Improving maternal health through social accountability: a case study from Orissa, India

Improving maternal health through social accountability: A case study from Orissa, India

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As maternal health specialists accelerate efforts toward MDG5a, attention is focusing on how to best improve service accountability to target communities as a strategy for more effective policy implementation. We present a case study of efforts to improve accountability in Orissa, India, focusing on the role of local women, intermediary groups, health providers, and elected politicians. We highlight three drivers of success: 1) the generation of demand for rights and better services, 2) the leverage of intermediaries to legitimise the demands of poor and marginalised women, and 3) the sensitisation of leaders and health providers to women's needs. We use the concepts of critical consciousness, social capital, and 'receptive social spaces' to outline a social-psychological account of the pathways between accountability and service effectiveness.

Keywords: accountability; maternal health; community participation; policy implementation; quality of care

Introduction

Millennium Development Goal Five (MDG5a)–the reduction of maternal mortality by 75% from 1990 to 2015–remains one of the MDG's toughest targets. The number of women who die annually from pregnancy and labour complications is 287,000, and 99% of these deaths occur in the developing world (WHO 2012). For every death, 20 more suffer preventable permanent disability (Reichenheim *et al.* 2009).

While decades of advocacy are yielding improvements in mothers' health in some settings, policy implementation lags in others. Improved service accountability to users is increasingly seen as a means of accelerating progress. Landmark documents by the WHO (WHO 2011), the Commission on the Social Determinants of Health (CSDH 2008), and the World Bank position 'social accountability', or 'citizen-led accountability', as a key pathway to improved health, development, and governance (Agarwal *et al.* 2009).

Drivers of poor maternal health include low awareness of the dangers of childbirth and how to avoid them, lack of value given to women's health in many settings, women's lack of confidence and power to assert their needs, economic inequalities, and poor health care provider

commitment to women's well-being. These problems are particularly acute in India (Vora *et al.* 2009, Scott and Shanker 2010), with the highest absolute number of maternal deaths (56,000) globally (WHO 2012). Recent government programmes are reducing the maternal mortality rate (MMR). India's MMR is 212 per 100,000 live births (India Office of Registrar General 2011a), but a long road remains as India's MDG5a target is 109.

Public and private entities in India often have weak capabilities to self-regulate and enforce accountability. Reference has been made to 'a systemic crisis of accountability' in India (Posani and Aiyar 2009, p.5). Consequently, citizen-led, hybrid forms of accountability are increasingly seen as necessary to fill this gap (Goetz and Jenkins 2001). How can maternal health policies and programming be more effectively rolled out? 'Social accountability planning', emphasising community mobilisation, potentially empowers women to assert their entitlements to health, and creates environments where policy-makers and service providers recognise the urgency of policy implementation, interventions, and services. It also opens possibilities for better service-user interfaces and opportunities for highlighting mismatches between top-down services and bottom-up health needs (Murthy 2008).

Though there are many forms of accountability–financial, performance, legal, and democratic–an emerging trend focuses on social (or 'people-centred') accountability (Brinkerhoff 2004, Malena *et al.* 2004). Social accountability can be defined as the mobilisation of communities to voice their concerns and assert their rights to accessible health services in the face of the social and systemic barriers undermining health (Murthy and Klugman 2004). Social accountability is seen as a tool for: 1) improving governance, 2) increasing development effectiveness, and 3) fostering empowerment. This accountability can generate new norms around health-seeking behaviours by educating communities about their maternal health rights and risks and mobilising them to take action (Malena *et al.* 2004).

While a growing body of literature examines social accountability relating to reproductive health generally, little focuses on maternal health. Indian groups such as SAHAYOG, CHETNA, and the Academy for Nursing Studies have sought to inform marginalised populations of their health entitlements as a means of facilitating accountability (Campbell and Scott 2011, SUMA 2009, George 2003b). Existing research fails to examine the psycho-social dynamics at the heart of social accountability efforts. We provide a case study of a social accountability initiative in the state of Orissa, India, seeking to identify the processes and psycho-social pathways through which social accountability is mediated, and to contribute to understandings of its potential in improving policy implementation and quality of care. Weak accountability plagues health care in both public and private sector settings, but this study focuses on the public health sphere.

The local context

Since 2005, the Indian government has increased efforts to tackle maternal mortality through the National Rural Health Mission (NRHM). NRHM initiatives include the following: the World Bank—supported Second Reproductive and Child Health (RCH-II) programme; the Janani Suraksha Yojana (JSY) programme, the recently-launched Janani-Shishu Suraksha Karyakram (JSSK) programme; and the Accredited Social Health Activist (ASHA) programme. These initiatives seek to improve access to maternal health care for marginalised women by establishing policies, guidelines, and entitlements that guarantee free care, referrals, and transportation, and stipulate standards for quality of care (Lim *et al.* 2010, NRHM 2012). Guidelines mandate that all women have access to skilled birth attendance, that all community health centres (CHCs) provide 24-7 access to delivery care, that all first referral units (FRUs) are equipped to provide emergency obstetric care, and that women are not denied services due to their inability to pay (NRHM 2012, Nath 2011).While some guidelines have been successfully

adopted, widespread implementation is patchy and beset by growing pains. Better targeting of services to the poorest women is needed. Health systems struggle to cope with the increased demand for institutional deliveries and programme monitoring is weak (Vora *et al.* 2009, Lim *et al.* 2010).

Community monitoring–an accountability mechanism built into the NRHM framework–is a process for community members, community-based organisations, local committees, and Panchayat representatives to systematically provide feedback on how the health system is performing. It can facilitate community-led action and help ensure health services are implemented as designed (Garg and Laskar 2010). Community monitoring has been piloted in select districts of nine Indian states, including Orissa. Within Orissa, it has been piloted in four districts (NRHM Community Action 2009), but it has yet to be adopted across Orissa or much of India (NRHM 2012).

Orissa is the ninth-largest state in terms of land mass and the 11th largest by population with 42 million residents (Directorate of Census Operations-Orissa 2011). The government classifies Orissa as 'economically backward', including it in eight 'Empowered Action Group' (EAG) states receiving additional national funding due to development lags (Arokiasamy and Gautam 2008). Women's status remains low: 41.8% participate in household decisions, 38.4% report spousal violence (IIPS 2008). Half of the women in Orissa are illiterate, undermining their ability to earn a living wage and negotiate health decisions in the home (Department of Health and Family Welfare 2003). These indicators are consistent with national indicators although the state of women's empowerment tends to be slightly lower in Orissa (IIPS and Macro International 2007).

The nutritional status of women ages 15 to 49 is an issue with 40.5% under the normal Body Mass Index (IIPS 2008). About 70% of women experience anaemia during pregnancy due to undernutrition, which increases the risk of post-partum haemorrhage, a leading cause of

maternal mortality (IIPS 2008). Though marriage is illegal under 18, early marriage is still practiced in some remote communities (IIPS and Macro International 2007). Newly married girls are expected to produce offspring, yet their bodies are often under developed resulting in a higher risk of mortality or morbidity (WHO 2006). Orissa has a sizable population of Scheduled Castes (SC), or dalit ('untouchable'), communities and Scheduled Tribes (ST), or adivasi, communities (heterogeneous tribal communities) (IIPS and Macro International 2007). These tend to be socially excluded, rural groups with less education, less access to government services, and higher rates of poverty and maternal and infant mortality (De Haan and Dubey 2005).

Orissa, like other Indian states, has a four-tiered public health system comprising: Health Sub-Centres (HSCs) for every 5000 people; Primary Health Centres (PHCs) for every 30,000; Community Health Centres (CHCs), with 30 beds, for every 120,000; and District Hospitals (DHs), with 100 beds, for every 1,000,000 (NRHM 2012). In Orissa, there is a shortfall between the number of needed HSCs and functional HSCs. Overcrowding occurs at DHs, which impacts quality of care, length of hospital stay, and overburdened health workers (NRHM 2012). In Orissa, 52% of villages have HSCs, 44% of villages have PHCs, and 40% of villages in Orissa have a private clinic or hospital (IIPS 2010). Institutional deliveries are on the rise from 23% in District Level Household and Facility Survey (DLHS)-1(1998-99) to 44% in DLHS-3 (2007-2008), and 32% of institutional deliveries after 1 January 2004 received JSY assistance (IIPS 2010). Orissa has an MMR of 258, the sixth highest among India's states and territories (India Office of Registrar General 2011b). Maternal health care is vulnerable to overburdened hospitals, weak peripheral facilities and referral systems, and a lack of health workers. These factors limit access to health services, contributing to neglect, mistreatment, poor quality of care, and cultures of bribery and corruption (Hulton *et al.* 2007, George 2007).

Theoretical framework

The study is framed by George's (2003a) conceptualisation of social accountability, 'as a referee of the dynamics in two-way relationships, between often unequal partners' (p. 161), such as patient and provider, health worker and government official, or elected representative and voter. George (2003a) asserts that three key elements of social accountability–*information*, *dialogue*, and *negotiation*–support marginalised groups in confronting disempowering relations, generating actionable representations of the drivers of neglect and strategies for tackling them, and transforming the way dominant and marginalised participants view themselves and their inter-relationships.

This study aims to expand on the empirical base for George's framework by identifying three new complementary processes, as demonstrated through the work of the Orissa chapter of an international maternal health civil society alliance, which support social accountability: 1) generating demand for rights and better services via *information*, 2) leveraging intermediaries to legitimise the demands of poor and marginalised women via *dialogue*, and 3) sensitising leaders and health providers to the needs of women through external and internal levers via *negotiation*. It also seeks to augment George's conceptualisation of the accountability by highlighting the psycho-social underpinnings of effective accountability, drawing on community health psychology, more particularly the concepts of critical consciousness, social capital, and the concept of 'receptive social spaces' for negotiation.

The study provides accounts of how these three processes and three psycho-social phenomena support successful social accountability efforts and eventual service improvements in public health settings. First, they begin to spark a change in the mind-set of policy-makers, planners, providers, and women. Second, they cultivate an ethos where women are more aware of their right to demand and receive quality health care, and health care providers are more aware

of their duty to provide this. These contribute a change in the dynamics of the two-way relationship and a move away from a culture where women are viewed as passive recipients of whatever quality of care the providers see fit to offer. We will argue that efforts by social accountability programmes–to change entrenched mind-sets of providers, to spark a genuine sense of concern, and to create an impetus for corrective action–can create opportunities for policy implementation and service improvement.

Our analysis below is framed by the inter-linked concepts of critical consciousness, social capital, and receptive social spaces that inform our assumptions about the psycho-social processes through which social accountability opens up spaces for improved opportunities for health. Critical consciousness is the process through which marginalised groups are 'awakened' and empowered through participatory learning (Freire 1973). It helps groups identify the social drivers of their marginalisation and formulate strategies to tackle them (Campbell *et al.* 2010). The development of critical consciousness complements the negotiation of the collective identities of excluded groups, paving the way for an empowering sense of group solidarity and an enhanced sense of agency to make forceful demands.

The second concept is social capital, which Putnam (1995) defines as the 'features of social organisation such as networks, norms, and social trust that facilitates coordination and cooperation for mutual benefit' (p.67). 'Linking social capital' refers to supportive links between marginalised communities and outside agencies and actors with the political and/or economic power to support them in achieving their goals (Szwezter and Woolcock 2004). According to Bourdieu (1986), inequalities in access to social capital are a key driver of social inequalities, and a key factor in hindering people from improving their life chances and well-being. Linking social capital is a useful concept for examining social movements where vulnerable groups attempt to push more powerful entities to recognise their rights.

A receptive social space constitutes an environment where the needs of those who traditionally have less power can be recognised by more powerful groups and it represents space for negotiation. Oftentimes, in order to create a 'receptive social space' (Campbell *et al.* 2010), or an 'in-between space' (Vaughan 2010), marginalised groups need to form ties with more powerful actors in order to attain legitimacy and this is done through linking social capital.

Methodology

The civil society alliance of organisations (hereafter referred to as 'the CSA') that framed our case study, the White Ribbon Alliance-India, is a volunteer coalition of civil society advocates including international and local NGOs, UN agencies, bilateral and multilateral agencies, professional societies, foundations, academics, and individuals committed to reducing maternal and newborn death and morbidity. In 2006, the alliance embarked on a social accountability programme to address high maternal mortality and the inadequate implementation of maternal health programmes, using three tools: 1) maternal death audits via verbal autopsies, 2) health facility checklists, and 3) public hearings and rallies to bring women together with government officials and service providers to address grievances around maternal care (WRA 2010a, WRA 2010b). This study focuses the public hearings, which presented an opportunity for community mobilisation and a rare occasion for highly marginalised women to assert control through collective action.

The public hearings are a forum for local women, the public, the media, and elected representatives to hold local health officials, health workers, health planners, and policy-makers accountable for implementing policies as designed so women can realise the health entitlements outlined through NRHM's initiatives such as RCH-II, JSY, and JSSK (WRA 2010a, WRA 2010b, NRHM 2012). These NHRM initiatives establish entitlements across the spectrum of maternal services–from the provision of antenatal care, to access to a skilled birth attendant, to

quality of care at the facility, to post-natal care (NRHM 2012). The public hearings are a means for women to become aware of their entitlements, share their stories, raise questions, and ask for changes in the system so they can avail themselves of their entitlements. Through this process, women can be sensitised to change their own individual health-seeking behaviour. The hearings often begin with a public rally through the streets. A hearing typically generates crowds of 100s or 1000s (WRA 2010a, WRA 2010b).

While other accountability tools vary based on audience, the public hearing is more of a one-size-fits-all tool meant to target several audiences simultaneously since it is a forum where grievances can be addressed in the open for all to see. Recognising that health policies evolve, the public hearings are way to facilitate accountability, before, during, and after the implementation of a programme. Lessons learned during the public hearings can inform the design of new health reforms (WRA 2010a, WRA 2010b). Our study, which used interviews and focus groups with a broad sample of programme participants, was approved by an ethics review board at the London School of Economics and Political Science. We conducted 20 hour-long semi-structured interviews with four health providers, three policy-makers and government officials, four media representatives, two representatives from partner NGOs, two national CSA staff, four state and district CSA staffers, and one ASHA. Interviews explored informants' views of the following: maternal health, the social accountability programme in Orissa, and barriers and pathways to implementing maternal health programmes in Orissa. We conducted four focus group discussions (FGDs) with a total of 70 local women (including expectant/new mothers and women of childbearing age) in four villages and a fifth smaller focus group with three ASHAs. Interviews and FGDs explored women's accounts of the impacts of social contexts and norms on maternal health and the potential for them to assert their rights for better health services. Audio-taped interviews and FGDs were conducted by the first author, who was assisted by a local Oriya-speaking interpreter who later translated and transcribed the audio into English.

Findings and discussion

We used Attride-Stirling's (2001) model for thematic network analysis involving a rigorous iterative coding and re-coding of data to uncover new patterns and meanings. This resulted in a coding frame of 43 basic themes grouped into nine organising themes, which were clustered into three global themes: 1) generating demand, 2) leveraging intermediaries, and 3) sensitising leaders. We identified complementary psycho-social phenomena–critical consciousness, social capital, and receptive social spaces–that have a mediating effect on the processes.

To protect informant anonymity, we identify them by category type and participant number: Health Providers (HP), Policy-Makers/Government Officials (PGO), Media (M), NGO Partners (NGO), CSA Staffers (CSA), and Focus Group Discussion Participants (FGD). For example, the first media interview informant would be M-1.

Process one: generating demand

The cornerstone of social accountability is people's capacity to voice their grievances and assert their entitlements. Four factors impacted efforts to generate such capacity: 1) awareness, 2) agency, 3) opportunities for women to publicly confront people in power, and 4) changes in mind-set among women.

Awareness

Women's awareness of their entitlements is a precursor to making demands for better maternal health services. In Orissa, baseline awareness of maternal health entitlements, risks associated in childbirth, and available maternal care services is very low: *'Awareness in our community, as well as with the mother is almost nil'* (PGO-1).

Awareness is influenced by the economic, geographic, and macro-social contours of the population.

> ‘In the tribal-dominated districts, literacy is very low for women and the [health] infrastructure is not available. Accessibility to the health care, it is abysmal, very poor in the tribal districts. And their power to voice, their power to demand services is very low also in tribal-dominated areas’ (CSA-4).

To improve awareness levels, the NRHM has established mechanisms to educate women about health issues, but health providers question the speed of the effect.

> ‘This information should reach at the community through the Village Health Nutrition Days. These are going on . . . our staff are repeatedly educating them about the care of the pregnant lady, about the hospitals, where to go at the time of need . . . but the public take it lightly. Social change will take hold very slowly’ (HP-3).

The CSA engages directly with women through the public hearing process and preceding rallies to educate them about maternal health and entitlements to quality care. It also links with women’s self-help groups (SHGs) to train group leaders and spread information about the public hearing, maternal health, and entitlements to their members (CSA-2).

The public hearing is a tool to create awareness and cause women to rethink behaviours and priorities.

> ‘The public hearing generates the awareness of the public that pregnancy is not a very simple thing . . . that they have to come to the facilities for the technical support’ (PGO-1).

However, some informants emphasised the need for long-term efforts to improve consciousness levels alongside one-off efforts, saying that delays in consciousness-raising hindered social accountability work.

> ‘Civil society has a responsibility. . . . You have to organise a lot of programmes for a long time, not for a short span of time . . . unless and until [there is] development of the consciousness of the women, I don’t think there is any output of the public hearing’ (M-1).

Agency

Opportunities for women to develop and exercise genuine agency are lacking among poor women in a context of deeply embedded patriarchal norms. This lack of agency impedes assertion of rights by women, which leads to poor maternal health outcomes. Women are not given power to control their own health decisions.

> 'There is male dominancy all over India. The pregnant lady is not able to take her decision individually. She has to depend upon her mother-in-law, her husband, or the society itself. This decision-making is also very late and they are coming to the institution very late. In spite of all effort done by the ASHA, pregnant women are not getting the effective maternal check-ups and early transportation' (HP-1).

Social traditions lead to women not prioritising their health during pregnancy.

> 'Many of the ladies are nutritionally malnourished during pregnancy. They usually take food after each and every family member has taken their food' (HP-3).

> 'Women [have] yet to understand what rights they are getting from the society; they know only their responsibility' (M-1).

Gender discrimination combined with factors such as poverty, caste, and class were said to contribute to a *'culture of silence'* (CSA-2). The public hearing process seeks to provide women with a safe space and catalytic spark to develop agency.

> 'The fear should not be there. They should throw out their fear, so we are creating the platform for that. [If] they are free from the fear, then they can ask questions to anybody, anywhere' (CSA-5).

> ‘The intention of public hearing is to add power to the voices of the voiceless. . . . It is minimising the gender inequality. . . . Women are coming from their old worlds and they’re marching as the whole. . . . And now they have more bargaining skill to have better entitlements, better facilities, and to fulfill their health needs’ (CSA-6).

Nevertheless, organisers remain realistic about limitations of the public hearing to serve as a primary source of newfound agency:

> ‘They are so deeply mired in tradition, it will take much more than a couple of public hearings’ (CSA-1).

Given the extent of social exclusion, gender inequality, and deprivation that women face, informants questioned the depth and sustainability of the resulting empowerment and emphasised the need for ongoing efforts to cultivate durable awareness and agency through critical consciousness programming.

Confronting power

An important component of generating demand for better services is women’s ability to confront powerful actors with the potential to change the system. The public hearing provides women with an avenue for collective action and an opportunity to mobilise the community to influence the power dynamics.

> ‘It creates a vibration in the power system’ (CSA-5).

> ‘We have had government functionaries who actually get surprised to see the women are talking [out], where at least for that time, they have safe space to talk about their issues’ (CSA-1).

Government officials say the public hearings fill a void by offering women a new and safe space to demand their needs.

> 'It was useful because the public grievance was not heard properly in any [other] forums. [The] public hearing was the only forum where women can speak confidently, because in one-to-one sessions . . . if they are suffering, they are not able to say. But in public, as a group, they can say anything' (PGO-2).

Our informants referred to triumphs for women who had voiced complaints in public hearings. One example was a woman who confronted a doctor who had demanded a bribe. The doctor was called in front of the public hearing and ordered to pay her back. The story made the news the next day.

In discussing what could be done to confront the culture of bribery, which discourages women from seeking institutional delivery, a woman said that it will require a sustained collective effort, noting that *'if just a few women stop [paying bribes],then the practice will continue*' (FGD-3 participant).

There are inherent risks associated with confronting power that should be considered. For example, some leaders and health workers may be reluctant to openly admit weaknesses in the system. They can become defensive and unwilling to accept the information shared. In serious cases, leaders and health providers could enact reprisals on vocal members of the public hearing. Also, if improvements are not evident to the community members after the hearing, women may become more discouraged than before. Taking these implications into account, it is critical that public hearing organisers and intermediaries, elected representatives and media do what they can in advance of a public hearing to assure grievances will be redressed and that there will be no reprisals. When there is a threat of either, the public hearings are not appropriate.

Change in mind-set

Participation in social accountability efforts offers the potential to generate a change in the mind-set of women and communities. Participants in this study revealed a perception that the public does not assign a high priority to maternal health.

> 'Actually, we have to generate in all the minds, each member of the public, that maternal health is a very essential need of the country' (PGO-1).

> 'Previously participants were thinking that maternal health services were just something provided to them in kindness . . . but after public hearing, these women will never think that it is something for them in kindness; it is their right' (CSA-4).

The public hearing offers the chance for women to develop a collective consciousness around maternal health. It becomes a shared struggle rather than an individual one, facilitating collective action and demand generation.

> 'In a large gathering, suppose somebody has suffered and she never told anybody. Once she listens to others, she [begins] thinking to herself, I was also suffering like that. So the thinking process of the woman becomes a change in total mass' (PGO-2).

Process two: leveraging intermediaries

Social accountability cannot occur in a vacuum—it requires the creation of spaces where the powerful will be receptive to the demands of the disenfranchised. The CSA has taken a strategic approach by leveraging intermediaries (e.g., journalists and celebrities) to enhance the credibility of social accountability efforts. It works to develop tools and methods to engage intermediaries and strategic alliances; and to mobilise intermediaries to spur follow-up action by more powerful actors. These efforts in Orissa reflect the embodiment of social capital.

The CSA is aware of the importance of developing a supportive environment to empower women.

> 'In today's India, any accountability initiatives won't succeed if we expect the woman herself to suddenly be empowered and informed and out on the streets demanding accountability. That is a little way off. So we're trying to get to the medium-range actors. White Ribbon Alliance has 1500 member NGOs. So we can do accountability activities where we have different stakeholders like our NGO partners, the media, elected representatives, and also champions. Since we can't take the accountability work to the last mile, we are using these intermediary bodies to initiate accountability work at the district level or at the block level, not yet at the village level or the family level or at the level of the individual' (CSA-1).

Tools and methods to engage intermediaries

The CSA has created tools to engage and inform intermediaries, including workshops for media and elected representatives, one-on-one sessions, and advocacy kits to educate and mobilise intermediaries for action. Hundreds of media representatives have attended media workshops and accompanied the CSA in the field to gain first-hand insights into the challenges.

> 'We have developed [advocacy] kits for media, for elected representatives, for Panchayats/PRI members (local political leaders), for champions also. And in those kits, we provide them the real picture of the maternal [health] scenario of the state and the programmes that the government is doing. We give some facts and figures to convince them and explain the important role they can play, which they are not aware of previously' (CSA-2).

The catalytic role of intermediaries

Intermediaries such as the media and celebrities provide key support for the public hearings.

> ‘In the public hearing, I was very happy that people got more freedom to speak . . . to activate the system, to sensitise the system . . . and in reply to the complaints, [the] Chief District Medical Officer also promised an enquiry about all the problems’ (M-2).

In addition to participating in public hearings, intermediaries play a role in other social accountability efforts. Media participate in the maternal death verbal autopsies. The media help to place maternal mortality on the political and public agenda, contributing to an enabling environment for social accountability. For example, one reporter wrote of a woman giving birth on the floor of an overcrowded hospital. The day after the story, the Governor of Orissa visited the facility to see what could be done to improve the situation.

Elected officials also have a role to play in raising the profile of maternal health among their powerful peers.

> ‘In any public hearing, we are involving the policy-maker, the elected representative so that they can raise that issue in the legislative assembly, they can contribute meaningfully for redesigning or reshaping the existing policy’ (CSA-6).

Process three—sensitising leaders and health providers to change mind-set

The CSA’s social accountability approaches–the public hearing, the verbal autopsies, the checklists, and the accompanying media coverage–are all designed to help sensitise political leaders and health care providers to the maternal health needs of vulnerable women and the current gaps in the health system regarding the provision of maternal services.

Need for change in mind-set

An overwhelming finding among the study participants was a need to generate a change in the mind-set among health leaders and health workers to improve accountability—specifically, the need to facilitate a sense of concern.

> ‘[Health staff] absenteeism . . . it absolutely depends upon the mentality, this mind-set . . . in spite of all these efforts from government side, the mind-set is yet to be changed’ (HP-1).

> ‘Accountability, you see, it depends upon [the] individual concern of the service provider’ (CSA-6).

> ‘Infrastructure will help in providing the quality service to the public, but there should be an attitude to help and solve the problem, which is an inner thing . . . service sincerity’ (HP-3).

External levers to change mind-set

Social accountability tools, such as the public hearing, can potentially act as external levers to change the mind-set.

> ‘After the public hearing event, the service providers, they’re more accountable to provide quality health care services’ (CSA-5).

Health providers and public officials expressed a desire to have the public hearings continue, because the hearings help shed a spotlight on gaps in the system.

> ‘This type of public hearing should be there because this should not be one-way communication. There should be feedback from the opposite side and we should take it very boldly–we should be introspective of ourselves. We should introspect people’s matters so that we can give better treatment or better facilities to the poor people. . . . This feedback should come from the community’ (HP-1).

The interviews showed that government officials and health providers perceive that the public hearings are having an impact on service delivery, the behaviour of workers, and their level of engagement in performing their duties.

> ‘[The] public hearing can improve accountability. When there is a mass attraction, then everybody will work sincerely because everybody will work on pressures. If there will be public pressure, then if somebody is not very effective or not sincere or committed, they have to improve’ (PGO-2).

> ‘From the public hearing, [an] immediate outcome is that our health department staff are becoming a little bit more careful in doing their jobs’ (HP-3).

Research participants discussed the need for follow-up consultations between state and local officials, health providers, and civil society leaders after the public hearings to synthesise the hearing’s findings and address issues more effectively.

Participants also talked about the need for additional external monitoring mechanisms for social accountability such as the appointment of an ombudsman to help monitor the implementation of services. There was also discussion around the need for greater transparency.

> ‘Transparency is needed, transparency is the main thing. So we are getting in annual 40 crore rupees through the NRHM [National Rural Health Mission], but still the media did not know how they are spending the money’ (M-3).

Internal levers to change mind-set

The government is beginning to pursue promising accountability initiatives, which are designed to improve the quality of care and maternal outcomes. For example, the government established and institutionalised Maternal Death Review Committees (MDRCs). The MDRCs are comprised of health officials and service providers who meet monthly to audit maternal deaths, identify gaps in the system, and pinpoint improvements needed through root cause analysis (HP-1, PGO-2). At the time of the present study, however, the efforts of the MDRCs were too new to be assessed.

The CSA supports the development of internal levers to sensitise elected representatives by engaging them to act as intermediaries and work to change the system from within. The CSA supports elected representatives by providing information and capacity-building around maternal health agenda setting.

The literature and participant interviews suggest that accountability initiatives must be system-led and system-supported in order for there to be meaningful and sustainable accountability around maternal health (Malena *et al.* 2004, CSA-1). Efforts such as the establishment of the MDRCs and the emergence of elected representatives who advocate for better maternal health policy implementation are critical and should be expanded to create more sustained and systemic-driven mechanisms to improve accountability.

The need to improve community monitoring was the most commonly identified pathway through which to facilitate a change in mind-set from within the system. One study participant mentioned that the NRHM established guidelines for community monitoring several years ago, but they have yet to be institutionalised and enforced.

> 'Community monitoring, it's a mechanism where local government leaders, local elected representatives, local health functionaries, and people like the health provider come together to monitor what's happening and track [it]. So on paper it's this wonderful mechanism. Now the national government has asked the state government to do it. In the last three years, I don't think anywhere community monitoring is happening because they can get away without doing it. So what we have to do is somehow make it mandatory' (CSA-1).

Community monitoring has been piloted and in support of some of these pilots, the CSA facilitated capacity-building of Gaon Kalyan Samiti (GSK) members on health and reproductive health issues, managerial functions, and the development of Village Health Plans through a participatory process using basic health information of the village. The GSK members were

trained on their roles and responsibilities and how to monitor the utilisation of community funds under NRHM and demand accountability.

Still, challenges remain with respect to scaling up from the pilot phase to universal implementation. An interview participant underscored the need for monitoring closer to where the problems are occurring. The participant identified overlooked villages, particularly in tribal communities.

> 'We have seen villages where the Chief District Medical Officer (CDMO) does not know the name of a village name in the block. And villagers, they did not know their Collector, or their CDMO, or their doctor. They know only the forest man because the forest officer is the only one patrolling in their areas. . . . If the Collector is monitoring these things properly, if the Collector is visiting the hospital once a week, then the system will also fall into a positive line, but the Collectors, the administrative officers, they're not preferring to go to the hospital. It's a very, very, very bad thing' (M-3).

Community monitoring must be scaled up beyond its current limited sphere of pilot programmes and adopted more universally. By institutionalising community monitoring and accountability mechanisms at a service-provision level, the government can develop a more concrete understanding of the gaps and be more effectively convinced to address them. Bringing accountability to the sub-block level can be expected to help increase concern among providers and transparency in the maternal health system. Negligence and exploitation can be more effectively addressed if accountability is managed by engaged stakeholders closer to where these offences occur. Thus, it is felt that bringing accountability to the 'last mile' could provide members of the community with a greater sense of individual and communal accountability by sensitising them to issues affecting their own health and mobilising participation in community activism to resolve them. A greater push for making community monitoring mandatory is needed—this will require more system-led involvement and greater involvement of the donor community so efforts can be realised at scale.

Conclusion

In light of the high number of preventable maternal deaths which still occur around the world, especially in places such as India, our case study used George's (2003a) model of social accountability as a springboard to examine its potential for improving the implementation of maternal health policies, programmes, and services in Orissa, paying particular attention to the role of public hearings. We have uncovered three processes that underpin social accountability: 1) generating demand, 2) leveraging intermediaries, and 3) sensitising leaders and health providers to the needs of women. We have highlighted the psycho-social pathways through which social accountability opens up the potential for positive impact—by raising critical consciousness among marginalised women, providing opportunities for them to share their experiences with more powerful people (social capital), and creating a receptive social environment in which powerful people are more willing to hear their demands.

At a programmatic and systemic level, social accountability efforts in Orissa are generating a positive impact on women, intermediaries, service providers, and government leaders. Social accountability efforts, such as the public hearing, are providing new ways for women to collectively voice their concerns and demands in a supported space. These demands are being reinforced and legitimised by intermediary partners such as local elected officials and the media, leading to enhanced receptivity to women's needs on the part of the leaders. Among the service providers and government leaders, the CSA's social accountability efforts are catalysing new levels of understanding around the gaps in the system. This new understanding opens up many opportunities for improved service delivery.

Perhaps the most significant finding of the study was the discovery that subtle mind-sets–among both marginalised women as well as leaders and service providers–play as much of a role in the success or failure of social accountability as any manifest factors and structural barriers.

Informants were unanimous in noting that a change of mind-set and the ability to generate a sense of concern were essential for realising a system that is more socially accountable. This discovery has implications that could impact the government's response to maternal health. In addition to working to improve infrastructure and increase the number of skilled health workers, our findings suggest the parallel need for government officials to further explore and scale up community monitoring efforts to facilitate a change in the mind-set of providers, patients, and local leaders alike.

While public hearings provide a critical forum and can promote accountability, it is one step and one tool of many needed to achieve sustainable social change. This type of long-term change can only be achieved through a combination of top-down (checklists, verbal autopsies, public interest litigation, and special rapporteur visits) and bottom-up (public hearings, report cards, community monitoring) accountability tools that challenge the ingrained socio-cultural norms that perpetuate health disparities in the first place.

This study focused on the processes and psycho-social pathways underpinning the public hearings. Future areas of study should examine how the public hearings compare to other accountability mechanisms. Additional exploration is needed around appropriate tools for fostering accountability in the private health sector. And finally, further study is needed to assess accountability in view of the new JSSK scheme.

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Study design, fieldwork, data analysis, and interpretation were conducted by the first author, under the supervision of the third author, who also assisted with the final manuscript. Neither author has links with the case study CSA. The second author is a member of the case study CSA that enabled the research to be completed, and contributed US$1000 to research expenses. She assisted the first author with practical aspects of the fieldwork (accessing informants, ground logistics, etc.). She also commented on the final manuscript, but her role in the latter contribution was strictly one of assisting with background material and fact-checking. She made no contribution to the interpretation of the findings, to the study's overall evaluation of the success of the programme, or to shaping the conclusions of the paper.

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