Chapter 1: Introduction

1.1 Problem statement

Maternal health is recognized as a major public health issue, especially in low- and middle-income countries (LMICs), where many women die of causes related to pregnancy and childbirth. Maternal health includes women’s health during pregnancy, childbirth and the post-partum period\(^1\).

Although maternal deaths have declined at the global level, they remain high in many LMICs, including India and Nepal. The World Health Organization (WHO) estimated that there were 303,000 maternal deaths in 2015, about 99% of these in developing countries\(^2\). India alone accounted for about 15% of the maternal deaths worldwide, second only to Nigeria. Even though Nepal made progress in meeting the national Millennium Development Goals (MDGs) target for maternal health, the country’s maternal mortality ratio (MMR) at 258 maternal deaths per 100,000 live births is higher than India’s 174 and other neighboring countries such as Bhutan (148) and Bangladesh (176)\(^2\).

Further, there are large differences within and among countries in maternal health globally. These are reflected in terms of MMR, and coverage or use of maternal health or obstetric care services, particularly antenatal care (ANC), health-facility deliveries or deliveries assisted by a skilled birth attendant (SBA) and postnatal care (PNC). Overall, the uptake of health services is low among the disadvantaged groups of women such as those who are poor, less educated, rural and from socially marginalized groups\(^3\)–\(^8\), revealing issues of inequities.

Maternal health inequities are related to accountability of the health sector

Health inequities refer to disparities in health, either in access to health services or in health outcomes, that are judged to be avoidable, unfair and unjust\(^9\). The factors causing such disparities are not due to natural or biological variations and individual’s or group(s)’ voluntary choice. Rather, they are due to social, economic and environmental factors or living and working conditions over which an individual or group(s) have no control\(^10\), and which are amenable to policies and interventions, and thus potentially avoidable\(^9\).

Most maternal deaths are avoidable through existing and available technologies and interventions. About 75–80% of maternal deaths are due to obstetric complications such as hemorrhage, hypertensive disorders, sepsis, obstructed labor and the complications of unsafe abortions\(^11\)–\(^13\). Most maternal deaths can be prevented through medical and social interventions aimed at preventing unintended pregnancies, making obstetric care available and accessible, and treating co-morbidities such as nutritional deficiencies, malaria and tuberculosis\(^11\),\(^14\).
Maternal health inequities also concern violations of women’s human rights and states’ failure to ensure access to quality maternal health services to every woman. States are obliged to ensure timely and non-discriminatory access to appropriate maternal health services through appropriate policy, legislative, budgetary and administrative measures. Existing maternal health inequities therefore indicate the lack of priority and government commitment, and particularly the health sector, to adequately recognize maternal health inequities and take necessary action to address them.

For example, countries like Denmark, Norway, Sweden or The Netherlands were able to reduce maternal deaths significantly towards the end of the 19th century, followed by all of the industrialized countries during the 20th century as a result of strong political will. Their actions included early recognition of the magnitude of maternal mortality and that it was avoidable and manageable. They soon identified priorities to mobilize adequate resources to curb the problem, professionalizing obstetric care through professional bodies (mainly midwives) and held professionals accountable for providing quality care. Countries like Malaysia and Sri Lanka also showed that a significant reduction of MMR can be equitably achieved through strong political will, accountability mechanisms and commitment that drive a sustained policy focus and coordinated efforts to ensure quality maternal health services are accessible to disadvantaged women. Similarly, examples from Indian states like Tamil Nadu show that sustained political commitment and strong health systems can lead to better maternal health outcomes. These cases demonstrate that state and health systems can play a crucial role in reducing maternal mortality and maternal health inequities.

Health-sector governance – which refers to rules (formal and informal) or practices pertaining to various health-sector actors and their authorities, roles and responsibilities, and abilities and willingness – is key to the health-sector performance and ultimately health outcomes, including maternal health. For instance, governance of the health sector can enhance the responsiveness of healthcare delivery systems to the citizens through established interests among state actors (politicians, policymakers and public officials) for people’s health needs; communicating these goals to frontline healthcare providers through policies, standards, etc., providing adequate resources and support to reach these goals; and exercising oversight and control along with incentives (rewards, sanctions) for compliance. The role of health-sector governance and health outcomes are partly presented in the following paragraph. Health outcomes, including maternal health, are also the result of several factors beyond the control or influence of the health sector, e.g. poverty, transportation, geographical and social barriers. However, health systems can also potentially address these factors through interventions such as inter-sectoral actions, empowerment and social and financial support.

Studies on maternal health illustrate that the poor performance of health systems leads to poor maternal health outcomes or even avoidable deaths. They highlight that the lack of accountability of the health systems as a part of governance – for example, lack of proper monitoring, grievance or
redress mechanisms – is responsible for their poor performance of the health systems. Human Rights Watch (HRW) particularly highlights that the *recurrent* gaps in health systems in the provision of healthcare, which is due to the systemic problems *repeating themselves instead being identified and fixed*, reflect accountability deficits. And the health sector which includes medical staff, frontline health workers and decisionmakers at all levels of the health systems, is liable or accountable for not establishing the appropriate systemic measures to address them.

Improved accountability in health systems has been critically highlighted as a part of better performance. *Social accountability*, or demand-side or citizen-led accountability, in particular has been increasingly underlined as an effective mechanism to improve public-sector accountability. Improved accountability of health systems can also lead to more responsive policies and effective services that address neglected issues, specifically for marginalized groups. Global strategies to achieve the Sustainable Development Goals (SDGs) have also explicitly emphasized the accountability of health systems as a core principle to attain the SDG in relation to maternal and perinatal health.

1.2 Why social accountability?

The potential and importance of citizens’ participation in planning and managing health services has been stressed since the 1978 World Health Conference at Alma-Ata. When citizens participate in the assessment and planning of health services, the services are more likely to address their needs, and thus become more responsive towards their needs and expectations. Participation of the poor and the communities – who bear the burden of existing inequities – in policy dialogues and accountability mechanisms could potentially address equity gaps. The relevance of social accountability, or citizen-led accountability, in the public sector is even more pronounced in countries where government systems are weak and persistently fail to provide adequate public services. Social accountability holds the potential to highlight and address the issues of responsiveness, quality and equity in maternal health services.

1.3 Research gaps

Although the relevance and potential of accountability, and in particular social accountability, has been emphasized in the literature on the health sector, few studies show how social accountability could contribute to better maternal health outcomes. For instance, we identified only four studies that explored the effect of social accountability mechanisms on maternal health (Dasgupta, Lodenstein *et al.*, Mafuta *et al.*, Papp *et al.*). More evidence is required to understand and analyze how accountability and social accountability mechanisms influence maternal health.
This thesis aims to contribute to the evidence base by exploring if and how social accountability mechanisms in the selected districts in Nepal and Gujarat state of India influence factors of maternal health and maternal health services.

1.4 Outline of the thesis

This thesis is organized in nine chapters. It begins with an introductory section – Chapter 1 provides the rationale and aim of the thesis, Chapter 2 presents theoretical concepts guiding the overall thesis, and Chapter 3 describes the research design.

Chapters 4 to 8 present the findings. Chapter 4 and Chapter 5 provide an overview of factors influencing maternal health outcomes in India and explain their link with accountability of the health sector. Chapter 6 gives an account of social accountability mechanisms in maternal health services in Gujarat, India and explains which factors of maternal health they address. It also offers an assessment framework on the functioning of the social accountability mechanisms. Chapter 7 and Chapter 8 provide an account of social accountability mechanisms in maternal health services in Doti and Kailali districts and Baglung district in Nepal. They further assess the functioning of the social accountability mechanism in light of the framework on functioning of social accountability mechanisms in Chapter 6.

Finally, Chapter 9 presents the conclusion and discussion reflecting on the research sub-questions and then answers the main research question. It also outlines a future research agenda.
Reference


34. Dasgupta J. Ten years of negotiating rights around maternal health in Uttar Pradesh, India.


