Chapter 9: Discussion and conclusion

In this chapter we present the conclusions from Chapters 4 to 8 in answering the three research sub-questions. We also present our analysis of the cross-case comparison for the empirical data from the three cases: Dahod and Panchmahal districts of Gujarat (India), Doti and Kailali and Baglung districts of Nepal in sections 9.1.2 and 9.1.3. The overall research question will be discussed in 9.2.

9.1 Answering research questions

9.1.1 What are the factors that influence maternal health outcomes, and how are they related to each other and to the accountability of health sector?

It is crucial to have a clear overview of factors influencing inequities in maternal health and their mechanisms of influence in order to effectively address them. In this section, we present the conclusions from the two scoping reviews (Chapters 4 and 5), which explored various factors influencing maternal health inequities in India, and their links with each other and health-sector accountability. Maternal health inequities are characterized in terms of higher MMR and poor access to or use of maternal health services among those living in poverty. Chapter 4 used the “Social Determinants of Maternal Health Framework” to explore the factors in the structural and intermediary categories and the link between them. Chapter 5 used the 1994 Thaddeus and Maine’s “Three-delay Model” to explore the factors. Their link with the accountability of the health sector was analyzed using the “Framework to Analyze Issues of Accountability” and adopting a narrative and interpretive synthesis approach.

Key messages

- A number of structural and intermediary factors influence each other positively or negatively at community, household and health system levels to impact maternal health outcomes in India.
- Health sector-related factors influence negatively for maternal deaths and inequities in India.
- Power appears to be the root cause of maternal health inequities and is an important structural factor. It is central to all community level accountability relations and in the health provider-patient relations.
- Reducing maternal health inequities would require addressing power asymmetries in communities and in the health sector.
i) Factors influencing maternal health outcomes and their relation with each other

A number of structural and intermediary factors were seen to influence maternal health outcomes in India, among which the most pertinent were:

**Structural factors:** enhancing – high economic status, higher education, being Christian, Sikh and Hindu; and limiting – poverty, patriarchal gender norms, being from socially backward castes such as Scheduled Castes/Scheduled Tribes (SCs/STs), being Muslim and its culture of Purdah and early marriage.

**Intermediary factors:** enhancing – women with exposure to mass media and health messages; and limiting – rural residence, early marriage and childbirth, higher parity.

These influences were found at multiple levels or contexts such as community, household, individual and health systems.

ii) Role of health-sector performance and accountability

A negative influence of factors related to the health sector was identified for maternal deaths and inequities in India. The factors related to the health sector were found to contribute to a large proportion of maternal deaths of the third delay, which primarily concerned the availability and quality of care. Such factors included limited infrastructure, equipment and supplies, and inadequate and incompetent staff. The health sector was also found to have influenced or not acted sufficiently to address factors related to other two delays. For example, the delay in deciding to seek appropriate healthcare due to women’s and their family members’ low awareness of maternal health risks and the importance of care, their negative experiences and perceptions of care (quality) provided at public health facilities, fear of health interventions such as surgery or caesarean sections; and the delay in reaching an appropriate facility due to financial difficulties and limited access to maternal healthcare services.

In Chapter 5, we found that the poor performance of the health sector in India could be framed as being potentially due to a lack of accountability. Poor accountability as a systemic problem was found at all levels of the health sector, which were interconnected with and influenced by each other. Central to the accountability problems were power asymmetries in the relationships between different actors in the hierarchical relationship within the health systems, as well as between the actors in the health sector and the citizens/pregnant women and recent mothers. Such accountability problems resulted in several gaps: in standards, e.g. policy gaps or conflicting/discriminatory policies and lack of political commitments; in implementing standards due to incapacities within the health system, limited representative politics and poor health workers’ performance; and in accountability functions, or poor answerability and absence of enforceability.
iii) Power as a crucial structural factor of maternal health inequities and central to health-sector accountability

Solar and Irwin identified power – in terms of domination of certain groups concerning the capacity to influence decisions and access to resources – as a crucial factor in generating social hierarchies and thus generating health inequities. In the Indian context power appears, in our reviews, as a crucial structural factor that is potentially responsible for inequities in maternal health. It played both at societal level and within the health sector. At the societal level, such power asymmetries were particularly observed to limit certain groups in access to and use of maternal health services. Such groups included the poor, uneducated, rural, socially marginalized groups (e.g. SC/ST, Muslim) and women in general due to discriminatory gender norms. This was potentially due to their exclusion from or incapacity to influence public policies or decisions regarding the services in meeting their needs and interests.

Further, the power asymmetries arising from the social contexts were observed in our reviews to encourage indifferent attitudes and behavior of health professionals towards women from disadvantaged groups, and consequently influences the attitude and behaviors of such women in not seeing themselves as genuine rights-holders (and thus silently enduring such behaviors by health professionals without complaining).

Within the health sector, power asymmetries were observed in our reviews both in patient–provider relationships and in hierarchical relationships among actors in the health sector. Healthcare professionals usually have more technical knowledge concerning health and healthcare and the power to determine what healthcare they would provide, placing the patients in a dependent and vulnerable position. Moreover, issues of power were also observed among healthcare professionals, who often blamed down to lower-level staff and controlled information that limited healthcare monitoring and accountability systems.

According to Solar and Irwin, “any serious effort to reduce health inequities will involve changing the distribution of power within society to the benefit of disadvantaged groups” (p.22). With regards to the influence of health-sector performance and accountability in India, our reviews support the suggestion of George and Subha Sri et al. that improving health-sector accountability and performance requires addressing the hierarchical power relationships in the health sector as well as empowering communities to influence health policies and actions. The World Bank, George and Papp et al. (in their study in Orissa in India) asserted that social accountability initiatives can potentially address such power asymmetries by empowering disadvantaged groups, and make the health sector accountable to their needs.

In the following sections, we summarize the existing social accountability mechanisms for optimizing maternal health services in the selected study sites, and how they contribute to better maternal health
outcomes in terms of addressing the negative factors of maternal health services and making the health sector accountable to women’s maternal health needs and interests.

9.1.2 Which are the existing social accountability mechanisms for maternal health in the study sites and how do they function?

In this section we present the conclusions derived from our empirical studies (Chapters 6 to 8), which were conducted to explore various social accountability mechanisms that exist in the selected districts of Gujarat and Nepal, and how they function.

<table>
<thead>
<tr>
<th>Key messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Various social accountability mechanisms exist for maternal health services from the government and the civil society in all study sites such as women groups and intermediaries, and community-based monitoring tools/activities.</td>
</tr>
<tr>
<td>- Social accountability functions include: information, dialogue and negotiation, and triggering institutional enforcement mechanisms or creating incentives for the health sector to respond.</td>
</tr>
<tr>
<td>- The embeddedness of the structures and tools/activities in the public or civil society sector influences the functioning of social accountability:</td>
</tr>
<tr>
<td>- formal government structures are limited due to lack of clear mandates, capacity and power to conduct social accountability roles</td>
</tr>
<tr>
<td>- technical expertise and resources facilitate the civil society structures to function</td>
</tr>
<tr>
<td>- CSOs predominantly play the role of an external facilitator for participatory processes in Nepal and for the collective empowerment and mobilization of women groups in Gujarat.</td>
</tr>
</tbody>
</table>

Social accountability mechanisms for maternal health services

As voicing health concerns directly to healthcare providers individually did not seem feasible for women for reasons such as lack of trust, fear of reprisals, etc., we identified three alternative mechanisms of social accountability that women use in the study sites (Table 10):
Table 10: Overview of existing social accountability mechanisms in the study sites

<table>
<thead>
<tr>
<th>Study site</th>
<th>Women's groups</th>
<th>Civil society</th>
<th>Government</th>
<th>Community-Based Monitoring Tools/Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gujarat</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Women’s Groups</td>
<td>Civil Society</td>
<td>Government</td>
<td>Civil society</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Community Monitor (CM) relatives</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Accredited Social Health Activist (ASHA)</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Female Health Worker (FHW)</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Village Health and Sanitation Committee</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>District Health Society</td>
</tr>
<tr>
<td>Nepal</td>
<td>Mothers’ Groups</td>
<td>CSO members/staff</td>
<td>-</td>
<td>Community Health Score Board*</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Community Health Score Board*</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Female Community Health Volunteer (FCHV)</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Auxiliary Nurse-Midwife (ANM)</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Health Facility Operation and Management Committee member</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Locally elected representative</td>
</tr>
</tbody>
</table>

*: identified, in our study, only in Doti and Kailali districts of Nepal

Gujarat: [Dahod and Panchmahal districts]
Nepal: [Doti, Kailali and Baglung districts]
Women’s groups – Women discussed issues or concerns regarding maternal health services in their groups (e.g. the government-created mothers’ groups in Nepal and the civil society organization (CSO) led women’s groups in Gujarat). The issues or concerns were either further passed on to the health sector through intermediaries (e.g. Accredited Social Health Activist (ASHA)/Female Community Health Volunteer (FCHV) and health committee members) in all study sites or they collectively shared them directly with the health sector, for example in Gujarat, in the village-level meetings and meetings with health facilities and in Nepal in social audits and Community Health Score-boards (CHSBs).

Intermediaries – Women used trusted intermediaries who included formal government structures, such as community health volunteers (e.g. ASHAs in Gujarat and FCHVs in Nepal), other healthcare providers (e.g. Female Health Workers (FHW) in Gujarat and Auxiliary Nurse-Midwife (ANM) and Staff Nurse in Nepal) and health committee members, including locally elected community members, and the CSO staff to voice their concerns about the maternal health service to the health sector.

Community-based monitoring tools/activities – Women participated in community-based monitoring (CBM) activities for health to hold the health sector accountable for maternal health services. These included the community monitoring and maternal death reviews (MDR) implemented by CSOs in Gujarat, and the social audits and CHSBs implemented by the public sector and CSOs in Nepal.

While the existing formal government structures that acted as intermediaries for social accountability were comparable in the study sites in both countries, differences were observed mainly in:

i) women’s groups – for example, in Gujarat the women’s groups were part of civil society, while in Nepal the mothers’ groups were part of the government structures;

ii) in Gujarat the CSO-led CBM activities such as community monitoring and MDR were integrated in women’s groups’ social accountability activities, including their empowerment and political mobilization, while in Nepal the CSO-led CHSBs and the government-led social audits were not linked to empowerment and political mobilization of the existing mothers’ groups; and

iii) in Gujarat the Panchayati Raj Institutions (PRI), or the local governance council at the village level, were identified as one of the major social accountability structures. The provision of Gram Sabhas or village council meetings, where any villager can participate in planning and implementing village development activities, including voicing grievances and concerns
related to health, was a major social accountability activity related to the council. Conversely, in Nepal a similar local village council or the Village Development Committee (VDC) was mentioned in very few instances, for example in supervising and managing health facilities. The lack of open meetings of the VDCs and their limited role in the health sector might be why they were not identified as a social accountability structure.

These differences seem to have influenced the functions and outcomes of the social accountability activities in the study sites, which are discussed below.

**Functioning of social accountability mechanisms**

In the case of India, Papp *et al.* and George showed that social accountability mechanisms can address power asymmetries between the health-sector actors and communities by empowering the marginalized groups, using information, dialogue and negotiation\textsuperscript{5,5}. They accomplish this by creating incentives for the health-sector actors and triggering accountability functions, ultimately resulting in the responsiveness of the health sector\textsuperscript{6–8}.

In our empirical studies, the social accountability functions mainly involved: *information* to create awareness and *information* about the performance of the health sector; *dialogue and negotiation*; and triggering *enforcement mechanisms* and *creating incentives*. The functions are discussed in detail in the following sections. A comparison of these functions of existing social accountability structures at our study sites are provided in Table 11 and described in detail in Appendix 5 and 6.
Table 11: Comparison of the functions of existing social accountability structures in the study sites

<table>
<thead>
<tr>
<th>Social accountability functions</th>
<th>Dahod/Panchmahal districts, Gujarat [India]</th>
<th>Doti/Kailali and Baglung districts [Nepal]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Accredited Social Health Activist/Female Health Worker</td>
<td>Panchayati Raj Institution or Gram Panchayat</td>
</tr>
<tr>
<td>Information to create awareness about maternal healthcare, services and entitlements</td>
<td>++++</td>
<td>+</td>
</tr>
<tr>
<td>Information about performance of the health sector</td>
<td>++</td>
<td>+++</td>
</tr>
<tr>
<td>Dialogue and negotiation with the health sector</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Trigger enforcement mechanisms and create incentives for the health-sector actors to respond</td>
<td>+</td>
<td>+++</td>
</tr>
</tbody>
</table>

*Note: rating is done based on ‘five plus’ (+++++) as the highest rating
n.a.: information not available
*: sub-committee of the Gram Panchayat
**: column on Village Development Committee was added to facilitate comparison with the corresponding structure in Gujarat, i.e. PRI
***: the role of civil society organizations for social accountability were found only in Doti and Kailali districts, particularly through Community Health Score Boards and Social Audits
i. Generate awareness among women and other community members about maternal health, health services and entitlements

Communities’ awareness about maternal care, healthcare services and state entitlements is a precondition for critical consciousness for informed choices for better health care as well as effective community participation and mobilization in social accountability processes\textsuperscript{2,5,9}. All social accountability structures (except the VDCs in Nepal) and activities created awareness among women, their families and other community members about these aspects of maternal health. The community health volunteers in both countries such as ASHAs and FCHVs in particular were highlighted among all the mechanisms for the awareness in addition to their critical role in linking women and their families with the health sector to provide health services, including maternal health services.

ii. Generate information about the performance of the health sector

The answerability component of accountability in the health sector concerns assessing performance of its actors or generating information and justification/explanations about their performance against expected standards or performance objectives\textsuperscript{8,10}. Such information in our study sites was generated by the social accountability mechanisms in terms of:

a) women’s and communities’ concerns, complaints or feedback during meetings of women’s and mother’s groups and women’s discussion with intermediaries such as ASHA and FCHV, health committee members, etc. in both countries; and

b) information generated by performance monitoring and assessment activities such as social audit and CHSB in Nepal and community monitoring and MDR in Gujarat, on communities’ perspectives and concerns regarding the quality of and gaps in maternal health care.

Not all of these mechanisms were found to function effectively in this aspect. For instance, in generating information about health-sector performance, the CSO-led community monitoring and MDR were particularly found to be effective in Gujarat, while in Nepal the CSO-led CHSBs as well as the government-led social audits were found to be effective. The role of formal government structures, mainly the ASHAs/FCHVs and health committees in Gujarat in particular, were limited in this respect either due to the absence of mandates (e.g. FCHV in Nepal) or the lack of awareness and capacity to perform this function (e.g. ASHA and health committees). Even though women in both countries mentioned feeling comfortable about voicing their complaints to ASHAs and FCHVs, the complaints mostly concerned medical/health problems rather than concerns or complaints about the health-sector performance. The village councils in Gujarat seemed better able to hear communities’ concerns and convey them to higher levels than the VHSCs, because the Gram Sabhas (or village council meetings) were open to all women to
participate, and some of the council members engaged the CSO-led women’s groups. However, the council meetings were conducted less frequently (every 3–6 months) than the VHSC meetings (every 1–3 months). Further challenges included the limited participation of villagers in the Gram Sabhas.

iii. Have dialogues and negotiations with the health sector

Social accountability mechanisms often facilitated the women’s group leaders/representatives, CSO staff and elected representatives to dialogue and negotiate with the health-sector actors. The voiced concerns generated from the existing social accountability mechanisms in the study sites were used for dialogue and negotiation.

The civil society structures and CSO-led activities mainly facilitated dialogue in both countries. For example, in Nepal social audits and CHSBs were described as facilitating dialogue and negotiation with the health sector. This particularly involved interaction between community (including political leaders, press/media, CSOs, etc.) and the health sector in assessing the latter’s performance with reasons/justifications and negotiating joint action plans and resources to address gaps in the health service.

In Gujarat the women’s group members, group leaders/representatives in particular, and the CSO staff conducted dialogue and negotiation with the health sector during the Village Health and Nutrition Days (VHNDs) (or community-based ANC clinics) and health-facility meetings, where they shared and discussed concerns about the health service identified in their group meetings, report cards and MDR with the health-sector actors. They also made collective demands and negotiated actions in terms of eliciting responses and mobilizing resources. They also had similar discussions during public dialogues they organized at sub-district and district levels and the village council meetings with public-sector (including health) actors.

The role of formal structures mainly the village council members and the communities’ representatives in the health committees in Gujarat, were limited to conveying community voices to the health-sector actors and advising them. This was mainly due to the lack of mandates and awareness about and capacity to carry out accountability functions. The dialogues and negotiations among the health committee members in Nepal were said to be influenced by local political representatives in their favor. Lack of power and fear of threats were also mentioned in Gujarat for village council members as a challenge in demanding accountability from government authorities. The democratic open forums such as Gram Sabhas, however, allowed the community members and particularly the women’s group leaders/representatives and the CSO staff to enter into dialogues and negotiations with the public-sector actors (including health) attending the meetings.
What enabled women to have dialogues and negotiations with the health sector?

Studies from India\textsuperscript{2,5,11} and other countries\textsuperscript{12} on social accountability suggested that dialogues and negotiations between the less powerful (e.g. citizens or marginalized groups) and the more powerful (e.g. public-service providers and government officials or dominant groups) require mediating or redressing the power asymmetries between them. This can be achieved through facilitating the dialogues and negotiations by external agents\textsuperscript{11} and the group/collective approach, including enhancing the political capabilities of the less powerful\textsuperscript{2,12}. Scott \textit{et al.}, referring to instances of health committee meetings in a rural block near New Delhi in India facilitated by an external NGO staff, highlighted that use of an external facilitator in participatory meetings can mediate relations between the less and the more powerful by maximizing the expression and representation of the marginalized within the communities and minimizing the possibility of elite capture\textsuperscript{11}. The collective approach, on the other hand, protects individuals from the risk of contesting power on their own, especially in settings where they traditionally lacked power\textsuperscript{2,12}. George and Dasgupta showed that the collective approaches of marginalized groups in India, which included forming their collective identities and action, enhanced their political capabilities to challenge the processes and decisions of their exclusion and enabled them to engage in dialogue and negotiation with the health sector\textsuperscript{2,9}. Such collective identities are formed on the basis of oppression when disadvantaged groups come together, discuss the underlying causes of social deprivation, and foster a sense of group solidarity and agency to collectively tackle causes of deprivation.

In our empirical studies, the mechanisms that enabled the CSO-led/facilitated dialogue and negotiations between the community and the health sector were observed to vary between the study sites. In Nepal the mediating role of the external facilitator (e.g. NGO staff) conducting the social audits and CHSBs and participation in groups (thus offering protection from individual risks) seem to have a critical role in facilitating dialogue and negotiation with the health sector. Conversely, in Gujarat, women’s groups enhanced political capabilities seem to have a significant role in enabling them to have dialogue and negotiations with the health sector. The local CBO, ‘ANANDI’ organized the women’s groups predominantly among rural and socially marginalized communities and empowered and mobilized them. By adopting a rights-based approach the CBO built the women’s capacity to collectively identify, discuss and reflect on issues related, but not limited, to maternal health. It also provided group members with trainings related to leadership, dialogue and negotiation to collectively voice their concerns and conduct dialogues and negotiations with the public-sector actors. These women’s groups brought together rural and socially marginalized women together and educated them about their
rights and entitlements. It provided spaces for them to share experiences and problems, discuss issues about deprivation and destitution, and articulate collective voices to generate changes, thus potentially leading them to the level of critical consciousness\(^5\). They then carried out collective actions, including the dialogue and negotiations with the public sector. The groups gave women a sense of entitlement and the agency required to confront unequal power\(^2\).

Further, the groups were also linked by the CBO to like-minded networks at state and national levels through which they learned from sharing experiences and created a social capital in advocating for (maternal) health rights. Papp et al., in a study in Orissa (India), explained that building such alliances facilitates social accountability by enhancing the legitimacy of and receptivity to the marginalized groups’ demands\(^5\). Moreover, in our study sites the longstanding presence (20 years) of the groups and CBO and their expert knowledge about the maternal healthcare issues and the communities may well have enhanced the legitimacy and receptivity of the groups’ demands for a responsive health sector\(^13\).

iv. Trigger enforcement mechanisms and create incentives for actors in the health sector to respond

Syntheses and literature on social accountability\(^2,4,7,8,14\) highlighted that information alone is not sufficient to produce change; the health sector should be prepared and willing to respond, and enforcement mechanisms such as rewards, sanctions and incentives are critical in this regard. Joshi and Houtzager in their synthesis article on social accountability mentioned that social accountability mechanisms seldom have formal authority to apply sanctions\(^6\). They can however trigger formal accountability mechanisms and the sanctions inherent in formal mechanisms, and create the incentives for healthcare providers to change their behavior and respond because of their fear of sanctions\(^6,7\).

To generate enforcement, the social accountability mechanisms in our study sites were found to apply one or more of the following strategies: triggering formal institutional monitoring and follow-up activities, application of soft\(^15\) or informal sanctions, and generating interests, incentives and fear of repercussions to encourage actors in the health sector to respond – this is further explained below.

In Gujarat the evidence generated from community monitoring encouraged healthcare officials to initiate monitoring and follow-up visits of community-based healthcare services and organize facility-level meetings.

The activities led by civil society, such as protests and public dialogues and the open forums like Gram Sabhas in Gujarat and social audits and CHSBs in Nepal, were observed to operate potentially through informal sanctions such as negative publicity or public exposure of the health sector’s performance. The public dialogues, Gram Sabhas, social audits and CHSBs were attended by various actors like
beneficiaries, service providers, political leaders, civil society, press/media, etc. Brinkerhoff, in his synthesis article on health systems’ accountability, argued that the publicity and exposure during such events are likely to create incentives for public-sector actors to avoid damaging their reputation. Further, the media involvement in such activities are likely to raise awareness about the problem, amplify demands and spur attention and follow-up for public-sector action. Lodenstein et al. in their review on the responsiveness of health providers to social accountability initiatives in LMICs explained that these are likely to encourage healthcare providers to be responsive when they fear the repercussions of poor performance from influential third parties such as politicians, the media and health authorities.

The social accountability initiatives, especially those facilitating interactions between community and health-sector actors, potentially generate incentives and interests for these actors to improve their performance. For example, in Gujarat the healthcare professionals had support from the women’s groups in reaching those who were previously unreached or were even provided assistance during institutional childbirth from trained traditional birth attendants (TBAs), protection and moral support from communities, and addressing workplace constraints such as lacking equipment, supplies, etc. These might also occur through the interaction between the community representatives and health sector actors in the health committee meetings both in Gujarat and Nepal, where gaps in the health service were said to have been discussed among the members and addressed in some cases. Social accountability initiatives that involve information sharing and dialogue between communities and healthcare providers, allowing the providers to explain their actions and to address their own concerns, generate a positive incentive as they create among healthcare providers’ feelings of support, safety and appreciation, which in turn are likely to create their receptivity and improved relations necessary for their responsiveness. Hupe and Hill and Topp et al. mentioned that service quality and responsiveness of frontline health providers are influenced by a wide range of contextual factors in which they work. In ensuring their accountability, Hupe and Hill stressed the need for other approaches, such as social accountability, rather than the command-control bureaucracy which aims to limit their discretion and autonomy by applying more rules, tighter control and stricter procedures.

The enforcement activities of the formal government structures in both countries were largely limited to sensitizing the health sector by providing information (e.g. ASHA/FCHV) and advising concerned health staff regarding the communities’ concerns about the health service and complaints (e.g. the village council in Gujarat and the health committees in both countries). This was particularly due to lack of clear mandates (e.g. for VHSC in Gujarat) and awareness about the role and capacity to perform this function (e.g. village council in Gujarat).
Reflection on the structure, activities and functions of existing social accountability mechanisms in the study sites

Role of CSOs. In our empirical studies, there was a significant role of CSOs to enable social accountability functions in both countries, except in Baglung (Nepal) where CSO-led activities were not reported. These roles mainly included:

Mediator’s role in participatory processes – King, referring to her study in rural Uganda and other literature on participatory rural development globally (including India), discussed the crucial role the NGOs play in social accountability at the local level by facilitating participatory processes and mediating relations between state and citizens among others. According to Cornwall and Brinkerhoff & Wetterberg the facilitation role of NGOs becomes crucial in invited spaces organized by the state to implement participative governance. In practice, such spaces suffer from imbalance in their capacity to use them for social accountability as citizens are dominated by state actors.

In our study sites, for example, the Gram Sabhas, social audits and health committee meetings were at risk of being dominated by the state actors. However, the CSOs played an important role in facilitating these processes and mediating relations between the health-sector actors and women for the dialogue and negotiations between them, but in different ways. For instance, NGOs acted as external facilitators during social audits and CHSBs in Nepal. In Gujarat they enabled, through their capacity-building activities, women leaders/representatives to represent their issues and have dialogues and negotiations in Gram Sabhas and health committee meetings.

Enhanced political capabilities of the women’s groups – Being part of a CSO, the women’s groups in Gujarat benefited from the community-empowerment activities, including enhanced political capabilities to confront the health sector in asserting their entitlements, representing unacknowledged and neglected issues and demanding their accountability, e.g. in the health-sector performance assessment, having dialogues and negotiations. They were also able to use information or evidence generated from the CSO-led activities such as community monitoring and MDR in addition to their meetings and participated in multiple forums including the open invited spaces for governance such as Gram Sabhas. Balestra et al. discussed how the engagement of marginalized groups in social accountability processes in Uttar Pradesh (India) through long-term, cumulative and sustained interactions with the state actors mediated their relationship with the state. A similar change in relationship in our study was also reported in Gujarat, particularly the change in the attitudes of the health-sector actors towards the women’s groups – for instance, not
demanding informal payments from them, perceiving them as being aware of their rights, and collaborating with the CSO.

The women’s groups also seem to benefit from their enhanced political capabilities to use the formal open forums such as Gram Sabhas (village council meetings) for social accountability. According to Cornwall, these open meetings are ‘invited’ political spaces from the government for citizens’ engagement in governance, and that the political efficacy of such engagement in terms of representation, participation, etc. are crucial for the effectiveness of these spaces\textsuperscript{21}. The political empowerment and mobilization of the women’s groups who participated and voiced their concerns in the village council meetings in India seem to have contributed to their social accountability function.

Literature on social accountability, for example, Joshi in her synthesis\textsuperscript{23} and King in her qualitative study in rural Uganda\textsuperscript{19}, stressed the need for social accountability initiatives in increasing political capabilities of low-income or marginalized groups to generate substantive social accountability outputs and they argued that the narrow, tool-based, tactical and apolitical approaches (e.g. scorecards, social audits) could lead to limited local-level responses only. King made her argument particularly for a political-economic context similar to India’s, which is characterized by power inequalities between the poor rural majority and a minority political elite, weak institutional accountability systems, and populist policies and citizen’s participation in governance constrained by inactive participatory governance mechanisms, tokenism and political patronage\textsuperscript{19}. Even the participatory governance spaces such as health committee meetings could lead only to limited, sporadic and short-term responses and outcomes if the authorities organizing or facilitating activities use participation as technical practice rather than political action. The enhanced political capabilities of the women’s groups in Gujarat, thus, seem to have advantage over the narrow, tool-based/tactical mechanisms – for example, CHSBs and social audits in Nepal. The advantage particularly seems to pertain to the enhanced capacity of the women’s groups in Gujarat to confront unequal power and mediate their relationship with the state, make use of the various other tools and spaces in carrying out accountability functions and triggering the enforcement mechanisms necessary for the response.

Papp et al. explained that on-going participatory group processes such as public hearings can also cultivate lasting awareness and agency through critical consciousness and can lead to the empowerment and mobilization of such groups\textsuperscript{5}. However, in our empirical studies, we do not have any indication that similar participatory activities, such as social audits and CHSBs, facilitated formation of collective agency among the disadvantaged groups.
The CSOs’ interest, motivation and investments in terms of technical expertise and resources as well as their facilitation of the overall social accountability activities/processes seem to be crucial factors in the overall social accountability activities in the study sites in both countries. For example, social accountability activities such as CHSB, community monitoring and MDR were implemented with technical and financial support from international NGOs or donors in our study sites. In Gujarat, the social accountability activities of ANANDI were driven by their motivation and engagement with the vulnerable and marginalized women in selected rural communities to address issues regarding their marginalization.

*Mandates, capacity and power of formal government structures.* The role of the formal government structures such as mothers’ groups (in Nepal), local village council and health committee members (in Gujarat), and ASHA/FCHV related to dialogue and negotiation and enforcement was limited. Lack of mandates, capacity and power were crucial factors that limited the potential for the social accountability functions of these structures in our study sites.

For instance, FCHVs (including mothers’ groups) in Nepal lacked clear mandates for social accountability; they only have the ‘link worker’ and ‘service extension worker’ roles. Health committees as well as elected representatives in Gujarat lacked the capacity and power to carry out social accountability functions. Our findings in this aspect echo the results of other studies from India and other countries. For example, Saprii et al. in their qualitative study explained that ASHA in India were assigned an ‘activist’ role in addition to those of ‘link worker’ and ‘service extension worker’. However, in practice the ‘activist’ role was less visible as the ASHA lacked awareness and capacity because the government capacity-building efforts focused mainly on the latter two roles. Scott et al. suggested that even though national policy of the Indian government promotes community participation in the public system through VHSCs, and particularly oversight and monitoring, the VHSCs lack proper support, power and coherent legal changes or policies to enable and nurture actions at local level. A similar situation of lack of support, power and legal provisions at local level for health committees with similar roles were also reported by Abimbola et al. in Nigeria and Lodenstein et al. in Benin, Guinea and the Democratic Republic of the Congo.

Conversely, HFOMCs in Nepal had the mandates as well as financial support for management and oversight of health facilities. They were given the responsibility to organize social accountability activities such as social audits and CHSBs by the government and the CSO, respectively. This enabled them to carry out social accountability functions more effectively compared to the VHSCs in Gujarat. However, the HFOMCs also often faced challenges related among others to limited budget and members not being active.
The mothers’ groups in Nepal, as a part of government structure, also seem to be constrained by the lack of mandate to carry out accountability functions and their empowerment is restricted to increased awareness about maternal health services and entitlements. Their participation in CHSB and social audits seem to be limited; the attendance and participation of marginalized groups in general was reported to be lacking in such activities in the study sites.

The CSOs in Gujarat, in addition to enhancing political capabilities of the women’s groups, used multi-pronged approach in the social accountability processes.

*Multi-pronged approach*. The women’s groups in Gujarat were observed to take a multi-pronged approach in the social accountability processes, for example, collective empowerment and mobilization of the disadvantaged women’s groups in the social accountability process, intervening at different level of district health system, adopting multiple strategies such as a constructive and collaborative approach through dialogues and negotiations as well as confrontational approach through protests, media pressures, etc.

Synthesis papers\textsuperscript{23,28} and studies from India\textsuperscript{9} and other settings\textsuperscript{19,26} have particularly highlighted the necessity of political capabilities of disadvantaged groups, and a multi-level and multi-pronged approach has been underlined for the success and effectiveness of social accountability interventions.

The differences in the overall structure and functions of the social accountability mechanisms in our study sites also seem to have an influence on the responsiveness of the health sector and maternal health outcomes, which are discussed in the following section.
9.1.3 What influence do the social accountability mechanisms in the study sites have on maternal health and maternal health outcomes?

Key messages

- Social accountability mechanisms generate health-sector responsiveness mainly in terms of changes in healthcare professionals’ attitude and provision of care at district level and below.

- Social accountability is likely to generate more health-sector responses through activities that take a multi-pronged and multi-level approach and stimulate collective empowerment and mobilization of disadvantaged groups.

- Social accountability mechanisms influence changes in structural and intermediary factors of maternal health ultimately improving the availability, access and use of maternal health services.

- Social accountability mechanisms can potentially address inequities in maternal health by addressing power asymmetries between disadvantaged groups and the health sector. The mechanisms can also improve health-sector accountability through communities’ engagement in health-sector governance.

Health-sector responsiveness

The existing social accountability mechanisms in our study were often perceived to generate responses from the health sector regarding women’s concerns, complaints, feedbacks or demands. They were mainly related to changes in health professionals’ attitude and behavior and the provision of care in terms of staff, infrastructure and equipment and supplies. They were therefore largely limited to district level and below in Gujarat and Nepal, particularly in Doti and Kailali districts. We lacked evidence on the response of the health sector in Baglung district potentially due to the lack of activities that allowed women and the health-sector actors to come together and discuss on issues related to health service delivery and the limitations of the formal government structures for accountability. Few central and state-level responses were reported in Gujarat and these mainly pertained to the government’s acknowledgement of the need to improve maternal health facilities and the state government’s effort to promote giving birth in public health facilities.

The reason why the health-sector responses were limited to the local level is particularly due to the challenge of generating responses from the district level and higher. It is partly due to the limited efforts in long-route of accountability. Studies on social accountability mechanisms focusing on the local levels in India and other contexts have described similar findings. The existing social accountability
mechanisms in our study, except for the few instances of women’s groups in Gujarat protesting at the state and national levels, mostly focused in strengthening the short-route or management aspects of the accountability relations through district and health-facility officials\(^4\).

**Influence on factors of maternal health and maternal health outcomes**

Social accountability interventions in maternal health are expected to improve the quality of and access to maternal health services\(^2,4,5,9,30,31\). In our study, they were perceived to increase the availability, accessibility and quality of maternal health services in the public health sector, and their use among women, mainly antenatal care (ANC) and institutional childbirth. These correspond with, particularly in Chapter 6, the perceived improvements in *structural* and *intermediary factors* of maternal health. They included: *structural factors* – governance, policy, health beliefs and women’s status; and *intermediary factors* – social capital, maternal health-related behavior and health systems-related factors such as strengthened ANC clinics, improved health facility resources and improved health providers’ attitudes and behaviors towards their patients, etc. The changes in structural factors were observed to influence the intermediary factors and vice versa. For example, improved governance enhanced regular and functional ANC clinics, which in turn improved health-seeking behavior, social capital influenced women’s status, among other outcomes.

Social accountability interventions could potentially address inequities in maternal health through the empowerment of the disadvantaged groups to have control over the factors that shape their health. In our study these factors concerned communities’ and women’s awareness of modern maternal healthcare and services. A crucial aspect of empowerment was observed particularly among the women’s group members in Gujarat in their enhanced capacity to make their voices heard by the relevant authorities, awareness about maternal health rights and entitlements, enhanced leadership and ability to engage with decision-makers, increased skills in oversight and management of health service provision, etc. This observation corroborates the findings of other studies on social accountability in health sector and empowerment\(^12,20,22,32\). The empowerment of the women’s groups in Gujarat corresponds to their collective empowerment and mobilization in addressing existing power asymmetries, mainly between them and the health-sector actors. As the groups in Gujarat mainly involved the disadvantaged women, they particularly seem to benefit more from the social accountability activities with their increased access to and use of maternal health services, thus addressing issues of health inequities.

It was observed in our study that by addressing power asymmetries between the communities and the health sector, social accountability interventions addressed the problems of accountability in the health sector and made it more responsive to the communities’ voices. This accountability was observed to have improved through enhanced accountability functions – *answerability*, or information and evidence about
health-sector performance, and enforceability, or rewards, sanctions, incentives, etc. due to women’s (and communities’) participation in accountability activities. Furthermore, the accountability of the health sector was also achieved through the constructive and systemic approach of the social accountability mechanisms. They were observed in terms of: collaboration between the health sector and civil society in addressing problems of maternal health services; and acting at various levels of the health system (e.g. in Gujarat), for instance, policy, governance, workplace environment of health professionals, and individual attitudes and behavior of frontline healthcare providers. However, the perceived changes in social accountability were limited for structural factors. This could possibly be due to the focus of the social accountability interventions at operational level.

9.2 Reflections on research design, approach and validity

In this section we reflect on the strengths and limitations of the research in terms of its design, approach and the validity of the findings.

Reflection of the study design and approach

The use of an emerging design and a multidisciplinary perspective. The study used an emerging research design and we integrated multidisciplinary perspectives (political science, public administration, development studies, epidemiology) and paradigms (etiological, institutionalist, collective action) through theoretical concepts and integrated frameworks in understanding and analysis of the research concepts as well as the influence of social accountability mechanisms. For instance, the linkages between power, health-sector accountability and maternal health inequities were explored from various perspectives, such as the institutionalist paradigm and the etiological perspective, which later informed the research approach, cases, methods and tools. Balestra et al. highlighted that research on social accountability processes such as community-based monitoring often adopt a narrow and limited focus, usually measuring health-service performance. Our study, through the multidisciplinary approach and inclusion of individuals from different categories and at multiple levels, therefore overcame this limitation.

Contextualization of (social) accountability. The initial phase of the study involved clarifying the concepts concerning maternal health inequities, accountability and social accountability, which particularly helped to contextualize accountability and social accountability within the maternal health and the Indian context. It helped to clarify the conceptual gaps concerning the influence of accountability on maternal health inequities from the limited number of existing empirical studies on maternal health services at different levels of Indian health system by adopting the narrative and interpretative synthesis approach. It also showed the relevance of social accountability mechanisms in addressing maternal health inequities particularly highlighting the influence of power asymmetries among various social groups and between
community groups and the health sector in generating and sustaining health inequities. Nepal was included at a later stage of the empirical study to obtain a wider perspective on and compare the use of social accountability structures and activities between two different countries in South Asia.

Involvement of implementing partners. We involved implementing partners and national- and state-level policy advisors at different stages in our study: they facilitated selection and recruitment of respondents, facilitated implementation of the study and were involved in data analysis and write up. We therefore applied to some extent a transdisciplinary approach by sharing and discussing the preliminary findings with some of the stakeholders (e.g. the CSO staff, who included among others project managers and field-level staff) in Gujarat. Moreover, the analyzed data were also shared with some of the study participants/respondents in Gujarat and Nepal (who are also co-authors of the chapters in Nepal). The sharing of data with the stakeholders and respondents allowed their perspectives to be integrated during the data analysis and interpretation and enhanced the potential of the study conclusions in terms of their applicability for better social accountability interventions. However, the involvement of implementing partners also had a limitation: the selection of the respondents was done in consultation with the local institutions supporting our field-level research activities, for example the CSOs and the District Public Health Office. This might have led to potential bias towards positive responses on effectiveness of initiatives led by such institutions. We tried to mitigate this by including respondents from both public sector and civil society.

Involvement of different levels in the health systems. We collected data from the relevant community groups and individuals at various levels of the health systems, in particular at district level and below. These particularly enabled us to understand the functioning of social accountability mechanisms and the influence of the mechanisms on maternal health from a broader perspective (e.g. community and health sector) and systemic level. At the same time, this is a limitation as the empirical analysis was mainly limited to district level and below. In Nepal, despite having interviewed the national-level policy advisors the focus of the study was primarily at district level and below. In Gujarat, we conducted in-depth interviews with civil society policy advisors. However, we were not able to conduct interviews with state-level government policy-makers/advisors and national-level policy-makers. This made it difficult to develop a comprehensive view of the social accountability activities at higher levels, for example the efforts of civil society through ‘Dead Women Talking’ i.e., MDRs from different Indian states and its demand for accountability at the national level in India. Interviews with such informants would have shed more light on the long-route of social accountability.
Study validity

We reflect on the validity of our study in terms of Krefting’s concepts of credibility, dependability, confirmability and transferability (terms used in quantitative research for internal validity, reliability, objectivity and external validity, respectively)\textsuperscript{35}. These concepts contribute to trustworthiness in qualitative research and we aimed to achieve these using strategies described below.

Credibility. The credibility, or truth value, in our research concerns the accurate description or interpretation in presenting the phenomena and experiences pertaining to social accountability in maternal health services in the study sites\textsuperscript{35}. This was achieved throughout the process of research design, data collection and analysis as described below. It mainly includes the use of a systematic and multidisciplinary and a systematic approach to research, and triangulation, member-checking and peer-debriefing.

Systematic and multidisciplinary. The study was conducted following a systematic approach through an emerging design process that started with two initial scoping reviews followed by an empirical phase. The scoping reviews were conducted following a systematic process of literature search using specific search terms in certain specific data-bases and search engines, and data extraction and analysis through definite tools such as conceptual frameworks and coding-trees. The reviews involved exploring, understanding and analyzing research concepts from multidisciplinary perspective and different paradigms. The empirical studies were conducted through the careful design of detailed interview and FGD guides for collecting data, which were adjusted for adequacy, appropriateness and clarity following pre-testing.

Triangulation, peer-debriefing and member-checking. The credibility of the scoping reviews as well as the empirical phase of the research was further enhanced through triangulation, peer-debriefing and member-checking\textsuperscript{36}. The collected data were analyzed using frameworks under the close supervision of the PhD supervisors, including cross-checking by the co-researchers. In addition to the checks by PhD supervisors, the data analyzed in the reviews and empirical studies underwent a peer-debriefing by external editors and reviewers of international journals\textsuperscript{35,36}. In the empirical studies, triangulation of the data collected from different categories of respondents was applied during data analysis to ensure their consistency, and when the differences occurred they were described and interpreted. Further, the analyzed data were sent back to some study participants/informants for member-checking to ensure the credibility of the interpretations\textsuperscript{35,36}. In addition, as the PhD student is a Nepali-speaking person, he had an advantage particularly in minimizing data loss and ensuring the credibility of the data during data translation from Nepali to English.
**Dependability.** The dependability is related to the consistency of the findings and strategies to achieve this included a stepwise replication of the methodology and the accurate description of data collection and analysis. Firstly, the accounts of the methodological processes followed were provided in detail for the scoping reviews and the empirical studies. Secondly, dependability of the study was achieved through the use of the same tools and techniques in the different empirical studies: for the case studies in India and Nepal the same tools and techniques were used, and these were improved when preparing and conducting the studies (learning from the different studies). In particular during training of the research teams by the PhD student prior to data collection, the use of the tools and techniques were discussed.

**Confirmability.** Confirmability or neutrality in the research was achieved through the PhD student’s reflexivity or minimal influence in the research process as well as checks by supervisors and co-researchers. The PhD student is from Nepal and has worked in maternal health and with CARE in the two study districts. Thus, he was acquainted with the Nepalese public health system, and context and issues related to maternal health in the study sites, specifically Doti and Kailali districts. This particularly enabled him to collaborate with CARE and the DPHO for the study and make necessary arrangements, e.g. logistics, for the master students for data collection in Nepal. This might have been a risk for researcher bias, but this was as much as possible addressed. Although the PhD student prepared the studies in Nepal together with the Master students, the latter collected the data independently. The PhD student did not have any influence on selecting the study sites, recruiting research assistants, sampling and selecting study participants. He also took precaution in minimizing research bias during the data analysis and interpretation, which was also ensured by the supervision from his supervisors. Moreover, the researchers and the co-researchers had no relationships with any of the study participants/informants prior to the commencement of the research, to minimize researcher bias.

The PhD student is a man and this might have influenced data collection and interpretation of female respondents, who were the main target group in the studies. This was addressed in Nepal, by having women as Master students and research assistants who collected and joined in the analysis of data. In Gujarat, the PhD student collected the data with the help of research assistants who were female. Further, the collaboration with the CSOs, including the women-led CBOs helped him to collect data with women in Gujarat.

However, having master students collecting data in Nepal had some limitations as they did not speak or understand Nepali. This might have limited understanding of concepts of social accountability and probing for further information during interviews and FGDs. However, this was as much as possible mitigated by close supervision of the master students by the PhD student during the data collection through frequent communication and feedback through emails.
Transferability. In qualitative research generalizability is not a commonly used term, and often the term transferability is used. Transferability in this research concerns the use of concepts, including frameworks, the processes/functions and outcomes of the existing social accountability mechanisms in maternal health services beyond the study settings. The frameworks used in the study, namely the “Social Determinants of Maternal Health Framework” and the “Framework to Analyze Issues of Accountability” can be widely used beyond the Indian contexts to identify and understand context-specific – structural and intermediary determinants of maternal health and their interlinkages for any given country and sub-national contexts; and accountability issues at different levels of health systems and their mechanism of influence for maternal health, respectively. These frameworks were developed by integrating existing frameworks widely used at global level in maternal health and health-sector governance.

Our findings regarding the mechanisms of influence of the social accountability structures and activities, e.g. collective actions and enhanced political capabilities of disadvantaged groups, are likely to be transferable to democratic contexts similar with India and Nepal, where the state acknowledges and is willing to provide its citizens these rights (e.g. freely seek information, have dialogue and negotiation with the state/public-sector actors). The comparison between Gujarat and Nepal enhanced the wider transferability of these findings in similar contexts. These might not have similar influence in a context where citizens’ spaces or opportunities for these activities (e.g. collective actions, confrontation with the state/public actors) are limited or restricted.

9.3 Policy implications

Enabling supply-side contexts. Several formal structures exist or were described as holding potential for social accountability in maternal health services. However, they faced challenges mainly in terms of:

i) clear roles and mandates (e.g. FCHVs and mothers’ groups in Nepal);

ii) capacity and ownership to carry out social accountability roles (e.g. health committees, locally elected representatives), especially due to lack of awareness about their roles and their responsibilities and the absence of proper training; and

iii) lack of timely and appropriate response from the health sector due to the slow bureaucratic cycle, lack of resources, and lack of capacity of the health sector to listen to community-level concerns in terms of supportive tools and enabling processes.

Brinkerhoff and Wetterberg referred to these as ‘supply-side factors’ and highlighted that these need as much emphasis as demand-side factors for effective social accountability interventions. Studies, not limited to health sector, in the Indian context and beyond on social accountability and health committees in particular have stressed the need for enabling supply-side factors for their effective
outcomes. Such factors include policy and legal mandates, acknowledging the autonomy of the committees, capacity training, willingness and resources to respond to citizen’s voices and demands at all levels of government, monitoring and support (e.g. lack of resistance) by higher-level governments, etc. Scott et al. particularly stressed that providing trainings to the structures of social accountability, such as health committee members, alone is not sufficient, when the other aspects of these factors, such as policy mandates, resources, etc., are not ensured. Social accountability interventions should give equal emphasis to addressing supply-side factors by addressing a broad range of these factors rather than focusing on only one aspect, e.g. capacity building.

**Strengthening demand-side contexts.** A major gap in existing social accountability mechanisms pertained to their limited coverage and participation of the disadvantaged groups mainly due to lack of awareness among women and community members about these mechanisms and challenges to their participation such as remoteness, the inability of women from less educated and remote areas to speak out due to discomfort, hesitation or shyness. This therefore calls for increasing the coverage of social accountability activities, such as community monitoring, social audits, CHSBs, especially to rural/remote areas, and facilitating the participation of disadvantaged groups in terms of their attendance and expressing themselves in such activities by increasing their awareness of such mechanisms and the capacity to voice their concerns, including enhancing their political capabilities.

**Enhancing the political capabilities of disadvantaged groups.** Among various social accountability initiatives that existed in our study sites, the collective approach to enhance political capabilities, for example the women’s group in Gujarat, was found to be particularly effective in terms of empowering women, especially the disadvantaged groups. It highlights that social accountability initiatives in general and those specifically aimed at addressing inequity in maternal health services should emphasize the collective political capacity of civil society to counter unequal power.

**Multi-level and systemic approach** – With the exception of a few instances in Gujarat, the health sector’s responses were mainly limited to the local level in both cases. Further, the realization of health-sector accountability problems as a systemic issue underlines the need for simultaneous initiatives at multiple levels of the health systems, giving as much emphasis to higher-level engagement as to local-level engagements through state–society interactions or shifting the incentives for state and/or political leaders to act in the public interests, and facilitating broader alliances and networking by civil society, etc.

**Constructive versus confrontational approach.** A constructive approach that enhanced collaborative practices between the health sector and the civil society, including the need to move away from ‘do not take risk, pass the buck to the next level’ attitude, was more likely to address problems systemically, create joint ownership of the plans by all actors involved in the process, strengthen relationships and build
trust between the health sector and civil society actors, etc. These examples mainly included tools/activities that involve dialogue and negotiations between the health-sector actors and the civil society, such as community score cards, public hearings and social audits. Such an approach has also been found to address barriers in the health services at the local level by mobilizing local-level resources\textsuperscript{29,37–41}.

Joshi, however, suggests that confrontational approaches such as protests and ‘naming and shaming’ can also be helpful, particularly at the national level, as threats or incentives for the government authorities to collaborate and take the protests and demands seriously; see Joshi\textsuperscript{23}. She also mentions that the confrontational approach may be the only viable option if initial attempts fail.

Our study suggests that social accountability interventions that take a multi-pronged approach are likely to have better results than those that only take a single approach. This particularly implies giving equal emphasis to supply and demand contexts, adopting context-specific strategies for both constructive and confrontational approaches, and enhancing political capabilities of disadvantaged groups.

As some of the village council (Panchayat) members in Gujarat mentioned that they became aware of health services and entitlements after joining the women’s groups, there are opportunities in terms of alliances between the existing formal government structures for social accountability (e.g. PRI members, VHSC) and the CSO, particularly in strengthening the formal structures to optimize their potential for social accountability. Therefore, joint forums between civil society and government structures such as health committees and elected representatives, seems to increase the likelihood of the latters’ engagement in representing and acting for the benefit of citizens.

There are also opportunities in Nepal in terms of alliances between the CSO and the formal government structure, especially the mothers’ groups, particularly in their empowerment and mobilization in social accountability activities with focus on enhancing the political capabilities of the disadvantaged groups.

Table 12 provides the study-site-specific and actor- (health sector or civil society) specific overview of these recommendations.
**Table 12: Overview of recommendations for each actor and study site based on the findings**

<table>
<thead>
<tr>
<th>Enable supply-side contexts</th>
<th>Gujarat (India)</th>
<th>Nepal</th>
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<tbody>
<tr>
<td><strong>Health-sector actor</strong></td>
<td>Ensure the enforcement of policy mandates on social accountability functions of structures such as VHSCs and ASHAs acknowledging their autonomy (the VHSCs in particular).</td>
<td><strong>Health-sector actor</strong>: Ensure policy and legal mandates for the social accountability functions of FCHVs and mothers’ groups, including their enforcement at the operational level.</td>
</tr>
<tr>
<td><strong>Health-sector and civil society actors</strong>: Increase the ownership (e.g. by informing and educating about their roles and responsibilities) and capacity (e.g. through trainings to perform their roles) of the existing structures such as ASHAs and VHSCs for social accountability.</td>
<td><strong>Health-sector actor</strong>: Establish proper mechanisms (e.g. supportive tools, enabling processes) at the higher-level of the health system to take-up community-level concerns.</td>
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<tr>
<th>Strengthening demand-side contexts</th>
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<tbody>
<tr>
<td><strong>Health-sector and civil society actors</strong>: Increase the coverage and awareness of social accountability activities and include all disadvantaged groups, especially in the remote and rural areas.</td>
<td><strong>Health-sector and civil society actors</strong>: Encourage the attendance of disadvantaged women in social accountability activities, especially the poor and from rural areas, by providing subsidies, e.g. monetary incentives, to FCHVs to conduct mothers’ group meetings and to women to promote their attendance in the meetings.</td>
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<th>Enhancing political capabilities</th>
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<tr>
<td><strong>Health-sector and civil society actors</strong>: Encourage active participation and engagement of disadvantaged women in social accountability activities, especially those who faced barriers expressing themselves such as uneducated and from rural areas, for instance, by educating and empowering them for their engagement in discussions among themselves and dialogues with the health-sector actors.</td>
<td><strong>Civil society actors</strong>: Enhance the collective political capabilities of disadvantaged groups, including the mothers’ groups to counter unequal</td>
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<tr>
<td>Gujarat (India)</td>
<td>Nepal</td>
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<tr>
<td><strong>Multi-level and systemic approach</strong></td>
<td>power relations. This would require delegating the role and support for this role by the health sector to the civil society.</td>
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<tr>
<td><strong>Health-sector</strong> and civil society actors: <strong>Multi-level and systemic approach</strong></td>
<td>Adopt multiple level and systemic approach, especially paying attention to higher-level engagement through state–society interactions, or enforcement measures or shifting the incentives for state and/or political leaders to act in the public interests.</td>
<td></td>
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<tr>
<td><strong>Civil society actor:</strong> <strong>Constructive and confrontational approach</strong></td>
<td>Adopt a constructive approach in social accountability activities such as using dialogues with the health sector, while strategically taking a confrontational approach in relevant contexts and when necessary.</td>
<td></td>
</tr>
<tr>
<td><strong>Health-sector</strong> and civil society actors: <strong>Constructive and confrontational approach</strong></td>
<td>Strengthen alliances between the formal government structures such as the PRIs and VHSCs and the CSO groups to optimize potential for social accountability.</td>
<td></td>
</tr>
<tr>
<td><strong>Health-sector</strong> and civil society actors: <strong>Constructive and confrontational approach</strong></td>
<td>Establish and strengthen alliances between the formal government structures such as the HFOMCs and the mothers’ groups to optimize potential for social accountability.</td>
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**Note:** We acknowledge that there is likely a need to formulate actions for the other actors (e.g. the health sector for enhancing political capabilities) in some cases or in the other country context (e.g. to strengthen demand context in Gujarat state), but our study findings did not allow us to identify these.
9.4 Recommendations for further research

The scoping reviews in *Chapters 4 and 5* identified power as a crucial factor for maternal health inequities and health-sector accountability. We call for further research in understanding how power operates at various dimensions of economic, social, political and health systems. Such an analysis can be used in designing effective interventions, including social accountability interventions, to address the problems of accountability and equity in health sector and beyond.

Our overall study builds evidence on the influence of social accountability mechanisms based on changes as perceived by the respondents. This does not yet confirm the actual changes. Our study had a limitation regarding social accountability activities at higher levels of the health sector. Another research gap pertains to documenting evidence on if participatory social accountability activities such as social audits and CHSBs on long-run lead to empowerment of disadvantaged groups through, e.g. critical consciousness, collective agency and collective actions. Our study in Gujarat suggests that social accountability that is focused particularly on disadvantaged groups is likely to benefit such groups and addresses inequity issues. We recommend further research on these aspects.

9.5 Overall conclusion

There were formal social accountability mechanisms for maternal health in the study sites both in the government and in civil society in terms of structures and activities, except in Baglung (Nepal) where no CSO-led activities were reported. They basically created awareness about maternal health, services and entitlements among women and community members, generated information about health-sector performance, enabled or facilitated women to have dialogue and negotiation with the health sector, and fostered institutional enforcement mechanisms or created incentives for the health sector to respond, thus creating health-sector responsiveness mainly in terms of changes in healthcare professionals’ attitudes and behavior and provision of care. In Gujarat, the social accountability mechanisms were perceived to potentially influence changes in structural and intermediary factors of maternal health ultimately improving the availability, access and use of maternal health services.

However, social accountability mechanisms did not function to their full potential and the government structures were particularly constrained due to the lack of clear mandates, capacity and power to conduct the social accountability functions. CSOs played a crucial role in the social accountability processes by facilitating dialogue and negotiations between women and the health-sector actors and enhancing political capabilities of disadvantaged women.

Our study suggests that social accountability mechanisms can potentially address inequities in maternal health by making health sector responsive to the needs, particularly of the disadvantaged groups, and
ultimately improving the availability, access and use of maternal health services by these groups. This is achieved through the empowerment of the disadvantaged groups by addressing power asymmetries between them and the health sector and enhancing the groups’ engagement in the accountability of the health sector. We argue that the mechanisms can have the best results when they employ a constructive, systemic or multi-level and multi-pronged approach and enhance the collective political capabilities of disadvantaged groups. Further, when social accountability mechanisms exist, it is crucial that women, especially disadvantaged women, are aware of them, that they are represented or actively participate in such platforms to voice their concerns, and that the health sector is able and willing to respond to these concerns appropriately.
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