

The viability of social accountability measures



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Uttar Pradesh is one of the most dangerous places in India to give birth: this state has a maternal mortality rate that was last seen in the UK in the 1940s. In an Article in this issue of *The Lancet Global Health*, Camilla Fabbri and colleagues¹ point out that in the villages they work in, 15% of women received at least four antenatal care visits during their pregnancy, 11% were counselled on three danger signs during pregnancy, and 39% received clean cord care. A high-profile trial² that used a checklist approach to address this inadequacy of care failed, finding no improvements in birth outcomes.

Rather than work directly with providers in the public sector, Fabbri and colleagues therefore trial a different approach of bottom-up social accountability, in which community members and health-care providers were given new information on the performance of maternal and child health services, and they were invited to work together to improve care. This approach had yielded spectacular results in Uganda, showing a 25% decrease in infant mortality; subsequent research showed that the effect worked primarily because of the provision of information rather than from community participation alone.^{3,4} Yet, Fabbri and colleagues were unable to detect any effects of any of their interventions on a wide range of maternal and neonatal health outcomes, which ranged from the number of antenatal care visits, to facility delivery, to clean cord care. Information about the poor conditions of childbirth, whether given to communities, to health providers, or both, did not spur improvement.

It would be tempting—and wrong—to dismiss these null findings as an artefact of the study design or poor implementation. In fact, what makes the results of the study by Fabbri and colleagues so compelling is precisely the care they take with the sampling, the cross-sectional cluster-randomised controlled design in four groups, the large sample sizes that allow them to rule out even small effect sizes, and the careful implementation that even recorded details such as the location of every village meeting, who was in attendance, and the nature of the discussion.

It would also be incorrect to add this approach to a long list of failed improvement efforts in Uttar Pradesh, and to argue that, in Uttar Pradesh, nothing works. Research in the same setting has shown that providing

information to mothers of the benefits of vaccination had a large effect on the frequency of vaccination.⁵ The study by Fabbri and colleagues meets the standards of a gold-standard community trial and leaves little room for alternate interpretations. Community-driven accountability measures do not work in this setting, even when communities realise that the care they are receiving is dangerous.

Fabbri and colleagues therefore raise serious questions about the viability of social mobilisation approaches and community-driven accountability measures in future efforts. Their study also raises doubts that performance feedback alone can drive improvement: if health-care providers realise that the care they provide is substandard and they are motivated to do better for their patients, they should have improved.

What went wrong? The authors point to the absence of agency and resources for concrete actions, starting from vague and non-specific actions (such as “I will create awareness and talk to women”), to little understanding of how information can be used to engender change. Perhaps without a concrete plan (such as monitoring providers on a weekly basis) and external resources that can effect such a plan, information alone will not help. Although this hypothesis might be true, other information interventions have had large effects in similar settings, leading us to wonder when and how information can lead to improvement.

One hypothesis that is worth exploring relies on the insight that most people in India (including pregnant mothers) live in communities with an array of choices. For primary care, they can visit low-quality informal providers, or they can choose to travel further to more expensive high-quality hospitals, if they have the means to do so. For childbirth, a large range of private clinics and hospitals expands the choice environment beyond the closest public health-care centre.

In this environment, designs that exploit the full choice environment by providing information on several providers could improve health outcomes both by relocating patients to better providers and offering incentives for providers to improve. As one example of the power of reallocation, in the USA, increased patient flows towards better hospitals between 1996 and 2008 accounted for a quarter of the increase in 30-day

survival rates for acute myocardial infarction.⁶ And as an example of the power of increased competitiveness, a study⁷ in Pakistan that tried this approach for education found large improvements in quality and a decrease in private sector fees as providers fought to maintain their consumer base.

Fabrizi and colleagues have clearly shown that in settings like Uttar Pradesh, where the patient-provider relationship is often marked by strict hierarchy and adversity, an approach that relies on citizens' voices alone is insufficient, even when patients know that the care they are receiving is substandard. Their results therefore force us to expand our thinking of how and when information can work, opening the agenda for deeper reflection of the social environment, the choice architecture, and the role of information.

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