Global Health Visions

COUNTRY CASE STUDY: INDIA

In-depth landscape analysis of accountability for maternal and newborn health in India

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This paper was developed with support from the Children's Investment Fund Foundation and the Bill & Melinda Gates Foundation. It was authored by Renuka Motihar and edited by Robyn K. Sneeringer, Susannah E. Canfield Hurd, and Kristen Cox Mehling.

This report does not provide a full review of theories, interventions, data, or findings related to MNH accountability efforts in India. It relied heavily on the contributions of interviewees and, as a result, may include generalizations or differences of opinion. Any mistakes or discrepancies are the sole responsibility of the authors and editors.

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Table of Contents

Introduction

In recent years India has made considerable progress in lowering maternal and newborn mortality rates. The Government of India's National Health Mission (NHM, formerly the National Rural Health Mission, or NRHM) has made both programmatic and financial commitments to ensure safe birthing and better neonatal health. Civil society organizations have also played a key role in accountability efforts, working to make the health system more responsive and efficient, and to ensure that the government is meeting the needs of India's diverse population.

Over the past 10 years, civil society accountability and monitoring efforts have existed at the local, state, and national levels. Accountability efforts within the health sector began when civil society first became involved in monitoring health services throughout small pockets of the country. By the time the Government of India's flagship health program, the NRHM, launched in 2005, community monitoring was being implemented and included in many government social service programs.

In the area of maternal and newborn health, social accountability mechanisms, such as making women and communities aware of their rights and entitlements and conducting maternal death reviews, have been prominent and often driven by civil society. In fact, many of these organizations have pioneered innovative approaches to citizen-based accountability that have been studied and adapted throughout India as well as in other countries.

Despite this progress, however, MNH accountability is still at the nascent stage compared to other fields such as education, employment, and food security. Linkages between government and community accountability programs are needed to continue progress towards improving maternal and newborn health outcomes. Toward this end, a review of current accountability efforts was conducted to better understand promising practices and emerging models in India. This case study seeks to summarize these national and state-level programs and players that could be leveraged for future MNH accountability efforts.

> *"In India, accountability in health is not a bubbling movement as the issue is complex. The field is in its infancy."*

National-level Accountability Programs and Players

In India, much of the MNH monitoring and accountability work in the last 10-15 years has been initiated by civil society organizations. This work has included a range of social accountability mechanisms such as making women and communities aware of their rights and entitlements, conducting maternal death reviews and verbal autopsies, using checklists at health facilities, developing scorecards/report cards, conducting fact finding missions in response to events/occurrences, organizing public hearings, working with elected representatives and the media, using the judicial process for legal recourse, and tracking budgets.

Some of the organizations that have been at the forefront of this MNH accountability work include **SATHI, CHETNA, Sahaj, the Center for Health and Social Justice (CHSJ), Sahayog, Prayas, the Centre for Catalyzing Change (formerly CEDPA India), Karuna Trust, and the Public Affairs Centre (southern India).** These organizations have been pioneers and front-runners, as most organizations avoid monitoring and accountability work for fear of reprisal and instead focus on health implementation, capacity building, program modeling, and supporting government efforts. Indeed, the broader landscape for accountability work in India is being threatened. Many CSOs feel the space for questioning is

shrinking, making them increasingly reluctant to do accountability work. In the last few months, for example, the government has cancelled over 9,000 charity licenses on charges that NGOs and funding agencies have not properly declared donations from abroad.

Alliances and coalitions, such as the **White Ribbon Alliance for Safe Motherhood India (WRAI)** and **CommonHealth (The Coalition of Maternal-Neonatal Health and Safe Abortion)** have also been working on MNH accountability (mostly on maternal health). Typically problems and solutions are generated at the local level, with more limited engagement at the state and national levels. These coalitions have been critical to expanding accountability efforts in different parts of India, as it is felt that working on accountability as a collective, rather than as individual organizations, leads to more effective programming. Other alliances like the **National Alliance for Maternal Health and Human Rights (NAMHHR)** have focused on policy advocacy, while the **Community of Practitioners on Accountability and Social Action in Health (COPASAH)** seeks to share experiences, learning, knowledge, and build the capacity of partners.

There are also accountability efforts focused on adolescents, though they are limited and many of the current government programs (RKSK[1] and Sabla[2]) are only in their initial phases. Organizations like **SAHAJ, Sahayog,** and **the Centre for Catalyzing Change** are examples, with projects focused on monitoring the Sabla adolescent girls program in different states.

Most of the maternal health accountability work has been at the community level and included raising awareness, highlighting voices and experiences of women, building capacities of women, and using social accountability mechanisms and tools. In many cases pictorial tools have been developed in the local language which have been used to monitor health service provision and facilities. The findings have then been shared with duty bearers and have resulted short-term changes and improved services at the local level, with some cases leading to change at the block or district levels. Changes have included making a non-functioning health facility such as a sub-center functional by providing power, water, and human resources (a doctor, nurses, and/or others). Additionally, fact-finding missions led by civil society after maternal deaths in hospitals have also brought about changes at both the state and national levels due to the involvement of the media in highlighting the cases. Despite these examples of improvement, however, long lasting changes have been harder to come by.

National Rural Health Mission

The **National Rural Health Mission (NRHM)**, launched by the Government of India in 2005, was tasked with decreasing maternal and child mortality by providing quality health services in rural areas and increasing community engagement in health service planning. This task continues under the **National Health Mission (NHM)**, which consolidated NRHM and the National Urban Health Mission in 2013.

Under the NHM, new spaces have been opened for civil society involvement in community monitoring and accountability efforts. The National **Advisory Group for Community Action (AGCA)**, hosted by the **Population Foundation of India (PFI)**, was created to explore ways to increase community participation. This led to the creation of the **Community Based Monitoring and Planning (CBMP)** framework that is now being implemented under the name **Community Action for Health**. CBMP bridges the gap between

[1] Rashtriya Kishor Swasthya Karyakram (RKSK) is a Ministry of Health & Family Welfare (GOI) program started in 2014 for adolescents ages 10-19. It focuses on nutrition, reproductive health, and substance abuse, among other issues.
[2] Sabla is a government program (of the Ministry of Women and Child Development) focusing on girls empowerment.

people and services by involving citizens in their monitoring and assessment, and providing them an opportunity to actively participate in the process of improving health services.

PROGRAM HIGHLIGHT: Community Action for Health (originally CBMP)

The NHM includes an accountability framework with three dimensions: (1) Program monitoring through a health management information system; (2) Periodic surveys; and (3) **Community Based Monitoring and Planning (CBMP, also known as Community Action for Health).** CBMP is a key strategy of NHM, which seeks to monitor various levels of the public health system by engaging civil society organizations and citizens. At its core, CBMP is people-centric, focused on tracking, recording, and reporting public health services that citizens themselves experience. CBMP is designed to ensure that the health needs and rights of the community are being fulfilled through data collection on local health services, report cards, and dialogues and hearings with health services providers and officials.

The primary aim of CBMP is to improve service delivery. By making people aware of their rights and entitlements, increasing knowledge about schemes like the **Janani Suraksha Yojana (JSY),**[3] now known as **JSSK (Janani Shishu Suraksha Karyakram)**, the **Rashtriya Swasthya Bima Yojana (RSBY),**[4] and understanding the roles and responsibilities of service providers, CBMP seeks to empower citizens to demand quality healthcare services.

To roll out CBMP, the **Ministry of Health and Family Welfare (MoHFW)** constituted the **National Advisory Group on Community Action (AGCA)** in 2005 – with 17 eminent civil society representatives and public health experts – to provide guidance and technical support for community action under NHM. MoHFW also supports the **Population Foundation of India (PFI)** to host the national secretariat and provide technical assistance to states on CBMP.[5]

CBMP processes are organized at primary health centers (PHC) at the village, block, district, and state levels. A state-level CSO typically coordinates community based monitoring and planning activities in coordination with district and block CBOs, as well as the State Health Department. Monitoring committees at each level of the system are responsible for: (1) reviewing and aggregating information from the level below; (2) monitoring healthcare service provision at its current level using tools such as report cards or budget monitoring lists; and (3) passing results up to the next, higher level. To ensure that effective linkages across committees from the village, PHC, block, and district levels, representative members participate in each of the committee levels. Sub-state committees then link to the state and national committees via representation.[i]

Once data has been collected at the district level and community partners have identified key gaps, information is disseminated and shared through public dialogues, hearings, and village health meetings. Authorities are expected to respond to citizen concerns and indicate how key issues will be addressed. Media coverage has also been utilized by a number of CBMP programs. In doing so, public awareness around rights, entitlements, and service quality increases, placing pressure on district health officers and other government officials to respond.

Coalition building is another key process to successful CBMP programs. Collective action on the part of CSOs working across the various levels drive implementation and government action. These organizations work together, along with the government, to find common ground and develop solutions at community, district, state, and national levels. Alliances are formed to provide input into policy and planning and collectively ensure that maternal and newborn health rights are being addressed.

[3] JSY is a safe motherhood intervention under the National Rural Health Mission (NHM). Its objective is to reduce maternal and neonatal mortality by promoting institutional delivery among poor pregnant women.
[4] RSBY is the Indian National Health Insurance Programme for the poor that provides hospitalization coverage up to 30,000 Rs.
[5] NRHM: National Consultation on Community Action for Health, October 28 -29, 2014 New Delhi, India. Organised by Ministry of Health and Family Welfare & Advisory Group on Community Action

STRENGTHS

1. **Raises Community Awareness of Rights and Entitlements**. The process can help to empower citizens and communities to participate in their country's governance, while providing an avenue to collect and document real issues that are affecting their lives.

2. **Strengthens Civil Society Alliances and Partnerships with Government.** Dialogues allow for mutual understanding between citizens, providers, and government officials. The evidence that is generated creates meaningful feedback to duty bearers and encourages continued collaboration and quick government response/remedial action. In the future communities from across districts and states need to be better connected in order to effectively address high-level officials.

WEAKNESSES

1. **Capacity Needs and Tools Have to be Tailored to Each Community**. Community needs and capacity vary greatly, so solutions must vary as well. For example, where literacy is low, questionnaires and report cards may not be appropriate. Furthermore, CBMP is a constant process that requires continued training, technical support, and follow-up to ensure impact.

2. **Ideas that Look Good on Paper Don't Always Translate to Action.** While the concept of CBMP has been good on paper, in practice implementation has varied across districts and states. When done systematically, the success of CBMP is clear; however, without clear planning on the part of the states, implementation may be met with varied results.

White Ribbon Alliance for Safe Motherhood India

White Ribbon Alliance for Safe Motherhood India (WRAI) is an alliance of organizations and individuals working on safe motherhood issues in India. The alliance sees its role as empowering communities so that demand-side social accountability acts as a monitoring input to improve the supply and quality of maternal health care while also improving governance, increasing development effectiveness, and building civic empowerment.

Since 2006, WRA-India has used social accountability efforts as a catalyst for system change to address the high volume of maternal deaths as well as barriers to the implementation of maternal health programs. The WRAI strategy employs several social watch techniques including tracking policy implementation, verbal autopsies, and national and state level campaigns; using checklists, score cards, and public hearings; and undertaking advocacy through regional language print and electronic media. They also work with elected representatives and the media to ensure the delivery of services and to raise awareness among women and communities on rights and entitlements.

> *"To plug gaps and holes in the health system, you need people's participation. We need a strategy for increased people's participation. We need to make health a social, people's movement."*

PROGRAM HIGHLIGHT: WRAI in Action – Citizen's Engagement Meeting

WRAI recently conducted a national level citizen's meeting in New Delhi with speakers from government, politics, NGOs, and elected female representatives who had monitored health services at the local level. They also screened citizen's video reports. The government officials spoke about the importance of empowering women and communities to demand services and entitlements, the need "to plug gaps" in services, and the "importance of people's participation to make health a people's movement." Suggestions from the meeting included the need for women, communities, and elected representatives to be aware of their rights and entitlements, the need to include marginalized populations in monitoring services, and the need to increase citizen engagement using easy-to-use tools. It was also stressed that women should know how to recognize danger signs and when to access services.

Coalition for Maternal-Neonatal Health and Safe Abortion

The **Coalition for Maternal-Neonatal Health and Safe Abortion (Commonhealth)** is a membership-based network of individuals and organizations with the goal of advocating for better access to and quality of maternal and neonatal health and safe abortion services. Regarding maternal health accountability, Commonhealth – with partner **Jan Swasthya Abhiyan (People's Health Movement)** – has primarily focused on training their partners in and conducting Maternal Death Reviews (MDR). MDRs conducted at the local level have managed to bring about some changes at the local and block levels, through sharing the findings with government functionaries. However, the response has been more variable at the state level. A report titled *Dead Women Talking* was developed covering 11 states, 23 organizations, and 40 blocks – including Uttar Pradesh and Rajasthan. It was disseminated at the state and national levels, with noted impacts in certain states such as Chattisgarh, where the government asked CSOs to train them on MDRs.

National Alliance for Maternal Health and Human Rights

The **National Alliance for Maternal Health and Human Rights (NAMHHR)** was started in 2010, with the secretariat based at the organization SAHAYOG. The impetus for its founding was an agreement among civil society organizations from seven different states about the need to strengthen maternal health as an issue of women's human rights. The group recognizes that there is an urgent need for women's organizations, health organizations, and groups working on law and human rights to come together on these issues. They feel strong rights-based strategies are needed to build greater accountability for thousands of preventable deaths among women in India. Their strategies include: community empowerment through organizing, monitoring and Jan Sunwais (public hearings); media and legislative advocacy; information dissemination: research studies and evidence building; recommendations on state government project implementation plans (PIPs); capacity building; and budget tracking. The alliance covers 15 states and primarily conducts research and policy advocacy at the national level. NAMHHR has conducted studies on women's experiences of institutional delivery in five states, and held public hearings at the state and national levels that included National Human Rights Commission (NHRC) members. They provide input into structures that have an oversight function such as the Parliamentary Committees and state and national level human rights commissions, resulting in better-informed parliamentarians and government officials.

State and Citizen-level Accountability Programs and Players

Uttar Pradesh

In the north Indian state of Uttar Pradesh, there has been limited engagement in the area of maternal and newborn health accountability, with some of the organizations including:

SAHAYOG

SAHAYOG is an organization dedicated to promoting gender equality and women's health. A pioneer in this space, they have worked closely with community based organizations (CBOs) and larger civil society networks to increase awareness, strengthen capacity, build partnerships, and promote research and policy change aimed at improving reproductive health and rights, both locally and nationally. For example, SAHAYOG has supported the formation of a grassroots organization of rural marginalized women called **Mahila Swasthya Adhikar Manch (Women's Health and Rights Forum; MSAM)**. MSAM has been at the forefront of accountability work by exercising 'active citizenship' through monitoring and advocacy for better health services. SAHAYOG also produces materials to raise awareness on rights and entitlements and capacity building of community-based groups, and engages in research and dissemination of findings to policy actors. It has developed simple, easy to use, pictorial tools for monitoring health services. It holds the secretariat for an alliance of CBOs and health activists at the state level called the **Health Watch Forum, Uttar Pradesh**. SAHAYOG has also facilitated district and state level dialogues of CBOs, government officials, and the media using evidence from studies and analyses that reflects grassroots realities.

Mahila Swasthya Adhikar Manch

Mahila Swasthya Adhikar Manch (MSAM) has grown over the years to be active in 10 districts of Uttar Pradesh, with groups of five elected leaders at the village, block, and district levels. Armed with information about their entitlements and state provisions, the MSAM women, in an exercise of 'active citizenship' through monitoring and advocacy, have taken up various aspects of the NRHM each year. For example, by auditing the payment of the conditional cash transfer under the JSY (2007-8), they examined how 'untied' health budgets were spent locally, how much poor families were spending (2009), and audited the compliance of health sub-centers with the Indian Public Health Standards (2010). Every monitoring exercise is followed by a formal presentation to district health officials by NGOs and MSAM women, as well as presentations at the state capital in front of state officials and the media. These interventions have been successful at bringing about changes at the local level.

Rajasthan

In the state of Rajasthan, the key players working on MNH citizen-led accountability have been **Prayas, the Center for Health, Training, and Nutrition Awareness (CHETNA), the secretariat of WRA Rajasthan-SUMA,** and **Mazdoor Kisan Shakti Sangathan (MKSS)**. Organizations such as **Action Research and Training for Health (ARTH)** have also worked on strengthening health services. The main accountability processes used for improving maternal and newborn health have been social accountability strategies, including raising awareness of rights and entitlements, highlighting women's voices and experiences, using checklists and community scorecards, strengthening health services, and undertaking maternal death reviews and fact-finding missions.

Prayas

Prayas, an organization based in Chittorgarh, Rajasthan, has been working on health and community development issues for a number of years. They have been the state nodal organization for the **Advisory Group of Community Action (AGCA)** and implemented early pilot projects that brought together health providers and the community for the first time. This pilot project provided inputs for NHM's community based monitoring initiative. Prayas has developed assessment tools for monitoring the delivery of health services and has been implementing projects on MNH accountability using a social determinants approach. They have also been involved in the campaign for free medicines in the state of Rajasthan.

Centre for Health Education, Training, and Nutrition Awareness

The **Centre for Health Education, Training, and Nutrition Awareness (CHETNA)**[ii] is an organization that has been working on health and nutrition issues for women, adolescents, and children using a life cycle approach.[6] They raise nutrition and health consciousness among disadvantaged social groups by enhancing the capacity of government and civil society functionaries. Networking, advocacy, and program planning is done at the local, state, national, regional, and international levels, though their activities are primarily focused on the states of Gujarat and Rajasthan. CHETNA is the secretariat of the **Rajasthan Alliance for Safe Motherhood-SUMA**[7], the state alliance advocating for maternal health. SUMA has been active in building the capacity of elected women representatives by using checklists, citizen's report cards, and public discourse.

Mazdoor Kisaan Shakti Sangathaniii

Mazdoor Kisaan Shakti Sangathan (MKSS) is an organization that has become well known in India for its use of 'public hearings' as an accountability mechanism. Based in Rajasthan, MKSS has pioneered a method for the rural poor to access information from government on schemes and benefits that they are entitled to. It has held public hearings that have encouraged ordinary citizens to speak out about problems in public works and schemes from which they are supposed to benefit. These hearings have exposed the ways in which public officials have siphoned off large amounts of funds from public works budgets. The first victory for the movement was the government notification under the Panchayats Act that the people could inspect records of all panchayat expenditure. Rajasthan passed the Right to Information Act in 2000, a development that was influenced greatly by the pressure of MKSS. There have been problems with the Act and its provisions, but it does show the influence that a people's movement can bring to bear on a government reluctant to take steps towards transparency and accountability. MKSS has implemented these meetings in several districts of Rajasthan and works with similar groups in other states on right to information issues.

Action Research and Training for Health

Action Research and Training for Health (ARTH) is an organization based in Udaipur, Rajasthan, that has worked with the government to strengthen health institutions and systems at the local and district levels. They have built mechanisms and tools such as checklists to help strengthen the quality of care and capacity of staff within health institutions. Their efforts have focused on improving services, access, and health system efficiency. The information gathered is used to guide remedial action at the health facility to improve equipment, staffing, and overall practices. ARTH's work also helps communities and patients navigate the health system, providing information on rights and entitlements so that individuals can be more pro-active.

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[6] Women's health is being viewed holistically as a continuum of care from birth through childhood, adolescence to adulthood and old age. This encompasses women's health at every stage of their life.

[7] SUMA is taken from Hindi words Surakshit Matritva (safe motherhood). http://chetnaindia.org/secretariat/rajasthan-white-ribbon-alliance/

Tools and Tactics

The key accountability tools highlighted in this section are those used by organizations and alliances for maternal and newborn health accountability in India. These include: maternal death reviews or verbal autopsies; checklists and scorecards/report cards for assessing services at health facilities; public hearings at the local, district, state and/or national levels; legal/judicial recourse for addressing rights violations in health; and budget analysis and tracking.

Maternal Death Reviews

Organizations and alliances have used maternal death reviews (MDRs) and/or verbal autopsies to better track and understand (1) maternal mortality, (2) institutional delivery, and (3) social disparities in mortality. The Government of India (GOI) mandated MDRs at the district level starting in 2010. While the GOI's efforts to institutionalize MDRs have tended to focus purely on medical causes, CSOs have used MDRs to evaluate the underlying social and human rights determinants that impact mortality outcomes.

> *"Why should women die? These are preventable deaths."*

CommonHealth, an alliance of civil society actors across 10 states, has led many of these efforts through the development and implementation of a social autopsy tool designed to document maternal deaths by capturing health system gaps and contextual factors that can contribute to maternal mortality (e.g. barriers to care, poor birth preparedness, transportation). By elevating the experiences of women who have died unnecessarily, civil society is able to more effectively engage the government through public dialogues and hearings.

The information gathered from verbal autopsies has been shared differently in different contexts. Some organizations have prepared a report after the MDR/verbal death autopsy and shared it with the health facility, service provider, and/or the local government so that appropriate action can be taken. In other cases, media representatives have filed reports to raise awareness, exert public pressure and stimulate dialogue. Other organizations have shared the findings from verbal autopsies during local public hearings with government officials, elected representatives, and the media.

STRENGTHS

Galvanizes Multiple Stakeholders Around a Common Cause. The strengths of this model are that it highlights the voices of communities and women and looks at the causes of deaths beyond only medical causes. This process has brought medical providers, civil society, elected representatives, and the media onto the same team and highlighted human stories and realities. Unlike many approaches, MDR programs in India work to integrate the environment that surrounds women's empowerment by focusing on social determinants as well.

WEAKNESSES

Success is Dependent on Specific Stakeholders and Context. The information gathered through this process is critical, but how it is received and the follow-up action taken depends on the specific context and stakeholders. The approach taken by CSOs and teams is important. There is general resistance from the health providers to cooperate in civil-society-led verbal autopsies.

Checklists and Scorecards

Checklists and community/citizen scorecards or report cards[8] are used to monitor health services at the health facility level. For example, the **Center for Catalyzing Change (C-3, formerly CEDPA)** has been training **elected women representatives (EWRs)** and other community members to play a critical role in monitoring health facilities. EWRs are trained on service-level benchmarks and equipped with checklists that they administer at different levels of the healthcare system, helping to identify systemic gaps that hinder the delivery of quality maternal health services.

> *"Through the training and use of the checklist, I learned about what should happen at the Anganwadi and health center." – Elected Woman*

These checklists have been developed by organizations **(Centre for Catalyzing Change, CHETNA, Sahaj, Prayas)** with adherence to Indian Public Health Standards, NHM guidelines, and facility assessment survey formats. Broadly, these checklists look at the logistics, availability, and functionality of equipment and the availability of supplies, medicines, and staffing. Information is typically collected during health care visits or during Village Health Sanitation and Nutrition days. The data are then analyzed and translated into report cards for dissemination at the facility, block, and district levels. Many other organizations are also utilizing checklists, report cards, and other monitoring tools within their various programs.

While some of the findings address larger, systemic health issues that require intervention at the state level, checklists are typically most useful at the village, block, and district levels. Through convergence meetings that bring together key stakeholders, officials can issue directives to the health workers to collaborate with the EWRs to improve service quality. Additionally, the officials are able to provide guidance on the usage of untied funds at the village level to find quick solutions to important local issues – like the purchase of examination tables, blood pressure machines, curtains, and other vital equipment.

In many cases, state and national level advocacy efforts are also done, where the EWRs present their accountability and monitoring work before legislators, journalists, civil society organizations, and others. A key learning is that it is essential for service providers to respond within a reasonable time to address the issues so that both communities and key stakeholders (like EWRs) are motivated to participate in the process of community monitoring.

STRENGTHS

1. **Easy to Implement**. The checklist model is a simple method for data collection and provides useful data for advocacy at the block and district levels.
2. **Promotes Collaboration.** Convergence meetings at the block level – where EWRs interface with officials to share their findings – also engender a collaborative spirit that helps build the support of government officials.

[8] Different terminology is used depending on the organization and/or program.

WEAKNESSES

1. **Illiteracy Can Pose Implementation Problems**. Low levels of literacy amongst women and elected representatives can pose challenges if the checklist is complicated. In many places, pictorial checklists have been developed to overcome this obstacle.
2. **Impact Highly Dependent on Follow-up**. Some solutions require systemic changes at the state and national levels. At times, however, the checklist data may be in conflict with official records, resulting in mixed incentives for government officials to follow-up. How and with whom the information is shared is therefore critical.

Public Hearings[iv]

Public Hearings have been used extensively by civil society organizations for accountability on issues such as education, employment, and health. Organizations such as **CHSJ, SAHAYOG, WRAI, SATHI, and the Society for Health Alternatives (Sahaj)** have been involved in these efforts, Typically, the findings from maternal death reviews, verbal autopsies, checklists, and scorecards are shared at these public hearings to stimulate discussion. The dates are usually decided well in advance to allow sufficient time to collect necessary evidence and testimonies. The event is usually held in the public health facility itself or at a common place that is easily accessible.

It is in this context that public hearings function as a mechanism to proactively seek accountability of the state, which can bridge horizontal and vertical forms of accountability. This hybrid form of accountability requires institutional support in the form of a legal mandate for non-government actors to act as agents of public sector oversight. The Jan Sunwai aims to achieve vertical accountability while energizing intra-state horizontal mechanisms. It provides a forum for justice that is more direct and accessible than the formal justice system, which is prolonged, technical, uncertain, and mostly remains inaccessible for the rural and the marginalized sections of the society.

TOOL HIGHLIGHT: Jan Sunwai

Jan Sunwai (JS) is a process that allows citizens to voice concerns, ask questions, and provide testimony to a panel on particular issues in a formal, open forum. The panel can be made up of NGOs, government officials, experts, elected representatives, media, or other key stakeholders. Key components of this process include:

- **Mobilization of People from Communities:** Local organizations mobilize people and activate groups from their area to come for the Jan Sunwai. Citizen participation is necessary to help apply group pressure towards the fulfillment of the demands made in the JS. Surveys can be conducted door-to-door to develop a findings report for presentation at the hearing.

- **Involving and Inviting Panchayat Representatives:** Panchayat Raj is a system of governance based on elected local bodies, which range across three levels: village, block, and district. As per the Constitution, Panchayats Raj Institutions (PRI) in their respective areas are required to prepare and execute plans for economic development and the promotion of social justice. The presence of PRI members in the Jan Sunwais builds political pressure for resolving the issues raised by the people, and helps to ensure interdepartmental coordination and response.

- **Inviting Government Officials:** The presence of health officials is essential for the success of public hearings. The Medical Officers of different PHCs in the region, Civil Surgeon (CS), District Health Officer (DHO), Additional Director of Health Services (ADHO), elected members of the state legislature, and others, are all invited and highly encouraged to participate.

- **Constituting a Panel of Judges:** Prominent experts from various fields such as teachers, lawyers, and healthcare professionals are invited to participate as panelists to mediate the dialogue and give an opinion or 'judgment.' This panel plays the pivotal role of listening to citizen complaints and ensuring a response by government officials. Prior to a JS, the panel is briefed about the purpose and survey findings. After listening to both sides, the panel gives their expert opinion. The opinion creates awareness among participants and also serves as a tool to pressure the government to implement its recommendations.

- **Media Involvement:** Media plays a vital role in disseminating the final opinion and recommendations of the JS. It is important to contact media in advance and familiarize them with the process and get their support.

- **Conducting Follow-up Meetings:** As a follow-up, a meeting is usually planned with the government officials shortly after the hearing. A targeted group of organizations and/or activists discuss and develop a plan of action to address the panel recommendations. If needed, further meetings are held to ensure the implementation.

Overall, civil society has an important role to play in facilitating the Jan Sunwai process. By helping to establish meaningful partnerships and facilitating citizen-state interaction, CSOs can encourage civic participation in government programs that aim to improve health outcomes.

STRENGTHS

1. **Creates a Forum for Multi-stakeholder Dialogue.** Public hearings provide an opportunity for engagement among different stakeholders, including those that do not often have a voice in policy debates.

2. **Empowers Marginalized Women to Voice Concerns**. Hearings allow poor, marginalized women to directly interact with government officials and health service providers that often hold power over individual service users. In so doing, they provide an opportunity for community mobilization and create space for women to assert their power through collective action.

WEAKNESSES

1. **Ensuring Government Official Participation is Difficult.** At times, government officials feel that CSOs do not have the legitimacy to conduct public hearings, and government officials are often defensive. Elected officials are hesitant to participate given the potential for political impacts and often only junior-level government functionaries participate.

2. **Follow-up Actions are Critical.** Actions that occur after the public hearings are critical not only for successful implementation of recommendations, but also to create additional motivation among key stakeholders.

Legal Empowerment and Human Rights

The Human Rights Law Network (HRLN)[v] (based in Delhi with state offices) is a collective of lawyers and social activists dedicated to using the legal system to advance human rights in India and the sub-continent. HRLN collaborates with human rights groups, grassroots development organizations, and social movements/alliances to enforce the rights of poor, marginalized people. HRLN provides pro bono legal services, conducts public interest litigation, engages in advocacy, conducts legal awareness programs, investigates violations, publishes 'know your rights' materials, and participates in campaigns.

HRLN seeks to:

- Promote a rights-based approach to reproductive health care throughout India.
- Encourage dialogue and collaboration between women's rights organizations, health groups, lawyers, and judges to utilize the legal system more effectively.

- Conduct fact-findings all around India to ascertain the situation on the ground.
- Provide *pro-bono* legal aid for the poor, marginalized, and vulnerable whose reproductive health rights have been violated.
- File Public Interest Litigation Cases (PILs) concerning reproductive rights to both High Courts and the Supreme Court of India, which rely on constitutional, legislative, and international human rights law provisions.
- Provide advocates and social activists with a concise summary of the main facts, legal arguments, and court orders in HRLN's PLIs through the publication of the *Mera Haq (My Right) Legal Case Series*.
- Produce 'know your rights' materials to increase awareness among Indian women and their partners about contraception, family planning, and other reproductive health issues.
- Organize events to promote reproductive rights issues, such as the *Mera Haq (My Right): Surviving Pregnancy with Dignity* photographic exhibition held in Delhi in May 2010.
- Conduct educational workshops and training seminars for activists to build capacity.
- Work in conjunction with the Women's Justice Initiative, People's Health Rights Initiative, Dalit Rights Initiative, and the Child Rights Initiative, to ensure that Dalit, Adivasi, and adolescent girls are recognized as special-risk groups of maternal mortality and morbidity.

TOOL HIGHLIGHT: HRLN's Reproductive Rights Initiative

HRLN's Reproductive Rights Initiative (RRI) works toward the realization in India of reproductive rights as defined in the Program of Action of the International Conference on Population and Development (1994), including the right of women to survive pregnancy with dignity. Against this backdrop, the RRI uses the legal system to combat violations of reproductive rights, ensure implementation of reproductive rights schemes, and to demand accountability where implementation is left wanting. Currently, HRLN has fifty ongoing cases in the courts (national and state level). Due to the Public Interest Litigation (PIL) filed by the RRI, reproductive rights have become justiciable in Indian courts and the HRLN team has had a number of successes.

Lack of functioning blood banks and blood storage facilities is of particular concern, as a lack of access to blood accounts for approximately 50 percent of all maternal deaths in India. In one case, a PIL was filed following a number of fact-finding missions that revealed that access to health facilities and quality maternal health services was very limited. As a result, a blood bank license was granted. Furthermore, the PIL resulted in major infrastructural overhauls of water/sanitation and electrical systems in all government health centers in Madhya Pradesh (Source: Sandesh Bansal v Union of India, Writ Petition No 9061/2008).[vi]

One of RRI's greatest successes to date has resulted from the groundbreaking order issued by the Delhi High Court in March 2010. In this case, the Court ordered a maternal death audit be carried out with respect to the pregnancy-related death of Shanti Devi, a member of a Scheduled Caste who died delivering her baby daughter at home without any medical assistance. This ruling set both a national and international legal precedent for ensuring maternal death accountability (See: Laxmi Mandal Vs. Deen Dayal Hari Nager Hospital & Ors).

In yet another example that was emblematic of the multiple rights violations suffered by Indian women and girls, RRI's PIL secured an order for the Union of India to devise a set of instructions to ensure that persons living below the poverty line (BPL) get their entitlements to free medical care (See: Jaitun v Maternity Home, MCD, Jangpura & Ors).

STRENGTHS

1. **Judicial Action Brings Change.** The strengths of using the legal system for maternal health and rights are clear in the successes that have brought about judicial precedent and social change (e.g. Laxmi Mandal case). When acted upon, these rulings have the ability to impact millions.

2. **Creates Legal Professional Partnerships.** This approach has allowed legal professionals to work collaboratively with alliances, coalitions, and women's health organizations. It is an alternative method to hold governments accountable and gives women a voice in the court.

WEAKNESSES

1. **Long and Arduous Process.** At times, the legal process can be very slow and prolonged. Additionally, there is dependence on the judge for the verdict and no guarantee of implementation of the court order, as it is up to the state.

Budget Tracking and Analysis

Budget accountability work in India has been led by the **International Budget Partnership (IBP)** and **Centre for Budget and Governance Accountability (CBGA).** IBP works in partnership with local civil society organizations (CSOs) to improve the management of public money, the delivery of public services, and the responsiveness of government to the needs of poor people. Along with work at the national level, they focus on the states of Maharashtra and Madhya Pradesh. IBP recognizes that local CSOs and citizens are uniquely well placed to understand budget issues and drive positive change. Doing so largely depends on the availability of budget information, the opportunity to participate in budget decisions, and the capacity of CSOs to do budget work.[vii]

CBGA is a policy research and advocacy organization based in New Delhi. It analyzes public policies and government finances in India and advocates for greater transparency, accountability, and public participation in budget processes. They facilitate the People's Budget initiative, which has members from across the country. CBGA has been tracking the flow of funds for maternal health from the central government to the district level, scrutinizing the national and state budgets, and the district program implementation plans. Its budget tracking work follows an outcome methodology that seeks to understand how much has been allocated and spent as well as what outcomes are delivered.

One of CBGA's primary areas of focus has been India's Reproductive and Child Health Program, which includes maternal health funding and, as of 2005,[viii] requires states to develop their own implementation plans. The program seeks to identify and manage high-risk pregnancies and provide antenatal care services to pregnant women, including iron prophylaxis, two doses of tetanus vaccines, and screenings and treatment for anemia. CBGA has tracked the flow of funds for this program in the states of Uttar Pradesh and Chhattisgarh in order to assess whether any gaps exist in the transfer of funds, and to determine what the money actually purchases at the district level. In doing so, the organization has identified a mismatch between what is allocated, what is released, and what is spent.

In order to understand how the funds that do reach the district level are spent, CBGA has conducted field visits to health facilities and interviews with district program management units, pregnant women, and women who have recently given birth. This fieldwork has allowed CBGA to assess the state of India's health infrastructure and understand the gaps that exist in actual service delivery. One of the biggest challenges that CBGA has faced is collecting budget information at the district level, mainly due to a weak data collection system and an absence of records documenting how money is spent. In addition, CBGA has faced resistance from local government officials when asking them to provide information on the budget.

CBGA's efforts offer an interesting approach to budget analysis: tracking the flow of funds from one level of government to another (due to decentralization) in order to uncover leakages that can

eventually affect service delivery. Despite India's critical increase in institutional deliveries, the quality of services is not optimal; the available funds often remain unused or are not allocated to actions that will ultimately save women's lives. CBGA's findings highlight the fact that additional budget allocations are not enough to reduce maternal mortality and ensure the right to safe motherhood. To be effective, an increase in funds must be coupled with an efficient spending scheme that is based on the actual needs of the targeted population.

Budget tracking on health issues in India has been done by a few organizations, mostly focusing on tracking untied funds and health spending. **Support for Advocacy and Training to Health Initiatives (SATHI),** an organization in Pune, Maharashtra, has integrated budget tracking into its community based planning and monitoring work.

STRENGTHS

1. **Transparent and Inclusive.** Provides a citizen's perspective on public finance, thereby demystifying the notion that budgets and public policy are an issue for only the 'experts' or government officials. Through this process, citizens can identify the gaps between a government's promises and its actions.

WEAKNESSES

2. **Poor Dissemination and Advocacy of Results.** There has been good budget analysis and tracking in India, but the advocacy and dissemination of that information has not been that effective.

"The question that arises is – where is the accountability failure? Is it the design of the policy or is it a last-mile failure?"

The **National Foundation for India,** in partnership with other organizations, will soon be embarking on a health and budget initiative in a few states. This will bring together health and budget groups and networks for the first time. The focus of the campaign will be on access to medicines and increased budget allocations for health, human resources training, and community based monitoring.

Information, Communication, and Technology

There are few examples of using ICT and mobile technology for MNH monitoring and accountability in India. These examples/models in many cases are in the nascent stages. Examples include **SAHAYOG's** Mera Swasthya Meri Awaaz campaign that uses the Ushahidi technology, an open access software platform. It helps create visual formats for tracking informal fees. The project is 4 years old and initially was implemented in the pilot phase in partnership with Columbia University's **Averting Maternal Death and Disability (AMDD)**. With support from the MacArthur Foundation for implementation in 4 districts, the project uses a toll free number, voice SMS, and Interactive Voice Response (IVR) for registering complaints by women. There is a prompt asking if and where the women had to pay informal fees for items such as ambulance services. These complaints get translated on a map showing the health facility. With the increase in numbers of complaints per facility, the size of the dot increases. This data is used to advocate at the district and state level to address informal fees.

TOOL HIGHLIGHT: WRAI, GramVaani, and Merck for Mothers Crowdsourcing Strategy[ix]

White Ribbon Alliance for Safe Motherhood India, in partnership with the social technology company **Gram Vaani** and **Merck for Mothers,** has developed a crowdsourcing strategy designed to engage and empower women to advocate for quality care. This includes the creation of an mHealth platform that allows women to rate the quality of the maternal health care they receive. The program, currently in pilot stages, includes radio campaigns and other traditional media channels to inform women of a free phone line they can use to evaluate the services they receive at public and private health care facilities. Utilizing a pre-programmed Interactive Voice Response (IVR) scorecard, women are asked to rate the quality of care they received during their visit. Participant feedback is then made accessible via the phone system to provide reviews of service providers and facilities, in order to inform a woman's decision on which health provider to utilize. This same information is aggregated and presented to health officials and providers in order to improve care. Over the long term, partners hope that the number of women participating will create an opportunity for communities to influence the standard of care, while providing information to women that can help them determine the best provider for care.

Pahel: Toward Empowering Women is an initiative by the **Centre for Catalyzing Change (C-3,** formerly **CEDPA India)** that aims to strengthen the voice, participation, and leadership skills of elected women representatives (EWR) in monitoring health services at three levels of local governance (Panchayati Raj Institutions). 1200 EWRs have been trained on service level benchmarks and equipped with checklists that they have administered over a period of three years at four levels of Health Facilities: Village Health Sanitation and Nutrition Centers, Health Sub Centers, Primary Health Centers, and District Hospitals. Currently the project is piloting mShakti, an IVR-based platform, to monitor the quality of service delivery at these four levels and ensure accountability for services. The key features of mShakti will include toll free calls, real time data collection, and analysis using a specially customized dashboard.

The European social enterprise **M4ID** is designing, producing, and launching a new digital activist service called MIMBA that will aim to increase understanding and awareness of maternal health, provide engaging participation options, and enable community building and self organization in support of MNCH programs worldwide. The first phase of the project will be implemented in India in late 2015.

Findings and Recommendations

***Recommendation 1*: Move civil society engagement in accountability beyond the grassroots.** *Social accountability programs dominate India's accountability landscape and few initiatives have been able to link local, state, and national efforts.*

- **Social accountability drives citizen and CSO engagement.** Public hearings, checklists, verbal autopsies, MDR, community score cards, and ICT are used to inform elected representatives, government officials, and the media to ensure delivery of services and raise awareness of individual rights and entitlements. Budget work for health is limited, given the lack of access to expenditure data. It is clear that these efforts take considerable time and consistent effort, therefore there should also be system-led approaches for sustainability.

- **Many civil society organizations are not interested in doing accountability work.** They would rather help the government in implementation and capacity building. This is further exacerbated by

the challenge of legitimacy, as at times civil society's legitimacy is questioned in demanding system improvements.

- **Communities need to be empowered, mobilized, and made aware of their rights and entitlements.** It is important to develop critical thinking in communities that utilize information for action. They need to be vigilant and take quality of care and maternal deaths seriously. In addition, they need to own the mechanisms and the tools need to be easy to use, in the local language, and contextually appropriate (e.g. pictorial if literacy levels are low).

- **Capacity and funding for citizen-led accountability should be strengthened in order for CSOs to gain legitimacy within the eyes of government and other partners**. Monitoring using tools such as budget tracking can help establish evidence and help create a synergy between civil society players.

***Recommendation 2*: Strengthen the chain of accountability between all levels and across all issue areas.** *Build on local accountability efforts and organizations. Partner with state systems and institutions to increase scale and improve the state-citizen relationship.*

- **Community voices are central to developing strong accountability systems.** It is important to highlight women's voices and their experiences engaging the health system. Local organizations with community linkages are best suited to do the monitoring and accountability work.

- **Country-level mechanisms need to be simplified.** Citizens should relate to the information being captured by using a bottom-up indicator development process that makes the mechanism easy to use.

- **Mandated oversight structures at the state and national level should be utilized** and work should be done to raise issues through these structures, such as the Human Rights Commissions and Parliamentary Committees.

- **Data is not easily available which makes monitoring and accountability efforts difficult.** The audit/assessment/evaluation of the health system has to be done by an independent team that is external to service delivery. Also, in addition to monitoring health facilities there also needs to be efforts for accountability within the health system that raises the issues and concerns of health providers and workers, such as the lack of housing or transportation.

- **India has had limited successes using global mechanisms,** such as the MDGs, iERG, and Countdown, due to data relevance, complexity, and lack of coordination. These mechanisms are not known in country and are also not translated into action at the national level. In addition, there are very few organizations working within global human rights frameworks.

- **Accountability needs to be bottom-up and protect civil society.** There is a need to have redress mechanisms and protection against reprisals for civil society. Government systems should install and implement accountability, and there needs to be more financial support and legitimacy given to civil society and citizen's led accountability efforts.

***Recommendation 3*: Support civil society at both the national and state levels to combat the shrinking space for government accountability and criticism.** *Fear of reprisal is a real risk and partners need to weigh the cost-benefit of engaging in potentially controversial activities.*

- **Accountability is perceived as risky, limiting CSO ability to engage.** As a result, more organizations tend to focus on implementation and supporting government health efforts.

- **Reluctance on the part of the government to engage in civil-society-led accountability efforts stems from the belief that it exposes the government to vulnerabilities.** Governments need to be persuaded that they should not be threatened by accountability, but instead view it as tool for progress and greater efficiency. Accountability should be viewed more about 'fact finding' than 'fault finding.'

***Recommendation 4*: Increase sustainable funding and support for accountability efforts within the maternal, newborn, and child health field.** *Governments and funding agencies need to see accountability approaches as essential to protect and champion the needs of the most at-risk populations, especially women and children.*

- **Very few donors are willing to support accountability actors.** The donor community needs to overcome apprehensions about backing social accountability efforts.

- **Funders need to partner with the right organizations**. Civil society partners should be grounded in rights-based approaches and rooted in context and on-the-ground realities. The organizations chosen as partners need to have the passion and commitment, and should be fully in tune with community needs. Experience shows that due to perceptions that the work is fraught with challenges, accountability is mostly done by local, indigenous organizations and much less by INGOs.

***Recommendation 5*: Concentrate time and resources on scaling up civil-society-led accountability efforts.** *Most programs are hyper-localized and those that do create linkages from the community to the national level are often only in select communities.*

- **There are examples of many small accountability efforts available throughout India.** However, there is a need at the local level for capacity building and funding for accountability efforts. There are very few funders supporting this issue and there is a need to make consistent, repeated, long-term investments.

- **Lessons should be gleaned from other fields.** Respondents agree that monitoring and accountability for health is essential work. There is a need to learn from the lessons of the accountability work in the education and food security sectors.

- **Alliances/coalitions have a long history in MNH advocacy, but less experience in accountability.** Programs are often focused on maternal health service delivery and on local problem solving. Small pilot projects are common, but few have been taken to the sub-national, regional, or national levels.

Conclusion

Overall, accountability for maternal and neonatal heath in India is still in its nascent stages. Accountability efforts related to education and other sectors have been vibrant and offer lessons for civil society engagement and organization. However, given that the current climate for civil society is shrinking, there is a need to find new ways and structures to raise issues so the health system is more efficient and responsive to the needs of poor, marginalized women and communities. Additionally, system-led efforts will also be critical to long-term success, as social accountability takes time and consistent effort. Governments and funding agencies need to see accountability approaches as essential to protecting the needs of the most at-risk populations, and to achieving the Millennium Development Goals and the Sustainable Development Goals.

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[i] Shukla, A., Jadhav SN. December 2013. *Community Based Monitoring and Planning in Maharashtra, India.* A Case Study. SATHI (Support for Advocacy and Training to Health Initiatives) with COPASAH (Community of Practitioners on Accountability and Social Action in Health) and support from Open Society Foundations.

[ii] Taken from http://www.whrap.org. For more information visit www.chetnaindia.org

[iii] http://www.mkssindia.org/

[iv] Shukla, A., Jadhav SN, op. cit.

[v] http://www.hrln.org/hrln/reproductive-rights/the-initiative.html

[vi] http://hrln.org/hrln/reproductive-rights/pils-a-cases/634-sandesh-bansal-v-union-of-india-wp-no-906108.html#ixzz3dwBPUnNF

[vii] http://internationalbudget.org/india/

[viii] International Budget Partnership and International Initiative on Maternal Mortality and Human Rights. May 2009. *The missing Link: Advanced Budget Work as a Tool to Hold Governments Accountable for Maternal Mortality Reduction Commitments*. http://righttomaternalhealth.org/resource/the-missing-link

[ix] Adapted from: http://www.gramvaani.org/?p=2039