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Brief Communication

Strengthening Social Accountability for Better Maternal Health Outcomes in Nepal

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ABSTRACT

Social accountability (SA) plays a significant role in strengthening health systems to deliver quality healthcare services, particularly in low-middle-income countries. In Nepal, SA approaches in the health sector have principally included citizen charters, social audits, and maternal and perinatal death surveillance and response components. SA has the potential to make a significant contribution to building a robust health system. However, its potential remains far from being realized. In this commentary, we briefly discuss the potentials as well as gaps with respect to the implementations issues concerning the citizen charter, social audit, functionalization of quality assurance committee, Maternal and Perinatal Death Surveillance and Response (MPDSR), and the role ambiguity of federalism. Addressing these barriers and constraints could make SA more effective in improving maternal health in Nepal.

Keywords social accountability, maternal health, health system, governance, quality of services, Nepal

BACKGROUND

Social accountability (SA) refers to an approach that aims to hold those in power and duty bearers accountable to citizens for their behavior and performance through civic engagement where individual or civil society organizations can directly or indirectly demand accountability and enforcement.[1] SA approach includes multifaceted process that combines a variety of tactics, promote group actions and citizen's voice alongside governmental reforms that increase public sector responsiveness to achieve the more promising results and outcomes.[2] It has been found that implementing the SA mechanism can strengthen governance, leading to more effective development by empowering stakeholders and strengthening service delivery.[3,4]

In the context of health system, various SA approaches and tools have been used in low-middle-income countries (LMICs) to improve public access to information, increase transparency, strengthen health system governance and involve the public in the decision-making process. In South and Southeast Asia, tools such as citizen charters, online information platforms, information desks, and awareness campaigns are widely used to facilitate citizen access to information and enhance government transparency. While approaches like social audits, public hearings, citizen report cards, community score cards, and complaint and grievance handling have been commonly used in these regions to strengthen government accountability and integrity. Similarly, to increase community participation in decision-making processes the participatory planning and participatory budget planning are mainly used SA approaches in the Asian contexts.[2] In Nepal, the World Bank has identified 21 SA tools and approaches that have been used by the government and development partners to strengthen public system governance to improve access to and service quality of the sector such as health, education, agriculture etc.[5]. In Nepal's health system, SA has been used to ensure client right to information, improve quality of care, give voice to community stakeholders, improve service efficiency and client satisfaction.[2,5,6] SA has also been found to be an effective strategy to improve maternal health, particularly in low resource settings.[3,7,8]

In 2009, the UN Human Rights Council recognized maternal mortality as preventable deaths and considered it a human rights violation. In line with this framework, SA is emphasized as critical to ensuring equitable access to quality maternal health services, shared by both the state and its citizens. As a result, the quality of care improved in developing countries and documented a remarkable reduction of maternal mortality by 2015.[9] With the enthusiastic outcome, world leaders committed to reducing the maternal mortality ratio (MMR) to 70/100,000 live births by 2030 and set it as sustainable development goal (SDGs) target. In commitment to reduction of maternal mortality, quality of care is emphasized widely and to make sure it will be available at all levels of care, SA approaches are adopted as a key intervention.[9] Despite global commitment and efforts, progress remains unevenly distributed across the world, highlighting the persistent disparities in achievement.[10] The SDG target remains elusive as the world has already covered two-thirds of the SDG miles, but the global MMR is reported at 223 deaths per 100,000 live births in 2020. Since 2016, the global progress in reduction of MMR is stagnant. The reported stagnation in MMR is a critical concern: estimated 287,000 women died from causes related to pregnancy, childbirth, and the postpartum period in 2020 alone. The preventable deaths of nearly 3 million women between 2010 and 2020 are not just a global tragedy, but also an indication of health disparities within and between countries and violation of human rights.[11] Although the global causes of maternal mortality are associated with direct biomedical causes, health system deficiencies leading to delays in access to care, inadequate quality of healthcare services, shortages of medical supplies and personnel, and lack of responsiveness are distal factors directly

associated with poor health governance.[11] Furthermore, social determinants such as women's socio-economic status, harmful cultural norms, gender disparities, limited access to sexual and reproductive health services, as well as broader issues like political instability and the fragility of health systems, also contributed to the challenge of maternal mortality.[10,11]

MATERNAL MORTALITY SITUATION IN NEPAL

Government of Nepal has prioritized maternal health as a national priority program, recognizing it as a crucial component of development. In line with the global MMR target, Nepal has also committed to reduce MMR 70 per100,000 live births by 2030.[12] However, in 2021, the MMR stands at 151 per 100,000 live births, marking an 83% reduction from the 1990.[13] Despite previous progress, data from the recent time period indicates a slowdown in the pace of decline, implying that it will be difficult to achieve the target of an MMR of 70 by 2030.[14–16]

Aside from the concern regarding the recent pace of the overall decline in MMR, disparities persist in the range of MMR varying from 98 to 207 per 100,000 live births in provinces.[13] Most maternal deaths in the country are reported in the postpartum period (61%), while 33% occur during pregnancy and 6% during childbirth. Furthermore, a significant proportion of these deaths (57%) take place in health facilities, while 26% at home.[13] Preventable maternal deaths continue to occur in health facilities, often linked to various delays, indicating a lack of quality services, poor referral management and deficiency of early screening of complications.[13] Like global cause of maternal deaths, in Nepal also majority of maternal mortalities are associated with direct obstetric causes which are proximal factors, however, the maternal ill-health is not only medical problems, but also a societal issue and is the outcomes of a complex interplay between eco-social factors, lifestyles and exposures, and individual-level factors.[11,12,17] Globally, much has been invested in addressing the primary biomedical causes of maternal death, particularly during the perinatal period with less focus on addressing the underlying determinants of adverse pregnancy and childbirth outcomes. It is therefore a need to explore how health systems can be structured to deliver effective interventions and mitigate the negative impact of social factors on maternal health.[18]

A global review on determinants of maternal mortality[11] has concluded that the health system provides a crucial opportunity to interrupt the chain of events that can potentially end in maternal death. For example, healthcare services and commodities, such as quality-assured uterotonics used to decrease postpartum blood loss in an anemic woman during childbirth, have the potential to mitigate the impact of eco-social influences that contribute to negative maternal health outcomes. Thus, the health system can be considered as a critical protective factor, capable of mitigating or reducing the impact of harmful risk factors. Insufficiency in quality of care in Nepal are often exacerbated by weak health system governance which are furthermore result of the inadequate SA measures or poor implementation of SA to improve system governance.[19–21] Persistent concerns [2,22–24] regarding transparency, corruption, and service quality further making these challenges worse.

SOCIAL ACCOUNTABILITY APPROACHES IN MATERNAL HEALTH IN NEPAL

In Nepal, a range of SA tools and mechanisms have been introduced to improve maternal health, and these include complaint boxes, social audits, maternal and perinatal deaths surveillance and response (MPDSR), citizen charters, and public audits.[25,26] The main purpose of these tools and mechanisms is to hold health service providers accountable for providing quality maternal health services delivery. Demand-side practices like the community health scoreboard and citizen report cards are designed to solicit the voices of marginalized communities and promote equity and inclusion in access to care. Additionally, oversight mechanisms such as health facility operation and management committees (HFOMC), health mothers' groups, and steering and coordination committees are established and mobilized at various levels to ensure voice of the women and marginalized communities and oversee and manage health services effectively.[12,25,27] The SA in maternal health has been shaped by the various policies and legislation of the country. The Constitution of Nepal has enshrined maternal health as a fundamental right of citizens. With the Right to Safe Motherhood and Reproductive Health Act of 2018 and its accompanying regulations, Nepal is committed to upholding, preserving, and fulfilling women's rights to safe motherhood and reproductive health services.[28] These laws aim to ensure the safety, quality, and accessibility of these services. Furthermore, the Public Health Service Act of 2018 and its regulations from 2020 recognize safe motherhood and newborn health services as essential components of primary health services.[29] In alignment with these legislative frameworks, Nepal has formulated various policies, strategies, and guidelines to guarantee that quality maternal care services are within reach, affordable, and available to all, with particular emphasis on reaching underserved populations. One such initiative is the Antenatal to Postnatal Continuum of Care Facilitation Guide 2022, which aims to safeguard the health of both the mother and the child and reduce maternal and newborn deaths/mortality rates.[12] Similarly, outcome #3 of the Safe Motherhood Roadmap 2030 emphasizes the enhancement of governance and the establishment of accountability mechanisms to drive improved maternal health outcomes in the country, ultimately aiming to achieve the SDG targets.[12]

SOCIAL ACCOUNTABILITY IMPLEMENTATION: GAPS AND WAY FORWARD IN NEPAL

There are several challenges in implementing SA in the maternal health: often due to unavailability and inadequate access to information for the community, meaningful engagement of community in SA process, weak enforceability mechanism and role ambiguity.[6,26,30,31] We reflect upon five implementation challenges of SA tools in the ensuing section.

Citizen's Charter

For SA to work better, it is essential to improve citizen's awareness by providing them information; uplift the social status of the marginalized groups and communities to voice and effective enforcement mechanism should be established to execute plan into action.[1] The Nepal Government Good Governance Act 2008, mandates that the Citizen's Charter

in health facilities must include comprehensive service details, including operating hours, personnel, fees, and compensation measures, in a manner visible to the public.[12] However, in the health sector, it was found that most HFOMCs and providers are familiar with the requirements and mandates of the citizen charters but, awareness among service users is low.[23,32] There is a lack of regular updates and complete information. Even when the Citizen's Charter is present in health facilities, contact with the focal point is often difficult, and they themselves are found to be unaware of the service provisions and mandates.[32] It is therefore important that the governments ensure that the Charter is prominently displayed in health facilities, that is updated in timely manner, and that information is disseminated through various channels. Using user-friendly inclusive technology (for e.g. considering client education, language requirements and disability status) and client's preference of accessing information. Additionally, HFOMCs should engage the community through various channels for dissemination and complaint management.[12,32]

Social Auditing

The social audit is another important SA tool employed by the government as part of the maternal health program. The social audit provides a platform for citizens to monitor the quality of health services and evaluate the performance of health facilities. Additionally, it aims to facilitate collaboration between community members and health workers to identify and rectify existing gaps.[23] Following the Local Authority Financial Administration Regulation, 2007, the Department of Health Services introduced the social audit as a mandatory measure to promote transparency and accountability of the *Aama* Programme (formerly Safe Delivery Incentive Programme) and free health care services by developing two separate social audit guidelines.[33] Most non-government organizations (NGOs) have been found to be regularly involved in auditing processes alongside civil society.[22,23,30,34] However, these NGOs that support the audit process often face unequal footing with the government, creating a power dynamic that hinders in-depth analysis of corruption and other quality concerns.[22,26,33] The reluctance of NGOs and civil society to critically review the performance of local government and health systems is frequently influenced by various factors. These include the dependency of certain NGOs on government funding opportunities, regulatory pressures imposed by the government, and the sensitivity of political dynamics surrounding such evaluations.[23,33]

Several evaluations of the social audit program have underscored the challenges posed by issues such as manipulated participation, falsification of information, and insufficient authority, which significantly affect the accountability aspect of social audits.[22,23,33] Addressing these factors is important in the development and implementation of social audit processes in order to achieve effective outcomes. However, empowering communities to supervise and implement social audit action plans may appear beneficial for establishing a partnership between the community and service providers, focusing on collaborative problem-solving effort.[30] Relational accountability is essential for building trust and responsiveness between the demand and supply sides in the health sector. Also, due to the unequal power dynamics between NGOs and the bureaucracy, the NGOs often fail to raise health system issues in front of the public disadvantaging marginalized voices. Therefore, it is important to develop and execute national SA directives in the health sector for transparent, effective, and quality implementation of SA approaches.[23]

Quality Assurance Committees

Quality Assurance Committees (QACs) have been formed at different levels (national to local) of the health system to ensure the quality delivery of maternal health services.[35] They act as an oversight mechanism for the quality improvement process, however during SA implementation they are governing bodies as well and, in most cases, answerable towards communities/service users concerns raised during the interactive process.[30,36,37] The key roles and responsibilities of these committees include discussing maternal and newborn health services with engagement of key external partners and stakeholders.[38] Nevertheless, it has been observed that the committees are not optimal in addressing maternal health issues and making recommendations for effective interventions and policy development. Meetings are scheduled based on interest and necessity rather than on a regular basis to discuss issues and address them in a timely manner, and coordinate resources and efforts to improve maternal health services.[19,37,39,40] Health planning at the local level through active citizen engagement is a crucial tool to ensure civic participation, allowing individuals and groups of people to advocate for their community's needs and push for budget allocation for maternal health programs. However, studies indicate that only a small percentage of people participate in this process, with higher involvement seen among socioeconomically privileged groups in the country.[41] Additionally, it has been noted that mostly local governments do not adhere to the seven-step planning process for annual budget development, leading to budget allocation being influenced by power politics.[24]

Maternal Perinatal Death Surveillance and Response System

The Maternal and Perinatal Death Surveillance and Response System (MPDSRS) is introduced by Family Welfare Division with the aim of monitoring and documenting all maternal deaths in real-time. The primary objectives of the program are to understand the underlying factors of maternal and perinatal mortality; and provide guidance on how to respond to and prevent future deaths.[42] Based on the lessons learned from Maternal Death Review, MPDSRS also seeks to delve into the circumstances surrounding maternal deaths. The surveillance process includes case identification, data collection, analysis of findings, recommendations for action, and ongoing evaluation and improvement of the system. The mechanism emphasized particularly on the response and action phase of surveillance to ensure that the gathered information is effectively utilized to prevent future deaths.[42] In the process of MPDSRS, one of the main tasks of the hospital/health facility management committees is to implement the action plans and the recommendations made by MPDSR committees based on cause of death analysis.[12] However, the failure to execute these action plans remains a concerning issue, often attributed to corruption and ineffective health system governance.[43] At the local level,

barriers such as poor quality of care, lack of empowerment, and insufficient community participation hinder equitable access to maternal health services.[12,21,38,44] It has been frequently noted that the HFOMC is inactive and does not fulfill its expected responsibilities.[19,36,40] The committee is key governing body of the health system, accountable for ensuring service available at their health facilities, however, the health facility survey 2021[39] shows that only half of the health facilities offer normal vaginal delivery services, and a mere 5% of all facilities mainly hospital provide caesarean section services in Nepal.

Safe delivery and the management of obstetric complications are crucial for saving women's lives in the event of complicated pregnancies, delivery and postpartum. The survey[39]also identified that only 73.4% of sanctioned post of health workers are fulfilled which indicates the lack of trained human resources in the health system including maternal health.[39] Similarly, due to frequent changes in government leadership, the management committee members of the hospital undergo recurrent changes, affecting the recruitment of health workers and the implementation of hospital plan. Additional challenges in the implementation of MPDSRS, is that the surveillance and response process specifically focus on individual mistakes, which might promote fear among health care workers around the management of obstetric emergency care resulting in reluctancy in implementing the MPDSRS at their health facility.[45] Thus, it is crucial to foster a constructive environment that addresses systemic weaknesses while offering opportunities for improvement. Nevertheless, the MPDSR system to work, as recommended by Nepal safe motherhood roadmap 2030[12], the government needs to improve the HFOMC monitoring and responsiveness for improving quality of care, and this may include putting reward and sanctions on place.

Governance and Management in the Federal Context

The constitution of Nepal has empowered local governments with authority over budgetary planning and control, semi-judicial processes, and service delivery in federal context. Additionally, it has also increased their accountability toward citizens, enhanced governance, and shared power and resources, all of which contribute to equitable, fair, and successful service delivery. Federalism in healthcare offers benefits, but it also has drawbacks because of role ambiguity of the provincial and local government, which has weakened the SA mechanism even further.[24] In the SA process, the province government's position is still unclear. Similarly, for the maternal health services, the provincial government is authorized body to operate and manage hospitals under its judiciary which are referral centers for the district and local hospitals, however due to role and responsibility unclarity and lack of coordination between local health facilities and hospitals, the referral systems are not functioning well.[12]

Despite widespread promotion of service coverage and expansion, ensuring service quality has emerged as a critical concern in maternal health, exacerbated by various health system challenges associated with federalism.[24,38] It has been observed that the coordination meeting and discussion between province and local government rarely happen to identify and agree the strategic location for birthing center and basic emergency obstetric and newborn care center development. With the delegation of the power to the local government, it has been noted that the establishment of birthing centers is often driven by political motives, lacking proper planning, budget, and infrastructure.[31] This political influence leads to a reluctance among local leaders to allocate necessary funds for the management of these centers, ultimately affecting the quality of healthcare services.[31] Therefore, the government needs to develop clear guidelines and directives for the provincial and local health government for better collaboration, accountability, and responsiveness for improving quality of care to address the delays associated with maternal deaths.[12,26,31] Similalrly, it is imperative to strengthen the capacity of local health systems to implement policies aligned with SDG.[21,38] In addition to the federal government's efforts to strengthen accountability mechanisms, identifying accountability gaps through situational analysis, and establishing monitoring mechanisms and remedies at the national level, it is essential to enforce local government to adherence to the constitutional mandates regarding SA and maternal health.

Despite recognizing the pivotal role of SA in amplifying the voices of marginalized and vulnerable communities, empowering them, and reinforcing state obligations, the effective implementation of SA within Nepal's health system remains lacking.[31] Recent studies have found that many of the existing SA measures are often superficially implemented in Nepal leaving it as a formality than embedding the process as a state mandate.[31] The action plans are often left on paper only and executions are rarely considered. Evidence shows that SA depends on a required level of administrative accountability within bureaucracy to rewards to service providers for responding citizen-user needs and sanctions for the acts that hinder system ability to deliver effective and quality services.[27] A study on SA in health system in Nepal[26] found that the health system failure to linking the SA process with administrative rewards and punishments leading SA impact questionable. Additional to failure, the weak laws enforceability is another aspect for staff accountability. The argument is supported by example of proliferation of private clinics nearby large hospitals, frequently with signboards advertising the proprietor's status as a doctor in the public hospital as a credential, these private clinics highlight the extent to which health system employees can violate official rules and norms with impunity.[23,25,30] To ensure the effectiveness of SA mechanisms, it is important for governments to prioritize citizen participation. This requires supporting and empowering civil society organizations, community groups, and movements, enabling them to effectively advocate for accountability and represent citizen interests. Additionally, given the evolving technological landscape and changing preferences in people's accessing information, leveraging technology is crucial. Mobile applications, social media platforms, and online reporting tools can facilitate real-time monitoring, data collection, and communication between citizens and government agencies, thereby strengthening SA processes and mechanisms and their impact. However, merely imposing SA system without considering the quality of the process and active civic engagement would

result in ineffective outcomes. Continuing to enforce SA tools and processes without prioritizing their quality and fostering civic engagement will yield no improvements in the healthcare system or quality of care in maternal health. Instead, it will result in a wastage of resources and ineffective outcomes.

CONCLUSION

In Nepal, SA approaches in the health sector have principally included citizen charters, social audits, and maternal and perinatal death surveillance and response components. SA has the potential to make a significant contribution towards making a robust health system. However, its potential remains far from being realized. The potentials as well as gaps exist with respect to the implementation issues concerning the citizen charter, social audit, functionality of quality assurance committees, MPDSR, and the federalism-related role and ambiguity. Further, gaps in implementation continue, including low community awareness, unequal power dynamics, and role ambiguity within the federal context. Addressing the gaps would warrant strengthening the implementation of the SA process, enhancing intergovernmental collaboration, placing judicial mandates and enforcement mechanisms, and enabling communities to actively participate in decision-making processes and above all a constructive environment that addresses systemic weaknesses and promotes collaboration.

ABRREVIATIONS

HFOMC	Health Facility Operation and Management Committee
LMICs	Low- and middle-income countries
MMR	Maternal mortality ratio
MPDSR	Maternal Perinatal Death Surveillance and Response
NGOs	Non-governmental organizations
SA	Social accountability
SDGs	Sustainable Development Goals

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