Voicing Aspirations to be Heard

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Abstract

Quality of maternal healthcare is one of the many pervasive public health challenges facing India. Maternal healthcare is defined as a fundamental human right and a crucial development issue by the UN, with direct links to the progress towards achieving the Sustainable Development Goals, especially reducing poverty (SDG1), ensuring healthy lives (SDG3) and achieving gender equality (SDG5). Whereas healthcare provision has traditionally been governed by a needs-based assessment approach founded on health resource utilisation data, social accountability is increasingly recognised and adopted by healthcare service providers as an approach that centres the perceptions and priorities of the recipient. There are many studies on the social accountability approach to maternal healthcare, but there is little current research on the link between aspirations and accountability in the context of low-resource maternal healthcare provision. Through the insights offered by social theorists including Bourdieu, Sen and Appadurai, this thesis examines a case study of the Hamara Swasthya Hamari Awaz campaign and the communications process it used to strengthen poor, rural Indian women’s voices and enable aspirations for better maternal healthcare. One semi-structured, in-depth interview and two secondary source interviews with campaign organisers, as well as 15 media texts and 121 social posts provided data about the campaign. The analysis revealed that the campaign used a social accountability approach, complemented by an operationalisation of the capacity to aspire approach, to: create a dialogue and information exchange with poor, rural Indian women; to amplify their voices about their priorities; and to support them to develop a capacity to aspire for, and realise that aspiration for, better maternal healthcare. By demonstrating the connection between the present and the future for these women, HSHA helped to form a platform for dialogue with traditional power-holders, leading to a sustainable aspiration-building framework for women’s empowerment on maternal health issues at the local, national and international levels.
Foreword

In my role as healthcare communications lead for a multinational public relations agency in Mumbai, I help public and private sector entities develop communications interventions that will inform, educate, empower, and encourage behaviour change on health and wellness issues. I see first-hand how the focus on the ‘blue-sky’ health systems change has a tendency to forget those marginalised populations for the sake of digitisation, or similar.

Therefore, my motivation for this thesis was to focus on those marginalised populations and explore in what ways there were programmes to help them develop a power of voice in their own health choices: to articulate what to expect, what to demand, and why it is acceptable for them to demand for more than what is usually provided to them.

I chose maternal healthcare particularly, having heard community activists, civil society organisations, international NGOs, health ministers and heads of state speak at the Partnership of Maternal, Newborn and Child Health’s (PMNCH) Partners’ Forum. India, as host country, highlighted its achievements in reducing the maternal mortality rate (MMR) in the past decade. However, India still accounts for 15 per cent of the global maternal mortality rate—around 45,000 Indian women die every year from pregnancy-related causes. India has also managed to encourage women into institutionalised births in health facilities, but this has led to overcrowding and implications for quality of care.

These consequences are serious, as Dr Aparajita Gogoi, national coordinator for the White Ribbon Alliance India (WRAI) and Executive Director of the Centre For Catalysing Change (c3) explained at the Harvard Global Maternal Health Symposium 2018. The

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1 An alliance of more than 1000 organisations working in the sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) communities, whose Secretariat is based at the World Health Organisation in Geneva.

biggest barrier to quality of maternal healthcare in India is the normalisation of women as second-class citizens. It is certainly a harsh truth, but one which Gogoi says has cemented the problem of sub-par solutions for the bottom-of-the-pyramid patient; that patient does not know what quality care looks like and so they cannot imagine, request or expect it. Yet, all women should be able to aspire to respect, dignity and quality maternal healthcare. Women are less likely to use healthcare facilities for childbirth, and therefore decrease the risk of complications and maternal mortality, if they do not receive quality, respectful care at these facilities.\(^3\)

Therein lies the conundrum in maternal healthcare in India. How do you encourage quality of care for all women in health facilities, in often low-resource settings? I focussed my thesis on a case study analysis of the *Hamara Swasthya Hamari Awaz* (Our Health Our Voices, HSHA) campaign run by the WRAI because as a communication for (health) development intervention its structure stood out among other local, international NGO and government campaigns which typically focus on resource provision, skill development or information dissemination. In contrast, the HSHA campaign facilitated actual action at the local level with communities of women seeing health service improvements for their individual concerns and developed a scope for a national collective voice for these women and took that to power-holders. Furthermore, and uniquely, it set the groundwork for this India-designed campaign to be taken to the global level. HSHA’s basic structure has been adopted by the global secretariat of the WRA in a social media-led campaign that aims to engage 1 million women worldwide in their one ask for better quality maternal healthcare. This thesis will examine how the HSHA equipped women at the bottom of the pyramid to advocate for the maternal care and respect in treatment to which they are entitled.

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\(^3\) Fenton and McConville (2017) reference a number of empirical studies the correlation between women’s experience of maternal healthcare facilities, and their preferences for health support in facility / at home.
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1. INTRODUCTION

India has many public health challenges that hinder social and economic development.\(^4\) Maternal health is one of the leading public health issues facing India; it accounts for 15 per cent of total global maternal deaths every year (WHO, Trends in Maternal Mortality 1990-2015). Maternal health is defined as a fundamental human right and a crucial development issue by the UN, with direct links to reducing poverty (SDG1), ensuring healthy lives (SDG3) and achieving gender equality (SDG5).\(^5\)


Maternal health challenges are commonly perceived as needs-based, characterised by the lack of resources and infrastructure. In India, this is clear in daily life on the streets of its cities where poor families give birth to and raise children, and in its villages where mothers have no choice but to give birth unaided at home, usually because the primary

\(^4\) India was ranked 154th out of 195 countries in The Lancet’s Global Burden of Disease study 2017. India has the highest TB burden in the world, the second-highest prevalence of diabetes in the world, and the third highest-rate of female cancer cases in the world https://www.thelancet.com/journals/laninf/article/PIIS1473-3099%2817%2930276-1/fulltext#seccestitle10

healthcare facility is too far from their home.\(^6\) Compare this to the speciality maternity hospitals run by Indian business families in the major cities, and the binary divide between experiences of childbirth in India is astounding. In a needs-based approach for maternal healthcare, the focus is on measuring facility infrastructure, human resources, and safety measures. This sidelines women’s perspectives, including how the woman was treated by facility staff, whether care was given in a timely fashion, or whether the facility was clean. As a highly personal experience, every woman has the right to quality, respectful care and the authority to make her own health decisions about her delivery no matter her social background or ability to pay.\(^7\)

Social accountability, as a form of ‘bottom-up’ or community advocacy which foregrounds their personal experience, is growing in the global context of transparency and accountability. This thesis focusses on the ways in which aspirations can help to inform a community-led accountability initiative for better quality maternal health, in turn to meet social development goals. The *Hamara Swasthya Hamari Awaz* (HSHA, literally: Our Health, Our Voices) campaign is taken as a case study to examine the ways in which communications bind together voice and aspirations. It will address concerns raised by social theorists who advocate that communications can spur social change in the short and longer-term.

This maternal health consultation was led by the WRAI, the national chapter of the global maternal health alliance that includes individuals, organisations and communities who together advocate for safe motherhood in India. From December 2016 to April 2017, the WRAI mobilised 184 member organisations in a campaign that sought to consult women for their one ‘ask’ to improve the quality of reproductive and maternal healthcare. The campaign’s successes—including engaging directly with JP Nadda, Minister of Health, to adopt the core of the WRAI’s Respectful Maternal Care

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\(^6\) Approximately 5% of Indian women live more than 10km from a health subcenter (first aid centre where uncomplicated deliveries can be performed), 29% live more than 10km from a PHC for more complicated deliveries, 82% live more than 10km from a government hospital. (International Institute for Population Sciences 2006)

\(^7\) As enshrined in the Respectful Maternal Care (RMC) Charter, accessible at: [www.whiteribbonalliance.org/respectfulcare](http://www.whiteribbonalliance.org/respectfulcare)
Charter in India’s Quality of Care for maternal health guidelines—are well documented through external relations. The campaign was so well-received that the global WRA has scaled this up to run globally through the social media-led What Women Want campaign.

Little, however, is reported about the ways in which the HSHA consultation bridged needs and aspirations for women’s maternal healthcare to build a citizen-engagement advocacy framework through the WRAI’s ‘Social Watch’ approach to social accountability. The Social Watch approach is centred on people, and focussed on mobilising civil society to hold governments accountable for their commitments (Futures Group, 2010: 3). As such, it is a bridge between the users and the providers of services. Aspiration can similarly be seen as a bridge between the present and the future, for people to be able to realise what is possible not just for aspiration, but what aspirations can be realised. This is particularly pertinent as a theoretical lens for marginalised communities such as those engaged through HSHA, as they are often unaccustomed to a practice of advocating for themselves through engrained social and gender norms across Indian communities. This will be further discussed in subsequent chapters.

The focus of this thesis is therefore on the role of aspirations to help inform women about their maternal health rights, to amplify their voices, and to build a platform from which they can negotiate for their maternal healthcare aspirations. This will be explored through the lens of an aspiration-based approach founded upon the work of Arjun Appadurai (2004). This emphasises the role of culture, voice and agency (Bourdieu, 2010) in building a cultural capacity (Sen, 1999) for aspiration which can empower women to make choices about their own healthcare.

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8 See Appendix.

9 The What Women Want campaign ran April 2018-April 2019 and sought to record 1 million women’s asks for better maternal healthcare. For more information see WRA: https://www.whatwomenwant.org/

10 See the White Ribbon Alliance model and strategy here: https://www.whiteribbonalliance.org/model/
The main research question that guides this thesis is therefore:

- How did the White Ribbon Alliance India’s *Hamara Swasthya Hamari Awaz* campaign use communication as a process to strengthen women’s voices and enable aspiration for better maternal healthcare?

Using a constructionist case study approach, it will focus on how the campaign framework was structured to encourage women’s voices, drawing synergies between the Social Watch framework and the operationalisation of the capacity to aspire approach. It will discuss how strengthened voice is linked to a capacity to aspire; how voice can build in the individual form to result in a collective outcome that realises aspirations. It will also explore how this framework was sustained in the relative short-term for the campaign, but how it has potential for long-term sustainable change for community-led advocacy for better maternal healthcare.

To address these research questions, it is first necessary to outline the current state of maternal healthcare in India. This will be covered in the Background chapter which will draw attention to a needs-based approach to healthcare and gaps in quality provision; followed by maternal healthcare in India.

The importance of voice as a conceptual tool, a heuristic device, will be delineated in the following chapter. It will be argued that, taking concepts and discourse from Couldry and Tacchi, ‘voice’ is a process with value and power and with specific concerns in its application in the context of women’s agency in development. That being the case, attention is drawn to HSHA which has developed a locally-grown, national framework for consultation that is now being replicated at the global level to advocate for appropriate, social justice-focussed maternal healthcare. The Literature Review chapter will also discuss the roles of accountability and social accountability in maternal healthcare.

These concerns are made visible in the HSHA campaign, which will be examined through the lens of a capacity to aspire built on voice and agency. The methodology section provides the philosophical and methodological approaches that ground this
thesis. In the following chapter, the campaign and empirical data gathered will be examined through the theoretical lens. Finally, in the concluding chapter, with a return to the research question, there is a discussion regarding whether HSHA provides a replicable framework for aspiration-building in maternal healthcare. It will also discuss potential areas to build on for future research.

2. BACKGROUND: MATERNAL HEALTHCARE IN INDIA

“Access is important, but women want to know what the access is to; they want a system that will save their lives.” — Harvard TH Chan School of Public Health professor Dr Margaret Kruk at the Global Maternal Health Symposium 2018

‘Needs’, just as ‘health,’ have a variety of definitions and these definitions, as well as the understanding of ‘health needs,’ has changed over time (Asadi-Lari et al, 2003). Needs-based approaches to healthcare historically defined the provision of healthcare services to their procurement; doctors were responsible for individual patient needs and healthcare procurement officials were responsible for the whole population’s needs (Gillam, 1992: 404). The understanding of health needs has evolved to a more ‘collaborative action’ approach which takes into consideration the views of stakeholders on what health care is needed (Asadi-Lari et al, 2003).

Gillam’s (1992) comparative approach uses geographical-based data to highlight areas of need for primary care. These include population levels and are usually based on practice activity levels. However, true health needs can be hard to determine based on these limited transaction recording measures, which do not take into account those needs outside of a healthcare facility for example, those in need who are homeless or otherwise incapable of attending a public health facility to be ‘counted’.

Jordan and Wright (1997) agree that there is no complete understanding of what a needs-based approach is, as it “means different things to different people.” Aligned with Gillam’s comparative approach, they assert that needs cannot be universally
understood through practice or facility-level data. To incorporate those social determinants of health, needs-based assessment should incorporate the views of other actors, in particular local patients’ perceptions of their own priorities in a consumer-defined approach (Gillam, 1992). The World Health Organisation’s Safe Motherhood Needs Assessment (2001) framework does reinforce the need for “diverse perspectives” in the design and implementation of national policy plans to include women, young people and women’s health advocates, however it assesses the structural ‘needs’ of maternal healthcare. Its stated outcomes are an assessment of resources; the skills of staff to provide the right level of care, and the availability of appropriate drugs, supplies, equipment, facilities and transport to patients.

This gap in incorporating patient perceptions is also a reality at the primary care level in India where most maternal healthcare is delivered. India has registered a sharp decline, faster than the global average, in MMR over the past decade, and is making progress towards meeting SDG3’s targets to decrease the global MMR to less than 70 per 100,000 live births by 2030. Yet, as previously referenced, India still records the highest absolute number of maternal deaths globally, and there is an urgent need to address maternal health as a priority public health concern.

Both formal research and anecdotal evidence indicate that mistreatment within maternal healthcare significantly decreases a woman’s likelihood of utilising professional healthcare services; she will choose dignity and respect in care over medical intervention and will use a traditional birthing attendant or family to help in her delivery at home. India has seen an increase in facility-based deliveries in the past decade, yet decline in maternal and neonatal mortality rates have not been as expected and studies have not found that government schemes offering cash incentives to women delivering in public health facilities have made impact on these outcomes (Afulani et al, 2018).

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12 In 2015–16, about 79% of women in India reported that they delivered in a health facility compared to 39% in 2005–6, representing a two-fold increase (Afulani et al, 2018)
Conversely, they have found that other factors such as relationships forged between women and communities and quality of care received at facilities play a larger role in encouraging institutional deliveries. Non-institutionalised births are more likely to result in maternal and newborn deaths, and higher rates of maternal deaths are often concentrated within more vulnerable, marginalized communities (Sanneving et al., 2013), those who are ‘unconnected’ from public service provision and therefore often ‘uncounted’ in needs-based assessments. Within these communities, a woman’s agency over her own decision-making and access to resources is limited (Ibid.) but Indian women from across castes and social classes still contend with a “pure gender bias” in their potential to access health care in India (Ibid.).

Therefore, absolutely central to building a maternal healthcare system that provides for all women, right to the poorest and most rural, and which all women want to use, is an approach that can take into consideration not just those who are using those systems already, but those who have chosen not to, or who do not currently have access to them. It could be argued therefore that the system requirements go beyond the structural needs of women and should now focus on the possibilities of a more aspiration-based approach that seeks to include marginalised voices and amplify them to bring about the change that they prioritise. While assessment of provision and access is clearly fundamental, women’s aspirations go beyond to also demand quality, dignified and respectful care for the long-term. This can be seen as a driver of positive change in the healthcare system in India.

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13 The government has pledged to increase numbers of primary health centres (PHCs) for communities across India — current numbers stand at just over 33,000 PHCs for India’s 640,867 villages (where 68.84% of India’s population resides per the 2011 Census).
3. LITERATURE REVIEW: ACCOUNTABILITY, VOICE AND AGENCY IN DEVELOPMENT FOR MATERNAL HEALTHCARE

The previous section discussed needs-based approaches to healthcare. There are fewer existing studies specific to aspiration-based approaches for maternal healthcare; however, in the field of social accountability for health, there is a close correlation made to aspirations as foundational mechanisms with which to build social accountability efforts. As such, this section will also present a review of social accountability for maternal healthcare and the roles of aspiration in a social accountability framework.

3.1 Accountability in maternal health in India

When Junior Health Minister Ashwini Kumar Choubey was asked in Parliament about the numbers of women who have benefitted from the Janani Suraksha Yojana (JSY)\textsuperscript{14} he quoted figures that are far in excess of those the National Rural Health Mission, run by his own Ministry, had quoted for the same period. An Indian online media house spotted the anomaly with previously published figures and ascertained there to be a disparity in the figures of 3.2 million people. This amounts to a gap of INR 1.92 billion (approximately $27.8 million) in JSY funds disbursement to beneficiaries. Such an example is a clear illustration of the weak capabilities of the public sector to enforce accountability at the state and central levels. This is not specific to the public sector; accountability is also a challenge shared by private healthcare sector actors.

As George argues, improving accountability leads to better healthcare provision, particularly in poor rural contexts where resource issues from human resources to infrastructure present structural challenges, and local community cultural and religious beliefs present socio-cultural challenges (George 2003: 161). Accountability can act as the bridge between service providers and service users/beneficiaries (Ibid.) to highlight

\textsuperscript{14} Literally ‘Safe Motherhood Scheme’, the Modi government’s flagship cash transfer scheme aimed at reducing maternal and neo-natal deaths in the country. \url{https://theprint.in/india/governance/how-many-benefitted-from-modi-govts-maternal-healthcare-scheme-minister-ministry-differ/186330/}
imbalances between policy interventions and service delivery on-ground, or community health needs (Papp et al, 2012: 450).

Where public and private sector players have not established effective accountability systems, communities can play a role. Citizen-led forms of accountability—often referred to as social accountability—are increasingly seen as having potential to bridge the gap and mediate the power, representation and transformation disparity left between unequal partners (George, 2003: 162). Social accountability for health is therefore centred on the rights of a community to raise its voice about their own concerns and to assert their right to accessible, affordable, quality healthcare, acknowledging and addressing the social and systemic barriers undermining health such as illiteracy rate, malnutrition, early or child marriage, and other factors contributing to poverty (Papp et al, 2012: 450).

3.2 Social accountability in maternal health

“Social accountability is a very important element when you talk of empowering communities at the grassroots level. [India has] wonderful [maternal health] policies on paper, wonderful schemes, but the problem is when we try to roll it out at the grassroots level the families and communities for whom these schemes and programmes are meant to be don’t really know about it. Sometimes even if they have the information they do not know what to do with that. That’s the reason it is extremely important to work with the communities so that they know what these policies and programmes promise and how they can get those.” — Dr Aparajita Gogoi, National Coordinator for India, White Ribbon Alliance

Adopting accountability measures that encourage the active participation of marginalised groups can support the assertiveness and empowerment of those who are socially excluded (George, 2003: 165). In this way, social accountability strategies seek to encourage institutional innovations that will project voice and build “citizen power vis-a-vis the state” (Fox, 2015: 346). There are several accepted strategic frameworks for social accountability in the development community, all under the larger definition of social accountability as a framework that empowers citizen engagement and supports public responsiveness from states and institutions (Ibid.).
Fox’s re-reading of the empirical studies on social accountability presents two different approaches: tactical and strategic. Tactical social accountability interventions focus on the dissemination of information to encourage citizens’ “voice,” in the assumption that they can use that voice collectively to influence public sector providers; strategic social accountability interventions use many tactics to empower collective action—“voice”—and bolster public sector responsiveness—“teeth” (Fox, 2015: 346).

Accountability processes therefore must include information to inform, dialogue to educate and empower, and negotiation to collaborate (George, 2003: 165), in order to follow this “voice and teeth” model and moderate the power imbalance between parties. Information is essential for improving awareness and access to health, but it is also usually technical or specialist information therefore creating a hierarchy of access to information. Without access, citizens cannot move to collective action for social change, and without information about what they are entitled to, people cannot demand what change it is that they want. Papp et al (2012: 453) expand on this to propose that critical consciousness (Freire, 1973) presents an opportunity for marginalised groups to be ‘awakened’ and empowered through participatory learning. It also provides a basis on which these groups can gather as a collective force to open dialogue; in this case as a form of ‘sisterhood’ for motherhood.

Dialogue is necessary as a redressal measure between imbalanced power relations; in health, power relations “define norms that maintain inequality within intimate relationships, households, communities, health services and other social institutions” (George, 2003: 164). Health and wellbeing are socially produced and this production is embedded in social structures (Pinto et al., 2018) as well as in health systems (George, 2003: 164); health outcomes are influenced by social determinants of health, themselves an expression of social and structural inequalities (Qadeer, 2011). This inequality necessitates dialogue between the values held by public officials and the values maintained by the broader public to recognise gaps and to spur change. Where this does not occur, inequalities remain; in India, poor patients are often perceived to be second-class citizens who should take what healthcare is offered and be grateful, regardless of its quality (George, 2003: 166). This is also true of
marginalised groups, whether marginalised through the caste system, through religion, ethnicity or gender (Pinto et al, 2018), all of which are considerations of power when discussing women’s status in India.15

Better dialogue can build patient-provider relationships that in turn help communities to negotiate with other stakeholders for what they want (George, 2003: 167). Through information and dialogue, communities gain a deeper understanding of their rights, and can use their voice to “gain a seat at the table” (Fox, 2015: 353) to negotiate for those rights to be heard and included in new health agendas. There is a role here for interlocutors (Ibid.) or supportive outside agencies or actors (Papp et al, 2012: 453), to ensure that the ‘voiceless’ exercise their right to voice effectively (Fox, 2015: 353) and build links with social capital with which to advocate for their collective rights (Papp et al, 2012: 453). They provide a channel for dialogue between patient and provider; spreading voice ‘horizontally’ to gain representation for the excluded and ‘vertically’ to gain political traction with service providers (Fox, 2015: 356) as well as delineating “receptive social space” for marginalised groups where their rights can be negotiated with more powerful actors in order to gain recognition (Papp et al, 2012: 453). As such, accountability serves as an important mediation resource which is best achieved through access to information, dialogue between actors and negotiated processes that represent all “participants involved, their relationships and the social contexts they operate in” (George, 2003: 168).

What is called for is a framework on which to develop community-level voice and teeth for improved maternal health in India. The WRAI’s Social Watch approach is a “people-centred strategy that mobilises civil society to hold governments accountable to their commitments” (Futures Group, 2010: 3) through gathering information, spreading

15 India is an incredibly socially and culturally diverse country. It is often described as 29 countries in one to demonstrate how different communities are from state to state because of their social contexts, particularly considering economic access, health, education and infrastructure as determinants of poverty. When considering the determinants of poverty for the communities consulted, therefore, it is necessary to view this through a specifically Indian gender lens (although wider determinants as listed also generally apply). Indian women are more likely to have lower levels of literacy, to have more limited access to paid work, or if they do to be paid lower wages, and have less access to land ownership or equal employment. (Haughton and Khandker, 2009: 146-151)
awareness and speaking out. These actions serve to build a collective capacity, a community voice, about what they want for maternal health care from their service providers and their government leaders. The three-tiered strategy can be seen to build upon Appadurai’s (2004) principles for ‘operationalising’ the capacity to aspire to reduce poverty. First, gather information about the production of consensus in a community, and between the community and the more powerful. Second, facilitate or encourage teaching and learning about how to “navigate the cultural map in which aspirations are located,” and finally exercise voice—speak out—as it is through voice that: “sinews of aspiration as a cultural capacity are built” (Appadurai, 2004: 83).

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<th>Approach</th>
<th>First phase</th>
<th>Second phase</th>
<th>Third phase</th>
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<tr>
<td><strong>WRAI Social Watch elements</strong></td>
<td>Gather information: Develop and share tools to monitor the maternal health situation</td>
<td>Spread awareness: Ensure that civil society has information on maternal health rights and government policies</td>
<td>Speak out: Give citizen groups opportunities to disseminate findings, share stories and demand change from decision-makers</td>
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<tr>
<td><strong>Principles for operationalising capacity to aspire</strong></td>
<td>Gather information about the production of consensus in a community and with power-holders</td>
<td>Facilitate learning about how to navigate the cultural map of aspirations</td>
<td>Exercise voice to build sinews of aspiration</td>
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Elements of a Social Watch campaign, Futures Group (2010) Promoting Accountability for Safe Motherhood; the principles for operationalising the capacity to aspire (Appadurai, 2004)

**3.3 Voice as process, value and power**

Couldry’s critique of voice (2010) asserts that there is a “crisis of voice” (Ibid.: 10) across the political, economic and cultural domains. Neoliberalism is at the centre of this crisis; its organizational strictures prevent, deny or undermine voice (Ibid.: 11); it is a “voice-denying rationality” which prioritises market functioning over any other form of human organisation (Ibid.: 20). Needs-based assessment can be seen to be the neoliberal stricture denying people’s voices in healthcare; a mechanism that social accountability seeks to oppose.
Couldry distinguishes between, but also bridges, the concepts of voice as process and voice as value. He defines voice as a social process that involves speaking—giving account of one’s life and conditions (Ibid.: 9)—and listening. Voice as a process abides by the principles that voice is: socially grounded; a form of reflexive agency; an embodied process; individual, collective or distributed; and is often undermined by rationalities or practices that exclude voice (Ibid.: 17-18). In short, voice is shaped by its social and cultural matter, it is a reflexive act of responsibility and is influenced by who is using voice, where they are and what systems they are bound by.

Voice as process, while of paramount importance, sometimes eclipses voice as value (Tacchi, 2016). Tacchi argues that valuing voice ensures that people’s opinions and experiences are “heard in the places and spaces where they might influence decision makers” (Ibid.: 30). In order for these voices to be heard in these spaces, there must be a framework in place that “[organizes] human life and resources” and values voice as a process (Couldry, 2010: 2). Couldry also approaches voice as capacity (2010: 10) but emphasizes the importance of listening. He argues that without effective voice, the legitimacy of modern democracies is called into question because recognition—the result of listening—is at “the heart of democracy” (Ibid.: 53). By articulating voice, a challenge is raised to the distance that neoliberal structures place between an individual and “what gives their life meaning,” the ability to tell their own story (Ibid.: 107).

Tacchi develops this thought further to consider the effects of neoliberalism on listening, asserting that there are some frameworks that are “structurally unsuited to listening” (Tacchi, 2013: 32) and so it is not clear that decision makers are listening, or have the mechanisms to allow them to listen to the excluded or marginalised communities that may want to have dialogue with them. Here again, comparisons can be drawn between the prioritisation of healthcare economic models defined in the needs-based assessment approach, which focusses on matching “inputs and outputs” (Couldry, 2010: 20) data and has little recourse for governments or service providers listening to patient voices.
Voice as process and value is often situated as theoretical concept to new digital communications technologies and social movements, or “new technologies of voice” (Tufte: 2017: 44-45). Yet it is an equally applicable conceptual approach to understand the relationship between voice and listening for campaigns in the more traditional communication for development field, such as HSHA. Specifically, how voice as value is linked to participatory development (Tacchi, 2016: 29), to ensure that voice reaches its target audiences for impact and results. Chair of Slum Dwellers International, Sheela Patel (2016) provides a conceptual bridge between voice and the capacity to aspire as a tool to build power among the poor. She sees voice as a collective representation (Ibid.: 132), which although active at different levels is still unevenly distributed. Herein Patel critically examines the role that intermediaries, local organisers or support NGOs, have in amplifying voice:

“Our experience informs us that we can’t expect the poor to claim the right to voice their opinions, dissent or represent their demands, unless they have both capacity and confidence to produce evidence to make those claims.” (Ibid.: 132)

Patel places importance on information, experience and data as empowerment tools for the poor to build voice. She asserts that without those tools, representatives of the poor remain “supplicants”; with these tools they have the potential to become “agents of change” (Ibid.: 134). It is the process of creating voice, therefore, that has a large influence on how the aspirations of the poor and marginalised are built. Patel notes that the poor often expect an intermediary agent to act on their voiced concerns; indeed, the act of voicing concerns is “assumed to lead to ‘others’ acting on the demands and expectations” (Ibid.: 133). Finally, and crucially, a truly empowered grassroots voice relies on a receptive framework which includes communities in building locally relevant responses to issues. Predetermined project frameworks, sometimes built by support NGOs or otherwise in place through outside actors, can exclude community voices in creating solutions (Ibid.: 136).
3.4 Marginalised women and agency in development

Indian women, particularly poor, rural-dwelling women, have traditionally had more limited access to healthcare because of a lack of resources, a lack of education and strict socio-cultural and religious norms\textsuperscript{16} that have traditionally limited women’s roles to the homestead and perpetuated health disparities (Papp et al 2012: 462). This is compounded by the additional layer of culturally and religiously-engrained bias towards those from lower castes\textsuperscript{17} and from adivasi (tribal) communities in India, who have traditionally been seen as of lower social status than other higher-castes and have been ritually employed for generations as rubbish collectors, sewage cleaners and other undesirable professions.

This social power hierarchy is particularly evident when the data for traditional home births and institutionalised births is analysed. The National Family Health Survey 4 (2015-2016) shows that the women who give birth at home, and not at any primary health centre or other medical institution, are predominantly women from the lower castes, scheduled tribes, or poorer socio-economic groups. Their experiences of care at health facilities plays a large role: “Disrespect and abuse are slowly become the norm, with [poor Indian] women believing that they are not entitled to anything better...”

\textsuperscript{16} The majority of India’s population is Hindu, but there is a significant Muslim minority population (Census, 2011 figures). In both religious doctrines, women have a specific role to play in the family which is enshrined in religious texts (and fiercely debated among religious scholars of both traditions). In a patriarchal reading of Hinduism’s Vedas, a woman’s primary duty is to help her husband in performing his duties, and enable him to carry on his family tradition: “Her father protects (her) in childhood, her husband protects (her) in youth, and her sons protect (her) in old age; a woman is never fit for independence.” (Manusmriti 9.3). Differing views propose the status of women as goddesses equal to gods. There is ongoing theological debate in both religious spheres on this topic, but in both Hindu and Muslim communities in India going back centuries, women were customarily secluded from society by means of wearing veils over head and face, or screening them by a curtain from men or strangers, or even isolating them in certain parts of a home without allowing them access to the outside world. Although this practice—purdah—is extremely rare in its most severe form in modern India, this cultural practice born from religious and social concepts of ‘purity’ have limited women’s roles in Indian society, in the workforce, in education and in healthcare.

\textsuperscript{17} There is an abundance of literature on India’s caste system, but the seminal text is from Dr BR Ambedkar, the author of independent India’s constitution and a Dalit (lowest caste). The Annihilation of Caste was written in 1936 and argues that caste is unscientific. Modern India continues to struggle with the caste system. Although contemporary law prohibits discrimination based on caste, the practice is still widespread across the country, propagated by the ingrained and very visible caste status in many Indian surnames among other factors.
and that the experience of childbirth comes packaged with [disrespect and abuse from healthcare professionals].” (Dr Gogoi, op-ed in the Hindustan Times, 19 November 2018)¹⁸

The HSHA campaign focussed on the voices of a group of women both marginalised because of their gender, but also because of their lower socio-economic status. Carruyo asserts that listening to the “dreams, hopes, visions and meanings” of people is key to understanding ‘development’ (2016: 306). In a context still affected by these hierarchies of power, centering the marginalised actor in the development process allows them to articulate their hopes and dreams to “contribute to the construction of the discourse and practice of development” which is useful for them and fits in with their lives. This can help to develop local level processes necessary for development progress, or “sustainable wellbeing” (Ibid: 313), which infuse cultural understanding and a sense of accountability in development progress at all levels and recognise the interconnected nature of women, nations and economies. Schmitz (2012) presents the human rights-based approach as the cornerstone of the social accountability framework for development. He asserts that the goal of these campaigns is often the realisation of human rights of some sort, whether the right to information, to public benefits, education or healthcare. As such, citizens are “rights-holders” and are enabled to “demand improved services from the duty-bearers, the government” (Schmitz, 2012: 528).

Women are increasingly recognised as these rights-holders and drivers of the development agenda. This is embodied in the Women, Culture and Development (WCD) approach which combines critical development, feminist and cultural studies to provide a framework in which marginalised actors, in particular women, are “neither victims nor heroes” but “play leading parts in the struggle against globalisation from above” (Bhavnani et al, 2016: 15). WCD provides a “structure of feeling” (Ibid: 5) which takes into account the “everyday experience” (Ibid: 10) that provides a framework to understand how people, and specifically women, actually live their lives and how

¹⁸ https://www.hindustantimes.com/analysis/maternity-should-be-a-memorable-experience/story-GHC3WosfMuu6gpGdEWYa1L.html
development can tend to needs beyond the economic. Carruyo asserts that money and supplies are only part of what a development project means; it is also a process to recognise the role of women as “co-creators” in the development process (Carruyo, 2016: 311). She advocates an alliance model of development which “requires knowing, or listening to, what people place importance on and why” which in turn creates a “pedagogy of mutual understanding” on development goals and the processes for accomplishing them (Ibid).

In developing such an alliance, agency is a real barrier; “lack of agency impedes assertion of rights by women, which leads to poor maternal health outcomes” (Papp et al 2012: 456). This gender discrimination, compounded with the factors of poverty, caste and class previously referenced, contributes to a “culture of silence” (Papp et al 2012: 456). At home, a woman’s views are seldom voiced, due to engrained socio-cultural, and patriarchal values. When a woman visits a healthcare institution therefore, she does not expect that doctors and nurses listen to her views on her own wants and needs for her own healthcare experiences (Dr A. Gogoi, Global Maternal Health Symposium, Sep 2018).

Speaking up, voicing concerns, or even asking questions of these authority figures is therefore a challenge. Papp et al (2012: 457) draw on the Social Watch tools used by the WRAI to demonstrate how creating a receptive social space in which to voice individual concerns and experiences can provide an opportunity for dialogue with power-holders. They also provide a platform to act as a collective; individually, marginalised women are less likely to feel enough agency to be able to speak out about their demands and aspirations. Collectively, concerns can be corroborated and amplified to the local representatives of government or other decision-makers, as women are able to collectively use their individual capabilities for voice and agency as a force for change, to aspire to better.
4. THEORETICAL FRAMEWORK: CAPABILITY AND ASPIRATIONS-BASED APPROACH

“Aspirations are never simply individual. They are always formed in interaction and in the thick of life.” (Appadurai, 2004: 67)

“A view from the ground would show that people’s interactions with maternal health services are never only about attaining health outcomes. These interactions are also about aspirations to have some control over their birth experience, to be treated with dignity and respect, and to use their choices around childbirth to signal who they are and who they want to be.” (Freedman, 2016: 2068)

The previous chapter drew attention to the importance of voice and agency in social accountability in maternal health, as key strategies to meet development targets. As Sen (1999) notes, poor individuals are often ‘voiceless’—they lack the capability to state their preferences, or their hopes for themselves beyond their current lived reality. For Bourdieu (2010) as reality is a social construct, informed by a specific social existence relational to the family, culture and education, so too is culture a form of “capital” that is constructed and which helps to form power hierarchies. Culture, Appadurai (2004) notes, is the “fabric of everyday understanding” and therefore has a key role to play in the productive relationship between culture and development in the battle against poverty (Appadurai, 2004: 83-84). Indeed, Sen (2004) argues that culture “engulfs our lives, our desires, our frustrations, our ambitions and the freedoms we seek” (Sen, 2004: 39), therefore simultaneously holding past and future attributes (Appadurai, 2004: 59). If culture is a constructed reality informed by socio-cultural norms, then cultural capacity must be analysed for its central influence on social value formation; and “one of the most important roles of culture lies in the possibility of learning from one another” (Ibid.: 38). The culture of talking and listening is therefore a driver for making interactive value formation, and in turn, making social change and development, possible (Ibid.: 42-43).

Clammer’s designation of development as an “ethnography of the future” as a framework to action induced knowledge for human satisfaction and social justice (Clammer, 2013: 129) therefore aligns with Sen’s capability approach to development which advances a framework to respond to the weaknesses of the neoliberal economic model of development (Sen, 2014: 525). This focusses on development as a process of
expanding real ‘freedoms’, and removal of the major sources of ‘unfreedom’ such as poverty and tyranny (Sen, 2014: 525-526). Freedoms here mean the processes that allow people freedom of actions and decisions and the opportunities that people have based on their personal and social circumstances (Ibid.: 527). By seeking out freedoms we inherently seek to expand the “functioning” that we are able to achieve as people—the things that we value doing or being, of which we are capable—defined by Sen as capabilities (Mehrotra, 2008: 386). Unfreedoms are the factors that limit a person’s freedom of action and decision-making for themselves through a lack of capability (Ibid.: 535).

Development is a process of expanding capabilities; Sen outlines this as a two-way process, a spur for “evaluation” not of income but of individual freedoms, and of “effectiveness,” aligning a person’s greater freedoms with their greater capabilities to help themselves. This can happen ‘top-down’ through public policy, in turn influenced by the ‘bottom-up’ participatory capabilities of the public (Sen, 2014: 527-528). Sen argues that this individual capability-development process, to build an individual’s “substantive freedoms,” then contributes to an overall development process for social change, although the formation of these human capabilities cannot be done without substantive public support (Ibid.: 534).

In his elaboration of Sen’s work, Mehrotra focusses on this critical linkage between top-down policy and bottom-up participation. He argues that ineffective service delivery can be improved through collective voice and local action (Mehrotra, 2008: 386). He first evaluates the capability approach to be too centred on the individual for the realisation of functionings (Ibid.: 388). Because there is an interdependency between the simple and complex functionings, for example the simple ability to read and write and the complex functioning as a participating member in community life, we must recognise that capabilities are not exclusively individual, and they must also be understood as forming a part of a larger community capability (Ibid.: 386).

He argues that this community or collective capability is crucial; “without the demand for effective services at the community level coming from ‘collective voice and collective action,’ the supply of services will remain poor quality, thus ineffective” (Ibid.:
In other words, the local level voice and collective action puts pressure on local power structures in a democracy to respond at the local level to local level needs, rather than depending on resource allocation at the national level (Ibid.: 389). Yet, agreeing with Sen, Mehrotra acknowledges that without the democratic structures at the national level, “micro-level democracy is inconceivable” (Ibid.: 387). The two-way process is key to operationalising the capabilities approach.

What role then for aspiration in spurring this collective voice and local action that is vital for capability expansion? Appadurai (2004) asserts that the capacity to aspire is a “natural ally” for the “future-oriented logic of development”; a “cultural capacity” which can be strengthened to offer people, especially the poor, the “resources required to contest and alter the conditions of their own poverty” (Appadurai, 2004: 59). Indeed, although limited by a constructed reality, aspirations are themselves “future-oriented” (Hart, 2016: 326); they are influenced to an extent by a person’s “habitus” (Bourdieu, 2010: 167)—the cultural and familial roots from which an individual grows—but aspirations matter as forward-looking signifiers of what has value and meaning for individuals or social groups, and offer “guidelines and navigational reference points, lode stars for action” (Hart, 2016: 336). Aspirations are in themselves a foundation for freedom, or a “precursor of many important capabilities which support human flourishing” (Ibid.). By constraining aspiration, capabilities are therefore constrained.

This sets a foundation for the understanding that the capacity of aspiration is unequally distributed among the global population, influenced by habitus; “the poor too aspire, but their conditions of existence and their past together limit their aspirations” (Nathan, 2005: 39) because they have no experience of living in a social and cultural context where not only the community has the capacity to aspire but also to realise their aspirations (Stade, 2016: 204). In short, the inequality in distribution is a function of socially-created unequal power structures (Bourdieu, 2010: 167) that limit communities in their capacity to aspire. Nussbaum asserts that: “habit, fear, low expectations and unjust backgrounds deform people’s choices and even their wishes for their own lives” (Nussbaum, 2005: 114). In order to fully realise the capacity to aspire for the
future, people must have “a basic level of capability in relation to being able to anticipate and imagine the future and exercise practical reason” (Hart, 2016: 336). It is insufficient to judge an individual’s agency or freedom, therefore level of ‘development,’ solely on the functioning of aspiring. We must understand the levels of freedom to aspire of these individuals as well as their capacity to transform that aspiration into a capability (Ibid.: 329) based on their cultural habitus, the socialised norms that inform thinking and behaviours, but also on the ‘field’ in which they operate—whether educational, cultural or religious, a network or a relationship (Bourdieu, 2010).

Therefore social opportunities, which Sen identifies as one type of substantive freedom, can be seen to be built through socialisation and democratic practice. Indeed, Sen believes that India can get much more from its democratic system than it does currently as the system is not just one of political elections, it is also marked as a framework for “public reasoning” which can bring about substantive freedoms (Sen, 2006: 166). Yet citizens need voice to participate in this system in order to bring about durable change to equalise the distribution of resources (Appadurai, 2013: 213). Without voice, the poor and disenfranchised turn to either pole of Hirschman’s typology: loyalty to core cultural values or “exit” from these values, potentially in protest or violence (Appadurai, 2004: 69). Voice, therefore, offers a third way that promotes sustainable social change, closely linked to the capacity to aspire (Ibid.: 70), which recognises in the poor and marginalised the power to voice aspirations and “draw fuel to desire and realise other possible lives” (Bifulco, 2013: 182).

To sustain this, communities need to develop methods which build collective capacity to aspire (Appadurai, 2013: 213; Nathan, 2005: 40) through the connection between the immediate and the future (Nathan, 2005: 39; Geertz, 1973). This is what Appadurai terms the cultural map of aspirations which help communities to navigate from cultural norms—terms of recognition—to aspirations for the future; ease of navigation depends on the frequency of use and the methods of sharing that navigational knowledge with the wider community (Appadurai, 2004: 69). Aspiration must be exercised like a muscle (Rapport, 2016: 217) because without previous experience, cultural traditions, or
habitual practice, “the possibility of imagining change and knowing how to achieve it is absent” (Ibid.).

It is also dependent on critical interventions, particularly the essential agency of women in development (Mehrotra, 2008: 401-402; Bhavnani et al, 2016: 15). Sen’s approach focusses on individual capabilities, rather than extrapolating this capability to the community agency level (Ibid.: 414); however, Mehrotra argues that for real, genuine participation the approach “needs to be contextualised at the level of the community—collective voice and collective action—to have operational use,” by holding local governments / governing structures accountable and creating an inter-dependency between the central, the local and the community (Ibid.: 415-416).

The HSHA campaign sought to follow this model, using voice to build an agency that bridged traditional socially-constructed power divides and let women speak directly to decision-makers. This thesis will now analyse the HSHA campaign through a social constructionist case study approach, focussing specifically on the ways in which it built this voice and agency through accountability and used them as heuristic devices (Merriam, 2014: 43-44) to build collective capacity for aspiration and action.
5. METHODOLOGY

It has been seen in previous chapters that India’s social and economic issues have provided challenges for development interventions by government, INGOs and multi-lateral development organisations alike. There are myriad maternal health interventions underway through government and INGO work, using technology and other communications interventions to disseminate information about maternal health rights and awareness of benefits.\(^{19}\)

HSHA presents a different strategy by focusing on the empowering of voice and agency of the women participants as a collective, and enabling aspiration by taking it a step further with the third stage of the Social Watch approach to help them amplify their voices to speak out to political decision makers, redressing the traditional power relations imbalance.

5.1 Research approach and reflexivity

In previous chapters, the importance of social constructions of reality has been evident through the lens of theorists including Bourdieu. The social constructionist approach, which draws attention to the multiple realities constructed by people, including researchers and participants in research, which are built according to their own constructions (Merriam, 2014: 8-9). In this way, it addresses the social subjectivity of meanings, actions, beliefs and experiences – each in an individual’s own background and social context (Cresswell, 2007: 20-21).

My own professional involvement in the field of maternal health in India, and my previous interaction with the WRAI, adds to my own subjective stance as a researcher. While I am not a member, nor affiliated to the WRAI in any way, I acknowledge that my prior knowledge of the WRAI’s work does inform my own interpretations in this thesis.

\(^{19}\) Prominent INGO examples include: UNICEF India’s work with central and state governments on Maternal Death Review and capacity-building; CARE India’s work in Uttar Pradesh on maternal health education for women and men. They follow information diffusion models. Government schemes are referenced throughout and include flagship programmes under the National Health Scheme, National Rural Health Mission. All focus on providing free benefits or subsidised care to pregnant women and lactating mothers.
Similarly, my status as an outside observer not embedded in the local culture or communities where these women live, nor familiar with the local languages, informs my constructed interpretations.

5.2 Methodological approach

The research design of this thesis uses a case study, in line with the qualitative, interpretive, constructionist approach (Blatter, 2008). The HSHA campaign aligns with the special features set for qualitative case studies to be particularistic, descriptive and heuristic (Merriam, 2014: 43-44). It is a defined campaign period with defined objectives; the output will be a descriptive analysis of the campaign which seeks to enlighten the researcher and readers’ knowledge and understanding of the case.

Several interpretative methods are used to investigate the case study: qualitative interviews, media text analysis from campaign reports and social posts. These methods also require a certain reflexivity in their research. Geertz (1973) asserted that interpreting cultures requires “thick description,” a method which qualitative case studies follow; they search for “meaning and understanding” while using the researcher as the primary data collector and analyser. They use an “inductive investigation strategy” which provides a result that is “richly descriptive” (Merriam, 2014: 39) and helps “to understand how voice matters, and by extension, how and why participation in development matters” (Tacchi, 2016: 119).

5.3 Data collection and analysis process

I originally planned to focus my thesis on the ways in which the consultation process enabled women to consider aspiration as a tool for empowerment. This would use responses of the participants to the consultation using focus groups and interviews. I found several limitations and challenges in this approach which were outside the scope of this thesis including requiring extensive on-ground research in very remote areas of India which would incur significant time and expense without the benefit of any
research grant (for travel and translation services from myriad regional languages). Further, as the consultation was carried out by alliance members, there is no centralised network from which I would be able to identify specific women to speak to. Even if I were to consider a random sample of women, it would be difficult given the consultation’s vast scope of 150,000 women in 24 different Indian states, to collect a truly representative sample of voices without necessitating travel to each of the communities in each of the states consulted.

As this thesis focusses heavily on the use of voice and accountability, ideally the research question would seek to engage these women directly in a process that included their voices. However, for the reasons stated above, this was not possible for this thesis process. As an alternative focus, and having undertaken the interview and media text research about the campaign, I refocussed my research to examine the campaign’s design and communications engagement methods to provide a qualitative view of how the campaign established a new system of accountability for maternal healthcare advocacy that showed how social accountability and aspirations can create a framework for short-term and long-term improvement in quality of maternal healthcare.

I undertook one interview with Ms Madhuparna Joshi, senior advisor for gender and governance at the Centre for Catalysing Change (c3). Joshi was instrumental in the HSHA campaign consultation design and implementation, particularly in the state of Bihar, as c3 acted as the secretariat for the WRAI. I chose to use in-depth and semi-structured interview in order to gain information (Brinkmann, 2008) about the campaign design and implementation first-hand from those who were immediately involved, as there has been a period of over two years since the end of the campaign. Specifically, I sought information on the design of the consultation, the methods of engagement deployed in the communities who participated in the consultation and the response from those participants to the survey. Therefore, it was important to interview a leading voice in the campaign.

The interview was conducted over the telephone. It lasted one hour and was conducted solely in English, a native language to both researcher and interviewee. Any
Hindi or other regional language phrases used during the interview were simultaneously translated into English. The interview was then transcribed for analysis purposes. I used an interview guide with semi-structured questions, grouped into the topic points that I wanted to cover in my research. I started with questions specific to the campaign design and then followed the guide per the conversation flow with the interviewee. This resulted in in-depth information about the campaign which described in detail its achievements and challenges.

The use of one interview with a campaign organiser does also pose concerns around bias given the interviewee’s continuing role in the organisation responsible for the campaign. Challenges to the campaign structure and critical reflection on the campaign outcomes is therefore an aspect that must be considered limited in the scope of the interview as there is no ‘contending’ voice to counter WRAI’s claims of success.

In order to address this to some extent, I used media reports on the campaign, in English and in Hindi\(^\text{20}\), to add to my analysis with local views of external observers (journalists, local political officials). In addition, I analysed donor reports about the campaign and campaign reports provided by the WRAI, which provided information on the campaign’s tactics and results. To search for the media texts I used Google as an online search engine, for the search terms “Hamara Swasthya Hamari Awaz,” “What Women Want,” “White Ribbon Alliance India” and “Dr Aparajita Gogoi,” in isolation and in combination. Most media texts were reported within the campaign time period (October 2016—April 2017) with peaks in reporting around the end of the campaign on the data results and Minister of Health’s endorsement. The 15 media texts analysed were written articles in online newspapers, magazines, and the WRAI, WRA and related alliance portals. In addition, I used two oral interviews with Dr Aparajita Gogoi which I sourced on YouTube from presentations at the Harvard TH Chan School of Public Health Global Maternal Health Symposium (September 2018), and the Women Delivery webinar on Accountability and Citizen-Engagement Campaigns (17 April 2019). I supplemented this with an analysis of 121 social media posts on the HSHA Facebook

\(^{20}\) Which I had professionally translated into English
page from 20 January-4 October 2017 which I used content analysis to examine through two parameters: type of content and theme.

The campaign’s use of Facebook as a platform for advocacy poses some limitations. The platform was not used as a participatory tool; women engaged in the consultation were not connected to the internet and therefore were not habitual Facebook users. Due to lack of electricity connections, lack of technological hardware, and lack of computer literacy, they could not access this platform to share their own views and voices. As such, the campaign Facebook page was used solely by the WRAI administrators who would select posts (text, image and video) recorded by alliance members in the field, in order to tell their stories. The women’s voices that we read and hear are therefore selected by WRAI power-holders themselves, with the aim of furthering the campaign message; there are no dissenting opinions about the quality of healthcare or experiences at health facilities, each post falls into a theme pre-selected by the WRAI.

5.4 Ethical considerations

In the interview with Ms Madhuparna Joshi I took the ethical considerations laid out by Brinkmann (2008) of confidentiality and informed consent. At the start of the interview I secured verbal consent to record the interview and use the transcription for thesis analysis. In addition, it was necessary to obtain consent for the use of campaign materials and reports in the thesis from the main donor of the campaign. I coordinated with the WRAI in order to obtain this in writing, in advance.

While Joshi has been publicly linked with the HSHA campaign and c3, and as such there were no confidentiality concerns in quoting her, when mentioning specific recorded women participants’ feedback to the consultation I ensured that all consent was taken from these participants at the time of consultation. Where this was not in place, the responses remain anonymous and identified only by the state from which that woman hails.
Other media texts (from online news sources and the HSHA Facebook page) are already in the public domain and therefore outside the bounds of ethical concerns about confidentiality and consent.
6. FINDINGS AND ANALYSIS
“By asking the simple yet profound question of what it is that women want for quality reproductive and maternal care, WRA India has amplified the voices of women and promoted their right to demand respectful, quality health care. By engaging policy leaders at the local and national levels WRA India’s promotion of a citizen-led Quality of Care framework is inspiring others to engage directly with their elected officials.” White Ribbon Alliance India blogpost

HSHA ‘One Ask’ postcards in Hindi and English

In October 2016, the WRAI launched the HSHA campaign to understand the rural woman’s perspective on and aspirations for quality maternal healthcare services. In its guidance for alliance members in the HSHA campaign, the WRAI provides a concise explanation as to the challenges of subjectivity that the concept of ‘quality’ of care presents (emphasis is my own).

“Quality means different things to different people. Some think quality is: access to skilled health provider, timely and full services in a clean and hygienic environment, respect and dignity, not spending money for free provisioned services etc. The quality of services is a major determinant in the decision of the women and her family to access care. The quality at health facilities remains a serious concern. At the heart of
understanding of “quality” from a woman’s perspective is the belief that she is receiving the best, most effective care that can be provided to her (and her soon-to-be-born child in case she is pregnant) so that she can have the best possible health outcome from the health system.” (HSHA Guidance Sheet)

This definition of ‘quality’ is an aspirational statement in and of itself. First, asking the woman to imagine the ‘best’ that there is to offer, and then a scenario in which she can receive the best. Yet as Dahl notes, aligned to Bourdieu’s concept of habitus, aspirations must be viewed from within their cultural contexts (2016: 231): quality means different things to different people. As such, the campaign established key objectives to first understand women’s awareness of rights and benefits for quality reproductive and maternal healthcare, and then to build on this knowledge to encourage engagement with aspirations for quality care. The objectives were:

1. To focus on women's needs for the best possible health outcomes;

2. To focus on women’s voices to understand what they want for quality reproductive and maternal care; and

3. To present these voices to the highest possible political leadership in India. This, with the expected outcome that these voices would provide central-level policymakers with a better understanding of what women value and ask for in terms of quality of care, which would in turn be invested in or committed to by political leadership.

Voice was strengthened though the consultation process using several key communications processes in order to build dialogue to level the distance between an individual and their ability to tell their own story (Couldry, 2010: 107). Alliance members went to the field and followed the information, experience and data framework set in place through the social accountability approach (Fox, 2015; Appadurai, 2014). They started the consultation with a 30-minute discussion with the women, sometimes one-to-one and sometimes in groups, to find out what they knew about the rights and benefits available to them through government schemes for reproductive, antenatal and maternal healthcare. Often, the women were not aware of the schemes that could
support them and could not imagine another reality than the one they were living, so did not spend time trying to (Nussbaum, 2001: 69). This discussion was therefore used to give information on what the consultation aimed to achieve, how their voices would be used once they recorded them and what sort of response they could expect back after the consultation was finished. This process can be seen to align on a tactical level with Appadurai’s navigation techniques of the cultural map of aspirations (2004: 83). In this instance, that map is the first bridge between knowledge of maternal healthcare rights and benefits, and power to voice concerns about not receiving these rights and benefits.

Once that first bridge of knowledge was built, the campaign sought to guide women further along the map towards enabling their own individual voices about the topic. In the strict social structures of rural India, says Madhuparna Joshi, women’s voices and bodies are ruled by a patriarchal religio-cultural system which seldom affords value to perceived women’s issues: “[In these communities] everything happening to women [is a result of] others deciding what is good for them.” The HSHA campaign sought to challenge the culture of silence around gender (Papp, 2012: 456), to bring women to the centre of the conversation and to ask them what they wanted for their own healthcare. Each woman was asked to submit her answer to complete the statement: “I want for quality reproductive and maternal healthcare…” This data was collected by alliance members at the local level through manual data entry forms, in English and Hindi, which were filled in according to the women’s responses. The interaction could be delivered in regional / local languages and then translated into English and Hindi as appropriate. Guidance notes were provided in English and Hindi to all the alliance members involved in data gathering to standardize collection and recording of data.

Joshi recounts that the discussion with the WRAI secretariat was how to structure those inputs, to gather the data and present it before the people's representatives in a way which “aggregated voice and elevated aspirations, to be heard at the highest level of decision-making,” an approach that has resonance with the Social Watch strategic social accountability framework combining voice and teeth (Fox, 2015) to hold
governments accountable for their commitments. Joshi noted that the campaign “deliberately championed women’s voices” and “[put] women at the center of their healthcare...[as WRAI research found that] the best possible health outcomes for Indian women come from directly involving the women themselves.” This is a central tenet in the operational framework of Sen’s capability theory; ineffective service delivery can be improved through collective voice and local action (Mehrotra, 2008: 386).

In a webinar to discuss the HSHA campaign21, National Coordinator of the WRAI Dr Aparajita Gogoi said that the main challenge was, as a power-holding organisation and individuals, to “figure out a mechanism to place women’s self-articulated needs at the centre of policies and programmes; to look at how we can bring in women to an accountability framework which starts at the bottom—at a district or a sub-national level—to bring this up to national and perhaps international level.” To put their voices at the centre of the campaign, organisers needed to be able to engage the women directly. When the large majority of these women are not connected by phone or internet, the task was on-ground and required face-to-face interaction to gather data that was also recorded offline. Gogoi (Women Deliver webinar, 17 April 2019) noted:

“We looked at the potential to use new communications technologies because of reach, scalability and cost-efficiency, but we went to the field and looked at the kind of women that we wanted to bring into the fold [and examined] what is their access to technology, literacy level, comfort level in adopting technology. What we realised was that of course the women that we are reaching out to are not in that frame in their lives where they can adopt and use technology. So we went back to simple offline collection through ‘postcards.’”

In these more traditional social structures Joshi noted that it was important to build the trust of the women being consulted to ensure that they felt safe to share their views in a confidential manner without fear of power hierarchies of any intermediary agents. The person conducting the consultation should be known to the women in some capacity, and should be able to conduct sessions with women to inform them of their rights, to

21 Organised by Women Deliver and attended by the researcher (17 April 2019). Recording available at: https://www.youtube.com/watch?v=Uvft90kk_E&feature=youtu.be&fbclid=IwAR3yMwkLegpAFtwq7OznVmcV2OTxd574XwNDcxoRJbNLXD52M2Weuj3-WY
get their views on the consultation question and to assure them of the ways in which their responses would be used.

Here, WRAI relied on the network of its alliance members already doing work in the 24 Indian states where the consultation ran. It was important to the WRAI that the consultation gathered in the voices of women who were seldom if ever heard outside their own families. This structure meant that the alliance member volunteers asking the consultation question were known to those communities and had some level of familiarity with the local social customs and norms. In some instances they were from the same district, or are frontline community workers in that community, which gave them an additional local connection to the people they were consulting. Joshi noted in interview that the HSHA campaign process was not designed as stand-alone, because the role of the intermediary was so crucial:

“This was also a good opportunity to build an alliance of civil society organisations who are working not just in the area of maternal health or reproductive rights, but they could also be working on anti-trafficking, livelihoods. It was a diverse and credible coalition.”

The credibility of intermediaries (Patel, 2016: 132) was vital in first sharing information with the women about rights and benefits, then having the conversation with the women to further facilitate their navigation of the ‘ask,’ and finally reporting their voices back to the WRAI secretariat for them to be ‘counted.’ Joshi elaborated on the challenges that they faced initially when consulting these communities of women:

“[The] challenge that we anticipated from the beginning [of the consultation is] the moment you ask anyone from the community what they want, they would obviously ask you—what are you gaining from this discussion, what can I gain? ‘If I tell you I want a lady doctor, would you be able to get it for me?’ We did not want to raise false hope; at the same time we wanted that aspiration to be there, so whoever spoke to them women was taken through a guided process of training...[to respond to these questions with reassurances such as] ‘You tell us what you would like, and we will help to put these forward and table these with the people who can actually do it.’”

This initial reassurance was vital to gain the trust of women being consulted, to inform them about their rights and benefits available to them. The next challenge, according to
Joshi, was helping the women to own their own stories—to exercise their reflexive agency (Couldry, 2010: 17)—and to understand that the consultation was an embodied process of voice and listening to them at the local, the regional and the national levels. Often, women are afraid to speak up as individuals; they were not accustomed to a framework which valued their individual and collective voices as their experience was of their voices being devalued in a system that prioritises market functioning (Ibid.: 18). Joshi noted in interview:

“Typically when you go and ask a woman in a village what they would want to improve, they would say that they need more jobs, and prices need to come down, things which [would benefit] every person living in the community. It was initially a bit of a surprise for these women that someone was asking them what they would want for themselves, what they want the health system to do for them. [Usually they would ask for] ‘better services for my child’ or ‘I want the doctor to be there for my child.’ So the fact that this was about *their* health [was] very empowering and [they realised] that ‘Ok, I can ask for something about my health’ and not just…the larger development issues that benefit everyone. So it was about the *owning* of the issue.”

While the consultation was centred on the one ask in order to present “a bold demand” before the Health Minister, Joshi noted that the process to arrive at that ask was difficult: “Sometimes women are not able to think through the whole range of things that they could ask for.” The women had little experience of being consulted for things which affect them and as such had difficulty in imagining what small steps, or big leaps, they could aspire to (Stade, 2016: 215-216) for their own healthcare.

The second bridge for the social accountability approach to build, therefore, was between enabling a voice and connecting it back to both lived experience of maternal health services and aspirations for the future for better services: the aspirational bridge between the present and the future (Appadurai, 2004). Alliance members were given a data entry sheet which listed out 53 options for the women’s ask. This codification was put into place to facilitate the data analysis of the 150,000 responses. However, if women wanted to distill their ask into another option, they could articulate that and record it on the form themselves or with the help of the alliance member as an open response in a 54th option.
The WRAI had set the list of 53 ‘asks’ at the start of the consultation based on the prior knowledge it had of fieldwork with these communities of women, and its extensive research and advocacy around maternal health, gender and governance. However, as explored in previous chapters, aspirations are not uniform; they are culturally relative (Stade, 2016: 212; Nathan, 2005: 38) and need to be set and viewed within cultural frames (Dahl, 2016: 231), they go beyond ‘Enlightenment values’ (Rapport, 2016: 218) and they are shaped by the cultural and social matter in whose context they are situated. Gogoi (Women Deliver webinar, 17 April 2019) affirmed this in the HSHA context:

“When we set out explaining to the women about the HSHA campaign, we needed to find a way to explain quality of care to them. As, if three women, no matter who they are, are asked what quality of care means, we would each come up with different ways to describe quality of care which fit with our own principles of quality.”

This challenging discourse on the hierarchy of aspirations can also be seen in Dahl’s critique of Appadurai when she notes that by setting “a scale of standards...stating what is normal and legitimate to strive for” (Dahl, 2016: 231), inherently some aspirations are seen as more legitimate than others. It must therefore be questioned who is ascribing these standards, how are they being measured and how is validity of aspirations defined? An observer’s notion of aspiration or agency is as culturally determined as that of the poor. There is therefore an inherent gap between cultural frames that must be acknowledged, particularly when examining goals; what observers count as attainable goals may differ from those of the poor.
The HSHA campaign therefore sought to uncover what mattered to this diverse range of women from communities across India. While the list of asks was compiled as a guide at the central level, it was adjusted to reflect the real on-ground contexts of women, to reflect their habitus and their fields of relevance. These insights were gathered through a small number of qualitative interviews and focus group discussions with women across five Indian states. This was structured to be confidential with the women, outside the bounds of the frontline community worker consultation process, to allow them to recount their experiences. Joshi noted:

“They told stories not just about neglect and abuse, but also about the intersections of gender with other forms of marginalisation such as caste and religion.”

Gogoi (Women Deliver webinar, 17 April 2019) noted that this qualitative research sought insights into what women exactly meant when they said disrespect and abuse —“What is happening, why is it happening? Is it due to overcrowding [at health facilities] or is it that disrespectful behaviour is becoming institutionalised?” Through these sessions, the WRAI built up a better profile of the women who would need the services of the government health facilities.

Joshi elaborated in interview that through the initial stages of the consultation the WRAI reviewed the form and added ‘asks’ that had transpired from the initial conversations with women. These included such asks as ‘no sexual harassment’ which stemmed from the insight that women felt violated when doctors didn’t ask for permissions before performing vaginal examinations. Similarly the ask for privacy on wards stemmed from an insight that often there are men from other families allowed to wander around the wards to visit relatives when pregnant women or women in labour are on neighbouring beds without privacy curtains. This engagement forms a bridge between the second-stage teaching and learning, and third-stage speaking out in the social accountability and aspiration framework, ensuring that the campaign structure foregrounded women’s own priorities.

Largely, the women’s responses focussed on the tangible outcomes that they could imagine, in places guided by the conversations with alliance members. Initially, these focussed on availability of basic services and medicines, cleanliness of facilities, and
provision of, or access to, resources. While there was no major difference in the trends in asks at the regional level, Joshi said when data was disaggregated further to the local level then asks reflected the local contexts and realities.

HSHA campaign results—national aggregation.

First and foremost, the women’s asks related to access to supplies and services; 36 percent of women consulted said that their one ask was access to maternal health entitlements including supplies and services. This included a number of categories on the list: free health services at the health facility; free ambulance service; availability of services and entitlements without informal payments; blood banks; cost effective treatments; post-delivery stay (in the health facility) for more than 48 hours.

The second most popular ask was dignity and respectful care, with 23 percent of women consulted asking for this during maternal care. Interestingly, Joshi noted, at the start of the consultation it was clear from conversations with women that there was “very little expectation of respect” when they sought healthcare services. She continued: “We tried to push [though consultation sessions] to see what was most important for women and clearly it was about availability and quality rather than respectful care.”
While the WRAI had devised the list of 53 options relating to factors that contributed toward quality of care, there is a segmentation between the access and availability of services and those relating to dignity and respect. The majority of the factors combined under dignity and respectful care state the manner in which women would like to be treated, using words such as “no discrimination,” “no sexual harassment,” “privacy,” “confidentiality,” and “informed choice.”

The language is therefore more related to states of feeling than the services options, although it must be noted that there are several factors within dignity and respectful care that could be seen to relate specifically to resources and services. These include: the provision of one bed / one stretcher per woman; fixed visiting hours and availability of a visitor’s room to ensure privacy; timely admission. These need to be viewed through the cultural frame of the women’s social context (Stade, 2016; Dahl, 2016; Nathan, 2005) to understand that when poor women are admitted to health facilities to give birth, they feel out of control in an environment which is foreign to them and are disempowered because they do not know their rights. Even when faced with under-
resourced facilities, it is undignified for more than one woman to occupy a bed or a stretcher, as every woman deserves equal, respectful treatment. The testimonials of thousands of the women consulted, and testimonials from other sources, indicate that this lack of resource contributes to her feeling of disempowerment, as does not having familial support before or during birth. As Madhuri Kumari (23 years old) recounted to WRAI alliance members: “When my labour pain started, instead of taking care of me, the nurse at the centre started screaming at me. One of the nurses asked me either to go to a private hospital or to deliver the baby at home.” Similarly, Janki Devi (32 years old) said that when admitted to a health facility, she did not know what her entitlements were, so she could not question anything that was told to her.

The HSHA campaign used Facebook\(^{22}\) to post testimonials in the form of images of women and their asks, or ‘vox pop’ video clips of them telling their ask to camera. These were referenced with their names, ages and where they come from to add legitimacy. Gogoi (Women Deliver webinar, 17 April 2019) asserts that the WRAI secretariat had some initial concerns about the level of confidentiality that the women being consulted would request, both in responding to the consultation and on social media usage, for fear of social repercussions or discrimination from local leaders for speaking out. To the contrary, women were willing to speak out: “Women wanted to be named, to supply their names, ages, villages and phone numbers [as they saw it as] ‘this is a way for my voice to be heard.’” Still this activation should be recognised for its one-way communication which does not fully realise the potential of a platform such as Facebook for participatory communication. The reach of the page was limited to the online population, thereby excluding the women engaged in the consultation. Where it did see success, Joshi noted, was in engaging the offices of state-level and local-level politicians with whom the on-ground post-campaign engagement was crucial to secure commitments and hold these power-holders to account to deliver on the commitments.

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\(^{22}\) The Facebook page was created in January 2017 and has 920 likes. Photos and videos of women and their HSHA asks were uploaded from the page creation to campaign end in March 2017. WRAI were the sole administrators of the Facebook page; they controlled content uploaded and comments shared.
Of the 121 Facebook posts analysed, 66 were testimonial images or videos of women who had taken part in the consultation. They included the woman’s ‘one ask’ in Hindi and English, her name, and village / district where she is from. Most of the images featured the woman holding the HSHA campaign postcard that she had filled out with her ask. The videos (five in total) featured the woman speaking directly to camera, giving a short background of her experience and her one ask for better maternal healthcare.

Examples of HSHA Facebook testimonial and accountability posts

Following the consultation, the women’s responses were distilled by the WRAI secretariat into demands to be presented at different levels of government. This was
formulated into a Charter of Demands (maang patra). In a high-level event attended by media and stakeholders from national government and the maternal health community, specific demands from the campaign were presented to the Health Minister J.P. Nadda on 10 April 2017. Based on the findings in the HSHA campaign, they comprised of eight demands from India’s women to its decision-makers at the national, state and local levels:

1. Invest in generating awareness to ensure that all entitlements are known and accessed by women
2. Improve time-bound payments to ensure that women can fully access entitlements
3. Strengthen monitoring mechanisms to track dispersal of all entitlements
4. Create a cadre of professional midwives and ensure 24x7 availability of skilled doctors and specialists
5. Commit to zero tolerance for abuse, to ensure that women receive respectful care without discrimination and abuse
6. Incorporate respectful care into Quality Assurance Guidelines and adopt the Respectful Maternal Care (RMC) Charter
7. Form Swachh Bharat Abhiyan (Clean India Mission) flying squads to conduct surprise visits to check cleanliness and hygiene in toilets, wards and labour rooms
8. Make display of free services and supplies mandatory at facilities to ensure easy access to information

Dr Gogoi (Women Deliver webinar, 17 April 2019) emphasised the importance of distilling the HSHA findings into specific asks so that political decision makers had actionable insights from the HSHA campaign, that were in a format that they recognised (Dahl, 2016: 229) which enabled their voices to be heard in the right places (Tacchi, 2016), when they did speak out (George, 2003; Appadurai, 2004; Futures Group, 2010; Rapport, 2016):

“It was important to recognise different outcomes are different levels. Instead of having one charter of demands, disseminating it and generally not getting very far, it is important to curate the demands for different target audiences and then ensure you adopt the right strategies to approach the right people for the right results.

Most of the demands from women did not really require any [national-level] policy change. When we presented to the National Health Minister we focussed on the
demand to ensure that government guidelines include Respectful Maternal Care (RMC) and to ensure zero tolerance for disrespect and abuse in facilities. When we disaggregated the data on demands and took them to the local levels, the demands had to be doable and something to which local elected representatives could commit. In many cases we found that they had the solutions already locally. It was about unlocking some of the money at local levels that rests with the health department, ensuring service availability.”

The poor have not traditionally had the recourse to the language and formats necessary to “speak within the idioms of power-holders” (Dahl, 2016: 229) but through the intermediary processes of the WRAI, the Charter of Demands presented credible evidence to these decision-makers (Ibid.: 230) to enable the women to follow the third stage of the social accountability framework, and aspiration operationalisation: to use their voice to speak out.

Gogoi further noted that it was important to employ a multi-channel external communications strategy to reach different target audiences. External communications methods and media were tailored to different target groups. While it was important for high-level political stakeholders to be engaged through one-to-one meetings and large events, the HSHA campaign also used local-level political stakeholders to write to state-level health ministers to advocate for the Charter of Demands as a follow-up action to HSHA. Similarly, WRAI undertook social and traditional media activation through the HSHA Campaign Facebook page and opinion editorials in traditional media23 in order to reach the wider public with HSHA campaign messaging. Finally, a 21-minute documentary film was aired on national broadcast channel NDTV 24x7 in April 201824 which contextualised women’s childbirth experiences, discussed healthcare practitioners’ points of view through interview and showed case studies of Respectful Maternal Care in action at government health facilities.

23 See Appendix. Placed in the period April-October 2017.

24 See Appendix. The documentary was not specifically related to the HSHA campaign, but took the themes of respectful, dignified maternal healthcare and contextualised them through hospital features and interviews with doctors and women (not part of the HSHA consultation).
Presentation of HSHA to Minister JP Nadda; Screenshot from NDTV 24x7 documentary

Following the presentation of the HSHA Charter of Demands to Minister Nadda, the WRAI issued a press release to national media about the campaign and the Ministry of Health and Family Welfare issued an official press release stating the Minister's recognition of the campaign, and posted a tweet from the Ministry’s twitter handle. These external communications tools helped to “legitimise” the campaign, Joshi notes, as public speech spurs both collective identification and recognition (Jacobson, 2016).

It was important to engage political decision-makers and other important health sector stakeholders at the national level. A satirical play, God Ki Delivery (Lit: Delivered through the womb) that incorporated the experiences many women undergo in the process of childbirth as collated during the HSHA campaign, was performed in New Delhi to an audience of 200 politicians. This spread the HSHA message wider to these stakeholders in a format and a language that they could relate to culturally, while noting the connection it had to real-life storytelling of the almost 150,000 consulted women.

This was also the case at the regional level:

26 Unfortunately, the researcher was not present at the play and there are no public records of the play available online, nor with the WRAI, and as such the play cannot be further analysed.
“Women reacted positively to the vernacular media coverage at the local level. They saw their testimonies playing a part in events attended by MLAs and covered by the media. The MLAs [also] read the campaign coverage and shared participation and updates on their own Facebook pages. In Bihar, the state health minister is on Twitter and Facebook and so by targeting him, we were able to spread the campaign message wider.”

This national-level, central government recognition spurred the regional and local activations that followed the campaign end. The Charter of Demands was also presented to State Health Ministers, and at village level there were government orders issued for conducting 20 Mahila Gram Sabhas\(^{27}\). These were held in April-May 2018, each with around 200 women participants along with Members of the Legislative Assembly (MLAs), medical officers in charge and the district magistrate. The events incorporated the presentation of the Charter of Demands, but also provided a platform for women to voice proposals relevant to their own local contexts. These women were predominantly community leaders, said Joshi, and they presented around 100 proposals to be considered by the Gram Sabha\(^{28}\); 20 of these resolutions were passed.

The HSHA Facebook page played an important role in holding state and local politicians to account for their commitments in the campaign follow-up period from May-October 2017. Of the 121 posts analysed, 48 posts related to local, state and national level events and engagements with locally elected representatives, MLAs, and Union Ministry of Health and Family Welfare officials. In these posts, the HSHA campaign organisers and alliance partners posted images of the event, a message in English and Hindi which tagged the government officials present to thank them for their engagement and repeat the commitment they made to the women’s demands. In some cases, the post also featured a picture of the letter a local representative wrote to the state health minister to urge them to commit to the HSHA Charter of Demands.

Furthermore, 11 of the 30-40 MLAs who attended these gatherings made commitments to the Charter of Demands, including purchasing ambulances, conducting surprise visits at health facilities, and appointing female doctors in rural

\(^{27}\) Women’s village council including all adult women from the village

\(^{28}\) Village council including all adult residents of the village
health facilities. Gogoi noted that HSHA, as an accountability campaign, needed to ensure that commitments were followed through:

“We started at the local levels to make tracking sheets. So if a locally elected representative or leader says that women in their district are finding it difficult to get to health facilities, and that they will fund four ambulances from their local area development funds, did that happen or not?”

These commitments were also tracked on the Facebook page; local officials were tagged in posts, and were recognised when they delivered on their commitments and the impact was felt in communities.

“In the HSHA campaign, women have asked for emergency referral [transport] facilities at all the government health centres. The demands of women leaders in the form of Maang Patra have been submitted before MLAs of their respective constituencies. As per recent announcements, Govt. of Bihar has ordered the purchase of 51 new ambulances and procurement of 249 more ambulances are [sic] in progress. Women who participated in this campaign hope that the key MLAs and health department officials who participated in the block/district/state-level events will fulfil their commitments. Our alliance partners will be following up on Maang Patra commitments at the local level.” HSHA Facebook post, 23 August 2017, accompanied by Hindi news articles announcing the procurement

Hindi news coverage of the ambulance procurement.  

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29 Headlines read: Chief Minister Nitish Kumar to inaugurate 51 ambulances today (L); Dial 102, ambulance will come within one hour (R). The articles detail the state health department HSHA commitments and explain the role that the dial 102 public service will have now it is equipped.
In Bihar, Joshi noted, in 14 districts there are female members of the panchayat\(^{30}\) keeping track of commitments and improvements and reporting this back to the women in the community. Joshi concludes that these are “small but significant changes” which women are seeing happen in their own communities as a direct result of their voices being exercised and heard in the right places (Tacchi, 2016: 30). While these changes were not systemic shifts in healthcare quality at population level, they did respond directly to the demands put forward by the women in those communities, to positively impact the local healthcare provision. In doing so, the women engaged in HSHA built the chain of voice, turning to voicing aspiration, which when heard resulted in structural engagement and intervention (Rapport, 2016: 218). This is the cultural map of aspirations in action.

This road map of aspiration is already being replicated at the national level in India through HSHA 2, the second-round campaign referenced as a follow-up to HSHA, which will engage women in telling their own childbirth experiences. Specifically, it looks at the quality of services at the time of delivery, and the access to entitlements and respectful care. Joshi noted that while HSHA looked at women’s aspirations when it came to health, HSHA 2 will look for “a more nuanced understanding of women’s aspirations” through a focus on women voicing their own stories and experiences as part of the consultation. The campaign structure is similar to HSHA in using on-ground, off-line data collection, and a multi-channel media and stakeholder campaign to share results and advocate for change. Joshi said that in the nine months since campaign start there is a tangible shift in data on women’s aspirations from availability of resources to quality of care, thanks to the framework set in place by HSHA.

The HSHA campaign has not just provided a framework for aspiration building at the national level. On 11 April 2018, the White Ribbon Alliance global secretariat launched the What Women Want (WWW) campaign. This global campaign is built on the locally generated HSHA campaign undertaken by the WRAI. WWW used social media tools to

\(^{30}\) Elected Village Council body that hears proposals from the Mahila Gram Sabha and Gram Sabha.
ask women across the world to submit their ask for better maternal healthcare. Similarly to the Indian campaign, it sought to support women to demand change, bring their demands to decision-makers and generate political support, investment and accountability for quality, equity and dignity in healthcare. It aimed to hear directly from 1 million women; as of May 2019, it had 1.2 million responses from women. These findings will be aggregated for a global picture of what women want and disaggregated by country, ultimately distilled to reflect the top 10 asks along with specific recommendations about how to drive tangible improvements for women’s health. This was the first time that a maternal health advocacy campaign built and delivered on a national scale in India has been scaled up to global level. Gogoi noted (Women Deliver webinar, 17 April 2019) that Indian alliance partners stepped in at the start of the WWW campaign and said that they wanted to support it from India, a testament to the success felt through the HSHA campaign to realise aspirations, not just for the women’s communities, but also for the alliance partners involved.

7. CONCLUSIONS

Previous chapters investigated the HSHA campaign design, structure, implementation and follow-up through the lens of a social accountability framework, which focussed on the use of voice and agency as heuristic devices to build a capacity to aspire. This section will summarise and contextualise the findings and analysis with the research question, discuss whether the HSHA campaign can be considered a framework for aspiration building, and finally propose suggestions for future research in complementary areas.

7.1 HSHA and voice, agency and aspiration

The focus of this thesis is on the ways in which the HSHA campaign strengthened the voices of thousands of women across India and enabled them to aspire for better maternal healthcare. This thesis was guided by the research question:
- How did the White Ribbon Alliance India’s *Hamara Swasthya Hamari Awaz* campaign use communication as a process to strengthen women’s voices and enable aspiration for better maternal healthcare?

The analysis revealed that the HSHA campaign undertook a multi-channel communications approach to strengthen voice and agency among the women consulted and to amplify their voices to power-holders in a way in which they would hear them (Tacchi, 2016). The HSHA campaign was structured to provide a social accountability framework to redress this power imbalance, which as per the Social Watch approach of the WRAI, gathered information, spread awareness, and encouraged speaking out about what women want from maternal healthcare. This process parallels Appadurai’s operationalisation of the capacity to aspire: gathering information about the consensus process in a community; encouraging learning about navigating the cultural map; and exercising voice as “through voice, sinews of aspiration as cultural capacity are built.” (Appadurai, 2004: 83)

The process of consultation therefore informed the women about these entitlements and the manner in which they can expect to be treated by medical staff according to their rights. It also facilitated teaching and learning about how to navigate the cultural map (Appadurai, 2004: 83) to ask for these rights and entitlements, first by exercising their individual voices as part of the consultation, guided by locally respected and trusted intermediaries (Patel, 2016: 132). Then, by taking that navigational knowledge and using it to direct their empowered voice. While Sen’s approach foregrounds the individual capability, the realisation of functionings of an individual (Mehrotra, 2008: 386-388), it also spurs public speech and citizen agency which are fundamental drivers of collective identification (Jacobson, 2016: 799). Appadurai’s capacity to aspire has a similar collective potential, as aspirations are largely formed in groups (Appadurai, 2004). The HSHA campaign can be seen to be a process that gathered these individual voices into a collective, empowered voice that could be presented to and heard at the highest levels of political decision-making.
The external communications in the campaign follow-up period strengthened the accountability mechanisms for the HSHA campaign and reinforced the power of the consultation’s collective voice. Most of the women consulted did not have access to social media platforms, and therefore the potential of Facebook as a participatory platform / engagement tool was not realized. Engagement on the platform was extremely limited to alliance members and donors, but it succeeded in targeting locally-elected representatives, state-level health ministers and the National Health Minister, to engage them in the campaign and ensure commitments were kept. A similar role was played by traditional media outreach for the HSHA campaign results at the national and state levels. Here, state-level media also sought to provide a feedback mechanism for the women consulted so that they could see commitments being made, and honoured, by their local representatives.

As Joshi noted, the campaign commitments being honoured at the local level were “small but significant”; what many observers might describe as a small, service availability or resource issue (one bed per woman; timely admission to hospital) meant a better quality of care for the women consulted. Aspirations must always be viewed within their specific cultural context (Stade, 2016; Dahl, 2016; Nathan, 2005). The final accountability step that strengthened the women’s voices was the follow-up on commitments. By involving women in the dialogue in Mahila Gram Sabhas at the village level, by working with local female elected representatives to track commitments and report them back to district and state-level officials, and by using Facebook as an accountability tool, they could draw the line between what they asked for and what was delivered. For many, Gogoi noted (Women Deliver webinar, 17 April 2019), this proved that their voice was strong enough to be heard and valued at the decision-maker level; this started the beginnings of sinews of aspiration among these communities.

7.2 HSHA as a framework for aspiration building?

Nathan (2005: 39) asserts that the “connection between the immediate and the future, a road map for going from the present to the future, is what builds the capacity to
aspire.” The HSHA campaign can be seen to have successfully built this connection for the women consulted through the Social Watch approach, and by following the operationalising model for the capacity to aspire.

First, they engaged the women in a process of discovery around the ways in which they currently voiced individual concerns or demands about their own healthcare. Second, they engaged the women in a teaching and learning process about the ways in which the women could expect to be treated, the rights and the benefits available to them. Finally, the campaign exercised voice—it allowed the women to speak out not just on the individual level, but amplified that individual voice into a collective capacity that caught attention at the local, state and national levels. Its replication at the national level in HSHA 2 and at the global level through WWW is testament to its sustainability as a framework for strengthening voice and enabling aspiration among women so that they can advocate for their own health outcomes.

7.3 Limitations and future research

Given a more flexible research timeline, it would be interesting to approach this campaign case study through ethnographic research into the longer-term effects of the HSHA campaign on the women consulted. Specifically, it would be interesting to investigate the regional variations and socio-economic or religious segmentation in the women’s experiences of maternal healthcare.

Now that the HSHA 2 and WWW campaigns are both well underway, another potential research angle could track the development of aspirations at the India level from HSHA 1 to HSHA 2 or to do a comparison of India and global campaigns.

(14,398 words)
REFERENCES


APPENDIX

Primary campaign materials:


2. HSHA campaign findings leaflet, available at: http://www.c3india.org/resources/publications/


4. HSHA campaign Facebook page, available at: www.facebook.com/HSHACampaign/

Secondary media texts on the HSHA campaign:


18. News18 TV news coverage of Bhojpur (Bihar) MLA event (Hindi): https://www.youtube.com/watch?v=bNk8G0dokZU

Secondary interviews with Dr Aparajita Gogoi:

1. Women Deliver webinar on accountability and citizen-engagement campaigns (17 April 2019) https://www.youtube.com/watch?v=UvfT90kK__E&feature=youtu.be&fbclid=IwAR3yMwkLegpAFtwq7OznVmcV2OTaxd574XwNDcxoRJbNLXD52M2Weuj3-WY
