March 2019

Building Coalitions to Support Maternal Health Quality of Care in India

So O'Neil, Divya Vohra, and Emma Pottinger

Coalitions are loose organizations of individuals or groups working toward a shared vision and common goal. Effective coalitions can bring about sweeping changes in policies and programs to improve the well-being of many people. Recognizing the importance of coalitions for systems change, the John D. and Catherine T. MacArthur Foundation's maternal health quality of care (MHQoC) strategy supports civil society organizations in promoting engagement around maternal health and rights. This brief describes these coalition-building efforts to further influence the field of MHQoC supported by the Foundation and other entities, the lessons learned from MHQoC grantees working with these key coalitions, and future directions and opportunities for coalitions in this space in India.

Introduction

The Indian Constitution protects citizens' right to health as inextricable from the right to life, equality, and nondiscrimination (Government of India n.d.).[1] The Supreme Court of India and other lawmakers and advocates have further interpreted the provisions under Articles 14, 15, and 21 to guarantee access to good health care and respect in treatment regardless of gender, class, caste, or religion. These interpretations of the Constitution have led to large strides in access to care. However, the increased access to care has not translated to major improvements in health and the quality of health care remains uneven across India. In addition, women and marginalized populations continue to experience gross violations of their rights in health care settings despite constitutional directives.

To address women's treatment and the need for improved quality in health care, the John D. and Catherine T. MacArthur Foundation has supported movements related to MHQoC. One of the distinct activities undertaken by grants under the MHQoC strategy included assisting coalitions to advance maternal health and rights. These coalitions range from those acting at national levels to smaller groups acting at local levels; the largest have as many as 4,500 members. Each boasts varying objectives: some have a very narrow focus, such as ending sex selection, whereas others have broader mandates, such as promoting women's rights for quality, respectful health care. Exhibit 1 provides an illustrative list of national-level coalitions in which MHQoC grantees participate—many with state-level chapters.

Cover photo by: Paula Bronstein. The Verbatim Agency/Getty Images.

MacArthur Foundation

MATHEMATICA Policy Research

Exhibit 1. Illustrative national coalitions addressing MHQoC in India

Coalition (level of organization and coverage)	Number and type of organizations in network	Purpose	Key activities
White Ribbon Alliance India (WRAI)*	• ~1,800 civil society organizations (CSOs) and individuals, mostly organized into state alliances	Promote safe childbirth and respectful maternity care	• Building capacity • Campaigning for policy change • Developing alliances
Voluntary Health Association of India (VHAI)	• 27 state voluntary health associations • More than 4,500 health and development institutions	Promote people-centered health policies	• Initiating and supporting grassroots health programs
National Alliance for Maternal Health and Human Rights (NAMHHR)*	• 37 CSOs across 14 states	Promote maternal health as a human rights issue	• Developing rights-based strategies for improving maternal health
Jan Swasthya Abhiyan (JSA; People's Health Movement)	• 21 national networks and organizations	Coordinate activities and actions on health and health care	• Promoting right to health and health care as a basic human right
Community of Practitioners on Accountability and Social Action in Health (COPASAH)	• 105 grassroots-level practitioners	Strengthen the field of community accountability	• Sharing resources • Building capacity
Coalition for Maternal-Neonatal Health and Safe Abortion (Common Health)*	• ~65 national- and state-level nongovernmental organizations, CSOs, providers, policymakers, lawyers, journalists, and other individuals across 23 states	Promote access to and quality of maternal and neonatal health and safe abortion services	• Conducting broad-based advocacy to mobilize citizens, health care providers, and policymakers

Source: Analysis of MHQoC strategy documents and data collected by Mathematica Policy Research.

Using these groups as examples, we discuss how coalitions focused on MHQoC in India began, their achievements, and lessons learned. This assessment of coalitions will provide insights on the current status and coverage of MHQoC coalitions, as well as where there could be gaps to inform future related efforts.

Building coalitions to advance maternal health and rights

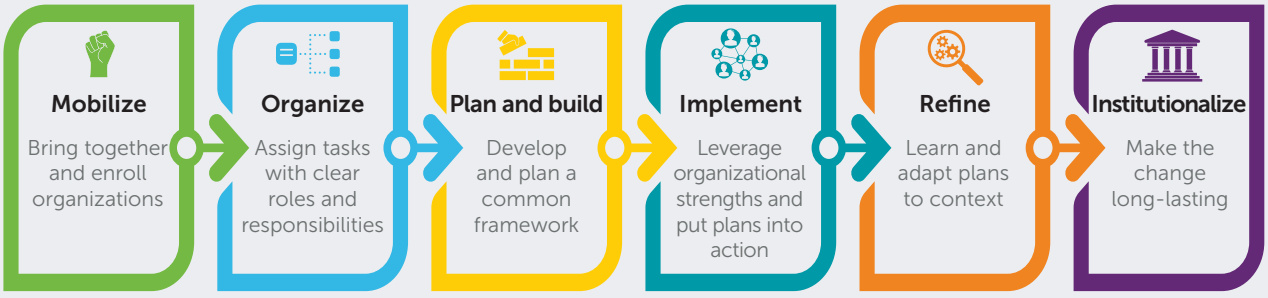
Effective advocacy efforts promoted by coalitions rely on successful implementation within **six key stages of coalition building:** mobilizing, establishing organizational structure, building capacity and planning for action, implementing, refining, and institutionalizing (Butterfoss 2007) (Exhibit 2). Most grants under the MHQoC strategy have implemented the earlier stages and have reached later stages of coalition building. Examining these MHQoC and other maternal health-related coalitions along these six stages will provide insights into the conditions conducive to launching a coalition, the various structures for running coalitions, and the way forward for coalitions that have achieved their initial mandates.

Mobilize: Rallying around a common cause while concurrently embracing diversity in motivations makes coalitions stronger.

A group of organizations or individuals prompt a coalition to mobilize by bringing organizations together and enlisting them in a common cause. Partnerships for and mobilization of MHQoC coalitions have tended to occur organically in India. Rather than purposefully seeking specific organizations because of their history, connections, or capabilities, MHQoC coalition partnerships in India have formed based on outreach to existing connections, chance meetings with one another, and recommendations from other health networks. This serendipitous approach to forming coalitions has led to a culture of inclusion in coalition work, but also to varying levels of engagement among different members.

For instance, the National Alliance for Maternal Health and Human Rights (NAMHHR) started as a group of 11 nongovernmental organizations from seven states coming together to study quality of care that women received during an institutional delivery. Similarly, the Coalition for Maternal-

Exhibit 2. Six stages for coalition building



Source: Adapted from the Coalitions and Partnerships in Community Health (Butterfoss 2007).

Neonatal Health and Safe Abortion (CommonHealth) began as a subset of Jan Swasthya Abhiyan (JSA), which focuses on primary health care; this JSA subset specifically came together to address MHQoC in India. The White Ribbon Alliance India (WRAI) began more than 20 years ago when results from the National Family Health Survey showed that the maternal mortality ratio in India had not declined in a decade and several stakeholders began to discuss the issue. In all these instances, coalition members got together and partnered around shared priorities and vision.

> ***To mobilize [a coalition, organizations] need to come together with a common agenda, shared vision, common understanding of the problem, and joint approach to solving it.***
>
> *–MacArthur grantee*

However, congruencies in priorities and vision did not guarantee easy collaboration. In fact, MHQoC strategy grantees did not always find it easy to coordinate with partners—even with interests in the same cause, the slight differences in missions, agendas, and context could translate into large divides. For example, CommonHealth has found that decisions about who can join state-level networks often depend largely on each state's unique political climate; states where unions are strong, for example, might allow health care workers' unions to join networks, whereas other state-level networks might prioritize grassroots, community-led groups instead. Variety in the makeup of state-level networks also creates challenges for developing cohesive, national-level strategies regarding core issues or constituencies.

Some coalitions, such as WRAI, have sought to mitigate tension between members by defining the coalition as broad-based, enabling and even encouraging member organizations to bring their own agendas and contexts to the table. The diversity of ideas and areas of focus among member organizations can also encourage new thinking among the broader coalition, helping to cultivate a widespread interest in quality issues within the maternal health field.

> ***[By] removing public health from being a biomedical issue that only doctors are concerned about to an issue that has links with gender-based violence, nutrition, water and sanitation—we have managed to bring that social determinants and rights-based perspective to the maternal health coalition.***
>
> *–MacArthur grantee*

In general, this approach to embrace coalition members' varying agendas and contexts has been seen as an advantage in India's landscape, given the variety of multilateral, governmental, and other agencies and organizations—also representing diverse interests—driving MHQoC. The way members consider, discuss, and promulgate issues within MHQoC coalitions often reflects individual member organizations' differences in opinions and views. Because the final messages agreed upon have to consider the many viewpoints, these messages end up resonating with the broad set of stakeholders external to the coalition that have to be convinced to act further.

Organize: Flexible, decentralized coalition structures enable members to seize opportunities and act quickly.

Once member organizations join together to form the coalition, the next task of the group involves establishing an organizational structure, which assigns tasks with clear roles and responsibilities to each member. Most coalitions supported by the MHQoC strategy have a secretariat serving as the coalition's backbone. The secretariat convenes periodic member meetings, raises funds to support coalition activities, and coordinates communication and sharing across members. Beyond the management role played by the secretariat, MHQoC coalitions can have a board of directors or steering committee to guide the coalition's activities and help coordinate across coalition members, task forces or working groups to support coalition activities around specific topics, and state chapters to oversee roll-out of coalition activities in particular states. Exhibit 3 lists the potential roles and describes their associated responsibilities, indicating coalitions that have these positions.

Exhibit 3. Governance and members of coalitions

Coalition position	Responsibilities	Coalitions having this position
Secretariat (lead agency)	Convenes coalition and oversees its operation without trying to exert control over the coalition's direction	NAMHHR* WRAI*
Steering committees	Coordinate across other committees; guide development of the coalition's values, goals, and activities	NAMHHR* COPASAH WRAI*
Task forces and working groups	Work on specific issues or topic areas	NAMHHR*
State chapters	Pursue the coalition's goals and conduct activities at the state level	WRAI CommonHealth*
Advisors	Individuals and nongovernmental organizations that are not members but advise the coalition	NAMHHR*

* Indicates coalition supported by the MacArthur Foundation under its MHQoC strategy.

COPASAH = Community of Practitioners on Accountability and Social Action in Health; NAMHHR = National Alliance for Maternal Health and Human Rights; WRAI = White Ribbon Alliance India.

Source: Analysis of MHQoC strategy documents and data collected by Mathematica Policy Research.

The diverse governance and membership arrangements help to highlight the inherent benefits and challenges within each type of coalition structure. For example, WRAI's secretariat is composed of five organizations that jointly share the burden of coordinating coalition activities, which minimizes the share of work shouldered by any single organization while still having a single body to help coordinate and lead the coalition. WRAI reports that this helps to ensure a loose and inclusive structure, and enables the coalition to not rely too heavily on donor funding to function.

> ***Running an alliance is extremely thankless because participants are often there only because it serves their own agenda. We recognize that it is okay to have your agenda, but you still engage because your larger goal is maternal health. Most coalitions break down when one member is intent on pushing its own agenda [on others].***
>
> *–MacArthur grantee*

However, this structure requires an added layer of communication, as the multiple organizations serving as secretariat must facilitate communication among themselves before communicating with other coalition members. In contrast, NAMHHR's secretariat is a single organization position with little bureaucracy in its governance structure. Yet, the coalition has found that no participating organization wanted to hold the position because, although seen as important, it is often a challenging job for one organization. As a result, NAMHHR's level of activity has varied depending on the secretariat's level of engagement.

In spite their varying structures, most coalitions describe themselves as flexible and decentralized. Because secretariats or other committees might not always be aware of circumstances on the ground, they allow members flexibility to act and take advantage of opportunities to advance the coalition's mission as they arise and empower members to make decisions rooted in their deep understanding of their local contexts. Coalition members believe that this structure enables grassroots movements to flourish, rather than imposing top-down structures that do not allow for the diversity of needs, voices, and opinions on the ground. CommonHealth, for example, allows individual state-level networks to take actions aligned with the movement's goals and values as they see fit, although CommonHealth acknowledges that it is sometimes important for the broader coalition to weigh in on whether a specific opportunity aligns appropriately with the movement's broader goals.

Plan and build: Creating, updating, and planning around a shared vision requires sufficient time and resources, which coalition leadership have difficulty obtaining.

Along with a governance structure, a strategic plan to organize activities is necessary to give the coalition direction, clarity in milestones for progress, and a timeline to keep members on task. To develop and implement a strong strategic plan acceptable to all members, key leaders within a coalition must have time to engage in frequent dialogue to achieve consensus when possible and to allow for members' differing opinions and priorities when necessary. Although members' willingness to volunteer their time and resources for these activities often reflects that they value the coalition's work, lack of formal funding often means that coalitions have varying capacity to develop, plan, and grow their activities. Thus, although some coalitions such as the WRAI have undergone a defined strategic planning effort and plan to continue to do so on a periodic basis, these efforts are often limited and can occur only every few years.

When coalitions have the capacity to undergo a planning phase of their work, a parallel activity is for lead agencies to ensure that the members have the capacity, or that the coalition can build their capacity, to implement the plan. For MHQoC coalitions, specific capacity-building activities have tended to be ad hoc and designed to respond to capacity needs at specific times. As such, coalition capacity-building activities have included trainings on grant writing when the coalition and its members require additional fiscal support, trainings on specific MHQoC-related activities (such as conducting maternal death reviews) that coalitions have decided to prioritize, and trainings on how to market key messages to policymakers before launching activities to raise awareness. In addition to such capacity-building activities, the organizations providing logistical support and guidance to the coalition itself also must build capacity for these activities, a need that coalition members themselves, donors, and other supporters often overlook. Exhibit 4 presents how two coalitions have worked through the key steps in developing a strategic plan.

> ***There are two kinds of capacities we need. One is our technical expertise. The second is our operational capacity. One reason our coalition has survived is because our secretariat has both.***
>
> *–MacArthur grantee*

Exhibit 4. Developing a strategic plan for a coalition to address MHQoC: WRAI and NAMHHR

Strategic planning step	WRAI	NAMHHR
Articulate need for change	Maternal mortality had not decreased significantly over the past two decades in India (WHO n.d.)	Most women face rights violations during institutional deliveries (Sahayog 2010)
Identify strategic issues to achieve change	Used data-driven approach to identify quality—not access—as the key driver of maternal and newborn health complications and deaths[a]	Conducted environmental scan to identify sterilization and the treatment of marginalized (particularly tribal) women as areas for change[b]
Align coalition mission and vision	Hold strategic planning session every four or five years to unify coalition's vision and direction	Require that member organizations apply a rights-based approach to maternal health work
Road map to achieve change	Take an opportunistic approach based on openings that emerge, including members acting individually to take advantage of opportunities that align with mission and vision	Influence Ministry of Health and Family Welfare and Planning Commission officials through fact-finding reports and contacts with key officials
Develop metrics and timeline against which to measure progress and document achievements	Measure responsiveness of government officials, the size of campaigns, media attention, numbers of public hearings, and the development of tools (such as monitoring checklists)	No clear metrics because because it is difficult to measure whether officials have been influenced by coalition activities
Plan for leadership succession and evolution	Continued leadership by WRAI as the secretariat, but decision-making process is multilevel and roles turn over periodically	Hand off of secretariat from Sahayog to CHSJ

Source: Steps for strategic planning adapted from McKay 2001; NAMHHR n.d.

[a] WRAI's recent "What Women Want" campaign, which includes responses from more than 150,000 women, indicated that access to maternal health entitlements, services provided with dignity and respect, and clean and hygienic health facilities are important components of what quality maternal health means to them.

[b] Specific issues identified included a lack of available services at primary health centers and community health centers, and the refusal or denial of services to poor women; discrimination and social exclusion and its impact on health access; corruption in the health system and harassment of the poor; the current vertical program approach focusing exclusively on childbirth has led to neglect of the continuum of care from pregnancy to the postpartum stage, and services for abortion or post-abortion complications; safety and continuum of care in home delivery; nutrition and right to food; accountability and surveillance systems to prevent maternal mortality; quality of care as a concern; grievance redressal systems; social security for pregnancy and childbirth; women in vulnerable situations and maternal health services; the weakening of health systems and persistent lack of skilled human resources, sufficient drugs, or supplies; considerable promotion of the private sector in health care provision at the policy level, without adequate regulation or evidence base; policy-level neglect of local knowledge, beliefs, practices, and resources; combined with poor use of providers from AYUSH and local Dais, who are indeed more accessible and affordable for the rural poor in India.

Implement: Without regular communication, coalitions can enter into dormancy.

When a coalition has developed its strategic plan and built its capacity, members must coordinate with one another and with external stakeholders to execute the plan. Regular communications among community members serve to promote activities that advance the strategic plan, and help to motivate coalition members and build momentum for the coalition's goals.

MHQoC coalition members primarily use emailed newsletters and communications as the primary mode of engaging coalition members in implementing activities between larger annual or biannual member meetings. This communication strategy, although relatively simple for upkeep, has one key challenge. Because members who oversee the communications often take on this task pro bono, the regularity of communications depends largely on coordinating members' ability to volunteer their time. For example, as NAMHHR communications have slowed in the past year, the coalition members have been less active and some say the coalition has entered a dormancy phase.

Refine: Critical reflection sessions among members support refining and strengthening coalition activities.

As coalitions implement their strategic plans, they must also develop mechanisms for sharing and assessing progress, holding each other accountable, and making course corrections as needed. Although MHQoC coalitions report continually refining their messaging and activities, they rarely define this process as separate from implementation the plan. For example, as one member of the WRAI noted, correcting the course and modifying the coalition's goals are built into the strategic plan itself; the plan allows for periodic updates to the coalition's areas of focus.

These updates are a benefit as coalition members have opportunities to share ideas and philosophies and discuss the tools that can help member organizations achieve their goal. Some coalitions choose to use time during annual or biannual all-member meetings to conduct in-depth critical reflection, and to discuss lessons learned and implications for future activities. Through such reflection sessions, WRAI decided to choose respectful maternity care as an area of focus in 2015. WRAI members came together to discuss combined results from qualitative research with 433 women on the realities of maternity care across four states, evidence of disrespect and abuse of

pregnant women, and research conducted with the India Council of Medical Research on challenges to respectful maternity care. In the end, members and other stakeholders endorsed the Respectful Maternity Care Charter, a consensus document on the universal rights of childbearing women, which highlighted the interest and commitment of the maternal health community to address these issues. WRAI has disseminated this charter among its 1,800 members and translated it into three prominent Indian languages. With this refinement to its direction, WRAI has become a common platform for advocates to promote institutionalization of respectful maternity care in India.

Institutionalize: Coalitions' activities become business-as-usual.

Mature coalitions ideally enter a final phase in which the coalition itself as well as the changes it seeks become the norm in individual, organizational, and system practices. Only one of the coalitions supported by the MHQoC strategy, WRAI, has reached this phase to date—potentially benefiting from its long history and being part of a global federation, WRAI has made significant progress in mainstreaming MHQoC issues, including shifting tasks of key maternal health functions to nurses and midwives, adopting respectful maternity care into government guidelines, and promoting certification procedures for private facilities. Over time, the coalition has expanded and evolved to take on the next frontier in addressing maternal health and rights issues, thereby assuring its continued presence and purpose as a coalition. The other MHQoC coalitions all report that they expect to continue their work to reach this phase; some coalitions, such as CommonHealth, seek to expand their membership to new geographic areas to achieve more wide-scale change.

Consequence of institutionalized coalition administrative functions

A key sign of institutionalization is a coalition becoming more self-sufficient, requiring fewer resources for the logistical and administrative tasks necessary to keep the coalition running as those tasks become embedded in daily organizational activities. This frees up critical donor funds for the coalition to use for on-the-ground MHQoC efforts. For example, WRAI notes that while maintaining its coalition could not be considered low-cost, it has spent less than $1 million on the coalition itself over the past 15 years. Through this cautious spending, WRAI ensures that most donations for MHQoC go directly to those activities, rather than for the work of running the coalition.

From implementation to influence

Because coalitions function in complex environments, their impacts can take a long time to observe and are difficult to attribute to any specific activity. Even though the coalitions in which MHQoC strategy grantees participate have gone through most of the key stages for coalition building, we cannot definitively say whether or how implementing each of these steps has directly affected these coalitions' ability to change social, policy, and political outcomes. Thus, to place MHQoC coalitions' achievements in context, we map their key activities and achievements against major events in India's maternal health landscape. This exercise demonstrates that coalitions are well attuned to the broader environment in which they function, and that they can both respond opportunistically to events around them and push proactively for change to promote MHQoC (Exhibit 5).

> ***[Policymakers] recognize the work we have done and privately they will tell us that it's a good analysis, but we cannot directly attribute changes to our work because the nature of advocacy is that there are many factors that lead to an outcome.***
>
> *–MacArthur grantee*

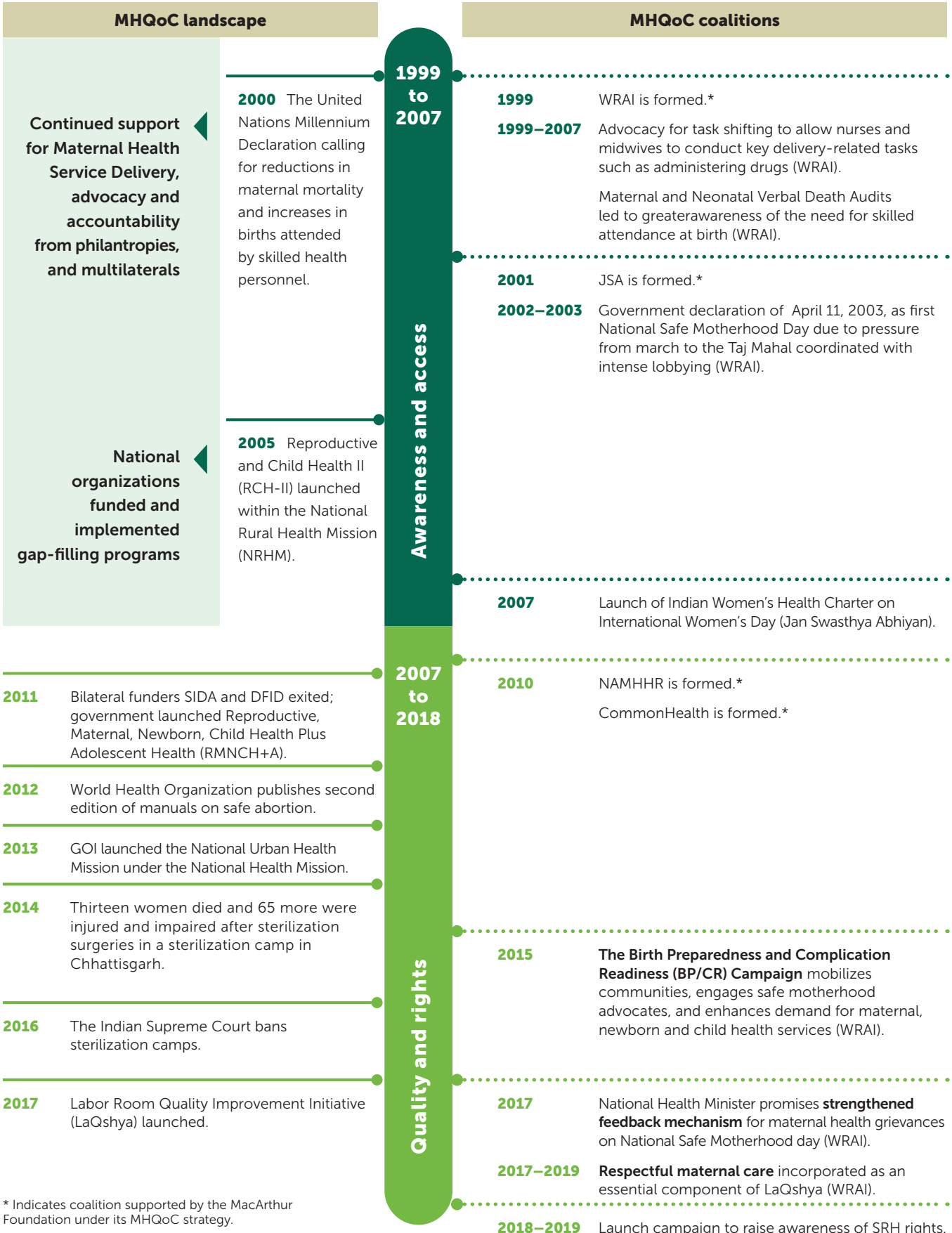
1999 to 2007: Raising awareness and increasing access

About the time that the United Nations called for reductions in maternal mortality and increased skilled birth attendants in the year 2000, WRAI and JSA formed. Although JSA focused on primary health care, gender and maternal health became a growing area of interest during that time. WRAI's focus was to accelerate the awareness of and interest in maternal health topics in India, particularly in increasing access to care. It mobilized people around the concepts of maternal mortality and maternal health. In particular, WRAI's 2002 March to the Taj raised the visibility of maternal mortality and contributed to the creation of National Safe Motherhood Day in 2003. In the period following these activities, the Government of India launched the Reproductive and Child Health-II Initiative to bring a focus to maternal and child health, immunization, and family planning under the National Rural Health Mission.

2008 to 2018: Focusing on quality and rights

In the past decade, the maternal health field in India has seen a growing emphasis on quality of care. During this time, MHQoC coalitions continued to raise awareness about maternal health but also began to focus on quality of care more specifically. Several coalitions capitalized on the growing government and public interest in this topic to promote positive policy change. For example, as the government embraced stringent standards and guidelines for labor room practices, WRAI worked with key officials to ensure that respectful maternity care became an essential component of the LaQshya standards for labor room quality. In addition, news of sterilization deaths in Chhattisgarh motivated several coalitions to advocate for banning sterilization camps and to promote a more woman-centered and rights-based approach to family planning.

Exhibit 5. MHQoC coalition milestones



* Indicates coalition supported by the MacArthur Foundation under its MHQoC strategy.

Source: O'Neil et al. 2017; analysis of MHQoC strategy documents and data collected by Mathematica Policy Research.

Charting the way forward: Evolution and growth for MHQoC coalitions

As momentum for MHQoC builds in India, coalitions will continue to have a key role in mobilizing individuals and organizations around key maternal health issues and bringing rights-based and patient-centered approaches to health care. As existing and new coalitions consider their work going forward, this examination of MHQoC coalitions highlights several key considerations to making an impact, changing norms, and enduring as catalysts.

Systematic documentation can help make the case for a coalition's relevancy and better position it as an influential actor in the MHQoC landscape. Coalition members have built strong and long-lasting relationships with policymakers and other key stakeholders in the maternal health field in India. Although it seems likely that these relationships have helped to raise the profile of MHQoC issues and promoted positive change, all coalitions have noted that tracing their influence on policy outcomes has been challenging, if not impossible. For example, although some coalition members have diligently tracked their interactions with specific policymakers, they find that policymakers rarely point to these interactions as a reason for making any specific policy decisions. However, tracing a coalition's influence and attributing specific maternal health outcomes to their work could be possible with stronger and more consistent documentation of a coalition's activities and interactions. This type of in-depth investigation can highlight a coalition's role in important maternal health changes, thereby encouraging others to join the movement, positioning it as a key stakeholder, and facilitating its ongoing relevance in the MHQoC movement.

> ***The [government] ministry is a little difficult in the sense that it will not tell you that it has used your findings or it has found [them] useful.***
>
> *–MacArthur grantee*

Periods of low activity or dormancy can be appropriate at times, but strong and consistent leadership keeps a coalition going. As MHQoC outcomes are achieved, coalitions and their individual members might decide that they no longer need to be as active or engaged as they once were. In those cases, allowing a coalition to go dormant could be a reasonable choice, thereby freeing members' time and resources to dedicate to other issues. However, MHQoC coalitions have demonstrated that strong and consistent leadership can help a coalition navigate slow periods and continue to remain relevant, whereas weaker leadership or frequent turnover can cause a coalition to lie dormant when it could be doing meaningful work to advance MHQoC. Organizational structures that allow for rotating leadership positions while maintaining a degree of consistency can help ensure that coalitions are well positioned to tackle new issues as they arise, and that if and when they go dormant, they do so purposefully, rather than as a result of decreased interest and engagement.

As coalitions meet their initial goals, considering the next frontier will help maintain focus and motivation. The maternal health landscape in India is constantly shifting, and the government has addressed and institutionalized some key issues embraced by MHQoC coalitions, such as task shifting to expand the cadres of providers who can offer maternal health services. As coalitions meet their key initial goals, they must consider their broader missions and next steps for advancing them. JSA's decision to spin off CommonHealth as a new coalition focused on maternal health demonstrates this kind of evolution: although JSA had worked broadly on gender and health for some time, members recognized that the growing interest in maternal health in India, coupled with the growing need to address the health rights of women, provided an opportunity to engage in deeper and more focused work in this area.

> ***[Our network] has also expanded from [not] only [focusing on] reproductive and child health services to human rights in health care. The fact that the … government is currently [focused more on] handing over public health services under public–private partnership, has made it all the more difficult for the poor to avail services [and with consistent quality]—leading to high out-of-pocket expenses. Our focus is to ensure that the poor are not bereft of services.***
>
> *–MacArthur grantee*

Conclusion

To reach sustainable development goals to reduce the maternal mortality ratio to 70 per 100,000 live births, India still has far to go from its 174 per 100,000 live births in 2015 (O'Neil et al. 2017). The slowdown in progress to reduce maternal mortality and continuing quality issues in health service delivery provide a platform for coalitions to continue rallying around. In particular, as access to maternal health care has expanded and quality receives greater attention, it will be especially important for maternal health coalitions to advocate for equitable access to high quality care. MHQoC coalitions recognize that this work will require greater emphasis on understanding and working with grassroots-level groups (as opposed to focusing on providers and other technical experts), and on building and maintaining links with broader movements supporting the rights of all Indian women.

References

Butterfoss, F.D. "Coalitions and Partnerships in Community Health." San Francisco, CA: Wiley & Sons, 2007.

Government of India. "Part III: Fundamental Rights." New Delhi: Ministry of External Affairs, n.d. Available at https://www.mea.gov.in/Images/pdf1/Part3.pdf. Accessed March 14, 2019.

McKay, E.G. "Strategic Planning: A Ten-Step Guide." Report from Memorandum of Understanding to Strengthen Accountancy and Improve Collaboration (MOSAICA) for the World Bank: Washington, DC: World Bank, 2001. Available at http://siteresources.worldbank.org/INTAFRREGTOPTEIA/Resources/mosaica_10_steps.pdf. Accessed March 14, 2019.

National Alliance for Maternal Health and Human Rights. "About NAMHHR." New Delhi: NAMHHR, n.d. Available at http://namhhr.blogspot.com/p/about-namhhr.html. Accessed March 14, 2019.

O'Neil, S., K. Naeve, and R. Ved. "An Examination of the Maternal Health Quality of Care Landscape in India." Report submitted to the MacArthur Foundation, March 2017. Cambridge, MA: Mathematica Policy Research, 2017. Available at https://www.macfound.org/media/files/50268_Landscape_Report_2017.03.02.pdf. Accessed March 19, 2019.

Sahayog. "The Crisis of Maternity: Healthcare and Maternity Benefits for Women Wage Workers in the Informal Sector in India." Uttar Pradesh, India: Sahayog, 2012. Available at https://aditigondal.files.wordpress.com/2012/08/the-crisis-of-maternity.pdf. Accessed March 14, 2019.

World Health Organization. "Maternal Mortality in 1990–2015: India." Geneva: WHO, n.d. Available at https://www.who.int/gho/maternal_health/countries/ind.pdf?ua=1. Accessed March 14, 2019.

Endnotes

[1] The landmark case of Pt. Parmanand Katara versus Union of India & Ors on August 28, 1989, established that health care providers cannot turn away any person in need of immediate medical treatment, regardless of class, caste, and criminal record.

The John D. and Catherine T. MacArthur Foundation supported the development of this brief. The authors collected the information in this brief through reviews of grant reports and documentation, site visits, and key informant interviews conducted from September 2016 to February 2019 for 28 grants made under the Foundation's MHQoC strategy in India. The contents of this brief are solely the responsibility of the authors and do not necessarily represent the official views of the MacArthur Foundation or of people who provided information for the study.