HHR
Health and Human Rights Journal

Using Technology to Claim Rights to Free Maternal Health Care: Lessons about Impact from the My Health, My Voice Pilot Project in India

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Abstract

My Health, My Voice is a human rights-based project that pilots the use of technology to monitor and display online data regarding informal payments for maternal health care in two districts of Uttar Pradesh, India. SAHAYOG, an organization based in Uttar Pradesh, partnered with a grassroots women's forum to inform women about their entitlements, to publicize the project, and to implement a toll-free hotline where women could report health providers' demands for informal payments. Between January 2012 and May 2013, the hotline recorded 873 reports of informal payment demands. Monitoring and evaluation revealed that the project enhanced women's knowledge of their entitlements, as well as their confidence to claim their rights. Anecdotal evidence suggests that health providers' demands for informal payments were reduced in response to the project, although hospital and district officials did not regularly consult the data. The use of technology accorded greater legitimacy among governmental stakeholders. Future research should examine the sustainability of changes, as well as the mechanisms driving health sector responsiveness.

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Competing interests: None declared.

Background

This article describes an innovative project aimed at enabling rural women to use mobile phones to document violations of maternal health entitlements and at leveraging that data for advocacy in Uttar Pradesh (UP), India. The project was undertaken in the context of growing recognition that maternal mortality and poor-quality maternal health care—including coercive demands for informal payments—signify a governmental failure to fulfill women's right to health.[1] In the context of this article, "informal payments" are payments for maternal health goods and services that are mandated to be free. Such payments have been associated with women's dissatisfaction with health services in UP.[2] Indeed, researchers examining health service delivery in low- and middle-income countries have concluded that fears about informal payments can be a key deterrent to seeking care, as well as financially catastrophic for many families.[3]

Maternal health in Uttar Pradesh

Maternal and neonatal mortality are declining in India, but unacceptable disparities persist among states. The most recent governmental estimate for the maternal mortality ratio in UP is 292 deaths per 100,000 live births, compared to a national ratio of 178 deaths per 100,000 live births.[4] As Jashodhara Dasgupta notes, SAHAYOG and its allies have termed maternal deaths and related ill-health a violation of "women's right to maternal health."[5] To promote skilled attendance at birth and reduce mortality, the government of India has launched several initiatives, including Janani Suraksha Yojana (JSY) in 2005 and Janani Shishu Suraksha Karyakram (JSSK) in 2011. Both are intended to boost the percentage of women who deliver their babies in a health facility; JSY even provides cash incentives to women to give birth in facilities.[6] However, Dasgupta has questioned the efficacy of the JSY approach, noting that for 20 cases of adverse maternal health outcomes documented by civil society groups between 2005 and 2007 in UP, the standard of obstetric services in public hospitals available to the poor was inadequate to save their lives, while demands for informal payments were fairly high.[7] JSSK is intended to address "high out of pocket expenses" and complement JSY by ensuring free delivery, including free clinical care, medications, and Caesarean sections; free food during stays in facilities; free blood; and free transportation to and from health facilities.[8]

Despite the normative policy acknowledgment of the unfair costs borne by the poor, JSY and JSSK have had a limited impact on the ability of poor communities to be recognized as genuine rights-holders and to be able to exercise their rights or claim state accountability for ensuring them. As Alicia Yamin notes, social relations constitute structures of choices, a case in point being entitlements conferred on poor women in contexts where they are often not seen, and do not see themselves, as worthy of having rights.[9] Provider-patient relationships are also deeply influenced by social contexts, and the social and economic status differences between providers and service users affect the capacity of poor users to obtain good-quality and respectful services.[10] The poor are at greater risk of being obliged to pay bribes in order to be seen by a health professional, of not receiving appropriate treatment, and of being humiliated by service providers.[11]

SAHAYOG is a development organization that has been working in UP since 1992 on women's health and rights and gender equality using human rights frameworks. Since 2004, SAHAYOG, in partnership with community-based organizations, has documented several instances of pregnant women being harassed for informal payments when going to hospitals during labor.

When JSSK was launched in 2011, the principal secretary of health and family welfare of the government of UP sent a formal letter to several international and national development organizations inviting them to provide monitoring and feedback on its implementation.[12] In response, SAHAYOG partnered with community-based organizations and a grassroots women's forum called Mahila Swasthya Adhikar Manch (MSAM) in UP, as well as with the Averting Maternal Death and Disability Program at Columbia University, to develop the campaign Mera Swasthya, Meri Aawaz (My Health, My Voice). Mera Swasthya,

Meri Aawaz was a pilot project aimed at tracking informal payment requests in two districts of UP. The campaign informed women about their entitlements to comprehensive free maternal health services and provided a toll-free hotline to allow women to report demands for informal payments. The hotline recorded reports of informal payment requests using interactive voice response technology on mobile phones. The reports were then plotted against each health facility on a map and displayed online, providing real-time data on the number (though not the rate) of informal payment requests. It was assumed that if women were armed with knowledge about their entitlements and equipped with a confidential mechanism to report harassment for informal payments, they would be able to realize their rights to free maternal health services. This article describes the pilot; contextualizes it in the broader fields of global health, human rights, and social accountability; and summarizes the lessons learned. The lessons emerged from a midterm and final evaluation conducted by SAHAYOG in collaboration with the Averting Maternal Death and Disability Program.

Human rights-based approaches, transparency, and accountability

Mera Swasthya, Meri Aawaz builds on several key trends in development. Transparency and accountability work is based on the premise that information can empower citizens and spur greater governmental responsiveness and accountability. In particular, *social* accountability entails civic engagement in demanding accountability. Though explicit links between human rights and "social accountability" projects are somewhat rare in the literature, social accountability campaigns often adopt human rights-based approaches (HRBAs) and promote the fulfillment of human rights. Specifically, they may involve the community in identifying priority issues and implementing activities, provide information and support for rights claiming, and foment collective action among the most excluded.[13] Moreover, in addition to employing a rights-based process, the goal of many social accountability campaigns is the realization of human rights—from the right to information to rights to public goods, such as education and health care. As rights-holders, citizens demand improved services from the duty-bearers, the government.[14]

As the field of social accountability matures, several lessons have emerged. Those that are most relevant to Mera Swasthya, Meri Aawaz include the supreme relevance of context: the effectiveness of particular strategies depends on the organizational, community, and governmental context.[15] In particular, while information may be necessary, and having access to information about governmental efforts to respect, protect, and fulfill human rights is in itself a right, transparency and monitoring may not be sufficient to effect change in the quality of health services.[16] Information is more likely to drive change if citizens perceive the information as actionable and if there are complementary activities targeting the government's incentives or capacity to respond.[17] In addition, information and preferences gathered via information and communication technologies must be explicitly presented to decision-makers. Simply aggregating crowd-sourced information and putting it in the public domain is inadequate; an individual or organization needs to proactively engage those with decision-making power.[18] This engagement of the government should go beyond the implementation of bounded social accountability "mechanisms" by using multipronged, context-sensitive strategies to create an enabling environment for change.[19] Lastly, citizens can be constrained by the risks entailed in expressing their voice and preferences. Risk may particularly affect the vulnerable, as they have the most to lose from challenging the power structure that—while exploitative—provides the local resources on which they depend.[20] For this reason, social accountability tools may be more inclusive and effective when they provide anonymity.[21]

JSY implicitly accepts the notion that poor maternal health indicators in India are primarily a demand-side issue: too few women give birth in health facilities because of their lack of knowledge, women's lack of power over the use of household funds, and the high opportunity and financial costs of going to a facility. JSY's approach suggests that the

problem can be rectified by giving women money. However, SAHAYOG has witnessed how poor quality of care, as defined clinically and non-clinically (for example, poor interpersonal communication, denial of care, disrespectful treatment, demands for informal payments, and the failure to provide basic clinical information to patients and families), undermines maternal health rights.

The Mera Swasthya, Meri Aawaz project

The Mera Swasthya, Meri Aawaz pilot project was developed to test whether a free telephone hotline connected to Ushahidi (www.ushahidi.com)—an open-source data management system that aggregates and displays data—could be tailored for illiterate women and used to monitor demands for informal payments.[22] The implementers also sought to understand how the project could inform and strengthen grassroots advocacy efforts around maternal health, how it could affect women's ability to claim their rights to maternal health care, and whether scale-up was feasible. To that end, it documented factors that contributed to success and failure, the project's adaptation over time, challenges, and remaining questions.

The project, which lasted from January 2012 to May 2013, was funded by the MacArthur Foundation. It was located in two districts—Azamgarh and Mirzapur—situated in India's northern state of UP. Azamgarh has a population of 4,613,913, with a literacy rate of 61% among women.[23] Mirzapur has a population of 2,496,970, with a literacy rate of 57% among women.[24] Together, the districts comprise about 3% of UP's population.

Partners involved in implementation

- *SAHAYOG*: Mera Swasthya, Meri Aawaz was managed and implemented by SAHAYOG, an organization that promotes gender equality and women's health from a human rights perspective by strengthening partnership-based advocacy. SAHAYOG is based in Lucknow, the capital of UP, and maintains an office in New Delhi.
- *Community-based organizations in Azamgarh and Mirzapur Districts*: One organization in each of the two pilot districts (Gramin Punarnirman Sansthan in Azamgarh and Shikhar Prashikshan Sansthan in Mirzapur) worked to promote the hotline, educate communities about their entitlements to free services, and provide technical support to women making reports to the hotline. SAHAYOG has partnered with these organizations in various maternal health accountability projects over several years.
- *Mahila Swasthya Adhikar Manch*: One of the main pillars of SAHAYOG's work in UP is its longstanding partnership with the Women's Health Rights Forum, known in Hindi as Mahila Swasthya Adhikar Manch. MSAM was created in 2006 by community-based organizations, including those involved in Mera Swasthya, Meri Aawaz. These organizations and SAHAYOG provide technical support to MSAM through an ongoing mentorship relationship. MSAM comprises approximately 1,000 poor, rural women leaders from Dalit, Muslim, and tribal communities. Prior to their engagement in MSAM, these women were uninformed about their rights and entitlements, hesitant to claim what had been promised by the government, and easily browbeaten by local officials and providers operating with a sense of impunity. SAHAYOG and the other organizations have enabled a process of "conscientization," informing MSAM members about their entitlements and building their capacities to claim them from the government.[25]

Over the past several years, MSAM women have leveraged this knowledge to engage in systematic monitoring and advocacy on various topics, such as corruption in the appointment of community health workers (ASHAs), and the timely payment of JSY incentives. In addition, they undertake awareness-raising, monitoring, and advocacy on other issues that are important to the community, including food security, livelihoods, and nutrition. Many members of MSAM have also successfully

competed in local council (*panchayat*) elections. While state-level systemic change remains elusive, there have been noticeable improvements in the provision of health services in villages where MSAM is active. MSAM members identified informal payments as a priority issue, providing the initial impetus for Mera Swasthya, Meri Aawaz.

Setup

The Mera Swasthya, Meri Aawaz reporting system is built around Ushahidi, which is used to crowdsource information from multiple sources, including text messages and social media. The project uses interactive voice response, in which an automated voice system guides women through the process of making a report. This is essential to the success of the project because many users are unable to read or write text messages. Technical support was provided by the Feminist Approach to Technology, a nongovernmental organization based in India.

The system works as follows: Women call the toll-free hotline to report having been asked to pay informal payments at a hospital. Each hospital in the project's districts is assigned a four-digit code. Callers are asked to enter the hospital's four-digit code as well as additional codes corresponding to the amount and purported justification for the payment (for example, "Press 2 if money was requested to pay for drugs.") The information collected is then mapped in an Ushahidi installation and can be viewed at www.meraswasthyameriaawaz.org. Callers reporting emergencies are immediately routed to a live person; the emergency line is staffed 24 hours a day by a representative of the partnering community-based organizations.

Promotion of the pilot

To inform residents of Azamgarh and Mirzapur about their entitlements and the project, SAHAYOG and the participating organizations implemented an extensive awareness-raising campaign. They began by holding district dialogues (launch events) in December 2011. They then distributed brochures, posters, fliers, and stickers with information on entitlements and how to register a complaint. In addition, they organized street plays, wall writing, and community meetings.

Government engagement

The government of UP has taken steps to increase civil society input in recent years, including the aforementioned formal request to SAHAYOG and other organizations to monitor the implementation of JSSK. SAHAYOG thus framed Mera Swasthya, Meri Aawaz as a government-supported program, facilitating high levels of participation by local officials in launch events and facilitating SAHAYOG's presence in hospitals.

Throughout the pilot, SAHAYOG and the community-based organizations regularly met with government officials from the block level (a subdistrict unit) up to the state level. These meetings included the pilot's launch, a midterm review, and final dialogue; 35 individual meetings with key health officials and providers in both districts; and six meetings with state-level officials in Lucknow.

Evaluation methods

To assess the acceptability and effectiveness of the pilot project, SAHAYOG developed a monitoring and evaluation plan. This plan included several components. First, a series of focus group discussions among MSAM members and other community members was conducted at the start, halfway point, and end of the pilot project. Narrative summaries from these discussions covered topics such as the experience of being charged informal payments, awareness of the project, utilization and opinions of the hotline, power dynamics between communities and the health system, and the evolution of actions and strategies used to challenge informal payments.

In addition, halfway through the pilot, SAHAYOG collected "most significant change" stories from women to document if and how the project had affected their lives and communities. Most significant change is a participatory method that entails soliciting personal stories from project participants

about any changes they had experienced and then creating a panel of stakeholders to discuss which of these changes are most significant.[26] SAHAYOG also conducted 12 in-depth interviews with district- and facility-level authorities from both districts to document the government's perspective on the frequency and relevance of demands for informal payments and to hear about governmental use of the reporting maps and any action taken to reduce demands for payments.

Another source of data included workshops and district-level dialogues that were held throughout the project to advance project objectives. These events were recorded and analyzed.

The core quantitative data came from the Ushahidi platform. Throughout the pilot, SAHAYOG continuously monitored the number of reports and their sources, and periodically discussed the results with the community-based organizations and MSAM members. The reports and maps were accessible in real time to anyone with an internet connection. The qualitative data collected through the focus groups, "most significant change" workshops, and district dialogues provided context on and insight into reporting patterns that could be seen in the quantitative data.

SAHAYOG's monitoring and evaluation attempted to assess the feasibility of the technology and the basic project model, as well as to discern impacts on society, the state, and state-society relations. Although the methods employed yielded useful insight, they were ultimately plagued by the same attribution challenges that typically affect evaluations in social accountability efforts and HRBAs. Evaluation tools, particularly those used within and for a specific time frame, have a limited capacity to capture the iterative nature of social accountability campaigns, as well as to measure important impacts like empowerment, changes in the structures that give rise to rights violations, and changes in relationships between the government and citizens.[27] Also, many successful efforts to foment change are led by multiple actors at multiple levels. Capturing these activities, their impact over time, and the elements that actually lead to success is not an easy endeavor.[28]

Moreover, due to funding and time limitations, the evaluation was not designed to measure change in the prevalence of informal payments as a result of the project. A quantitative evaluation approach focused on the prevalence of informal payments—such as a cluster randomized trial or a pre- and post-project survey of the prevalence of demands for informal payments—is theoretically possible but would be quite expensive (since it would necessitate a large random sample), and it would not uncover *how* change is effected or the extent to which important human rights goals like empowerment and structural change are being realized.[29] Instead, the project's monitoring and evaluation efforts assessed the process of implementation and relevant contextual factors, leading to findings that have since informed scale-up and that will form the basis for upcoming in-depth implementation research.

Project process and results

Daily operation

Between January 2012 and May 2013, the Mera Swasthya, Meri Aawaz hotline recorded 873 reports of informal payments. Reports came from 22 government health facilities in Azamgarh and 18 government health facilities in Mirzapur; reports in both districts were from district hospitals, community health clinics, and primary health clinics.

The implementing community-based organizations in Azamgarh and Mirzapur do not work throughout both districts; their work with MSAM is focused on three blocks per district (each block has an approximate population of 100,000). Nonetheless, insofar as possible, SAHAYOG and the organizations also tried to conduct campaign activities outside these blocks. Data were disaggregated in order to understand whether there was any difference in reporting patterns due to the stronger presence of MSAM. In both districts, reporting was proportionally higher in blocks with an active MSAM presence: 41% of all reports came from the six blocks with this presence. The remaining 59% of reports came from 31 blocks without MSAM presence.

As shown in Figure 1, almost half (44%) of all reports concerned payments made for food or for transportation to and from first-level facilities (community health clinics and primary health clinics). One-fifth (20%) of reports were for payments for medicines, diagnostic tests, or supplies, such as gloves and soap. Another 20% were for ambulances to secondary- or tertiary-level facilities. Nearly 60% of all payments reported to the hotline were for amounts over Rs. 500 (about US$8).

During the pilot period, 31 emergency calls were made to the hotline. These calls were made when health professionals refused to admit women into facilities or when pregnant women were asked for payments as a precondition to receiving treatment (most requests for payments come after the services have been rendered). In these cases, the hotline representative immediately contacted a senior health official in the district, who intervened to ensure that the emergency was addressed.

Project challenges

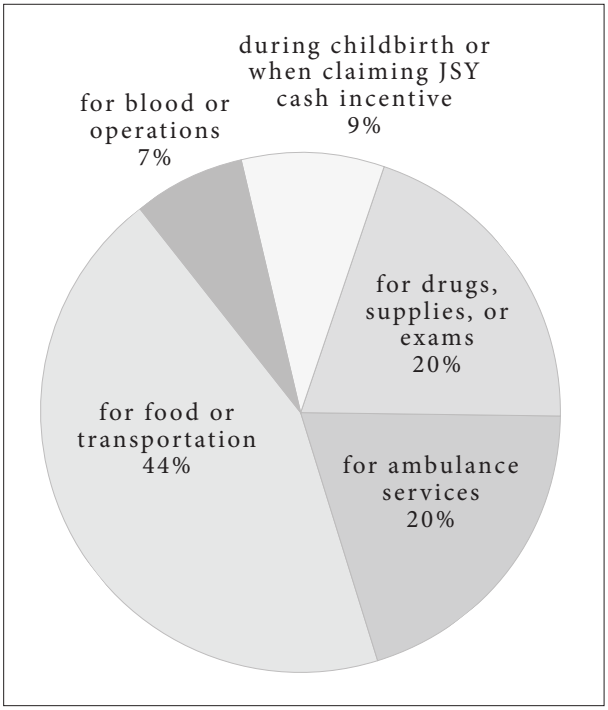
The midterm and concluding interviews with health officials revealed that the maps displaying informal payment reports were not viewed or used as frequently as had been hoped. Managers at the district level had access to computers and the internet, but they reported that they did not view the data on a regular basis. For most, the only time they viewed the maps was when they were presented at Mera Swasthya, Meri Aawaz workshops. Women in the two districts had no access to the internet or computers and thus almost never saw the maps.

During the midterm workshops, some women reported experiencing difficulties in using the hotline. Mobile phones, while widely available at the household level, were not frequently used by women. In addition, while women had no trouble understanding the words spoken on the interactive voice responses, the system was difficult for some to use because there were many codes from which to choose. The community-based organizations assisted women by showing them how to use the phones and helping them troubleshoot when they experienced problems. Halfway through the pilot, based on women's responses during the midterm workshops, the number of interactive voice response options was reduced to simplify the system. By the end of the project, women reported fewer problems.

Initially, only one phone line was used for the hotline. Thus, as reported during focus group discussions, some women received a busy signal when trying to call. Though they were counseled to keep trying and to call the community-based organizations if they experienced too much of a delay in making a report, some grew discouraged after multiple tries.

Despite some challenges in making reports, women reported in the focus groups that the hotline was useful because they could make reports anonymously and because the data collected through the system provided proof that informal payments were being demanded, but without naming and shaming particular health providers. Women therefore felt that they could safely return to the health facility to seek services without retaliation. This feature was key for users, since, in the past, women lodging complaints through official mechanisms were sometimes confronted by the health worker in question.

FIGURE 1. Types of payments requested between January 2012 and May 2013



Women also appreciated seeing a record of their report, which they were shown during the workshops. With earlier written complaints lodged by some women, the process seemed uncertain: papers were passed from one person to another, and women never knew the ultimate recipient (or outcome) of their complaint. With Mera Swasthya, Meri Aawaz, they had more confidence that their report was being seen, since it was always available online.

As part of the campaign, women were told that making a report to the hotline would not ensure that they got their money back. Indeed, some were frustrated by the lack of possibility for individual redress. Despite this, MSAM members remained motivated to be part of a movement seeking to stop informal payments, regardless of whether immediate remedies were possible.

Knowledge and empowerment

During focus group discussions and the "most significant change" workshops, women reported that Mera Swasthya, Meri Aawaz fostered knowledge and empowerment. Many had previously felt obliged to make informal payments out of fear of being neglected or abused if they did not. They felt that the demands for payment were made because providers knew that the women were illiterate and poor and could not or would not file a complaint. As one woman from Mirzapur stated during a focus group, "They don't ask for money from people who are educated and well informed. We are poor, we don't have information. They know we will give whatever they ask for."

The community-based organizations explained that the hotline helped women feel more powerful and hopeful that they could end the harassment routinely encountered in government facilities. One organizational partner in Mirzapur felt that the hotline was especially useful given that many of the women are illiterate: "Our women don't know how to write, so earlier they would have to get someone to write out applications on their behalf and to record cases that they wanted to complain about. But this hotline has removed that barrier because women can now use the phone to register their complaint, and this has increased their sense of independence."

The awareness-building campaign was crucial. In focus group discussions, women repeatedly referred to the importance of the Mera Swasthya, Meri Aawaz pamphlet that had been distributed by the participating organizations. The pamphlet's details regarding maternal health entitlements, along with the toll-free number linking them to people outside of the facility, empowered women to advocate for themselves. They reported that in some cases, merely showing the providers the pamphlet was sufficient to avoid having to make an informal payment.

By the end of the project, MSAM members were known for challenging informal payments. Therefore, some primary health clinic staff stopped demanding informal payments once they knew that the woman was in some way affiliated with MSAM. The staff tended to treat women better in such cases; as a woman from Azamgarh described during a midterm focus group discussion, "The [community health worker] told the staff that I am a member of the MSAM. Hearing this they treated me very well and did not ask for any money at all."

Government response

It is important to note that we could not draw conclusions on the changing rates of informal payment requests. This is because there was no baseline and because fluctuating rates in reporting could be due to factors other than actual changes in the frequency of payment demands (such as waxing and waning community buy-in, variation in the extent of campaigning, and changing levels of entitlements awareness).

At the start of the project, government officials and district-level health officials acknowledged informal payments in health facilities but did not prioritize tackling the problem. The project was well received by these officials. In interviews, many officials stated that the data from the Ushahidi platform could be used for better monitoring and for taking action against facilities where informal payments were being demanded. While most government officials reported not looking at the map

or website outside of the SAHAYOG-organized dialogues and workshops, we learned in the most significant change workshops and interviews with community-based organizations that some government-led action resulted from the project.

One example comes from Azamgarh. Through focus group discussions with MSAM women, we learned that following a block-level sharing of the Mera Swasthya, Meri Aawaz data, government officials took immediate action to remedy problems identified at one facility, including by fixing the water supply, improving electricity, providing free medicines, and offering food to women in the hospital following delivery. In addition, staff behavior toward women improved. The additional director of the Azamgarh District stated that the act of registering complaints was very important and that the Ushahidi data was useful because it made officials realize the enormity of the problem. Our analysis of the reporting patterns showed that the number of reports made about this particular facility dropped from an average of 18 reports per month before the block-level dialogue (January to November 2012) to 3 reports per month after the dialogue. The comments of the additional director and others lead us to believe that this decrease in reports was likely because requests for informal payments decreased. In this case, the dialogue was a catalytic event, as it triggered positive changes that included not only reductions in demands for informal payments but also improvements in staff behavior and infrastructure. The success of this dialogue also provided a boost to the MSAM women's confidence in their ability to effect improvements in their health facilities.

Discussion and lessons learned

The evaluation provided clear lessons relating to the project's daily operation and impact. Larger questions remain about how to better foster institutional response to the data and whether the project will yield long-term improvements in the protection of women's maternal health rights. After some adjustments, the project continues to operate in the initial districts, as well as in two scale-up districts. This continuation will allow us to tackle some of the larger impact questions in the future, through both research and routine monitoring.

Operation of the technical components

Not immediately reaching the interactive voice responses (in other words, getting a busy signal) when calling the hotline is a critical obstacle that must be addressed. Thus, SAHAYOG now maintains one hotline number hosted through multiple phone lines, ensuring that callers never hear a busy signal.

The project has also installed a landline, as well as fast and stable broadband connections, ensuring that the hotline is always operational. Finally, as noted above, SAHAYOG has decreased the number of interactive voice response options, making the system easier to navigate.

Importance of campaigning and having a trusted presence on the ground

Women need to know their entitlements and be motivated to report, even if individual redress is unlikely. Informal payments for services are widespread and normalized in UP. Despite the fact that these payments often deter women from seeking care, women may not think that the situation can be changed. In this context, informing women about their entitlements and the project is essential—as is support, both technical and moral, in using the hotline.

There was low (or no) reporting in some areas, and reporting frequency varied over time. Geographic variation within the pilot districts was almost certainly due to the presence (or absence) of MSAM. Women in MSAM areas know their entitlements and are thus more likely to report violations. Moreover, MSAM members continuously inform women in the community about the hotline and support them in using it. In an effort to encourage reporting in non-MSAM areas, SAHAYOG and the community-based organizations engaged a campaigner, which resulted in a marginal increase in reporting from these areas.

MSAM has worked on a range of issues over many years, building trust and expectations about

governmental obligations for service delivery among women in the community. Because of its efforts, women in the community have identified deficits in governmental service delivery and have advocated for better services at the local, district, and state levels. They understand the potential utility of making complaints, even when an immediate remedy is unlikely. Women in MSAM areas may also feel somewhat protected by the MSAM organization, as MSAM women have significant rights literacy and can help women navigate bureaucracies. For example, they often accompany women during labor and delivery in local health facilities. The importance of MSAM's long-term presence points to the relevance of impact evaluation methods that can capture changes over the long term, as well as the likely contribution of efforts that are outside the project in question.

Indeed, by the end of the pilot, SAHAYOG concluded that it should have put more resources into campaigning, perhaps by hiring more campaigners in each district who could have had responsibility for specific blocks. SAHAYOG had initially engaged only one campaigner per district, with a SAHAYOG team member as a supervisor. Due to the geographic distances and problems with transportation and security, it was difficult for the campaigner to reach all blocks within the district, particularly blocks where the community-based organization was not present to facilitate the person's entry.

Government response

SAHAYOG's interactions with district officials and hospital managers were largely positive. These individuals seemed to interpret Mera Swasthya, Meri Aawaz as a project that helped them accomplish their goals, rather than as an adversarial outside intervention. However, hospital managers and district officials appeared to not regularly refer to the online real-time feedback on the informal payments being demanded at specific facilities, despite their overall insistence that this information was useful and the fact that the National Rural Health Mission had formally requested SAHAYOG's assistance with JSSK monitoring. Regardless of an official governmental commitment to monitoring informal payments, it could be that individual district and block officials were reluctant to actively oppose informal payments, potentially because they were closer to those who benefit from and rely on these payments. It could also be that district officials are already overwhelmed with essential routine tasks and that looking at the map of informal payment requests was not considered essential.

At the same time, the fact that these individuals did not consult the data does not mean that the data did not affect their behavior; it is possible that their knowledge of the data being online influenced them.

The degree of government responsiveness may also relate to norms around data use in the Indian public health system. Public health research has shown that using data for decision-making is poorly entrenched at the facility level in India. In general, facility- and district-level officials collect data to report on targets to their supervisors, not to guide local-level priority setting. In this context, their engagement with and use of the Mera Swasthya, Meri Aawaz data would be novel. Indeed, an assessment of transparency policies found that effective policies were those that integrated new information into existing decision-making routines.[30] Mera Swasthya, Meri Aawaz produces new information, but there are no local level decision-making routines in which the information can be integrated.

Over the long term, government responsiveness—or lack thereof—may affect community commitment to the project. Particularly in the case of an information and communications technology project, users might have high expectations for responsiveness.[31] If they do not see results, they may discontinue reporting.

Did it matter that this is a "technology project"?

A sober approach to information and communications technology is warranted. By itself, this technology cannot effect the shifts in rights consciousness, power, and incentives that are necessary to end informal payments. Moreover, like any other input, this technology is just a tool. Users must know that a violation has taken place, be taught how to use technology to report the violation, be

motivated to use the technology, and feel safe using it—and the technology needs to function. All of this is part of a larger strategy to actively claim rights. At the same time, Mera Swasthya, Meri Aawaz added value to previous efforts in that it aggregated complaints, in contrast to traditional narrative forms of human rights reporting. The platform used was appropriate for that aggregation, and the fact that it is online conferred a level of credibility that, at least for now, seemed to make it more persuasive to the intended audience.

Earlier efforts to combat informal payments involved complaints about specific providers, which were often seen as faultfinding. In contrast, Mera Swasthya, Meri Aawaz has the objective of system correction. No particular provider is the target. Instead, only the facility is identified. As a result, accountability lies with the people in charge of the facility and those higher up in the health system. Often, the person requesting the payment is at the bottom of the health facility hierarchy. This person may be requesting money in order to redistribute it to others, and thus individual providers are not always appropriate targets of accountability efforts. Moreover, facility-, block-, and district-level data can be presented as health system performance data, and thus used as a basis for making systems improvements. Use of the Ushahidi platform made this data aggregation easier, as the system is automated.

SAHAYOG and the community-based organizations found that district officials were more willing to listen to them and took them more seriously than in the past. This may have been partly due to SAHAYOG's official role in monitoring JSSK, but SAHAYOG felt that it was primarily because the organizations were bringing what were perceived to be systematic data, rather than just anecdotal stories. The fact that the data were on the internet convinced officials— not just because the data were publicly accessible (and thus a means to shame them) but also because the internet is associated with elite knowledge and access. In brief, documenting payment demands in real time and aggregating the data online appeared to increase governmental willingness to attend to rights claims.

Conclusion

Change at both the individual health provider and the systems level is needed to end informal payments and, ultimately, to fulfill poor women's right to health. It appears that Mera Swasthya, Meri Aawaz contributed to changes at both levels. The evaluation methods used in this pilot produced a rich description of the acceptability and effects of the project interventions and provided useful information to inform replication and scale-up. Meaningful changes in the way that women were able to take an active role in monitoring informal payments and transparently share this information, as well as a shift in the power dynamics between these women and the health system, were described and documented, though attribution to the pilot interventions is difficult to prove.

More time and more rigorous evaluation are required to assess the sustainability, mechanisms, and contexts for changes at the individual and systems levels. The pilot and evaluation described here helped lead to project improvements and the development of a more in-depth research approach for project expansion. Our upcoming research will use ethnographic methods, including observations of health facilities, and will hopefully indicate how—and under what conditions—providers change their behavior in response to Mera Swasthya, Meri Aawaz. We will use an iterative process that enables us to detect and then explore why there are more improvements in some facilities than others. Moreover, since the project has been ongoing for several years, this research will provide insight into the arc of change over time, as well as the likely relationship between campaigning length and intensity, support from community organizations, district-level leadership, other human rights efforts in the domain of health, and impact. This research will also employ a comparative approach (analyzing similar projects in India and elsewhere) to better understand state responsiveness. Under what conditions do health officials use the data generated by the project to foster meaningful change in health rights on the ground? While this research will still not be able to provide a precise measurement of project impact on the prevalence of informal payments, it will offer

greater insight into how and when efforts like Mera Swasthya, Meri Aawaz can lead to improvements in maternal health rights.

Acknowledgments

Mera Swasthya, Meri Aawaz benefited from the expert contributions of Lynn P. Freedman, Gayatri Buragohain, and Aaron Huslage. Rajdev Chaturvedi from Gramin Punarnirman Sansthan in Azamgarh and Sandhya Misra from Shikhar Prashikshan Sansthan in Mirzapur were crucial to its implementation and evaluation.

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