements by the then government, rather than to solely uphold its commitment to global normative standards agreed upon at the Millennium Summit in 2000. In fact, the findings of the study point to how the state may appropriate such normative standards to uphold national pride (in comparison to its neighbors, such as Bangladesh, with supposedly less political and economic clout) resulting in half-hearted policy commitments which can be best described as knee-jerk reaction, rather than a well thought out policy. Elite elements (such as the executive branch) of the ruling class within the state further appropriate such commitment to push an agenda that has been apparently delegitimized in an earlier era because of its unethical nature. In other words, global development paradigm shifts may embrace normative standards and interests within the development establishment may politicize emergent discourse by adding the language of human rights to it. But this is problematic since the material conditions caused by earlier development paradigms cannot simply be reversed and ignored. Unless such material and other depravities are addressed by pursuing radically alternative notion of development – one whose incessant logic does not exclusively equate development with GDP growth and recognize the deep injustices facing the poor and disempowered – calls for state obligation to such normative guarantees (let alone human rights guarantees) will remain meaningless in practice and lead to poorly planned welfare entitlements (such as CCTs like JSY) rather than human rights entitlements (Hulme 2007/2009; Fukuda-Parr 2007; Fischer 2013; Darrow 2013). Ensuring that the developing (but simultaneously liberalizing, deregulating and shrinking) state can fulfill even minimal welfare guarantees for its maternal citizens requires strengthening state capacity, which is difficult without civil society collaboration (Ibid., Patel and Mitlin 2009). But such possibilities are impaired by the politicization of human rights by the development establishment that is driving a
growing wedge between state and civil society. Human rights can be genuinely politically empowering to underscore gender, social and economic injustices underlying adverse maternal health outcomes, but whether its politicization by donors and civil society groups is undermining advancements in health and health care planning and administration required to improve maternal health and wellbeing needs to be considered by practitioners and scholars (Fukuda-Parr and Stewart 2010; IDS Policy Briefing 2003). In a nutshell, state capacity to support human right to maternal health should be reconciled with present realities arising in historical politics of development which also has implications for political will since a liberalizing state is less likely to fulfill the social contract (or whatever minimal existed of it).

Fourth, the findings of the study show that current civil society efforts in India are largely concentrated on attributing responsibility for maternal health/death to the health system as a state institution. Insufficient attention is paid to other elements within the state that fail to guarantee substantive equality to women and the role of community and family. Some maternal health and human rights scholars have underscored the link between maternal health injustices and other gender injustices, and stressed the significance of women’s weaker status and lesser worth in the family and community to lack of political concern for maternal deaths (Cook and Dickens 2001; Fathalla 2006; George, Iyer and Sen 2005; Sen 2011). Even though there is awareness of this reality among maternal health right advocates in India, the tendency to work in issue silos and failure to communicate and collaborate with those working on cross-cutting issues (child marriage, female malnourishment, female education, gender and domestic violence, to name a few) results in partial efforts in seeking state accountability for adverse maternal health outcomes. Arguably, not every women’s group can work on the entire range of women’s issues but discursive exchange is critical to resist the power and oppression of the state and its resilient patriarchal attitude. At the same time, the normalization and invisibilization of (some) maternal
deaths by poorer segments of the society cannot be untied from generating political commitment from the state. Overcoming this barrier involves changing social attitude, which is a difficult and long-term process, as respondents in this study have identified. But still, it requires investment in form of time, energy and resources to generate public awareness about the preventable nature of such deaths. In applying this learning elsewhere and given that politics of women’s rights are context dependent it will be important to consider the cross-cutting gender issues related to maternal health in the specific context and how they are captured/excluded (and to what extent) in advocacy efforts of maternal health NGOs and coalitions.

A fifth issue, revealed by this study, is the limitation of seeking legal accountability for maternal health/death in the Indian context and ways this can be mitigated. Courts may be able to uphold individual access to justice, but their ability to create “transformative accountability” as proposed by Yamin (2010/2013a/2013b) is severely compromised. Yamin’s proposal maintains that judicial recognition of women’s rights to maternal health should be accompanied by creation of a “national plan of action”, including corresponding budget support, strategic oversight, and establishment of mechanisms of quality assurance (2010, 96). This is hardly the case in the Delhi High Court judgment, which is due to lack of constitutional clarity on specific state obligations for health and health care. Even the issue of individual access to justice as upheld by the Delhi High Court in both petitions confirms what some socio-legal theorists have argued are reflective of poor access to legal aid in India (Epp 1998, Baxi 1988, Sood 2008). Yet, such rights claimants are provided access to courts by PILOs seeking to advance their organizational agendas and maintain their relevance. It speaks to the issue of poor funding and other support for legal aid in justice systems in developing countries, which makes PILOs more reliant on donor funding and focused on advancing donor agenda (Epp 1998/2003). This should not be assumed to undermine the role of strategic litigation in seeking legal accountability for maternal health/death. On the
contrary, the findings in the Delhi High Court confirm Hunt and Bueno de Mesquita’s (2010)’s speculation that strategic litigation may be more useful in seeking access to health care especially concrete remedies and specific interventions, rather than addressing underlying structural determinants and issues of social justice. Indeed, this points to the importance of reconciling the limitations of strategic litigation with the prospects of other advocacy strategies – such as lobbying – that can systematically address more complex issues, which arise from social injustices. Such collaboration can also help mitigate the unrealized potential of the “soft” orders or directives included in the Delhi High Court judgment. The involvement and support of a broader constituency, particularly grassroots groups, can leverage such judgments to help raise public awareness and create political pressure on the state (including alerting the consequences of inaction). The Indian experience demonstrates the importance of legal opportunity and legal opportunity structures as drivers of strategic litigation for maternal health/death, lack of justiciable right to health as a constraining feature for broader systemic reform, and the dynamics of relationship between legal and non-legal groups as determining whether the potential of a progressive judgment can be realized beyond the legal arena to affect social outcomes and equity.

A sixth contribution of this study confirms the various feminist struggles that have come to characterize the advance of women’s rights in development in India and elsewhere, although the specific struggle for reproductive justice in India is quite distinct (Howard 1995; Molyneux and Razavi 2003; Sen 2005; Cornwall and Molyneux 2006; Gideon 2006; Bradshaw 2006; Antrobus 2005; Hayes 2005; Yamin and Boulanger 2014; Germain, Dixon-Muller and Sen 2009; Cornwall, Harrison and Whitehead ed. 2007; Rai 2008; Molyneux and Lazar 2003; Tsikata 2007; John 2012/2008; Phadke 2003; Alvarez 1999/2009; Hartcourt 2013; Molyneux 2007/2013; Toyo 2006). On one hand, the struggle for reproductive justice in India faces some of the similar challenges as feminist struggles elsewhere, such as donor led agenda setting and aid politics,
creation of issue silos, NGO-ization, selective institutionalization of feminist demands, and state cooptation of feminist agenda. On the other hand, the findings of this study indicate that the strides made by the first wave of the Indian feminist health movement in advancing an agenda of reproductive choice and rights leading to the creation of the NPP in 2000 has been largely met by rhetorical rather than real political commitment by the state. In fact, the patriarchal and highly resilient state has reinvented its logic and elements within the state and continues to pursue older coercive population policy agendas, albeit through newer strategies. This reinvented logic is quite unique in that the global attention paid to maternal mortality reduction as a result of the MDGs – that many women’s health advocates globally have argued to be narrow, technical and depoliticized – has been politicized most prominently by locating it in family planning politics in the domestic context. This cunning reorientation of the state is distinct from the continuing global discourse (ever in the SDGs round) over advancing women’s sexual and reproductive health and rights in response to resurgence of religious and conservative attitudes in the aftermath of the 1990s (the progressive decade for women’s rights) (Chappell 2000/2006; Sen and Durano 2014; Stuart and Woodroffe 2016; O’Manique and Fourie 2016).

At the same time, the chilling effects of liberalization, privatization and deregulation of the health sector in India have generated newer concerns involving women’s health, which range from lack of provision of basic, quality and affordable health care to promotion of reproductive self-determination among some poor women willing to become surrogates for foreign nationals to support India’s multi-million dollar Assisted Reproductive Technologies (ARTs) industry [until the Supreme Court’s directives to legislate the issue in October 2015 that is currently pending before the legislature] (Pande 2010/2011; Baylis 2014). While the contributing factors are similar to elsewhere in developing countries (Gideon 2006; Bradshaw 2006), the nature of the outcome is distinct. The result is that the discursive context of reproductive choice and rights in
India is highly politicized and contested, unlike the politicization that characterizes its global counterpart. This suggests a need for discourse reconstruction among Indian feminist health advocates concerned with different maternal/reproductive health issues and belonging to different waves (generations). To that end, the reproductive justice frame has prospects because it can accommodate different reproductive needs and interests of varied groups of women while also acknowledging a wide range of structural factors (family, community, state and elements within it) and conditions (historical, political, social, economic, environmental, cultural, and geographic) that affect women’s ability to choose (Sister Song 2015). By extension, it also squarely locates the politics of achievement of reproductive justice in the context of state-citizenship relationship and exclusionary politics of development – be it in terms of lack of citizenship guarantee to health and health care and/or access to welfare entitlement upon fulfillment of difficult conditions.

The contributions of this study delineated so far suggest that there are various limitations of using normative policy frames, such as a human rights frame, to advance development outcomes. The analytical and symbolic potential of human rights, which can outline a set of political and social benchmarks to examine the consequences of under- and unequal development are important strengths and underscore the aspirational dimension of the framework. The normative and subjective nature of human rights framework allows advocates to apply and adopt it to different contexts to expose context-specific socio-political struggles. Yet, there are several practical challenges (political and methodological) in operationalizing a human rights framework in practice. The abstract and normative characteristics can limit the transformative potential of the framework due to inherent constraints of the context. These constraints can be outcome of historical, socio-political and economic changes – arising from domestic circumstances and resulting from global conditions – that determine political will, availability of resources, and state
capacity (independently and in combination with previous two factors) to deliver on normative guarantees irrespective of what states commit to at the global level. Unless the effects of earlier paradigms of development can be undone, use of normative policy frames such as a human rights frame will politicize development rather than provide opportunities for genuine empowerment. This politicization can in fact undermine local grassroots human rights claims of genuine struggles for empowerment, which are rooted in distinct collective experiences of unequal citizenship status.

A number of research gaps emerge from this study. First, this study limited itself to examining the politics of framing adverse maternal health outcomes as human rights injustices. It did not study the ways women’s participation in community based monitoring strategies at grassroots level or being petitioners in litigation and having a favorable judgment affected their agency and ability to negotiate better maternal health care. To conclusively speak on the transformative potential of human rights to advance maternal health outcomes, it will be necessary to ask: Whether, how and to what extent does such participation (accompanied by education, awareness, and generation of human rights-consciousness) empower women to negotiate better maternal health and health care entitlements from providers and the health system? Does such empowerment have any effects (and what) on their agency and ability to negotiate their rights and entitlements in other spheres of their lives (including private sphere)?

Second, it will be important to study diffusion of ideas through different levels of domestic institutions and the ways their appropriation by certain elite interests (privileged male from upper class and caste concerned with national “overpopulation”) affect policy design and implementation at the street level. This study (and Shiffman and Ved 2007) has demonstrated that generation of political priority for maternal morbidity and mortality in India had some connection to the emergence of the issue as a priority concern in the MDGs. Yet, respondents
referred to a shift that happened in attitude from the level of elected officials at the national level to that at the level of appointed senior officials at the policy making level, pointing to the ways the older dominant policy frame (family planning and population control) re-emerged despite the existence of the NPP in 2000. This points to resilience of certain ideas in the mindset of policy makers (and possibly even in the national consciousness given the heightened focus on fertility control historically). It is therefore important to ask: how do such frames come to exist, persist and how can they be transformed? What implications do they have for design and implementation of policies directed toward certain key constituency/collective that are considered responsible for contributing to “overpopulation” (in relation to pregnancy and child birth or other welfare administration related policy arenas)? How does the politics of federalism as seen in India interact with such design and affect outcomes at the street level?

Third, the politicization of human rights by the development establishment and promotion of legal accountability may be fueling cause and human rights lawyering in contexts (such as India) where legal opportunity and legal opportunity structure are present. These realities raise several questions that need to be explored at greater length. They are: what are the consequences of such emergent phenomenon to grass roots rights politics and social justice movements in developing countries? What effects do they have on access to courts and justice those without “moving stories” (as perceived by cause lawyers) to share before the court? And, what effects do they have on availability (however minimal) of legal aid in resource poor context?

Likewise, the findings of the study raise issues of civil society accountability, which the literature on maternal health and human rights is largely silent on. Who are maternal health right advocates accountable to in claiming to speak for the rights of poor and disempowered pregnant and parturient women? Who decides what are priority concerns (including needs and strategic gender interests) in relation to maternal health/death and which one should be raised before the
state (including when, how, and before which element of the state)? What impact does such prioritization have on ability to resolve the policy problem? By extension, who are donors accountable to for picking and choosing which civil society groups they will support to achieve their agenda? Although the literature on maternal health and human rights does raise the issue of donor accountability, it is in relation to bilateral donor cooperation and accountability for meeting aid commitments (Yamin 2010 / 2013a; Hunt and Bueno De Mesquita 2010). This notion of accountability needs to be reconsidered with the shifting landscape of donor politics in development and growing significance of philanthropic donors. In a recent study assessing the diversity of donor landscape in maternal health and the nature of activities undertaken by donors, Deleye and Lang (2014) maintain that philanthropic donors have the “capacity to be innovative and creative, take risks” similar to in case of MacArthur Foundation in this study (9). But given that such donors “have no voters, shareholders or customers” it is important to consider the implications of their activities and strategies for maternal health politics in India and elsewhere (Ibid.). To that effect, more research is required in both these areas of civil society and donor accountability in relation to maternal health and human rights politics, and human rights and development more broadly.

Finally, in assessing the significance of judicialization of maternal health to advance reproductive justice for all women, this study limited itself to the 2010 Delhi High Court case and its judgment. At the time of field research in late 2012, there were “more than thirty cases” (according to a senior official of the Reproductive Rights Unit of HRLN) in various stages of hearing in various High Courts and the Supreme Court in India. These cases were using the Delhi High Court judgment as a precedent. Moving forward, it would be important to examine the effects of these various court cases and judgments (where available) on advancing reproductive
justice for Indian women, both direct and indirect on systemic change and beyond (on legal and social mobilization surrounding human right to maternal health).

**Concluding Thoughts**

The findings of this study have implications in light of several changes that have come to characterize the politics of development, maternal health (and more broadly women’s health) and human rights globally and in India. In September 2015, a global political consensus was reached on a new development agenda, the Agenda for Sustainable Development. This shift from the Millennium Development Agenda (2000-2015) has been accompanied by an added emphasis on the centrality of human rights to development. To that end, the United Nations OHCHR reminds: “The Millennium Development Goals served as a proxy for certain economic and social rights but ignored other important human rights linkages. By contrast, human rights principles and standards are now strongly reflected in an ambitious new global development framework, the 2030 Agenda for Sustainable Development” (2016, n.p.). The findings of this study would suggest cautious optimism on the practical potential of integrating human rights with development. Nevertheless, SDG 3 (Ensure healthy lives and promote well being) emphasizes greater investment in health financing and resources (3.c), improvement of health system capacity (3.d) and achieving universal health coverage (3.8), which if implemented can change the domestic conditions within countries. They can strengthen state capacity and provide the necessary discursive anchoring to articulate claims to right to health in countries, such as India. But its prospects will be conditional upon fulfillment of several parallel and cross-cutting goals – those pertaining to sustainable and inclusive economic development (SDG 8) and promotion of fairer trade and reduction of inequality among countries (SDG 10), including fulfillment of
promise of aid where applicable – that enhance the ability of developing states to truly provide
for its citizens (Sustainable Development Knowledge Platform 2015).

It is equally noteworthy that “maternal mortality reduction” remains a priority focus (Goal
3.1) within the good health and well being goal (SDG 3). After all, it is one of the eight MDGs on
which progress lagged behind the most (Maternal Health Task Force 2015; Yamin and Boulanger
2014). Yet, the goal of achieving sexual and reproductive health and reproductive rights (Goal
5.6) within the gender equality and empowerment of women and girls (SDG 5) has also
resurfaced (along with several other goals that can advance gender equality in both public and
private spheres and in different dimensions of women’s lives – political, economic, social, and
familial) (Sustainable Development Knowledge Platform 2015). On one hand this is encouraging
news, on the other hand this disconnected appearance of two deeply linked issues (maternal
mortality reduction and sexual and reproductive health and right) is concerning. What
implications would this have for the struggle for reproductive justice in adding the language of
human rights (as encouraged by the UN led development establishment) to these goals (albeit
SDG 5.6 is already framed as a right where as SDG 3.1 has retained its “depoliticized”
configuration)? Could it further polarize needs and interests of respective rights claimants or
present prospects for consolidating (but not assimilating) such claims under the frame of
reproductive justice? What will the character of the struggles (at the global, national and local
levels) look like in an environment of selective donor attention, continued NGOization and
tendency to work in issue silos among feminist groups and organizations in the developing
countries? Can the ongoing realities of aid and NGO politics in poor countries undermine
achievement of these consolidated agenda for advancing women’s rights in the era of SDGs?
These are likely to be important and emerging concerns for scholars and practitioners.
At the same time, recent developments at the 60th Meeting of the United Nations Committee on Status on Women held in March 2016 would underscore the importance of locating domestic/national struggles for reproductive justice in the broader politics of citizenship rights of women. The “conclusion agreement” reached between governments in attendance and women’s rights advocates at this session ended in relegating government responsibility for “development and enforcement of policies and legal frameworks and the strengthening of health systems that make universally accessible and available quality comprehensive sexual and reproductive health-care services, commodities, information and education, including …where such services are permitted by national law” (UN Economic and Social Council 2016, 14; emphasis added). This would suggest that efforts to make progress on SDG 3.1 and 5.6 are already compromised and the development establishment’s efforts to politicize global political consensus on the SDGs has already been reduced to rhetoric on the issue of women’s health. This reminds one of similar developments in the wake of formulation of the MDGs, which also excluded the strides made by women’s rights advocates at the ICPD Conference and the Beijing Declaration respectively in 1994 and 1995 (Eyben 2004). Existing laws and policies in national contexts will continue to determine women’s access to essential health services suggesting the centrality of citizenship rights and entitlements – be it for health, or women’s rights and rights of social minorities. This struggle is likely to be distinct depending on national context and may range from closing the gap between formal legal and constitutional guarantee of equality and substantive equality to that of securing such guarantees where none exist. Unless, such local struggles can be overcome, opportunities presented by discursive shifts in development from welfare-based to human rights-based will likely remain unfulfilled. In the meanwhile, the continued emphasis on human rights by the development establishment is more likely to politicize women’s health issues rather than provide opportunities for genuine empowerment.
Several changes have also occurred within India (of significance to the findings of this study) since the field research for this study was completed in April 2013. In May of 2014 in a landslide victory in the general elections, Indians elected the Hindu Nationalist Bharatiya Janata Party (BJP) as the governing party at the Centre (The Guardian 2014). Shortly after, in December 2014 the BJP dismantled the National Planning Commission ridding the country of its tradition of governing through the five year National Plans (popularly termed “Soviet Era Planning” by critics). This was replaced by the “Niti Ayoga” (National Institute for Transforming India), which the BJP argued would allow sub-national authorities to actually function in a decentralized manner as indicated in the Indian Constitution. The Niti Ayoga has been accompanied by a new Governing Council of State Chief Ministers and is headed by the Prime Minister. Whether and how this change will affect planning and policy making in India at the national and sub-national level, including the activities of Central MoHFW and accountability for health, remains to be seen.

The accompanying cabinet resolution underscores the important role of government as “enabler” of legislation, policy and regulation, rather than “provider” of services to people (contrary to the previous governing party INC). It also highlighted its major constituency as the Indian middle class, especially the “neo-middle class and the small and medium business enterprises”, who were key to BJP’s victory100 (Mehra 2015). Yet, in early 2016 the Central MoHFW acquired the Rashtriya Swasthya Bima Yojana (National Health Insurance Scheme or RSBY) from the Ministry of Labour, which is supposedly the first step toward universal health coverage as outlined in the 12th Five Year National Plan (2012-2017) launched by the previous

100 It is said that the middle class was frustrated by dawdling GDP growth rates in latter half of 2000, sluggish “development”, repeated cases of government involvement in massive corruption scandals) and galvanized by the promise of a clean (corruption wise) and well governed India.
government, although in form of universal health insurance. The repeated and shifting discursive reconstruction of “universal health care” into “universal health coverage”, and now “universal health insurance” is notable. The RSBY is set to roll out in 2017-18 and aims to provide access to health care to 50 million (previously available to 15 million) citizens of BPL category based not simply on income but also “deprivations” listed in the socio-economic caste census, thus covering a population greater than just total BPL population. Some respondents of this study had speculated such a move. However, the gradually increasing state commitment to health, as a result, is noteworthy. More research is required to understanding whether this signals growing politicization of health and health care in India or is an outcome of emergent political priority for health, or perhaps both. Either way, the implications for citizenship politics and public policy are difficult to overlook. According to some media reports, sub-national authorities will be able to customize the basket of services provided under the scheme as well as add financial coverage based on resources available (Ghosh 2016; Sharma 2016). This will likely have an impact on access to health care and effect on health disparity within states and between states. It is, however, unclear whether there will be an improvement or further decline – especially in light of the further stigmatization of the health care seekers under scheme (identified based on caste deprivation), which is not impossible given the growing sentiment of anti-minority and resurgence in violence against Dalits and Muslims that the BJP government seems to have turned a blind eye to.

At the same time the President of Vishwya Hindu Parishad (VHP), an ideologically extremist wing within BJP has publicly called for Hindu women to have more children to help support the growth of the religion to maintain its majority status and “keep up” with Muslim women who supposedly have higher fertility rates (Verma 2015). According to the Indian Census of 2011, Hindus form approximately 79.80 percent of the population, while Muslims constitute
14.23 percent (Census Commissioner 2011). The politicization of women’s bodies, reproduction and motherhood in wake of nationalist sentiments, even if only rhetorical, will be of interest to feminist scholars and practitioners. Additionally, in late 2015 the BJP Government launched public consultation on a new scheme to subsidize injectable contraceptives (specifically Depo Provera) for poor women to “modernize contraceptive choices for women” and support its national population stabilization plans. Not surprisingly, some women’s health groups have come to view this with suspicion, while others believe the subsidization increases women’s choices (Nigam 2015; Tribon 2016, n.p.). The Bill and Melinda Gates Foundation (a partner on this project) has applauded the Indian Government for this action. In an exclusive interview with Hindustan Times, Melinda Gates argued that this was a safer option than sterilization on which India indeed has an abysmal record (Biswas 2014; McCoy 2014; Pulla 2014). Melinda Gates maintains this is a positive investment in family planning given the very slow improvement on access to contraception in India and also the high un-met need among the country’s youth (Hindustan Times 2016; New York Times 2016). Injectable contraceptives, especially Depo Provera has had a dubious history in India, since their administration without consent and several incidences of lack of safety once led women’s rights advocates to approach the Supreme Court in 1986 (Tribon 2016; see Rao 2008). Although the Supreme Court did not ban injectable contraceptives, it cautioned the government and recommended close monitoring. However, “the highest decision-making body on technical matters in the Ministry of Health & Family Welfare, in 1995 held that Depo-Provera is not recommended for inclusion in the FPP [Family Planning Program]” (Nigam 2015). India’s efforts to stabilize its population by enabling greater contraceptive choice will likely further complicate the political struggle for reproductive justice. Additionally, in October 2015 the Supreme Court of India ordered the government to legislate commercial gestational surrogacy, which is multimillion dollar global industry. Both issues have
implications for reproductive self-determination and raise issues of reproductive choice and rights. The government responded by banning commercial surrogacy for foreigners (but keeping it available for heterosexual married nationals) and took immediate steps (but comprehensive legislation is pending). This has attracted criticism from feminist health scholars and practitioners globally who emphasize the importance of regulation (to uphold women’s right to reproductive-self determination) rather than knee-jerk reaction of a ban that can send the industry underground (thus perpetuating further exploitation) (The Guardian 2015/2016; Pande 2015). These recent developments suggest that the debate over reproductive choice and rights in India are growing increasingly complex and are far from being resolved anytime soon. The need for a well-defined struggle for reproductive justice is, therefore, imminent.
Appendix

Appendix 1: International Human Rights Law Cited in Delhi High Court Case Petitions

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<tr>
<th>UDHR</th>
<th>Article 25</th>
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<td>“(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (2) Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.”</td>
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<th>ICESCR</th>
<th>Article 10</th>
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<td>“The States Parties to the present Covenant recognize that: 1. The widest possible protection and assistance should be accorded to the family, which is the natural and fundamental group unit of society, particularly for its establishment and while it is responsible for the care and education of dependent children. Marriage must be entered into with the free consent of the intending spouses. 2. Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period working mothers should be accorded paid leave or leave with adequate social security benefits. 3. Special measures of protection and assistance should be taken on behalf of all children and young persons without any discrimination for reasons of parentage or other conditions. Children and young persons should be protected from economic and social exploitation. Their employment in work harmful to their morals or health or dangerous to life or likely to hamper their normal development should be punishable by law. States should also set age limits below which the paid employment of child labour should be prohibited and punishable by law.”</td>
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| Article 12 |
| “1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for...” |
the healthy development of the child; …

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.”

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<th><strong>CEDAW</strong></th>
<th><strong>Article 12</strong></th>
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<td>1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.</td>
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<td>2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.</td>
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<th><strong>Article 14</strong></th>
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<td>1. States Parties shall take into account the particular problems faced by rural women and the significant roles which rural women play in the economic survival of their families, including their work in the non-monetized sectors of the economy, and shall take all appropriate measures to ensure the application of the provisions of the present Convention to women in rural areas.</td>
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<tr>
<td>2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:</td>
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<tr>
<td>(b) To have access to adequate health care facilities, including information, counselling and services in family planning;</td>
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<td>(c) To benefit directly from social security programmes; …</td>
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<tr>
<td>(h) To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications.</td>
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Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:

(a) To diminish infant and child mortality;

(b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;

(d) To ensure appropriate pre-natal and post-natal health care for mothers; …

(f) To develop preventive health care, guidance for parents and family planning education and services.”

Article 27

1. States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.

2. The parent(s) or others responsible for the child have the primary responsibility to secure, within their abilities and financial capacities, the conditions of living necessary for the child's development.

3. States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.

4. States Parties shall take all appropriate measures to secure the recovery of maintenance for the child from the parents or other persons having financial responsibility for the child, both within the State Party and from abroad. In particular, where the person having financial responsibility for the child lives in a State different from that of the child, States Parties shall promote the accession to international agreements or the conclusion of such agreements, as well as the making of other appropriate arrangements.
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