Improving performance and responsiveness of maternal health services through social accountability mechanisms in the Democratic Republic of the Congo

Strengthening the interface role in community participation

Eric M. Mafuta
Improving performance and responsiveness of maternal health services through social accountability mechanisms in the Democratic Republic of the Congo

Strengthening the interface role in community participation

ACADEMISCH PROEFSCHRIFT

ter verkrijging van de graad Doctor aan
de Vrije Universiteit Amsterdam,
op gezag van de rector magnificus
prof.dr. V. Subramaniam,
in het openbaar te verdedigen
ten overstaan van de promotiecommissie
van de Faculteit der Bètawetenschappen
op dinsdag 19 december 2017 om 11.45 uur
in de auditorium van de universiteit,
De Boelelaan 1105

door

Eric Musalu Mafuta
geboren te Gemena, Democratisch Republiek Congo
<table>
<thead>
<tr>
<th>rollen</th>
<th>namen</th>
</tr>
</thead>
<tbody>
<tr>
<td>promotor</td>
<td>prof. dr. J.T. de Cock Buning</td>
</tr>
<tr>
<td>copromotoren</td>
<td>dr. M.A. Dieleman</td>
</tr>
<tr>
<td></td>
<td>prof. dr. T.N.M. Mambu</td>
</tr>
</tbody>
</table>
# Content

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>11</td>
</tr>
<tr>
<td>2</td>
<td>Theoretical perspectives</td>
<td>23</td>
</tr>
<tr>
<td>3</td>
<td>Research methodology</td>
<td>35</td>
</tr>
<tr>
<td>4</td>
<td>Understand the local context and its possible influences on shaping, implementing, and running social accountability initiatives for maternal health services in rural Democratic Republic of the Congo: a contextual factor analysis</td>
<td>53</td>
</tr>
<tr>
<td>5</td>
<td>Social accountability for maternal health services in Muanda and Bolenge Health zones, Democratic Republic of the Congo: a situation analysis</td>
<td>83</td>
</tr>
<tr>
<td>6</td>
<td>Factors influencing the capacity of women to voice their concerns about maternal health services in the Muanda and Bolenge Health zones, Democratic Republic of the Congo: a multi-method study</td>
<td>119</td>
</tr>
<tr>
<td>7</td>
<td>Social accountability in primary health care in West and Central Africa: exploring the role of health facility committees</td>
<td>153</td>
</tr>
<tr>
<td>8</td>
<td>Participatory approach to design social accountability interventions to improve maternal health services: a case study from the Democratic Republic of the Congo</td>
<td>185</td>
</tr>
<tr>
<td>9</td>
<td>Can community participation improve social accountability for maternal health services? Preliminary results from a pilot study in two rural health zones, in the Democratic Republic of the Congo</td>
<td>219</td>
</tr>
<tr>
<td>10</td>
<td>Discussion and conclusions</td>
<td>259</td>
</tr>
<tr>
<td></td>
<td>Summary</td>
<td>293</td>
</tr>
<tr>
<td></td>
<td>Samenvatting</td>
<td>303</td>
</tr>
<tr>
<td></td>
<td>Résumé</td>
<td>313</td>
</tr>
<tr>
<td></td>
<td>Acknowledgements</td>
<td>325</td>
</tr>
<tr>
<td></td>
<td>About the author</td>
<td>313</td>
</tr>
</tbody>
</table>
Account

Chapters 4 to 9 are based on co-authored articles that are published, in press or under review for publication in peer reviewed journals.

Chapter 4

Chapter 5

Chapter 6

Chapter 7
Chapter 8

Chapter 9
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-Based Organizations</td>
</tr>
<tr>
<td>CGAT</td>
<td>Centre de Gestion et d'Accompagnement Technique des mutuelles de santé</td>
</tr>
<tr>
<td>CHW</td>
<td>Community health workers</td>
</tr>
<tr>
<td>CMO</td>
<td>Context-Mechanisms-Outcome</td>
</tr>
<tr>
<td>DRC</td>
<td>Democratic Republic of the Congo</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith-Based Organisations</td>
</tr>
<tr>
<td>FHP</td>
<td>Family Health Project</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>HC</td>
<td>Health committee</td>
</tr>
<tr>
<td>HH</td>
<td>Household</td>
</tr>
<tr>
<td>HIV-AIDS</td>
<td>Human Immunodeficiency Virus- Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>HZ</td>
<td>Health Zone</td>
</tr>
<tr>
<td>ILA</td>
<td>Interactive Learning and Action Approach</td>
</tr>
<tr>
<td>INS</td>
<td>Institut National des Statistiques (French for National Institute of Statistics)</td>
</tr>
<tr>
<td>IRB</td>
<td>Internal Review Board</td>
</tr>
<tr>
<td>KSPH</td>
<td>Kinshasa School of Public Health</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MICS</td>
<td>Multi-Indicators Cluster Survey</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Ratio</td>
</tr>
<tr>
<td>MRT</td>
<td>Middle-Range Theories</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organizations</td>
</tr>
<tr>
<td>OR</td>
<td>Odd ratio</td>
</tr>
<tr>
<td>PBF</td>
<td>Performance-Based Financing</td>
</tr>
<tr>
<td>RR</td>
<td>Relative Risk</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Funds for Populations Activities</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations International Children Emergency Funds</td>
</tr>
<tr>
<td>VHC</td>
<td>Village Health Committee</td>
</tr>
<tr>
<td>VU</td>
<td>Vrije Universiteit Amsterdam</td>
</tr>
<tr>
<td>WB</td>
<td>World Bank</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
CHAPTER 1

Introduction
Chapter 1

1.1 Problem statement

Maternal mortality remains a major public health issue in developing countries such as the Democratic Republic of the Congo (DRC), which is counted among the 40 countries that have a maternal mortality ratio (MMR) exceeding 300 maternal deaths for every 100,000 living births [1]. Estimates from 2012 (when this thesis research began) place DRC MMR around 547 maternal deaths for every 100,000 living births [2]. Nearly 2/3 of this high maternal mortality is due to direct obstetrical complications, e.g. haemorrhage, eclampsia, sepsis and obstructed labour, and to unsafe abortion [3,4]. The other 1/3 results from indirect causes or an existing medical condition made worse by pregnancy or delivery such as malaria, anaemia, hepatitis, HIV-AIDS, tuberculosis, and malnutrition [4,5].

Among the factors that contribute to maternal death are pregnancies that are too early, too close, too late and/or too many [6]. Maternal deaths are also influenced by factors summarized as the «three delays» model, including delays in (i) deciding to seek appropriate medical help for an obstetric emergency; (ii) reaching an appropriate obstetric facility; and (iii) receiving adequate care once in the facility [5,7–9]. Other related maternal mortality factors are health systems weaknesses [10,11], insufficient availability of reproductive health goods and services [12], socio-cultural barriers [5,7], wars and armed conflicts [5,13].

To address this public health issue, DRC subscribed not only to the Safe Motherhood Initiative but also to the International Conference on Population and Development's recommendations, Millennium Development Goals (MDG) and Sustainable Development Goals (SDG). All these strategies emphasized the utilisation of health services and are mainly based on strategies developed in the Safe Motherhood Initiative [4,14–17]. DRC has achieved only 42% reduction from the level in 2000 [1], mainly because of the deteriorating political and socio-economic situation which did not permit the extension of optimal coverage in health services nor eliminate contextual factors like conflicts and wars [6,13,18].

Leberghe and De Brouwere (2001) thought that the level of improvement of the utilization of maternal health services is not just a problem of the availability of health services with skilled providers and equipment, it also depends on the way providers work with and behave towards the population and how they respond to the population's needs and expectations [19].
To hold health service providers accountable for the way they work and behave towards the population and respond to its expectations introduces social accountability dimensions [20,21].

Social accountability includes mechanisms that aim to enable citizens to make politicians, policy makers and health providers responsible for their performance and results [22–24]. The population’s involvement in public services through accountability mechanisms is considered important especially in fragile and post-conflict countries like DRC where the regulation of governmental structures is generally weak and not implemented efficiently [25–27]. It is argued that if the citizens are empowered, especially women and vulnerable groups, and take part with authority in the decision-making process and contribute to change, maternal health services are likely to be adapted to their needs and contribute more to the reduction of maternal mortality [28,29]. Furthermore, social accountability in health services

Figure 1.1. Administrative map of Democratic Republic of the Congo (Source: Nations Online Project)
has been promoted as a strategy to improve the quality of health services and performance of health providers in low- and middle-income countries (LMICs).

In the DRC as in many developing countries, the beneficiary population is involved in health services’ activities through community participation [30–37], organised around health committees and community health workers. However, evidence of the effect of community participation on health provider accountability is scarce [27,37–39], and little is known about the effectiveness of social accountability on improving the quality of health services and performance of health providers [40]. In addition, even though the existing literature reports that some social accountability initiatives have produced health-related outcomes such as reduced child mortality and increased child weight, it also reveals a lack of evaluation at the level of service delivery [41,42] and does not provide evidence about the functioning of social accountability in health delivery and its relationship with the health providers’ responsiveness [19,38,43].

This PhD research aims to contribute evidence to inform policy aimed at improving maternal health by the use of social accountability. It examined the effectiveness of social accountability mechanisms in improving the responsiveness and performance of maternal health services at selected health facilities in 2 health zones in the DRC. The research overall objective is:
To assess whether and how social accountability mechanisms increase the responsiveness and performance of maternal health services in the DRC in order to inform policy-making on maternal health.

The main research question to be answered through this study is: *How can social accountability mechanisms increase maternal health services’ responsiveness and performance?*

### 1.2 Background

The context in which the study was conducted is described below. First, the administrative and political organization of the DRC is presented, followed by an overview of the health care status and maternal health situation and a description of the organization of its health care system. Then insights into key elements of community participation in rural areas are summarized. The section ends with an outline of the present thesis.
**Demographics, administrative and political organization**

The DRC is situated in Central Africa. It is the second largest country in Africa, with a surface area of 2,345,409 km². The country formerly known as Zaire shares borders with 9 other countries. It is an almost landlocked country with a short coastline of 100 km on the Atlantic Ocean (Figure 1.1.). It is the third most populous country in Sub-Saharan Africa, with a population estimated at 75 million in 2016, using a projection from the last census conducted in 1984. Over 70% of the population lives in rural areas. The DRC has a diversity of tribes and ethnicities, with more than 450 tribes, classified into four ethnic groups, including Bantu and Pygmies.

Independent since 1960, the DRC was ruled by a dictatorship for 30 years, followed by a period of political turbulence and wars. Currently classified as a post-conflict and fragile state [44], it is organized like a republic, decentralized, with a presidential-parliamentary democratic regime run by a president directly elected by the citizens for five years and by officials elected to act as legislators. The legislature then elects the executive from its members to form the central government. Every province is directed by a governor, with a provincial government and a provincial assembly. The DRC has 26 provinces, 145 administrative territories and 77 towns. Public administration has been decentralized through the devolution of powers to smaller geographical units since 2006.

**Health care status and maternal health**

Despite remarkable improvements since 1990, the DRC still has relatively poor general and maternal health indicators compared to the rest of the African continent. Table 1.1 summarizes selected health indicators of the DRC compared to African averages for 2014. Overall life expectancy at birth is only 52 years, and the crude mortality rate is 372 deaths per 1000 people, with a total fertility rate of 6.6. Under-five mortality rate is 98 per 1,000 live births, while the maternal mortality ratio is 846 per 100,000 live births [45]. However, antenatal care coverage for at least one visit and birth attendance by skilled health providers are estimated at 88.4% and 80.1%, respectively, which is better than the African average, estimated at 77% and 71%, respectively [46].
Table 1.1. Health care status and maternal health indicators of the DRC compared to African averages for 2014

<table>
<thead>
<tr>
<th>Variables</th>
<th>DRC</th>
<th>Source of DRC data</th>
<th>Africa</th>
<th>Source of Africa data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population aged less than 15 years (%)</td>
<td>46</td>
<td>WDR 2015</td>
<td>42</td>
<td>AAHS-2016</td>
</tr>
<tr>
<td>Human development index</td>
<td>0.433</td>
<td>WDR 2015</td>
<td>0.518</td>
<td>WDR 2015</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>52</td>
<td>AAHS-2016</td>
<td>58</td>
<td>AAHS-2016</td>
</tr>
<tr>
<td>Male</td>
<td>51</td>
<td>AAHS-2016</td>
<td>57</td>
<td>AAHS-2016</td>
</tr>
<tr>
<td>Female</td>
<td>54</td>
<td>AAHS-2016</td>
<td>60</td>
<td>AAHS-2016</td>
</tr>
<tr>
<td>Crude mortality rate (per 1000 people)</td>
<td>372</td>
<td>AAHS-2016</td>
<td>306</td>
<td>AAHS-2016</td>
</tr>
<tr>
<td>Male</td>
<td>379</td>
<td>AAHS-2016</td>
<td>332</td>
<td>AAHS-2016</td>
</tr>
<tr>
<td>Female</td>
<td>320</td>
<td>AAHS-2016</td>
<td>281</td>
<td>AAHS-2016</td>
</tr>
<tr>
<td>Under 5 years mortality rate (per 1000 live births)</td>
<td>98</td>
<td>AAHS-2016</td>
<td>81</td>
<td>AAHS-2016</td>
</tr>
<tr>
<td>Total fertility rate (per women)</td>
<td>6.6</td>
<td>DHS-2014</td>
<td>4.9</td>
<td>AAHS-2016</td>
</tr>
<tr>
<td>Contraceptive use (%)</td>
<td>20.4</td>
<td>DHS-2014</td>
<td>28</td>
<td>AAHS-2016</td>
</tr>
<tr>
<td>Modern contraceptive use (% of women aged 15-49)</td>
<td>8.1</td>
<td>DHS-2014</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Antenatal coverage at least one visit (%)</td>
<td>88.4</td>
<td>DHS-2014</td>
<td>77</td>
<td>AAHS-2016</td>
</tr>
<tr>
<td>Antenatal coverage at least four visits (%)</td>
<td>48</td>
<td>DHS-2014</td>
<td>48</td>
<td>AAHS-2016</td>
</tr>
<tr>
<td>Birth attended by skilled health personnel (%)</td>
<td>80.1</td>
<td>DHS-2014</td>
<td>71</td>
<td>AAHS-2016</td>
</tr>
<tr>
<td>Maternal mortality ratio</td>
<td>846</td>
<td>DHS-2014</td>
<td>542</td>
<td>AAHS-2016</td>
</tr>
</tbody>
</table>

Sources: [45,47]

**Health system organization in the DRC**

The health sector follows nearly the same subdivision as the administration, with 26 provincial health divisions [10]. The DRC has a three-tier health system, with central, intermediate and peripheral levels. The peripheral level is represented by health zones, which correspond to health districts in other African countries. Each health zone is supposed to have a general referral hospital, and is subdivided into small health units known as health areas. Public health services are provided following a hierarchy from health centres at the health area level to national referral hospitals. The health centres provide essential primary health care, while the higher levels are supposed to provide increasingly specialized and well-defined services [48].

Approximately 30% of general referral hospitals and 60% of health centres at the health zone level belong to faith-based organizations and less than 10% belong to other private
sector providers. Private providers are mainly present in cities. Similar to most low-income countries, the public health system in the DRC faces challenges that hamper the quality of service delivery. For example, there are frequent stock-outs, a lack of adequate diagnostics, outdated infrastructure, inadequate equipment, no integration of new technologies, staff shortages, and poor motivation and limited capacities to perform their tasks [49].

Community participation in rural DRC

In the DRC as in other developing countries, the community is involved in the health service's activities through community participation [30–37]. Community participation is one of the pillars of the national health policy in DRC, is based on primary health care strategies and is organized at the level of the health area. A health area is the lowest tier of the health system. It covers at least 5000 inhabitants and has a health centre that provides a comprehensive healthcare package, including community health activities. The nurse in-charge is responsible for both clinical care and community activities, and is supported by volunteer community health workers and a health committee. Community health workers and the health committee are the two forms of community participation in the health sector in the DRC [50,51]. Community health workers (CHWs) are volunteers, elected or not by community members, who carry out community-related health activities through home visits or community sensitization campaigns. All CHWs from a village form a community sensitization cell, “Cellule d’animation communautaire” in French, chaired by an elected delegate, who is a member of the health committee. CHWs are supposed to carry out between 15-25 home visits each month and to report their activities to their delegate, who, in turn, reports to the health committee [50].

The health committee is composed of representatives of population groups living in a health area, including delegates of CHWs and the nurse in-charge of the local health centre. It is meant to act as a steering committee for the health centre and coordinates community participation activities in the health area. The health committee meets at least monthly to discuss activities that were carried out and plan those to be conducted the following month. It is intended to be the voice of the population and is supposed to channel their perceived needs, to transmit their expectations, to participate in the identification of health-related needs, in the planning, in the monitoring, and in the assessment of health services, and to make providers accountable [52].
1.3. Outline of the thesis

This thesis is organized as follows. After the introduction of the rationale and the aim of this thesis (Chapter 1), the two following chapters present the theoretical perspectives (Chapter 2) and describe the research methodology (Chapter 3).

Chapters 4-9 of this thesis present the findings of the study. These chapters have already been published, accepted for publication or submitted for publication as journal articles. They are slightly adapted to ensure consistency of terminology and reference style. They are organized in two parts.

Part I is concerned with the existing situation of social accountability in maternal health in rural areas in the two research sites. Chapter 4 provides insights into local contextual factors and discusses their possible influences on shaping, implementing and running social accountability initiatives at the local level using qualitative research methods. The current situation regarding social accountability in maternal health services at the two research sites is described in Chapter 5. Chapter 6 analyses factors that influence the capacity of women to voice their concerns and expectations regarding maternal health services at the rural health service level, and Chapter 7 explores the actual and potential role of health committees in the facilitation of social accountability mechanisms.

Part II is concerned with the development of social accountability at the local level. Chapter 8 describes the development of a social accountability intervention that aimed to improve health services’ responsiveness and performance in two health zones in DRC, by involving beneficiaries, representatives of the health sector and local authorities in the advisory participation process. Chapter 9 reports on the evaluation of the effectiveness of the social accountability intervention by providing insights into whether it worked, for whom, how and under what conditions.

In Chapter 10 the main research question is answered based on the findings. These answers are subsequently discussed and placed in a broader context and the implications of the findings presented.
References

CHAPTER 2

Theoretical perspectives
This chapter presents some of the theoretical concepts on which this thesis is based. First, it presents concepts of health service performance, health providers’ responsiveness and social accountability in health services. An understanding of these concepts and related frameworks are necessary to address the aim of this thesis. Then the chapter elaborates on the relationship between health service performance, health providers’ responsiveness and accountability mechanisms.

2.1. Health service performance

In this thesis, the focus is on health service performance. WHO (2007) describes a performant health service as one that provides quality, effective, individual or collective health interventions, without risk to those who need them. To be performant, health service interventions need to be timely and occur where they are needed with a minimal waste of resources. However, the concept of performance even in health service provision is multidimensional and used in multifaceted ways, and the underlying assumptions are diverse [1]. The standard definition of performance can include either what the performer does as behaviour, activity or intervention, or the result of the behaviour, activity or intervention [2]. For Murray and Frenk (2000), the concept of performance is more complex than simply recording the level of goal attainment. It involves relating goal attainment to what could be achieved, suggesting a relative concept. The performance of the entire health service must be related to the performance of its various components [3]. Rowe et al. (2005) defined the performance as adherence to an accepted standard or guidelines [4].

The performance of health services generally, and that of maternal health services in particular, through health service provision is directly translated in improvement of health in terms of reduced maternal mortality (i.e. quality) and of the distribution of health in the population between individuals and between groups (i.e. equity). However, health services also have intermediate goals such as accessibility, utilization, coverage and quality. Other authors also include responsiveness to users among health service performance [5,6]. In this thesis, health service performance is defined as what health providers do as behaviour or activities, including responsiveness to users.
2.2. The responsiveness of health services

Health service responsiveness is defined as the capacity of health services to respond to the population’s expectations. It generally constitutes one of the fundamental objectives of the health system and corresponds to the capacity of health services to limit infringements of the dignity and autonomy of the individual, as well as the fears and shame associated with a condition. Responsiveness contains two main dimensions: respect for the person and attention paid to the client. The impact of responsiveness on the improvement of health can be explained by the fact that a health service which answers the desires and expectations of the population better encourages potential patients to use the service if they think that they will be treated well [7].

In the context of accountability, responsiveness can be defined as changes made to the health service in terms of health service performance or health providers’ behaviour on the basis of ideas or concerns raised by or with community members, different subpopulations and vulnerable groups [8–10].

2.3. Social accountability

Social accountability is one of the accountability mechanisms used in health systems governance. In 2004, the World Bank conceptualized the performance of a service as the result of the relations of accountability between three actors: citizens, providers and policy makers. Accountability was defined as a process within a principal-agent relationship through which the behaviour and performance of the agent are assessed against pre-set standards by the principal and where misdeeds and wrongdoing are sanctioned. According to the World Bank, five components characterize an accountable relationship: (i) delegation; (ii) financing; (iii) performance; (iv) information about the performance; and (v) enforceability. The achievement of an accountable principal-agent relationship requires taking several steps in an on-going dynamic process, involving repeated interactions between the principal and agent. It is assumed that the agent, an accountable actor, receives a clear delegation from the principal, with clear objectives and actions to carry out. He is expected to have adequate resources and conduct his activities (performance). His contribution is assessed through information
gathered by the principal, who then acts to encourage good performance and discourage poor performance, holding the agent responsible for results and actions. The World Bank identifies health service provision insufficiency as a weakness in one of the accountability relationships or in the capacities of one of the actors to fulfil his role. Health service performance reflects the degree of interaction between actors and the fulfilment of their roles.

The accountability in health systems can concern the finances, performance and policy according to Brinkerhoff [11]. Financial accountability concerns tracking and reporting on allocation, disbursement and use of financial resources, using appropriate tools. The accountability for performance concerns its evaluation and measurement as well as the improvement of services. It refers to the demonstration and measure of the performance in light of the targeted objectives. Political or social accountability concerns the relation between the state and the citizens, and covers governance, citizen's participation, equity, transparency, responsiveness and development of confidence. It also takes into account the citizens' expectations and the way the public representatives act to formulate and implement the policies, offer the public goods and services, gain their confidence and carry out the social contract. The main characteristic of political or social accountability is
responsiveness according to Brinkerhoff. Performance accountability is connected to political or social accountability as the criteria for performance include responsiveness to citizens and achievement of service delivery targets that meet their needs and demands.

The direct engagement of the public, citizens or communities in the accountability systems can be exerted through exit or voice strategies [12]. Exit strategies relate to citizens’ ability to hold health providers accountable by exercising their exit option and turning to alternative suppliers of a given service, while voice strategies concern the ability of citizens to influence the outcome of a service through some forms of participation or articulation of protest or feedback.

Accountability strategies in the health sector can be achieved through the long route between governments (politicians, policymakers, bureaucrats…) and citizens, which involves broader social and political change, or through the short route between service providers and users [8]. These sets of actors (citizens, providers and policy makers) are linked in power and accountability relationships (Figure 2.1.). The long route to accountability linking community to providers through policymakers (government, state) illustrates accountability relationships associated with vertical accountability mechanisms, which function to promote answerability within the health system’s hierarchy. Community-elected representatives can hold policymakers accountable for public health services. Policymakers and other actors at the state level may hold facilities and providers accountable through monitoring progress towards the achievement of health care targets, setting budget and expenditure guidelines, and providing supervision and oversight [13,14]. However, because of the high demands on institutional performance that full accountability along the long route poses [15], especially in a country with low regulation capacities and limited performance-monitoring capacity, and having to deal with failures in the long route [16], the case is often made that efforts should be focused on strengthening the short route to accountability.

The short route is illustrated in Figure 2.1 by horizontal arrows which depict accountability relationships between providers and patients and citizens. It is known as external or social accountability. The “short route” puts citizens as clients in direct communication with service providers. Through this mechanism, the users exercise “client power” to demand accountability from service providers [16]. It encompasses processes through which citizens
and patients may express their preferences about services and may be involved in monitoring and supervising facilities and providers. The functioning of external accountability processes requires providers to be responsive to citizen inputs, including through taking action to alter services in response to ideas or concerns raised by citizens [8,14].

The main limitation of the World Bank model is that it only promotes formal accountability mechanisms and direct citizens’ actions. It presents a simple way of thinking about accountability and does not address issues of context, like the complex political and social environment in developing countries [17].

Taking into account the criticism formulated about the World Bank model, Lodenstein et al. [18] conceptualized social accountability as a process including three elements: (i) Citizen engagement, which includes individual participation and voice or collective expression of one’s expectations and concerns without formal ways of enforcement; (ii) Citizen oversight, which includes involving citizens in the collective monitoring and evaluation of health services and the performance of health service providers, sanctioning when poor performance occurs and rewarding when the performance is perceived as good; (iii) Both might result in a higher degree of responsive health services, thus contributing to improved health. According to Lodenstein et al. social accountability mechanisms, responsive behaviour, and their consequences are influenced by contextual factors, such as societal values, gender relations, levels of political stability and health system characteristics.

Despite recognizing the influence of contexts and describing the link between social accountability and its impact on the health sector, the model proposed by Lodenstein et al. did not provide a clear description of the functioning of a social accountability mechanism. By describing the components and steps involved in effective social accountability initiatives, Baez-Camargo and Jacobs asserted that social accountability involves at least three core elements: voice, enforceability and answerability. Voice includes the mechanisms, formal and informal, through which people individually or collectively express their concerns and expectations, and demand accountability from power holders. Enforceability comprises the means available to sanction non-compliance, wrongdoing and/or not appropriately fulfilling the mandate. Answerability refers to the obligation of the power holder to provide an account and the people’s right to receive a response. Answerability also involves a feedback
process through which citizens can be informed of the use made of the information they have provided. According to Baez-Camargo and Jacobs, to be effective, the voice of citizens needs to be articulated into actionable demands and transmitted to the relevant actors and decision makers, who have enforcement capabilities in order to generate answerability from the service providers and local authorities (Figure 2.2.) [10]. Baez-Camargo and Jacobs assumed that the capacity of citizens (in this case, women) to voice their concerns is influenced by the knowledge they have of the health providers’ mandate, of their own rights and entitlements including their patients’ rights as consumers, and of

![Diagram of components and steps involved in effective social accountability initiatives](image)

**Figure 2.2.** Components and steps involved in effective social accountability initiatives (adapted from Baez-Camargo and Jacobs, 2013)
the specific obligations that health providers have to fulfil in the course of health service provision [10]. They argued that social accountability is not an output or an outcome, but rather a process. This implies that assessing accountability should concern looking at whether the different steps involved in achieving accountability within an institutional relationship are present or not [15]. The model proposed by Baez-Camargo and Jacobs was used as conceptual model for studying the social accountability process in this study.

2.4. Relation between social accountability mechanisms, health providers’ responsiveness, health service quality and health outcomes

Despite the growing literature on social or community accountability, most papers on social accountability are about interventions that enhance the service providers’ accountability to the consumers they serve, and they focus on voice interventions [19]. Voice interventions are initiatives that enable citizens to influence the outcome of service through some form of participation or articulation of protest or feedback [12]. Six types of voice interventions are generally described: (i) participation in various forms of participatory institutions; (ii) direct governance in the form of consumer boards; (iii) consumer evaluation/satisfaction survey that provides feedback to management; (iv) the enlistment of voice agents such as consumer rights groups, non-governmental organizations, ombudsmen; (v) empowerment of consumers through knowledge and training; and (vi) consumer rights organizations. A literature review on voice intervention and its effect on the improvement of the quality and responsiveness of public health service provision found that despite the existence of many studies, very few focus on quantitative outcomes measuring the impact of voice interventions on service quality and consumer satisfaction [19].

The literature review also showed that voice interventions may have a potential to build citizen participation and accountability of service providers to some extent, but there is little evidence that the service quality improves as a result. It was also found that programs that empower consumers by providing knowledge about specific issues and providers seem to be effective in improving service quality and satisfaction [20–22]. The existing literature also confirmed that the type of voice intervention with the most evidence of effectiveness
Theoretical perspectives

in improving service quality is customer feedback or scorecards [23,24] despite studies that did not clearly establish the cause-effect relationship with score cards. Therefore, it can be concluded that, first, there is little direct evidence about how voice intervention may work to improve service quality and, second, there is a lack of studies about the value of citizen participation as a means of exerting pressure on service providers to change their behaviour [19,25]. Literature is scarce on responsiveness in the health service and its link with social accountability. However, some previous studies showed that an improvement in health service responsiveness, as perceived by clients, can potentially increase the service uptake [26]. Reviewing the available empirical literature on accountability mechanisms linked to peripheral health facilities, Molyneux et al. (2012) found that the most thoroughly studied mechanisms are committees such as health centre committee.

In spite of the challenges met in their functioning as community accountability mechanisms, they found that health committees were taking on an increasing role in monitoring, planning and management, building up a sense of ownership in the community. Molyneux et al. noticed also the paucity of published empirical data concerning community accountability in health delivery and called for further research [8].

In conclusion, there is a scarcity of published empirical data concerning community accountability in health delivery and its relationship to health providers’ responsiveness. Very few studies focus on quantitative outcomes measuring the impact of voice interventions on service quality and consumer satisfaction. The current study was initiated to address some of these limitations and to continue working on the effectiveness of community accountability mechanisms in developing countries.
References

Theoretical perspectives

CHAPTER 3

Research methodology
In Chapter 1, the problem of maternal mortality was described, and the probable effect of social accountability mechanisms in reducing maternal mortality underlined. In Chapter 2, the theoretical concepts that inform this thesis were described. The present chapter describes the research methods employed for this thesis and starts by presenting the research objectives and the main question. It also describes the research approach that was used to answer the main question. Subsequently, a number of studies are presented that were developed to answer the research sub-questions and specific methods that were used when conducting this research.

3.1. Research objectives

The main objective of the thesis is to gain insight into whether and how social accountability mechanisms increase the responsiveness and performance of maternal health services in the DRC in order to contribute to policy-making for social accountability in maternal health.

The specific objectives are:
1. To identify and analyse existing mechanisms through which the interests of citizens are expressed and integrated into maternal health service standards, policy and planning, and human resource performance management in the DRC;
2. To assess whether specific accountability mechanisms result in the improved performance of maternal health service delivery and its use in the DRC;
3. To develop a conceptual framework for accountability that incorporates contextual factors, enabling change in maternal health service performance in the DRC.

3.2. Research questions

The main question to answer through this study is:

"How can social accountability mechanisms increase the responsiveness and performance of maternal health services?"
### Table 3.1. Overview of research sub-questions, research process, study-level questions and studies

<table>
<thead>
<tr>
<th>Research questions</th>
<th>ILA Phase</th>
<th>Specific research questions</th>
<th>Studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the existing social accountability mechanisms through which the concerns, expectations, questions and complaints of women could be expressed and taken into account in maternal health service provision?</td>
<td>1- Initiation and preparation</td>
<td>What existing local contextual factors can influence a social accountability initiative and the capacity of the community members, specifically women, to be engaged in it?</td>
<td>Study 1</td>
</tr>
<tr>
<td></td>
<td>2- Collection, exchange and integration</td>
<td>What mechanisms and experiences exist regarding social accountability in maternal health services in Kongo Central and Equateur?</td>
<td>Study 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What factors could influence the capacity of women in rural areas in the DRC to voice their concerns and expectations about health services to health providers?</td>
<td>Study 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How do health committees facilitate social accountability? (How do providers respond?)</td>
<td>Study 4</td>
</tr>
<tr>
<td>What is the effect of social accountability mechanisms on the responsiveness and performances of maternal health service providers?</td>
<td>2- Collection, exchange and integration 3- Priority setting and planning; Project formulation</td>
<td>Which social accountability mechanisms are needed in order to improve maternal health services’ responsiveness and performance? How could community groups be involved in designing these social accountability mechanisms to make them more relevant?</td>
<td>Study 5</td>
</tr>
<tr>
<td></td>
<td>4- Project formulation and implementation</td>
<td>What is the effectiveness of SAI to influence HP responsiveness? What are the conditions for social accountability to effectively contribute to health worker responsiveness and improved quality of maternal healthcare?</td>
<td>Study 6</td>
</tr>
</tbody>
</table>
Chapter 3

The main question can be subdivided into the following specific sub-questions:

1. **What are the existing social accountability mechanisms through which the concerns, expectations, questions and complaints of women could be expressed and taken into account in maternal health service provision?**

2. **What is the effect of social accountability mechanisms on the responsiveness and performance of maternal health service providers?**

### 3.3. Research approach

The research questions were investigated using the Interactive Learning and Action (ILA) approach. ILA was used here as it has been found suitable to study complex social phenomenon occurring at the interface between several domains, even ones as wide-ranging as agriculture, health and biotechnology. It has been applied in many countries, including developing countries such as South Africa [1,2], Indonesia [3], and Bangladesh [4]. It was also used in this study, in the form of a Dialogue Model, as it offers guidelines and principles on how to consult with and integrate issues from different stakeholder groups in an advisory process. Developed at the Athena Institute, VU University Amsterdam, it has been applied to involve participants, to set a research agenda in a scientific advisory process, in the development of clinical guidelines, and in the improvement of health research practices [5–9]. The evaluation of ILA applied in previous research studies showed an effective and appropriate participation of stakeholders and allowed useful and adequate reflection on the perspectives of participants [5–8].

ILA is based on six principles: active engagement of beneficiaries, conducive social conditions, respect for experiential knowledge, mutual learning, emergent and flexible design, and facilitation process. It is roughly divided into four phases, with the outcome of one phase serving as the input for the following phase. The four phases are: initiation and preparation; collection, exchange and integration; priority setting and planning; and project formulation and implementation [2]. The research study went through these phases as depicted in Figure 3.1. The next section provides a summary of each phase. Table 3.1. provides an overview of the relationship between the research questions, research approach phases, specific studies and their research questions.
Phase 1. Initiation and preparation
The initiation and preparation phase was carried out from January 2012 to June 2013. All organizations involved in maternal health at the DRC national level were identified, and a partnership was established between the research team and health sector partners who were interested in research and implementing or planning to implement an intervention with a social accountability component. During this phase, research sites were selected and a preliminary evaluation of their local context done. This first phase contributed to understanding the socio-cultural, economic and governance contexts in which interventions aimed at setting up social accountability would be implemented. More specifically, it focused on describing and discussing different organizations or projects intervening in the two intervention health zones, collaboration between local partners, community organization (especially involving women) and the relationship between local organizations and the partners’ projects.

Phase 2. Collection, exchange and integration
The collection stage took place from September 2013 to December 2014. It focused on identifying and analysing the maternal health services from various perspectives at the research site level in order to identify the existing social accountability mechanisms. It also determined the population’s needs and expectations with regard to maternal healthcare services, as well as maternal health service responsiveness and performance in the selected health areas. The functioning of the health committee with regard to its interface role in social accountability was also explored, and factors that influence the capacity of women to voice their concerns regarding maternal health services at the rural health service level were identified.

The exchange and integration stage was carried out from February to April 2015. It focused on documenting the reactions of actor groups in the two health zones and of the health partners to the findings of the exploratory study and the context analysis carried out in phases 1 and 2. Exchange meetings were organized with various groups of participants at different levels of the health systems to share the research findings and collect suggestions for improvement. Afterwards, dialogue meetings were held with representatives of participant groups to integrate the suggestions received into one intervention proposal.
Chapter 3

Figure 3.1. Research process flow

Phase 1 (Study 1)
- Constitution of research team
- Analysis of contexts
- Stakeholder analysis
- Research partnership

Phase 2 (Studie 2)
- Health facilities performance survey
- Health providers group discussion and interview

Phase 2 (Study 5)
- Community and stakeholder reports

Phase 2 (Study 6)
- Joint/Dialogue meeting

Phase 4 (Study 4)
- Community monitoring/survey

Phase 4 (Study 6)
- Progress with collection of data in health facilities

Phase 5-6
- Action Plan Feedback to Health Providers and Training of CHVs
Phases 3 & 4. Priority setting and planning; Project formulation and implementation
Priority setting, planning and project formulation were conducted at a national level in April 2015 during a workshop with research partners and officers from the Ministry of Health with the aim of developing a social accountability intervention for implementation. Intervention proposals from the two health zones were used for formulating one social accountability intervention for implementation in the two health zones. These phases integrated parts that were developed in different contexts into the whole, building one intervention proposal. The social accountability intervention components were selected and extensively described in light of their technical feasibility, of their alignment with the current health policy and of existing interventions in the two health zones, namely the performance-based financing intervention in Muanda HZ and the community-based health insurance intervention in the Bolenge HZ.

The designed intervention was implemented through workshops held with community health workers and health committee members, with representatives of community groups including women’s groups in each site, and with health providers from April to May 2015. These workshops were carried out by health zone management team officers supported by research partners. The implemented intervention operated for one year and was monitored monthly. Its first cycle was evaluated from May to June 2016.

3.4. Research design
This study is part of health policy and systems research, and deals with health system governance. Research designs used in this study included case study, multiple methods study including cross-sectional study and qualitative studies, and quasi-experimental designs. The research was divided into two parts, regarding the existing situation of social accountability in maternal health services at the local level in rural areas and the experimental process of building social accountability at the local level.
Chapter 3

Part 1. Existing situation of social accountability in maternal health in rural area in DRC

The first research question was investigated by conducting four individual studies. The relationship between the first research question and the four studies can be seen in Table 3.2. These studies mostly used case-study design. This is an approach to research that facilitates ‘detailed examination of a phenomenon within its context using a variety of data sources’ [10,11]. Case-study research is recognized as being particularly useful when the focus is on seeking answers to ‘why’ and ‘how’ questions and when the context of the research is important. It allows the researcher to explore individuals or organizations, simple or complex interventions, relationships, communities, or programs, and supports the deconstruction and subsequent reconstruction of various phenomena [10–12]. The case-study approach was used in this thesis as it takes into account the complexity of the social accountability process by acknowledging the importance of various elements such as actors and contexts, but also by providing insights into specific characteristics of research sites. It was also used because this thesis aimed at an in-depth exploration of a social accountability process to answer why and how questions, applying several data collection methods and using multiple sources of data.

A cross-sectional design study was also used in this thesis as part of a mixed methods approach. It involved a survey methodology that is often used for creating an image of a phenomenon, situation, person and event in the short term and at a particular period of time, or showing how things are related to each other [13]. In this thesis, a household survey was carried out to gain more understanding of women’s socio-demographic and economic characteristics and their experiences with the maternal health services.

Part 2. Building social accountability at the local level

The second research question was investigated by employing two individual studies. The first used a participatory action research based on the Dialogue Model [7,8] and the second, a quasi-experimental (as pre-post-) community intervention implemented in the two health zones.
Table 3.2. Overview of research methods applied in this thesis

<table>
<thead>
<tr>
<th>Study</th>
<th>Study type and data collection methods</th>
<th>Respondents</th>
<th>Chapters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study 1</td>
<td>Multiple methods study: Qualitative study (32 semi-structured interviews) and document review</td>
<td>Health providers, community members, local leaders including community group representatives</td>
<td>4</td>
</tr>
<tr>
<td>Study 2</td>
<td>Qualitative study: 48 semi-structured interviews</td>
<td>Community members (women, men, grandmothers and mothers-in-law), health providers, local health partners, community health workers, health zone management officers</td>
<td>5</td>
</tr>
<tr>
<td>Study 3</td>
<td>Multiple methods study: Secondary analysis of data of two qualitative studies and a household survey (n=517)</td>
<td>Household survey with women of reproductive age</td>
<td>6</td>
</tr>
<tr>
<td>Study 4</td>
<td>Qualitative study in 11 health centers in 3 countries: 90 semi-structured interviews, 22 focus group discussions.</td>
<td>Community members, health committee members, community health workers, health providers</td>
<td>7</td>
</tr>
<tr>
<td>Study 5</td>
<td>Participatory action research process: 12 focus group discussions and one workshop, n=92 participants)</td>
<td>Community members, community group representatives, committee health members, health providers, health zone management officers, local authorities, health partners</td>
<td>8</td>
</tr>
<tr>
<td>Study 6</td>
<td>Multiple methods study: Document review, follow-up with 64 semi-structured interviews.</td>
<td>Community members, community group representatives, health providers, health zone management officers, local authorities</td>
<td>9</td>
</tr>
</tbody>
</table>

3.5. Study area and selection

The research intervention was carried out in two health zones (HZ). They were chosen for convenience because that was where the research partners worked. Muanda HZ is situated in the province of Kongo Central in the southwest. It is 90% rural and 10% urban. The urban part is represented by the city of Muanda. Bolenge HZ is situated in Equateur in the northwest and is one of the three HZs of Mbandaka. It’s a rural region. These HZs were chosen according to the following criteria: (1) having maternal mortality and morbidity problems; (2) accessible
in rural or urban-rural setting; (3) a stable population, a condition which allows the social cohesion necessary for the feasibility of the accountability mechanisms; and (4) benefitting from an intervention led by a partner aiming at the development of accountability mechanisms, targeting the improvement of maternal health. The HZ of Muanda in Kongo Central benefits from a performance-based financing program, supported by Cordaid; and the HZ of Bolenge in Equateur benefits from support for the promotion of community health insurance, under the supervision of Medicus Mundi. They had estimated mid-year populations of 137,178 and 79,648 in 2013, split into nine and ten health areas, respectively.

The study was conducted in two health areas, representing cases, purposefully selected in the two HZs. To be selected, the health area must have a functioning health centre, providing a comprehensive basic maternal healthcare package according to DRC national health policy and an optimal population size of more than 5000 inhabitants. The use of two research sites with different contexts helped in drawing conclusions by comparing and integrating the data from sites into the whole [8]

### 3.6. Study participants and sampling

The main study population of this thesis consisted of people involved in a social accountability process in maternal health services, including community members and health providers (see Table 3.2.). Community members were men and women of reproductive age, community health workers, members of the health committee, and village leaders. Apart from respondents in the household survey, respondents in the qualitative studies in this thesis were enrolled through purposive sampling using specified criteria. All respondents were 17 years or older. In each site, respondents were recruited with the support of the health zone management team, health providers or a village leader. With the collaboration of the health management team officer in charge of community activities or of the health providers, identified respondents were contacted and an appointment was made for data collection.

For the household survey, women were enrolled through a multi-stage sampling process. The sample size for each health area was estimated following the assumption that women of reproductive age represent about 20% in an average population of 5000 persons and
the sample size concerned around 15% of them. This sample size allowed us to take into consideration a sample size calculation using the proportion of pregnant women who deliver assisted by a skilled health provider. The minimal sample size for each health area was computed in 96.4 using a formula that takes into account the quasi-experimental design adopted in the second part of this thesis [14]. Health providers included health service providers involved in maternal health, members of the health zone management team, and health project managers involved in the health partners’ activities at the local level.

3.7. Data collection methods

In line with various research designs described above, a range of qualitative and quantitative approaches of data collection was used in this thesis, including document review, non-participative observations, semi-structured interviews, focus group discussions, and structured interviews with questionnaires (see Table 3). A detail description of the research approaches can be found in Chapters 4 to 9.

3.8. Data processing and analysis

Semi-structured interviews and the focus group discussions were transcribed verbatim in Lingala, one of main local languages, translated into French and checked by research team members. Observations were transcribed in notes. Observation notes and the transcripts were processed and coded using Atlas-ti 7 software (ATLAS.ti GmbH, Berlin). Both deductive and inductive approaches of data analysis were used in this thesis. The data were subjected to thematic or content analysis based on conceptual frameworks or on research questions [15,16].

Quantitative data from the household survey were recorded using Epi Info 7 (CDC, Atlanta), and statistical analyses were performed using SPSS 23.0 (IBM, Chicago). The data were summarized using proportions for categorical variables and means with standard deviations (SD) for quantitative variables. The association between categorical variables was tested
using Pearson’s or likelihood-ratio chi-square test as well as the Fisher test when appropriate. Proportions and means were compared using the chi-square test and Student’s t-test, respectively. Whenever a quantitative variable was not normally distributed, the median was used for summarizing the data, and a non-parametric test was used to compare the medians. A logistic prediction model was made using the backward procedure in order to identify factors associated with the dependent phenomenon. Independent variables included socio-demographic and health and health service characteristics. Statistical significance was fixed at p=0.05.

Data from the document review extracted using Checklist, Excel files or text document with regard to their qualitative or quantitative nature were processed and analysed according to procedures described earlier in this section.

### 3.9. Research teams

The research team varied in composition for each study. For the study of the context, data were collected through interviews by the PhD student. The situation analysis was conducted by a research team that consisted of three persons: the PhD student, a research intern from the Athena Institute, and a research assistant from the Department of Sociology and Anthropology at the University of Kinshasa. The participatory research activities were conducted by a research team consisting of three persons: the PhD student and a Master student from the Athena Institute, assisted by a research assistant from a local higher education institution acting as translator/collaborator. The implementation workshops were conducted by health zone management team officers in collaboration with the health sector partner and the research team. Monitoring activities with regard to the intervention were carried out by two community facilitators from local non-governmental organisations. They provided and discussed monthly monitoring reports with the PhD student. Follow-up interviews were conducted by the PhD student. Interviews were recorded and transcribed in French.

The research process was supervised by three senior researchers from the VU University Amsterdam, KIT Amsterdam (the Netherlands) and Kinshasa School of Public Health (the DRC), and the research findings were discussed with health partners who were members
of the research partnership. This research was part of WOTRO Improving maternal health through social accountability in Burundi and the Democratic Republic of the Congo, launched in 2012 and funded by WOTRO, a division of the Netherlands Organization for Scientific Research.

3.10. Validity and quality assurance

Various strategies were used to enhance the validity of the results and conclusions and to minimize the effects of researcher bias and influence during data collection, analysis and interpretation. The following strategies were employed and are briefly described: triangulations, data saturation, multidisciplinary, interdisciplinary, member checking and feedback from research partners. Other strategies used included the training of research team members, the use of pre-tested tools, a validated protocol, and conceptual frameworks to guide data collection and analysis.

The main strategy to enhance validity was triangulation, including data collection, data sources, and investigator triangulations. Both qualitative and quantitative data collection methods were used, including semi-structured interviews, focus group discussions, participatory research, document review, and surveys. Respondents from different categories were involved, ranging from community members to local authorities. In this thesis, triangulation was achieved by comparing findings from data collected using different data collection methods and/or by comparing data collected from a variety of participants.

These data were discussed using an interdisciplinary approach with researchers representing different fields of expertise in social accountability, community participation, qualitative research, human resources management, and maternal health services. The researchers resided in the research area during the data collection and carried out a preliminary analysis in order to understand the context. They regularly spent time in the community in the study area from the end of 2012, and this encouraged an atmosphere of trust and respect in interaction with participants. To enhance the validity further, the findings of each research process were regularly presented for a member check to respondents, and for feedback to research partners, health providers and representatives of community groups involved in the
process, and to Ministry of Public Health officers in charge of community participation, policy making and maternal health, in accordance with the transdisciplinary approach. This reduced the risk of misinterpretation, while it gave participants the opportunity to clarify and explain the findings arising. To avoid subjective conclusions, the researchers discussed the findings and fieldwork notes with supervisors and in the team.

All researchers involved in the fieldwork were trained in data collection methods, and the entire research project was guided following a validated research protocol, providing conceptual frameworks and research tools. All research tools were pre-tested and translated into local languages. Qualitative research data were audio-recorded and transcribed verbatim in Lingala, and then translated into French or English for analysis. They were also back-translated to check that the translation was correct. Data analysis was usually carried out by at least two researchers, guided by conceptual frameworks, and discussed with all members of the research team.

3.11. Ethical considerations

Ethical approval was obtained from the Kinshasa School of Public Health Ethics Committee. The research project adhered to ethical principles, in particular voluntary consent granted by the participants, confidentiality and anonymity during data collection, secure data management and storage, risks and benefits. Respondents did not benefit directly from the study except for reimbursement of their transportation expenses to the focus group discussions. There were no major risks for women participating studies. But as the semi-structured interviews and questionnaire addressed topics that could be sensitive and very personal for those who had experienced events such as inappropriate care and care complications, the research assistants were trained to deal with these situations, specifically to provide psychological support to participants who expressed any signs of distress during the interview and to refer those participants to local support. Specifically for the household survey, respondents were given the phone number of a local psychological support provider who could assist them to get help if needed. Respondents were also told that with their approval, the interviewer would inform the supervisor about their distress and assist with referral information in order to get help.
Confidentiality of the information provided by the participants was assured by limiting access to the data to the researchers who were directly involved in the thesis and focus group, by discussing confidentiality issues with participants, and by providing clear instructions at the beginning of each focus group discussion. The data collection was anonymous, and no names were attached to the transcripts. Identifiable data were not shared with anyone outside the immediate research team, and data were managed anonymously using only category type, sex, age, and research site, if necessary for quotations. Research transcripts and questionnaires were computerized and kept in a password-protected computer. All participants enrolled in the study provided informed written or oral consent. All participants aged under 18 years old provided their assent in addition to parental consent.
References


CHAPTER 4

Understand the local context and its possible influences on shaping, implementing, and running social accountability initiatives for maternal health services in rural Democratic Republic of the Congo: a contextual factor analysis
Abstract

Social accountability has to be configured according to the context in which it operates. This paper aimed to identify local contextual factors in two health zones in the Democratic Republic of the Congo and discuss their possible influences on shaping, implementing and running social accountability initiatives. Data on local socio-cultural characteristics, the governance context, and socio-economic conditions related to social accountability enabling factors were collected in the two health zones using semi-structured interviews and document reviews, and were analyzed using thematic analysis.

The study showed that the contexts of the two health zones were similar and characterized by the existence of several community groups, similarly structured and using similar decision-making processes. They were not involved in the health sector’s activities and had no link with the health committee, even though they acknowledged its existence. They were not networked as they focused on their own activities and did not have enough capacity in terms of social mobilization or exerting pressure on public authorities or providers. Women were not perceived as marginalized as they often occupied other positions in the community besides carrying out domestic tasks and participated in community groups. However, they were still subject to the local male dominance culture, which restrains their involvement in decision-making, as they tend to be less educated, unemployed and suffer from a lack of resources or specific skills. The socio-economic context is characterized by subsistence activities and a low employment rate, which limits the community members’ incomes and increases their dependence on external support. The governance context was characterized by imperfect implementation of political decentralization. Community groups advocating community rights are identified as “political” and are not welcomed. The community groups seemed not to be interested in the health center’s information and had no access to media as it is non-existent.

The local contexts in the two health zones seemed not to be supportive of the operation of social accountability initiatives. However, they offer starting points for social accountability initiatives if better use is made of existing contextual factors, for instance by making community groups work together and improving their capacities in terms of knowledge and information.
4.1. Background

Maternal mortality remains a major public health issue in developing countries including the Democratic Republic of the Congo (DRC) [1], a country classified among fragile and conflict-affected states [2,3]. Current estimations place the maternal mortality ratio (MMR) in DRC at about 846 maternal deaths per 100,000 live births [4]. Nearly two-thirds of this is due to direct obstetrical complications including hemorrhage, eclampsia, sepsis, obstructed labor, and unsafe abortion [5,6]. The remaining one-third is due to indirect causes or pre-existing medical conditions made worse by pregnancy or delivery such as malaria, anemia, hepatitis, HIV-AIDS, tuberculosis, and malnutrition [6,7]. Pregnancies are also occurring too early, too close, too late or too many times as suggested by the high fecundity (6.6 children per woman), early fecundity among adolescents (21.2%) and the short inter-genesic interval (27.1% births) [4]. Other factors associated with maternal mortality involve health systems weaknesses [8,9], including the poor availability of reproductive health goods and services [10], socio-cultural barriers [7,11], and armed conflicts [7,12].

To address this high maternal mortality, DRC subscribed to the recommendations of the Safe Motherhood Initiative (SMI) [6,13–16], International Conference on Population and Development, and the fifth Millennium Development Goal (MDG 5). Implemented SMI interventions led to a real improvement of maternal health indicators [7,17-19] but still fell short of the 2015 MDG 5's target [1,4]. The low achievement of SMI targets has led some authors to call for significant efforts to improve and expand existing survival measures known to stem maternal deaths. They have encouraged setting up additional measures such as taking into consideration the perception of women [6] and removing financial barriers [6,20,21]. They also propose integrating global health priorities interventions, for example HIV services and antenatal care provision [6,22]. Other authors suggested adding new interventions that target the providers' behavior and responsiveness [13,14,23–25] in line with social accountability initiatives [26,27].

Social accountability is defined as “accountability that relies on civic engagement i.e. in which citizens and/or civil society organizations participate directly or indirectly in exacting accountability” [28] and holding politicians, policy makers and healthcare providers responsible for their performance [28–31]. According to Lodenstein et al. (2013), social
accountability comprises two main components. The first is citizen engagement, which includes individual participation in service provision and expressing one’s expectations and concerns in an effort to influence government policy, governance processes or other public services such as health services (voice). The second is citizen oversight, which includes involving citizens in the collective monitoring and evaluation of health services and the performance of health service providers, sanctioning when poor performance occurs and rewarding when the performance is perceived as being good [32].

In DRC, as in many developing countries, the beneficiary population is involved in health services including maternal healthcare through community participation. Community participation is one of the pillars of the national health policy, based on primary health care strategies [33]. In general, the rationale for community participation in health is to better respond to communities’ needs, designing programs that take into account contextual influences on health, and increasing public accountability for health [33]. In this article, we draw references to social accountability as one form of community participation and as discussed in literature [28, 32, 33].

As part of community participation, social accountability is viewed as a process of empowerment and as a social practice, in which communities are actively involved in changing the conditions that affect their health. Several authors such as Bukenya et al. (2012), Lodenstein et al. (2013), and Joshi (2014) argue that social accountability interventions and their effects are influenced by contextual factors, such as societal values, gender relations, levels of political stability and health system characteristics [32,34,35]. According to Thindwa et al. (2003), these contextual factors can assist or hinder the community, individuals or groups in promoting the community’s interests [36]. This indicates a need to understand the various local settings that can support or hinder the implementation and outcome of a social accountability intervention that aims to improve maternal health services.

This paper aimed to answer the following research question: What existing local contextual factors can influence the shaping, the implementation or the running of a social accountability initiative and the capacity of the community members, specifically women, to be engaged in it?
4.2. Methods

A multiple case-study approach was employed to identify local contextual factors and discuss their possible influences on shaping, implementing and running social accountability initiatives at local level using qualitative research methods. It was conducted from May to June 2013 in two health zones (HZ) of DRC, the Muanda HZ (Kongo Central) and the Bolenge HZ (Equateur). These HZ were purposively selected. The case study inclusion criteria were: 1) health zone in post-conflict situation currently involved in sustainable development activities; and 2) the presence of health sector partners implementing or planning to implement health interventions including social accountability components for more than four years, targeting amongst others the improvement of maternal health. Details of the selected HZ are described in Table 4.1.

An initial exploratory discussion were held separately with HZ officers and main community leaders to map out key community actors involved in maternal health at the local level, from which a representative sample was purposively selected to participate in the interviews. Among these community actors included public officers such as health services providers, political and administrative authorities, HZ authorities, and community representatives such as community leaders, community group members, women groups members, health committee members, and community health workers. The project managers of the NGO projects in both HZ were also included in the sample. Participants were purposively selected using maximum variation and identified from the pool of actors listed above. Selection was based on gender, age, involvement at community level activities in relation to health or other administrative functions. The selected individuals were then approached through community health workers (CHWs) or HZ officers in-charge of community activities to participate in the interviews. No contacted individual refused to participate.

The interview guides were based on a conceptual model built on the framework and key concepts from Thindwa et al. (2003) enriched by those drawn from Marston et al. [33], McCoy et al.[37], Bukenya et al.[34], and Lodenstein et al[32]. The framework from Thindwa et al. distinguishes four contextual factors that can enable or constrain the capacity of community members to engage in community development activities at the national and local levels in a sustained and effective manner. These factors are "the legal and regulatory framework; the
political and governance context; socio-cultural characteristics; and economic conditions. They in turn influence the “enabling elements” which are: “the freedom of citizens to associate (Association); their ability to mobilize resources to fulfill the objectives of their organizations (Resources); their ability to voice i.e. formulate, articulate and convey opinion collectively (Voice); their access to information, necessary for their ability to exercise voice, engage in negotiation and gain access to resources (Information); and the existence of spaces and rules of engagement for negotiation and public debate” (Negotiation). In this study, we put together the legal and regulatory framework with the political and governance context, and we extend the concept of resources beyond financial ones. We used this framework to explore if the context in the selected districts in DRC is enabling the shaping and implementation of social accountability interventions/mechanisms. Some variables related to community participation drawn from Marston et al.[33], McCoy et al.[37], Bukenya et al.[34], and Lodenstein et al.[32] were used to further operationalize the main factors in the framework, such as societal values, status of women, health committee recognition by the community and its interface role. The interview guides were adapted, pretested, and validated for the DRC local settings and for maternal health by the study team (see Table 4.2).

Data were collected through individual semi-structured interviews and a document review. At each study site the research team interviewed selected actors. Face-to-face interviews were held in a quiet place away from other people to optimize privacy, and lasted 35 minutes on average. They were conducted in French or Lingala, and tape-recorded with the participants’ permission. There were no follow-up interviews as these were single-round interview discussions. A documentary review was used to collect information on the health center’s activities, community groups’ activities, and socio-economic, political, and demographic data using a data collection form. Documents reviewed included the health center’s annual reports, health projects’ annual reports, health committee’s monthly reports, and some national policy documents.

Recorded in-depth interviews were transcribed verbatim. The interviewers proofread the transcribed work to cross-check accuracy of content since the interview transcripts were not returned for participant check and comment. The interview transcripts and data extracted from the documents were analyzed using the thematic approach [38], based on our context analysis conceptual model. A coding plan was developed using data from the first three interview transcripts and the core concepts of the conceptual model.
Table 4.2. Local contextual factors analysis conceptual model

<table>
<thead>
<tr>
<th>Enabling elements</th>
<th>Socio-cultural characteristics</th>
<th>Legal and regulatory framework and Governance context</th>
<th>Socio-economic conditions</th>
</tr>
</thead>
</table>
| Association       | - Existence of social structures supportive of community participation  
|                   | - Existence of actors involved in maternal health issues in local settings  
|                   | - Existence of community network, organizations or groups  
|                   | - Existing local experience of participation or of citizen engagement  
|                   | - Women's status/Gender barriers  
|                   | - Level of women participation in communities' activities  
|                   | - Existing political system  
|                   | - Existing of national/local political context supportive of community participation  
|                   | - Freedom of association  
|                   | - Existing recognition and accreditation policies and practices related to the freedom of association, of information, of convening meetings  
|                   | - Socio-economic characteristics of population  
|                   | - Impact of local economy on members' contribution, on association autonomy and advocacy  
|                   | - Impact on contribution by members and cost of convening meetings  
|                   | - Cost of legal registrations and accreditation  
| Resources         | - Social mobilization capacity within the community  
|                   | - Co-memberships  
|                   | - Existence of a history of community mobilization or social/citizen engagement  
|                   | - History of interactions between associations/groups  
|                   | - Decision making process within groups  
|                   | - The individual capacity to collective action (social mobilization)  
|                   | - Decentralization  
|                   | - Availability of basic services such as water supply, electricity/Infrastructures  
|                   | - Main occupations of the population/Earning potential of the population/Size of and stresses in the economy unemployment  
| Voice             | - Existing media/Access to media/Communication practices in local settings (use of media by different social groups)  
|                   | - Level of political control of means of expression/media  
|                   | - Freedom of expression  
|                   | - Media related laws  
|                   | - Cost associated with expressing views in media  
| Information       | - Access to Information  
|                   | - Information network  
|                   | - Literacy  
|                   | - Freedom of information  
|                   | - Rights to access public information/Ability to demystify information  
|                   | - Cost for access to information  
| Negotiation       | - Existing social values and hierarchies  
|                   | - Distribution of ethnicity and tribes  
|                   | - Existence of excluded or marginalized population/social inclusion  
|                   | - Existing social structures in place that enable women to actively participate  
|                   | - Social capital/social pressures capacity/capacity of actors or groups to negotiate change  
|                   | - Level of women’s participation in decision making  
|                   | - Existence of legally established dialogue spaces such as referendum or forum in local level/Existence of health committee  
|                   | - Level of trust officials have in the demand or the organization mobilizing citizen action  
|                   | - Local government authorities’ capacities to engage  
|                   | - Bargaining power  
|                   | - Impact of economic constraints in autonomy and advocacy  

59
Two members of the research team read and re-read each transcript thoroughly and assigned codes to each section of the text. Data processing was performed using Atlas-ti 6.1.1© software (ATLAS-ti GmbH, Berlin). Thematic analysis was performed to build a common and comprehensive understanding of the local context with respect to themes expressed by community members, triangulated by those coming from providers and public officers and the document review. Four steps were taken to enhance the credibility of the study: the research team received training in interview techniques, the interview guides were pre-tested and adapted accordingly; the results and interpretations were critically discussed by the research team and shared with local health partners and participants. The interview guides were written in French, translated into Lingala, and translated back into French.

The study received ethical approval from the Kinshasa School of Public Health Institutional Review Board. The necessary administrative authorizations were obtained at the provincial and local levels. All participants were fully informed about the nature and implications of the study, and granted voluntary written consent to participate. Written informed consent was obtained from all participants to publish information containing some individual person’s data such as age, sex, occupation, location as they were important for understanding the research study. None of them received a payment for participation. All research procedures were conducted in accordance with the Helsinki Declaration.

### 4.3. Results

The section starts with a description of the participants followed by three sub-sections presenting research results according to the specific contexts: socio-cultural, governance and socio-economic. In this presentation, findings from the two sites are presented together if they are similar, and separately when they differ between the sites.

In total, 35 semi-structured interviews were conducted with participants in the two sites. Table 4.3. presents an overview of the participants according to the type of their organization and expertise.
4.3.1 Socio-cultural characteristics

Existing community associations and groups

The interviews revealed that the communities in the two sites have several formal and informal community organizations, associations, and groups of varying sizes, hereafter referred to as community groups. While their exact number is not known, they all have a similar structure: an executive committee supported by a general assembly. Almost all of the community groups have statutory documents such as internal regulations and statutes, which guide the group’s decision-making process. However, only formal community groups have submitted their statutory documents to the local administrative office for authorization.
Chapter 4

Decision-making within existing community groups takes place through meetings and the plenary assembly. Most of them asserted that by collecting their members’ expectations or views, which were discussed and debated during meetings, the final decisions were made by consensus. The interviews revealed that community groups did not take into account the views of non-members.

Apart from the health committee, all other community groups have a special focus and can be broadly classified into five main categories: (i) Financial support groups such as local mutual aid associations (LMAA), groups for mutual financial/professional support called “ristourne”, and community health insurance schemes; (ii) Faith-based groups such as faith-based youth's or women's associations and churches; (iii) Collective or common-interest groups such as associations of vulnerable persons, youth associations, women's associations; (iv) Groups working on local development issues: nongovernmental organizations (NGO), community groups for development; and (v) Activity-based groups such as dialogue structures with firms, cooperatives, village committees, groups advocating the right of natives/professional groups. Brief descriptions of the main community groups obtained from the interviews are provided in Box 4.1.

These community groups were distributed differently across the research sites. Not all participants were aware of the existence of every community group. We used radar charts to indicate the percentage of specific community groups that were mentioned by participants (Figure 4.1.). In the chart, community groups which have similar goals are grouped together. In Bolenge, the most frequently mentioned community groups were financial support groups (48.5%) and activity-based groups (30.3%). In Muanda, the most frequently mentioned ones were activity-based groups (50.0%) followed by groups working on development issues (25.0%). The study allowed us to compile a list of actors (individual or groups) that could be involved in maternal health according to the participants' opinions. The majority of the participants at both sites mentioned the community groups’ leaders, apart from health providers and members of the health committee. An interesting finding is that users were mentioned as actors in Bolenge but not in Muanda.
Box 4.1. Description of main community associations and groups as emerged from interviews

1. **Local mutual aid association**
   A local mutual aid association (LMAA) is a group at the level of a village that is based on religious, professional affinities or residential closeness, and collects financial contributions following a fixed frequency to support each other under certain conditions. It is composed of an executive committee and the members, who together constitute a general assembly. It is governed by an internal regulation order or statutes. Generally, executive committee members are not paid a salary, and the association does not offer paid lucrative services. LMAAs are purely local, without any links to external partners. In certain cases, they form structures of dialogue, intended to manage the relations and the conflicts between them. Some are constituted only by women. LMAA can take several forms, such as women’s associations, associations of natives, and farming women associations.

2. **Local development nongovernmental organization (NGO)**
   The NGOs engaged in development activities are groups of people around core activities. These people share certain competencies allowing them to realize their goals. In the contexts of DR Congo, NGOs often look for financing to implement activities. They are active in the fight against HIV AIDS, sexual violence, and poverty. Even if the members put together funds, the survival of these associations depends mainly on external financing. Most of them have benefitted from training provided by external partners like the United Nations Development Program (UNDP), Congo Competences or Cordaid to improve the functioning of their organization. Often, NGOs count fewer local members than LMAA associations.

3. **Associations advocating the interest of natives or professional groups**
   Associations advocating the interest of natives and professional groups such as fisherman or farmers are groups of persons exercising the same profession or natives living in a region with natural resources which are exploited by companies or firms. They are constituted to advocate the interests of their members or help them to work together efficiently. They are especially numerous in Muanda HZ due to the oil exploitation and the fisheries. Their activities focus solely around their objectives, and their members are not interested in other sectors.

4. **Dialogue structures with firms**
   The dialogue structure is mentioned mainly in the Muanda HZ. It is a group of community representatives, coming from different backgrounds, that works like an interface between firms that run mineral resources exploitation and the natives. It coordinates the population’s demands and is in charge of validating the small community projects such as building a dwelling pit or a school before submitting them to the partner companies for financing. The dialogue structure is often initiated by the firms themselves, which have a special administrative unit in charge of the local development affairs. Many members of dialogue structures have benefitted from training in local development and community participation.
Experiences in social mobilization and networking

Many participants from community groups within the two health zones declared that their groups had participated directly or indirectly in solving community problems, although there were few perceived social mobilization activities within the community. Existing community groups seemed to be focused only on their core activities and rarely extended their activities to mobilize citizen and state actors to engage in community activities or extended their activities to the health sector. Most community group members explained that their groups were not involved in the health sector’s activities and had never taken decisions concerning health nor public health service provision. They stated that the community members’ engagement in the health sector was organized around the health committee.

However, some past experiences of participation in community activities by these groups exist at both sites: for example, by supporting and mobilizing their members to contribute to the building of the local school. Two types of community groups, those working on local development issues and activity-based groups seemed to manifest more social mobilization and advocacy for action than other community groups. They had both benefitted from technical/financial support and capacity building provided by external partners such as international NGOs and enterprises, which were more present in Muanda. Nevertheless, some participants (health providers and public officers) asserted that those social mobilization
activities were rarely initiated by the community members themselves but were organized and piloted by external organizations.

With respect to networking, it is apparent from the data that very few relationships were established between the local groups themselves, between the local groups and external NGOs, and between the local groups and governmental bodies. There was no shared networking platform between the groups, and they did not conduct joint activities. Furthermore, some participants pointed out that the community groups did not have enough capacity and expertise to express their views or to exert pressure on the public authorities or health providers. A few participants, mainly the community group representatives, thought the opposite, asserting that it was the ineffectiveness or the lack of responsiveness from health providers and public authorities which dissuaded them and made them less pro-active.

Other participants argued that they lacked a champion to take their expectations and needs to the health providers/public authorities. Some community group representatives explained that the community groups’ capacity to express views or exert pressure was also hindered by their inability to build cross-boundary alliances or coalition with other groups, as local authorities use the strategy to individualize the population’s demands or dismantle the most active groups.

“Local associations did not sufficiently manifest their capacity to be the voice of the community in front of authorities or other persons. We think that the community voicing does not function and authorities would not response to our request. We had not yet identified a community group that could speak up and influence the decision-making.” (Male, community group member)

However, several community group representatives stressed that some groups working on local development issues and some activity-based groups in Muanda had benefitted from training and were currently contracted by the Muanda Funds Holding Agency, a partner of Cordaid, to monitor the health center’s performances through a community verification survey.
Cultural diversity and marginalized population

Both health zones house a large number of tribes and ethnic groups (more than 10). Participants perceived that this multiplicity of tribes and ethnic groups did not constitute a problem for the constitution and functioning of community groups.

“Our village comprises inhabitants that came from other tribes such as ... The cultural identity and customs of each person do not affect the functioning of our community groups. This large variety of cultures does not influence the function of our groups.” (Male, community group member)

Nevertheless, health project managers and health providers revealed that sometimes friction occurred between natives and non-natives, particularly in affluent locations such as Muanda.

“Here, we sometimes have some problems. Natives are ... and did use to call other people foreigners and sometimes marginalize them.” (Female, community group member)

When asked about marginalized groups, most people mentioned the Pygmies in Bolenge and Basolongo in Muanda. Participants asserted that members of those groups were less integrated with other community groups, had their own social system, were generally more vulnerable, less educated, and poorer, and had less access to employment. According to a public officer, the government made efforts in terms of sensitization and education to reduce marginalization and increase their integration with other groups. Despite these efforts, some community group members explained that people from these marginalized groups did not become members of existing community groups for financial, religious, or personal reasons.

Women’s status and participation in community groups’ activities

With respect to women’s status, many participants asserted that women were not marginalized in the community, arguing that women often occupy important positions in the communities and are not solely consigned to domestic tasks.

“The women participate in management or within the associations, a woman can be president, vice president, advisors and men are members as well.”

(Male, community group member)
“In the community, it is true that before women were less considered than men. However, nowadays with the action of non-governmental organizations, the effort of the state through the education of women, they are equal. A woman can realize what she wants depending on competences and skills she has. For example, the in-charge of the health center is a lady...” (Female, community group member)

The interviews revealed that women participated in the community groups. With respect to their composition, the local communities have groups with only women or only men as members, and others that included both men and women. In the latter category, women participated in decision-making during the general assembly and plenary and were also elected to governing bodies. However, most of the time, women were appointed to positions such as treasurer, social assistant, caregiver or group’s advisor, which, according to some participants are associated with the traditional view that women have a higher caring capacity and sense of righteousness and honesty.

Nevertheless, a few participants stated that there are differences between men and women. A health provider from Bolenge, for example, asserted that women did not effectively participate in decision-making in the local society, linking this situation to the local culture of male dominance. As an example, this health provider stated that women more often come to the health center accompanied by their husbands or their mothers-in-law and were rarely the chairperson in groups that included both men and women.

“Women are not really involved in decision making. It is the culture. Very often, when they are sick, they are always accompanied by them husbands when coming to the hospital. But I am not informed with regard to the decision-making within the associations where the women and the men are members” (Female, Health provider)

Very few participants argued that a woman could only be more active and autonomous in their local community if she had led a business with financial resources, possessed specific skills and competencies, occupied a political or economic position in society, or was well educated. However, most participants recognized that women at the local level rarely satisfied the above-mentioned conditions.
“In reality, men and women are equal. The issue is that women in our environment...do not have the required competences or educational level for being effectively involved in decision-making.”
(Male, community group member)

Some participants associated the perception of the improvement of women’s status with some community groups’ activities such as local NGOs that focused on women’s empowerment, and with the national education policy that encourages the education of girls, at least to the primary school level. They also mentioned some barriers to women’s empowerment and education such as the challenging socio-economic situations which prevent families from schooling their children, especially girls, and local customs which encourage early marriage.

“Yes, women are very important, women here often work in fishery, the land/field or trading, thus they don’t study. We don’t really have women capable of working or expressing themselves very well. Often when women go to ...there, that is all, they get married there and they have their life there. Here, women are not emancipated, maybe less than 20% of them work, mainly as small traders."
(Female, Women's community organization).

**Existing media and access to information**

The interviews also revealed that media which could enable a large number of community members to be reached were relatively non-existent at the community level. Neither papers nor radio broadcasting or television were found at the local level. Even if some inhabitants could organize radio reception from a city situated in the neighborhood (more than 15 km away), these stations rarely broadcast local information. Health-related information exchanges are mainly based on interpersonal communication and sensitization, conducted by community health workers or in small-scale health education meetings organized in the health center. Except for members of the health committees, community members did not have access to information about the health center’s activities and asserted a lack of interest because they did not work at the health center. Alternatively, they thought that health providers would not appreciate their interest.
4.3.2. Governance context

The two research sites are both located in health zones, which are part of the territory’s administrative system. Moreover, though the Congolese constitution prescribes the implementation of decentralization, several participants asserted that decentralization is not effective and local political entities have not yet been installed, such as the local councils and local elected representatives necessary for local political participation. They stated that the power and decision-making are still centralized at the national level or at the provincial level, and they expected more from the decentralization, such as the facilitation of administrative procedures and resource allocation.

“Nothing more has changed with respect to the decentralization, and it is not effective yet.” (Male, community group member)

Despite this, most participants asserted that the political situation does not prevent the organization of interest groups. Some participants stated that the local political context sometimes favors group formation, even though community groups have to follow certain regulations and require authorization from the local political authorities, in order to hold public meetings and implement their activities.

“The political level currently does not cause a problem for community groups. Existing groups have to respect the law. They must make themselves known to the political authority and follow the political and administrative regulations... by paying taxes and charges prescribed by the law.” (Male, public officer)

Some participants revealed that certain community groups, specifically those committed to human rights and community interests, are not welcomed by the authorities at the national or local level. They stated that the authorities readily considered a group committed to advocating the population’s interests, such as the right to health care or to education, as “political” because then it becomes the responsibility of the national government. These participants also added that the government or local authorities therefore considered that demanding one’s rights was equal to being critical of the government.
Chapter 4

“Community groups have to refrain from “bad” activities. If not, the state will intervene. The state can get involved if the groups address political matters, speak negatively of the government or in case of public disturbances as well or open conflicts among members or in the community.” (Male, public officer)

This understanding of the commitment to human rights as a political activity induced several community groups to declare their apolitical nature and assert the freedom of their members from affiliation to any political party. Moreover, some participants (10/35) argued that the governance context could have a negative effect on the functioning of community groups especially during election times, as it drives the community groups away from their primary goals, patronizing them through donations and gifts to take a political position and to work for political parties.

“The negative influence of the political context occurs during electoral propaganda, several people follow politicians who could give them money and gifts instead of getting involved in community engagement. They are sure to be beneficiaries of the generosity of politicians... The community participation disappears almost entirely during these periods of intense political activity.” (Male, Health Zone management team)

As an element of governance, some participants acknowledged that community activities associated with health were organized by the health committee, as required by the national health policy. They asserted that a health committee is composed of community health workers, whose members were responsible for community participation activities and acted as “bridges” between the community and the related health center. However, some participants claimed that the health committee was dependent on the health center team, which provides funding and directions for its activities. They also stated that most of the health committee members were not elected by the community but were chosen by the nurse in charge of the health center, and therefore, they concluded that the health committee members were not really representative of the community’s opinions. With respect to the relationship between community groups and the health committee, participants stated that community groups did not have links to the health committee. However, they recognized that most of the health committee members and community health workers were also members of community groups, even though these groups did not seem to use this co-membership to develop links with the health committee or vice versa, and to be involved in health activities.
4.3.3. Socio-economic conditions

There are some differences in the socio-economic conditions in the two sites. In Bolenge, there is neither a safe water supply nor electricity, and the majority of the population work in subsistence agriculture, fishing, or farming. The local wages are very low. The annual average per capita income is less than $298. The few people with a regular salary worked mainly as civil servants in the education or health sector with very low salaries [39]. The Muanda HZ, on the other hand, is a region with increasing oil production and profits from a strategic trading position between the borders of Angola and Congo Brazzaville. Muanda houses the agencies of several enterprises and banks. Firms which produced oil provided electricity and safe water to several villages and sometimes offered seasonal working opportunities to the local populations. These firms sometimes invested in local initiatives through the local development committee they established.

Despite these differences, the majority of community members at both sites are very poor. Most of them did not have enough financial resources to fund community activities and were inclined to believe that external partners always have funding to give them or to invest in their community projects or activities. Neither site received subsidies from the government (Appendix 4.1.).

4.4. Discussion

The principal aim of this multiple case study was two-fold. The first aim was to identify local contextual factors in two DRC health zones. The second aim was to discuss their influence on the shaping, the implementation and the running of social accountability at the local level. To this end, we used a conceptual model adapted from Thindwa et al. [36] enriched by concepts drawn from Marston et al.[33], McCoy et al.[37], Bukunya et al.[34], and Lodenstein et al. [32] which allowed us to identify contextual factors that are necessary for community engagement and to match them with enabling elements for social accountability.

This study has highlighted some enabling and constraining factors as being important in the shaping, the implementation and the running of a social accountability initiative at the local level.
Chapter 4

Enabling factors
This study shows that "Association" is facilitated by socio-cultural characteristics such as the existence of formal and informal community groups, the willingness of the population to support each other, previous positive experiences with community engagement, and the involvement of women in community groups. Governance factors which support "Association" at both sites include the existence of a regulatory framework for community groups, acceptance of community groups by the local authorities, and the national recognition of community health committees as legitimate health governance bodies. The socio-economic conditions in Bolenge motivated community members to form groups in order to pool their meager resources through mutual aid associations.

Potential capacities to mobilize “Resources” to fulfill their objectives exist in Bolenge and Muanda in terms of socio-cultural characteristics such as the co-membership of several community groups; a history of social mobilization activities by some community groups; and the use of discussion and debates for decision-making within community groups. In addition, in Muanda oil firms and NGOs supported some local community groups in the form of capacity building in organization and funding.

Regarding "Negotiation", potential space and rules of community engagement exist as health committees are the legal interface between the community groups and the health providers, although currently these committees do not function optimally according to respondents.

Constraining factors
Regarding "Association", constraining socio-cultural characteristics include the lack of networks and platforms between groups. In addition, community groups seem to have a narrow focus on their own core activities and insufficient capacity for community mobilization.

Concerning "Resources", socio-economic conditions of limited employment opportunities and meager income from subsistence farming prevent community members from contributing to community projects. This situation, associated with a lack of government funding, makes community groups dependent on external financial support.
Regarding "Voice" and access to "Information", limitations were found in the low coverage of radio and other media at rural levels. It was also observed that community members did not seem interested in information related to the health services’ performance. An underlying reason might be the low socio-economic conditions and corresponding low level of education among community members, especially women. An additional socio-cultural constraint is the weak capacity and expertise of community groups to express their views or to exert pressure on service providers.

Constraints in "Negotiation" play out in the governance context as local authorities hinder community groups that are promoting the interests of citizens. Additional "Negotiation" constraints include the selection of health committee members by public health providers rather than community members, and the neglected interface function of health committees. The authorities even employ active strategies to individualize the population’s demands and dismantle the most active community groups promoting community interests. In addition, decentralization is not fully implemented, and decision-making regarding the health services and other basic services takes place at the central level, which limits people’s influence on the decision-making and accountability of local authorities.

The situation described here seems unfavorable and presents limitations to shaping, implementing and carrying out social accountability for health service improvement.

Several authors underlined the importance of some contextual factors necessary to enable the harmonious implementation and smooth running of social accountability, which are lacking in these health zones, such as the existence of a coalition and social mobilization [26,28,33,35,40–44]. Other authors stressed the importance of the capacity of community groups to express their views or to exert pressure on health providers or on the public authorities [45,46], a well-functioning health committee [45,47] especially considering the limited influence of health providers [48,49], competent decentralization [45,50], and the role of the media in providing access to information [28] as enabling factors of social accountability.

Regarding constraints, several authors have also identified some contextual factors that can hinder social accountability such as the low status of women [26,44,51,52] and the identification of social actions promoting citizens’ interests as a political activity.
However, the existing context in the two health zones in DRC could offer several starting points to initiate social accountability in local maternal health services [36]. Better use could be made of existing community groups for enabling the local context through strengthening coalition building among themselves and between them and the health committee in line with Falisse et al. (2012) in Burundi [48] and Dasgupta (2011) in India [26], and building capacity in terms of an interface role, of generating and using information about the health center’s performance, of knowledge/information about entitlements and the health service performance in line with experience provided in the social accountability literature [44,46,49,53,54].

To proceed, one option is to use the co-membership of some community members in the health committee and in existing community groups as an entry point for building coalitions, which is a process of negotiation, building interactions, and creating common trust among existing actors and groups [55]. One way of strengthening coalition-building is through the use of participative approaches, such as the interactive learning and action approach. For instance, Swaans et al. (2009) in South Africa, Björkman and Svensson (2009) in Uganda, and Dasgupta (2011) in India provide an overview of a coalition-building process around HIV and agriculture, community monitoring of health care and maternal health. In DRC the coalition could be built around the health committee and community health workers, as they are perceived by other community members as bridges between the community and the health providers with the support of the HZ management team and health partners. This coalition could support community mobilization strategies to enhance participation at the local level and strengthen existing community groups.

The second line of action is capacity-building. This can be done through the involvement of community groups using participatory approaches in generating information on their own views and concerns, in discussing them with health committee members and health providers, and by making information available to them [37,56]. Capacity-building of community groups can also be done by involving them in community problem-solving. They would then be involved in defining, implementing, monitoring, and evaluating health activities. Some examples of successful capacity-building interventions in local settings using participative approaches are provided by Swaans et al. (2008) in South Africa [57], Björkman and Svensson (2009) in Uganda [53], Katahoire et al. (2015) in Kenya [58], and Manandhar et al. (2004) in Nepal [22].
The capacity-building would also concern the health committee. It can be used to support its interface role better [59], which is necessary to facilitate communication and dialogue between community members and health providers through training and supervision [45,50]. The women should occupy a special place in these initiatives so as to improve their capacities to be pro-actively engaged in decision making and involvement in these health initiatives.

**Implication for policy**

Contextual factors such as described in the present study are more likely to be somewhat found at the local level in several low-and middle income countries, as reported in existing literature from Benin [23, 51], Burundi [48], Uganda [58], Tanzania [60] and India [26,44]. This highlights that the conceptual model as adapted can be used in other setting in order to generate information about local contexts. This information can be used to shape more appropriate actionable interventions with regard to social accountability.

**Study limitations**

Generalization of our findings is limited because of its case study nature and the small number of health zones in which the study took place. In addition, we did not have data on all contextual factors provided by the conceptual model and did not explore the effects of national-level contextual factors on local settings [28]. However, the findings in our study are largely in line with the literature, and the participants’ responses were largely overlapping. The study thereby provides useful starting points for further research on contextual factors influencing the shaping, the implementation and the functioning of social accountability initiatives in local settings. Second this study is the first to provide in-depth insights of local level contextual factors [44]. Previous studies contributed more to national and subnational levels [26, 34-36, 59]. Third, the modified conceptual model could be used as an analytical tool in other context different from DRC.

**Research team and reflexivity**

The researcher in charge of interviewing participants was a medical doctor, trained in maternal health practice and with a background in quantitative methodology. He and most of the respondents were of the same age. He introduced himself as a researcher from the local university. He noted his impressions after the interviews, and they were discussed
during a daily debriefing meeting with his supervisors. His notes were included in the data analysis. The latter was mainly conducted by the first author and the second author, who has a social sciences background. Their backgrounds could have influenced the data analysis and interpretation. To reduce these influences, the data analysis was conducted using the framework and involved extensive interaction with supervisors. They read the narrative on their own terms, and judged how they were responding emotionally and intellectually to this person. They put themselves, their background, history, and experiences in relation to the respondent and inserted their findings into the framework. This allowed the authors to examine how their assumptions and views might affect their interpretation of the respondent’s words, or their writing about the person. Research team members had no relationship with participants prior to study commencement. Participants learned about researchers and the research during consent administration. All the stages of data analysis were supervised by three supervisors with experienced in qualitative data analysis and the findings were discussed with a Social, Policy and Administration Sciences specialist from the University of Kinshasa, DRC.

4.5. Conclusions

The local contexts in the two health zones seemed not to be supportive of the shaping and implementation of social accountability initiatives. However, they offer starting points for social accountability initiatives if better use is made of existing contextual enabling factors, for instance by making community groups work together and improving their capacities in terms of knowledge and information.
Appendix 4.1. Contextual Factors analysis conceptual model /Mapping of Data

<table>
<thead>
<tr>
<th>Enabling elements</th>
<th>Socio-cultural characteristics</th>
<th>Legal and regulatory framework and Governance context</th>
<th>Socio-economic conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Association</td>
<td>Existence of social structures supportive of community participation (+)</td>
<td>Existing political system (+)</td>
<td>Socio-economic characteristics of population (-)</td>
</tr>
<tr>
<td></td>
<td>Existence of actors involved in maternal health issues in local settings (+)</td>
<td>Existing of national/local political context supportive of community participation (+)</td>
<td>Impact of local economy on members' contribution, on association autonomy and advocacy (±)</td>
</tr>
<tr>
<td></td>
<td>Existence of community network organizations or groups (-)</td>
<td>Freedom of association (+)</td>
<td>Impact on contribution by members and cost of convening meetings (-)</td>
</tr>
<tr>
<td></td>
<td>Existing local experience of participation or of citizen engagement (+)</td>
<td>Existing recognition and accreditation policies and practices related to the freedom of association, of information, of convening meetings (+)</td>
<td>Cost of legal registrations and accreditation (-)</td>
</tr>
<tr>
<td></td>
<td>Women's status /Gender barriers (-)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Level of women participation in communities' activities (+)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources</td>
<td>Social mobilization capacity within the community (-)</td>
<td>The individual capacity to collective action (social mobilization) (-)</td>
<td>Availability of basic services such as water supply, electricity/Infrastructures (±)</td>
</tr>
<tr>
<td></td>
<td>Co-memberships (+)</td>
<td>Decentralization</td>
<td>Main occupations of the population/Earning potential of the population/ Size of and stresses in the economy unemployment (-)</td>
</tr>
<tr>
<td></td>
<td>Existence of a history of community mobilization or social/citizen engagement (+)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>History of interactions between associations/groups (-)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decision making process within groups (+)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voice</td>
<td>Existing media/Access to media/Communication practices in local settings (use of media by different social groups)(-)</td>
<td>Level of political control of means of expression/media Freedom of expression Media related laws</td>
<td>Cost associated with expressing views in media</td>
</tr>
<tr>
<td>Information</td>
<td>Access to Information (-)</td>
<td>Freedom of information Rights to access public information/Ability to demystify information</td>
<td>Cost for access to information</td>
</tr>
<tr>
<td></td>
<td>Information network</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Literacy (-)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negotiation</td>
<td>Existing social values and hierarchies (-)</td>
<td>Existence of legally established dialogue spaces such as referendum or forum in local level (-)/Existence of health committee (+)</td>
<td>Bargaining power (±)</td>
</tr>
<tr>
<td></td>
<td>Distribution of ethnicity and tribes (-)</td>
<td>Level of trust officials have in the demand or the organization mobilizing citizen action (-)</td>
<td>Impact of economic constraints in autonomy and advocacy (±)</td>
</tr>
<tr>
<td></td>
<td>Existence of excluded or marginalized population /social inclusion (-)</td>
<td>Local government authorities' capacities to engage (-)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Existing social structures in place that enable women to actively participate (+)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social capital/social pressures capacity/capacity of actors or groups to negotiate change (-)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Level of women's participation in decision making (-)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legends: (+): enabling factors (-): Constraining factors No sign: no observed factor
References


CHAPTER 5

Social accountability for maternal health services in Muanda and Bolenge Health zones, Democratic Republic of the Congo: a situation analysis
Abstract

The Democratic Republic of the Congo is one of the countries in Sub-Saharan Africa with the highest maternal mortality ratio estimated at 846 deaths per 100,000 live births. Innovative strategies such as social accountability are needed to improve both health service delivery and utilization. Indeed, social accountability is a form of citizen engagement defined as the ‘extent and capability of citizens to hold politicians, policy makers and providers accountable and make them responsive to their needs.’ This study explores existing social accountability mechanisms through which women’s concerns are expressed and responded to by health providers in local settings.

An exploratory study was conducted in two health zones with purposively sampled respondents including twenty-five women, five men, five health providers, two health zone officers and eleven community stakeholders. Data on women’s voice and oversight and health providers’ responsiveness were collected using semi-structured interviews and analysed using thematic analysis.

In the two health zones, women rarely voiced their concerns and expectations about health services. This reluctance was due to: the absence of procedures to express them, to the lack of knowledge thereof, fear of reprisals, of being misunderstood as well as factors such as age-related power, ethnicity backgrounds, and women’s status. The means most often mentioned by women for expressing their concerns were as individuals rather than as a collective. They did not use them instead; instead they looked to intermediaries, mostly, trusted health providers, community health workers and local leaders. Their perceptions of health providers’ responsiveness varied. For women, there were no mechanisms for oversight in place. Individual discontent with malpractice was not shown to health providers. In contrast, health providers mentioned community health workers, health committee, and community based organizations as formal oversight mechanisms. All respondents recognized the lack of coalition around maternal health despite the many local associations and groups.

Social accountability is relatively inexistent in the maternal health services in the two health zones. For social accountability to be promoted, efforts need to be made to create its mechanisms and to open the local context settings to dialogue, which appears structurally absent.
5.1. Background

Maternal mortality remains a major health issue in developing countries such as the Democratic Republic of the Congo (DRC) [1]. A recent survey estimated the maternal mortality ratio at 846 deaths per 100,000 live births [2], indicating that the DRC has not reached the MDG 5’s target [2,3]. Interventions to reduce maternal morbidity and mortality emphasize the health service utilization through facility-based childbirth and skilled attendance at birth with timely referral for emergency obstetric care if complications occur [4,5].

Skilled providers, appropriate equipment and services are important but there is no guarantee for responsive services. Service quality as perceived by its patients can improve the health service utilization by changing the behaviour of healthcare providers towards their patients and by improving their responsiveness to needs and expectations of patients [6–9]. One way of assessing and improving the behaviour of providers towards patients is through the use of social accountability mechanisms [10,11].

Social accountability is defined as, ‘accountability that relies on civic engagement, i.e. in which citizens and/or civil society organizations participate directly or indirectly in exerting accountability’ [12] and holding politicians, policy makers and service providers responsible for their performance [13–15]. Functioning social accountability mechanisms should result in responsive services, defined as changes made to the service on the basis of ideas or concerns raised by users [16,17]. Responsiveness also corresponds to the capacity of the service to limit abusive behaviour or inappropriate treatment by providers as well as to mitigate the fears and the shame which are associated with problems [13]. In the health sector, a responsive health service favours health by impacting the choice of persons and encouraging the use of health care by the population [18]. It is argued that, under certain conditions, social accountability mechanisms can trigger the responsiveness of health service providers and policymakers. Increased responsiveness is ultimately expected to result in a stronger health, such as an increase in user satisfaction or service utilization, or a decrease in the prevalence of disease, in our case maternal mortality.

Some examples of successful community participation projects with accountability mechanisms come from rural Nepal and rural Cambodia, where respectively Manandhar et
al. (2004) and Skinner and Rathavy (2009) showed that when the citizens, are empowered to express their views and discuss the quality of health facility performance, when their views are taken into account in the decision making process, that could contribute to change, i.e. maternal health services could be adapted to their needs and might contribute better to the reduction of maternal mortality [19,20]. In Nepal, for example, at the end of the project, the maternal mortality ratio was about 80% lower within the intervention areas compared to the controls clusters [19]. Involving citizens could be an important strategy to improve the relationship between providers and clients particularly in fragile states, which are characterized by weak government systems and poor health indicators [16]. To date, we have not identified studies exploring social accountability for maternal health services performance and responsiveness in the DRC.

This paper presents some of the perceived realities of the current situation regarding social accountability in maternal health services in one health zone in the province of Bas-Congo and one health zone in the province of Equateur in the DRC.

5.2. Methods

Research question and conceptual framework
We aimed at answering the following question: What mechanisms and experiences exist regarding social accountability in maternal health services in Bas-Congo and Equateur? In order to answer this question, we implemented an exploratory study in two Health Zones using the conceptual framework of social accountability proposed by Lodenstein et al [21], refer to Figure 5.1.

This model distinguishes three elements in a social accountability mechanism: (1) Citizen engagement, includes individual participation and voice or collective expression of one’s expectations and concerns without formal ways of enforcement; (2) Citizen oversight, which includes involving citizens in collective monitoring and evaluation of health services and the performance of health service providers, sanctioning when the poor performance occurs and rewarding when the performance is perceived as of quality; (3) Both might result in a higher degree of responsive health services, thus contributing to improve health. Social
accountability mechanisms, responsive behaviour, and their consequences are influenced by contextual factors, such as societal values, gender relations, levels of political stability and health system characteristics. In the current paper, we explore only elements of social accountability mechanisms without taking into account contextual factors.

**Study setting**

The DRC is divided into 516 Health Zones (HZs), and each health zone has 10-20 health areas. Each health area consists of several villages and is serviced by a health centre. A functioning health centre is a health facility that provides an essential healthcare package comprising of among other activities, under five years’ growth and development screening and maternal health care to approximately 5,000 people in rural settings and to 15,000 in urban settings [22]. Health centres normally charge user fees. Each health centre should have a health committee that is in charge of managing health centre resources, planning and monitoring activities of the centre, identifying population’s health needs, and organizing community-based health activities by community health workers. The health committee consists of about 10 members and includes health providers, representatives of community health workers, and elected community leaders [22,23]. Every month, Community Health Workers (CHWs), who are in principle in charge of visiting 15-25 households in a village, submit a report to

---

**Figure 5.1.** Conceptual framework for social accountability (Lodenstein et al., 2013)
their representatives at the health committee. The latter then present a summary at the health committee meeting and receive from health providers a report on the health centre’s performance. A functioning health committee carries out its planned activities, meets monthly to discuss community health issues and reports them to the Health Zone management team [24].

It is within two of these health zones that the study was carried out: Muanda and Bolenge. They were selected on the basis of the following criteria: a rural zone, in which an organization implements (or intends to implement) an intervention with a social accountability component and that would be interested in having research-action added to their programme.

Muanda HZ is situated in Bas Congo, one of the richest provinces of the DRC, at the crossroads of trading routes between Angola, Congo Brazzaville and the DRC [25]. Since 2008, it has benefited from a performance based financing (PBF) project aimed at improving health services supported by Cordaid, an international NGO. Bolenge HZ is situated in Equateur, one of the poorest provinces in the DRC [26]. Bolenge benefits from a community-based health insurance scheme supported by Medicus Mundi. All performance based financing and

### Table 5.1. Essential contexts indicators of selected study health zones

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Muanda HZ</th>
<th>Bolenge HZ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (inhabitants)</td>
<td>137 178</td>
<td>79 648</td>
</tr>
<tr>
<td>Number of health centres</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Number of referral health facilities</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Health facility attendance rate (%)</td>
<td>43.8</td>
<td>46.5</td>
</tr>
<tr>
<td>Antenatal health care attendance rate (%)</td>
<td>98.0</td>
<td>91.3</td>
</tr>
<tr>
<td>Pregnant women with more 4 visits and more (%)</td>
<td>46.2</td>
<td>40.2</td>
</tr>
<tr>
<td>Health providers’ attendance at birth rate (%)</td>
<td>95.1</td>
<td>78.4</td>
</tr>
<tr>
<td>Main population occupations</td>
<td>Agriculture, Fishery, Small trade, Oil Firm employment</td>
<td>Agriculture, Fishery, Small trade</td>
</tr>
<tr>
<td>Population composition (Ethnic groups)</td>
<td>Bantu</td>
<td>Bantu, Pygmies</td>
</tr>
<tr>
<td>Safe water supply</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Electric power supply</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
community based health insurance scheme have a social accountability component. Table 5.1 provides an overview of these health zones. In each health zone, the main selection criterion for one health area to be purposively selected was for its functioning health centre and a functioning health committee.

**Study population and sampling**
Within the selected Health Areas, two different groups were included as respondents. The first group comprises of community members: women within the reproductive age (between 15 and 49), with a child or expecting a child or with a history of recent pregnancy complications, men and their mothers-in-law. For maximum variation purposes, three different age groups were established among women: ≤ 19 years; 20-35 years and >35 years according to risk for pregnancies related issues [27,28]. In each health area at least three women in each age category, two men, and two mothers-in-law were included, until no new information emerged from interviews.

The second group consisted of health providers: the nurse in charge of the health centre and a regular nurse, responsible for the provision of maternal health services.

In addition, key informants were interviewed: the health zone chief officer (HZCO), the health project manager, the political administrative authority, a women association representative, health committee member, a community health worker and a traditional birth attendant. They were selected according to their influence in the community, and their understanding of women’s needs.

**Data collection and issues**
Community members, health providers and key informants were interviewed between September and October 2013 by means of individual in-depth semi-structured, audiotaped interviews with an interview guide on; the specific content areas based on the aim of the study, the current literature on social accountability and other topics addressing similar aspects. These areas were women’s expectations, needs and concerns regarding maternal health services, as well as (in) formal ways to voice and express their concerns. Also explored was citizen oversight, identification of procedures in place for women to monitor and evaluate health providers’ performance and to reward or sanction health providers. The researchers also explored the perceived health providers’ responsiveness.
Community members were approached outside of their homes and invited to participate in this research. A community health worker was consulted to assist in identifying community members that could be invited and to whom interviews could be submitted. When their consent was provided, the interview took place in their homes. Health providers and most key informants were approached at their workplace. The interviews took place after work, once they agreed to participate and their consent was provided. Interviews consisted of approximately 45-minute audio recordings were conducted in Lingala or in French. The field team consisted of three researchers; firstly an author, a research assistant from the Athena Institute/VU Amsterdam, and a research assistant from the University of Kinshasa, supervised by a senior researcher. The CHW who guided researchers did not participate in the interview and was excluded as a respondent. Interviews with women and mothers-in-law were conducted by female research assistants. On the other hand, interviews with men, health providers and key informants were carried out by the first author. A debriefing session was held after each fieldwork day during which themes, impressions of the findings and procedures were discussed and documented in field notes.

Data processing and analysis

Interviews were transcribed verbatim in Lingala, translated into French and checked by two team members. Atlas-ti 6.1 software (ATLAS.ti GmbH, Berlin) was used to organize the qualitative data. Both inductive and deductive approaches of thematic content analysis were used. The analysis was performed in two main stages. During the first stage, each transcript was separately read, identifying themes that emerge based on the SA framework and research questions, but when a new theme emerged, it was included. At this stage, transcripts were read repeatedly so as to become familiar with the participants’ stories and to identify themes in each of the separate interviews. These first impressions, thoughts and initial analysis were recorded. During the second stage, the researchers examined themes that had arisen in the initial analysis of each separate interview, seeking connections, similarities and differences. Four steps were taken to enhance the credibility of the study - the research team received training in interview techniques, the interview guides were pre-tested and adapted accordingly and the interview guides were written in French, translated into local languages and translated back into French. The results and interpretations were critically discussed by the research team and with local health partners.
Ethical considerations
The study was approved by the Institutional Review Board, Kinshasa School of Public Health and all research procedures were in accordance with the Helsinki Declaration. Most participants provided written consent, and four community members provided oral consent prior to interviews. To protect interviewees’ anonymity, only category type and research site were used.

5.3. Results
The results’ section commences with a description of the respondents; thereafter research results are presented on expectations, voice, oversight and perceived responsiveness.

Participants
In total, 48 interviews were conducted in the two selected areas, viz., 27 in Bolenge HZ, and 21 in Muanda HZ. Table 5.2 shows an overview of the participants who were interviewed. Since the focus is on maternal health, women in their reproductive period presented the largest group of respondents (n=21). Their ages ranged from 17-39 years (median: 27 years). The median number of children per woman was three offspring with ages ranging from two weeks to six years; most of them were from Bantu tribes except in Bolenge where some Pygmies reside. Women were mostly farmers, with a primary school education and lived with a partner. Four women had experienced complications during their pregnancy, and one had miscarried (Tables 5.3 and 5.4).

Women’s concerns and complaints regarding health services
The term ‘voice’ comprises of five aspects in English: speaking up with respect to needs, expectations and concerns regarding healthcare facilities. It also comprises of complaints about healthcare services. In Lingala these different aspects of the word ‘voice’ are translated by the word posa, which literally means ‘concerns.’
In the text, the word ‘concern’ is used, and therefore, also refers to expectations and needs. However, to what extent these are actually voiced, in the sense of speaking out, will be reported in the section entitled ‘women’s voice.’
### Table 5.2. Respondents’ categories

<table>
<thead>
<tr>
<th>Respondents categories</th>
<th>Bolenge</th>
<th>Muanda</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health providers</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Health Officers</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Head Nurses</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Maternal health nurses</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Community Key Informants</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community association president</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Women association presidents</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Health committee president</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Community health workers</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Health Project managers</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Local authority</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Community members</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Women</td>
<td>11</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>Mother in law</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>27</td>
<td>21</td>
<td>48</td>
</tr>
</tbody>
</table>

### Table 5.3. Women characteristics (Muanda)

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Age</th>
<th>Number of children</th>
<th>Last child’s age</th>
<th>ANC</th>
<th>Occupation</th>
<th>Birthing place</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>28</td>
<td>2</td>
<td>2 months</td>
<td>Yes</td>
<td>Hair styler</td>
<td>Muanda city HC</td>
</tr>
<tr>
<td>002</td>
<td>39</td>
<td>6</td>
<td>4 months</td>
<td>Yes</td>
<td>Saleswoman/nurse</td>
<td>Muanda GRH</td>
</tr>
<tr>
<td>003</td>
<td>18</td>
<td>1</td>
<td>2 weeks</td>
<td>Yes</td>
<td>Student</td>
<td>Hygiene HC</td>
</tr>
<tr>
<td>004</td>
<td>23</td>
<td>1</td>
<td>1 month ½</td>
<td>Yes</td>
<td>Housewife/Farmer</td>
<td>Nsiamfumu HC</td>
</tr>
<tr>
<td>005</td>
<td>27</td>
<td>3</td>
<td>5 years</td>
<td>Yes</td>
<td>Housewife/ saleswoman</td>
<td>Muanda GRH (*)</td>
</tr>
<tr>
<td>006</td>
<td>33</td>
<td>6</td>
<td>2 months</td>
<td>Yes</td>
<td>Housewife/ Teacher</td>
<td>Muanda GRH (*)</td>
</tr>
<tr>
<td>007</td>
<td>28</td>
<td>4</td>
<td>1 months ½</td>
<td>Yes</td>
<td>Saleswoman</td>
<td>Nsiamfumu HC</td>
</tr>
<tr>
<td>008</td>
<td>17</td>
<td>0</td>
<td>-</td>
<td>Yes</td>
<td>Student</td>
<td>Pregnant (*)</td>
</tr>
<tr>
<td>009</td>
<td>17</td>
<td>0</td>
<td>-</td>
<td>Yes</td>
<td>Student</td>
<td>Pregnant (*)</td>
</tr>
</tbody>
</table>

Legend: (*) History of complications HC: Health centre GRH: General Referral Hospital ANC: Antenatal care
As a matter of fact, the researchers dealt with women's concerns and complaints regarding maternal health services. At both sites, most women sounded positive about the health care provided, they did not complain about it and were unsure on what to ask. Most women perceived healthcare providers (HPs) as professionals who have the required skills to cure/help them. They believed that they had less knowledge than HPs because they considered themselves laypersons unable to judge how healthcare should be provided. They were unsure on how to converse and make their concerns known to HPs, as portrayed in the following quotation:

“When I have a problem related to my health or my pregnancy, I go to the HP and tell him all I noticed and felt. He will provide me with healthcare. I don’t see another way to proceed. I follow only what the nurse tells me to do. What he says is good for my health. It is up to him to direct my healthcare process.” (Woman, Bolenge)

Table 5.4. Women’s characteristics (Bolenge)

<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Age</th>
<th>Number of children</th>
<th>Last child’s age</th>
<th>ANC</th>
<th>Occupation</th>
<th>Birthing place</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>37</td>
<td>4</td>
<td>6 years</td>
<td>Yes</td>
<td>Housewife/Farmer</td>
<td>Bolenge GRH (*)</td>
</tr>
<tr>
<td>002</td>
<td>31</td>
<td>7</td>
<td>4 days</td>
<td>Yes</td>
<td>Housewife/Farmer</td>
<td>Iyonda HC</td>
</tr>
<tr>
<td>003</td>
<td>27</td>
<td>3</td>
<td>2 months</td>
<td>Yes</td>
<td>Housewife/Farmer</td>
<td>Iyonda HC</td>
</tr>
<tr>
<td>004</td>
<td>33</td>
<td>1</td>
<td>12 days</td>
<td>Yes</td>
<td>Teacher</td>
<td>Pregnant (*)</td>
</tr>
<tr>
<td>005</td>
<td>25</td>
<td>2</td>
<td>2 months</td>
<td>Yes</td>
<td>Housewife/Farmer</td>
<td>On the road to Iyonda (P)</td>
</tr>
<tr>
<td>006</td>
<td>18</td>
<td>1</td>
<td>5 days</td>
<td>Yes</td>
<td>Student</td>
<td>Iyonda HC</td>
</tr>
<tr>
<td>007</td>
<td>28</td>
<td>4</td>
<td>1 month ½</td>
<td>Yes</td>
<td>Housewife/Farmer</td>
<td>Iyonda HC</td>
</tr>
<tr>
<td>008</td>
<td>17</td>
<td>0</td>
<td>-</td>
<td>Yes</td>
<td>Student</td>
<td>Pregnant</td>
</tr>
<tr>
<td>009</td>
<td>23</td>
<td>4</td>
<td>2 months</td>
<td>Yes</td>
<td>Housewife/Farmer</td>
<td>Iyonda HC</td>
</tr>
<tr>
<td>010</td>
<td>27</td>
<td>4</td>
<td>4 days</td>
<td>Yes</td>
<td>Housewife/Farmer</td>
<td>Iyonda HC (P)</td>
</tr>
<tr>
<td>011</td>
<td>22</td>
<td>2 (1D)</td>
<td>2 weeks</td>
<td>Yes</td>
<td>Housewife/Farmer</td>
<td>Iyonda HC</td>
</tr>
</tbody>
</table>

(D) Deceased (*) History of complications (P) Pygmy HC: Health centre GRH: General Referral Hospital ANC: Antenatal care
Few women have raised concerns, and this holds true at both sites. Women expected that the local health centre would be extended in the future, with additional rooms for maternal healthcare even an operating theatre, that equipment such as laboratories and ultrasound devices would be added, that medicines would be made more readily available preferably free of charge, as well as an ambulance to transfer women to the referral hospital. They wanted to have a physician as chief of staff at the health centre. The above mentioned expectations were raised mainly by women who had attended health facilities other than the local health centre, or who had heard about other facilities from other persons’ experiences, or who had a history of recent pregnancy complications.

During the interviews, few women in both communities mentioned maternal health services or HPs. Only one woman, belonging to ≤ 19 years group, mentioned poor treatment during delivery. This is in contradiction with key informants who claimed to have heard about many experiences involving inappropriate behaviour and poor treatment in health services but acknowledged that women often did not report these.

**Women’s voice**

Regarding concerns or complaints about health services, women need to find ways to communicate these to HPs. In this study, it appeared that women did not express their concerns/complaints to HPs. None of the women interviewed reported having heard about a woman bringing forward her concerns/complaints on her own.

However, it became obvious that when they had concerns/complaints about health services, women often looked for support from their immediate family members especially their husbands, their mothers, and their mothers-in-law. The majority of key informants confirmed that hardly any woman would express concerns and complaints.

**Reported reasons for women not to express concerns and complaints**

The researchers explored the reason(s) why this occurred. Apart from the fact that women believed that they were laypersons and therefore unable to judge how health care should be provided, respondents mentioned fear of reprisals as the main reason. Nine respondents from Bolenge and three from Muanda indicated that women also feared that if they expressed their concerns to HPs, the attitude of the latter would change and therefore they may risk poor treatment as illustrated by the following quote:
“Health providers are complicated, if you have a problem with them. They can get angry and abuse you.” (Woman, Muanda)

The majority of respondents at both sites mentioned that there was no formal system in place at the local health centres, or a representative of the population who could present complaints or concerns to HPs. Consequently, women failed to report because they were uncertain on how to voice their concerns, without a risk of reprisal.

Secondly, several respondents from both sites mentioned that women consider themselves as being unable to influence healthcare functioning or the behaviour of HPs, as highlighted by a key informant:

“Often, women do nothing; they are disarmed....especially in front of health providers.” (KI, Muanda)

Thirdly, some community members at both sites (n=3) stated that women feared that complaints or concerns would threaten the work of HPs, and that they would be responsible for the “others’ loss of employment” as stated below:

“When I have a complaint about a health care provider, I do not express it because it is not good to put other people’s work at risk. It is his workplace, I cannot endanger his job. Reporting an incident against a provider is considered as endangering his work.” (Mother-in-law, Muanda)

Other reasons mentioned were related to socio-cultural contexts based on age differences. For example, one woman from Bolenge and one from Muanda responded that they were ashamed to report incidents as they were younger than HPs. Another woman stated that in most Congolese customs, a younger woman is not expected to complain about an older person as highlighted in this quote:

“I feel deeply ashamed; I do not know how to go and complain to somebody [with laugh]. Health providers are older; I will not feel comfortable to speak to them about my complaints or concerns.” (Woman, Bolenge)
Three respondents from Bolenge and three from Muanda mentioned that it is not customary for the population to complain, people preferring to wait until the decision maker notices the incident:

“We do not tell her [the head nurse] anything, we don’t speak, we don’t complain, we are just waiting. We do not know what to do; we are expecting that the authorities themselves will find out.”(Woman, Bolenge)

Something specific to Muanda: one woman explained that in Muanda, tribesmen prefer not to engage a complaint or a concern in order to avoid trouble in the community.

Another explanation mentioned by three respondents in Muanda and in Bolenge is the preference for the women to rather attend another health facility, using an exit strategy as reported below:

“In case of inappropriate practices, it is preferable to go and follow the treatment somewhere else. It can happen that a bad practice occurs once. If for the second time, you come across the same situation, you can go to another healthcare facility.”(Man, Muanda)

Possible ways to communicate and complain
Reported possibilities to channel concerns and complaints could be regrouped into using; (a) intermediaries, (b) informal communication, and (c) formal structures.

(a) Using intermediaries

In our study, women answered that they could communicate individually through another person other than the concerned HP. This person could be found within or outside the health centre. For example, five women from Bolenge and eight from Muanda shared that it was possible for them to communicate with; the nurse in charge of the health centre, a Health Zone Officer or another health care provider who may report to the relevant health provider. This depends mainly on the level of confidence the woman has in her relationship with the person she has contacted:
“When a healthcare provider behaves inappropriately, we prefer to speak to another health worker so that the latter can speak to his colleague. We avoid speaking ourselves in order to avoid problem as the concerned HP could bear a grudge against us and that would become a problem.”(Woman, Muanda)

Respondents also mentioned that women could use a person outside the health facility; this was often the community health worker (CHW). Eleven respondents from Bolenge and seven from Muanda mentioned that women could report their concerns to CHWs. According to the respondents, CHWs who live in the same community and are involved in health activities within the community could be easily reached and were accessible to the population. This is confirmed by a CHW:

“The information regarding women’s concerns often stands out when we as CHWs have noticed for example that there is a woman who gave birth in another health facility or at home. We visited her and we asked her why she went elsewhere when there was a health centre there. It is through these visits that we are aware of health providers’ absence and a lack of expertise or equipment. We present this to health providers during the Health committee’s meeting”(KI, Muanda)

Women were said to expect that CHWs could have the courage to talk to HPs, because they were working together. However, two women from Bolenge and one from Muanda expressed doubts about the ability of a CHW to influence the behaviour or decisions of HPs. They did not know what happened after their report to a CHW as reported in this quote:

“The last time, I told them [CHWs] what I had noticed in the centre. I reported to them because they can have the courage to go to speak to health providers… However, I do not know if they delivered my message.” (Woman, Muanda)

Community leaders such as a local authority, a village chief, or an administrative chief officer could also be approached. According to three respondents from Bolenge and eight from Muanda, the community leaders could be approached because the women believed that the former could influence the HPs and that their concerns were more likely to be accepted by HPs than when brought by women.
Chapter 5

Two community members from Bolenge stated that it could be possible for women to report their concerns or complaints to external persons who could come and ask questions or make surveys in the community for the purpose of collecting population concerns, arguing that these persons could be effective in transmitting these concerns to decision makers. It is interesting to point out that the respondents did not mention national or regional members of parliament even though they have their roots at local level.

(a) Using informal communication

Although people do not complain individually to staff, culturally there are various ways to communicate. For example, eight respondents in Bolenge and two in Muananda mentioned that some women believed that by not approaching anyone to complain, they could express their discontent loudly, through gossip and rustle or create rumours in the community about HPs, hoping that it would reach them.

"Women like other members of this community always have a behaviour that consists of shouting aloud their complaints about Health Centre on the road. You will see one or two people speak aloud on the road when they disagree... these complaints are often the origin of rumours in the community." (CHW, Bolenge).

(b) Using formal structures

According to HPs and some key informants, women could formally report through community health workers to health committees. HPs reported that they used CHWs as means of handling interaction between them and community members and for collecting information from the community and households during home visits. They added that the collected information is presented and discussed during monthly health committee’s meeting as feedback from the community:

"For example, we learnt that a woman delivered at home through CHWs. As health providers, we know all women who attend antenatal care at the Health Centre, when we realize that a woman does not come any more, we send CHWs to get information about it. So, CHWs came and collected the information regarding what happened and gave us the information." (Health Provider, Bolenge)
A situation analysis

Two key informants confirmed that which is stated above and added that after the health committee meeting, a report had to be sent to the health zone management team. However, it is important to highlight that community members themselves did not talk about a formal system and that they often talked about CHWs rather than health committees suggesting that most women did not link CHWs to health committees.

Specific to Muanda where Cordaid PBF program was implemented, some key informants (health zone chief officer, purchasing agent manager) mentioned that women could report to members of the community-based organizations when the latter carried out household surveys. According to these key informants, the PBF program included community evaluation of the health centre by community-based organizations that were contracted to make visits in randomly selected community households especially those who had attended the local health centre, for collecting views or experiences about the use of this health centre. The findings of their survey were sent to the health zone management team through the purchasing agent. However, none of the women interviewed mentioned community-based organizations and seemed unaware that there was a local organization that visited community households to collect views or experiences about the use of the local health centre. Furthermore, other key informants and most of the CHWs did not mention having heard about such activities.

It is also worth highlighting that none of the community members interviewed at both sites mentioned that community associations, organizations or coalitions could be used by women to express their voice.

Respondents thought that although there were many associations in their community such as local mutual aid associations, professional associations, nongovernmental organizations, there were no organizations that monitored health centre activities, or had healthcare goals or discussed healthcare issues during their meetings. Furthermore, the women interviewed answered that they did not believe in speaking out in a group or collectively because groups were often not heard by HPs and rulers or that collective action was not appreciated.

“I prefer to go alone to express my concerns. I do not like speaking in a group, because often the group is not well considered....the interlocutor is going to answer you without taking to heart what he tells you. I prefer to express my concerns by myself to be well understood.”(Woman, Muanda)
Moreover, community members did not mention that they could either meet together as a group to present their concerns about healthcare services to the health centre staff, or organize collective actions such as demonstrations, public campaigns, or public hearing meetings. HPs reported that during health activities such as antenatal care and postnatal care implemented in the health centre, women were given the opportunity to express their concerns:

“During health visits, we allow them to ask questions or voice their concerns, just after the health education session. If a woman has sensitive concerns, she can come to the office, we can discuss them privately.” (Nurse, Bolenge)

HPs mentioned something that was specific to Muanda: when home visits were carried out following up on women who had attended a health centre, the latter were given the opportunity to ask about concerns or complaints.

“During home visits I carried out, I ask them [women] questions about nurses’ behaviour during ANC for example. Up to now, they have told us that they are satisfied.” (Nurse, Muanda)

However, health zones chief officers recognized that there is no formal channel that collects information related to the concerns/complaints by the population in the current health information system. They also recognized that most reports from health committees did not mention complaints by the population as well, making it difficult to assess the responsiveness of healthcare providers to the concerns/complaints of the population. They added that they had never received complaints against healthcare providers via any health committee reports and that not a single health centre offered opportunities to discuss as a team any complaints or concerns by clients.

**Existing community oversight systems**

As mentioned above, community members answered that they were excluded in monitoring and evaluating health services. However, according to key informants and HPs, the community exerted oversight on health services through health committees. They reported that during monthly health committee meetings, the nurse-in-charge should provide information about health centre performance to the population through their representatives. During these meetings, community health workers’ representatives should report the information gathered
from the community. However, most respondents mentioned that within the health committee the health staff did not share information about health centre performance, but simply shared their expectations from the community in terms of targets and problems regarding health service activities, such as the underachievement of targets regarding the number of antenatal care visits or home deliveries. The interviews by key informants revealed that community health workers’ representatives or committee members participating in these meetings did not deal with community concerns as they did not formally collect them, therefore the health staff was not informed about them. As a consequence, according to the respondents, women were mostly informed about health centre performance or the behaviour of healthcare providers through interpersonal communications rather than through formal systems.

“I have no information about the activities of the Health Committee.” (KI, Muanda)
“The last time we met, I told them [CHW] what I had found in the centre...However, I do not know if they delivered my message.”(Woman, Muanda)

“Women of these villages, most of the time, do not take a particular action, but they would prefer to go to different health facilities. You will see them taking another direction...they will tell you that they intend to change because some care did not exist in the former health centre.”(CHW, Muanda)

Another aspect specific to Muanda is the statement made by the manager of the Purchasing Agency that the use of community-based organizations surveys is the community monitoring of health centre performance under PBF settings. The findings of these surveys are reported directly to the Purchasing Agency and not to healthcare providers. It is the Purchasing Agency which presents a summary of the findings during health zone monitoring meetings and provides feedback to health providers. The purchasing agent manager argued that these surveys were aimed at reducing the fear of reprisals and assured more transparency and confidentiality to the community monitoring process. Nevertheless, HPs asserted that because CBOs did not report survey findings to them and that reports were compiled collectively for all health centres belonging to a health zone, they were unaware of grievances brought against them on the one hand. On the other hand, they added that because no community representative participated in health zone monitoring meetings, the community was unaware of either the survey findings of the CBOs or of any decisions made to address them.
Community enforceability mechanisms
While people do not complain as individuals to staff, culturally there are various ways to acknowledge and communicate good performance and this is mainly done as individuals according to the respondents. For instance, to reward good performance, women thanked health staff, and gave them small gifts or small amounts of money, or even reported positively about HPs. This is embedded in local customs. Women highlighted that it was not compulsory but optional. It is a means for the population to acknowledge what health staff has done for them.

“The encouragement is often offered individually. For example, when you are satisfied with the service provided, you can willingly reward the health worker with sugar or milk.” (Woman, Bolenge)

Three community members from Muanda believed that to encourage HPs, women had to continue attending the health centre or to motivate their acquaintances through their testimonies regarding the use of the local health centre instead of going to another health facility. They expected that it would help HPs improve their skills and their income through users’ fees.

Some respondents mentioned that they could report to their acquaintances or members of their social networks, expecting to induce a specific HPs’ behaviour indirectly. For example, five respondents from Muanda and three from Bolenge thought that to discourage improper practices, they should give negative comments about the health centre services to their acquaintances, motivating them to go to another health facility, thus reducing health service intake and affecting either the reputation, the financial turnover or the motivation of HPs.

“Women in these villages, most of the time, do not take a particular action, but they would go to a different health facility. You would meet them on the road taking another direction...they would tell you that they were going to a different health facility because of the shortcoming or inadequacies of the health centre.”(KI, Muanda)

On the other hand, this could also work positively: two respondents, a woman and a man, from Muanda mentioned that they could mention to their acquaintances the performance
at the health centre, showing the good performance of the health staff. This could reach HPs indirectly. They argued that it was a way of encouraging health staff and attracting more users, thereby increasing a health centre’s financial resources and personnel incentives through users’ fees:

“To encourage them [Healthcare providers], we advertise about their HC. We mentioned their good deeds and give a good report. Good testimonies incite the health staff to work better and maintain an acceptable level of service.”(Woman, Muanda)

Respondents also mentioned that they could discourage malpractices, by thanking or rewarding HPs who performed well in the presence of those who were not aiming to trigger change in the latter. Alternatively, they could do the opposite of what they did to encourage appropriate behaviour or treatment by HPs. However, none of the respondents claimed to have visited traditional healers or traditional birth attendants for reproductive health issues as a consequence of the lack of trust or responsiveness in the health services.

**Health providers’ responsiveness according to the community**

Interviews showed that most women and key informants believed that health staff members were responsive to women’s concerns when they talked of their health problems, by supporting their opinions by the perceived attention they received from HPs during health centre visits. They also based their views on the perceived change in the service or HPs’ attitude:

“When you expressed your concerns, you would find that the staff improved in the next session. For example, a [male] nurse replaced for a time the lady who usually performed Antenatal care. But he was very nervous. I expressed my concerns to the head nurse. The latter talked with him; he changed and became less nervous with clients.” (Woman, Muanda)

Three respondents from Bolenge and two from Muanda thought that even though there was no change in the provision of health service, the health staffs were responsive because they took the time to explain to users why there had been no change or showed a receptive disposition:

“Health care providers take into account women’s concerns, because they speak about it even if we have not seen clear decisions yet.”(Mother-in-law, Bolenge)
One community member from Bolenge and two from Muanda stated that HPs were not responsive to patients’ concerns as no change was perceived after receiving those concerns. Moreover, they were likely to get angry and scold the complainant.

5.4. Discussion

In this study we established the extent to which the main elements required for social accountability were perceived and the potential for maternal health services to be strengthened in the DRC. Despite contextual differences, both sites showed similar results. Interestingly, in spite of the low position of the DRC in maternal health statistics [1,2], women responded to our survey positively about the health care provided. Only a few women voiced explicit complaints against health providers, and some communicated them directly to the health provider. The majority preferred to use indirect channels such as intermediaries, within or outside the health facility, or to go to another health facility. Perceptions on responsiveness of health staff to women’s concerns varied among community members and key informants, and were both positive and negative. This study shows that for community members no formal procedures appeared to be in place to collectively monitor and evaluate health worker performance and to hold health staff accountable. However, two formal routes for accountability seem to exist, according to the healthcare providers or key informants but somehow health providers were not reached. The first being the health committee route where women report their concerns to the community health workers, who in turn report them to a health committee. The second being the CBOs’ route, where women participated in satisfactory surveys carried out by community-based organizations with the results of these surveys being transmitted to health zone meetings and discussed with health providers. In our study an insignificant number of women expressed their concerns, and this is in sharp contrast to the more critical statements from other community members and the placement of the DRC on the lowest rung of health statistics for maternal health services in the world.

We will discuss below the reason why we regard the self-reported low level of complaints as not being reflective of reality but rather as being caused by context, i.e. unfulfilled preconditions to express complaints. Expressing complaints is an essential first step to let the feedback loop work in the accountability structure. However, complaining presupposes
A situation analysis

three elements: (i) Knowledge symmetry, women know that the service can and should be better, (ii) Power symmetry, they are able and willing to express their concerns and (iii) Safe conditions, there are opportunities to do so without negative repercussions, e.g., collectively or anonymously.

Low expression of concerns observed in our study could be accounted for through information/knowledge asymmetry. The latter was also observed by Grossmann-Kendall et al. (2001) in Benin, an exploratory qualitative study among 19 women having different backgrounds who had recently given birth in a referral hospital. It was discovered that the majority of women had very little information of medical procedures, causes of complications, purposes of treatments, and hardly had the opportunity to express their views to anyone even to ask a question because of this asymmetry [8]. Similar findings have been reported in other studies and reviews [29–31]. According to Georges (2003), referring to case studies of participatory processes from Asia, especially India, from Europe and from Latin America aiming at improving sexual and reproductive health service delivery and summarizing one of the barriers in accountability mechanisms, people cannot demand services and accountability if they do not know what they are entitled to.

The deficit in expressing concerns may also be associated with illiteracy, education, economic, socio-cultural, reproductive factors, marital status, age, previous health service experiences, and ethnicity. This is in line with other cases from African countries such as Uganda [32], South Africa, Kenya [33] and Malawi, and from Asia (India, Bangladesh, Nepal) and in Latin America (Bolivia). They emphasized the importance of taking into account culture and context when community participation and accountability strategies are to be established and implemented [34,35].

Secondly, power asymmetry reducing the motivation to speak out was observed in our case and this corroborates studies carried out in Tanzania [5], Benin [29], Uganda [32], and South Africa [33,36]. For instance, McMahon et al. explore how rural Tanzanian women and their male partners described disrespectful and abusive experiences/treatment during childbirth in facilities and how they responded. They found that, regarding disrespectful and abusive treatment, women were more likely to resign, go back home, reject some facilities and attend different ones. Associated factors reported in existing studies are fear of reprisals, of victimization or further abuse, of not receiving required care, of
stigma and shame [30,31,37,38]. D’Oliveira et al. (2002) analysed research from Peru, Brazil, Jamaica, Nigeria, Tanzania, South Africa, Canada, USA, Pakistan, and Turkey and discussed forms of violent abuse by health providers. They related them to the asymmetry of power between health providers and patients and argued that this abuse is a means of controlling patients that is learnt during training and reinforced in health facilities. Power asymmetry can also be rooted in social cultural contexts. Indeed not complaining can be part and parcel of the tribal customs as well as the respect due to older people. Thus power asymmetry is also related to gender relations [10,38,39], ethnicity [16,40,41], and to the organization and structures within which the individual actor works and lives [42].

Other system factors mentioned are the absence of mechanisms for communicating grievances, the failure of systems to note and punish patient abusers and the indifference of health staff regarding patients complaints, reported in South Africa [36], in Uganda [32] and other countries [33,37,38,44,45]. There is also a lack of feedback systems in health services [38].

The third element (condition) in citizen engagement encompasses options for collective action to express concerns and anonymous complaints. Our study shows that women did not collectively express concerns, but either refrained from doing anything at all or approached intermediaries such as CHWs, external monitors, authority, and stakeholders in feedback or reporting health care. This choice is based on the women’s perception of the ability of these intermediaries to influence the behaviour of health providers, thus indicating a strategy to counter power asymmetry. The use and importance of intermediaries as brokers between community members and health services have been reported in other studies from Uganda [46], India [47] and also in some review papers [48,49].

The physical absence of a powerful coalition to voice concerns emerged in our study in spite of the presence of numerous small community associations such as mutual care and support groups, self-help groups, and indigenous community initiatives. This situation hampers social accountability, whereas collective efforts could result in a power balance and at the same time protect individuals who may be put at risk if they contest authorities on their own [45] and offer support to organize public hearings, campaigns or demonstrations related to social pressure and collective rewarding [38]. Moreover, collective action imposes a process
of self-reflection among the powerful actors which may result in improvement even though a fundamental shift in the power balance is unnecessary [50]. It is unclear why a stronger coalition to voice concerns did not emerge in our settings. One possible explanation is that in the DRC individual and collective freedoms are not really warranted in practice, and social activities taking collective expressions of opinions are considered as political activities by the rulers. Rulers thus discourage this type of voice, fearing that a community mobilization drives to a broader struggle for democracy and freedom. Also refer to McCoy et al. (2012), who discussed in their systematic literature review an example from apartheid South Africa, where community mobilization around health was a 'vehicle that helped black communities to develop a sense of control, pride and agency, that were ingredients in the broader struggle for democracy and freedom' [23].

When women speak out in the hope of receiving the improvements promised, certain procedures to monitor and evaluate the performance of health staff should be in place. Our study highlights that according to women there is a lack of formal community procedures to monitor and evaluate the performance of health staff. In the absence of such formal mechanisms, women can only rely on moral accountability, based on social norms that work through shame and embarrassment, pressures to maintain reputation and status, and the threat of violence. Moral accountability is comparatively less difficult for people to use than engaging in more formally structured means of complaint or feedback [51]. The culture of the Congolese for rewarding and sanctioning individually is based on moral accountability, e.g., by providing allowances or offering grades, provides entry points for more formal mechanisms of social accountability. However, these will need to ‘compete’ with other forms of accountability to be acceptable to health providers. Furthermore rewarding strategies like PBF or community-based health insurance schemes offer an opportunity to further build on.

The absence of a channel to collect information from the population, the perceived ineffectiveness of CHWs and health committees and the failure by health providers to report to the population via health committees [32] limit the responsiveness of the health services. This can be explained by the observation that both the clinical and registration practices in health centres were restricted to the data needed by local health authorities and the Ministry of Health and excluded the experiences and needs of patients and the population. As matter of fact, publishing health centre data as aggregate outcomes [52], can improve awareness and accountability [45]. It is noteworthy that health services are unaware of the concerns of the population and that the population lacks an overview of health service performance.
In this study, we also identified six interesting inconsistencies which might shed light on the complexities behind the causes and solutions to constructively communicate complaints to health providers and actors. The first contrast being that healthcare providers equate an absence of complaints with an absence of problems, insinuating that they are blameless, even though they are aware that directly communicating a complaint to a health provider is unacceptable, due to gender, knowledge and power asymmetries. The low level of complaint reporting is well documented also in developed countries and should be known by HPs. For instance, Gal and Doron (2007), in a survey carried out in Israel, found that around two-thirds of the persons who had a grievance to report on health service did not complain even though there were formal systems to do so [53]. The situation is exacerbated by the absence or lack of any formal or informal systems of accountability as reported by Goetz [33] in a study carried out in South Africa [36] and which is similar to our case in the DRC. The no complaint=no problem attitude seems to be embedded in the ‘health professional culture that condones controlling behaviour and in ideologies of patients’ inferiority and healthcare providers’ intellectual and moral superiority imparted through training and socialization in health facilities’ [33,36,37,43]. This observation limits the reliability of health providers as informants in accountability mechanisms. Solutions might be found in an extension of the HPs’ curriculum in respect to professional conduct and patient services.

In the second contrast, interviewees in the community stated that there was no formal system for handling complaints or concerns regarding health services while healthcare providers were referring to the health committee and community health workers. This situation can be explained by the fact that community members do not see community health workers as interface actors between health services on the one hand and the community on the other hand, but only as health service agents working within the community as highlighted by Falisse et al. (2012) in a study in Burundi [54] and Bisimwa et al. (2009) in the DRC [55]. Furthermore, community members did not link health committees to CHWs, as also mentioned by Falisse et al (2012) [54], McCoy et al (2012) [23], and Goodman et al (2011) in Kenya [56].

Thirdly, there is an inconsistency between good virtue/intention and good performance. Our study shows that a number of women prefer to see a change in health service after their concerns are raised. For other women an expression of good intention on the part of
health workers is acceptable as a response to complaints. This is a phenomenon frequently reported in health system research of people embedded in one historical tradition often failing to see opportunities, which are visible to outsiders. In other words, this passivity stems from health providers who can identify the problem but cannot do anything about it. Furthermore, in most low-income countries confronted by funding constraints, frontline healthcare providers have no control over budget allocation, nor indeed are they able to adequately respond to community expectations. In this situation, the community might value their intention (though incapacitated), rather than their action. This is supported by Berlan and Shiffman (2012) when they reported that consumers view respectful interactions as significant elements of quality care [38]. On the other hand, Bovens (2007) who analysed and assessed accountability, reported that ‘accountability’ is often used interchangeably with virtuous behaviour and is present when public services are performed in a courteous manner [57]. Likewise, in most African norms, an action, even when an action has a good outcome, it is not valued if it is accompanied by a bad attitude. Indeed, even when it has a bad outcome, an action is accepted if it is accompanied by a good attitude/intention. Moreover, adopting a positive attitude towards a woman who is expressing a complaint can be interpreted as an implicit cognitive and silent message as “I received your complaint.” It may also be interpreted as an act of respect towards women’s rights, without changing profoundly the situation of women. That is how providers can keep the power status quo in place.

Fourthly, according to key informants in this study, the PBF survey data were communicated to the health zone level and returned to healthcare providers’ representatives. On the other hand, healthcare providers claimed that they were unaware of any survey results, nor were there any community representatives participating in the meeting when data were shared. This suggests that the data were only openly discussed among health providers, but not across hierarchies. This is due to, the fact that in PBF settings, CBOs are disallowed from conducting a survey and contacting health providers. This warrants independent and functions separation; and secondly, the results of small surveys are outsourced to purchasing agencies that summarize them for the entire health zone and not for a specific health facility. Therefore, the results are presented as a consolidated situation for all health facilities mostly as comments without compulsion for change. This situation led Falisse et al. (2012) in Burundi to propose that use of CBOs are complementary to health committees for the enhancement of voicing concerns [54].
Fifthly, the study shows that because of power asymmetries, women avoided direct and formal approaches for complaining. At the same time they did not support group or collective action. Women, in our study, asserted that collective action is unwelcomed by local authorities and groups are unheard. All over the world collective action is usually advocated and organized to explicitly express needs and complaints. We surmise that this inconsistency is not only a cultural aspect but is also the result of a political history and of the consideration of people who organized actions in group as ‘political activists.’ Furthermore, they were said to be non-representative of the people on whose behalf they were speaking. According to George (2003), this is one way for authorities to retain power, legitimizing people as beneficiaries and consumers only if they are passive, dependent and isolated individuals, rather than as citizens and active participants in their own health care [45].

This study also highlights solutions to lodge complaints against health providers. Firstly, we mentioned the satisfaction survey conducted by Community Based Organizations (CBOs) under performance-based financing scheme. This allows for avoiding a direct formal approach. Yet, this system is not a channel that people can voluntarily use to voice their concerns unlike other methods described here, but it is a community oversight. Secondly, as reported by Falisse et al (2012), CBOs are paid for quarterly collecting data from the community, pointing out that financial incentives remain the primary driver of CBOs and not the community interest. Moreover, the users’ information is conveyed only indirectly to health centres and the staffs are not compelled to change. Thus the voice of concerns is limited, leaving intact the power of persuasion [54]. However, in the Muanda program, health providers are contractually obliged to make changes in order to maintain the scheme, transforming the Purchasing Agency into a main protagonist of accountability relationships [14]. The CBO survey as community voice remains limited as the population and the community key informants asserted that they ignored them. Thus, in order to strengthen this voice locally, it would be interesting to transmit a copy of their findings to the community through the health committee-community health workers’ network.

Some local actors appear in our study as important players to raise accountability mechanisms. These actors are health services supervisors, local authorities and community health workers. The women interviewed believed that they could influence healthcare providers, who are more likely to accept concerns coming from them. Health supervisors and local authorities
are often hierarchically superior to healthcare providers and could be informed indirectly by those who receive reports of misconduct. They are able to act at different levels. For example, the health zone chief officer, being responsible for the health zone, could punish health providers at General Referral Hospitals, either nurses or doctors as well as health centre nurses for their recklessness, when there are complaints against them. Local authorities on their part could counterbalance the health providers’ power at local level, considering that they are traditional power holders and more often members of the health committee. The community health workers representatives are also important players in raising social accountability issues. Unlike common community health workers, these representatives are who for the most part are well educated and more able to counterbalance health providers. The possible implications of those actors were also highlighted by some authors such as Bjorkman and Svensson (2009) in Uganda [52], Maluka (2011) in Tanzania [42] and McCoy et al. (2012).

Our study has some limitations. First, our selection criteria (health zones with active NGOs and functional health centres) introduced a selection bias as the selected zones include high performing health facilities hiding the common DRC health facility situation. However, our selection criteria followed a critical case sampling: if accountability insufficiency related to poor health providers’ attitudes could be found at these particularly well-functioning facilities, then it was likely that the same accountability problems would exist at other health facilities that were less efficient with the current poor functioning regulations for health services. Still, both sites can represent the DRC rural situation, including sites with NGOs supporting the community besides governmental health provisions.

Secondly, limitations are related to data collection. Data were collected from only two health zones and from a small number of respondents, and might not represent the situation in the other zones in the DR Congo. In addition, as data were collected retrospectively there might have been a recall bias. However, in this qualitative study, it is not the representativeness of the sample that matters but the representativeness of information. In our study, we reached saturation and used triangulation to confirm and check the accuracy of data. Our findings can be comparable to those of countries such as Uganda, Tanzania and India where social accountability was explored considerably, but they are also specific to the DRC. This can suggest that the number of informants was sufficient for collecting the type of issues
occurring in the community and that the data are not the result of an unfortunate choice of sites.

Other limitations could be related to research team and reflexivity. The field team consisted of three persons: two female and one male researchers. The two female were single and had not yet experienced either pregnancy or childbirth. Both of them had a social sciences background and had already worked in maternal health research. They were in charge of women’s interviews and were quite similar in terms of age but different with regard to the socio-demographic characteristics (education, occupation...). The researcher in charge of interviewing key informants, health providers and male community members was a medical doctor, trained in maternal health practice and having quantitative methods background. During his previous experience in health provision, he objectively experienced women health services attendance with its problems such as abusive and disrespectful treatment, delays and women’s mortalities. He and most of the respondents were of the same age. All researchers introduced themselves as research students coming from the local university, the research team members noted their impressions after the interviews, and these were discussed during a daily debriefing meeting. Those notes were included in data analysis. The latter was mainly conducted by the first author. His background could have influenced the data analysis and interpretation. Nevertheless, to reduce these influences, the data analysis was conducted using the SA framework, moreover voice-centred relational method of data analysis was used. This method has reflexive elements built into it. It revolves around a set of three or more readings of the interview text. One of these readings involves a ‘reader-response’ element in which the researcher reads for himself in the text using a ‘worksheet’ technique whereby the respondent’s words are laid out in one column and the researcher’s reactions and interpretations are laid out in an adjacent column [58]. He puts himself, his background, history and experiences in relation to the respondent. He reads the narrative on his own terms, listening for how he is responding emotionally and intellectually to this person. This allows the researcher to examine how and where some of his assumptions and views might affect his interpretation of the respondent’s words, or how he later writes about the person. Finally all the data analysis process was supervised by three supervisors, more experienced in qualitative data analysis.
5.5. Conclusions

This study explores existing mechanisms in rural DRC through which interests of women are expressed and integrated into maternal health service standards in selected sites in DRC. Its findings show that formal social accountability mechanisms are absent in maternal health services in the DRC. Some building blocks which are likely to create social accountability are present. These are community associations and health committees and their interest and willingness to promote collective engagement have to be explored. However, as options for enhancement of voice and oversight, important steps at community and health facility level still have to be taken to allow collective engagement, voice, response and monitoring. It is necessary to ensure that women are aware of their rights to health while at the same time having a safe space to express their concerns when these rights are unmet. Improving social accountability in maternal health services requires intervention by creating spaces where health providers and women are enabled to have constructive dialogue, and health providers can be more receptive to discuss health concerns or demands made by women.
Chapter 5

References


50. George A. “By papers and pens, you can only do so much”: views about accountability and human resource management from Indian government health administrators and workers. Int J Health Plann Mgmt. 2009; DOI: 10.1002/hpm.

CHAPTER 6

Factors influencing the capacity of women to voice their concerns about maternal health services in the Muanda and Bolenge Health zones, Democratic Republic of the Congo: a multi-method study
Abstract

This paper aims to identify those factors that influence the capacity of women to voice their concerns regarding maternal health services at the rural health service level. A secondary analysis was conducted of the data from two qualitative and one quantitative study previously carried out in two Health Zones in the Democratic Republic of the Congo. The data processing and analysis focused on data related to factors that influence the capacity of women to voice their concerns, such as knowledge about maternal health services and the mandate of the health providers, awareness about what health services they can expect, and awareness about their health rights as consumers. The analysis also focused on the characteristics of women that influence their ability to identify, and address specific problems. Transcripts from qualitative studies were analysed using an inductive content analysis. Data from the quantitative study were summarized using proportions for categorical variables and means with standard deviations for quantitative variables.

Data were analysed from 21 interviews and 12 focus groups (n=92) and one household survey (n=517). Women living in the rural setting were mostly farmers/fisherwomen (39.7%) or worked at odd jobs (20.3%), with only a primary school education or had not completed secondary school (94.6%). A large proportion was younger than 20 years old (21.9%). The majority of women could describe the maternal health service provision they received but were not able to describe what they should receive as care. They had insufficient knowledge of the health services before their first visit. They were not able to explain the mandate of the health providers precisely. The information they received mostly concerns the types of health services they could receive in local health centre but not the real content of those services, nor their rights and entitlements. They were unaware of their entitlements and rights pertaining to health services. They believed that they were laypersons and therefore unable to judge health providers, but when provided with some tools such as a checklist, they reported some abusive and disrespectful treatments, mainly undignified care and informal payments. However, community members asserted that the reported actions were not reprehensible acts but actions for encouraging a woman and to make her understand the risk of maternal death or of new-born death.
The study shows that many factors influence the capacity of women in DRC rural settings to voice their concerns and that this is mainly associated with insufficient knowledge. The majority of women are poorly educated, of low economic status, and living in a socio-cultural context in which they learn to accept some categories of inappropriate care. These findings suggest that initiatives to implement social accountability must include components to address community capacity-building, health providers’ responsiveness and the socio-cultural norms issues.

### 6.1. Background

With a ratio of 846 maternal deaths per 100,000 live births in 2014 [1], the Democratic Republic of the Congo (DRC) has a high maternal mortality. Three-quarters of these deaths occurred during childbirth and the postnatal period [2]. Interventions to reduce maternal morbidity and mortality emphasize facility-based childbirth and skilled attendance during delivery with timely referral for emergency obstetric care if complications occur [3,4]. Progress towards achieving a reduction of maternal deaths has been slow because any improvements require the removal of social, financial and geographical barriers to access to skilled birth attendants, as well as addressing the health system challenges of low income countries [5–7]. To address this situation, additional strategies beyond providing skilled personnel and improving equipment and infrastructure are needed, such as those aiming to increase service uptake by women [8,9]. One of them restructures the social relationships of the main actors at stake through social accountability mechanisms. These mechanisms refer to a set of response mechanisms that facilitate health services providers to take into consideration the needs, expectations, concerns or complaints of users about the services they provide [10,11], and thus they improve the professional behaviour of providers towards clients [10,11]. These voice-response mechanisms aim to make the services more responsive for improving health service quality, contributing to an increase in health service utilization.

Social accountability involves at least three core elements: voice, enforceability and answerability. Voice includes mechanisms, formal and informal, through which people individually or collectively express their concerns and expectations, and demand accountability from power holders. Enforceability comprises the means available to sanction
non-compliance, wrongdoing and/or not appropriately fulfilling the mandate. Answerability refers to the obligation for the power holder to provide an account and the people's right to receive a response. Social accountability also involves a feedback process through which citizens can be informed of the use made of information they have provided. To be effective, the voice of citizens needs to be articulated into actionable demands, and transmitted to the relevant actors and decision makers, who have enforcement capabilities in order to generate answerability from the services providers and local authorities (refer to Figure 6.1) [12]. In a previous study exploring existing social accountability mechanisms in rural settings in the DRC, the researchers found that very few women voiced their concerns and complaints about the health services to health providers. The interviews revealed that women in these settings are unused to expressing their concerns or expectations with the aim to improve the health service provision. Their expectations extended only to health service inputs such as assigning a doctor to the local health centre, extending the health service centre with more wards, supplying more drugs and equipment, and providing free care. They did not consider the improvement of the quality of care provided and their own role and the role of health providers in optimizing the personal quality of care given the financial constraints of their setting. In addition, the researchers found that the women encountered many barriers to expressing their concerns to relevant actors and decision makers. Moreover, several factors were identified that hampered social accountability at the local level in the rural setting such as the absence of procedures to channel concerns, the fear of reprisals or of being misunderstood, as well as factors such as age-related power, ethnicity backgrounds, and women's status [13]. Yet, we do not have information on whether women in these settings are aware of their rights and entitlements, understand the mandate of the health providers, or feel abused by the health services.

According to Baez-Camargo and Jacobs, the capacity of citizens (in this case, women) to voice their concerns is influenced by the knowledge they have of the mandate of the health providers, of their rights and entitlements including their patients' rights as consumers and, of the specific obligations that health providers have to fulfil in the course of health service provision [12]. In line with the literature on the implementation of social accountability mechanisms, the researchers assume that the capacity of women to voice their concerns is influenced by the knowledge of their entitlements in terms of information about available maternal health services and the type, quality and quantity of care they can expect or that health providers
are supposed to provide based on their mandate [14,15], and by information about national health standards, entitlements and performance [16]. It is also influenced by the awareness about their health rights as consumers [17,18]. In this paper, we defined the mandate of the health provider as what is expected from him/her according to the health policy [19], and the entitlement as a healthcare or a health service that a woman has the right to receive from a health provider according to the health policy. The DRC national health policy, in line with the 2006 constitution, guarantees the right to health as one of the basic human rights, following international human rights treaties and the World Health Organization (WHO) constitution [7,20,21]. Under the 2006 constitution, it is the responsibility of national and provincial governments to protect and uphold the citizen's rights to health services of quality-appropriate standards. Furthermore, the national health policy emphasizes communication,
information and awareness of women about the content of healthcare and advice on health as essential components that guarantee the effectiveness of maternal health [1,7,21]. Efforts were made towards achieving a reduction in maternal deaths by making information about a maternal healthcare package widely available to women specifically and the community in general.

To date, we have not identified a study in the DRC that has explored the factors that influence the capacity of women to voice their concerns and expectations regarding maternal health services, specifically in rural settings, in terms of knowledge of their rights and entitlements and the health providers’ mandate, and awareness of the health service they can expect to receive. This paper aims to answer the following questions: What are the socio-demographic characteristics of women in rural settings? What knowledge do women have of the mandate of health providers and health services? What awareness do women have of their rights and entitlements with regard to health services including their patients’ rights as consumers?

6.2. Methods

Study designs
In order to answer these questions, we re-analysed two qualitative and one quantitative study, previously carried out in two health zones of the DRC. The first study aimed at exploring the existing situation of social accountability. The second study was a household survey carried out to gain more understanding of women's socio-demographic and economic characteristics and their experiences with maternal health services. It was motivated by the contradictory observation that most of the women participants in the first study did not complain about the health service while other community members did, and it aimed to assess the existence and distribution of disrespectful treatment during the use of maternal health services.

The findings of these two previous studies were used as input for the third study, which used focus groups to discuss and validate these findings. The aim was to validate the results of the two previous studies and to invite the community to reflect on social accountability regarding maternal health services.
Study settings
The three studies were carried out in two different health zones (HZs): the Muanda HZ in Kongo Central Province in the south-west and the Bolenge HZ in Equateur Province in the north-west. These HZs were purposefully selected because of the presence of a health partnership supporting or aiming to support an intervention involving social accountability mechanisms. In each HZ, one health area with a functioning health centre was randomly selected. A second health area with a functioning health centre was added for the household survey. A functioning health centre is defined according to the DRC National Health Policy as a health facility that provides an essential healthcare package at the first level, comprising basic maternal health services such as antenatal care, essential obstetric care (childbirth attended), postnatal care, family planning and tetanus immunization [21,22].

Study population and sampling
Participants in the first study were mainly women of reproductive age (15-49 years old), expectant or with a child aged younger than six months, with or without a history of recent pregnancy complications. They were selected using purposive sampling. In each health area at least nine were included, until no new information emerged from the interviews. In addition, purposively sampled key informants were interviewed, specifically women's association representatives, female health committee members and community health workers. Also included were women who were either mothers or mothers-in-law of a daughter or daughter-in-law who recently gave birth or was expectant.

Participants in the household survey were selected by a multi-stage sampling procedure. In each HZ, two health catchment areas with a functioning health centre were selected using a simple random sampling process. The minimum sample size was computed as 89 for each health area. All villages with more than 200 inhabitants were listed in each health area, and one-third was selected using a systematic sampling process. All households with a woman aged 15-49 years old from these selected villages who had attended a health facility for maternal healthcare specifically for antenatal care within the past 6 months or who had experienced childbirth in the preceding 6 months were numbered to build a sampling frame with the collaboration of the community health workers. In each health area, households satisfying the eligibility criteria were selected using a systematic sampling process, and all eligible women present in the selected households were recruited and surveyed.
Participants in the focus group discussions (FGDs) of the third study were selected purposively among men and their community groups’ representatives, women and their community groups’ representatives, community health workers and health committee members, and key informants including health providers, health zone management team officer, health partners and local authorities. In each category, 12 persons were purposively identified by the research team members based on a context analysis, informed by community health workers and health providers, and invited to attend the FGDs with the collaboration of the health zone management team officer. The inclusion criteria used were: (1) aged between 17-75 years, (2) living in the community for more than two years, (3) belonging to the target groups.

**Data collection and issues**

For the first study, women and key informants were interviewed between September and October 2013 using semi-structured, audiotaped interviews with an interview guide. The interview guide contained questions that explore women’s experiences of the health services, women’s expectations, needs and concerns regarding maternal health services, as well as formal and informal ways to voice their concerns. Women were approached outside of their homes and invited to participate in this research. A community health worker (CHW) was consulted to assist in identifying women who could be invited and to whom interviews could be arranged. When their consent was provided, the interview took place in their homes. Interviews lasted approximately 45 minutes and were conducted in Lingala or French. The field team consisted of a researcher and first author (EM), a research assistant from the Athena Institute/VU Amsterdam, and a research assistant from the University of Kinshasa, supervised by senior researchers (TM, MD). The CHW who guided the researchers did not assist with the interviewing and was excluded as a participant. Interviews with women were conducted by the female research assistants. Interviews with key informants were carried out by the first author (EM). A debriefing session was held after each fieldwork day during which themes, impressions of the findings and procedures were discussed and documented in field notes.

The household survey was carried out between October and December 2014. Face-to-face, no repeated interviews were conducted in the local language using a questionnaire. The survey questions were constructed using Demographic and Health Survey (DHS) household characteristics [23], social accountability model [24], disrespect and abuse framework [5,25],
and the health services’ responsiveness tools [18]. The latter drew on patient health rights such as the right to be treated with respect, the right to comply or the right to an effective communication (see Box 6.1). The disrespect and abuse framework was used to ensure that mistreatment was seen and measured in the same way as in recent studies.

<table>
<thead>
<tr>
<th>Box 6.1. List of patients’ rights as consumers and disrespectful items included in the checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part 1. Patient rights as consumers</strong></td>
</tr>
<tr>
<td>- Right to be treated with respect;</td>
</tr>
<tr>
<td>- Right to be free of any discrimination and exploitation;</td>
</tr>
<tr>
<td>- Right to dignity, independence and autonomy;</td>
</tr>
<tr>
<td>- Right to an effective communication;</td>
</tr>
<tr>
<td>- Right to be fully informed;</td>
</tr>
<tr>
<td>- Right to health services of appropriate standards;</td>
</tr>
<tr>
<td>- Right to grant informed consent;</td>
</tr>
<tr>
<td>- Right to complain;</td>
</tr>
<tr>
<td>- Right to confidentiality</td>
</tr>
<tr>
<td><strong>Part 2. Disrespect and abuse items included in the checklist</strong></td>
</tr>
<tr>
<td>- Body seen by others;</td>
</tr>
<tr>
<td>- Shouting/scolding;</td>
</tr>
<tr>
<td>- Request or suggestion of bribes or informal payments for better care;</td>
</tr>
<tr>
<td>- Threatening to withhold treatment;</td>
</tr>
<tr>
<td>- Threatening comments or negative or discouraging/disparaging comments;</td>
</tr>
<tr>
<td>- Ignoring or abandoning patient when in need;</td>
</tr>
<tr>
<td>- Delivered alone;</td>
</tr>
<tr>
<td>- Non-consent for tubal ligation;</td>
</tr>
<tr>
<td>- Non-consent for hysterectomy;</td>
</tr>
<tr>
<td>- Non-consent for Caesarean section;</td>
</tr>
<tr>
<td>- Hitting, slapping, pushing, pinching or otherwise beating the patient; sexual harassment;</td>
</tr>
<tr>
<td>- Rape and detention due to failure to pay.</td>
</tr>
</tbody>
</table>

The data collection procedure went as follows. After introducing herself and obtaining informed consent, the research assistant collected the participant’s characteristics. Then the assistant told the participant about two stories containing a disrespectful and abusive event and asked her whether she had experienced anything similar during her last maternal health visit (see Box 6.2). In addition, the research assistant asked the respondent if she had experienced specific events, using a checklist of disrespectful and abusive events, derived from Kruk et al. (2014). This checklist was used to gain greater specificity of understanding.
the woman’s experience (Box 6.1). Responses to each question were categorized as ‘yes’ or ‘no’. A participant was labelled as having experienced a disrespectful and abusive event during the last health service visit if she answered ‘yes’ to at least one of the items [26].

**Box 6.2. Vignettes recounted to the participant during the survey**

Dear participant,

I will recount to you two short stories about two ladies living in another village. The first story is about a lady named Marie. This lady was seven months’ pregnant and went to the local health centre for antenatal care. Although she reached the health centre on time, the nurse made her wait on a bench for more than four hours before attending to her. While attending to her, the nurse left the door open, allowing other patients to see her body and Marie was asked for extra money at the end of the examination.

I would like to know whether you encountered a similar situation yourself during your last visit to the local health centre for antenatal care. Have you ever encountered another situation that you were unhappy with?

The second story is about another lady named Anne who, for her second pregnancy, visited the local health centre for the delivery. As she did not appropriately follow the antenatal care schedule, the midwife scolded her in front of other women and did not assist her when her labour started, and slapped her on the thigh because she was unable to push the baby out.

I would like to know whether you encountered a similar situation yourself during your last visit to the local health centre for delivery. Have you ever encountered another situation that you were unhappy with?

The research assistant continued with checking her perception of the health providers’ responsiveness and satisfaction with the health service. Lastly, the research assistant asked the respondent whether she would visit the health service again or recommend it to her relatives based on her experiences.

Each interview lasted approximately 25 minutes. The interviews were conducted at the participants’ homes by trained research assistants. They were instructed to interview the women in private without other family members being present. Research assistants received four days of training including a pre-test day. The research methodology was pretested in a town sector different from those selected for the study, which helped to calibrate the research
tools and refine the understanding of abusive and disrespectful treatment in local settings. The research assistants were female and supervised by two research interns from the Kinshasa School of Public Health.

During the third study, four FGDs were held separately with each category group in each health area. The FGDs were organized and facilitated by the first author, who was supported by a local researcher, from February to May 2015. A FGD guide was used to structure the discussion. Potential participants were approached outside of their homes and invited to the meeting, which aimed to discuss the extent to which the results of the context analysis and the exploratory research reflected the reality of their community. The FGDs were held in a quiet place to optimize privacy and lasted on average an hour. They were conducted in Lingala, and audio recorded with the consent of participants.

**Data processing and analysis**

Regarding the qualitative studies, the interviews (first study) and focus groups (third study) were transcribed verbatim in Lingala, translated into French and checked by two team members. Atlas-ti 7 software (ATLAS.ti GmbH, Berlin) was used to organize the qualitative data. Data processing and analysis only focused on data related to factors influencing the capacity of women to express themselves, in terms of knowledge about maternal health services and the mandate of health providers, awareness of what health services they can expect, awareness about their health rights and entitlements including their patient rights as consumers.

The transcripts were analysed using deductive content analysis. The analysis was performed in three main stages. During the first stage, the transcripts were read repeatedly to become familiar with the participants’ stories and to identify themes associated with the ‘capacity of woman’ aspects. All identified themes were recorded and labelled with a unique code to compile a list of subcategories with regard to explored aspects. During the second stage, the researchers used the list of subcategories to code each separate interview or FGD transcript. During the third stage, subcategories were merged into categories corresponding to the explored aspects by seeking connections, similarities and differences providing a means of describing these categories and to generate knowledge. The process of analysis was completed by the first author and discussed with other authors and local health partners.
Data from the household survey (second study) were recorded using Epi Info 7 (CDC, Atlanta), and statistical analyses were performed using SPSS 23.0 (IBM, Chicago). The data were summarized using proportions for categorical variables and means with standard deviations (SD) for quantitative variables. The association between categorical variables was tested using Pearson's or likelihood-ratio chi-squared test as well as the Fisher test when appropriate. Proportions and means were compared using the chi-squared test and Student t-test, respectively. Whenever a quantitative variable was not normally distributed, the median was used for summarizing the data, and a non-parametric test was used to compare the medians. A logistic prediction model was made using the backward procedure in order to identify the characteristics of women associated with poor treatment. Independent variables included socio-demographic and health characteristics, such as age, parity, education level, marital status, occupation, religion, mode of transportation used to visit the health facility, respondent category (pregnant women or ever given birth), maternal health facility location, being informed about health facility activities, the collection of users’ views and complication history. The statistical significance was fixed at p=0.05.

**Ethics approval and consent**

The research protocol was submitted to and approved by the Internal Review Board, Kinshasa School of Public Health. The necessary administrative authorizations were obtained from the provincial and local levels. All participants were fully informed about the nature and implications of the study, and voluntarily provided in their consent to participate in writing. For minor respondents aged 15–17 years, consent from their parent/guardian was obtained after obtaining the participant’s assent. There were no major risks for women participating in the household study. But as the questionnaire addressed topics that could be sensitive and very personal for those who had experienced such events, the research assistants were trained to deal with these situations, specifically to provide psychological support to participants who expressed any signs of distress during the interview and to refer those participants to local support. All of the participants were given a phone number of a local psychological support provider who could assist the respondent to get help if needed. Respondents were also informed that with their approval, the interviewer would inform the supervisor about their distress and assist with referral information in order to get help. There were no direct benefits to participating in the interviews and household study, but participants in the FGDs received reimbursement of their travel expenses at the end of the meeting. All research procedures were in accordance with the Helsinki Declaration II.
Written informed consent was obtained from all participants to publish information containing some individual person’s data such as age, sex, occupation, location as they were important for understanding the research study.

6.3. Results

The first section describes the characteristics of the participants. The second section presents the results about factors that influence the capacity of women to express themselves, in terms of knowledge about maternal health services and the mandate of health providers, awareness of what health services they can expect, capacity of women to detect mistreatment and demand improvement, by combining data from the three studies.

6.3.1. Participants’ characteristics

For the first study, 48 interviews were conducted in the two selected areas: 27 in Bolenge HZ and 21 in Muanda HZ. Since the focus of this study was on maternal health, women of reproductive age formed the largest group. In total, 21 women of reproductive age were interviewed in the first study. Their ages ranged from 17-39 years (median: 27 years). The median number of children per woman was three, with ages ranging from two weeks to six years. The women were mostly farmers, with a primary school education, and lived with a partner.

For the second study, 517 women of reproductive age who had visited the health services for maternal healthcare participated in the household survey (response rate: 100%), 195 from Muanda HZ (37.7%) and 322 (62.3%) from Bolenge HZ. Participants were 25.82 years old on average (SD=7.34), and more than one-fifth was younger than 20 years old (21.9%). The majority had not completed secondary school (94.6%) and lived with a partner (86.5%). Approximately one-third headed their household (33.3%). Most of them were farmers/fisherwomen (39.7%) or lived from odd jobs (28.2%) such as small traders, sewers and hairdressers. At the time of the study, one-third of these women were pregnant (28.8%) and two-thirds had recently had a child (71.2%). Half of them already had three children. Most participants had visited the health centre in their area for antenatal care or delivery (71.2%).
(Table 6.1). Their partners were mainly farmers/fishermen (65.4%) or lived from odd jobs (15.9%), and their level of education was mostly primary or secondary school (80.1%) (See Appendix 6.1).

For the third study, 92 participants aged 22-67 were involved in the process. Females represented 42.4% (n=39). The level of the participants’ education ranged from no formal education to Master’s degree. With regard to women participants, their level of education ranged from no formal education to secondary school (Table 6.2).

6.3.2. Factors influencing the capacity of women to voice

Before detailing the findings on factors influencing the capacity of women to voice their views, it is noteworthy to highlight that participants in FGDs unanimously agreed that it is important for women to express and bring forward their concerns relating to maternal health service provision to health providers.

They considered that expressing their views and concerns was the only way for women to make their concerns known and to help health providers to improve the situation in case of any problem.

“It is important to inform the nurse in charge of the health centre...He/she needs to know in order to address this issue. If he/she does not know, this problem will continue” (Women, FGD, Bolenge)

On the other hand, participants in the FGDs agreed that women in local settings do not voice their concerns regarding health services. They recognized that women did not have any capacity to voice their views.

“We do not have any capacity to speak out. We are not able to go to see health providers and to oblige them to correct this or that thing. What is the main issue? ...as it is a habit which exists...” (Women, FGD, Muanda)

Regarding the factors that influenced the capacity of women to voice their concerns and expectations about maternal health services, data reanalysis identified four factors: (1)
Table 6.1. Individual characteristics of respondents by abusive and disrespectful treatment, Muanda and Bolenge, 2014

<table>
<thead>
<tr>
<th>Variables</th>
<th>Experiences of mistreatment</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Yes (n=26)</td>
</tr>
<tr>
<td>Health zone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muanda</td>
<td>195 (37.7%)</td>
<td>14 (7.2%)</td>
</tr>
<tr>
<td>Bolenge</td>
<td>322 (62.3%)</td>
<td>12 (3.7%)</td>
</tr>
<tr>
<td>Health catchment area</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kitona</td>
<td>98 (19.0%)</td>
<td>5 (5.1%)</td>
</tr>
<tr>
<td>Nsiamfumu</td>
<td>97 (18.8%)</td>
<td>9 (9.3%)</td>
</tr>
<tr>
<td>Iyonda</td>
<td>160 (30.9%)</td>
<td>3 (1.9%)</td>
</tr>
<tr>
<td>Wendji Secli</td>
<td>162 (31.3%)</td>
<td>9 (5.6%)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Younger than 20 years</td>
<td>113 (21.9%)</td>
<td>8 (7.1%)</td>
</tr>
<tr>
<td>20 years and older</td>
<td>404 (78.1%)</td>
<td>18 (4.5%)</td>
</tr>
<tr>
<td>Age (mean ±SD)</td>
<td>25.8 ±7.3</td>
<td>25.4 ±7.8</td>
</tr>
<tr>
<td>Age (median, range)</td>
<td>24.0 (15-48)</td>
<td></td>
</tr>
<tr>
<td>Education level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below secondary school</td>
<td>489 (94.6%)</td>
<td>16 (3.3%)</td>
</tr>
<tr>
<td>Secondary school and above</td>
<td>28 (5.4%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live in partnership</td>
<td>447 (86.5%)</td>
<td>21 (4.7%)</td>
</tr>
<tr>
<td>Live out of partnership</td>
<td>70 (13.5%)</td>
<td>5 (7.1%)</td>
</tr>
<tr>
<td>Respondent’s occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Civil servant/police/army</td>
<td>4 (0.8%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Private sector employee</td>
<td>8 (1.5%)</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Farmer/fisherman</td>
<td>205 (39.7%)</td>
<td>9 (4.4%)</td>
</tr>
<tr>
<td>Small trader/odd jobs</td>
<td>146 (28.2%)</td>
<td>7 (4.8%)</td>
</tr>
<tr>
<td>No specific job</td>
<td>154 (29.8%)</td>
<td>10 (6.5%)</td>
</tr>
<tr>
<td>Respondent’s religion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catholic</td>
<td>191 (36.9%)</td>
<td>9 (4.7%)</td>
</tr>
<tr>
<td>Protestant</td>
<td>98 (19.0%)</td>
<td>5 (5.1%)</td>
</tr>
<tr>
<td>Other Christian churches</td>
<td>206 (39.8%)</td>
<td>11 (5.3%)</td>
</tr>
<tr>
<td>Others (Muslim, Animist, Agnostic, Atheist)</td>
<td>22 (4.3%)</td>
<td>1 (4.5%)</td>
</tr>
<tr>
<td>Mode of transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>On foot</td>
<td>375 (72.5%)</td>
<td>18 (4.8%)</td>
</tr>
<tr>
<td>Bicycle</td>
<td>44 (8.5%)</td>
<td>1 (2.3%)</td>
</tr>
<tr>
<td>Motorcycles and cars</td>
<td>98 (19.0%)</td>
<td>7 (7.1%)</td>
</tr>
</tbody>
</table>
Chapter 6

<table>
<thead>
<tr>
<th>Respondent’s category</th>
<th>144 (28.8%)</th>
<th>9 (6.0%)</th>
<th>140 (94.0%)</th>
<th>0.503</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant</td>
<td>368 (71.2%)</td>
<td>17 (4.6%)</td>
<td>351 (94.4%)</td>
<td></td>
</tr>
<tr>
<td>Recently delivered</td>
<td>3.3 ± 2.4</td>
<td>3.4 ± 2.8</td>
<td>3.3 ± 2.4</td>
<td>0.786</td>
</tr>
<tr>
<td>Number of deliveries</td>
<td>3.00 (0-12)</td>
<td>2.50 (0-12)</td>
<td>3.00 (0-11)</td>
<td>0.741</td>
</tr>
<tr>
<td>Childbirth</td>
<td></td>
<td>0.949</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No previous birth</td>
<td>142 (27.5)</td>
<td>7 (4.9%)</td>
<td>135 (95.1%)</td>
<td></td>
</tr>
<tr>
<td>and first birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 births and more</td>
<td>375 (72.5)</td>
<td>19 (5.1%)</td>
<td>356 (94.9%)</td>
<td></td>
</tr>
<tr>
<td>Health provision</td>
<td>0.948</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>location</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local health area</td>
<td>368 (71.2%)</td>
<td>19 (5.2%)</td>
<td>349 (94.8%)</td>
<td></td>
</tr>
<tr>
<td>centre</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other health area</td>
<td>49 (9.5%)</td>
<td>2 (4.1%)</td>
<td>47 (95.9%)</td>
<td></td>
</tr>
<tr>
<td>facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health facility out</td>
<td>100 (19.3%)</td>
<td>5 (5.0%)</td>
<td>95 (95.0%)</td>
<td></td>
</tr>
<tr>
<td>of health area</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distance residence-</td>
<td>3.2 ± 4.1</td>
<td>4.1 ± 6.2</td>
<td>3.1 ± 3.9</td>
<td>0.231</td>
</tr>
<tr>
<td>health facility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Km) (mean ± SD)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informed about health</td>
<td>359 (69.4%)</td>
<td>10 (2.8%)</td>
<td>349 (97.2%)</td>
<td>0.000</td>
</tr>
<tr>
<td>centres activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health centres collect</td>
<td>288 (55.7%)</td>
<td>10 (3.5%)</td>
<td>278 (96.5%)</td>
<td>0.069</td>
</tr>
<tr>
<td>users’ views (Yes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complications (Yes)</td>
<td>97 (18.8%)</td>
<td>5 (5.2%)</td>
<td>92 (94.8%)</td>
<td>0.168</td>
</tr>
<tr>
<td>Ethnicity (Bantus)</td>
<td>499 (96.5%)</td>
<td>26 (5.2%)</td>
<td>473 (94.8%)</td>
<td>0.320</td>
</tr>
<tr>
<td>Native of the territory/indigenous (Yes)</td>
<td>255 (49.3%)</td>
<td>15 (5.9%)</td>
<td>240 (94.1%)</td>
<td>0.381</td>
</tr>
<tr>
<td>Knew or heard about a relative or a neighbour who experienced described situation (Yes)</td>
<td>38 (7.4%)</td>
<td>2 (7.7%)</td>
<td>36 (7.3%)</td>
<td>0.945</td>
</tr>
</tbody>
</table>

Table 6.2. Characteristics of participants in focus group discussions

<table>
<thead>
<tr>
<th>Participants in focus groups</th>
<th>Location</th>
<th>Number</th>
<th>Sex</th>
<th>Age</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key informants</td>
<td>Muanda 12</td>
<td>9</td>
<td>3</td>
<td>30-65</td>
<td>P5 MPH</td>
</tr>
<tr>
<td></td>
<td>Bolenge 8</td>
<td>7</td>
<td>1</td>
<td>31-45</td>
<td>U3 G6/MD</td>
</tr>
<tr>
<td>Community health workers and</td>
<td>Muanda 12</td>
<td>6</td>
<td>6</td>
<td>23-67</td>
<td>P6 U3</td>
</tr>
<tr>
<td>Health committee members</td>
<td>Bolenge 12</td>
<td>7</td>
<td>5</td>
<td>25-65</td>
<td>P4 U1</td>
</tr>
<tr>
<td>Men and men's groups'</td>
<td>Muanda 12</td>
<td>12</td>
<td>-</td>
<td>25-57</td>
<td>P6 U2</td>
</tr>
<tr>
<td>representatives</td>
<td>Bolenge 12</td>
<td>12</td>
<td>-</td>
<td>31-63</td>
<td>P4 U1</td>
</tr>
<tr>
<td>Women and women's groups'</td>
<td>Muanda 12</td>
<td>-</td>
<td>12</td>
<td>23-45</td>
<td>P6 S6</td>
</tr>
<tr>
<td>representatives</td>
<td>Bolenge 12</td>
<td>-</td>
<td>12</td>
<td>22-54</td>
<td>NE S6</td>
</tr>
<tr>
<td>Total</td>
<td>92</td>
<td>53</td>
<td>39</td>
<td>22-67</td>
<td>No MPH</td>
</tr>
</tbody>
</table>

Legend: M: Male; F: Female; NE: No education; P: Primary; S: Secondary; U: Undergraduate; MD: Medical doctor; MPH: Master in Public Health

134
women’s knowledge of maternal health services and the mandate of health providers; (2) information about the health services women should expect; (3) awareness of their entitlements and rights including their rights as consumers, and (4) socio-cultural barriers to expressing themselves.

(1) **Women’s knowledge of maternal health services and the mandate of health providers**
When asked to recount their experience of the maternal health services provided to them by the local health services, the majority of women faithfully described the maternal health service provision as they received it, irrespective of the type of service they had received. The description of health provision by women who visited more than twice was more precise than that by those who visited once or twice. In their description, they relied on what they had received as maternal health services.

> “When we visit for antenatal care, health providers gather us together and give us a seat in a place near the health centre. The session always begins with health education and communication... They provide us with advice...Then comes the physical examination. You go into the health provider’s room, she asks you questions about your health, examines you, and takes measures of your stomach with a ribbon meter and checks it with a metal device. Sometimes, they also take your weight and direct you in the laboratories for examinations of blood, urine and tools”
> (Women, Interview, Bolenge)

But when asked about what they knew about the health services before visiting the local health centre or about the type of health services they expected, most participants were unable to provide a clear answer.

> “We did not know all these before we attended the health centre for antenatal care”
> (Women, Interview, Bolenge)

Some of them answered based on what they had heard from their mother or mother-in-law or their relatives and neighbours. Most of the time, their descriptions were based on what their sources had received themselves as maternal healthcare and not on what they had thought they should or wanted to receive as care. Those who attended antenatal care for the first time
reported that they were accompanied by their mother or their mother-in-law when they lived in the same community. These companions were in charge of providing them with advice and guiding their first steps in the health services, as the interviewee lacked knowledge of health services.

Regarding the mandate of health providers related to maternal health, the majority of women answered that health providers are in charge of providing healthcare, but they were not able to explain precisely what this healthcare included and how health providers should provide it. In their account, they were unable to determine which services were missing in the health facility.

“We are not able to understand their job. We know nothing about their work. Health providers perform their duty as they have learnt” (Women, FGD, Bolenge)

(2) Information about the health services women should expect
The interviews revealed that women received formal information about maternal health services through two main channels. The first channel was the health education session led by the health provider at the health centre when the women were attending maternal healthcare. The second channel was the health awareness created through home visits or mass campaigns carried out by CHWs at the household level in the community. None of the women mentioned media such as radio or the health education courses provided at school, not even the youngest participants who were still pupils. Nor did they mention information booklets and flyers, widely made available by the National Reproductive Health Programme. It also emerged from the interviews that the women received informal information about maternal health services from relatives, specifically their mother and mother-in-law, siblings, peers and neighbours. This was in line with the results of the household survey, as around seven out of ten respondents had responded that they had had some information about their health facilities and health services (69.4%) (Table 6.1). Half of them had been informed by health providers (50.1%), approximately a quarter by CHWs (25.3%) or neighbours or relatives (23.7%).

However, the interviews revealed that most women who claimed to be informed about health services had information about the types of health services they could receive at the local
health centre such as antenatal care, delivery, immunization or post-natal care, but not about the real content of the services they should receive (package), which seemed to be more technical information. The interviews also showed that none of these channels provided information about health service performance (health services statistics), the mandate of health providers or the rights of patients.

(3) Awareness of their entitlements and rights
While it is uncommon for women specifically and people in general to know what they should expect from the technical aspects of healthcare, they are expected to be aware of non-technical aspects such as interpersonal relationships, right to complain, and health service responsiveness.

The majority of women in the interviews during the first study were positive about the healthcare provided to them and asserted there was nothing to complain about or request, even for non-technical aspects. Regarding their expectations and needs, the majority of women responded they had no specific expectations and needs, and they were content with the healthcare the health workers provided. They did not know what more to ask for. They believed that they were laypersons and therefore unable to judge the health providers.

“*What I want? I want that the health providers provide me with healthcare and give me necessary drugs. But I am not able to choose what care to seek for or what I need. All that health providers consider necessary for me, I accept...I am sure that they cannot harm my health*” (Women, Interview, Bolenge)

“We do not have a choice. All things are performed as they habitually do according to me” (Women, Interview, Bolenge)

The above findings led the research team to assume that the healthcare in health settings was provided in a friendly manner, or the women were unable to detect inadequate health services, and thus not able to assert their health rights as consumers.

This situation stimulated the research team to use more sensitive tools. The use of tools such as short illustrative stories (vignettes) and the WHO checklist aiming at improving the
capture of information from the community during the household survey allowed us to detect 26 participants with experiences of abusive and disrespectful care while attending maternal healthcare during the survey (n=571), representing 5.0% (CI 95%: 3.4-7.2%) (Table 6.1). The most commonly recognized event was undignified care, mentioned by ten participants. Others included inappropriate demand for payment and physical abuse. More specifically, the most common events reported were being hit/slapped/pushed/beaten, being shouted at/scolded, and being requested or receiving demands for informal payment for better care. Six participants also mentioned the experience of delivering on their own/not benefitting from antenatal services during their visit (Table 6.3). Furthermore, 38 participants (7.4%) asserted that they knew or heard about a relative or neighbour who experienced mistreatment like that described in the vignettes (Table 6.1).

Table 6.3. Personal abusive and disrespectful experiences (n, %)

<table>
<thead>
<tr>
<th>Grouped mistreatment events</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undignified care</td>
<td>10 (1.9%)</td>
</tr>
<tr>
<td>Shouting at patient/scolding the patient</td>
<td>7 (1.4%)</td>
</tr>
<tr>
<td>Threatening to withhold treatment</td>
<td>4 (0.8%)</td>
</tr>
<tr>
<td>Threatening comments or negative or discouraging/disparaging comments</td>
<td>3 (0.6%)</td>
</tr>
<tr>
<td>Abandonment or neglect</td>
<td>8 (1.5%)</td>
</tr>
<tr>
<td>Ignoring or abandoning patient when in need or when called</td>
<td>2 (0.4%)</td>
</tr>
<tr>
<td>Delivered alone/no performance of antenatal care actions during visit</td>
<td>6 (1.2%)</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>8 (1.5%)</td>
</tr>
<tr>
<td>Hitting, slapping, pushing, pinching or otherwise beating the patient</td>
<td>8 (1.5%)</td>
</tr>
<tr>
<td>Sexual abuse or harassment</td>
<td>2 (0.4%)</td>
</tr>
<tr>
<td>Otherwise hurting the patient</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>No/Lack of confidential care</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Allowing patient body seen by others</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>Revealing confidential patient’s information to other persons</td>
<td>0 (0.0%)</td>
</tr>
<tr>
<td>No consented care (perform healthcare without permission/ information)</td>
<td>5 (1.0%)</td>
</tr>
<tr>
<td>Inappropriate demands for payment</td>
<td>9 (1.7%)</td>
</tr>
<tr>
<td>Request or demand for informal payment for better care</td>
<td>6 (1.2%)</td>
</tr>
<tr>
<td>Detention of the mother or of the baby due to failure to pay</td>
<td>4 (0.8%)</td>
</tr>
</tbody>
</table>
Table 6.4. Household survey. Assessment of health service responsiveness using adapted WHO checklist (n, %)

<table>
<thead>
<tr>
<th>Health service responsiveness aspects</th>
<th>Frequency (n=517)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of attention/health provider does not respond in reasonable time</td>
<td>31 (6.0%)</td>
</tr>
<tr>
<td>Health facility rooms are unclean</td>
<td>11 (2.1%)</td>
</tr>
<tr>
<td>Health facility rooms are small</td>
<td>18 (3.5%)</td>
</tr>
<tr>
<td>Did not choose the health providers</td>
<td>499 (95.6%)</td>
</tr>
<tr>
<td>Have an explanation of her health problem or healthcare provided</td>
<td>373 (72.1%)</td>
</tr>
<tr>
<td>Give her opinion in the choice of healthcare</td>
<td>167 (32.3%)</td>
</tr>
</tbody>
</table>

With regard to the health service responsiveness, the participants mentioned that the health providers gave them an explanation about their health problem or the healthcare they received (72.1%) (Table 6.4). Around half of them also asserted that the health providers listened to their opinions and views during their last visit (55.7%) and were confident that the health providers took their opinions into account (86.1%). They based their confidence on the improvement of the health services (48.8%) and good collaboration with the health providers after the feedback (12.5%).

Table 6.5. Health service satisfaction and abusive and disrespectful experiences

<table>
<thead>
<tr>
<th>Health services quality satisfaction assessment</th>
<th>Total</th>
<th>Mistreatment experiences</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Very satisfied</td>
<td>77 (15.1%)</td>
<td>1 (1.3%)</td>
<td>76 (98.7%)</td>
</tr>
<tr>
<td>Satisfied</td>
<td>232 (45.4%)</td>
<td>11 (4.7%)</td>
<td>221 (95.3%)</td>
</tr>
<tr>
<td>Indifferent/Neutral</td>
<td>50 (9.8%)</td>
<td>7 (14.0%)</td>
<td>43 (86.0%)</td>
</tr>
<tr>
<td>Not satisfied/Unsatisfied</td>
<td>124 (24.3%)</td>
<td>7 (5.6%)</td>
<td>117 (94.4%)</td>
</tr>
<tr>
<td>Very unsatisfied</td>
<td>28 (5.5%)</td>
<td>0 (0.0%)</td>
<td>28 (100.0%)</td>
</tr>
</tbody>
</table>

It is emerged from the analysis of the household survey data that disrespectful and abusive events were mentioned less frequently by the participants who claimed to have information about their health facilities issues (38.5% versus 61.5%) (p<0.001). Furthermore, the logistic regression performed to identify factors associated with disrespectful and abusive treatment uncovered the fact of being informed about the health facility issues as the only factor (OR=0.245; CI 95%:0.113-0.574).
The study also showed that having experienced disrespectful and abusive treatment influenced the satisfaction of the woman as user (p=0.016) (Table 6.5) and reduced her intention of visiting in the future and recommending the facility to another person (p<0.001) (Table 6.6), even though the majority of women asserted that they did not have a choice of health providers as their rural area (95.6%) had a limited availability of health services (Table 6.4).

<table>
<thead>
<tr>
<th>Mistreatment experiences</th>
<th>Total</th>
<th>Intention of future attendance or of recommending to another relative</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td>26 (5.0%)</td>
<td>18 (69.2%)</td>
<td>8 (30.8%)</td>
</tr>
<tr>
<td>No</td>
<td>491 (95.0%)</td>
<td>473 (96.3%)</td>
<td>18 (3.7%)</td>
</tr>
</tbody>
</table>

The majority of participants in FGDs recognized that women were not aware of their entitlements and rights regarding health services. It also emerged that the women were unaware that they have the right to be treated with respect and dignity or to receive the defined medical standard of the interventions and services, and that they do not have to accept some practices which are in reality abusive and disrespectful. Moreover, they asserted that they have learned from the discussion that they have the right to complain, or to be completely informed about the care they received, which they did not know before.

“...And this is why I have already said that I cannot blame health providers, I cannot say so much as I do not know how to say if it is bad or it is done properly. For example, during the delivery, health providers slapped the woman. If she does not know if it is good or it is bad, how could she tell this doctor: you hurt me? Or the health provider act inappropriately, but she says to herself that it is like that normally” (Woman, FGD, Muanda)

“If these types of meetings [FGDs] are continually organized, people will attend and gain knowledge...Then in this case, when they have to claim something from health providers, they will use clear words. They shall not doubt, the woman will not doubt either. She knows what she can say because she learned, and she knows that the thing was not done appropriately” (Man, FGD, Muanda)
(4) Socio-cultural barriers to expressing themselves

Discussion in FGDs about the extent to which the results of the context analysis and the exploratory research reflected the reality of their community showed the existence of social codes in the community under study. It emerged that, apart from community health workers and health committee members, other participants in the focus groups, specifically community members, found it inappropriate to be informed about health services’ data, as they did not work in the health services. They asserted that they did not need data or information from the health centre. They claimed that the population is not interested in learning about health centre activities because this was seen to be as an attempt at controlling the health providers’ work.

“I cannot waste my time in checking the work of the health providers when I visit the health centre. It is not my job. I visit the health centre for care and not to check the others’ job” (Women, FGD, Bolenge)

Reacting to interviews and the household survey, community members except for key informants denied the existence of disrespectful and abusive treatment at the local health centre. They asserted that they had no complaints about the health services and that they were satisfied. Regarding the complaints about physical abuse or insult that emerged from some interviews, community participants disagreed, asserting that there was no physical abuse at their health centres, while key informants recognized them and promised to take action to correct the situation.

“I think that mistreatments are very common in hospital but not here in our health centre. We have heard that in hospital, when a woman is not able to push the child out during the delivery, some birth attendants lightly slap her. It is not that she is slapped for nothing. I do not agree” (CHW, Women, FGD, Muanda).

The community members claimed that the reports did not describe reprehensible acts but actions to encourage a woman and make her understand her situation. They asserted that the success of maternal health issues is the responsibility of the health provider, who is accountable for this and, not the women who attends. They recognized the action but asserted that the intention was not to harm but to encourage the woman. However, some
participants stated that mistreatments are very common in the general hospital, but it is difficult to put complaints forward. Furthermore, some participants in FGDs asserted that when reprimanding women who did not adhere to the “rules”, some health providers’ reaction gave the impression of being insulting. However, they recognized it as more of a local manner of speaking rather than an insult.

“Regarding physical abuses in the delivery room...I think that we cannot call them physical abuses or slaps. For us, there are ways to encourage women. The health providers do not slap them nor hurt them. These cannot kill them. It is to remind you that you have to make the step and push out the child” (Women, FGD, Bolenge)

“We have here women who are not able to take care of their children nor of their own hygiene. In this case, health providers act as a well-intentioned parent who reprimands her daughter. It is not a scolding nor an insult” (Woman, FGD, Bolenge)

Generally, the health providers, local authorities, health zone management team officers agreed on the results presented during the meeting and on the reported abusive treatment and inappropriate behaviour of the health providers. They promised to work on improving the situation. However, they concurred that there were not many complaints about health services in local settings.

6.4. Discussion

While there is a growing interest in implementing social accountability mechanisms in maternal health services, there is still a need to understand the factors that influence the capacity of women to be engaged in voice mechanisms in low- and middle-income countries. In this study, one main barrier is the knowledge gap; women at the local level have insufficient information and knowledge about health services standards and the health provider’s mandate. They are unaware of the health services they should expect according to the prevalent health policy. Furthermore, they are insufficiently informed about their entitlements and rights regarding maternal health services even though guaranteed in the health policy that is in line with the Constitution. Findings also show that the majority of women are poorly educated, have a low
economic status, and are living in a socio-cultural context where their fundamental human
di rights are so frequently violated during childbirth that such care is seen by the community as
ormal, making them accept some categories of inappropriate care. All these elements raise
barriers to detecting inappropriate care and asserting what they are entitled to. These last
three characteristics also raise barriers to expressing themselves, even if they recognized
experiences of mistreatment and inappropriate care. The study additionally shows that the
use of appropriate tools such as vignettes or checklists and strategies by the research team
could help women to identify some health services issues they were not aware of.

In the current study, the knowledge gap of maternal care-seeking women was evident in terms
of health services standards and health providers’ mandates. This is in contrast to claims from
the National Reproductive Health Programme that efforts were made to make them widely
available as an essential component in achieving the reduction of maternal mortality. This
knowledge gap is also described in the literature and is rooted first in low health literacy,
the associated low availability of health information and support, as women do not have any
access to sufficient information about the health services and healthcare [14,27–29]. In most
of the DRC health zones, the access to health information for the population in general and
women in particular is mainly through four sources: health education courses at school; health
education sessions during health visit; sensitization and health campaigns through CHWs
or through the mass media; and interpersonal communication. Health education courses at
school focus mostly on individual health issues and diseases rather than public health issues
[30]. Other sources provide very fragmented and elementary information, which does not
allow a deeper understanding of the practice of health services [31,32]. This all contributes to
knowledge asymmetry, posing a classic barrier so that when visiting health services, a woman
may not have sufficient information to judge the quality and performance, and thus may not
detect inappropriate care, demand the ‘right’ kind of healthcare or assert her patient’s rights
as a consumer [17,33–35]. Thus, strategies and tools which could increase the knowledge,
information or awareness of women such as WHO responsiveness [18], disrespectful and
abusive framework [5,25,26], media or public hearing [14] could be useful to improve the
detection of inadequate health service issues [10].

According to Apolinario et al. (2013) in a Brazilian study, health literacy is also associated
with socio-demographic variables, including educational attainment and major lifetime
occupation. However, Mayuzumi (2004) found in a study in Bangladesh that some health issues also stem from deeply rooted socio-economic, cultural and environmental contexts, which people cannot easily change when operating on an individual basis [36]. In our study, most community members seemed to agree that some reported mistreatments are justified by the higher priority of delivering a healthy baby, so this act is actually a “means to encourage her” or this is related to the way of reprimanding someone using a “local manner of speaking”. This is in line with the existing literature from Tanzania [4], Ghana [37,38] and Lebanon [39].

In an ideal world, it can be assumed that women as clients have a clear knowledge about their needs when visiting a health service. They do not necessarily know what to expect from the more technical aspects of healthcare. But it can be assumed that women clearly know what they should expect in terms of interpersonal relations related to healthcare, constituting their rights e.g. to have their healthcare explained, to be informed about the disease, to receive respectful care. The study shows that women were not aware of their rights as patients. The fact that they tend not to be adequately informed of their rights nor know what to expect as healthcare suggests that they are not able to evaluate healthcare or to judge what constitutes good quality healthcare. This situation is more likely to put them in a difficult position to claim their rights. This is in line with a study from Tanzania, where the awareness of rights is considered a “new culture” [40]. Moreover, recent studies have observed that the intervention aimed at increasing women’s awareness of their rights was found to be associated with an increase in reporting of mistreatment [41].

On the other hand, as it was assumed that women would not know what to expect of healthcare, it is the duty of health providers, in charge of providing the technical aspect of healthcare, to be more responsive during health service visits in providing them with information and explanations about healthcare. In addition, the health zone management team should supervise the health providers to make them more responsive to providing adequate healthcare, including interpersonal relation aspects.

**Study limitations**

This study had some limitations related to its secondary analysis design. First, it utilizes data collected for other studies, with quite different objectives, even if the original studies aimed to understand women’s experiences of maternal health services in the Democratic Republic
of the Congo. The second limitation is linked to the non-equivalent and non-homogenous presence of the concepts examined by the various primary studies. However, the secondary analysis helps to investigate a subject that the original analysis did not deal with. It helps to gain insights into this subject, which is important for accountability mechanisms [42]. The number of studies and the variance of methods increased the study validation by triangulation [43].

This study’s findings were limited to knowledge, information, and awareness. It did not provide insights into skills and contexts enabling women to use knowledge to voice their concerns. These crucial aspects were investigated in previous studies [13,44].

**Research team and reflexivity**

As with any qualitative content analysis, the data interpretation could be influenced by the background and the views of the research team members. To reduce these influences, the data analysis was conducted using a framework, refining the definition of variables. Second, the materials used were taken from datasets by the researchers who collected the original research and carried out the original studies. Third, the data were collected and analysed by a research team integrating researchers from a variety of disciplines, who collaborated in the research programme with common research questions and objective. This interdisciplinarity allowed knowledge integration and limited the influence of the researcher’s subjectivity. Finally, the data were collected in interaction with the participants. The findings were discussed not only within the research team but also with local health partners, community members and health providers. The inclusion of end-users in the process allowed local knowledge and the interest of various stakeholders with different societal perspectives and culturally distant to be integrated. This transdisciplinarity increased transparency and reliability.

**6.5. Conclusion**

In summary, our findings have shown that women in rural health zones of DRC suffer mainly from a structural knowledge gap, i.e. insufficient knowledge of health services standards and health providers’ mandate, inadequate awareness of their entitlements and rights. This is an important barrier to their voice as they are not able to detect inappropriate care and
to assert what they are entitled to. In terms of socio-demographic determinants, we found that the majority of women are poorly educated, have a low economic status, and are living in a socio-cultural context that makes them accept some categories of inappropriate care as normal. Based on the findings, we suggest that initiatives to implement social accountability mechanisms must include at least a community capacity-building component in terms of basic information on healthcare standards and health providers’ mandate and awareness of patient rights. They must also include components which address the health providers’ responsiveness in terms of improving the provision of health information during health service attendance. From our analysis we might recommend expanding the information collection efforts to other sectors, such as integrating public health issues in school health education modules beginning in primary school and addressing some socio-cultural norms beyond providing knowledge/information.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Total</th>
<th>Experiences of mistreatment</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (n=26)</td>
<td>No (n=491)</td>
<td></td>
</tr>
<tr>
<td>Household head</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td>0.561</td>
</tr>
<tr>
<td>Male</td>
<td>456 (88.2%)</td>
<td>434 (95.2%)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>61 (11.8%)</td>
<td>57 (93.4%)</td>
<td></td>
</tr>
<tr>
<td>Age (mean ± SD)</td>
<td>39.3 ± 11.5</td>
<td>39.3 ± 11.4</td>
<td>0.900</td>
</tr>
<tr>
<td>Age (median)</td>
<td>38.0 (18-84)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td>0.777**</td>
</tr>
<tr>
<td>Catholic</td>
<td>197 (38.1%)</td>
<td>187 (94.9%)</td>
<td></td>
</tr>
<tr>
<td>Protestant</td>
<td>99 (19.1%)</td>
<td>94 (94.9%)</td>
<td></td>
</tr>
<tr>
<td>Kimbanguist</td>
<td>21 (4.1%)</td>
<td>21 (100.0%)</td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>26 (5.0%)</td>
<td>24 (92.3%)</td>
<td></td>
</tr>
<tr>
<td>Evangelical churches</td>
<td>123 (23.8%)</td>
<td>120 (97.6%)</td>
<td></td>
</tr>
<tr>
<td>Jehovah’s witness</td>
<td>9 (1.7%)</td>
<td>8 (88.9%)</td>
<td></td>
</tr>
<tr>
<td>Other independent Christians</td>
<td>17 (3.3%)</td>
<td>14 (82.4%)</td>
<td></td>
</tr>
<tr>
<td>Animist</td>
<td>3 (0.6%)</td>
<td>3 (100.0%)</td>
<td></td>
</tr>
<tr>
<td>Branhamist</td>
<td>7 (1.4%)</td>
<td>6 (85.7%)</td>
<td></td>
</tr>
<tr>
<td>No religion</td>
<td>15 (2.9%)</td>
<td>14 (93.3%)</td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td>0.437**</td>
</tr>
<tr>
<td>Civil servant/police/army</td>
<td>38 (7.4%)</td>
<td>36 (94.7%)</td>
<td></td>
</tr>
<tr>
<td>Private sector employee</td>
<td>26 (5.0%)</td>
<td>26 (100.0%)</td>
<td></td>
</tr>
<tr>
<td>Farmer/fisherman</td>
<td>338 (65.4%)</td>
<td>320 (94.7%)</td>
<td></td>
</tr>
<tr>
<td>Small traders</td>
<td>26 (5.0%)</td>
<td>25 (96.2%)</td>
<td></td>
</tr>
<tr>
<td>Other small jobs</td>
<td>82 (15.9%)</td>
<td>77 (93.9%)</td>
<td></td>
</tr>
<tr>
<td>Jobless</td>
<td>7 (1.4%)</td>
<td>7 (100.0%)</td>
<td></td>
</tr>
<tr>
<td>Education level</td>
<td></td>
<td></td>
<td>0.054</td>
</tr>
<tr>
<td>Lower to secondary school</td>
<td>414 (80.1%)</td>
<td>397 (95.9%)</td>
<td></td>
</tr>
<tr>
<td>Secondary education and greater</td>
<td>103 (19.9%)</td>
<td>94 (91.3%)</td>
<td></td>
</tr>
<tr>
<td>Household size (mean ± SD)</td>
<td>6.5 ± 3.0</td>
<td>6.5 ± 3.0</td>
<td>0.655</td>
</tr>
</tbody>
</table>
### Appendix 6.2. Characteristics of respondents’ partners or husband by mistreatment experiences, Muanda and Bolenge, 2014.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Total</th>
<th>Mistreatment experiences</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes (n=26)</td>
<td>No (n=491)</td>
</tr>
<tr>
<td>Same as household head</td>
<td>360 (67.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td>0.364**</td>
</tr>
<tr>
<td>Civil servant/police/army</td>
<td>29 (5.6%)</td>
<td>2 (6.9%)</td>
<td>27 (93.1%)</td>
</tr>
<tr>
<td>Private sector employee</td>
<td>27 (5.2%)</td>
<td>0 (0.0%)</td>
<td>27 (100.0%)</td>
</tr>
<tr>
<td>Farmer/fisherman</td>
<td>318 (61.5%)</td>
<td>14 (4.4%)</td>
<td>304 (95.6%)</td>
</tr>
<tr>
<td>Small traders</td>
<td>31 (6.0%)</td>
<td>2 (6.5%)</td>
<td>29 (93.5%)</td>
</tr>
<tr>
<td>Other small jobs</td>
<td>91 (17.6%)</td>
<td>7 (7.7%)</td>
<td>84 (92.3%)</td>
</tr>
<tr>
<td>Jobless</td>
<td>13 (2.5%)</td>
<td>0 (0.0%)</td>
<td>13 (100.0%)</td>
</tr>
<tr>
<td>Pupil/Student</td>
<td>8 (1.5%)</td>
<td>1 (12.5%)</td>
<td>7 (87.5%)</td>
</tr>
<tr>
<td>Age of partner</td>
<td></td>
<td></td>
<td>0.805</td>
</tr>
<tr>
<td>Less than 20 years</td>
<td>13 (2.5%)</td>
<td>1 (7.7%)</td>
<td>12 (92.3%)</td>
</tr>
<tr>
<td>20-24 years</td>
<td>83 (16.1%)</td>
<td>5 (6.0%)</td>
<td>78 (94.0%)</td>
</tr>
<tr>
<td>25 years and more</td>
<td>421 (81.4%)</td>
<td>20 (4.8%)</td>
<td>401 (95.2%)</td>
</tr>
<tr>
<td>Age (mean ± SD)</td>
<td>32.6 ± 8.7</td>
<td>32.1±9.7</td>
<td>32.6 ±8.6</td>
</tr>
<tr>
<td>Age (median, range)</td>
<td>32.0 (16-68)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion</td>
<td></td>
<td></td>
<td>0.443**</td>
</tr>
<tr>
<td>Catholics</td>
<td>183 (35.4%)</td>
<td>8 (4.4%)</td>
<td>175 (95.6%)</td>
</tr>
<tr>
<td>Protestants</td>
<td>103 (19.9%)</td>
<td>5 (4.9%)</td>
<td>98 (95.1%)</td>
</tr>
<tr>
<td>Kimbanguists</td>
<td>18 (3.5%)</td>
<td>0 (0.0%)</td>
<td>18 (100.0%)</td>
</tr>
<tr>
<td>Muslims</td>
<td>25 (4.8%)</td>
<td>2 (8.0%)</td>
<td>23 (92.0%)</td>
</tr>
<tr>
<td>Evangelical churches</td>
<td>131 (25.3%)</td>
<td>6 (4.6%)</td>
<td>125 (95.4%)</td>
</tr>
<tr>
<td>Jehovah witness</td>
<td>10 (1.9%)</td>
<td>1 (10.0%)</td>
<td>9 (90.0%)</td>
</tr>
<tr>
<td>Other independent Christians</td>
<td>19 (3.7%)</td>
<td>3 (15.8%)</td>
<td>16 (84.2%)</td>
</tr>
<tr>
<td>Animists</td>
<td>6 (1.2%)</td>
<td>0 (0.0%)</td>
<td>6 (100.0%)</td>
</tr>
<tr>
<td>No religion</td>
<td>15 (2.9%)</td>
<td>0 (0.0%)</td>
<td>15 (100.0%)</td>
</tr>
<tr>
<td>Branhaimists</td>
<td>7 (1.4%)</td>
<td>1 (14.3%)</td>
<td>6 (85.7%)</td>
</tr>
<tr>
<td>Level of education</td>
<td></td>
<td></td>
<td>0.272</td>
</tr>
<tr>
<td>Less than secondary school</td>
<td>403 (77.9%)</td>
<td>18 (4.5%)</td>
<td>385 (95.5%)</td>
</tr>
<tr>
<td>Secondary school and up education</td>
<td>114 (22.1%)</td>
<td>8 (7.0%)</td>
<td>106 (93.0%)</td>
</tr>
</tbody>
</table>
References

Chapitre 6


38. Rominski SD, Lori J, Nakua E, Dzomeku V, Moyer CA. When the baby remains there for a long time, it is going to die so you have to hit her small for the baby to come out”: justification of disrespectful and abusive care during childbirth among midwifery students in Ghana. Health Policy Plan. 2016;10.1093/heapol/czw114.


CHAPTER 7

Social accountability in primary health care in West and Central Africa: exploring the role of health facility committees
Abstract

Social accountability has been emphasised as an important strategy to increase the quality, equity, and responsiveness of health services. In many countries, health facility committees (HFCs) provide the accountability interface between health providers and citizens or users of health services. This article explores the social accountability practices facilitated by HFCs in Benin, Guinea and the Democratic Republic of Congo.

The paper is based on a cross-case comparison of 11 HFCs across the three countries. The HFCs were purposefully selected based on the (past) presence of community participation support programs. The cases were derived from qualitative research involving document analysis as well as interviews and focus group discussions with health workers, citizens, committee members, and local authorities.

Most HFCs facilitate social accountability by engaging with health providers in person or through meetings to discuss service failures, leading to changes in the quality of services, such as improved health worker presence, the availability of night shifts, the display of drug prices and replacement of poorly functioning health workers. Social accountability practices are however often individualised and not systematic, and their success depends on HFC leadership and synergy with other community structures. The absence of remuneration for HFC members does not seem to affect HFC engagement in social accountability.

Most HFCs in this study offer a social accountability forum, but the informal and non-systematic character and limited community consultation leave opportunities for the exclusion of voices of marginalised groups. More inclusive, coherent and authoritative social accountability practices can be developed by making explicit the mandate of HFC in the planning, monitoring, and supervision of health services; providing instruments for organising local accountability processes; strengthening opportunities for community input and feedback; and strengthening links to formal administrative accountability mechanisms in the health system.

7.1. Background

Since the 1978 Alma-Ata Declaration on Primary Health Care, participation has been a central theme of health policy and programming. The 2008 World Health Report re-emphasizes the
values of community participation to achieve "people-centred" health systems [1]. Health service users are increasingly seen as citizens who should be allowed to voice their concerns actively, to shape health services and policies in the public interest and hold health providers and policymakers accountable [2, 3]. The expectations of this form of accountability referred to as social accountability are high, in particular in countries where health systems face persistent service delivery failures [4]. In many low-and-middle-income countries, health facility committees (HFC) are one of the well-known vehicles for community participation. They are involved in the co-management of primary public health facilities, in the spirit of the Bamako Initiative that was launched in 1987 (see Table 7.1). While the Alma-Ata Declaration expressed the key principles of Primary Health Care, the Bamako Initiative operationalized the principle of community participation in the organisation of health services. It introduced measures that aimed to give users, through representatives in HFCs, say in determining access to services and the use of funds obtained through the sale of drugs. Some HFCs, especially in health centres with high utilisation rates, developed into structures with significant influence on the management of human, financial and material resources needed to provide quality of care [5, 6, 7].

**Table 7.1. The Bamako Initiative**

<table>
<thead>
<tr>
<th>Background</th>
<th>The Bamako Initiative (BI) is a policy statement, adopted in 1987 by African health ministers in Bamako, Mali. It was developed in the context of economic crises and negative effects of adjustment programmes in many Sub-Saharan countries. Formulated by UNICEF and WHO, the initiative aimed to promote universal access to primary health care.</th>
</tr>
</thead>
</table>
| Objectives | • Strengthen the management and financing of health care at the local level.  
• Promote community participation.  
• Improve the supply, management and use of essential drugs.  
• Ensure sustainable financing of primary health care units. |
| Principles | Decentralisation of decision-making to health districts and of financial management to communities; partial cost-recovery through the sale of essential drugs; sufficient funding for primary healthcare by governments; exemption policies for the poorest groups in society; health promotion and a multi-sectorial approach to health care. |

*Source: Ridde (2004)*[7]*

In many countries, HFCs are attached to health centres and elected by community members to facilitate communication and feedback processes between health providers and citizens or users of health services. They, therefore, have the potential to ensure financial and social accountability of health providers to communities and to strengthen the democratic governance of health systems more generally [8].
Recent literature reviews on HFCs found that the extent to which HFCs in developing countries can influence service provision is mixed. This is due to the diversity in the composition of HFCs, their roles and responsibilities, the availability of resources, as well as the differences in health systems and policies, community and societal contexts in which HFCs operate [4, 9, 10]. These reviews led to a better conceptualization of contextual elements that influence HFC effectiveness, but they also called for more empirical tests of the frameworks. Based on a synthesis of findings from case studies in West and Central Africa, this paper explores the functioning of HFCs, in particular with regard to their actual and potential role in the facilitation of social accountability. A recent systematic review of the literature on community participation by George et al. revealed that most studies on the topic focus on participation in health promotion interventions and effects on service uptake and less on community involvement and empowerment in the governance of health services [11].

This paper aims to address this research gap and to provide recommendations as to how the role of HFCs in social accountability can be enhanced.

7.2. The social accountability role of HFC
Social accountability is a contested concept used in a variety of disciplines, including in the context of professional health education [12], New Public Management [13] and participatory democracy [14]. In the health sector, social accountability is often viewed as an advanced form of community participation whereby citizens take action to enhance the accountability of politicians, policymakers and service providers. The role of HFCs in social accountability has rarely been assessed. HFCs are defined as “any formally constituted structures with community representation that has an explicit link to a health facility and whose primary purpose is to enable community participation with the aims of improving health service provision and health outcomes” [9]. HFCs can exist at several levels and take different forms from village level health committees to community health groups and hospital boards for district hospitals [4]. This study focuses on HFCs at the level of primary healthcare centres offering basic packages of healthcare.

HFCs can perform two sets of activities to improve health service provision, presented in Table 7.2 as two roles. The first role is to support the functioning of health facilities and the objectives of health providers.
Exploring the role of health facility committees

HFCs serve as an extension of service providers and engage in community outreach, the co-management of health centre resources and the facilitation of repairs and fundraising. This role is quite prevalent in practices of HFCs in low-and-middle-income countries [10]. McCoy et al. refer to the activities under this role as facing “inwardly” [9].

Table 7.2. Main roles and activities of health facility committees

<table>
<thead>
<tr>
<th>Main roles</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inward role: support health facility &amp; workers</td>
<td>Co-management – of health facility resources and services</td>
</tr>
<tr>
<td></td>
<td>Resource generator – in the form of material resources, labour and funds for health facility</td>
</tr>
<tr>
<td></td>
<td>Community outreach – to help the health facility reach into the community for the purpose of health promotion and improving health-seeking behaviour; organisation of community-based health activities</td>
</tr>
<tr>
<td>2. Outward role: facilitating citizen voice and accountability</td>
<td>Advocacy – to act as a community voice to advocate (e.g. to local politicians and health managers higher up the health system) on behalf of the health facility</td>
</tr>
<tr>
<td></td>
<td>Social leveller – to help mitigate social stratification by defending rights of marginalised sections of the community/public</td>
</tr>
<tr>
<td></td>
<td>Control of quality and management – including the monitoring of use and quality of material, financial resources and the performance of health workers, results of health services</td>
</tr>
<tr>
<td></td>
<td>Provide accountability interface by initiating and facilitating feedback process between users/citizens and health providers and authorities by following the steps in an accountability cycle: Information/data collection – information on performance through monitoring, the collection, interpretation and articulation of users’ and citizens’ views, demands and complaints. Dialogue/forum – provide a means to transmit, question and discuss this information to/with health providers and authorities and claim improvements. Consequences – follow up on responses and decisions taken and for results; when responses or explanations fail, there should be a possibility to reward/sanction health providers’ actions and results. Counter feedback to users’ and citizens.</td>
</tr>
</tbody>
</table>

The second role supports users’ and citizens’ voice and the “bottom-up” integration of community preferences in decision-making in service delivery. McCoy et al. call this the “outward” role [9]. HFCs activities include advocating for access to health care (“social leveller”) or resources (“advocacy”), the monitoring of the quality of care and the use of funds (“control of quality and management”) and the facilitation of feedback mechanisms.
between health providers and users ("provide accountability interface"). Whether or not, and how HFCs perform these roles varies, as HFCs are complex entities embedded in country-specific political, historical and health system contexts [9, 10]. Moreover, in many countries, HFC members work as unpaid volunteers; HFC effectiveness, then, depends on the personal commitment of individual members.

This paper explores the activities HFCs currently perform in providing a social accountability interface only (4th “outward role” in Table 2) that are summarised in four steps: information/data collection, dialogue/forum, consequences and counter-feedback to users [15]. In line with Bovens, HFCs provide a “forum” where they question health providers’ behaviour and actions, and where health providers provide explanations or justifications; when such explanation or justification fails, consequences (sanctions or rewards) can follow [15]. We added the fourth step “counter feedback to users and citizens” as HFCs are representative of the communities in which they operate and have, themselves too, the obligation to report on their activities and results to the larger community. Apart from assessing the functioning of the accountability cycle in the study countries, we also aimed to explore the effect on health providers’ responsiveness to community issues and demands and the factors that shape HFCs as social accountability interfaces. Figure 7.1 summarises the conceptual framework for the study. It combines concepts from the work by McCoy et al. and Molyneux et al. on HFCs, and
Exploring the role of health facility committees

from Bovens’ accountability theory [4, 9, 15]. This framework supported the data collection and analysis.

The four steps of the accountability cycle are expected to affect health provider responsiveness, an intermediary effect of social accountability initiatives [16]. Responsiveness broadly refers to the extent to which a health provider or health policymaker acts upon needs and demands expressed by users, the community or HFCs [16]. The ability of HFCs to influence provider responsiveness and service provision depends on several interacting factors related to the wider social, cultural, political and health system context and the local context regarding community and HFCs features [4, 9, 10, 15, 17]. In this study we were interested in one particular community feature: the presence of other interface structures such as community health workers or local councils. We assumed that other community groups, also those beyond the direct environment of health facilities, demand accountability and advocate for improvements in health services and hence influence the scope and reach of HFCs [18].

Based on the conceptual framework, the three main research questions of the study are: how is the accountability role of HFCs described in policies? How do HFCs currently facilitate social accountability? What factors shape the role of HFCs as facilitators of social accountability?

7.3. Methods

This article is based on findings from three country studies that were conducted in 2013 and 2014 in Benin, Guinea and the Democratic Republic of Congo (DRC) [19–21]. The studies were initiated in the context of the French Muskoka Initiative with UNICEF WCARO that funds operational research in Francophone countries in West and Central Africa to support the emergence of innovative approaches to health systems development. The study adopted a qualitative case-study methodology to understand social accountability practices in selected primary health care settings within their real-life context [22].

Selection of study sites
The countries were purposively selected; criteria included francophone countries, government commitment to the Bamako Initiative, community participation and HFC development and
long-term experience with HFC programmes. In each country, districts (department in Benin, zones de santé in DRC, prefectures in Guinea) were purposively sampled taking into account the presence of community participation support programmes. In Guinea, two prefectures were selected relatively close to the capital Conakry because of the Ebola epidemic that had not yet reached the capital at the time of the fieldwork.

Within the districts, four health centres were selected based on their health performance. Based on suggestions by McCoy et al, we assumed that well-performing facilities could be associated with well-performing HFCs [9]. We used health performance indicators as selection criteria (external consultation, assisted deliveries and antenatal care coverage). Not all provinces disposed of performance data, therefore in some cases; the researchers depended on the knowledge of health authorities. The facility closest to the national capital was at 60km (Guinea) and the most remote facility was at 220 km. from Kinshasa (DRC). Initially, each country team had selected four study HFCs; in Guinea, the dataset of one HFC got lost, totalling the total number of study sites at 11.

**Data collection and analysis**

In each country, a research team was set up consisting of a senior researcher, a researcher and research assistants. In Benin, the Belgian Technical Cooperation (BTC) participated in the design of the study. The overall study was coordinated by the Royal Tropical Institute (KIT). Senior researchers participated in the protocol and tool development and organised training for the research teams in their respective countries. Data collection took place between January and April 2014. Each country team had a backstopping advisor KIT, who supported data collection, analysis and feedback on interim reports.

An initial review of the health, decentralisation and community participation policies helped to understand the background of HFCs, the evolution of the Bamako Initiative and the formal arrangements about to the role of HFCs in social accountability. Secondly, to investigate the practices of HFCs in facilitating social accountability, we used a mix of methods including semi-structured interviews, focus group discussions and document reviews, each with specific tools. Each of the tools addressed three main topics: (1) characteristics of the HFC and the health facility (local context), (2) examples of social accountability practices, and (3) participants’ perceptions of the effectiveness of social accountability relations and practices. The triangulation of different sources of evidence to answer the same questions was expected to strengthen the validity of the findings [22].
For the interviews, we targeted participants at each health facility site representing health providers, local authorities, HFC members, community based associations and users (male and female) in order to collect a diversity of views on, and experiences with, the HFCs. A total of 95 individual interviews and 22 focus group discussions were held with different actors (see Table 7.3). The selection and recruitment process differed between the countries, depending on prevalent local procedures. In DRC, the health zone director communicated to the HFC chairman who selected participants based on criteria and numbers set by the researchers. In Guinea, a site visit prior to data collection supported the identification of participants and the issuance of formal invitations through the local authorities. In Benin, the identification and recruitment of participants was done by the HFC chairmen, based on the selection criteria provided by the researchers. Some documents were collected locally including minutes of HFC meetings and health facility reports. Not all HFCs disposed of written material.

Table 7.3. Data collection method per country

<table>
<thead>
<tr>
<th>Country and No. of HFCs</th>
<th>Individual interviews</th>
<th>Focus Group Discussions: 6-12 participants each</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>33</td>
<td>6</td>
</tr>
<tr>
<td>4 HFCs</td>
<td>Health provider (n=12)</td>
<td>Male citizens (n=3)</td>
</tr>
<tr>
<td></td>
<td>Local authorities (n=6)</td>
<td>Female citizens (n=3)</td>
</tr>
<tr>
<td></td>
<td>HFC members (n=12)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other interface structure (n=3)</td>
<td></td>
</tr>
<tr>
<td>Guinea</td>
<td>28</td>
<td>6</td>
</tr>
<tr>
<td>3 HFCs</td>
<td>Health provider (n=9)</td>
<td>Male citizens (n=3)</td>
</tr>
<tr>
<td></td>
<td>Local authorities (n=7)</td>
<td>Female citizens (n=3)</td>
</tr>
<tr>
<td></td>
<td>HFC members (n=9)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other interface structure (n=3)</td>
<td></td>
</tr>
<tr>
<td>DRC</td>
<td>34</td>
<td>10</td>
</tr>
<tr>
<td>4 HFCs</td>
<td>Health provider (n=11)</td>
<td>Male citizens (n=4)</td>
</tr>
<tr>
<td></td>
<td>Local authorities (n=9)</td>
<td>Female citizens (n=4)</td>
</tr>
<tr>
<td></td>
<td>HFC members (n=14)</td>
<td>HFC members mixed (n=2)</td>
</tr>
</tbody>
</table>

All individual interviews were audio-recorded and transcribed in Word. The transcripts of interviews held in local languages, were translated into French. Coding was done based on a coding guide developed jointly by the three research teams based on the conceptual framework and research questions. The coding was done through software Atlas-ti in Benin and the DRC.
and in Guinea in Microsoft Excel. The country research teams carried out the analysis and triangulation of country-level data. Each HFC was described as an individual case during a workshop in June 2014 where the researchers also jointly identified the first common patterns in the findings. This paper is based on a qualitative cross-case synthesis [23] that considered the findings of the country studies collectively and aimed to identify, from 11 case studies, common patterns and trends in the way HFCs perform a social accountability interface role. Authors synthesised this data from all three countries on the basis of the country research reports, the initial joint synthesis and their access to the primary data. The activities that are performed by HFCs as accountability interfaces were selected for inclusion in this paper based on a review of their clarity in describing the activity and its effect and on the basis of data (respondent) and data source triangulation. At least two groups out of four participant groups needed to have contributed to the example or the example needed to be confirmed by documentary evidence. Data about contextual factors were derived from the country reports but also by returning to the original data. To identify patterns across the countries and to include the relevant data in this analysis, a regular return to data was needed as well as some re-coding, in particular of contextual factors. Hence, the analysis was an iterative process of explanation building as proposed by Yin [22]. Investigator triangulation and team discussions contributed to the interpretation of themes and the identification of patterns across the cases, progressively leading to a better understanding and confidence in the synthesis findings [24]. Information on policy and legal country contexts was derived from previous outputs of the country studies and external literature. Regular validation of findings between the main author and the country research teams was done to ensure the quality of the results.

**Ethical considerations**

Approval for the research was obtained from ethical review boards at the Department of Sociology, Anthropology of the University of Abomey, Benin, and the Kinshasa School of Public Health in Kinshasa and the Ministry of Health in Guinea in 2013. Prior to all interviews, written consent was obtained from study participants. To protect the identity of the facilities and participants, general pseudonyms have been used in the reporting. No individual persons’ data or images were reported in this manuscript.
7.4. Findings

The first section describes the political and legal context and the evolution of health facility committees in the three countries. The second section discusses the interface role that HFCs currently play, and the last section discusses how contextual factors shape the accountability role of HFCs.

Evolution of HFCs in policies in Benin, Guinea and DRC

In Benin, Guinea and DRC, different types of health committees have been set up from 1979, first as local initiatives and later scaled up to other parts of the country. In all three settings, the health centre level is the lowest level that has an HFC. District or regional hospitals usually have advisory boards or boards of directors but they do not have as main task to enhance community involvement. Table 7.4 presents the key features of current HFCs attached to primary health care centres. The table shows that the three countries have HFCs of similar compositions. They all have community as well as health worker representatives, around nine members who are elected for two to three years. Health worker representatives cannot be elected as board members or chairpersons but can act as secretaries. HFC compositions differ in that guidelines in Benin and Guinea prescribe the need to include representatives from different social groups, while in DRC community health workers form a large proportion of the membership. In the three countries, there is a clear policy commitment to community participation and reference is made to HFCs in many health sector strategies as well as health system strengthening plans.

In the three countries, there is a clear policy commitment to community participation and reference is made to HFCs in many health sector strategies as well as health system strengthening plans.

In Benin, community participation is considered a crosscutting issue and is integrated into different health policies and reform documents. Since the Bamako Initiative, several types of community structures have been installed; it is the health facility management committee (COGECs) that is assessed in this study, further referred to as HFC. After the countrywide installation of HFCs from 1995, the Ministry of Health further defined the mandate and powers of the HFCs in 2004 and 2006. Bylaws stipulate that HFCs are involved in the monitoring of the budget formulation and execution, the management of user fees, the establishment of drug
inventories and orders. The texts specify that HFCs are to promote financial transparency of pricing policies and to prevent extortion of patients and illegal drug sales. They have to report health workers suspected of fund diversion or embezzlement to the authorities to enable disciplinary measures. HFCs are further supposed to contribute to conflict resolution between the community and health providers [25, 32]. The Ministry further suggests strengthening the ethical behaviour of health workers through the training of user associations [32]. For each of the different functions, a training manual exists with concrete suggestions for conflict management and financial control [33].

In Guinea, the Ministry of Health, in its National Health Development Plan (2004), envisions communities as owners of health facilities instead of clients. The Ministry envisions the development of formative supervision and participatory monitoring with communities to enhance the quality of primary health services [28]. HFCs are supposed to plan and monitor health services at health facility level. They also engage in supervision, including the checking of health workers’ presence and quality of the reception of patients. The HFC training manual emphasises that supervision is meant to solve problems rather than to control or inspect [34].

Table 7.4. Features of health facility committees attached to primary health care centres

<table>
<thead>
<tr>
<th>Feature</th>
<th>Benin</th>
<th>Guinea</th>
<th>DRC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denomination</td>
<td>Health Facility Management Committee (COGECS)</td>
<td>Health Management Committee (COGES)</td>
<td>Health Development Committee (CODESA)</td>
</tr>
<tr>
<td>Number of HFCs</td>
<td>587</td>
<td>410</td>
<td>8,126 (against 8,504 planned)</td>
</tr>
<tr>
<td>Catchment area of rural HFC (norm)</td>
<td>5,000 – 15,000 inhabitants</td>
<td>5,000 – 10,000 inhabitants</td>
<td>5,000 – 15,000 inhabitants</td>
</tr>
<tr>
<td>Membership</td>
<td>9 members, elected for 3 years through general assembly; representing community, local associations, health workers and local council</td>
<td>9 members, elected for 2 years, representing civil society, religious leaders, women, youth. The facility manager represents the health workers.</td>
<td>10+ members, elected for 2 years, representing community health workers (chair), civil society and the health centre Officer in Charge (OiC). The OiC cannot be a member of the HFC executive board.</td>
</tr>
</tbody>
</table>

Sources: Benin [25, 26], Guinea [27-29], DRC [30, 31]
HFCs are expected to “maintain a continuous dialogue” between health providers and the community to reduce conflicts and to transmit perceptions and expectations of the community to providers. Community participation policies in the health sector are increasingly aligned with the overall decentralisation policy that established local governments from 1988. This means that HFCs are now under the authority of local councils and are accountable to local councillors and the mayor. A government-adopted training manual of 2011 reflects this setup; it describes responsibilities of both HFCs and the health, political and administrative authorities [34]. After this study, the health system has undergone many changes as a result of the Ebola epidemic, whereby the role and mandate of HFCs are also being revisited.

Community participation in DRC has been revitalised in 2000 as a result of a health sector review that observed continued high mortality and morbidity rates. The Ministry of Health proposed to transform the ineffective or non-existent health management committees into multidisciplinary, multi-sectoral health development committees. The new HFCs are strongly associated with Community Health Workers (CHW) who play an important role in health care in the DRC in the context of a shortage of trained health professionals [35,36]. Each village has a CHW representative in the HFC. The HFC manual lists a range of responsibilities for the HFCs including planning and monitoring of health activities in collaboration with health professionals [36]. The integration of this governance reform in other health-related policies is yet to be realised. The implementation of the new policy is uneven with some districts benefiting from NGO support and others not.

The data presented here show that the policy framework of HFCs in the three countries has been revised in the last decade, approximately 15 years after the Bamako Initiative. This revision mostly concerned a more precise definition of the mandate and responsibilities of HFCs. In many countries, including in Benin and Guinea, the Bamako Initiative was initially interpreted as a cost recovery mechanism but the revisions in Benin and Guinea re-emphasize the role of communities in controlling the management of health facilities which includes not only financial control but also the monitoring of the quality of care [6]. The revision in DRC is more driven by a renewed commitment, in particular of external donors, to strengthen the position of community health workers (CHW) in primary health care.

For the three countries, the central role assigned to HFCs in most official documents as well as training manuals is related to the role that we classify as the “inward” role to support the
facility and health workers. Despite increased commitment in new bylaws and health policies to strengthen the “outward” role of facilitating social accountability, the researchers did not find specifications of the actual powers and tools for HFCs to take up this role. For example, in both Benin and Guinea, HFCs are expected to monitor health service delivery but ways to address, report or sanction poor service delivery, are not defined. When roles and powers of HFCs to hold health workers to account are only partially defined, it can be expected that many HFCs do not take up this role or develop an approach based on their own experience and practices. In the following, we will focus on these practices to facilitate social accountability according to the 4 steps of the accountability cycle presented in the framework.

**HFC practices in facilitating social accountability**

Table 7.5 provides a summary of the study findings with regard to activities carried out by HFCs within each of the accountability steps. A more detailed account of these steps is provided in the paragraphs that follow.

1. **Information and data collection**
   HFCs collect information on the performance of the health facility in two ways: through direct observation, monitoring and supervision in health facilities and through users approaching HFC members.

<table>
<thead>
<tr>
<th>Accountability interface steps</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information/data collection</td>
<td>Direct observation and supervision in health facilities</td>
</tr>
<tr>
<td></td>
<td>Users approaching individual HFC members</td>
</tr>
<tr>
<td>Dialogue/forum</td>
<td>Direct and immediate problem solving</td>
</tr>
<tr>
<td></td>
<td>Direct - during HFC meetings</td>
</tr>
<tr>
<td>Consequences – follow-up</td>
<td>No follow-up or follow-up with no results</td>
</tr>
<tr>
<td></td>
<td>Local regulation</td>
</tr>
<tr>
<td></td>
<td>Involvement of health authorities</td>
</tr>
<tr>
<td>Counter feedback to community</td>
<td>No activities</td>
</tr>
</tbody>
</table>

The first method, direct observation and supervision, is strongly related to the traditional role that HFCs have been attributed in the Bamako initiative. Although the three countries
followed different paths in implementing the Bamako Initiative, the task of controlling drug management and the financial books at health facility level is key in most of the studied HFCs. An HFC chairman in Guinea illustrates the determination of many HFCs in this domain with regard to supervision of the delivery and management of drugs:

“We control workers’ presence in the health centre and drug prices. We have achieved results such as compliance with drug prices. The health workers were planning to buy and sell the drugs and collecting money without involving us. We demanded our participation in the ordering and reception of the drugs and the deposit of amounts received from drug sales before signing any document” (HFC chairman Guinea, HFCG1).

Besides this core task, in many cases, HFC members are present in the health facility on a daily basis to monitor the quality of care. Through their interaction with patients, they collect and share information about the health services, but they do not document their interactions. A second way in which HFCs obtain data on health worker performance is through users and citizens approaching individual HFC members directly on the street or in other public spaces or during health information and communication sessions. The latter strategy is particularly prevalent in DRC, where HFC members (including CHW) are conducting home visits for sensitization and public health data collection purposes. Users and companions (who escort patients) use this opportunity to share their concerns about the performance of the health facility without explicitly being invited to. In Guinea, respondents give examples of individual HFC members treating complaints on the spot on a case-by-case basis. Table 7.6 presents the main issues brought forward by users to HFC members across the 11 cases, in order of importance and triangulated by data from users, health workers as well as HFC members.

In none of the study sites, HFC members pro-actively seek users’ opinions or ask people to share needs, demands, expectations or complaints about health services. Tools such as patient satisfaction forms are not in use or are not managed or accessed by HFCs.

Some HFCs combine methods such as in a case in Guinea where members are present on a daily basis to monitor the quality of care, and to discuss directly with health providers in cases of poor performance. This active supervision is more likely to happen after a user complaint is received.
Table 7.6. Complaints brought forward by users to HFC members

<table>
<thead>
<tr>
<th>Material and financial issues</th>
<th>Health worker performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>High drug prices</td>
<td>Availability of staff</td>
</tr>
<tr>
<td>Lack of drugs, equipment</td>
<td>Absence of staff resulting in non-treatment (day)</td>
</tr>
<tr>
<td>Quality of drugs (illicit or wrong drugs)</td>
<td>Task shifting (assistant as manager instead of doctor)</td>
</tr>
<tr>
<td>Overbilling of drugs</td>
<td>Absence of staff (night)</td>
</tr>
<tr>
<td>Financial accessibility in case of emergency</td>
<td>Unfriendly behaviour of health workers and auxiliary staff</td>
</tr>
<tr>
<td>High consultation fees</td>
<td>Quality of reception/welcoming of patients who arrive at the health facility</td>
</tr>
<tr>
<td>Financial harassment/informal payments including:</td>
<td>Detention/bribing of patients who cannot pay their consultation fees</td>
</tr>
<tr>
<td>direct cash payments to staff where the transaction is not recorded and patients are either not given a receipt or are issued a false one double payment (by the health worker and at the official cash payment point)</td>
<td></td>
</tr>
<tr>
<td>Lack of blood</td>
<td>Inebriated health workers</td>
</tr>
</tbody>
</table>

2. Dialogue/forum and effect

We identified two ways HFCs use to channel concerns and complaints to health providers. One is the direct pathway whereby health providers are contacted directly, mostly individually; the second is the use of HFC meetings to discuss issues. The responsiveness of health providers to these dialogues is also assessed.

Individual dialogue

Transmission of community concerns directly to providers occurs face-to-face or by telephone. Participants shared a number of examples whereby HFC members confront health providers immediately after having received a complaint (Benin, Guinea). An officer in charge of a health facility and a female participant in Benin stated for example:

“When they observe awkward behaviour, complaints from the village, they call me on the phone... and I go... So this is how they behave and ... how they do their control...either by phone and I will come and check” (OIC, Benin, HFCB3).

“There are no arguments between health workers and patients here, and if it is the case, the HFC intervenes. HFC members calm everyone, they manage the situation and peace returns” (FGD women, Benin, HFCB3).
Financial accessibility is a major problem for many patients in the three countries, especially in systems where patients have to pay before they are treated or where informal payments are widespread. Complaints about informal consultation fees and high drug prices are very common in the three countries as observed from the FGD with users and HFC members. HFCs seem to deal with these complaints in different ways. They facilitate access by convincing health workers to provide services by guaranteeing the payment, or by negotiating a credit system as the examples illustrate:

“On a Saturday we were working at the health centre, a mother brought a child with anaemia. She did not have much money so that the pharmacy did not want to give her a blood bag for the child. Members of the health committee, who noticed this, vouched for this woman and have promised to pay if the woman did not pay. The pharmacy gave her the blood bag and the child was transfused” (FGD HFC members, DRC, HFCD4).

Dialogue in HFC meetings
Another way of addressing complaints regarding the quality of care that the HFC receives is through HFC meetings. From both interviews, FGD and minutes of HFC meetings, it was observed that HFCs regularly discuss two main issues: health worker behaviour and drug management. Behaviour concerned absenteeism, informal payments, inebriation and unfriendly treatment of patients. Service users in both DRC and Guinea mentioned they had reported absenteeism to the HFC and they were aware of the HFC having addressed the issue in HFC meetings. According to women in an FGD in DRC, this resulted in nurses being more quickly available in emergency cases and in Guinea the officer in charge has developed a publicly displayed table with staff working hours that is, according to both female users and the officer in charge, being respected. Some respondents in DRC explain that by openly discussing health worker behaviour during a HFC meeting, frustrations from both sides are shared and listened to and that this process helps to address poor behaviour, at least in the short term. There was one case in Benin where the good collaboration between HFC members and health workers even got its own proverb “there is no problem” (“Toukada mou léo”) which refers to a mutual commitment to rectify problems and not let the oil stain.

In Benin and Guinea, HFCs often prioritise drug pricing and related problems such as embezzlement or overcharging in their HFC meetings. Some HFCs meticulously collect health passes, drug prescriptions and patient bills and compare with similar bills and with official
prices. When there is visible proof (e.g. written bills), and when verification is possible, HFCs bring a strong case to the table that health managers cannot ignore. In Benin, a facility manager explains the dilemma's this poses to him:

“When they [HFC] call me to come and check the bills at the dispensary...I must say that I try to save my agent...I cannot undress my agent in front of them like that because it's a secret between us. Or they [HFC] come directly to surprise us at a meeting with certain bills, I then give the floor and try to calm the HFC while scolding the agent who is at fault...we arrange it together. But last time it almost escalated, and if it were not for our vigilance, they would have locked someone. We were angry with them, we must defend the culprit” (OIC, Benin, HFCB3).

While the systematic collection of evidence to detect fraud is practised by some HFCs, the collection and transmission of evidence on non-financial matters (e.g. health worker absenteeism or behaviour) is less systematic in the study sites and seems to be acted upon on a case-by-case basis.

3. Consequences and follow-up
As suggested in the previous section, sometimes dialogue and on-site mediation between HFC members and health providers ease frustration. Explanations for behaviour, for example by the facility in charge, may reduce tensions and solve a case. In a number of instances, however, HFCs pursue their quest for change by introducing local enforcement methods or by involving district health authorities.

Local regulation
Strong levels of negotiation and local regulation and enforcement were observed in two sites. In one case in Benin, a HFC introduced regulations and sanctions to enforce health providers’ financial accountability. These included the formal interdiction to sell parallel drugs using the health facility prescription orders or to sell drugs on credit without approval by the HFC. The HFC further decided that health workers who had issued false bills had to repay the debts to the health facility, which some of them have started doing. Finally, the HFC issued a warning that health workers who would fail to apply these rules would be transferred elsewhere. One HFC in DRC had appointed one member as complaint manager who had the task to follow-up the decisions made and actions identified during HFC meetings and to keep them on the
agenda when the facility in charge failed to implement them. Although health providers in most sites appreciate the contributions of HFCs in co-management, they were less receptive of HFCs engaging in monitoring consultation payments and fraud detection. In Benin, an HFC member believed that providers "can threaten to kill HFC members over too much scrutiny".

**Involvement of district authorities**

Community demands or complaints often move up the hierarchy after having been discussed in the HFC meeting. In Guinea this process seems most formalised whereby the transmission of complaints follows a route from the communities to health posts to health facility managers and up to the district authorities, written down in the monthly monitoring reports:

"During some meetings, HFC members get to discuss populations' complaints. An example is a situation of a health post, which was debated even on the management board. The officer in charge did not get along very well with people because he came to work inebriated. This complaint was sent to the HFC and sent up to the communal council, the health facility and the District Health Team. The worker was eventually replaced" (OIC, Guinea, HFCG2).

Similar examples were reported in DRC, where poor health worker attitude was discussed by HFCs and reported to village chiefs or health authorities, first orally and then written:

"There was a health worker, who had a habit of overcharging services and who did not treat patients well. Several community members reported these complaints to members of the health committee. The committee spoke to the provider, who, instead of changing, continued to act in the same way. Finally, after several complaints, the health committee sent reports to Health Zone Management Office who sacked the health worker in question?" (FGC HFC, DRC, HFCD1).

"Previously, there was a provider here at the health centre. He did not touch the patients, he used a pen to feel and inspect a patient. He did not use his hands like other providers. The people saw it and forwarded a complaint to the central office through the health committee and promised to report this attitude to higher instances or make a court case. This provider was transferred elsewhere" (FGD men, DRC, HFCD1).
In similar cases, however, the HFC has not been able to trigger sanctions:

“A recent complaint we received was about a vaccination officer who was often inebriated at work... we have repeatedly informed health officials verbally before writing a letter, but so far they have not found a solution...Because it is the State that affects its agents and we often mention in our reports, but in vain. The state must resolve the complaints because it is the state that affects workers in communities”(HFC Chairman, Guinea, HFCG1)

In the cases mentioned, the main result is a transfer of the health worker to another health facility or the dismissal of a health worker. One HFC in Benin took a different approach to deal with health workers overcharging patients. The HFC required health workers to pledge adherence to the jointly established price list for drugs and to accept the working conditions at the health facility. The pledging was done in front of the district health authority as to enforce the use of this agreement.

4. Counter feedback to community
The last step in the accountability cycle, counter feedback to the community, does not seem to be practised. When community members report complaints to members of the HFC, most of them indicate they do not know whether their concerns reach the providers. Hence, they do not know whether the HFC members are reactive themselves or whether it is just a lack of counter feedback to the community, even if the concerns have been treated. Some HFC members confirm that they do not report back to the community; instead, they expect users to see the achievements of the HFC when visiting the health facility.

Factors shaping the role of HFCs in facilitating social accountability
With regard to the wider context, the countries share similar policy and legal contexts whereby there is a political commitment to community participation and social accountability by HFCs but limited support and legitimisation through legal tools or practical guidelines. This may explain the observation that none of the HFCs studied applies the accountability cycle in a systematic (regular) or complete (all four steps) way. HFC members and others may not be aware of their role or not have the appropriate instruments and power to perform the role. On the other hand, the findings suggest that despite a disabling legal and political context, the HFCs in the study areas seem to use the limited space or develop the necessary approaches
Exploring the role of health facility committees

locally to facilitate social accountability. In the following section, we explore the factors that shape the potential of HFCs to provide an accountability interface. It is based on a comparative analysis of the 11 HFC cases presented in the country studies. It addressed three factors: the election and representation of HFCs, remuneration of HFC members and the presence of other interface structures.

**Mode of elections, composition, representation, leadership.**

In all cases, HFCs were installed through an official event, but in none of the cases, HFCs were elected as anticipated in the regulations. Even in cases where elections had taken place in a transparent manner, resulting in an initial representation of different groups in the community, the composition changed soon after installation. Members who were not active or members who are believed to be incompetent or too old were soon replaced. In one HFC in Benin, for example, the Chairman replaced a treasurer deemed “too uneducated”. In two other HFCs, a locally elected councillor took the place reserved for an NGO representative. Sometimes new members are added without a consultation or vote within the HFCs. As a consequence, sometime after the elections, the composition has changed significantly, and in practice, only the executive board (chairman, treasurer) is active. Hence, the mode of election does not seem to be the problem but the recomposition of HFCs that occurred in all cases post-election. In some cases, it led to internal oppositions and unsolvable tensions between members, for example in struggles over the treasurer function. These tensions were also observable during group interviews in the study sites in Benin and Guinea. In others, it led to individualism of members (Benin) and apathy. In two cases, HFC leadership seemed to mitigate these problems; a capable and active chairman or board who insist on actively engaging with the community and providers.

**Remuneration**

In all three countries, participants mentioned the lack of remuneration for HFC members as an obstacle to the proper functioning of HFCs. In the case of Guinea, however, where HFC members are not paid and where external technical and financial assistance was largely absent, HFCs had similar levels of activity like the ones in Benin that had been receiving support for some years. Participants explained this intrinsic motivation of HFC members as a result of long periods of conflict and health facility destruction in that particular area. They argued that citizens had developed a greater sense of responsibility to manage their affairs.
In one site in DRC, HFC members developed their internal operation manual in the absence of government-provided guidelines and, instead of receiving institutionalised support, they received occasional voluntary contributions from communities or individual deputies.

Community features: existence of multiple interfaces

As suggested in the conceptual framework, the presence of other interface structures and in particular their credibility in the eyes of the users and citizens can also influence the use and effectiveness of HFCs as accountability channels. The study aimed to explore this by asking respondents about the presence and performance of other participatory structures.

Although HFCs in the three countries are mentioned as the dominant formal structure providing “the bridge” between users and providers, other interface structures or persons play a similar role.

In Benin, respondents mentioned a large variety of actors such as mutual health insurance associations, women’s and youth associations, NGO’s, and community health workers, but also village leaders and local administrators (“chef d’arrondissement”). In a health facility that had a passive HFC, it was the village council that received and managed complaints. Participants perceived community-based health insurance structures (“mutuelles de santé”), introduced in the 1990’s, as potential strong negotiators but they cover only 5% of the population and hence might not represent the larger community. Participants also mentioned district level platforms in the context of performance-based financing as potential accountability facilitators.

In Guinea, respondents cited the role of elected councillors in local government as well as prefects (government representatives). In Guinea, the HFCs operate synergistically with other local associations, local government and authorities. The democratic decentralisation process in Guinea, introduced since 1990, seems to have led to institutionalised forms of local decision making, as expressed in many examples given by respondents. They are part of larger government efforts to decentralise governance to the local level and act jointly with local governments, education committees, etc. to strengthen the democratic base. Respondents suggested that the strong formal link between HFCs and local government empowered the HFCs and enforced local decision-making.

In DRC, respondents mentioned community health workers and village chiefs and in some areas religious leaders. There seems to be an overlap between HFCs and CHW; CHWs perform
health interventions, and they constitute channels through which users share their problems and complaints, as they are members of HFCs. CHWs are generally better known as health workers than as HFC members. Some respondents appreciated the direct effect that village chiefs could have on providers’ behaviour because of their traditional and perennial authority, but they were less positive about the accountability of village chiefs to the community. Participants mentioned religious leaders as emerging actors in health, primarily used to transfer health messages from providers to the community because of their influence on the community. An HFC member expressed that, regardless of who plays an interface role, there is a need to have a structure like the HFC to bridge the interests of “foreign” health workers and local communities:

“If there are no health committees, providers can deviate, misbehave or destroy infrastructure because providers are foreigners, people from elsewhere who are assigned to the health centre and one day they will leave but the centre will remain. The committee consists of villagers who do not want the centre to be destroyed” (FGD, HFC member, HFCD1).

Although users recognise the need to have an interface structure, they explain that such an interface is only useful to them if they respond to a certain number of criteria. When respondents were asked to identify key characteristics of a “good” interface they mentioned the ability to show leadership and authority vis-a-vis providers; transparency in management and decision making; and the ability to accompany users in the facility. Women in Benin, in particular, emphasised this latter aspect by stating that HFCs main role should be to “alleviate the pain and anger patients live with as a result of unfriendly treatment and poor services at health facilities”. If they fail to do so, they argued, users are even more inclined to avoid the health facility.

7.5. Discussion

Community participation for the purpose of accountability and improved health facility governance has not traditionally been a major component of health programs and evaluation studies. This study aimed to explore the role of Health Facility Committees (HFC) in providing a forum for social accountability in Benin, Guinea and DRC. The findings show that HFCs
address access and quality failures in health service delivery through the reception of users’ complaints and regular interaction with health facility managers and workers. The way in which HFCs collect, translate and present concerns and complaints to service providers is sometimes ad-hoc and informal but in some cases more or less institutionalised, for example through HFC meetings. In the absence of (known) formal guidelines or procedures, some HFCs have instituted forms of local regulation to address misbehaviour or fraud by health workers. Through such local dialogues and measures, some improvements are reported such as improved health worker presence, the availability of night shifts, and the display of drug prices. The HFCs in the three countries do not have the power to impose formal sanctions or rewards to health providers in cases of poor responsiveness. Some HFCs, therefore, appeal to the district health authorities enabling the activation of administrative accountability measures of the health system. HFCs then induced the transfer of poorly performing health workers. Although a transfer may not be considered a solution to the problem, it is a formal sanction in many health systems.

From Bovens’ perspective, we can conclude that most HFCs in our study offer a social accountability forum to assess, question and judge health worker actions and behaviour and to enforce change through linkages to authorities [15]. On the other hand, we saw that the first (data collection) and the last step (counter feedback to service users) of the accountability cycle are less practised and institutionalised. This seems a missed opportunity as service users stress the need to have a structure that represents them at the health centre that acts as a “bridge”, mediator and advocate. Moreover, we saw that reporting to health authorities does not always lead to action; some cases of serious or repeated misbehaviour remain unaddressed by health authorities. Hence, there exists an accountability relation between HFCs and health providers, but its’ functioning is variable and, although effective for some cases of poor performance, not always coherent, authoritative and inclusive [15].

The observation that many social accountability actions are informal and personal in nature is consistent with findings of other studies on the topic. Molyneux et al., for example, suggest that the use of personal relationships and social networks in social accountability is more common than the use of formally instituted mechanisms [4]. Also, the confused election and installation processes of HFCs whereby positions are recomposed is a phenomenon that occurs elsewhere and regularly in local management committees in West-Africa, not only in the health sector [37]. We saw that internal reshuffling of positions might lead to individualistic rather than collective or institutionalised social accountability processes. Many issues are
dealt with by an individual HFC member, and even when handled collectively, a small group of HFC members may dominate the HFC agenda. Biased representativeness, combined with limited community consultation (step 1) may translate in HFCs receiving only a fraction of community concerns about the health centre. A similar point is made by Knippenberg et al. who found that in Benin, Guinea and Mali, the voice of marginalised groups is excluded in primary health care management because of elitism in HFCs [38].

The absence of a systemic and collectively agreed feedback procedure leaves additional opportunities for concerns and issues to be overlooked. Even when HFCs actively collect complaints, there are risks that the complaints get lost because of poor documentation [39, 40]. Also, a lack of arbitration and transparency in decision-making can lead to biased or unfair outcomes, in particular when health providers are themselves involved in the issue, when they dominate HFC decision making or when politicians or ‘patrons’ interfere with the judgment or sanctioning of health providers’ performance [41, 42]. Some of these risks of biased processes and outcomes of social accountability may also apply to the HFCs in our study. We, however, recognise the tension Loewenson et al. describe between influential individuals having the leverage to engage with health providers and improve the quality of care and the simultaneous absence of the voice of more marginalised groups [43].

Members often include school directors, teachers, village chiefs, religious leaders and in one case an ex-military officer, who each can draw on a form of authority and legitimacy in their interactions with health providers, even where health providers are HFC members. For example, the two HFCs who instituted forms of local regulation to call health workers to account were headed by school directors. Although power asymmetries may remain between communities or patients and health providers, they may be more balanced and less pronounced between “elite” community members and health providers. Furthermore, HFCs that have an “elite” composition may form alliances with health providers to lobby the health system and local government authorities. In their study on HFCs in Nigeria, Abimbola et al. argue that members with a high social or economic status are particularly important in contexts where HFCs receive little government or external support; they can bear the costs of participation and facilitate all the functions HFCs are expected to play [44]. The question remains how linkages and accountability relations between HFC representatives and communities, in particular, marginalised groups and women, can be ensured. The tension between representation and influence is likely to be present in other social structures such
as women’s groups, local governments or health insurance associations and is not limited
to HFCs; it will remain an important point in future debates and research on the nature of
collective action and power relations in social accountability.

**Practical implications**
The conceptual framework of this study provides a useful lens to identify barriers and
opportunities for strengthening social accountability through HFCs. Our findings affirm the
importance of HFCs for health service and system responsiveness and, therefore, support
recent calls on governments to acknowledge HFCs in their policies and on funders and global
policymakers to support HFCs’ role in the governance of health systems [8]. It is clear that,
to develop more coherent, authoritative and inclusive social accountability processes and
achieve more equitable outcomes, actions at multiple levels and with multiple actors are
required.

HFCs need to be empowered through a more explicit mandate in the field of planning,
monitoring and supervision of (clearly defined quality issues within) primary health service
delivery. They need instruments to propose agreements, allow more systematic data collection
and documentation and skills to engage in dialogue and feedback with health providers
and other stakeholders. The consequences of a lack of responsiveness of health providers
to HFC feedback need to be clearly defined. In a pilot project in Mali, for example, HFCs are
empowered through a results-based contracting approach with health providers. Rather
than relying on higher-level health authorities for follow-up and enforcement, HFCs have the
possibility to attach predetermined rewards and sanctions to health provider performance
[45]. Such contracting approach may increase the formalisation of roles and transparency
of social accountability processes that is now often absent. Pilot initiatives with Community
Scorecards involving HFCs in DRC have contributed to more inclusive interactions between
communities and health providers [46]. Their validation, up scaling and embedding in the
wider health system, however, requires more complex reforms.

Social accountability relations are part of a larger governance landscape. HFCs as
accountability forums will not be successful if they cannot leverage formal sources of power
such as those within the administrative accountability system. This means that district health
management teams need the institutional capacity, power and incentives to supervise health
workers and follow up on community concerns and complaints. Decentralisation reforms and
devolved budgets enable such capacity [46]. Also, formulations or revisions of community
participation guidelines need to define HFCs position and complementarity vis-à-vis other interface structures, such as health insurance platforms in Benin, [47], local governments in Guinea and CHWs in DRC. In DRC, CHWs are elected within their communities; as HFC members, they constitute an important channel for service users' voice. Hence, through the strengthening of HFCs, the organisation of CHWs and community voice can be strengthened and vice-versa [48]. This may not apply to contexts where CHWs are employed by the Ministry of Health (where they might be perceived more as health workers than as community representatives) or where they are not members of HFCs (having limited influence in formal community structures). Hence, HFCs should be conceptualised as one accountability forum amidst other structures that can perform similar or complementary roles, each according to their competencies, position (facility-based or external) and power.

Furthermore, our findings suggest that HFCs can generate responsiveness and improved community-health centre linkages at the local level. But, as suggested elsewhere, is it not likely that HFCs engagement in local social accountability leads to the kinds of increases in human and financial resources and drugs needed for good quality of care [49]. Therefore, social accountability initiatives need to distinguish between different levels of responsibility and take into account providers’ capacities and resources to respond to concerns and claims raised by HFCs. Initiatives also need to consider how accountability practices and procedures can be respectful of health providers’ rights to transparent and fair feedback processes and consequences. Finally, a challenge in practice will be how to sustain social accountability practices through HFCs in the face of other pressing health and health system challenges. The Ebola epidemic in Guinea, for example, re-emphasizes the role of HFCs: that of health messengers and surveillance assistants. In DRC, policy discussions revolve around the need to develop more intersectoral committees to address the broader determinants of health. In the context of changing needs for community participation, HFCs will be asked or required to shift priorities and navigate their multiple roles. In such contexts, it will be important to reflect on ways in which feedback loops and accountability forums can be maintained at the local level to ensure that poor health worker practices are addressed and to promote people-centred health services.

**Strengths and limitations**

This study contributes to a further understanding of the potential of HFCs in strengthening health provider accountability and responsiveness. Although the findings present just a
fraction of a whole range of practices and factors characterising the interaction between service users, HFCs and health providers in the study sites, they provide a synopsis of current practices and challenges of social accountability across three countries. In research synthesis, decisions are made on the most relevant aspects to cover. The team took such decisions iteratively with key moments of consultation between the researchers and the authors. The final set of themes covered in the paper, however, is more a subjective choice of the authors and therefore they may have disregarded important themes to the three country contexts. Furthermore, although coordination and quality assurance measures were in place, the country research teams worked in different contexts and with varying qualitative research experience that might have influenced the quality of the interviews, and the type of responses researchers got. Finally, because the initial research questions focused on the potential accountability role of HFCs and in interviews we inquired about examples of 'good' practice, there may be a bias in the results; the data provided more positive examples than expressions of dissatisfaction with HFC performance.

7.6. Conclusions

This qualitative study explores the ways in which HFCs in West and Central Africa facilitate social accountability in primary health care. The findings confirm that many barriers to the quality of daily service provision can be addressed at the frontline of service provision even if accountability relations are poorly defined in policies or operationalised in guidelines. The study concludes that policymakers and funders should recognise and further support the role of HFCs in promoting responsive health services. For HFCs to facilitate social accountability in an inclusive and sustainable way at the operational level, their mandate and powers in service monitoring need to be made more explicit, and they need instruments to facilitate a full accountability cycle, in particular regarding community consultation and feedback.
References

18. Falisse JB. 25th Bamako Initiative Anniversary Series: from Community Participation to Community Accountability - Interview with S. Molyneux. Harmonization for Health In Africa Blogs; 2013.


CHAPTER 8

Participatory approach to design social accountability interventions to improve maternal health services: a case study from the Democratic Republic of the Congo
Abstract

Social accountability (SA) comprises a set of mechanisms aiming to, on the one hand, enable users to raise their concerns about the health services provided to them (voice), and to hold health providers (HPs) accountable for actions and decisions related to the health service provision. On the other hand, they aim to facilitate HPs to take into account users’ needs and expectations in providing care. This article describes the development of a SA intervention that aims to improve health services responsiveness in two health zones in the Democratic Republic of the Congo. Beneficiaries including men, women, community health workers (CHWs), representatives of the health sector and local authorities were purposively selected and involved in an advisory process using the Dialogue Model in the two health zones: (1) Eight focus group discussions (FGDs) were organized separately during consultation aimed at sharing and discussing results from the situation analysis, and collecting suggestions for improvement, (2) Representatives of participants in previous FGDs were involved in dialogue meetings for prioritizing and integrating suggestions from FGDs, and (3) the integrated suggestions were discussed by research partners and set as intervention components. All the processes were audio-taped, transcribed and analysed using inductive content analysis. Overall there were 121 participants involved in the process, 51 were female. They provided 48 suggestions. Their suggestions were integrated into six intervention components during dialogue meetings: (1) use CHWs and a health committee for collecting and transmitting community concerns about health services, (2) build the capacity of the community in terms of knowledge and information, (3) involve community leaders through dialogue meetings, (4) improve the attitude of HPs towards voice and the management of voice at health facility level, (5) involve the health service supervisors in community participation and; (6) use other existing interventions. These components were then articulated into three intervention components during programming to: create a formal voice system, introduce dialogue meetings improving enforceability and answerability, and enhance the health providers’ responsiveness. The use of the Dialogue Model, a participatory process, allowed beneficiaries to be involved with other community stakeholders having different perspectives and types of knowledge in an advisory process and to articulate their suggestions on a combination of SA intervention components, specific for the two health zones contexts.
8.1. Background

With a ratio of 846 maternal deaths per 100,000 live births [1], the Democratic Republic of the Congo (DRC) is one of the countries presenting with a high maternal mortality. Three-quarters of these deaths occurred during childbirth and postnatal periods [2]. Interventions to reduce maternal morbidity and mortality emphasize facility-based childbirth and skilled attendance during delivery with timely referral for emergency obstetric care if complications occur [3,4]. Progress towards achieving a reduction of maternal deaths has been slowed because improvements require overcoming financial, geographical and socio-cultural barriers to accessing skilled birth attendants, as well as poor quality of care at facilities.

To address this situation, innovative strategies beyond providing skilled personnel, improving equipment, and infrastructures are needed [5,6]. Some of these strategies have to deal with improving women’s service uptake, by improving quality of care and the health provider-user relationship. One of these strategies consists of the use of social accountability mechanisms. Social accountability mechanisms are mechanisms that lead health service providers to take into consideration users’ expectations and needs [7,8]. They aim to improve the responsiveness and behaviour of health providers towards users [7,8]. Social accountability relies on civic engagement, i.e. in which citizens and/or civil society organizations participate directly or indirectly, formally or informally in exacting accountability [9] and bringing politicians, policy makers and healthcare providers to account as responsible for their performance [10–13]. While a growing body of literature examines social accountability and describes its mechanisms [13–16], little is known on how to shape social accountability mechanisms to fit a specific context and how to involve beneficiaries in this process [13,17].

According to Georges, poor involvement of beneficiaries in the design of most health programmes has limited their efficacy. As policy makers are becoming aware of this, increasingly beneficiaries are involved in decision-making regarding health policy, treatment and health research, mainly in high-income countries [18]. To develop a functional social accountability mechanism, a multi-phased participatory approach is useful, involving a broad range of actors with different perspectives and types of knowledge. An example is the Dialogue Model [19,20] which includes a joint learning process among stakeholders [20].
A study on social accountability in maternal health in two health zones in the DRC that we conducted in 2013 showed that very few women voiced their concerns and complaints to health providers, although study respondents asserted the existence of inappropriate care in local health services. Interviews revealed that women in rural area are not used to expressing their concerns and they did not mention the quality of care or health providers’ behaviour. In addition, the study showed that women did not know how to transmit their concerns to relevant actors and decision makers or how their concerns were managed within the health services. This study also revealed that this situation is mainly due to the absence of procedures to express concerns, the lack of knowledge thereof, fear of reprisals or of being misunderstood by health providers as well as factors such as age-related power, ethnicity, and the low socio-economic status of women [21]. To develop interventions based on these outcomes some questions required answering in the light of these findings: Which social accountability mechanisms are needed in order to improve maternal health services responsiveness and performance? How could community groups be involved in designing these social accountability mechanisms to make them more relevant?

This article describes the development of a social accountability intervention that aims to improve maternal health services responsiveness and performance in two health zones in the DRC, by involving beneficiaries, representatives of the health sector and local authorities in the advisory participatory process using the Dialogue Model.

### 8.2. Methods

**Study design**

In order to answer the research questions, we developed a participatory action research process, based on the Dialogue Model [19,20] in two health zones. The two health zones (HZs): Muanda HZ in Kongo Central Province in the southwest and Bolenge HZ in the Equateur Province in the northwest, were purposively selected according to the presence of a health partnership supporting or aiming to support an intervention containing a social accountability mechanism [21].
Designing a social accountability intervention

**Phase 1 Exploration and preparation**
- Constitution of research team
- Analysis of contexts
- Stakeholders' analysis
- Health facilities performance survey
- Health providers' interviews
- Community members' interviews
- Key informants' interviews
- Stakeholders' interviews

**Phase 2 consultation and prioritization**
- Focus groups with women and their groups' representatives
- Focus group with men and their groups' representatives
- Focus group with community health workers and the health committee members
- Focus group with key informants

**Phases 3 and 4 Integration and prioritization**
- Joint /Dialogue meeting

**Phase 5 Programming**
- Action plan/Intervention program

**Phase 6 Implementation**
- Implementation of the intervention program

**Figure 8.1. Visualization of the Dialogue Model process**
The Dialogue Model was chosen as a participatory action approach as it was found suitable to be used when dealing with complex phenomena occurring in an interface, as it allows to achieve appropriate participation [18], and offers guidelines and principles on how to consult and integrate issues from different stakeholder groups in an advisory process. It is based on six principles: active engagement of beneficiaries, conducive social conditions, respect for experiential knowledge, mutual learning, emergent and flexible design, and facilitation process. It is roughly divided into six phases, the product of a phase serving as inputs for the following phase. The six phases are: initiation and preparation, consultation, prioritization, integration, programming, and implementation [22].

The Dialogue Model was slightly adapted for its application to the context of community participation in intervention development in the two health zones by putting two of the six phases together: integration and prioritization phases, and four of its phases were conducted during this reported process (Figure 8.1). The implementation phase of the Dialogue Model (DM) was considered as mandate of the health partners and health providers and is beyond the scope of this paper.

First, the initiation and preparation phase was conducted. This included identification of organisations involved in maternal health, an invitation to the organisations which consented to participate in the project to attend a workshop on the project contents and approach and the establishment of a partnership between the research team and health sector partners. The inclusion criteria for the partnership was that the organisation is a DRC health partner that implements or plans to implement an intervention with a social accountability component and is interested in research on social accountability. In addition, a context analysis and an exploratory study were carried out, mapping contextual factors that influence social accountability initiatives and interviewing relevant actor groups about the existing social accountability mechanisms at the two research sites. Research methods and findings of the exploratory study are described elsewhere [21].

Second, the consultation phase was carried out to obtain the reactions of actor groups in the two health zones and of the health partners on the findings of the exploratory study and the context analysis carried out in phase 1, and develop lists of intervention suggestions from each
actor group to improve social accountability for maternal health services. In this phase, at the national and provincial levels, meetings were organized with health sector partners involved in maternal health, including community representatives, ministry of health officers and non-governmental organizations representatives. The aim of these meetings was to share and discuss findings, and inform policy makers. Policy briefs were developed and disseminated. This step will be described elsewhere.

In the two health zones, four focus group discussions (FGDs) were held with four different actor groups: women beneficiaries and their community groups’ representatives (n=12), men and their community groups’ representatives (n=12), community health workers and health committee members (n=12); representatives of the health sector at local level including health providers, health zone officers, health partners, and local authorities (n=12). As it is equally important to have men involved in maternal health, they were also involved in equal numbers with women in the process. A FGD guide was used to structure the discussion. In each FGD, participants were invited to discuss the extent to which the results of the context analysis and the exploratory research reflected the reality of their community (See Box 8.1).

Subsequently, they were asked to provide suggestions for improving the situation. These suggestions were summarized in a list of interventions components and validated by the participants. The research team also informed participants about the next phase: integration and prioritization.

The third phase combined integration and prioritization. In this phase suggestions coming from the four participating FGDs were integrated into one shared intervention. The integration and prioritization was organized as a dialogue meeting at each site. In this meeting representatives of all participating FGDs were convened to discuss suggestions and perspectives of the different groups and to integrate them in one intervention proposal.
Chapter 8

Box 8.1. Summary of the situation analysis of social accountability mechanisms in rural setting in the DRC (Mafuta et al, 2015)

In a previous study exploring existing social accountability mechanisms in rural settings in the DRC, we found that women were positive regarding the health care that they received and very few were able to express clearly during interviews their concerns about health care or health providers. We also found very few women voiced their concerns and complaints about health services to health providers. Interviews revealed that women in these settings were not used to expressing their concerns and did not develop this habit. Therefore, we noticed that women raised very few expectations in order to improve the health service provision.

In their expectations, they only emphasized health service inputs such as assigning a doctor in the local health centre, extending the health service centre with more wards, supplying drugs and equipment and providing free care. They did not emphasize the quality of care or health providers’ behaviour.

In addition, we discovered that women did not know either how to transmit their concerns to relevant actors and decision makers or how their concerns were managed within the health services. Among reasons that could explain this situation were the absence of procedures to express them, the lack of knowledge thereof, the fear of reprisals, of being misunderstood as well as factors such as age-related power, ethnicity backgrounds, and women’s status.

From the list of people who had participated in previous phases of the project, twelve participants were invited to attend the dialogue meeting at each research site on the basis of their background, willingness to enter into a dialogue, open-mindedness, capability to express themselves clearly, succinctly and constructively as assessed during the focus groups and their availability. Participants in equal number for each group included beneficiaries: men and women (n=4), community health workers and health committee members (n=4), and representatives of the health sector and local authorities (n=4). The research team provided assistance to the beneficiaries groups. Prior to the meeting, the research team discussed the suggestions of their own group with selected participants in order to prepare them for the integration meeting and provide training on negotiation and advisory skills, especially with community members. The integration meeting was held in a quiet place and at an appropriate
Designing a social accountability intervention

time, facilitated by research team members using non-technical language. The construction of an integrated proposal was done by the participants in the meeting using a process of ordering and ranking: Firstly, the list of suggestions of each actor group was separately and repeatedly read by participants so as to become familiar and to identify the main ideas for improving social accountability. Then, they were invited to regroup suggestions having similar meanings using post-it, forming intervention components and to propose a description of the content of each intervention component. For each discussion, each participant group was allocated equal conversation time. Subsequently, using the same procedure, intervention components targeting similar actors were further regrouped into intervention main-components. The integration process was completed by describing each intervention of the main-components. At the end of the meeting, the main result was a single integrated intervention proposal, which was discussed and validated by the participants. The research team informed participants about the next step: the programming phase.

The fourth phase, programming, was conducted at a national level with the aim of developing a social accountability intervention for implementation. The two community intervention proposals were used as a basis for formulating social accountability interventions that are to be implemented in the two HZs. This phase was conducted during a workshop held in Kinshasa by the research team and the health partners, specifically representatives of Cordaid, Medicus Mundi and officers from the Ministry of Health. They discussed the results of the integration phase, and selected intervention components for social accountability. Considerations for the selection of suggestions from the integration phase to include as social accountability intervention components in programming phase comprise: (1) the technical feasibility to implement the suggestion taking into account the current health policy and; (2) the possibility to improve or to use existing health sector intervention or community elements. After that they discussed modification to be introduced in existing interventions where opportunities for social accountability exist such as in the performance based financing intervention in Muanda HZ and the community based health insurance intervention in the Bolenge HZ. The programming workshop was facilitated by the research team, and was audio-taped and transcribed verbatim.
Participants in different phases

Participants in the FGDs during consultation phase and integration phase were sampled purposively in relation to relevant stakeholder groups: among community members (women, men, representatives of their community groups, community health workers and health committee members) and representatives of the health sector (health providers, health zone management officers, local health partners), and local authorities. Other inclusion criteria used were: (1) aged between 17-75 years, and (2) living in the community for more than two years. Based on the inclusion criteria, a list of people to invite was established with the collaboration of community health workers and local authorities. Participants were sampled using a systematic sampling procedure in order to select 12 persons for each category if their number was more than 12. In a category where participants were less or equal to 12, all were de facto included. These persons were contacted and invited to participate using community health workers. Those who expressed a willingness and interest to participate were included in the study. This allowed the researchers to capture the maximum information and experiences of the different stakeholders. Community members were approached outside their homes and health sector representatives and local authorities in their workplace, and invited to participate in the FGDs and integration meetings. The programming workshop gathered research partners comprising of officers from the Ministry of Public Health, health partners (Cordaid and Medicus Mundi) and the research team.

Data collection and documentation of the participatory process

Phases 2 to 5 were organized from February to May 2015 and were facilitated by the research team. The FGDs and integration meetings were held in a quiet place, far from other people to optimize privacy and lasted on average for approximately two hours. They were conducted in Lingala and in French, audio-recorded with the consent of the participants. A brief report of each meeting was written by the research team members and orally discussed with the participants for member check.

A debriefing session among the research team was held after each group meeting during which themes, impressions of the findings and procedures were discussed and documented in field notes, and group meeting reports were written. The field team was supervised by three senior researchers.
Data analysis
Recorded group meetings were generally transcribed *verbatim* in Lingala, translated into French and checked by two team members, then, combined with field notes, and mini-reports produced by the research team after each meeting. These transcripts were analysed using an inductive content approach in order to identify emergent themes and trends in the data (23). The research team read and re-read the transcripts to become familiar with the whole data set. Subsequently, the analytical approach was to label participants’ suggestions and coded in sub-categories. Several sub-categories having similar ideas or relating to the same topic were used to construct categories. Categories in turn were regrouped into themes by grouping categories relating to similar actors. Throughout the analysis, the team used notes from the two integration meetings to describe categories and themes. Moreover, the use of the notes from the integration meetings helped to assure the trustworthiness of the analysis. The analysis process was then discussed with two supervisors (MD and TDCB).

Ethics approval and consent to participate
The research protocol was approved by the Kinshasa School of Public Health Internal Review Board. All participants were fully informed about the nature, the implications of the study and the freedom to opt out any time should they feel uncomfortable, and voluntarily provided written consented to participate.

Participants in focus groups received reimbursement for transportation fees at the end of the meeting. Written informed consent was obtained from all participants to publish information containing some individual person’s data such as age, sex, occupation, location as they were important for understanding the research study. All research procedures were in accordance with the Declaration of Helsinki.

8.3. Results
Overall, 121 participants aged 22-67 were involved in the process. Women represented around one-third (n=51). The level of education of participants ranged from no education to master’s degree. In Table 8.1 an overview is given of the characteristics of the participants in the FGDs, integration meetings and workshop.
Table 8.1. Characteristics of participants in group meetings

<table>
<thead>
<tr>
<th>Participants</th>
<th>Location</th>
<th>Number</th>
<th>Sex</th>
<th>Age</th>
<th>Education</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>M</td>
<td>F</td>
<td>Age</td>
</tr>
<tr>
<td>Focus groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Representatives of the Health sector and local authorities</td>
<td>Muanda</td>
<td>12</td>
<td>9</td>
<td>3</td>
<td>30-65</td>
</tr>
<tr>
<td></td>
<td>Bolenge</td>
<td>8</td>
<td>7</td>
<td>1</td>
<td>31-45</td>
</tr>
<tr>
<td>Community Health workers and Health committee members</td>
<td>Muanda</td>
<td>12</td>
<td>6</td>
<td>6</td>
<td>23-67</td>
</tr>
<tr>
<td></td>
<td>Bolenge</td>
<td>12</td>
<td>7</td>
<td>5</td>
<td>25-65</td>
</tr>
<tr>
<td>Men and men’s groups representatives</td>
<td>Muanda</td>
<td>12</td>
<td>12</td>
<td>-</td>
<td>25-57</td>
</tr>
<tr>
<td></td>
<td>Bolenge</td>
<td>12</td>
<td>12</td>
<td>-</td>
<td>31-63</td>
</tr>
<tr>
<td>Women and women’s groups representatives</td>
<td>Muanda</td>
<td>12</td>
<td>-</td>
<td>12</td>
<td>23-45</td>
</tr>
<tr>
<td></td>
<td>Bolenge</td>
<td>12</td>
<td>-</td>
<td>12</td>
<td>22-54</td>
</tr>
<tr>
<td>Dialogue meetings</td>
<td>Muanda</td>
<td>12</td>
<td>6</td>
<td>6</td>
<td>32-55</td>
</tr>
<tr>
<td></td>
<td>Bolenge</td>
<td>12</td>
<td>6</td>
<td>6</td>
<td>33-60</td>
</tr>
<tr>
<td>Workshop with Health partners</td>
<td>Kinshasa</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>32-55</td>
</tr>
<tr>
<td>Total</td>
<td>121</td>
<td>70</td>
<td>51</td>
<td>22-67</td>
<td>No</td>
</tr>
</tbody>
</table>


Consultation phase

Overall, four FGDs were organized in the consultation phase at each site. In general, combining data from both sites, participants from different backgrounds initially provided 48 suggestions which partly overlapped (Table 8.2). Participants of these FGDs made suggestions according to their knowledge and experiences of the local setting, trying to find solutions that they thought were important from their perspectives. Women, men, community health workers (CHWs) as well as local authorities at both sites suggested the use of CHWs as intermediary and interface for collecting the population’s needs and expectations and transmitting them for discussion at the health committee’s meeting. They suggested that the health committee evaluates health services at local level and creates a feedback loop to inform the population about the health committee’s decision using the same CHWs. Furthermore, both women and men suggested that the capacity of the community on maternal health matters developed by sensitization and awareness activities.
Designing a social accountability intervention

Actions to improve health providers’ attitudes toward voice and the management of voice at facility level or the involvement of health sector supervisors such as the health zone management officers were also suggested by the community FGDs. The proposed actions included the training of health providers because participants thought that health providers needed to be sensitized to respect the voice and rights of patients. Almost all their suggestions were agreed upon by other groups.

The CHWs, representatives of the health sector and local authorities had knowledge of the current process in health services because they had already been working within the community. Their suggestions were mainly based on their experiences of the local health sector and the national health policy. For example, CHWs suggested that they be trained on the interface role and provided with funds to cover expenditures occurring during their activities such as transportation for improving their work within the community. Moreover, they suggested a periodic involvement of other community leaders in health committee meetings so as to build a coalition around the concerns of the community. Nearly all the suggestions by the representatives of the health sector were also proposed by other groups.

**Integration and prioritization phase**

The 48 suggestions made during the consultation phase were inputs for the integration phase. Facilitated by the research team, twelve participants previously engaged in the process discussed suggestions from each of the different groups with the aim to reach consensus on what the most important suggestions were, by looking at similar proposals from the different groups. Thus they regrouped 48 suggestions into 11 categories and finally articulated them in 6 themes as intervention components for social accountability.

Table 8.3 provides a mapping of the 11 categories of suggestions among the different groups. It emerged from the integration meetings that in Muanda and Bolenge the most widely supported suggestions to improve social accountability were almost the same and included: the use of CHWs’ networks, capacity building of the community, coalition building around social accountability, improvement of the management of concerns of the community by health providers at facility level, and the involvement of the HZ management team in community participation.
Table 8.2. Suggestions for improving social accountability in maternal health services in local settings

<table>
<thead>
<tr>
<th>Muanda informants</th>
<th>Bolenge</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To reach out to the population about expressing their concerns and complaints, and health providers about being responsive;</td>
<td>• To use CHWs for reporting complaints and concerns about health services;</td>
</tr>
<tr>
<td>• The awareness activities at population level would be done by CHWs mainly during home visits;</td>
<td>• To reach out to the population about all existing social accountability mechanisms;</td>
</tr>
<tr>
<td>• To provide CHWs with a small incentive;</td>
<td>• To improve the work of CHWs by an adequate trainings and their choice through community election;</td>
</tr>
<tr>
<td>• To improve community recognition of CHWs through an election process in the community;</td>
<td>• The training of CHWs would be done by the HMT members in charge of community activities;</td>
</tr>
<tr>
<td>• To train CHWs for improving their activities;</td>
<td>• To improve the functioning of health committee;</td>
</tr>
<tr>
<td>• The health providers could also get population’s voice through community survey conducted in PBF settings;</td>
<td>• To reach out to health providers for improving their responsiveness;</td>
</tr>
<tr>
<td>• to initiate periodic meetings between CHW, HC members, health providers and decision-makers to share and discuss health issues;</td>
<td>• To document population’s complaints and concerns using a formal system of records;</td>
</tr>
<tr>
<td>• To encourage the participation of the HZMT Officer in these meetings;</td>
<td>• To include local authorities and community leaders specifically religious leaders in the process;</td>
</tr>
<tr>
<td>• To work on improving the women’s confidence in CHWs</td>
<td>• To bring forward complaints and concerns about GRH using CHWs, who could report them during Health committee meeting and through this latter’s report, to HZMT officer;</td>
</tr>
<tr>
<td>• To reduce the “cutting” practices sometimes used when writing Health committee’s meeting report.</td>
<td>• To use mechanisms of Community Health Insurance</td>
</tr>
</tbody>
</table>

Community health workers/Health committee’s members

<table>
<thead>
<tr>
<th>Muanda</th>
<th>Bolenge</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To still continue to receive from the population concerns, questions and complaints using home visits;</td>
<td>• Observed that all accountability is centred on the nurse in- charge, who receives information from the health committee and has to be responsive with his team;</td>
</tr>
<tr>
<td>• To bring them forward to health providers during dialogue meeting and the health committee meeting;</td>
<td>• To organize two meetings, one for the CHWs and their delegates in the health committee and the health committee meeting;</td>
</tr>
<tr>
<td>• To make all decision as a group and not individually;</td>
<td>• To transmit decisions of the health committee to the CHWs for closing the loop;</td>
</tr>
<tr>
<td>• To sensitize population to report their concerns;</td>
<td>• To organize public meetings putting together the health committee, the health centre providers and the community with the possibility of public questions and answers.</td>
</tr>
<tr>
<td>• To ask HMTO to be present in their meeting in order to get complaints and concerns about the GRH;</td>
<td>• To invite to these meetings local associations’ representatives and authorities specifically the HZMT officers;</td>
</tr>
<tr>
<td>• To recognize that their number is not optimal given the sunk cost of working without being paid and the difficulty of enlisting local associations to become involved in non-remunerated activities.</td>
<td>• To collect actively information from the population mainly during home visits and to make a summary in the report;</td>
</tr>
<tr>
<td></td>
<td>• To provide some financial incentives to CHWs</td>
</tr>
</tbody>
</table>
### Men and their groups' representatives

- To sensitize the population specifically men on health problems, in order to increase their knowledge, enabling them to express easily their concerns and to monitor health centre activities, in collaboration with community associations (and churches);
- To use CHWs’ networks to report their concerns and complaints;
- To increase the number of CHWs;
- To use local associations/groups for informing the population;
- To organize periodically meetings with community leaders, notables, local associations’ representatives, HC members, CHWs and health providers, invited by the health committee to discuss health concerns;
- To improve the health centre supervision by the HZMT.

### Women and their groups’ representatives

- To organize periodic meetings putting together community members and health providers in order to allow the population to directly bring forward their grievances about health services to health providers;
- To use CHWs for collecting population’s concerns;
- To invite women to participate in these meetings by CHWs through their associations/groups;
- To bring forward complaints and concerns directly to the person in charge of health facilities;

### Women and their groups’ representatives

- To use CHWs for reporting complaints and concerns about health services, for avoiding health providers’ reprisals;
- To train CHWs to bring forward their concerns to health providers;
- Health providers have to discuss concerns of the population as a team for improving health services provision.

The six themes that are proposed to be developed as intervention components to improve social accountability in maternal health services were formulated by clustering categories of suggestions having similar actions, those targeting the same actors or those that have to be implemented by similar actors: (1) Use CHWs and health committee(s) as interface for collecting community concerns; (2) Build the capacity of population especially women; (3) Build coalition around social accountability and maternal health through dialogue meetings; (4) Improve the involvement and support of the HZ management team to community participation; (5) Improve the attitude of health providers with regard to community concerns and the management of voice at health facility level, and; (6) Use of existing intervention integrating social accountability aspects.
Table 8.3. Mapping of Interventions proposition according to participant groups

<table>
<thead>
<tr>
<th>Propositions</th>
<th>Muanda</th>
<th>Bolenge</th>
<th>Propositions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>REP</td>
<td>CHW</td>
<td>MEN</td>
</tr>
<tr>
<td>Use CHWs’ network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Build capacity of the population</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Build coalition around SA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve HP voice management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Involve HZMT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve HP attitude towards voice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motivate CHWs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Build capacity of the CHWs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organization of CHWs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use PBF components</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use CHIS components</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend:
Gray coloured: mentioned by participant category. Number: Number of categories having mentioned the suggestion
REP: representatives of health sector and local authorities CHW: Community health workers SA: social accountability HP: Health providers HZMT: Health zone management team PBF: Performance based financing CHIS: Community health insurance scheme

Programming phase

These six themes were presented and used as inputs by research partners during programming workshops. Research partners used suggestions coming from the integration meetings at the two sites. They agreed with the relevance of most of suggestions. They used them for drafting intervention components so as to adapt them to on-going interventions at the two research sites in order to increase community engagement (community, CHWs, health committee) and participation in social accountability mechanisms.

Below, we describe the emergent categories for which consensus was reached among all groups and that were validated after the 4 phases were finalised.
1. Use community health workers and health committee as interface for collecting community concerns

Participants from the different actor groups agreed that some community members work within the community as CHWs. They suggested that the latter might act as intermediaries between community members, especially women and health providers, for bringing forward their expectations, needs, complaints, and questions. Participants observed that CHWs could bring up these needs and expectations at the health committee meeting, where any issues could be discussed and find ways to proceed, take appropriate actions and provide feedback. The mutual communication between CHWs and health committee members might facilitate a voice mechanism to bring community concerns to the health facility. The use of community health workers and health committee members as interface included (i) to collect the concerns of the population through the activities of community health workers, (ii) to build the capacity of CHWs and the health committee as interface between community and health providers, (iii) to organize activities of CHWs and the health committee, and (iv) to improve the motivation of CHWs. These social accountability activities are described below.

(i). Collect the population’s concerns through the activities of community health workers

All participants in the integration meetings in particular community members stated that most of the community members already recognised CHWs as people coming from their community; who passed by their homes or were in their community groups and who brought them information from the health facility. They also knew them as people who carried out health sensitizations and campaigns. Thus, they proposed that CHWs could also have a role in collecting information from the community during these activities. They asserted that the use of CHWs as intermediates could keep women from fear of reprisals as the women in the community trusted them, and would improve their involvement in voice and health services monitoring. Community members reiterated that they preferred to voice their concerns rather than switch to another health facility.

“For avoiding conflicts, as we have CHWs, it is good that all the problems are declared to them and that when they come to the meetings, that they report them to the other members and health providers. It is known that the nurse in charge sits among them and when they will speak about it, the nurse in charge can listen to the complaints and the
concerns of the community. He so can when he has meeting with his team at the level of the health centre, to talk about it to the other health providers to make adequate decisions” (Community member, Woman, Bolenge)

(ii). Build the capacity of community health workers and health committee as interface
Most representatives of the health sector and local authorities and CHWs raised concerns about the lack of capacity of most CHWs in performing interface activities and proposed therefore to sensitize them, and to train them about their role as interface between health providers and the community. They proposed that the training should especially focus on the active collection of community information on the perception of health care provision but also on providing feedback. They thought that this training would improve the way CHWs worked within the community, improving their role as ‘bridge’. They asserted that CHWs needed to have skills and competences to carry out home visits, to provide feedback, and to manage confidentiality and anonymity of community members who came to them.

“Thus it is necessary to focus on the training of CHWs, especially on the confidentiality. Because if CHW does not manage very well community concerns and discloses the identity of the community member who raised the concern, he will lose the confidence of the community” (Representative, Woman, Bolenge)

(iii). Organize activities of community health workers and health committees
Most participants in the integration meetings noted that CHWs regularly visited homes and community groups. They proposed that during the home visits CHWs might collect data from community members, improve the reporting of mistreatments, follow-up with community members decisions made during health committee, and provide feedback to the community as well. However, they observed that CHWs did not have appropriate tools or resources for carrying out these activities.

They therefore proposed to the HZ management team to provide them with appropriate tools and resources such as pens and notebooks for writing down community concerns. They also observed that CHWs and health committee (HC) members needed some resources, for instance funding of transportation costs for those coming from remote locations to the main village to attend meetings. They also proposed that CHWs and HC members required a
notebook in which they could summarize their reports extensively during their meeting before discussing them at the health committee with health providers. Some participants, mostly CHWs, raised concerns about the key position of health providers in the health committee and their tendency to delete some information from the CHWs’ reports in final notes to be sent to the HZ management team. Participants also proposed to summarize decisions and actions proposed by the health committees with regard to community concerns, to bring them to the attention of community members using the CHWs’ network and to reach people who raised concerns.

“The work of CHWs has to be formalized even by using a scrap of paper, it will allow a better follow of their activities” (Representative, Man, Bolenge)

(iv). Improve the motivation of community health workers

Participants mostly CHWs, representatives of the health sector and local authorities raised the issue of motivation and the insufficient number of CHWs. They observed that currently active CHWs did not optimally cover all households in the health area for home visits, as per requirement of the national policy. According to them, this was the case because CHWs are not remunerated for activities they carry out within the community in constrictive socio-economic contexts. They proposed for instance to support some activities of CHWs by using performance based financing with indicators such as the number of households visits carried out, the number of patients brought to the health facility, and the number of concerns reported.

“I would like to highlight and support this point, he raises something important, the heart of the problem. If there is funding or financial resources, I would suggest to provide us [CHWs] with a financial incentive...We will be more motivated to carry out community activities. We will work more efficiently” (CHW, Man, Muanda)

2. Build capacity of community members especially women

Participants in both FGDs during consultation and the integration meetings recognized that one of the main reasons for women not voicing their concerns was their lack of knowledge/information on health service standards and what they were entitled to. They observed that women did not use opportunities such as CHWs’ and HCs’ network as a way of
brining forward their concerns. They then proposed to inform women through community sensitization, home visits, and health education sessions about health services standards and their entitlements, CHWs and HC. They proposed that CHWs could also bring information on community health best practices such as antenatal care, the immunization program, the importance of community voice in the improvement of the health services, and follow-up concerns as well. Participants also proposed to CHWs to use existing community groups and church as channels for reaching a larger audience.

“It would maybe be better to speak about building their capacities. Maybe women in the community have some difficulties to express their complaints... But if we explain them the procedure to follow in case of an abuse in a health facility, if the woman understands that the fact that she raises her problem, brings forward her complaints, is in the way to improve, I believe that it is possible” (Representative, Man, Bolenge)

3. Build coalitions around social accountability through dialogue within the community

From the suggestions by the FGDs, around approximately 50 % of the participants in the integration meetings proposed to create a discussion platform beyond the HC in order to involve local leaders such as community groups’ representatives (women, men) and religious leaders. They argued that this discussion platform could counterbalance the power of the health providers, and their influences on the choice, decision-making and activities of CHWs and the HC. They proposed to include community leaders such as community groups’ representatives (women, men), village notables and administrative officers because of their influence in mobilizing people and diffusing information within their groups. Moreover, they included; men given their role in decision-making at household level, the current policy orientation emphasizing the involvement of men in maternal health and considering that women sometimes report to them some concerns about health services. Furthermore, religious leaders had to be included because of their current influence on their parishioners. The aim of these meetings, according to participants would be to increase the involvement and knowledge of other stakeholders on maternal health and social accountability, and to build a coalition around maternal health and social accountability in order to build a social pressure.
“Could arrange it so that in the meetings of the health committee, even once a quarter, we invited even the village chiefs, the persons in charge of churches, secretaries of associations in case the president does not have time so that they come to hear what we discuss here?” (CHW, Woman, Muanda)

4. Increase the involvement and the support of the health zone management team to community participation activities

More than half of the representatives of the health sector and local authorities, and CHWs asserted that they had noticed that the HZ management team (HZMT) neglected community participation and did not appropriately support the activities of the CHWs. They stressed the importance of the HZMT in order to improve the organization of HC and the selection of CHWs. Representatives and CHWs required that the HZMT was involved in the training of CHWs and HC in their roles, and in the supervision of their activities in order to counterbalance the power of health providers as the HZMT could sanction the latter. They asserted that they would like to see the HZMT officer chairing the dialogue meeting, supervising personally the election of CHWs, and participating periodically in the HC meeting.

“The Health zone management team chief officer also has to participate, personally, in some meetings of the HC, even in absence of the nurse in charge of the health centre, in order to learn himself about the community” (Representative, Women, Muanda).

5. Improve the attitude of health providers towards voice and the management of voice at health facility level

According to almost all of the community members participating in the integration meetings, it could be the attitude of health providers towards voice and their position within social accountability mechanisms that were the main constraints for social accountability.

“Because if CHWs do not manage to keep secret of the population and go so far as to say that such family told me that such nurse scolded them and if this one is not flexible to receive remarks, this will create a conflict. What will make that the user will be afraid to express his problem in these conditions..., we [health providers] must be flexible to receive remarks because if we ignite, it will be difficult to us to receive soon the complaints of the population and we shall not be capable of correcting our behaviour”. (Representative, Man, Bolenge)
Almost all community members participating in the integration meeting proposed that the HZMT trains health providers on users’ voice, given their central position in social accountability in health services. This training would help to improve their attitude and disposition. Moreover, participants proposed that health providers possibly be trained on communication skills. Participants added that health providers are required to improve the health centre management in order to take into account population’s concerns, and regularly discuss them at the health centre as a team and to respond thereto. They also proposed that the local health centre put mechanisms in place for handling concerns and where it was unable do so refer these to the next level on the hierarchy. They thought that one step would be to manage and reduce the workload of health providers, to allow them to hear patients’ concerns, and to improve the working conditions of the former.

“Health providers have to be sensitized because there are also badly educated health providers, who welcome badly patients or shout on them, who do not take into account their concerns or do not know how to manage patients’ needs” (Representative, Man, Bolenge)

6. Use existing intervention mechanisms

Some participants especially representatives of the health sector and local authorities noticed that social accountability initiatives should not to be set up in isolation. They asserted that patients found it useful as a community to speak out as for groups using for instance community based health insurance. Representatives of the health sector from Muanda, proposed to use a community verification survey carried out by a community based organization for collecting community views about health services. They proposed also to set in place mechanisms for reporting results from the community verification survey to health providers and community members, and to improve the follow-up of recommendations, in order to make health providers more accountable (Figure 8.2). Representatives of the health sector and local authorities from Bolenge proposed to use mechanisms set in place in community based health insurance such as to file concerns by means of a telephone or cellular call to the medical advisor, based on predominantly oral tradition culture and to complete to some extent the complaint books (Figure 8.3).
Description: In yellow and bold red are described the modifications introduced by community in the intervention carried out by Cordaid in Muanda. Arrows show how information is circulating in the model. Concerns from community previously collected through community verification (1) and transmitted to health zone management team (3) and to health providers (3) via the purchasing agent (2) are collected by community health workers (1) and transmitted to the health committee (1) in charge of organizing the dialogue meeting. The health committee will also receive information collected by community verification via the purchasing agent (5) and the HZMT (5). The health committee will send its feedback through CHWs, realizing the two-directional communication.

Description: In yellow and bold red are described the modifications introduced by community in the intervention supported by Medicus Mundi in Bolenge. Arrows show how information is circulating in the model. Concerns from community previously collected through community survey and suggestion box (1) and transmitted to health zone management team (3) and to health providers (3) via the CHIS office (2) are collected by community health workers (1) and transmitted to the health committee (1) in charge of organizing the dialogue meeting. The health committee will also receive information collected by community survey via the CHIS office (5) and the HZMT (6). The health committee will send its feedback through CHWs, realizing a two-directional communication.
Adaptation and design

Based on what was suggested in the two health zones, research partners comprising of Cordaid representatives, Medicus Mundi, officers of the Ministry of Health and the research team adapted the health partners existing interventions in order to include the suggested components. It resulted in two variants depending on the existing interventions. Their goal for this adaptation was to increase community engagement and control of the social accountability mechanisms (community, CHWs, Health committee) rather than to have them in the control of the health zone level entities (HZMT, CHIS office, and the Purchasing Agent).

Research partners formulated an intervention proposal with three components: (1) Improving voice by creating a formal reporting system by using and improving community health workers and health committee’s activities; (2) improving answerability and responsiveness of health providers by enhancing the health committee and by training health providers on social accountability related aspects, and (3) Improving enforceability using social pressure by introducing a dialogue meeting and by involving the HZMT in their supervision.

Figure 8.3. Medicus Mundi’s Community Health Insurance Model and modifications in Bolenge
The three components were proposed by research partners to be integrated as modifications in existing partners’ interventions or to be introduced even in the health area without existing interventions. They proposed also to introduce the three components in the selected health areas through a series of workshops carried out by the HZMT and described key intervention components, suggested implementation activities and underlined rationale.

8.4. Discussion

While there is a growing interest in implementing social accountability mechanisms in health especially in maternal health services delivery, there are still limited insights into the involvement of beneficiaries in the design of suitable social accountability mechanisms and the type of mechanisms to use.

In this study, the first research question that needs to be answered is: Which social accountability mechanisms are needed in order to improve maternal health services responsiveness and performance? The use of DM allows participants to come up with a social accountability initiative that includes different components needed to be combined in order to address most of the challenges raised from the exploration and preparation phase [21]. The final selection of actions was based on the consensus among participants, reflecting inputs and perspectives of community members as well as of other participants involved. It includes three components: (i) Improving voice by creating a formal reporting system by using and improving community health workers and the health committee’s activities; (ii) improving answerability and responsiveness of health providers by enhancing the health committee and by training health providers on social accountability related aspects, and (iii) Improving enforceability using social pressure by introducing a dialogue meeting and by involving the HZMT in their supervision. Roughly, their proposal translates the improvement of the current community participation process in terms of improved organization and coordination of community activities having as expected outcome, an increased voice and fostered community enforceability. These outcomes are more likely to trigger the answerability of health providers.

The analysis of the proposed intervention shows that its components address at least the three core elements of the social accountability namely voice, enforceability and answerability
Chapter 8

[13,27]. The proposed intervention makes allowance for the following to be fulfilled: "the premise that voice is ineffective unless it can elicit answerability and enforceability" [13,28]. The proposed actions are consistent with literature on social accountability in the health sector [6,14,29–31] and community health workers [32–34]. For instance, the proposed components gather the two categories of factors, related to the health system and sociocultural influences that according to Berlan and Shiffman (2012) may shape health provider accountability.

In general, the intervention proposal leading to social accountability seems to be easy to translate into actions in order to improve social accountability in maternal health services, hence becoming feasible. Regarding support, all its components have been grounded on suggestions provided during the consultation phase and were assessed by health partners in accordance with the existing policy line. Secondly, their implementation in practice depends mainly on existing elements and resources such as community health workers, the health committee and health providers [35]. Furthermore, the proposed intervention by suggesting the link between CHWs and HC activities and the introduction of interface role increases the potential of improving community participation based social accountability, previously found to be ineffective when based on health committee only [6,14,31,36]. In the suggested initiative, CHWs by actively collecting community concerns and communicating feedback from the health committee allow both to open and close the feedback loop [13,37]. The transmission of community concerns to a strengthened health committee, anchored to other community stakeholders through the dialogue platform increases the potential of generating answerability of health providers. The link of the health committee, aware of its missions with local stakeholders increases its enforceability capacity [6,38,39]. The enforceability capacity in this model could also be increased by the involvement of the health zone management team, which possesses the supervision and control power on health providers.

The proposed model is mainly based on local elements, already existing at the local level in contrast with other social accountability mechanisms which use external actors for collecting community concerns and for exerting enforceability such as community score cards [37,38] and performance based financing [28] or that promote inappropriate tools such as suggestion box in a context of high illiteracy [42]. However, the implementation of few of its activities need financial resources such as providing financial incentives to CHWs, notebooks for
Designing a social accountability intervention

CHWs or financial support/remuneration for supervision. This could be a limitation, as their implementation is strongly dependent on the commitment of health partners to financially support the programme due to government financial constraints and the constraining socio-economic context at the local level [36].

This study was also carried out to answer the second research question: How could community groups be involved in designing these social accountability mechanisms to make them more relevant? This study applied the DM in order to involve community participants in the intervention design process on social accountability. Previous studies which implemented the DM in the health sector applied it to involve participants; in a scientific advisory process to set a research agenda, in the development of clinical guidelines, and in the improvement of health research practices [18–20,22,37]. The evaluation of the DM applied to these research studies showed that the DM demonstrated the effective participation of stakeholders involved and allowed to usefully and adequately reflect the perspectives of participants [18–20,22]. We consider that our study successfully implemented the DM as it followed the process as described in seminal papers [18]. Moreover, our study implemented the phases from: consultation to programming, formally set as part of this research and the resulting intervention proposal reflects participants’ perspectives taking into account local contexts [20]. Furthermore, in our study, community members were facilitated to develop their own voice and suggestions, and they were prepared for integration with other stakeholder groups namely health providers and local authorities. Participants were able to explain and justify their propositions. This provides a participatory process similar to those provided by other participative approaches such as the community-based intervention using local facilitators, co-creation and co-creating knowledge translation [24–26].

In this study, we implemented most of the key elements which were described as the strengths of the DM [18] i.e. to acknowledge and facilitate different groups of stakeholders’ influence on the intervention design, and to guard procedural fairness. In our study, different participant groups were able to participate in the process as we used non-technical language and scientific knowledge was not presupposed. They provided their suggestions based on their values, experiences and knowledge. Furthermore, the process provided opportunities for knowledge sharing between participants and mutual learning. Its interactive character stimulated co-construction of the suggested intervention components [35]. For example,
CHWs suggested to be paid or to receive other forms of motivation, while health providers and managers who are supposed to apply the national health policy considered CHWs as volunteers. Community members expressed their concerns about the attitude of health providers regarding the community voice as they anticipated possible responses from the health providers, and CHWs made others aware that they did not have notebooks and pens for documenting their activities.

We observed that the strategy to let different groups meet separately prior to the integration meetings stimulated an open-exchange of experiences among equals allowing each group to build its own point of view. The integration meetings provided opportunities to representatives of different groups to sit together and to build by consensus a shared proposal. Furthermore, the researcher as facilitator took care that in the discussion all groups were represented in a balanced way, this was supposed to prevent community members from being overruled by other groups such as health providers and health managers, even though, it is known that the balance of numbers does not necessarily equal the balance of power [20,35]. This facilitation process was handled by the research team, independent from health service providers, community groups and NGO partners. All participants were equally treated and discussions were open during all meetings, as well as respectful and collaborative in the integration meeting.

**Implication for policy and practice**

The proposed intervention as described in the present study suggests some modifications in the national health policy with regards to community participation and improvements in health system practices [31,38]. Findings of this study suggest to clearly insert in the missions of CHWs, the active collection and the transmission of community concerns [39]; and in the missions of HC, the interface role, the management of community concerns collected through CHWs and the organization of dialogue meetings. In terms of practices in the health system, the findings of this study suggest an improvement in the organization and the operation of community participation, and an improvement of its supervision by the health zone management team [39–41]. The study findings also raise some issues such as the motivation of CHWs and the central position of health providers in community participation [39,41,42].
Study limitations

This study had some limitations related to the study design as the DM in this study was based on focus group technique. For instance, the focus group technique was used as data collection method in the Dialogue model in a context characterized by asymmetry of knowledge and powers [20,35]. This situation presents a risk for one group to be dominated by another, thereby losing its knowledge inputs. Despite the adoption of a method designed to minimize an unequal power dynamic and asymmetries between participants, there is an inherent inequity between community members and representatives of health sectors and local authorities. This was an on-going ethical concern for us. However by using the DM process, we had tried to be attentive to preventing asymmetries and creating a fair and meaningful process. Some precautions were set: the separation of stakeholder groups in the first round of focus groups, an equal number of participants for each of the groups in the dialogue meetings, the selection of open-minded participants, the use of non-technical language, the equal distribution of speaking time, the respect of conversation time, the assistance of community groups and a fair facilitation being transparent and equitable in our partnership with participants. Additionally, the DM as strength, the management of the meeting enabled a dialogical process rather than a shifting of control process. According to Abma and Broerse (2010) the integration meeting stimulates mutual learning between stakeholders by the development of a shared action proposal supported by all participants, as they spend adequate time to build reciprocal relationships and to foster mutual respect and knowledge integration. A further strength of the DM is its use of the different phases in the dialogue process for building consensus and enabling the different perspectives to be included despite the asymmetry of knowledge and power.

A second limitation relating to the DM is the representativeness of the participants and the actions identified. In the organization of the process, we used purposive sampling as we preferred to find community members committed to improving maternal health service, and possibly committing themselves to actions and follow-up implementation. Even though criteria were used, their implementation by the research team could have been biased due to the researchers’ subjectivity and this may unintentionally have led to the exclusion of the most marginalised and vulnerable participants. However, at the same time, we verified our previous focus group discussions as to whether these community members were still in line with the rest of the community. Furthermore, the integration meeting provided us with the
participants’ insights in the support of the various suggestions that were collected and that were made by participants. Finally, the credibility of our findings has been enhanced through validation by participants. The fairness was warranted through the open and respectful participation and the consideration of their inputs in the final proposal [20,35].

Thirdly, the study was neither designed to be nationally representative in the action proposed, nor representative of a particular health zone. However, the distinct characteristics of the two communities enabled us to generalize the robustness and potential of the proposed intervention to raise social accountability in maternal health services as well as in all local health centres that provide maternal health services as part of a comprehensive healthcare package.

**Research team and reflexivity**

As with any qualitative content analysis, interpretation could be influenced by the background and views of the research team members. Thus, in this study, even though the data collection and analysis were mainly performed by the first author, findings were discussed with supervisors, local health partners and community members, to support trustworthiness.

### 8.5. Conclusion

The use of the Dialogue Model facilitated the involvement of community beneficiaries amongst women with other stakeholders having different perspectives and types of knowledge in a participatory advisory process and to articulate their suggestions on a combination of social accountability intervention components, which address the three core elements that need to be minimally present, voice, answerability and enforceability. Even though this intervention proposal is specific for the two health zones contexts, it is practically feasible. Its components drawn upon suggestions coming from the stakeholders are mostly in line with the current health policy and could be easily implemented as they used existing resources but need additional (financial) resources only for supervision and support.
References

Designing a social accountability intervention


CHAPTER 9

Can community participation improve social accountability for maternal health services? Preliminary results from a pilot study in two rural health zones, in the Democratic Republic of the Congo
Abstract

Social accountability is often promoted as a viable strategy for improving health services performance and responsiveness. There is little evidence of its effectiveness, however. This article describes our assessment of whether a social accountability intervention based on community participation can improve health services performance and responsiveness and under what conditions.

Utilizing a quasi-experimental design, we conducted an intervention in two health zones in the Democratic Republic of the Congo based on increasing community participation and aiming to improve voice, enforceability and answerability. It consisted of (1) involving community health workers and the health committee in collecting, transmitting and discussing community concerns about health services; (2) building the capacity of the community in terms of knowledge and information; (3) involving community leaders through dialogue meetings with the health committee and health providers; (4) discussing with the health provider their attitude towards voice and the management of voice at the health facility level; (5) involving the health service supervisors in supporting community participation activities; and (6) using other existing interventions. To assess the intervention, we monitored community participation activities and conducted semi-structured interviews with participants and a document review. The collected data were related to voice, enforceability and answerability as well as the contexts, mechanisms underlying the intervention activities and their outcomes. Community health workers and health committee members carried out home visits, reaching almost every household in the community, and collected community concerns during those home visits. These community concerns were transmitted and discussed during health committee meetings with health providers, who had the opportunity to explain and justify themselves. Taking into account those concerns, the health providers made changes in the health services and their behaviour, suggesting an improvement of performance and responsiveness. Factors facilitating the health providers’ answerability or health providers’ responsiveness include the perception of the legitimacy of the health committee, financial incentives, social pressure and administrative accountability. Contextual conditions that were found to be important for triggering the health providers’ answerability were the existence of local community health workers and a health committee, known to the community, trained in their formal role, and the situation in which the health services are mainly funded through users’ fees and supervised by a health zone management team. Our study highlighted the
importance of structuring existing community participation, training health providers, community health workers and health committee members in social accountability, and the interface role of the health committee in order to improve social accountability in the health services.

9.1. Background

The United Nations Sustainable Development Goal 3 (SDG-3) aims to reduce the global maternal mortality ratio (MMR) to less than 70 per 100,000 live births by 2030. It is set to continue its efforts as despite the progress already made, the MMR is still high in most low- and middle-income countries, including the Democratic Republic of the Congo (DRC). Available data suggest that DRC has achieved a 21.2% reduction from the 1990 level [1], although its current MMR is still too high, with an estimated 846 maternal deaths per 100,000 live births [2].

Among the strategies implemented to reduce maternal mortality, increasing health service utilization has been acknowledged to be a cost-effective strategy on the demand side, in addition to improving the health providers’ skills and health services infrastructure and equipment on the supply side. More institutional deliveries and skilled attendance during delivery assure timely referral to emergency obstetric care if complications occur [3,4]. Use of maternal health services is influenced by the quality of the interpersonal relations between the health providers and users [5]. Many authors indicate that the improvement of access and utilization of maternal health services is not only a problem of the availability of health services with skilled providers, it also depends also on the way providers work and behave towards the population and how they respond to the population’s needs and expectations [6–10]. These elements affect the quality of the provider-user’s encounter and introduces social accountability aspects into the health services [11].

Social accountability is about accountability relationships between health providers and patients and citizens. It encompasses a set of mechanisms involving at least voice, enforceability and answerability [12]. These mechanisms aim to enable users to raise their concerns about the health services provided to them, and to hold health providers accountable for their actions and decisions related to the health service provision. On the other hand, they
aim to facilitate health providers to take the users’ needs and expectations into account when providing care. It is assumed that they contribute to improving the responsiveness of health services, in terms of the quality of care and interpersonal relationships between users and health providers [11]. Social accountability has been promoted as a strategy to improve the quality and performance of health providers in low- and middle-income countries, despite there being little evidence of its effectiveness [13–19].

To supply this evidence, a social accountability initiative was designed and implemented as a pilot in two health zones in DRC [20]. This intervention used community participation as its process and aimed to increase the engagement of community members in the monitoring of health services, community stakeholders and health services supervisors in order to improve community voice and enforceability as well as the health service providers’ answerability [12,21].

This paper reports on the evaluation of the effectiveness of this intervention to improve health service responsiveness and performance. It provides insights into how, why, and in what contexts this intervention positively affects social accountability and health service responsiveness. The main research question of this study is: What is the effect of social accountability mechanisms on maternal health service performance and responsiveness, and how, why and in what context do they work?

The hypothesis being tested is that increased citizen engagement and citizen oversight of maternal health services provision are linked to improved voice and answerability of health providers, and thereby to an improvement of maternal health services quality and responsiveness to the perceived needs of citizens.

9.2. Community participation in rural DRC

In DRC as in many developing countries, the beneficiary population seen as a community is involved in the health services’ activities through community participation [22,23]. Community participation is one of the pillars of the DRC national health policy, based on primary health care strategies, and is organized at the local level, represented by the health
Assessing a pilot intervention

area. A health area covers at least 5000 inhabitants and has a health centre that provides a comprehensive healthcare package, including community health activities. The nurse in-charge is responsible for both clinical care and community activities and monitors all health services activities with the support of community health workers (CHWs) and a health committee (HC) for community activities. CHWs and HC are the two main forms of community participation in the health sector in DRC [24,25].

The HC is composed of representatives of population groups living in the community, including delegates of CHWs, and the nurse in-charge of the local health centre. According to the policy, it is supposed to act as a steering committee for the health centre and coordinate community participation activities in the health area, which are mostly carried out by CHWs. It is also expected to be the voice of the population. It is supposed to collect and express their perceived needs, transmit their expectations, participate in the identification of health-related needs and in the planning, monitoring, and assessment of health services, and make providers accountable [22,26]. On paper, a HC meets at least monthly to discuss activities that have been carried out and plan those to be conducted the following month. Actions and decisions taken during their meetings are summarized in minutes, signed by the health provider in-charge and the HC president. A copy of these minutes is transmitted to the health zone management team (HZMT) office, and some information is recorded in the national health information system (NHIS). Their activities are supervised by the health provider in-charge and HZMT officers [22]. In practice, the activities and functioning differ from one HC to another [27,28].

CHWs are community members, volunteers elected by their villages or chosen by the health providers (HPs) to conduct community-related health activities through home visits or community sensitization campaigns. All CHWs from a village form a community sensitization cell, "Cellule d’animation communautaire" in French, chaired by an elected delegate, who is a member of the HC. Each CHW is supposed to carry out 15-25 home visits each month and to report their activities to a delegate who, in turn, reports to the HC.

However, studies show that most HCs and CHWs in DRC are often more of an aid to the health services, equipped to realize health centre activities in the community, such as the mobilization of resources, promotion of healthy behaviour and provision of simple healthcare. Other aspects such as planning, monitoring-evaluation and expressing the population’s needs
and expectations appear to be less developed [25,29–32]. In addition, in DRC as in most countries using CHWs, sometimes the link between CHWs and HC is not clearly stated and understood [31,32]. Therefore, what community members want and their assessment of the health services are often not channelled to the HPs nor to the authorities, reducing their capacity to exercise pressure for change [15,27,28].

9.3. Materials and methods

Study Design
A quasi-experimental design (as pre-post-intervention with two groups) was implemented in the two health zones in southwest (Kongo Central) and mid-west (Equateur) provinces of DRC. Each health zone represented a community group. This design was chosen as the intervention was implemented, after the pre-test, in one group and compared to the second group at an initial time point and at a later one; the same intervention was administered to the group that initially served as the control group. It was also chosen because the intervention was a pilot meant to demonstrate the replicability of the intervention in two different settings [33].

Intervention
The social accountability intervention was initiated in 2015 as the implementation phase of an Interactive Learning and Action (ILA) approach [34–36]. It was run as a pilot over a period of 12 months between April 2015 and June 2016. The intervention was implemented in the two health areas by their respective HZMT with the collaboration of the research team. The intervention package was formulated as changes required to improve community participation [37] in order to support community engagement and monitoring of health services, and to address the challenges described above. It had three specific objectives with regard to social accountability: increase voice by creating a formal reporting system by using and improving CHWs’ and HC’s activities; improve the answerability of HPs by enhancing the HC and by training HPs on social accountability-related aspects; improve the answerability of HPs and community enforceability capacity by introducing a dialogue meeting, by involving the HZMT in the supervision of community activities and by using existing intervention mechanisms, namely those provided by a performance-based financing scheme and community-based health insurance (Table 9.1).
The conceptual model in Figure 9.1 demonstrates the linkage among components of the intervention based on improved community participation and their results. The key elements of the intervention include activities that contribute to increasing community engagement and community monitoring of health services. They are effective in triggering health services responsiveness only if they modify the power relations between health providers and users by changing power, knowledge, social and economic relations [15,38].

**Delivery of the intervention**

The components of the intervention were implemented in the pilot sites using two-hour workshops conducted by the HZMT officers in accordance with the current policy on human resources capacity building, supported by the health partners and the research team. Developing the support of the research team and health partners was the first step of the process. It consisted of discussing specific concepts and process with regard to the HZMT roles, including training and supervision of HPs, CHWs, and HC members, health services responsiveness, social accountability, home visit process, patients’ rights and entitlements. Three workshops were held at each site. The first workshop involved CHWs and HC members and aimed at building their capacities and improving the content of their activities by introducing social accountability aspects. CHWs and HC members were also trained in their role as an interface between the community and the health providers. The curriculum used during this workshop was built on the current community participation guidelines [23], but the main concept of social accountability was added with an emphasis on collecting people’s views, concerns or complaints about the health services. The topics of the session included the vision on and organization of community participation, the home visit procedures, the interface role of CHWs and HC, health service responsiveness, concepts of abuse and disrespect, the rights of patients, and the community oversight of the HPs through the HC.

The workshop helped to develop strategies to make CHWs more active in collecting the population’s concerns and summarizing them for an appropriate presentation as the population representatives at the HC meeting or the dialogue meetings. CHWs were trained to encourage community members, specifically women, to voice their concerns about the health services and the behaviour of HPs and to provide information about health topics including social accountability, quality of services, patients’ rights, and health services standards to build community health literacy.
Table 9.1. Intervention objectives, activities and outcomes

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Activities</th>
<th>Direct and indirect outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve voice by creating a formal reporting system by using and improving CHWs and HC's activities.</td>
<td>Use CHWs for collecting community opinions, concerns, expectations and questions about health services mainly when carrying out home-visits; Use CHWs for providing basic health information to community members during home-visits in order to build community awareness and literacy; Transmit the collected community concerns to the HC and, the dissemination of the decisions and actions of HC as well as the feedback of health providers (HPs) to the community.</td>
<td>Community members are reporting their concerns and feedback about health services to CHWs. Community concerns are transmitted to the HPs during HC’s meeting. The knowledge and awareness of community members are built through information brought by CHWs.</td>
</tr>
<tr>
<td>Improve the answerability of HPs by enhancing the HC and by training HPs on social accountability related aspects.</td>
<td>Discuss community concerns collected and transmitted by CHWs during monthly HC meetings and by the training of HPs on social accountability related aspects.</td>
<td>Community concerns are communicated and discussed with HPs during HC meetings; health providers receiving community concerns are perceived as answerable or responsive to these concerns (40).</td>
</tr>
<tr>
<td>Improve the enforceability mechanisms using social pressure by introducing a dialogue meeting, by involving the HZMT the supervision of community activities and by using existing intervention mechanisms.</td>
<td>Organize dialogue meetings to allow the involvement of other stakeholders in HC activities; Encourage the involvement of HPs’ supervisors in community participation activities.</td>
<td>Other community stakeholders and HPs’ supervisors are involved in community participation activities or are informed about community concerns.</td>
</tr>
</tbody>
</table>
In addition, they were trained in the feedback process, namely the reporting of health services functioning indicators and information coming from the HC for the community during home visits and getting feedback on the information provided. To improve the reporting and the documentation of health concerns and complaints, CHWs were provided with notebooks and pencils.

The workshop also served to improve the quality and the functioning of the HC. The main idea was to set the HC as the entity at the local level in charge of managing the population's concerns and complaints and of steering the dialogue meetings in order to institutionalize the social accountability initiative. This initiative aimed to shift the management of the population's views and the reactions to those views to the HC, situated at the health area level. This decentralization of the management of users' views encouraged ownership of the process by community members. The HC members were instructed to send a copy of the minutes of HC meetings to the HZMT and to advocate for having these minutes taken into account during the PHC monitoring meeting, carried out at the health zone level. This is very important for the success of the social accountability initiative. It involved the HZMT in the process and shared the community voice collected at the health area level with the health zone level. Topics discussed during the workshop included the management of the reporting process mechanisms, based on the CHWs' networks, and the use of reporting tools; and regarding the information process, CWH and HC members were trained in creating summaries and preparing and steering dialogue meetings.

The second workshop was held with representatives of community groups, comprising women's associations and HC members. It aimed at initiating the dialogue meeting and discussing the involvement of representatives of community groups in the social accountability process. The dialogue meeting was introduced as a supplementary activity for the HC at the research sites.
**Figure 9.1. Theories of change of a social accountability initiative**

**Hypothesis:**

**Process:**
- Increased voice/information of the population
- Increased community oversight

**Means to raise citizen engagement and voices:**
- Community meeting
- Learning activities
- Empowerment
- Education
- Exchange meeting
- Conscious raising activities

**Means to raise citizen oversight**

**Means of raising community power:**
- Community health insurance
- Performance-based financing
- Microfinance

**Change in power relation:** Clients have power and coalition, social pressure

**Change in knowledge relations:** knowledge, requirements, rules, protocols

**Change in economic relation:** Consumer and client role

**Outputs:**
- Increased response to perceived needs and expectations (improved attitudes, appropriate behavior, change in quality of service)

**Outcome:**
- Increased uptake of maternal health services

**Impact:**
- Drop of the problem as a reduced risk of maternal morbidity and mortality

- Clients trust in health services
  - Increased satisfaction with Health Care Provider
  - Decreased users complaints
  - Reduced claims due to the providers
  - Increased treatment adherence

- Women increase maternal health services utilization

**Mechanisms:** Why, How? If works?
It was planned as a meeting which would be convened every 3 or 6 months with representatives and other influential actors from the community to enhance the coalition around maternal health, social accountability, citizen monitoring of health services, and the dialogue between the community and the health providers. The dialogue meeting was conceived as a learning cycle during which complaints and concerns unresolved during the normal HC meeting would be discussed in the presence of other, more powerful stakeholders. To make the process more constructive and less confronting for HPs and to improve the answerability and responsiveness of HPs to community concerns, HC members and HPs were taught to present a draft report on unsolved issues for discussion and suggest remedial actions. The meeting was convened under the responsibility of the highest local administrative authorities within the health area catchment, namely the sector administrative officer.

It was funded by the health centre as a HC meeting expanded to include other stakeholders such as village chiefs, local administrative authorities and notables, local associations’ representatives, women’s association representatives and CHW representatives. A summary of patient complaints and of the action plan was disseminated within the community using the CHWs’ network as part of the feedback process. The feedback aimed at raising the process transparency and population awareness. This dissemination aimed to allow the population to link their complaints, suggestions and ideas to the perceived change made in the health services by HPs.

The last and third workshop was held with HPs. It aimed at improving the management of community voice at the health centre level. Discussions with HPs encompassed their role in social accountability mechanisms, their vision and organization of community participation, the home visit process, the interface role of CHWs and HCs, the health service responsiveness, concepts of abuse and disrespect, rights of patients, the dialogue meeting and community oversight of the HPs through the HC. The workshop helped to develop strategies to make HPs more responsive and accountable to community views. Other topics discussed included the importance for HPs of discussing community concerns in the health centre team and including health services responsiveness, health services standards, patients’ rights and entitlements among topics to discuss with CHWs and community members.
Study sites

The intervention was carried out in two purposively selected health zones (HZ), Muanda in Kongo central and Bolenge in Equateur. The inclusion criteria for intervention areas were: 1) health zone in post-conflict situation currently involved in sustainable development activities; and 2) the presence of health sector partners implementing or planning to implement health interventions including social accountability components for more than four years, targeting the improvement of maternal health. In each HZ, one health area was selected: Nsiamfumu Health Area in the HZ of Muanda and Iyonda Health Area in the HZ of Bolenge. The inclusion criterion was a functioning health centre. The two health areas were selected to serve as a comparison to each other, as they are situated in two different HZs and have different social, economic and cultural backgrounds.

Evaluation

The evaluation of the intervention was conducted from April 2015 to June 2016 and aimed to explore the way in which the social accountability intervention worked in the two different contexts and its effects on the health service performance and responsiveness. First, it provided evidence about how well the intervention was operationalised in practice. Second, it was designed to determine what works, why it works, and under what circumstances. For this purpose, a realist evaluation lens was used. The realist approach provides a framework for interrogating the process of implementing the complex social intervention and its resulting outcomes as a means of testing and advancing the theoretical understanding of how aspects of the intervention trigger different types of outcome under certain circumstances [39–42]. The realist evaluation aims to identify what types of context (C) and mechanisms (M) produced which outcomes (O), forming a specific CMO configuration, by exploring the way in which a programme unfolded in practice in different contexts. This study used a realist lens as it did not conduct a full realist evaluation process; rather, elements of the realist evaluation helped to identify the CMO configurations that underlay the results of the intervention (43).

According to the intervention objectives, three outcomes were measured. The first outcome was the increased voice. It was measured quantitatively by the number of households having reported a concern, a question or a complaint. It was also presented as the proportion of the number of reporting households compared to the total number of households visited. In addition, the content of the concern was described qualitatively. The second outcome
was community concern that was transmitted and discussed in HC. It was measured by the number of HC meetings at which community concerns were discussed and by the content of the concerns discussed. Secondary outcomes included the number of dialogue meetings organized and the number of HZMT actions taken to address community concerns. The third outcome was related to the health providers’ responsiveness. It took two forms: receptivity, defined as changes in the attitudes of HPs toward community concerns; and responsiveness, defined as changes in behaviour or in performance introduced in line with community concerns.

**Data collection and sampling**
Both qualitative and quantitative data related to the social accountability intervention outcomes, health providers’ responsiveness, and perception of social accountability mechanisms were collected using semi-structured interviews and a document review, according to a predefined set of variables.

Semi-structured interviews were carried out with community members, key informants and health providers (see Table 9.2). The document review analysed CHW activity reports, minutes of the health committee meetings, and monthly reports from the health centre. The data collection was carried out before and after the implementation of the social accountability intervention. Data collecting tools comprised interview guides, a CHW activity form, and a health service performance form.

**Table 9.2. Characteristics of participants in follow up interviews**

<table>
<thead>
<tr>
<th>Participants</th>
<th>Location</th>
<th>Number</th>
<th>Sex</th>
<th>Age</th>
<th>Education level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community health workers and committee members</td>
<td>Muanda</td>
<td>14</td>
<td>7</td>
<td>25-67</td>
<td>P6-U1</td>
</tr>
<tr>
<td></td>
<td>Bolenge</td>
<td>14</td>
<td>8</td>
<td>23-58</td>
<td>P5-U3</td>
</tr>
<tr>
<td>Women and women group’s representative</td>
<td>Muanda</td>
<td>6</td>
<td>-</td>
<td>23-45</td>
<td>P6-U2</td>
</tr>
<tr>
<td></td>
<td>Bolenge</td>
<td>5</td>
<td>-</td>
<td>24-55</td>
<td>P4-U1</td>
</tr>
<tr>
<td>Men and men group’s representative</td>
<td>Muanda</td>
<td>5</td>
<td>5</td>
<td>25-47</td>
<td>NE-S6</td>
</tr>
<tr>
<td></td>
<td>Bolenge</td>
<td>6</td>
<td>6</td>
<td>23-60</td>
<td>NE-U3</td>
</tr>
<tr>
<td>Key informants</td>
<td>Muanda</td>
<td>7</td>
<td>5</td>
<td>30-55</td>
<td>D6-MPH</td>
</tr>
<tr>
<td></td>
<td>Bolenge</td>
<td>7</td>
<td>5</td>
<td>31-46</td>
<td>D6-U6/MD</td>
</tr>
<tr>
<td>Total</td>
<td>64</td>
<td>36</td>
<td>28</td>
<td>23-67</td>
<td>NE-MPH</td>
</tr>
</tbody>
</table>
Semi-structured interviews were audio-recorded with the respondents’ permission and carried out in a quiet place in Lingala or French, lasting 45 minutes on average. At each research site, the research team sought to interview participants purposively sampled on the basis of their role in service provision and social accountability initiatives across different levels: practice (health providers) and organizational (HZMT officers, health partners, health committee members, community representatives) and women (health service users). At the community level, a purposive approach to sampling was used with the aim of selecting participants (mainly women) who participated in the process and provided concerns, questions or complaints when in contact with CHWs during the semi-structured interviews. From each site, at least five women were recruited and interviewed. At the health service level, the research team recruited the HP in-charge and HPs involved in maternal health care. At the health zone level, the research team recruited *ipsa facto* the HZMT chief officer and the HZMT officer in-charge of community activities. The topic guides were informed by the realist framework to elicit information on the three key elements: (1) Contexts – views about social accountability initiatives, the way program components were implemented, the way change was facilitated, current practice and culture in the health area, the local context of maternal health care provision and enabling and constraining factors; (2) Mechanisms – views of how the program components worked, how the changes were interpreted and acted upon, and experiences of implementing the change; (3) Outcomes – perceived changes in practice and service performance, impact on roles, workload and relationships.

The document review provided both quantitative and qualitative data and was based on documents produced during the monitoring process. The intervention process was monitored on a monthly basis by local supervisors. This monitoring was important as it helped us to understand why an outcome was achieved (or not). It consisted of collecting data produced by CHWs from their activities, data about HC meetings including copies of the minutes, and data produced by the health centre including the health system information form. A monitoring frame of the intervention was developed and used, comprising community concerns and questions collected by CHWs, the HC meeting reports, home visits’ logs to assess the number of visits, CHWs’ satisfaction and women’s perception of the visit, and changes introduced by HPs in healthcare provision to address the clients’ concerns. Each month, the local supervisor held a meeting with the HP in-charge and HC members to discuss and validate reports to be sent to the HZMT office and to research team members, and to provide feedback to participants about the process.
Data processing and analysis
Quantitative data were recorded in an Excel spreadsheet and summarized using mean ± standard deviation or proportions. They were represented in tabular form, demonstrating the trends of the social accountability intervention components. Qualitative data were transcribed verbatim, accompanied by notes taken during interviews, and analysed using the deductive content approach. The analysis was performed according to the main research objectives (outcomes) and focused on generating CMO configurations. Briefly, the analytical steps involved familiarization with data during which the transcripts were read and re-read independently, applying the coding frame based on a realist lens to all transcripts. All codes that suggested a change in people’s minds and actions (reasoning, feeling, behaviour, attitudes and beliefs at individual, interpersonal, social and organizational levels) in response to changes introduced by the programme were classified as mechanisms. Codes that described the pre-existing enabling or disabling conditions, as well as measures introduced by the programme to support implementation were categorized as contexts. Codes that described the intended and unintended consequences of the programme in terms of voicing, support of the voice process, responsiveness, whether behavioural, attitudinal or clinical, were classified as outcomes. These outcomes were related to the intervention objectives. This categorization of data into contexts, mechanisms, and outcomes in CMO configurations was done for each of the programme components, for each category of respondents and for each research site. The CMO configurations were refined by identifying the similarities and differences across research sites and participant categories, to generate common CMO configurations.

Ethical considerations
The approval of the Kinshasa School of Public Health Ethics Committee was granted for the implementation of the intervention. The research adhered to the ethical principles of the Declaration of Helsinki II, in particular the voluntary consent obtained from the participants, confidentiality and anonymity in data collection. The participants did not receive any direct benefit from the study. The results of this study provide information to be used to design a comprehensive study and may also support the Ministry of Health Directorate in charge of community participation. All participants provided written informed consent.
9.4. Results

The results section provides an overview of how the social accountability intervention worked at the two sites, describing the outcomes actually resulting from the intervention and the reasoning processes reflecting how participants framed and interpreted their own actions, decisions and relations. It is organized according to the intervention components as follows. The first sub-section describes findings related to the collection and transmission of community concerns. The second sub-section provides results related to the discussion of issues collected at the health committee level. The third sub-section covers outcomes regarding answerability, including the responsiveness of health providers, while the fourth sub-section is about the organization of the dialogue meetings and the involvement of other stakeholders in the social accountability process. The following results are based on the follow-up and the evaluation after the first year. In each sub-section, the CMO configurations are presented in tables. The last columns of each table indicate in grey the categories of participants who raised ideas during the interviews.

At baseline, before the implementation of the intervention, CHWs and HC members were unaware of their interface role and did not collect community concerns and nor discuss them in HC meetings, although they carried out home visits and held HC meetings, implementing some elements of the national health policy (Table 9.3).

Collection and transmission of community concerns

The analysis of CHW reports and health committee minutes showed that CHWs carried out home visits within the community and took the opportunity to collect community concerns, expectations and questions about health services (Table 9.3). During the first cycle of the intervention that lasted 12 months, CHWs carried out 1580 home visits in Nsiamfumu HA (Muanda) and 1226 in Iyonda HA (Bolenge). They visited almost every household in the health area and included both users and non-users of the local health centre. Monthly on average, at each site, 10 CHWs worked on community health activities, and each CHW visited 12 households in Muanda and 10 households in Bolenge.
Table 9.3. Performances of activities of community health workers in the two selected health areas from April 2015 to June 2016

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of households visited</td>
<td>87</td>
<td>77</td>
<td>85</td>
<td>134</td>
<td>137</td>
<td>85</td>
<td>127</td>
<td>134</td>
<td>146</td>
<td>145</td>
<td>13.0</td>
<td>128</td>
<td>121</td>
<td>1580</td>
<td>121.5</td>
<td>23.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average number of households visited by CHW</td>
<td>10.9</td>
<td>11.0</td>
<td>10.6</td>
<td>13.4</td>
<td>12.5</td>
<td>7.7</td>
<td>11.5</td>
<td>12.2</td>
<td>13.1</td>
<td>13.3</td>
<td>13.2</td>
<td>11.8</td>
<td>11.6</td>
<td>11.0</td>
<td>12.8</td>
<td>11.8</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>Total number of people reached in visited HH</td>
<td>444</td>
<td>374</td>
<td>418</td>
<td>695</td>
<td>661</td>
<td>398</td>
<td>668</td>
<td>606</td>
<td>623</td>
<td>781</td>
<td>705</td>
<td>644</td>
<td>620</td>
<td>601</td>
<td>7794</td>
<td>599.5</td>
<td>125.5</td>
<td></td>
</tr>
<tr>
<td>Average number of people reached</td>
<td>55.5</td>
<td>53.4</td>
<td>52.3</td>
<td>69.5</td>
<td>60.1</td>
<td>36.2</td>
<td>60.7</td>
<td>55.1</td>
<td>62.3</td>
<td>71.0</td>
<td>64.1</td>
<td>58.5</td>
<td>56.4</td>
<td>54.6</td>
<td>63.0</td>
<td>58.0</td>
<td>8.8</td>
<td></td>
</tr>
<tr>
<td>Number of households visited with concerns</td>
<td>0</td>
<td>12</td>
<td>16</td>
<td>29</td>
<td>18</td>
<td>14</td>
<td>6</td>
<td>7</td>
<td>15</td>
<td>20</td>
<td>7</td>
<td>8</td>
<td>10</td>
<td>12</td>
<td>174</td>
<td>13.4</td>
<td>6.4</td>
<td></td>
</tr>
<tr>
<td>Proportion of households with concerns (%)</td>
<td>0.0</td>
<td>15.6</td>
<td>18.8</td>
<td>21.6</td>
<td>13.1</td>
<td>16.5</td>
<td>4.7</td>
<td>5.2</td>
<td>11.5</td>
<td>13.7</td>
<td>4.8</td>
<td>6.2</td>
<td>7.8</td>
<td>9.9</td>
<td>11.0</td>
<td>11.5</td>
<td>5.6</td>
<td></td>
</tr>
<tr>
<td>Average number of HH by CHW with concerns</td>
<td>0.0</td>
<td>1.7</td>
<td>2.0</td>
<td>2.9</td>
<td>1.6</td>
<td>1.3</td>
<td>0.5</td>
<td>0.6</td>
<td>1.5</td>
<td>1.8</td>
<td>0.6</td>
<td>0.7</td>
<td>0.9</td>
<td>1.1</td>
<td>1.4</td>
<td>1.3</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>Number of active CHWs</td>
<td>8</td>
<td>7</td>
<td>8</td>
<td>10</td>
<td>11</td>
<td>11</td>
<td>10</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>11</td>
<td>174</td>
<td>13.4</td>
<td>13.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of HC meeting held monthly</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>13</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HC meeting with community concerns discussed</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>13</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site 2. Bolenge (Iyonda HA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of households visited</td>
<td>85</td>
<td>116</td>
<td>81</td>
<td>84</td>
<td>94</td>
<td>88</td>
<td>82</td>
<td>72</td>
<td>60</td>
<td>128</td>
<td>102</td>
<td>114</td>
<td>106</td>
<td>114</td>
<td>101.0</td>
<td>122</td>
<td>94.3</td>
<td>18.9</td>
</tr>
<tr>
<td>Average number of households visited by CHW</td>
<td>8.5</td>
<td>12.9</td>
<td>9.0</td>
<td>9.3</td>
<td>11.8</td>
<td>11.0</td>
<td>10.3</td>
<td>9.0</td>
<td>7.5</td>
<td>10.7</td>
<td>8.5</td>
<td>9.5</td>
<td>8.8</td>
<td>9.5</td>
<td>8.4</td>
<td>10.2</td>
<td>9.5</td>
<td>12.2</td>
</tr>
<tr>
<td>Total number of people reached in visited HH</td>
<td>429</td>
<td>585</td>
<td>408</td>
<td>423</td>
<td>474</td>
<td>444</td>
<td>413</td>
<td>363</td>
<td>302</td>
<td>645</td>
<td>514</td>
<td>575</td>
<td>520</td>
<td>537</td>
<td>473.0</td>
<td>609</td>
<td>468.5</td>
<td>91.4</td>
</tr>
<tr>
<td>Average number of people reached</td>
<td>42.9</td>
<td>65.0</td>
<td>45.3</td>
<td>47.0</td>
<td>59.3</td>
<td>55.5</td>
<td>51.6</td>
<td>45.4</td>
<td>37.8</td>
<td>53.8</td>
<td>42.8</td>
<td>47.9</td>
<td>43.3</td>
<td>44.8</td>
<td>39.4</td>
<td>50.8</td>
<td>47.2</td>
<td>6.3</td>
</tr>
<tr>
<td>Number of households visited with concerns</td>
<td>0</td>
<td>0</td>
<td>23</td>
<td>22</td>
<td>19</td>
<td>18</td>
<td>15</td>
<td>15</td>
<td>28</td>
<td>23</td>
<td>25</td>
<td>21</td>
<td>20</td>
<td>19</td>
<td>270</td>
<td>20.8</td>
<td>3.7</td>
<td></td>
</tr>
<tr>
<td>Proportion of households with concerns (%)</td>
<td>0.0</td>
<td>0.0</td>
<td>28.4</td>
<td>26.2</td>
<td>23.4</td>
<td>21.6</td>
<td>22.0</td>
<td>20.8</td>
<td>25.0</td>
<td>21.9</td>
<td>22.5</td>
<td>21.9</td>
<td>19.8</td>
<td>17.5</td>
<td>18.8</td>
<td>22.0</td>
<td>22.3</td>
<td>3.0</td>
</tr>
<tr>
<td>Average number of HH by CHW with concerns</td>
<td>0.0</td>
<td>0.0</td>
<td>2.6</td>
<td>2.4</td>
<td>2.8</td>
<td>2.4</td>
<td>2.3</td>
<td>1.9</td>
<td>1.9</td>
<td>2.3</td>
<td>1.9</td>
<td>2.1</td>
<td>1.8</td>
<td>1.7</td>
<td>1.6</td>
<td>2.3</td>
<td>2.1</td>
<td>4.0</td>
</tr>
<tr>
<td>Number of active CHWs</td>
<td>10</td>
<td>9</td>
<td>9</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>10.0</td>
<td>10.0</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>Number of HC meeting held monthly</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>15</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HC meeting with community concerns discussed</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>13</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend: in grey filled column, baseline data for both sites IT: Intervention SD: Standard deviation HA: Health area HC: Health committee CHW: Community health workers HH: Households.
### Table 9.4. Community concerns collected by community health workers

<table>
<thead>
<tr>
<th>Community concerns</th>
<th>Content of concerns and quotations</th>
<th>Nsiamfumu Muanda</th>
<th>Lyonda Bolenge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care pricing</td>
<td>Providing free care, respect flat fees per episode of disease, higher fee - for service payments, overbilling of drugs, high consultation fees</td>
<td>++</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td><em>&quot;The nurses give a prescription with a lot of medicines that are very often not necessary for treating the disease, at the risk of complicating the health problem, just to increase the bill&quot; (CHW report, Muanda)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health providers staffing</td>
<td>Appointment of doctor in the local health centre</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Availability of health care</td>
<td>Install a blood transfusion unit and dental care unit or provide ultrasound devices.</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of care</td>
<td>Delay before being examined, no bed nets, unclean toilets and rooms, patient asked to clean rooms, Lack of drugs</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td></td>
<td><em>&quot;We do not know who is in charge of cleaning the health centre. Often it is the patients or their relatives who sweep the room their sick person occupies&quot; (CHW report, Bolenge)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behaviour of health providers</td>
<td>Absenteeism, delay, informal payment, unnecessary care, care related to payment, verbal abuse, no confidentiality, presence of drunk nurse, financial accessibility in case of emergency, financial harassment/informal payments</td>
<td>+++</td>
<td>++</td>
</tr>
<tr>
<td></td>
<td><em>&quot;The only problem is that the nurses often scold the women during childbirth, especially if they have no money. They express unfriendly words towards women&quot; (CHW report, Bolenge)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>&quot;The midwives sometimes ask us for some money in an informal way&quot; (CHW report, Bolenge)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>&quot;There is a nurse who was not kind, who provided no clear advice before and after the treatment, it is the nurse called [Name of the nurse]. The nurse does not even speak with the sick person. She is always angry&quot; (CHW report, Muanda).</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health service management</td>
<td>Refusal of debt, absence of lights during the night, lack of medicine in the health centre.</td>
<td>++</td>
<td>+++</td>
</tr>
<tr>
<td></td>
<td><em>Patients are treated at night in the darkness because the light is not good in the health centre&quot; (CHW report, Bolenge)</em></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Legend: +: very few mentioned; ++ often mentioned; +++ very often mentioned
CHWs recorded in total 174 households with concerns in Muanda and 270 in Bolenge, representing on average 11.5% and 22.3% of visited households, respectively. The data showed that when CHWs did not actively ask for feedback and concerns, community members rarely provided them. Table 9.4 gives an overview of concerns collected during home visits.

It is worth noting that the data on performance and information about community participation activities at both sites were reported in the national health information system differently from the CHWs’ monitoring. For instance, while a summary made by CHWs in the health committee meeting minutes showed that CHWs conducted 121 home visits in May 2016 in Nsiamfumu HA, the NHIS reported only one home visit.

Regarding building community capacity and literacy, reports of CHWs’ activities showed that they provided health information during home visits on a wide range of topics, such as individual hygiene, social accountability and health providers’ responsiveness. Health topics which were shared during the first cycle are summarized in Table 9.5. The interviews with community members showed that they mainly reported their concerns to CHWs because they know them and trust them and therefore fear reprisal less.

The use of CHWs as intermediaries to express the community voice by community members was enabled by a variety of factors related to broader intervention contexts (Table 6). Contextual enablers of trust include having CHWs who are community members, living in the same village, sharing the same socio-cultural background, known by community members as community members who carry out health activities within the community on behalf of the health centre.

The second main reason raised by community members during interviews was that CHWs actively collected their concerns by asking them during home visits to provide their feedback, expectations, needs or questions about the health services. Context enablers of the active collection of community concerns included the training and support provided through the intervention programme. Other reasons with their contexts enablers are summarized in Table 9.6.
Table 9.5. Topics discussed with community by community health workers during home visits

<table>
<thead>
<tr>
<th>Topics discussed with community</th>
<th>Bolenge</th>
<th>Muanda</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria prevention (Bed-nets, mosquitoes, treatment, Intermittent preventive treatment)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health services pricing (flat fees pricing)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perception of Health services provision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health providers behaviors and responsiveness (including during childbirth)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community concerns about health services (Getting advice from and asking question to health providers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social accountability (voice, suggestions, questions, expectations)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hygiene of hands (Including hand washing)/Use of latrines/Individual hygiene</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promotion of local health services attendance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antenatal health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immunization (Importance, schedule, management of side effects)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality of health care (Perception and report)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supplementation of Vitamin A and deworming (Albendazole, Ivermectine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management of diarrheal diseases at home (prevention, care)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community health workers and health committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Importance of patients opinions for health providers (community needs and expectations)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholera/Use of safe water/Management of pits/ Hygiene of foods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever home management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reasons of attending other health facilities than the Health centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraception</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demand of informal payment in health facility/ No respectful care in health centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home childbirth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal mortality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debt management in the health facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of medicines and drugs sold by ambulatory and no registered traders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor interventions in health facility</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 9.6. The context-mechanism (CM) explaining why community members reported their concerns to community health workers (O) in the two health zones in DRC

<table>
<thead>
<tr>
<th>Contexts “In a context where…”</th>
<th>Mechanisms</th>
<th>CHWs</th>
<th>HPs</th>
<th>CMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHWs are living in the same community, they are known, sharing same cultural and social background, are carrying out sensitization and home visits as bridge between community and health providers.</td>
<td>Community members feel confident and trusting, and have less fear of reprisal as they know CHWs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“I have reported to them because I know them. They are walking in our village, vaccinating our children and talking with parents, explaining to them the importance of the immunizations. Also, they came to our home and asked us a lot of questions about our household and took measurements of the children who were present”. (Community member_0158_Muanda)</td>
<td>Community members feel stimulated by perceived change at the health facility level that they could relate to their previous voice.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community members are encouraged as they perceive that the information they provided can help to improve the health services and are convinced that the opinion they provided is important to get the health facility to improve.</td>
<td>Community members feel encouraged when they are searching for an explanation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training provided during the implementation workshop provides them with knowledge and materials</td>
<td>CHWs actively collect concerns and ask for feedback. “I gave them my opinion about the health service because they asked me. If they did not ask, I would not express myself”. (Community member_169_Bolenge)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CHWs: Community health workers HPs: Health providers CMs: Community members
Discussion of collected issues at health committee level

CHWs who actively collected community concerns transmitted them to the HC through their delegates, who participated in HC meetings. These concerns were presented and discussed in HC meetings in the presence of HPs in-charge. In contrast to baseline, community concerns were discussed during HC meetings organized after the implementation of the intervention. These HC meetings were held at least once a month on a regular basis (see Table 9.3). The concerns discussed, explanations provided, actions and decisions taken were summarized in the minutes of the meeting (refer to Table 9.7 for a sample).

Table 9.7. Extract of the minutes of a health committee meeting

| "The meeting began at 10:17 under the chair of the Vice president of the health committee...Among points in discussion... (3) Community opinions regarding the health centre... (3) Regarding the health centre, health care activities are going fine. But community is still complaining regarding billing associated with the facility delivery. Community members are declaring that the health centre bill is very expensive and that some of them were scolded by health providers during delivery at the health centre this month. Some CHWs reported also that they are scolded by some health providers who declared that they are making trouble at their workplace. About them, health committee members are asking the HPs through the HP in-charge to carry out their activities according to their obligations and to allow them also to carry out their activities in all responsibility..." (Extract of Health committee meeting, 20/01/2016, Bolenge). |

Participants in interviews provided several patterns as underlying motivations of the activities of CHWs and HC members (Table 9.8). Two main mechanisms emerged that supported the collection and transmission of community concerns by CHWs and HC members: 1) the understanding by CHWs and HC members of their role as representatives of the community, mainly enabled by the training provided during the intervention; 2) CHWs and HC members were motivated to resolve health service problems because they were themselves members of the community and were confronted with the same problems.

Answerability including responsiveness of health providers

In general, participants in HC asserted that HPs exhibited good attitudes during HC meetings. They asserted that HPs listened to the HC members, recognizing issues and concerns raised by community, showing fairness to divergent views, and were receptive to what CHWs contributed.
Table 9.8. The context-mechanism (CM) explaining why community health workers carried out their activities regarding interface roles (O) in the two health zones in DRC

<table>
<thead>
<tr>
<th>Contexts “In a context where...”</th>
<th>Mechanisms</th>
<th>CHWs</th>
<th>HPs</th>
<th>CMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHWs are living in the same community, they are known, sharing same cultural and social background, are carrying out sensitization and home visits as bridge between community and health providers</td>
<td>CHWs and HC members feel motivated to resolve health facility problems as members of the community</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
</tr>
<tr>
<td>Programme training and requirement: to present CHWs’ report during health committee and training of CHWs and HC members</td>
<td>CHWs and HC members are internally motivated as representatives of the community, recognized by the health policy (their legitimacy)</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
</tr>
<tr>
<td></td>
<td>CHWs and HC members have better knowledge of their role and activities and want to carry out their duties</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
</tr>
<tr>
<td>HPs have an influence on CHWs’ activities and appointments (HP)</td>
<td>CHWs and HC members are encouraged by the interest of CHWs to support and protect their community</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
</tr>
<tr>
<td></td>
<td>CHWs and HC members are stimulated to collect and report community concerns as they are members of the same community</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
</tr>
<tr>
<td></td>
<td>CHWs and HC members perceive health providers’ compliance and willingness to learn from the community</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
</tr>
<tr>
<td></td>
<td>CHWs and HC members perceive good collaboration between health providers and them even after HC meetings</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
</tr>
<tr>
<td>HPs during health committee meeting asked questions about home visits and community concerns</td>
<td>CHWs and HC members are encouraged by the willingness to provide information to health providers that they consider as partners.</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
</tr>
<tr>
<td>CHWs are volunteers and are not paid for carrying out community activities. The health partners provide performance-based findings for CHWs’ activities in a context of socio-economic constraints</td>
<td>CHWs and HC members are externally motivated by financial incentives, promised by performance-based funding.</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
</tr>
<tr>
<td>CHWs and HC are community members elected by others to represent them</td>
<td>CHWs and HC members perceive themselves as accountable to the community members who elected them</td>
<td>☑️</td>
<td>☑️</td>
<td>☑️</td>
</tr>
</tbody>
</table>
They asserted also that during HC meetings, HPs had an opportunity to explain themselves, discuss and address issues brought forward by CHWs by providing suggestions of actions to be undertaken. They testified that all issues and challenges raised by CHWs’ reports during the HC meetings were discussed even though actions and solutions were limited to what the HP in-charge was able to address, with or without the support of the HC members. Some CHWs indicated during interviews that HPs changed the performance of their job in response to concerns raised by the community. Other CHWs asserted that HPs favourably valued their activities as evidenced by them buying notebooks to replace the full ones, suggesting an improvement in the answerability of HPs.

Table 9.9. Illustrations of health providers’ answerability and responsiveness

<table>
<thead>
<tr>
<th>Domains</th>
<th>Quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care pricing</td>
<td>“I noticed that healthcare prices fell and we enjoy a good working attitude from health providers. Even if the person does not have enough money, the health providers provide healthcare first at least to prevent his health situation deteriorating” (CHW report, Bolenge)</td>
</tr>
<tr>
<td>Financial accessibility in case of emergency</td>
<td>“The health centre fired the male nurse who had repeatedly been accused by the patients of being drunk when on duty” (CHW report, Bolenge)</td>
</tr>
<tr>
<td>Behaviour of health providers</td>
<td>“I would suggest that health authorities provide more health material and equipment in the health centre. Before, the light at night in the health centre was a problem but we notice that now it is fine. The health centre has light and health providers are working in good conditions” (CM_159_Muanda)</td>
</tr>
<tr>
<td>Health service management</td>
<td>“I was going to say the same thing, especially the fact that before the health providers used to not take care of us when we have no money... But at present when we arrive at the health centre even though we have no money, they provide the care first and for the rest, you need to fetch money” (CM_160_Muanda)</td>
</tr>
<tr>
<td>Behaviour of health providers</td>
<td>“Let us take, for example, the case of the doctor; the health provider answered us during the health committee meeting that as long as the density of the population in this community remains low, we shall not be able to pay for a doctor, and the Health zone management team will not send a doctor to the local health centre” (CHW_152_Muanda)</td>
</tr>
<tr>
<td>Financial accessibility in case of emergency</td>
<td>“He [the health provider in-charge] never gets angry, on the contrary he is satisfied with all the complaints we [CHWs] brought him. He said that complaints from the community help them to improve their work in the health centre” (CHW_175_Bolenge)</td>
</tr>
</tbody>
</table>

The perception of the responsiveness of HPs was confirmed by community members. Some of them asserted that even though they were not sure what CHWs did with their opinions after collecting them, they noticed changes in the health service provision or in the health service,
suggesting an improvement of the responsiveness of HPs to community concerns (Tables 9.4 and 9.9).

Participants in interviews came up with three mechanisms underlying the answerability and responsiveness of HPs to community concerns brought forward by CHWs and HC members (Table 9.10).

Table 9.10. The context-mechanism (CM) explaining the answerability and responsiveness of health providers (O) in the two health zones in DRC.

<table>
<thead>
<tr>
<th>Contexts “In a context where...”</th>
<th>Mechanisms</th>
<th>CHWs</th>
<th>HPs</th>
<th>CMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health facilities at the local level are funded through out-of-pocket payments and are dependent on population attendance</td>
<td>HPS are externally motivated, financial incentives</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HPs are externally motivated, the capacity of community members to exert social pressure on health providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HPs control the decision-making process or resources needed for improving the situation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health facilities at local level are under supervision and decision of the health zone management team</td>
<td>HPs are scared of being fired for inappropriate behaviour</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHWs are elected to be representative of the community and are working in collaboration with HPs, are trained, and their role and mission are recognized by the health policy (programme inputs).</td>
<td>HPs perceive legitimacy of community health workers and health committee members (who better understand their roles and mission)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme training and requirement: presentation of CHWs’ report during health committee and training of HPs. CHWs are present, and all come from the village of the health area.</td>
<td>HPs respond to the need to have information and feedback from community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HPs are externally motivated, their job ethics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In context where media journalists are looking for information in countryside and collecting population concerns to be broadcast in main cities, where authorities and local decision-makers are located.</td>
<td>HPs prevent the involvement of “local authorities and local decision-makers” more likely to have information from media and to sanction their actions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>HPs need to control the diffusion of information within the community</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The cross-comparison of the explanations provided allows us to specify three mechanisms supporting the responsiveness of HPs with regard to community concerns: 1) HPs are motivated by financial incentives as the users’ fees coming from community members are the main source of funding of the health services at the local level. This is because HPs provide services in a context where health facilities at the local level are mainly funded through out-of-pocket payments; 2) HPs are motivated by the legitimacy of HC members, as representatives of the community. Contextual factors that enabled this mechanism included the choosing of CHWs and HC members by the community and their training provided during the implementation of the intervention programme; 3) HPs showed more answerability and responsiveness because they had control over resources and the decision-making process required to address the issues raised by the community. This mechanism was prominent in the context where health facilities are managed at the local level and do not depend on a higher level for resources and decision-making. The contextual factor that constrained the answerability and the responsiveness of HPs was the cost of addressing the issues in terms of financial resources in a context of low health systems funding.

**Organization of dialogue meeting and involvement of other stakeholders**

None of health areas organized a dialogue meeting with external stakeholders during the course of the first year of the intervention. Although they recognized that it is important for local authorities and community stakeholders to know the important issues related to health and the health facility as they have power over the population and HPs, who are more likely to listen to them, most of the respondents explained that the dialogue meeting was not organized because they did not encounter a specific issue nor an attitude of HPs that required them to organize a dialogue meeting.

“We have not organized a dialogue meeting in our health area as we do not find an issue for which the HPs were not able to answer” (CHW, Muanda)

“Some village chiefs are already members of the HC even though they do not regularly participate in health committee meetings. They are considered advisors, so they are informed of the health committee issues and can react without organizing a special meeting” (CHW, Bolenge)
However, HC members and HPs in-charge at the two sites indicated that some informal contacts were carried out with external stakeholders with regard to concerns raised by community members, specifically those requiring more financial resources.

“With regard to the safe water supply in the health centre, during the meeting, we decided to contact a program named ‘Village assaini’ [Cleaned villages], and we had also written to the... [Local firm] with the support of village chiefs so that they can insert us into their program to be able to benefit from drillings. These letters were already written and sent off.” (CHW_152_Muanda)

With regard to the discussion of concerns in the team, HPs in-charge asserted that they have discussed issues raised by CHWs during HC meetings with other HPs in the team, but other HPs did not support this opinion, asserting that they learned themselves about some of these issues raised by community members when appointed as acting in-charge during the absence or holiday leave of the nurses in-charge. With regard to the involvement of the HZMT in the process, CHWs and HC members indicated that they did not receive feedback from HZMT in general, and they therefore argued that the HZMT did not care about community activities. They indicated that they did not receive any support or supervision visits from the HZMT, despite the transmission of their reports through the HPs. They postulated that information from CHWs did not reach the HZMT or was not transmitted appropriately to HZTM officers. On their side, HZMT officers and HPs asserted that all health facilities are under the responsibility of the HZMT. They argued that HZMT officers led the supervision and received reports from all these health facilities (HFs). They indicated that all HFs received integrated supervision, including community participation activities. However, HZMT officers recognized that they did not have enough resources to support supervision activities and contented themselves with receiving a report through the NHIS and monitoring the presentation. The HZMT officers argued that HZMT represents a framework above the HPs where even community members or their representatives can talk about the HF without the presence of the HPs in-charge. HZMT chief officers argued that the perceived lack of support of the HZMT was due to the fact that all reports from the HC seemed normal and did not require specific actions. To support their claim, they provided a narrative from another health area than the research sites for which the HZMT had received alarming information concerning the HPs and was obliged to make a local visit and to discuss the issue with community members and local stakeholders.
9.5. Discussion

This study was initiated with the aim of evaluating the implementation and effect of an intervention aimed at improving social accountability in the health services. It was carried out to explore the mechanisms underlying the working of the intervention and the influence of context in two rural health zones in the Democratic Republic of the Congo. It aimed to improve the social accountability in maternal health by reinforcing the community participation process [37] by inserting community-oriented activities including interface roles and social accountability.

The study showed that trained CHWs, carrying out home visits, could be used effectively to collect a variety of community concerns ranging from individual health problems to health services problems, suggesting an increased community voice and monitoring of health services. These community concerns were documented in specific notebooks, facilitating their monitoring and reporting. Trained CHWs could also be used to provide community health information including those related to the social accountability process. Providing the community with health information could contribute to building community knowledge and awareness, thus improving their capability to detect health services problems and articulate their concerns. The study also showed that community members communicate their concerns to CHWs because of the trusting and confident relationship between them and the active collection strategy applied by CHWs. This was made possible by the existence of familiar CHWs within the community and the intervention programme, which provided training and instructions to CHWs. The study also showed that CHWs could aggregate the collected concerns, transmit them to the HC, where they could be discussed every month with HPs in-charge of the local health centres. This HC meeting provided HPs with the opportunity to provide an explanation and plan actions for dealing with community concerns, suggesting an improved answerability of the health providers. The community concerns, explanations and proposed actions were reported in the minutes of the meetings and transmitted to the HZMT. The clear link between CHWs and HC improved the lines of communication between community members and HC members. A better understanding of their interface roles, the desire to resolve their own community health issues, the attitude of HPs and the provision of small financial incentives were mentioned as the main motivators of CHWs and HC members for collecting, transmitting and discussing community concerns. Enablers included the
presence of trained CHWs and HC and their training programmes as input of the intervention programme.

The improvement of the answerability and responsiveness of HPs suggested an improvement of the community enforceability capacity, as perceived by HPs. The study also documented some changes implemented in the health services related to concerns raised by community members, suggesting an improvement of the responsiveness of HPs to community concerns. The improvement of the community enforceability capacity is linked to a better understanding by HPs of social accountability and HP responsiveness, and of the legitimacy of the HC. It is also linked to a better understanding of HC members of their legitimacy as representatives of the community, of their role and mission, the training of HC members in clear interface activities and the support of other local stakeholders. The desire to maintain an optimal attendance at the health centre, the main source of funding of health centres in the DRC context, and a favourable social image within the community were also mentioned as motivators. Context enablers included the existence of a trained and effective HC, the link with other stakeholders who were more influential and powerful than HPs, and the context situation in which the health services are mainly funded through users’ fees and supervised by the HZMT. The situation described in this paper corresponds to an improvement of the situation compared to what was previously described in the same setting [44,45].

As mentioned in literature reviews on social accountability [15,46,47], the study results further support the importance of training the actors involved in social accountability mechanisms, including HPs and HC members, so that they can understand their role and mission. This training allows them to clarify their role and mission and empowers them to manage their roles appropriately, contributing to improving the functioning of community participation in which the social accountability initiative was embedded. This improvement consisted of adding community-oriented activities to the health services-oriented activities of CHWs and the HC.

The positive role of CHWs as “natural” intermediaries between community members, the HC and HPs to support social accountability at the local level was shown in this study. This study took advantage of their unique position within the community to use them as intermediaries to collect and aggregate community concerns. This step was also suggested by
other authors [43]. The use of CHWs as intermediaries helped to reduce the fear of reprisals and victimization which made community members, specifically women, reluctant to voice their concerns to HPs [44]. CHWs were also used as information bearers of more than just health information, contributing to building community awareness and knowledge; they also provided health services and health committee feedback, thus increasing the community members’ confidence, trust and ownership towards community participation-based social accountability. Both the use of intermediaries [27,28,48–51], the community awareness and knowledge leading to informed citizen engagement [49,52–56] and community members’ confidence, trust and ownership [17,44,52,57,58] were found to be important for the operation of social accountability in various settings as they contribute to improving the citizen voice. Proposing that CHWs collect, aggregate and transmit community concerns does not seem to be a problem, as it does not add an extra effort to their usual work, since community concerns can be collected during home visits.

Another important feature of this programme was the clear link created between CHWs and the HC, which represents the communities. This link improved communication lines between the community and their representatives and helped to keep the HC members including HP in-charge informed about community concerns [12]. It also helped to avoid isolating the HC as social accountability mechanism, as was reported in studies carried out in DRC [28], Burundi [27], and Kenya [59], and in reviews [15,47,60], and ensured that the HC was embedded in the community. It also ensured that the community voice was transmitted to the HC, a “decision space” at lower levels of the health system [46], comprising or having links to community members or stakeholders with enforceability capacity such as village chiefs, group representatives or health services supervisors [60,61], who have the capacity of speaking for community members when it comes to negotiating answerability and changes in health services. This link through the HC with other stakeholders and the HZMT allows aggregation and representation to be combined, the tactical approach to be joined with the strategic approach, complementing social accountability with other governance approaches such as bureaucratic accountability that enable and sustain responsiveness [46,5]. This link through the HC encourages the formation of a nucleus able to promote collective action [15,49,55,61–67] and community mobilization [52,59], increasing pressure on HPs for accountability.
Another important finding was that an improvement of community participation by including social accountability aspects has the potential to trigger the responsiveness of health providers. The study showed that the increase of voice and community monitoring and the strengthening of the HC were associated with an improvement in the attitudes of HPs. This is in line with findings from other authors [46,53,60,68]. This result also matches recent studies indicating that an increased “decision space” at lower levels of the health system might enhance its responsiveness to the varying needs of clients and citizens as it provides community members with the opportunity to voice their concerns and needs [46]. The health services responsiveness in this study was perceived by community members, including CHWs. It was not measured objectively. The perception of the responsiveness of HPs by community members was found to be important for the functioning of social accountability mechanisms, as the latter could be hampered by a perceived history of unfulfilled needs, leading to a perception that holding providers accountable is a waste of time, as shown by Cleary et al. (2013) in their review on social accountability in a health facility at the peripheral level.

The findings of this study are important for policy-makers, researchers, practitioners, evaluators, and programme designers because the realist lens adopted here provides elements that could be replicated and tested in other developing countries using community participation. These elements, provided as context-mechanism-outcome configurations, are transferable as they could be used in setting up programmes and initiatives or in supporting reflection and decision-making. One of the issues that emerged from these findings and constitutes a transferable element is the importance of training CHWs and HCs in their role and mission, as well as training HPs in social accountability aspects. The training was a key characteristic of the proposed intervention programme, and it could easily be replicated in countries using community participation programmes. Another issue that constitutes a transferable element is related to the reorganization of the community participation process, such as the establishment of a clear link between CHWs and HC, the provision of necessary materials, and the management of the community participation process, including supervision and monitoring. Other factors that could improve community participation involve incentive systems and also constitute transferable elements that could help practitioners and policy-makers wishing to organize social accountability initiatives based on community participation.
Some of the issues emerging from the findings related specifically to the reasoning underlying the responsiveness of HPs also constitute transferable elements. This reasoning could be used to guide the formulation of strategies aiming to trigger HPs’ responsiveness. This study showed that the perception by HPs of users of services as consumers rather than as patients, whose money could finance the health services, was a powerful motivator for them to respond to community concerns. HPs were thus more likely to work towards maintaining an optimal attendance, including improving their responsiveness. This is in line with previous review articles on HPs’ responsiveness [15,62] and is relevant in a context where the health services are mainly funded by users’ fees.

This study supports the conclusions of previous studies on HCs and CHWs [46,59,61] as well as on HPs’ responsiveness [15,62] that the responsiveness of HPs depends on the perception of the legitimacy of HC and CHWs as representatives or delegates of the community. The legitimacy of these community structures is clearly enacted in the national health policy but is sometimes ignored as HC members and CHWs are unaware of this disposition. This legitimacy is also tarnished by the limited capacities of HC members, the lack of transparency of their recruitment, the capture of the community participation process by the elite and political parties. The perception of this legitimacy by health providers guarantees a trust relationship and collaboration rather than competition between HPs and HC members [46].

The responsiveness of HPs was also found to be guided by the fear of repercussion from influential stakeholders such as the HZMT officers, local traditional authorities, media officers and community groups’ representatives. Most of these influential stakeholders are linked or networked with HC members or in a direct hierarchy with HPs. This result emphasises the complementarity between internal and external accountability approaches [55,69] and is in line with previous studies and reviews [48,49,61,62].

The study also showed that the perception of support and collaboration between HPs and HC members influences the HPs’ responsiveness [49,62]. HPs apparently value community concerns but were unable to get them by themselves and recognize that these concerns help them to get feedback from the community, which is necessary to improve their services. Other motivators of the responsiveness of HPs included the feeling of moral obligation linked to the social image of HPs within the community or to social pressure [62,70] or to their professional
ethics [68], and the perception of the control they have over resources and decision-making [15,46,62].

The study also showed the central position of HPs in the success of a social accountability programme in the health services. This is related to their role at a low level of the health systems. In DRC, they are in charge of both clinical and community activities. They are also members of the HC and supervise CHWs and their activities in their health area [22]. In this study, HPs were involved in all of the activities and were trained in social accountability, patients’ rights, and community participation in order to build their understanding of the process and to engage them in the change. This is in line with Berlan and Shiffman (2012), who asserted that the training of health providers in social accountability is important as it can affect the way they are socialized to think about accountability. In addition, this study showed that constraints in contexts could influence their commitment to social accountability.

**Study limitations and strengths**

The study suffered from several limitations. It only included two of the health zones in the DRC, and the findings cannot therefore be generalized to the whole country. Other limitations were the quasi-experimental study design of the intervention, the short duration of the implementation, the fact that the process evaluation was conducted by the research team which supported the implementation team and not by an external evaluation team, and the use of the realist lens in data analysis and presentation as this study did not employ a full realist evaluation; rather, elements of a realist evaluation were used during the analysis of the qualitative data.

The strengths of this study include the use of several different data collection methods and data sources that allowed a triangulation of sources and of methods, the use of the quasi-experimental study in two different settings and at multiple times, providing greater validity to the study results. This design is often applied to health systems where new interventions are being introduced gradually. The use of the quasi-experimental design is also justified by the small sample size available and ethical considerations, as the intervention was believed to be beneficial prior to the implementation. Other strengths include the use of ILA, with which the evaluation can be conducted by the research team, and of the realist approach, which has been found suitable for assessing complex social interventions and provides opportunities to identify transferable patterns built on CMO configurations.
References


Assessing a pilot intervention

CHAPTER 10

Discussion and conclusions
Social accountability mechanisms are currently being increasingly promoted as an additional strategy for improving health service responsiveness, in order to improve maternal health service uptake by women [1–4]. Maternal health service uptake is currently considered the cornerstone of efforts aimed at reducing maternal mortality in low- and middle-income countries [5,6]. The objective of this PhD research was to gain insights into whether and how social accountability mechanisms increase the responsiveness and performance of maternal health services in DR Congo in order to contribute to policy-making on social accountability in maternal health.

To study social accountability in maternal health services, the social accountability framework provided by Camargo and Jacobs (2013) was used. In this framework, social accountability is described as a set of mechanisms aiming to enable users to raise their concerns about the health services provided to them, and to hold health providers accountable for actions and decisions related to the health service provision. On the other hand, they aim to facilitate health providers to take users’ needs and expectations into account when providing care. It is assumed that they contribute to improving the responsiveness of services, in terms of the quality of care and the interpersonal relationships between users and health providers. Social accountability involves at least three core elements: voice, enforceability and answerability. Voice includes mechanisms, formal and informal, through which people individually or collectively express their concerns and expectations, and demand accountability from power holders. Enforceability comprises the means available to sanction non-compliance, wrongdoing and/or not appropriately fulfilling the mandate. It also entails the possibility of penalties or other consequences for failing to answer accountability claims. Answerability refers to the obligation for the power holder to provide information and justification about their actions (account) and the people’s right to receive a response (see Figure 2.2) [7]. In this thesis, responsiveness was defined as the extent to which a health provider demonstrates ‘receptivity’ to the ideas and concerns raised by citizens and to which he/she intends or actually ‘implements changes’ to the decision-making or management structure, culture, policies or practices, or ‘changes behaviour’ at the point of service [8].

This framework suggests a dynamic situation in which health providers are continuously facing changing environments and then adapting their practices to satisfy professional values and personal goals [9]. In this thesis, it was hypothesized that social accountability
mechanisms contribute to increased health services responsiveness by improving community engagement and/or community oversight in the health services. This was expected to result in increased community voice and strengthened support for community enforceability, able to trigger the answerability of health providers to the voice. For social accountability in maternal health services to work, women need to express their concerns and have channels to provide feedback, and providers need to be open to user feedback and willing and able to change their practices.

As social accountability in maternal health services is a complex social phenomenon [10] occurring in the interface between the community and health services [11], the Interactive Learning and Action (ILA) approach was taken as the research process, which was applied in two research sites deliberately selected as cases in two provinces in the rural Democratic Republic of the Congo, i.e. Kongo Central and Equateur. In addition, a research partnership was established between Ministry of Public Health agencies in charge of community participation and of reproductive health, two health sector financial and technical partners (both international nongovernmental organizations, NGOs), and the research team. The research partnership aimed at facilitating policy dialogue and research findings uptake in terms of setting a policy agenda for the Ministry of Public Health agencies and implementing research findings for NGOs. The two NGOs (Cordaid and Medicus Mundi) were supporting the implementation of performance-based financing and a community-based health insurance scheme, respectively.

This chapter discusses the main findings of the thesis in answer to the research question. Subsequently, the main conclusions and lessons for policy and practice are presented in relation to the theoretical framework. Finally, a reflection is made on the research approach and the validity of the research findings. The chapter ends with some suggestions for further research in the field of social accountability.
Summary of main findings

This PhD research was initiated to answer the following main research question:

> How can social accountability mechanisms increase maternal health services responsiveness and performance?

Informed by the ILA approach and in line with the existing literature on health providers performance that suggests that understanding the existing situation is required to promote more effective practices in the health sector [9], the main question was divided into two issues. The first part of the study considered the contexts, existing social accountability mechanisms and how women in the two research sites express their concerns about health services. The second part of the study addressed the question of what are the effects of social accountability in relation to health services responsiveness and how does it influence health services performance and responsiveness? This section will synthesize the two parts, and I will reflect on these findings.

1. Existing situation of social accountability in maternal health in rural area in DRC

This first part considers the main findings which answer the following research question that was investigated in four studies:

> What are the existing social accountability mechanisms through which the concerns, expectations, questions and complaints of women could be expressed and taken into account in maternal health services provision?

In the first study (Chapter 4), the context at the two sites was considered and its influence on the operations of a social accountability mechanism analysed. The second, exploratory study (Chapter 5) examined how the concerns, expectations, questions and complaints of women are expressed and taken into account in maternal health provision. The third study (Chapter 6) considered additional factors that could influence the capacity of women to express their concerns in maternal health services. The fourth study (Chapter 7) explored how the health committee, an existing social accountability mechanism, currently functions in regard to its
role in social accountability. These main findings are presented according to the three core components of a social accountability initiative, i.e. voice, enforceability and answerability (see also Figure 2.2).

Voice

My findings indicated that the women in these locations did not complain about the healthcare provided and were not used to raising their concerns, complaints and expectations about the health services. They were unsure of how to discuss and make their concerns known to health providers and did not express their discontent to health providers (Chapter 5). The study also revealed that women avoided direct and formal approaches for complaining and at the same time did not support the collective. This reluctance was related to the fear of reprisal and victimization due to power relations as they are not sure about the response of health providers to this voice. In addition, they suffered from a lack of mechanisms for reporting that guarantee anonymity and avoid reprisal. They also had insufficient knowledge and information about their rights and entitlements, the health providers' mandate and healthcare standards (Chapter 6). Instead, the study showed that women preferred approaching intermediaries such as trusted community health workers, local leaders, chiefs, community representatives and health providers' relatives or using informal approaches such as gossip and rumours. The choice of intermediaries was often based on trust, socio-cultural features, and perceived capacity to influence health providers.

The research also found that several contextual factors affected the individual and community levels. These contextual factors concerned age-related power, cultural norms as women in these settings grew up in a culture characterized by male dominance, the social value of childbirth and social considerations of health care, or the local customs to abstain from complaining (Chapters 4 and 5). The research found that health providers, community health workers and health committee members believed that community concerns could be communicated to community health workers and the health committee or collected through community groups (Chapter 5).
We also noted that the health committee, which was mentioned by health providers and enacted in the national policy as a structure in charge of presenting the voice of the community, did not work appropriately with regard to its role. It did not collect the community voice nor provide feedback from health services to the community (Chapter 7). This formal role was not known to most of the community members who mentioned community health workers as intermediaries rather than the health committee (Chapter 5). The reason for this appeared to be the lack of emphasis on community-oriented activities such as the community voice in the national health policy (Chapters 5 and 7). Instead, the orientation of its current activities is towards the health provider, such as distributing bed nets, preventative drugs and devices, and leading immunization campaigns. In addition, the great reliance and dependence of the health committee on the health providers and its distance from the community health workers and other community stakeholders and groups were also noted (Chapter 7). All these factors result in insufficient community participation with regard to social accountability.

Chapters 4 and 5 also showed that some interventions in the health sector such as a performance-based financing scheme and community health insurance scheme periodically collected the concerns of community members using community-based organizations. These community-based organizations were contracted and paid by nongovernmental organizations (NGOs), working in partnership with the Ministry of Public Health. They carried out surveys such as satisfaction surveys. In community health insurance projects, the suggestion box was used as well. However, it appeared that they collected only data related to healthcare activities provided by the health facilities according to contracts signed with the NGO, and most of the time, they were coming from outside the community. Research showed (Chapter 5) that the information collected was transmitted to the fund holder agent, which managed the contract between the health facilities and the NGO, and only reached the health providers via the health zone management team and in general terms. The collected information was not shared with the community, which thus could not validate it or use it to hold the health providers accountable.

It also became evident that the national health information system did not collect data related to community voice as there was no specific form for recording community concerns, and in addition, the health zone management team did not appropriately carry out the supervision and monitoring of the health services (Chapter 5). This explains why it is difficult to obtain
Discussion and conclusions

reliable data on the effect of voice activities through the national health information system, and this hinders the input of community activities in the health sector.

**Enforceability**

According to the framework provided by Camargo and Jacobs (2013) (Chapter 2), the concerns of citizens, articulated into actionable demands, have to be transmitted to the relevant actors and decision makers who have enforcement capabilities in order to generate answerability. Enforceability is understood as the means available to sanction non-compliance, wrongdoing and/or not appropriately fulfilling the mandate. In this study, it was observed (Chapters 5 and 6) that women considered themselves as being unable to influence the functioning of the health service or the behaviour of the health providers, as they believed that they had less knowledge than the health providers and were unable to judge how healthcare should be provided as laypersons. They did mention community health workers as potential intermediaries that they could use for making their concerns known to health providers, even though they expressed doubts about the ability of community health workers to influence the behaviour or decisions of health providers. The women considered community leaders such as village chiefs and community groups’ representatives and health service supervisors as potential intermediaries who could influence the health providers and make their concerns more likely to be accepted by the health providers. Few women asserted that they could influence the health providers by acting through the social network to boycott the health services, reduce health service provision and affect both the reputation and the income of health providers (Chapter 5). The study also revealed that the women did not envision collective actions, as community activities for the collective expression of opinion are considered political activities, and there is an absence of any powerful coalition to voice concerns despite the presence of numerous community groups (Chapters 4 and 5).

The study revealed that the local context is quite constraining and provides little support for the operation of social accountability mechanisms. The general governance context is characterized by an inadequate implementation of decentralization, keeping decision power and real authority still centralized far from beneficiaries in a context of a post-conflict and fragile state (Chapter 4). This situation reduces the enforceability capacities of the local
community. It was found that even though the health zone management team is close to
the local level, the constraint in health financing prevented it from supporting community
activities and appropriately supervising the health providers, reducing the administrative
accountability of health providers (Chapters 5 and 7).

Regarding performance-based financing and community health insurance scheme, it
appeared that the community was not involved in an enforceability mechanism as the
information collected was sent to the fund holder agents and through them to the health zone
management team, which exerted enforceability according to the contract between the health
providers and the fund holder agents (Chapter 5).

**Answerability**

Answerability refers to the obligation of the power holder to provide an account and the
people’s right to receive a response. According to Camargo and Jacobs (2013), answerability
can only be generated if the concerns of citizens, articulated into actionable demands, are
presented by relevant actors with enforcement capabilities. It also includes the response
from the service providers triggered by the voice, as a clear manifestation of accountability
as a two-way process between two actors. In this study, as the community’s concerns did not
reach the health providers, the opinions of community members regarding the answerability
of health providers were contradictory (Chapter 5). The community members seemed not to
perceive health providers as responsive, but considered them more likely to get angry and
to scold the complaining person. The study also showed that the health providers did not
provide community members or their representatives with information about the health
facility performance (Chapters 5, 6 and 7). It did reveal that the health committee offered
room for a dialogue between health providers and community representatives, where health
facility issues and health matters could be discussed (Chapter 5 and 7). With regard to
performance-based financing and community health insurance schemes, the study showed
that the community was unaware of the processes involving the answerability of the health
providers as the community or their representatives did not participate in meetings where
the information collected was presented and discussed (Chapter 5).
Answerability also involves a feedback process through which citizens can be informed of the use made of the information they provided. In this study, it was found that; first, women asserted that they did not know what happened with their report to a community health worker (Chapter 5). Second, feedback to community members did not seem to be a priority for the health committee (Chapter 7). Finally, regarding performance-based financing and community health insurance scheme, the community did not receive feedback for its concerns as the information was managed at the level of the health zone management team and fund holder agents (Chapter 5).

It can be concluded that social accountability mechanisms are relatively non-functional in rural DRC and that the concerns, expectations, questions and complaints of women about the maternal health services were not formally taken into account by health providers as the latter were ignorant of them. Despite this, the study revealed that the local level presented elements that can be used to build social accountability initiatives such as the presence of community health workers and the health committee, community leaders who could be power holders, and community groups that could organize collective action.

2. Building social accountability at the local level
The second part of this thesis comprised two studies which together answer the following research question:

What is the effect of social accountability mechanisms on the responsiveness and performance of maternal health service providers and how do they work?

The first study (Chapter 8) concerned an experiment with the development of a social accountability mechanism that might deal with the challenges raised while answering the first research question, which explored existing social accountability mechanisms through which the concerns, expectations, questions and complaints of women could be expressed and taken into account in maternal health services provision. For this, the Dialogue Model was applied to carry out an advisory process in two health zones involving beneficiaries, representatives of the health sector and local authorities. This advisory process resulted in a social accountability experiment integrating six components: (1) involve community health workers and the health committee in collecting, transmitting and discussing community
concerns about health services (voice); (2) build the capacity of the community in terms of knowledge and information; (3) involve community leaders through dialogue meetings with the health committee and health providers; (4) discuss with the health providers their attitude towards voice and the management of voice at the health facility level; (5) involve the health service supervisors in supporting community participation activities; and (6) use other existing interventions, like performance-based financing and a community health insurance scheme.

These components were then integrated into three intervention modules targeting the increase of voice, enforceability and answerability at the community level, which are essential components of a social accountability mechanism. This study showed that the Dialogue Model, an instrument of the Interactive Learning and Action (ILA) approach could be suitable as a process to involve community members and other stakeholders when dealing with issues in the interface between the health services and the community.

In the second study (Chapter 9), the intervention modules developed were implemented over one year as a pilot and evaluated in order to assess their effectiveness to improve voice, answerability, and community enforceability, and thus maternal health services responsiveness and performance. The experiment consisted of improving the community participation process by training community health workers and the health committee in their interface roles, by structuring the collection and documentation of community feedback/complaints by community health workers as intermediaries, and by organizing dialogues between the health committee and health providers. It also involved discussing social accountability issues with health providers. The data showed that the community health workers had collected a variety of community concerns ranging from individual health problems to health services problems. These community concerns were documented in specific notebooks, facilitating their monitoring and reporting, suggesting an increased community voice and monitoring of health services. The study also showed that the community health workers provided the community with health information, contributing to building community knowledge, health literacy and awareness, and therefore contributing to improving their capability to detect health services problems and articulate their concerns. The collected concerns were transmitted to the health committee and discussed every month with health providers from the local health centres, who then had the opportunity to provide an explanation and
set actions for dealing with community concerns, suggesting an improved answerability of the health providers. The community concerns, explanations and actions suggested were reported in the minutes of the meeting and transmitted to the health zone management team. However, despite the records of community concerns and data on community activities, it was observed that the information was underreported in the national health information system by the health providers, thus reducing the value of community participation for the health sector.

The improvement of the answerability of the health providers suggested an improvement of the community enforceability capacity, which could be explained by the experimental setting, which combined the training of health providers to understand the role and mission of the health committee and of health committee members in clear interface activities and support of other local stakeholders. The study also documented some changes implemented in the health services related to concerns raised by community members, suggesting an improvement of the responsiveness of health providers to community concerns.

In terms of a realist evaluation approach, the mechanisms triggered by this social accountability intervention pilot were: Facilitation of voice: the collection and transmission of community concerns were realized in a trust-engendering way by using community health workers and the health committee as intermediaries, which gave confidence to the women and anchored community protection and support, facilitating the health providers' answerability or health providers' responsiveness, the perception of the legitimacy of the health committee, financial incentives, social pressure and administrative accountability.

A change in the existing traditional power relation was realized between health providers and community members who use the health facility. Our study showed that from a situation in which the women were scared of reprisal, were less aware of their rights and entitlements, had insufficient knowledge of the health service and healthcare, considered themselves laypersons unable to judge the quality of care, the social accountability experiment produced several modifications. The use of community health workers as intermediaries between the community and health providers led to growing trust and confidence helped to reduce the fear of reprisal and increased the voicing of community concerns. Given their privileged position and the trust-based relation they represent, their use was also suggested by
other authors after having explored their unique position in Ethiopia, Kenya, Malawi and Mozambique [12,13] and assessed their performance and motivation in India [14,15]. They also help to provide health information to women, contributing to reducing the knowledge and awareness gap, and to improving their capability to detect inappropriate care. The role of community health workers in the provision of health information within the community was also highlighted in reviews of the literature on community health workers in low- and middle-income countries [16] and in the United States [17], on community-level interventions [18], on community engagement in performance-based incentive programmes [19], and in studies of community health workers in Tanzania [20] and India [21]. The use of health committees and other intermediaries worked through the perception of legitimacy, social pressure, bureaucratic accountability and financial motivator to counter-balance the power of health providers, as suggested by previous reviews of social accountability [4,22]. The use of all these intermediaries has helped to avoid confrontations, privileging a soft shift of power relations through dialogue and a trust-based relationship within the community. They fostered an improved dialogue between health providers and community members, especially women, and between women and other stakeholders in the community, contributing to opening the local context settings to dialogue. Therefore, women were less scared of expressing their concerns and showing their discontent, finding an appropriate structure for a constructive dialogue in community health workers. Similar evidence on the importance of intermediaries in mediating voice was observed in rural Ghana [23] and in India [24].

The following five contextual conditions were found to be important for increasing the voice of the community, improving enforceability and triggering health providers’ answerability for our studies in rural DRC: the existence of local community health workers and a health committee in place, known by the community, trained in their formal role, enacted in the national health policy, and the situation in which the health services are mainly funded through users’ fees and supervised by the health zone management team (Chapter 9).

Based on this sub-question of part 2, it can be concluded that a social accountability initiative based on empowered community health workers and a strengthened health committee, associated with training of the health providers and the involvement of intermediaries, has the potential to increase the voice of the community, improve enforceability and trigger the health providers’ answerability. The outcome contributes to improving the responsiveness and performance of the health providers.
Lessons learned: Implications for social accountability practice

In this section, the implications of the findings for practice are considered. Key lessons we draw for the improvement of maternal health services by means of social accountability practice include the need to reorganize and strengthen the current community participation process, e.g. community-centred activities, to facilitate indirect voice mechanisms, and to coordinate the social accountability initiative by combining several components. We observed a positive effect when we involved the beneficiaries in designing a social accountability initiative which fits the culture of the community and respects the important role of the health providers.

The social accountability experiment aimed to improve the community participation process. The existing community participation process was reorganized and strengthened in several points.

Community health workers and health committee members can, after some training, take an intermediate role between the community and health providers (Chapters 8 and 9). First, community health workers and health committee members were trained in their interface roles. The training of community health workers included the social accountability aspect, their interface role, the home visit process, and the active collection and reporting of community concerns. The training of health committee members stressed in addition the health providers’ responsiveness, the management of community concerns, dialogue meetings and links with community health workers. The training was carried out by the health zone management team supported by the research team. Training improved the interface role of the community health workers and health committee members between the community and the health providers. They helped to broaden the activities of the community health workers and health committee members beyond promotion, preventative and curative activities by introducing community-centred activities, which had often been neglected in most of the programmes involving community health workers and the health committee.

We learned that community health workers are regarded by the community as trusted intermediates to voice concerns to health providers (Chapters 8 and 9). Second, community health workers and health committee members were provided with materials for documenting their activities and improving their reporting. They were instructed to actively collect
community concerns during their community activities, to summarize and transmit them to the health committee through their representatives. The use of community health workers as intermediaries to collect community concerns gave women an indirect voice mechanism; our study had shown that the direct speaking option was difficult as women in a rural setting feared reprisal or victimization or were unsure about the response of the health providers if they voiced their concerns. The use of community health workers as “natural” intermediaries was promoted as this indirect way seemed easier as the women felt more comfortable voicing their concerns through a trusted person or someone they perceived as having more power than the health providers. In a wide variety of developing countries and contexts such as India [3,24], Burundi [19,25], Indonesia and Mexico [19], Malawi [26] and DRC [27], the use of intermediaries was found to contribute to improving the voice of the community, but these intermediaries were rarely community health workers [12].

In our study, community health workers were not only linked to but were also represented on the health committee by their elected delegates. This allowed them to be sure that the concerns of the community reached the health committee and that the latter takes them into account when discussing health facility issues with the health providers (Chapter 9). Third, the combination of activities carried out by community health workers with those of the health committee did improve the communication lines between community members (mainly in contact with community health workers) and the health committee and with the health providers. It thus avoided the pitfall that the health committee was considered in isolation as the main facilitator of the social accountability mechanism as in reviews on social accountability [4,28,29], the health committee [30,31], community scorecards in Eastern DRC [27] and voice mechanisms in performance-based financing in Burundi [25]. At the same time this combination guaranteed that the health committee does regularly receive information about community concerns through the clear link with community health workers and establishes a feedback loop. In DRC [32,33], as in other countries using community health workers and health committees such as Burundi [25], Rwanda [34], Mozambique [35] and Tanzania [20], the link between community health workers and the health committee might not be clear. This link was also not mentioned in some reviews of health committees in low- and middle-income countries [29–31] and of community health workers drawn from experiences in four African countries [12] or from the United States [17,36].
When the collection of community concerns is carried out continuously and covers all community households, this will improve the community monitoring of health services in a context of high illiteracy, predominantly oral tradition and health financing constraints (Chapter 9). Fourth, the availability of documentation materials provided an opportunity to collect data about the community health workers’ actions, which is currently lacking in the national health information systems. The provision of these materials and financial incentives, provided in a performance-based manner, also contribute to the motivation of community health workers. Positive effects of providing working materials and incentives to community health workers were also observed in Tanzania [37], Ethiopia, Kenya, Malawi and Mozambique [16] and India [15]. Reviews of community health workers in low- and middle-income countries have also reported similar results [38]. Our study showed that community health workers’ activities covered all the existing households in the health area over one year, including ones which did not use the health services or participate in health insurance. The collection of community concerns was done during home visits, which are one of the recognized activities of community health workers in DRC [39], Nigeria [40], Uganda [41], Tanzania [20,37], Ethiopia, Kenya, Malawi and Mozambique [12], Kenya [42], Pakistan [43], India [14] and the United States [17]. Normally, the collection of concerns did not add to their usual workload, except for writing down what they heard. Normally, apart from providing notebooks and pens, the activities were not costly, and the health centre could afford this expenditure and provide notebooks and pens. Our strategy differs from other ones using paid and external community-based organizations on a repetitive time basis [25–27] or suggestion box [44,45], given this context of high illiteracy, predominantly oral tradition and health financing constraints.

Most of the elements applied in order to strengthen the community participation process constitute innovations which did not exist in the current national health policy [46–48]. Therefore, these findings could be policy elements to strengthen community participation and the maternal health services uptake in DRC.

A community coalition building component through a dialogue meeting and platform was important to engage other influential and powerful intermediaries in social accountability and health including maternal health in addition to the health committee (Chapter 9). The social accountability interventions tested in this PhD research combined several components, which were integrated to open the local context to dialogue. Use was made of existing factors
identified during the situational study, such as a coalition building component, aiming to set up a platform and a dialogue meeting. A community coalition building component through a dialogue meeting and platform was important to engage other influential and powerful intermediaries in social accountability and health including maternal health in addition to the health committee. The importance of engaging intermediaries through coalition building for improving social accountability in the health services was highlighted in reviews of community capacity building [49], in social accountability studies carried out in India [24] and in reviews drawn from other low- and middle-income countries [8]. Their involvement was important to initiate a coalition around the health services and social accountability. Linked to the health committee, they contributed to improving the enforceability capacity of the community as most of them were more powerful and influential than the health provider, health committee members and community health workers. Just like other authors, we observed that these intermediaries are able to trigger social pressure, mobilize other high-ranked stakeholders such as the health zone management team officer and the territory administrators, and facilitate a collective action [4]. Coalition building is an important element of social accountability [24].

Community capacity building was carried out in the health sector as well as in the development programme over a long timeframe. But it did not emphasize aspects related to social accountability, health services responsiveness and the rights of patients as users (Chapter 7). Community capacity building plays a key role in improving the function of a social accountability mechanism as asserted in conceptual papers on social accountability [50–53] and confirmed by studies carried out in India [24]. People cannot express their concerns if they do not know what they are entitled to [1]. Even though community capacity building was carried out in the health sector as well as in the development programme over a long timeframe, it did not emphasize aspects related to social accountability, health services responsiveness and the rights of patients as users. Introducing these aspects helped to build the community members’ knowledge and awareness, contributing to their ability to detect inappropriate behaviour and disrespectful care, thus leading to an increased expression of voice [22,54].

The elements of Box 10.1 explain the central role of the health provider, and his/her influence on the success of any social accountability mechanism in the health services. This explains the
importance of his/her training in health services responsiveness, patients’ rights and social accountability aspects. The training aims to influence the way providers are socialized to think about accountability [4] and to create ownership in a context where community participation activities are not well supervised by the health zone management team. In our study, we observed that the incentives for the health providers’ responsiveness range from external factors to internal factors, and their activation depends on the context. This is in line with Baez-Camargo, for example, who noticed that health providers are clearly interested in being accountable to those who have decision-making power over their status, career path or wealth [53]. This is also in line with the existing literature in countries applying a users’ fee payment [4]. However, another study showed that health providers are sensitive to public embarrassment if pressure is exerted on their social capital, affecting their reputation and discretion [55].

The Interactive Learning and Action approach was a useful approach for involving different community groups with different perspectives in developing more suitable and context-specific initiatives. The social accountability experiment used in this study was framed by involving beneficiaries using the Dialogue Model, one of the Interactive Learning and Action approach tools (Chapter 8), and the overall research used ILA as research process. The use of ILA through its interdisciplinarity increased the likelihood of getting a proposal from the advisory process that would be acceptable by all participants as it integrated their perspective and values [56]. ILA provided framework for working in the interface of the health services and the community. Our study showed that it is feasible to apply the Dialogue Model as well as other ILA tools in other settings and other sectors as long as the ILA principles and steps are followed and applied appropriately. Our study showed also that ILA principles such as mutual learning, the use of non-technical expression, the respect of experiential knowledge and a fair facilitation could easily be implemented in DRC rural contexts as they were previously used in various sectors and settings like food security and HIV-AIDS in South Africa [56], women entrepreneurship in Bangladesh [57], and leprosy stigma reduction in Indonesia [58]. They were also applied in the Netherlands to involve patients in agenda settings in various research areas [59-61].
Chapter 10

**Box 10.1. Dominant role of health providers**

This PhD research showed that the management of the health services in DRC is predominantly in the hands of the health providers. Therefore, they are essential actors in the design and functioning of a social accountability mechanism in the health sector in the rural setting of DRC. Their central position is related to the organization of the health systems at the local level [46]. In DRC, the local level is represented by a health area. A rural health area covers at least 5000 inhabitants and contains a health centre. The health centre provides a comprehensive healthcare package, including community health activities. The nurse in-charge is responsible for both clinical care and community activities. The latter are carried out with the support of community health workers and the health committee [39]. The nurse in-charge has control of both clinical care and community activities [39,54] and is supervised by health zone management team officers. The nurse in-charge is a member of the health committee, the structure which coordinates community participation activities in the health area. He/she is present when the health committee meets at least monthly to discuss activities that were carried out and plan those to be conducted the following month. He/she is the one who signs the minutes (together with the health committee president that summarizes the discussions, decisions and actions of the health committee. He/she is in charge of transmitting a copy of the minutes to the health zone management team office and of reporting some information to the national health information system.

NGOs used implementing agencies at the local level and had fewer insights at the community level than expected (Chapters 8 and 9). The PhD research was carried out in research partnership with Ministry of Public Health agencies and two NGOs, as implementing health partners. The partnership was established to facilitate the policy dialogue and uptake of the research findings in terms of policy agenda setting for Ministry of Public Health agencies and the implementation of findings for NGOs, as the implementation and replication of such interventions in a resource-constrained setting like DRC require the support of NGOs. According to the ILA framework, from the inception of the research project as well as during its course, the research team prepared the materials, shared findings and discussed practice and policy implications with the research partners. They provided their observations, participated in the analysis and reflections, took part in learning, supported research and were included in the authors’ list. The inclusion of end-users of the research findings in the process added value to the
research project in terms of trans-disciplinarity. While the findings were used in policy agenda setting, their implementation by the research partners was limited. NGOs used implementing agencies at the local level and have fewer insights at the community level than expected. In addition, they did not change their programme settings to implement the changes proposed by the research findings, thus not benefiting from the partnership.

**Policy implications**

Based on the key lessons presented above, policy recommendations can be formulated to optimize maternal health services uptake by means of social accountability initiatives in rural local settings. Policymakers should be made aware of the fact that the current national health policy and its derived documents emphasize mainly community participation activities and are health provider-oriented [46,47]. In order to optimize maternal health services by means of social accountability, a modification of the national health policy regarding community participation is needed for community health workers and the health committee to realize their interface role.

Policymakers should also recognise the importance of regularly training community members working as community health workers and engaged in the health committee by providing them with a policy booklet clearly describing their role, mission and entitlements. This is related to the observed lack of clear knowledge of their role and mission and to the low involvement of community members as community health workers. This recommendation matches those formulated in earlier studies carried out in Africa and Asia [12,14,16,37,42]. To handle the vested interests of health providers, I would recommend that this training be carried out preferably by the health zone management team officer in charge of community activities in the presence of all health providers working in the local health centre and on an annual basis in order to provide all new participants engaged in community activities with this basic knowledge.

The findings of this PhD research also suggest the need to improve the organization, support, supervision and reporting of community-based activities. This is associated with the unavoidable question of health systems financing. One positive aspect is that accountability
feedback loops are in principle a low-cost system dependent on the willingness of the beneficiaries to suggest improvements. In order to use a social accountability initiative based on community participation, efforts need to be made to organize community health workers’ activities and their link to health committee activities [15,16,20,35,37]. Cost reduction could be achieved by integrating and coordinating activities and using funding opportunities: e.g. Global Funds and Global Alliance for Vaccines and Immunization (GAVI) Health Systems Strengthening financing or performance-based financing programmes as promoted by the World Bank and other NGOs such as Cordaid.

Policymakers should probably also recognise the importance of building broader coalitions around health services by facilitating platforms at the community level [24]. At the local level, it is possible to build a coalition around maternal health services and to leverage powerful intermediaries by respecting the process suggested in the national health policy and community participation strategic framework during the recruitment of community health workers and election of health committee members. Efforts have to be made at the health zone level and the provincial level in terms of supervision, coordination and communication to monitor the community participation process in order to ensure transparency and fairness. The latter are the cornerstones for building a coalition and ensuring the involvement of all actors in community participation.

Our findings also highlight the need to improve the health literacy of community members. One way involves improving the content of the health education program provided in schools [62]. Currently, the health education programme mainly emphasizes individual and personal health-related problems (e.g. Promoting hygiene and recognizing symptoms) rather than public health service options. It is true that HIV/AIDS and immunization have already been introduced in some health education programmes related to efforts made through Global Funds and GAVI. Supplementary efforts are needed to progressively introduce information related to maternal health, health services, social accountability, non-communicable diseases, rights and entitlements of patients.

Policymakers should also recognise the importance of improving the basic training of health providers and health managers and of providing refresher training of health providers and health managers on topics related to social accountability, ethics, rights of patients, quality of
services and interpersonal relationships. Health managers should include the involvement of health providers in social accountability among supervision issues.

**Theoretical implications**

Social accountability in health services is an innovation in DRC and in most low- and middle-countries; more data are needed on its key issues and on strategies to improve its implementation and effectiveness. The lessons learned in this PhD research are important for future work in this area. However, for the further development of social accountability mechanisms in maternal health services, it is important to put these lessons into a broader theoretical perspective. When we relate the lessons of this research to the three essential components of a social accountability approach, as described in the theoretical framework of this thesis (Chapter 2), i.e. voice, enforceability and answerability, some interesting issues emerge. In this section, we would like to discuss these issues according to the three components and introduce some new elements. These issues may not be completely new, but they have not received specific attention within the social accountability approaches. They appear to be relevant in the context of DRC, and perhaps of other low- and middle-countries.

**Voice**

The study has raised various questions about the type of voice strategy that is most effective in the context of rural DRC. Effective voice supposes that the citizen voice is articulated into actionable demands and transmitted to the relevant actors and decision makers, who have enforcement capabilities in order to generate answerability from the service providers and local authorities. People need to have specific characteristics and capacities and may require knowledge of health services standards, health providers’ obligations, and their own entitlements to be able to voice their concerns. Direct voice seems to be especially difficult for those women who are poor, illiterate, living in a society with male dominance, and ignorant of health services standards, health providers’ duty and their own health rights. Direct voice seems to be difficult in a context where power relationships exist between health providers and patients/citizen. In DRC, extreme gender differences in literacy, discrimination by health providers (not providing services, abuse and bullying) against poor, young, unmarried but pregnant women, constant fear among the population of saying something that can be used
against them make women reluctant to voice their concerns. This study described the effort to improve voice by using intermediaries that are trusted by the patients/citizen. The involvement of intermediaries makes the voice process indirect rather than the direct form usually prescribed for social accountability. This is why ‘indirect voice’ is such a key issue for the voice process in the DRC context. The implication for social accountability is two-fold. First, specific attention needs to be paid to identifying which actors could be the most effective intermediaries for collecting and transmitting community concerns. It is here that a participatory process such as ILA is required and suitable. The participatory process may involve beneficiaries, health providers, community leaders and local authorities.

Second, the intermediation has to be able to facilitate safe and confidential documentation of community concerns as well as ensure the faithful and accurate transmission of the community concerns, as the outcome of the activity is to make health providers aware of the community concerns and questions. At the same time, these intermediaries have to participate in the feedback process, transmitting information from health providers to community members about what is done with the community concerns. This results in an interesting, stimulating, iterative, dynamic on-going and two-way process, with a stronger emphasis on a trust relationship and dialogue.

**Enforceability**

Difference in power relations among community members and health providers is the main factor that influences the action taken by health providers. This study suggests that community members might not always have enough power to confront health providers and make them more responsive. Because of power asymmetry linked to information, expertise, legitimacy, wealth and social capital and because of a reluctance to use collective action, individual patients/citizens tend to have less enforceability capability than other community actors such as health committee members, local authorities, local association representatives or external actors such as health zone management team officers. They could, however, play a role as intermediaries to put forward patient concerns to health providers on behalf of community members. This leads to indirect enforceability. These actors are involved in social accountability through community coalition building by which social accountability can be integrated with other types of accountability (e.g. bureaucratic accountability through the health zone management team). Various contextual factors also influence the enforceability
capacity of the community. This study shows that at the local level, there are other actors with more power who could be used, and their involvement through community coalition building and a dialogue platform was a successful strategy leading to the concept of indirect enforceability, as the enforceability is exerted by actors even in the absence of community members.

**Answerability**
Answerability includes providing justification or an account to community members, introducing change in the service provision in response to community concerns and providing information about what has been done with them. Answerability is shaped by enforceability. Thus, actors with more enforceability capability are more likely to generate answerability from health providers that could induce or catalyse change in the health services or behaviour of health providers, as perceived by patients (health providers’ responsiveness). As community concerns are presented by intermediaries during a health committee meeting, it is to these intermediaries that health providers provide justification and account for the community concerns they have transmitted and articulated. In the context of DRC, the health committee provides an appropriate space for dialogue and answerability. Intermediaries who receive justification and an account could then generate feedback. In any case, change is introduced to the health service provision, which could be perceived by users/community members even if they are not informed about what was done with their voice. The feedback process could then facilitate relating the voice to the change they perceived in the health services.

**Contextual factors**
Several features of the local setting have been identified that are detrimental to the effective operation of social accountability mechanisms, such as under-resourced health systems, the organization of the community participation process, the non-implementation of political decentralization, a constrained socio-economic situation, and the political perception of activities relating to community rights. Typical DRC health systems, socio-economic and governance contexts which shape power relations between actors impact the operation of social accountability mechanisms. These features stress the importance of analysing the local context in addition to the national context when implementing a social accountability approach. There is a need to pay attention to the underlying contextual factors and mechanisms that may prevent and hinder an affective social accountability process. A participatory process
is a suitable way to reduce uncertainties related to contextual factors and to involve other stakeholders in the success, suggesting a holistic approach and integrating strategies from different sectors. All of these features are summarized in an adapted conceptual model (see Figure 10.1).

The conceptual model represents the short route of accountability and illustrates the relationship between providers and patients/citizens and the associated accountability processes in which the evidence from the empirical component of this thesis has been captured and combined with insights from the literature review on social accountability [7]. The arrows illustrate different components and steps necessary to facilitate social accountability. Different shapes and colours of arrows (in terms of size, direction and transparency) indicate that the target, function, impact and continuance of social accountability components differ.

Through this proposed framework, the study emphasized social accountability as an ongoing dynamic process between community members and health providers that involves at least three core elements: (1) voice, (2) enforceability, and (3) answerability, which together form a cycle. However, the framework recognized, first, that most of the social accountability components have their own dynamics and are indirect rather than direct as they make use of intermediaries. Second, the social accountability mechanism is influenced by the characteristics and background of actors, including the health providers who participate in it, and by the contexts in which it operates, including the health systems, socio-economic and governance contexts which shape power relations between actors.

**Research strengths and weaknesses**

A major strength of this PhD research is the combination of methods, which were chosen based on their suitability to answer the research questions. This study combines quantitative and qualitative data, collected using various data collection strategies, in order to construct an in-depth understanding of the reality of social accountability in a rural setting. The order in which they were employed allowed each sub-study to build on the understanding gained in previous study rounds following the interactive learning and action approach.
Figure 10.1. Components and steps involved in effective social accountability initiatives (adapted from Baez-Camargo and Jacobs, 2013)
Description: Dark arrows indicate voice process; green arrows answerability and feedback; red arrows the enforceability process; and the blue arrow the health service responsiveness. Actors include citizens/users, health service providers and those with enforceability capacity.
This study also used secondary analysis design, utilizing data collected for other studies with quite different objectives, even the non-equivalent and non-homogenous presence of the concepts examined by the various primary studies, to investigate a subject that the original analysis did not deal with. Secondary analysis of the data helps to gain insights into this subject, which is important for accountability mechanisms [63].

The number of study designs and the variety of methods used in this study increased its internal validity by triangulation [64]. As with any qualitative content analysis, the data collection, analysis and interpretation could be influenced by the background and views of the research team members. To reduce these influences, data collections were carried out according to predefined protocols and tools, and all of the methodology was pretested. Second, the data collectors were trained prior to each data collection phase, and the team comprised researchers from different disciplines. Aside from the health providers and health zone management team members, the research team members had no relationship with the participants prior to study commencement. The participants learned about the researchers and the research during the ethical consent procedure. Third, after data collection, research notes including the researcher’s impressions and reflections were recorded in transcripts, and after each fieldwork day, a briefing session was held during which the research team discussed the themes and emergent ideas. Validation by the participants was also performed to check their opinion of the research results, specifically after dialogue meetings and meetings with stakeholders. Fourth, the data analysis was conducted using pre-defined frameworks, refining the definition of variables and coding tables. It was supervised by three supervisors, who were more experienced in qualitative data analysis. The research team involved in data collection and analysis integrated researchers from a variety of disciplines, who collaborated in the research programme with common research questions and objectives. This interdisciplinarity allowed knowledge integration and limited the influence of the researcher’s subjectivity.

Finally, the data were collected in interaction with the participants. The findings and sometimes raw data were discussed not only within the research team but also with local health partners, community members, health providers and external experts to support trustworthiness. The inclusion of end-users in the process allowed local knowledge and the interest of various culturally distant stakeholders with different societal perspectives to be integrated. This transdisciplinarity increased the transparency and reliability.
Generalization of the findings of this PhD research is limited because of its case-study nature and the small number of health zones in which it took place. The selection criteria (health zones with active NGOs and functional health centres) introduced a selection bias as the selected zones include well-performing health facilities hiding the common DRC health facility situation. The study was neither designed to be nationally representative nor representative of a particular health zone. However, the selected health zones are on a gradient of rural health zones in DRC. In addition, the data collection did not include national-level data. However, the study provides useful starting points for further research on contextual factors influencing the shaping, implementation and functioning of social accountability initiatives in local settings. Second, this study is the first to provide in-depth insights into local-level contextual factors, complementing previous studies on more national and sub-national levels. Third, the contextualized conceptual model could be used as an analytical tool in similar contexts to DRC.

In addition, the selection criteria followed a critical case sampling: if inadequate social accountability related to poor health providers’ attitudes could be found at these particularly well-functioning facilities, then it was likely that the same accountability problems would exist at other health facilities that were less efficient given the current, poorly functioning regulations for health services. Both sites can represent the DRC rural situation, including ones with NGOs supporting the community in addition to the governmental health provision. Furthermore, the distinct characteristics of the two health zones with different communities enabled us to generalize the robustness and potential of the proposed intervention to raise social accountability in maternal health services as well as in all local health centres that provide maternal health services as part of a comprehensive healthcare package.

There were limitations related to data collection. Data were collected from only two health zones and from a small number of respondents, and might not represent the situation in the other zones in DRC. In addition, as data were collected retrospectively, there might have been a recall bias. In this qualitative study, however, it is not the representativeness of the sample that matters but the representativeness of the contextual information. Saturation was reached in this study as the participants’ responses were largely overlapping, and triangulation was used to confirm and check the accuracy of the data.
The second limitation related to data collection was associated with the data collection technique used in the Dialogue Model. In the Dialogue model, focus group technique was used and it was applied in a context characterized by asymmetry of knowledge and powers [65,66]. This situation presents a risk of one group being dominated by another, thereby losing its knowledge inputs. Despite the adoption of a method designed to minimize an unequal power dynamic and asymmetries between participants, there is an inherent inequity between community members and representatives of health sectors and local authorities. By using the Dialogue Model process, we tried to be attentive to preventing asymmetries and creating a fair and meaningful process. Some precautions were taken: the separation of stakeholder groups in the first round of focus groups, an equal number of participants for each of the stakeholder groups in the dialogue meetings, the selection of open-minded participants, the use of non-technical language, the equal distribution of speaking time, the respect of conversation time, the assistance of community groups and a fair facilitation being transparent and equitable in our partnership with participants. One of the strengths of the Dialogue Model is that the management of the meeting enables a dialogue-based process rather than a shifting of control process. According to Abma and Broerse (2010), the Dialogue Model stimulates mutual learning between stakeholders by developing a shared action proposal supported by all participants, as they spend enough time together to build reciprocal relationships and to foster mutual respect and knowledge integration. A further strength of the Dialogue Model is its use of the different phases in the dialogue process for building consensus and enabling the different perspectives to be included despite the asymmetry of knowledge and power.

The third limitation relating to the Dialogue Model was the representativeness of the participants and the actions identified during the integration phase. In the organization of the process, purposive sampling was used to find community members committed to improving the maternal health service, and preferably committed to taking action and follow-up implementation. Even though criteria were used, their implementation by the research team could have been biased due to the researchers’ subjectivity, and this may have unintentionally led to the exclusion of the most marginalised and vulnerable participants. At the same time, previous focus group discussions verified whether these community members were still in line with the rest of the community. Furthermore, the integration meeting provided participants’ insights into the support of the various suggestions that were made by participants and collected. Finally, the credibility of the findings was enhanced through validation by the
participants. Fairness was warranted through the open and respectful participation and the consideration of their inputs in the final proposal [65,66].

It is worth highlighting that the research presented in this thesis was focused only on the social accountability experiment based on the health committee, community health workers and any intermediaries they could mobilize. Related interesting issues were not investigated, i.e. performance-based financing and community health insurance-based social accountability, score cards, empowerment, bureaucratic accountability, and quantitative effects on health service utilization and its impact on maternal health.

**Further research**

Based on the findings of this PhD research, five avenues for possible future research focusing on social accountability in health services in rural settings could be considered. First, the research study was experimentally implemented as a pilot intervention and was conducted for only one cycle, and needs to be continued for another cycle in order to correct some issues raised during its implementation before being scaled up. Second, we are interested in discovering to what extent the action plans developed during the dialogue in the health committee resulted in more health service uptake as it was found to improve health service responsiveness. The third avenue concerns the effect of social accountability on indirect outcomes such as health literacy and the empowerment of community members. Fourth, the outcomes produced by the social accountability initiative based on community health workers and the health committee could be compared with those produced by other initiatives such as performance-based financing and community health insurance. Finally, additional research could be carried out to study the effect of broad contexts on the operation of the developed social accountability.
References

Discussion and conclusions


Discussion and conclusions

Summary
Summary

Introduction

The Democratic Republic of the Congo (DRC), a post-conflict and fragile state in Central Africa, is confronting high maternal mortality. Strategies to reduce maternal mortality emphasize the increased use of maternal health services. Social accountability mechanisms are currently being promoted as an additional strategy for improving health service responsiveness, in order to encourage maternal health service use despite little evidence of its effectiveness. The research for this thesis was carried out with the objective to gain insights into whether and how social accountability mechanisms increase the responsiveness and performance of maternal health services in DRC in order to contribute to policy-making involving social accountability in maternal health.

This study was initiated to answer the following main research question:

How can social accountability mechanisms increase maternal health services responsiveness and performance?

To study social accountability in maternal health services, the social accountability framework provided by Baez-Camargo and Jacobs was used. In this framework, social accountability is described as a set of mechanisms aiming to enable users to raise their concerns about the health services provided to them, and to hold health providers accountable for actions and decisions related to the health service provision. They also aim to facilitate health providers taking users’ needs and expectations into account when providing care. At least three core elements are assumed to be involved: voice, enforceability and answerability. Voice includes mechanisms, formal and informal, through which people individually or collectively express their concerns and expectations, and demand accountability from power holders. Enforceability comprises the means available to sanction non-compliance, wrongdoing and/or not appropriately fulfilling the mandate. It entails the possibility of penalties or other consequences for failing to answer accountability claims. Answerability refers to the obligation for the power holder to provide information and justification about their actions (account) and the people’s right to receive a response, including the feedback process and responsiveness. Responsiveness was defined as the extent to which a health provider demonstrates ‘receptivity’ to the ideas and concerns raised by citizens and to which he/she intends to or actually ‘implements changes’
to the decision-making or management structure, culture, policies or practices, or ‘changes behaviour’ at the point of service. The supposition is that for social accountability in maternal health services to work, women need to express their concerns and have channels to provide feedback, and providers need to be open to user feedback and willing and able to change practices.

Research design

The research approach used in this thesis was the Interactive Learning and Action approach, as social accountability in maternal health services is a complex social phenomenon occurring in the interface between the community and the health services. The research was carried out at two sites deliberately selected as cases in two provinces in rural DRC. The study population included people involved in the social accountability process in maternal health services specifically; community members and health providers mainly selected using a purposive sampling strategy. Both qualitative and quantitative data collection approaches were used, such as documentary review, non-participative observations, semi-structured interviews, focus group discussions and structured interviews with questionnaires.

Semi-structured interviews and focus group discussions were transcribed verbatim in Lingala, one of main local languages, translated into French and checked by research team members. Observations were transcribed in notes. Both the observation notes and the transcripts were processed and coded using Atlas-ti 7 software. Deductive and inductive, thematic and content analysis approaches of data analysis were applied. Quantitative data from the household survey were recorded using Epi Info 7, and statistical analyses were performed using SPSS 23.0. The data were summarized using proportions for categorical variables and means with standard deviations for quantitative variables. The association between categorical variables was tested using Pearson’s or likelihood-ratio chi-square test as well as Fisher’s exact test when appropriate. Proportions and means were compared using the chi-square test and Student’s t-test, respectively. Whenever a quantitative variable was not normally distributed, the median was used for summarizing the data, and a non-parametric test was used to compare the medians. A logistic prediction model was prepared using the backward procedure in order to identify factors associated with the dependent phenomenon. Independent variables included
socio-demographic, health and health service characteristics. The statistical significance was fixed at p=0.05. Data from the documentary review were processed and analysed with regard to their qualitative or quantitative nature according to the procedures described above. All participants provided informed consent prior to participation, and the thesis adhered to ethical principles according to Helsinki Declaration II.

The research process was roughly divided into four phases, the product of one phase serving as the input for the following phase. The four phases were: initiation and preparation; collection, exchange and integration; priority setting and planning; and project formulation and implementation. Following this process, the research was divided into two parts. The first part of the thesis, chapters 4 to 7, addresses the question of contexts, of existing social accountability mechanisms and of how women in the two research sites express their concerns about health services. The second part of the thesis addresses the question of what are the effects of social accountability in relation to health services responsiveness, considering the challenges raised in the first part.

**Existing situation of social accountability mechanisms in the rural DRC health zones**

Chapter 4 presents a multiple case study conducted to explore the context at the two sites and to analyse its influence on the operation of a social accountability mechanism. In Chapter 5, we explore how the concerns, expectations, questions and complaints of women are expressed and taken into account in maternal health provision in the two DRC rural health zones. The third study, reported in Chapter 6, examines using mixed methods to find additional factors that could influence the capacity of women to express their concerns about maternal health services, and Chapter 7 is a multiple case study that reflected on how the health committee, as the preeminent existing social accountability mechanism, functioned in regard to its role in social accountability.

The main findings regarding the existing situation of social accountability are presented according to the three core components of a social accountability mechanism. The first part of the thesis showed that voice mechanisms did not work in the DRC rural health zones and
that women in these locations did not complain about the healthcare provided, nor were they used to raising their concerns, complaints and expectations about the health services. This reluctance was related to the fear of reprisal and victimization due to power relations as they were not sure about the response of health providers to their action. Women also lacked knowledge about the available mechanisms for reporting concerns that guarantee anonymity and no reprisal, and have insufficient knowledge and information about their rights and entitlements, awareness of the health providers’ mandate and the healthcare standards.

The research also found that several contextual factors affected the individual and community levels. These contextual factors concern age-related power, cultural norms as women in these settings grew up in a culture characterized by male dominance, the social value of childbirth and social considerations of health care, or the local customs to abstain from complaining.

The research showed that the health committee mentioned by participants did not collect the community voice nor provide feedback from the health services to the community. It is more often ignored by community members, resulting in insufficient community participation with regard to social accountability. The study also showed that some interventions used in health sectors such as a performance-based financing scheme and community health insurance scheme did not constitute appropriate voice mechanisms in the context of DRC.

In terms of enforceability, it was observed that the women considered themselves unable to influence the course of the functioning of the health service or the behaviour of the health providers, as they believed that they have less knowledge than the health providers, being laypersons unable to judge how healthcare should be provided. The study also revealed that women did not envision collective actions, as community activities involving the collective expression of opinion are considered political activities, and no powerful coalition has arisen to voice concerns despite the presence of numerous community groups.

The study revealed that the local context is quite constraining and provides little support for the operation of social accountability mechanisms, and the community was not involved in exerting enforceability capabilities in a performance-based financing and community health insurance scheme, all activities being done by external actors.
Community members seemed unable to imagine health providers as responsive as the latter are perceived as more likely to get angry and scold the complaining party for direct voicing. Additionally, the study showed that the health providers did not provide community members or their representatives with information about the health facility’s performance.

This led to the conclusion that social accountability mechanisms were relatively non-functional in rural DRC and that the concerns, expectations, questions and complaints of women about the maternal health services were not formally taken into account by health providers as they were ignorant of them. This situation calls for a more appropriate social accountability mechanism that takes into account the challenges met in DRC rural health zones.

**Design, implementation and effects of a social accountability intervention**

The second part of the thesis addresses the question of what are the effects of social accountability in relation to health services responsiveness, considering the challenges raised in the first part. Chapter 8 describes a social accountability intervention. It was a participatory research study that reported on the process implemented in order to develop a social accountability initiative that might deal with all of the contextual challenges raised while answering the first sub-question. In this study, the Dialogue Model was applied to carry out an advisory process involving the beneficiaries, representatives of the health sector and local authorities in the two health zones. Chapter 9 describes the implementation and the evaluation of the experiment suggested by the participants in Chapter 8, using a community quasi-experimental study design, comprising a partial realist evaluation.

To address the challenge raised above with regard to social accountability, participants in the Dialogue Model suggested a social accountability experiment integrating six components: (i) involve community health workers and the health committee in collecting, transmitting and discussing community concerns about health services (voice); (ii) build the capacity of the community in terms of knowledge and information; (iii) involve community leaders through dialogue meetings with the health committee and health providers; (iv) discuss
with the health providers their attitude towards voice and the management of voice at the health facility level; (v) involve the health service supervisors in supporting community participation activities; and (vi) use other existing interventions, like a performance-based financing and community health insurance scheme. This experiment was implemented as a pilot intervention lasting 12 months.

Its evaluation showed that community health workers had collected a variety of community concerns ranging from individual health problems to health services problems, suggesting an increased community voice and monitoring of health services. It also showed that community health workers provided the community with health information, building community knowledge and awareness, and therefore contributing to improving their capability to detect health services problems and articulate their concerns. The collected concerns were transmitted to the health committee and discussed every month with health providers from the local health centres, who then had the opportunity to provide an explanation and set actions for dealing with community concerns, suggesting an improved answerability of the health providers. The community concerns, explanations and actions suggested were reported in the minutes of the meetings and transmitted to the health zone management team.

The improvement of the answerability of the health providers suggested an improvement in the community enforceability capacity which could be explained by the experimental setting, which combined the training of health providers to understand the role and mission of the health committee and that of health committee members in clear interface activities and with the support of other local stakeholders. The study also documented some changes implemented in health services related to concerns raised by community members, suggesting an improvement of the responsiveness of health providers to community concerns. The mechanisms triggered by this initiative for the facilitation of voice included the trust relationship among community members and community health workers and the health committee used as intermediaries, which gave confidence to the women and anchored community protection and support. The mechanisms triggered by this initiative for the facilitation of the health providers’ answerability or health providers’ responsiveness included the perception of the legitimacy of the health committee, financial incentives, social pressure and administrative accountability.
The experiment implemented a social accountability initiative and contributed to modifying the existing power relations between health provider and users. Five contextual conditions were found to be important: the existence of local community health workers and a health committee in place, known by the community, trained in their formal role, enacted in the national health policy, and the situation in which the health services are mainly funded through users' fees and supervised by a health zone management team.

**Discussion and conclusion**

In Chapter 10, the findings and lessons learned are discussed. Research findings supported the hypothesis of this study and showed that for social accountability in maternal health services to work, women need to express their concerns and have channels to provide feedback, and providers need to be open to user feedback and willing and able to change their practices. It also showed that community participation as currently practised has to be enhanced in order to improve the social accountability of health service providers. Specifically, the findings revealed that a social accountability initiative based on empowered community health workers and a strengthened health committee, associated with the training of health providers and the involvement of intermediaries, has the potential to increase the voice of the community, to improve the enforceability and to trigger the health providers’ answerability. The result contributes to improving the responsiveness and performance of health providers.

These findings suggest the need to reorganize and strengthen the current community participation process, e.g. community-centred activities, to facilitate indirect voice mechanisms, to coordinate a social accountability initiative by combining several components, and the importance of involving the health providers in the process.

Further research should examine the effect of the social accountability due to improved community participation on improving the health service uptake, health literacy and empowerment of the community members.
Samenvatting
**Introductie**

De Democratische Republiek Congo (DRC), een naoorlogse en fragiele staat in Centraal Afrika, wordt geconfronteerd met hoge maternale sterfte. Strategieën om maternale sterfte te verminderen benadrukken met klem dat gezondheidszorgdiensten voor moeders meer gebruikt moeten worden. Sociale verantwoordingsmechanismen (Social accountability mechanisms) worden tegenwoordig gepromoot als een aanvullende strategie voor het verbeteren van de responsiviteit van gezondheidszorgdiensten, om het gebruik van deze gezondheidszorgdiensten aan te moedigen, ondanks dat er weinig bewijs is over de effectiviteit ervan. Het onderzoek van dit proefschrift is gedaan met als doel meer inzicht te krijgen in, of en hoe sociale verantwoordingsmechanismen de responsiviteit en prestaties van maternale gezondheidszorg in DRC te verhogen, om zo bij te dragen aan beleid op het gebied van sociale verantwoording in de maternale gezondheidszorg. Deze studie geeft antwoord op de volgende hoofdonderzoeksvraag:

*Hoe kunnen sociale verantwoordingsmechanismen de responsiviteit verhogen en prestaties verbeteren van de maternale gezondheidszorg?*

Dit onderzoek maakt gebruik van het Social accountability framework van Baez-Canargo en Jacobs om de sociale *verantwoordingsmechanismen* in de gezondheidszorgdiensten voor moeders te onderzoeken. In dit kader wordt ‘sociale verantwoording’ beschreven als een aantal mechanismen, datde gebruiker in staat stelt om zijn of haar zorgen te uiten over de gezondheidszorgdiensten en om zorgverleners verantwoordelijk te houden voor hun acties en beslissingen in zorgvoorzieningen. Daarbij helpt het zorgverleners om rekening te houden met de behoeften en verwachtingen van gebruikers van zorg. Volgens dit kader zijn tenminste drie concepten betrokken: stem (voice), afdwingbaarheid (enforceability) en verantwoording (answerability).

Het concept ‘stem’ omvat de mechanismen, formeel en informeel, waardoor mensen individueel of collectief hun zorgen en verwachtingen kunnen uiten aan zorgverleners om verantwoording van zorgverleners te vragen. Het concept ‘afdwingbaarheid’ omvat de middelen die beschikbaar zijn om strafmaatregelen te treffen voor het niet naleven, overtreden of het op niet passende wijze vervullen van zorgverplichtingen. Het gaat over de mogelijkheid
Samenvatting

om zorgverleners sancties of andere consequenties op te leggen, wanneer zij geen gehoor geven aan deaansprakelijkheidsclaims.

Het concept ‘verantwoording’ betekent de verplichting van de machthebbenden om informatie en rechtvaardiging te geven over hun acties, en het recht van de mensen om een antwoord te krijgen, waaronder feedback processen en responsiviteit. ‘Responsiviteit’ wordt gedefinieerd als de mate waarin zorgverleners ‘ontvankelijk’ zijn voor de ideeën en zorgen van burgers én met welke intenties de zorgverleners daadwerkelijk ‘veranderingen implementeren’ in het besluitvormingsproces of managementstructuur, cultuur, beleid of praktijk, of ‘gedragsveranderingen’ ten aanzien van zorg. De veronderstelling vangoede sociale verantwoording in maternale gezondheidszorg is dat moeders hun zorgen kunnen uiten en kanalen hebben om feedback te geven aan zorgverleners. Daarbij moeten zorgverleners openstaan voor de feedback van de gebruikers en in staat zijn om aan de hand daarvan veranderingen in de praktijk te brengen.

Onderzoeksdesign

In dit proefschrift is de Interactive Learning and Action approach gebruikt, omdat sociale verantwoording in de maternale zorg een complex sociaal fenomeen is dat optreedt in de interface tussen de gemeenschap en de gezondheidszorg. Dit onderzoek is uitgevoerd op twee locaties. Er is bewust gekozen voor twee gezondheidszones in ruraal DRC. De onderzoekspopulatie bestaat uit mensen die betrokken zijn in het proces van sociale verantwoording in de maternale gezondheidszorg. Leden van de gemeenschap en zorgverleners werden geselecteerd aan de hand van een doelgerichte selectiestrategie. Zowel kwalitatieve als kwantitatieve dataverzameling methoden werden gebruikt, zoals bestuderen van documenten, niet-participatieve observaties, semigestructureerde interviews, focusgroepdiscussies en gestructureerde interviews met vragenlijsten.


305
Samenvatting

Deductieve en inductieve analyses werden toegepast. Kwantitatieve gegevens van de huishoudelijke enquêtes werden opgenomen met Epi Info 7, en statistische data-analyses werden gedaan met SPSS 23.0. Categorische data werd beschreven door middel van proporties; continue data door middel van gemiddelden en standaarddeviaties. Associaties tussen categorische variabelen werden getest met Pearsons of ‘likelihood-ratio’ chi-kwadraattoetsen en, indien nodig, Fishers exact toetsen. Proporties en gemiddelden werden vergeleken met respectievelijk chi-kwadraattoetsen en Students t-tests. Wanneer een kwantitatieve variabele niet normaal was verdeeld, dan werd de mediaan gebruikt voor het samenvatten van de data. Een non-parametrische test werd gebruikt om de medianen te vergelijken. Een logistiek voorspellingsmodel werd gebruikt met een omgekeerde procedure om factoren te identificeren geassocieerd met de afhankelijke variabele. Onafhankelijke variabelen waren onder andere sociaal demografisch karakteristieken, karakteristieken van gezondheid en gezondheidszorg. De statistische significatie was \( p=0.05 \). Alle deelnemers gaven ‘informed consent’ voordat ze meededen aan het onderzoek. Het proefschrift is goedgekeurd volgens de ethische principes van de Helsinki Declaration II.

Het onderzoeksproces werd in vier fasen verdeeld, het product van elke fase werd gebruikt als input voor de volgende fase. De vier fasen waren: initiatie en voorbereiding; dataverzameling, uitwisseling en integratie; prioriteiten stellen en plannen, en project formulering en implementatie. Na dit proces werd het onderzoek opgedeeld in twee delen. Het eerste deel van dit proefschrift, hoofdstuk 4 tot en met 7, gaat over de context van bestaand sociale verantwoordingsmechanismen en over hoe vrouwen in beide onderzoekslocaties hun zorgen over de gezondheidszorg uiten. Het tweede deel van dit proefschrift gaat over de vraag wat de effecten van sociale verantwoording zijn in relatie tot de responsiviteit van de gezondheidszorg, in het licht van de uitdagingen uit het eerste deel.

**Bestaande situatie van sociale verantwoordingsmechanismen in twee onderzoekslocaties**

Hoofdstuk 4 beschrijft een meervoudige casusstudie die is uitgevoerd om de context van de beide onderzoekslocaties te verkennen en om de invloed daarvan op de werking van de sociale verantwoording te analyseren. In hoofdstuk 5 wordt uiteengezet hoe de zorgen,
Samenvatting

verwachtingen, vragen en klachten van vrouwen worden geuit en hoe de maternale zorg van beide rurale gezondheidszones in DRC hier rekening meehouden. De derde studie, beschreven in hoofdstuk 6, onderzoekt aan de hand van mixed-methods aanvullende factoren die de mogelijkheden van vrouwen om hun zorgen te uiten over de maternale zorg kan beïnvloeden. Hoofdstuk 7 is een meervoudige casusstudie, waarin wordt gereflecteerd op hoe het lokale gezondheidscomité, als bestaand sociaal verantwoordingsmechanisme, werkt in het kader van haar functie in sociale verantwoording.

De resultaten met betrekking tot de bestaande situatie van sociale verantwoording zijn beschreven volgens de drie concepten van sociale verantwoording. Het eerste deel van dit proefschrift toont aan dat de stemmechanismen in beide gezondheidszones in DRC niet werkten. Ook blijkt dat vrouwen in beide zones niet klaagden over hun zorg, noch gewend waren om hun zorgen te uiten of te klagen, noch om hun verwachtingen over de zorg aan te geven. Deze terughoudendheid was gerelateerd aan angst voor vergelding en represailles vanwege bestaande machtsverhoudingen, omdat vrouwen niet wisten hoe de zorgverleners zouden reageren. Daarnaast hadden vrouwen weinig kennis over beschikbare mechanismen die anonimiteit garanderen; zonder vergelding. Bovendien hadden vrouwen onvoldoende kennis over hun rechten, over het mandaat van zorgverleners en over zorgstandaarden. Uit dit onderzoek blijkt dat meerdere contextuele factoren op individueel- en op gemeenschapsniveau invloed uitoefenen. Deze contextuele factoren betreffen leeftijdsgestage, culturele normen (vrouwen groeien op in een cultuur waar mannen dominant zijn), de sociale waarde van geboorte en sociale overwegingen met betrekking tot de gezondheidszorg en het lokale gebruik om niet te klagen.

Dit onderzoek laat zien dat het gezondheidscomité, volgens de deelnemers, niet bezig was met het verzamelen van de ‘stem’ van de gemeenschap of feedback te geven aan de zorgverleners. Vaker nog werd dit door de gemeenschap genegeerd, wat resulteerde in onvoldoende gemeenschapsparticipatie met betrekking tot sociale verantwoording. Daarnaast toont deze studie dat sommige interventies die werden gebruikt in de gezondheidssector, zoals een financieringsschema gebaseerd op prestatie of gemeenschappelijke zorgverzekeringsschema’s niet de bijdragen aan geschikte ‘stem’-mechanismen in de context van DRC.
Samenvatting

In termen van ‘afdwingbaarheid’ werd opgemerkt dat vrouwen zichzelf niet in staat achten om invloed uit te oefenen op de kwaliteit van zorg of het gedrag van de zorgverleners. Dit komt omdat ze geloven dat wanneer ze minder kennis hebben dan de zorgverleners, ze niet kunnen oordelen over hoe zorg gegeven zou moeten worden. Uit deze studie bleek ook zij geen collectieve acties voor ogen hadden, omdat gemeenschapsactiviteiten die gaan over het uiten van meningen worden gezien als politieke activiteiten, en er zijn geen krachtige coalities ontstaan om zorgen te uiten, ondanks de aanwezigheid van meerdere gemeenschapsgroepen. Deze studie liet zien dat de lokale context vrij beperkend is en weinig ondersteuning biedt voor de werking van sociale verantwoordingsmechanismen. Ook bleek de gemeenschap niet betrokken te worden bij het afdwingen van op prestaties gebaseerde financieringschema's of gemeenschappelijke zorgverzekeringsschema's. Dit werd alleen gedaan door activiteiten van externe actoren. Leden van de gemeenschap leken niet in staat om zorgverleners te zien als ontvankelijk. Ze verwachten eerder dat zorgverleners boos zouden worden en hun zouden uitschelden voor het uiten van hun ‘stem’. Daarnaast toonde deze studie dat zorgverleners geen informatie aan de leden van de gemeenschap of hun vertegenwoordigers gaven over de prestaties van de gezondheidszorginstelling. Op basis hiervan kan geconcludeerd worden dat sociale verantwoordingsmechanismen relatief gezien niet functioneel waren in rurale DRCen dat zorgen, verwachtingen, vragen en klachten van vrouwen over de maternale gezondheidszorg formeel niet door zorgverleners in overweging werden genomen, omdat zij zich daar niet bewust van waren. Deze situatie vraagt om meer passende sociale verantwoordingsmechanismen, die rekening houden met de uitdagingen van rurale gezondheidszones in DRC.

Ontwerp, implementatie en effecten van een sociale verantwoordingsinterventie

Het tweede deel van dit proefschrift richt zich op de vraag wat de effecten van een sociale verantwoording zijn in relatie tot de responsiviteit van de gezondheidszorg, in het licht van de uitdagingen uit het eerste deel van dit proefschrift. Hoofdstuk 8 beschrijft de sociale verantwoordingsinterventie. Dit was een participatieve onderzoeksstudie die het
implementatieproces van een te ontwikkelensociaal verantwoordingsinitiatief beschrijft dat zou kunnen dealen met alle contextuele uitdagingen, die aan de orde kwamen in het eerste deel. In deze studie is het Dialoogmodel toegepast om een adviesproces uit te voeren, waarbij zorgontvangers, vertegenwoordigers van de gezondheidszorgsector en lokale autoriteiten in de twee onderzoekslocaties werden betrokken. Hoofdstuk 9 beschrijft de implementatie en evaluatie van de interventie die door de deelnemers in hoofdstuk 8 wordt voorgesteld, door gebruik te maken van een gemeenschaps-quasi-experimenteel studiesdesign, met een partierel realistische evaluatie.

Om de uitdagingen die hiervoor zijn beschreven in het kader van sociale verantwoording te adresseren, stelden de deelnemers in het Dialoogmodel voor om een experiment uit te voeren, waarin de volgende 6 componenten zijn geïntegreerd: (i) betrek de gemeenschapswerkers en het gezondheidscomité bij het verzamelen van, overdragen aan en discussiëren over gemeenschappelijke zorgen met betrekking tot de zorgverlening ('stem'); (ii) versterk de capaciteit van de gemeenschap in termen van kennis en informatie; (iii) betrek gemeenschapsleiders door diaologsessies met het gezondheidscomité en zorgverleners te houden; (iv) bespreek met zorgverleners hun houding ten aanzien van de ‘stem’ en het management van de ‘stem’ op zorginstellingsniveau; (v) betrek de leidinggevenden bij het ondersteunen van activiteiten in het kader van gemeenschapsparticipatie; en (vi) maak gebruik van andere bestaande interventies, zoals de op prestaties gebaseerde financieringsschema’s of gemeenschappelijke zorgverzekeringsschema’s. Dit experiment is geïmplementeerd als een pilot interventie gedurende 12 maanden.

De evaluatie van het experiment toont aan dat de gezondheidswerkers een verscheidenheid aan zorgen van de gemeenschap hadden verzameld, variërend van individuele gezondheidsproblemen tot problemen van de gezondheidsdienst. Dit suggereert een toegenomen ‘stem’ van de gemeenschap en het beter monitoren van de gezondheidszorg door hen. Het toont ook aan dat gezondheidswerkers de gemeenschap informatie over gezondheid gaven en bijdragen aan kennis en bewustzijn binnen de gemeenschap en eveneens bijdragen aan het verbeteren van de bewustzijn van de zorgverleners. Dit experiment is geïmplementeerd als een pilot interventie gedurende 12 maanden.
om uitleg te geven en acties in gang te zetten. Dit suggereerde een verbeterde 'verantwoording' van de zorgverleners. De zorgen van de gemeenschap, de verklaringen en voorgestelde acties werden opgeschreven in de notulen van de bijeenkomsten en overgedragen aan het managementteam van de gezondheidszone.

De verbeterde 'verantwoording' van de zorgverleners suggereerde een verbeterde capaciteit van de gemeenschap in 'afdwingbaarheid'. Dit zou toegeschreven kunnen worden aan de experimentele setting, die training voor zorgverleners en leden van het gezondheidscomitécombineerde om de rol en missie van het gezondheidscomité beter te leren kennen. Dit gebeurde met duidelijke interfacete activiteiten en met de ondersteuning van andere lokale stakeholders. De studie observeerde ook veranderingen in de gezondheidszorg die werden geïmplementeerd op basis van zorgen van de leden van de gemeenschap. Dit suggereert een verbeterde 'ontvankelijkheid' van zorgverleners voor de zorgen van de gemeenschap. The mechanismen die door dit initiatief werden getriggerd voor het mogelijk maken van de 'stem', waren een vertrouwensrelatie tussen leden van de gemeenschap en de gemeenschapswerkers, met het gezondheidscomité als intermediaire. Dit gaf de vrouwen vertrouwen en verankerde bescherming en ondersteuning van de gemeenschap. De mechanismen die door dit initiatief werden getriggerd voor het faciliteren van de 'verantwoording' en 'ontvankelijkheid' van zorgverleners waren: de perceptie van de legitimiteit van het gezondheidscomité, financiële vergoedingen, sociale druk en administratieve verantwoording. Het experiment heeft een sociaal verantwoordingsinitiatief geïmplementeerd en bijgedragen en het veranderen van bestaande machtsverhoudingen tussen zorgverleners en gebruikers. Vijf contextuele condities waren daarbij van belang: het bestaan van lokale gemeenschapswerkers en een gezondheidscomité, diebekend zijnbij de gemeenschap, die getraind zijnin hun formele rol, die ingebed zijn in landelijk beleid, een situatie waarin de zorg hoofdzakelijk wordt gefinancierd door gebruikersvergoedingen en gecontroleerd wordt door een managementteam van de gezondheidszone.

Discussie en conclusie

In hoofdstuk 10 worden de resultaten en geleerde lessen van deze studie bediscussieerd. De resultaten ondersteunen de hypothese en laten zien dat voor het slagen sociale
verantwoording in maternale zorg, vrouwen hun zorgen moeten uiten en kanalen moeten hebben om feedback te geven. Daarnaast moeten zorgverleners open staan voor de feedback van de zorggebruikers en bereid zijn om op basis daarvan veranderingen in hun werkwijze aan te brengen. Tevens lieten de resultaten zien dat gemeenschapsparticipatie in haar huidige vorm versterkt moet worden om zo de sociale verantwoording van zorgverleners te verbeteren. Bovendien lieten de resultaten zien dat een sociaal verantwoordingsinitiatief, in potentie de ‘stem’ van de gemeenschap kan versterken, de ‘afdwingbaarheid’ kan verbeteren en de ‘verantwoording’ van de zorgverleners kan aanpakken. Het resultaat draagt bij aan een verbeterde ontvankelijkheid en prestatie van de zorgverleners.

Deze bevindingen suggereren de noodzaak om het huidige gemeenschapsparticipatieproces te reorganiseren en te versterken, bijvoorbeeld door het organiseren van gemeenschapsactiviteiten om indirecte ‘stem’ mechanismen te faciliteren, of door het coördineren van een sociaal verantwoordingsinitiatief waarin meerdere componenten worden gecombineerd en waarin zorgverleners in het proces worden betrokken. Toekomstig onderzoek zou gericht moeten zijn op het onderzoeken van de effecten van sociale verantwoording (door toegenomen gemeenschapsparticipatie) op het verbeteren van de zorgopnamen, gezondheidsvaardigheden en dekracht van de gemeenschap.
Résumé
Introduction

La République Démocratique du Congo (RDC), pays classé parmi les états fragiles et en post-conflit situé en Afrique Centrale est confrontée comme plusieurs pays en voie de développement entre autre à une mortalité maternelle élevée. Les stratégies actuelles utilisées pour réduire ce problème de santé publique faisant partie de l’agenda des objectifs de développement durable se basent sur l’augmentation de l’utilisation de services de santé maternelle. Cependant l’utilisation des services est influencée par plusieurs facteurs parmi lesquels l’offre de soins et services basés sur les besoins et les attentes des utilisateurs et fournis par les prestataires dans le respect des relations interpersonnels. Les services de santé sont appelés à offrir les soins et services qui rencontrent la satisfaction des usages car basés sur leur besoins et attentes. La redevabilité sociale a été depuis une décennie en promotion comme une stratégie additionnelle pour améliorer la réactivité de service de santé, dans le but d’encourager l’utilisation de services de santé maternelle bien que peu d’évidence existe sur son efficacité. La recherche ayant conduit à cette thèse a été initiée avec comme objectif de déterminer l’efficacité des mécanismes de redevabilité sociale à améliorer la réactivité et les performances de services de santé maternelle en RDC et leurs mécanismes d’action, dans le but de contribuer à la formulation des politiques impliquant la redevabilité sociale en santé maternelle. L’étude a été initiée pour répondre à la principale question de recherche suivante :

Comment les mécanismes de redevabilité sociale peuvent-ils augmenter la réactivité et la performance de services de santé maternelle ?

Pour étudier la redevabilité sociale dans les services de santé maternelle, le modèle de redevabilité sociale proposé par Baez-Camargo et Jacobs a été utilisé. Ce modèle décrit la redevabilité sociale comme un ensemble de mécanismes qui facilitent et permettent aux utilisateurs de services de faire savoir leurs préoccupations concernant les services et soins reçus aux prestataires et de tenir ces derniers redevables pour les décisions prises et actions posées en relation avec l’offre de soins. La redevabilité sociale vise également à permettre aux prestataires de services de prendre en compte les besoins et les attentes des utilisateurs lorsqu’ils offrent les services. Le modèle de redevabilité sociale de Baez-Camargo et Jacobs décrit la redevabilité sociale comme un processus ayant au moins trois composantes : la voix, la justification ou la réponse et la capacité de sanctionner. La voix inclut tous les
Résumé

mécanismes formels comme informels, au travers desquels la population, individuellement ou collectivement, exprime ses préoccupations et attentes et demande la redevabilité des prestataires de services ou d’autres détenteurs de pouvoir. La capacité de sanctionner comprend les moyens disponibles à la population ou leurs mandataires pour sanctionner la non adhésion au mandat accordé, les mauvaises actions ou tout manquement au mandat accordé ou encore toute réalisation inappropriée de services. Elle englobe aussi la possibilité de pénalités ou d’autres conséquences en cas de défaillance pour répondre aux demandes de redevabilité. La justification ou réponse réfère à l’obligation pour les détenteurs de pouvoir, ici les prestataires de service, de fournir les informations et de justifier leurs actions et décisions (rendre compte) et pour la population le droit de demander et recevoir cette justification ou réponse. La justification ou réponse induit aussi le processus de feedback (rétroaction) et la réactivité. La réactivité a été définie comme la mesure dans laquelle les prestataires de services montrent leur réceptivité par rapport aux idées et préoccupations soulevées par la population et/ou dans laquelle ils tendent ou mettent en œuvre des modifications dans leurs actions, décisions, gestion de services, culture, politique, pratique ou comportement en rapport avec les services. L’hypothèse dans cette recherche est que pour que la redevabilité sociale en santé maternelle fonctionne et influence la performance et la réactivité des prestataires, les femmes doivent exprimer leurs préoccupations, attentes et besoins et elles doivent avoir des canaux le faire d’une part et de l’autre part, les prestataires doivent être ouverts aux feedbacks des utilisatrices et avoir la volonté et la capacité de changer leurs pratiques.

Matériels et méthodes

La recherche dont est issue cette thèse de doctorat a utilisé l’approche d’apprentissage et d’action interactifs comme l’approche de recherche du fait que la redevabilité sociale dans les services de santé maternelle est un phénomène social complexe survenant dans l’interface entre la communauté et les services de santé. La recherche a été menée dans deux sites sélectionnés de manière raisonnée comme cas dans la partie rurale de deux provinces de la République Démocratique du Congo. La population d’étude a inclus les personnes habituellement impliquées dans le processus de redevabilité sociale dans les services de santé maternelle, notamment les membres de la communauté et les prestataires de soins. Ces participants ont été principalement sélectionnés par choix raisonnée. Les techniques de
collecte de données qualitatives aussi bien que quantitatives ont été utilisées lors de l’étude incluant la revue documentaire, l’observation non participative, l’interview semi-structurée, la discussion de groupe focalisée et l’entretien structurée avec questionnaire.

Les interviews semi-structurées et les discussions de groupe focalisées ont été transcrites en Lingala, une langue nationale de la RDC, respectant les verbatim en Lingala, traduites en Français et vérifiées par les membres de l’équipe de recherche. Les données d’observation ont également été transrites en notes d’observation. Ces transcrits ont été traités et codifiés en utilisant le logiciel Atlas-ti 7 sur base de guide de codification pré-élaboré. Les approches déductive et inductive, thématique aussi bien que du contenu d’analyse de données ont été utilisées dans cette recherche. Les données quantitatives provenant de l’enquête des ménages ont été codifiées, enregistrées à l’aide du logiciel Epi Info 7 et les analyses statistiques ont été réalisées sur SPSS 23.0. Les données ont été résumées sous forme de proportions pour les variables catégorielles et sous forme de moyenne avec écart-type pour les variables numériques. L’association entre les variables catégorielles a été testée à l’aide de Chi-carré de Pearson ou de ratio de vraisemblance aussi bien que le test exact de Fisher selon le cas. Les proportions et les moyennes ont été comparées en utilisant respectivement le test de Chi-carré et le test t de Student. Lorsqu’une variable quantitative n’était pas normalement distribuée, la médiane a été utilisée pour résumer les données et un test non paramétrique a été utilisé pour comparer les médianes. Un modèle de régression logistique utilisant l’approche descendante pas-à-pas a été utilisé pour identifier les facteurs associés à un phénomène dépendant. Les variables indépendantes incluaient les caractéristiques socio-démographiques, les caractéristiques de santé et les caractéristiques de services de santé. Le seuil de signification statistique était fixé à p=0,05. Les données de la revue documentaire étaient traitées et analysées selon leur nature qualitative ou quantitative en utilisant les procédures ci-dessus décrites. Tous les participants ont donné leur consentement éclairé avant de participer aux études et la recherche dont est issue cette thèse a adhéré à tous les principes éthiques recommandés par la Déclaration d’Helsinki II.

Le processus de recherche a été divisé en quatre phases, le produit d’une phase servant de ressources pour la phase suivante. Les quatre phases étaient les suivantes: l’initiation et préparation ; collecte, échange et intégration ; priorisation, planification et formulation du projet et l’implémentation. En fonction de ce processus, la recherche a été scindée en deux
Résumé

parties. La première partie de cette thèse, du chapitre 4 au 7, a exploré le contexte et des mécanismes de redevabilité existants notamment comment les femmes dans les sites de recherche expriment leurs préoccupations en rapport avec les services de santé maternelle. La deuxième partie de la thèse a cherché à répondre à la question en rapport avec les effets de mécanismes de redevabilité sociale en terme de performance et réactivité de services de santé maternelle, en prenant en compte les défis identifiés dans la première partie.

Résultats

Situation des mécanismes de redevabilité sociale existants dans les zones de santé rurale de la RDC

Le Chapitre 4 présente une étude de cas multiples menée pour explorer le contexte au niveau de sites de recherche et analyser l'influence de ce contexte sur le fonctionnement de mécanismes de redevabilité sociale. Dans le chapitre 5, a été exploré comment les préoccupations, les attentes, les besoins, les questions et les plaintes de femmes étaient exprimées et prises en compte dans l’offre de service de santé maternelle dans les deux zones de santé rurale de la RDC. La troisième étude, rapportée dans le Chapitre 6, a examiné en utilisant les méthodes mixtes les facteurs additionnels qui influencent la capacité de femmes à exprimer leurs préoccupations en rapport avec les services de santé maternelle et le Chapitre 7 est une étude de cas multiples qui a exploré comment le comité de santé, un mécanisme de redevabilité sociale existant mentionné par plusieurs acteurs, fonctionne en rapport avec son rôle dans la redevabilité sociale.

Les principaux résultats en rapport avec la situation des mécanismes de redevabilité sociale existant ont été présentés en suivant les trois principales composantes d’un mécanisme de redevabilité sociale. Les études ont montré que les mécanismes de la voix ne fonctionnaient pas dans les deux zones de santé rurales de la RDC et que les femmes habitant dans ce milieu ne se plaignaient pas des services de santé reçus, ni n’avaient l’habitude de soulever ses préoccupations, plaintes ou attentes en rapport avec les services de santé. Cette situation de réserve était due à la peur de représailles et de victimisation, associées aux relations de pouvoir entre les prestataires et les utilisatrices, étant donné qu’elles n’étaient pas certaines de la réponse ou de la réaction de prestataires de soins à leurs actions. Les études ont également montré que les femmes dans ce milieu manquent de connaissances en rapport avec les mécanismes de rapportage disponibles, qui garantissent l’anonymat et la non représailles,
elles ont aussi de connaissances et des informations insuffisantes en rapport avec leurs droits et avantages en rapport avec les services de santé. Elles ne sont pas au courant du mandat et obligations des prestataires de services ainsi que des standards concernant les services de santé.

Les études ont également montré que plusieurs facteurs contextuels pouvaient affecter le fonctionnement de mécanismes de redevabilité sociale. Ces facteurs concernaient les individus ou la communauté toute entière. Ces facteurs contextuels étaient en rapport avec le pouvoir lié à l’âge, les normes sociales étant donné que les femmes dans ce milieu grandissaient et vivaient dans une culture caractérisée par la dominance masculine, la valeur sociale du mariage et d’avoir des enfants, les considérations sociales en rapport avec les soins de santé ou encore les coutumes locales comme celle qui vise à réduire les plaintes et promouvoir les attentes à l’amiable. Les études ont montré que le comité de santé cité par plusieurs participants et acteurs comme mécanismes de redevabilité sociale existant ne collectaient pas la voix de la communauté ni ne rapportait à la communauté les rétroactions provenant de services de santé. Il était plus souvent ignoré de membres de la communauté, résultant à une participation communautaire insuffisante eu égard à la redevabilité sociale. Les études ont également montré que certaines interventions menées dans le secteur de la santé comme le financement basé sur les résultats et les mutuelles de santé ne constituaient pas de mécanismes appropriés pour porter la voix de la communauté dans le contexte de la RDC.

En termes de capacité de sanction, il a été observé que les femmes se considéraient elles-mêmes comme incapables d’influencer le cours ou le fonctionnement de services de santé ou le comportement des prestataires de services. Elles croyaient qu’elles avaient moins de connaissances que les prestataires de soins, étant de communs de mortels, qu’elles étaient incapables de juger comment les soins de santé devraient être offerts. Les études ont aussi révélé que les femmes n’envisageaient même pas des actions collectives, puisqu’elles voyaient que les activités communautaires sous forme d’une expression collective des opinions étaient considérées comme des activités politiques par le gouvernant et qu’il n’existait pas de coalitions assez puissantes qui puissent faire monter les préoccupations de la communauté aux prestataires de santé et autres détenteurs du pouvoir malgré la présence de plusieurs groupes communautaires.
Il est aussi ressorti des études que le contexte local était assez contraignant et ne fournissait qu’un appui limité au fonctionnement des mécanismes de redevabilité sociale, notamment par la mise en œuvre incomplète de la décentralisation, mais aussi du fait que la communauté n’étaient pas impliquée dans l’exercice de la coercition et de la sanction dans les interventions sous le financement basé sur les résultats et les mutuelles de santé, activités exécutées par des acteurs extérieurs à la communauté.

Les membres de la communauté semblaient incapables d’imaginer les prestataires de soins comme réactifs puisqu’ils les percevaient plus comme enclins à se mettre en colère et de s’emporter contre les plaignants lors d’une expression directe de la voix. En plus, il est ressorti des études que les prestataires de services ne fournissaient pas aux membres de la communauté ni à leurs représentants les informations en rapport avec la performance des services de santé.

Les résultats ci-dessus ont conduit à la conclusion que les mécanismes de redevabilité sociale étaient relativement non fonctionnels dans la partie rurale de la RDC et que les préoccupations, les attentes, les questions et les plaintes de femmes en rapport avec la performance des services de santé maternelles n’étaient pas formellement prises en compte par les prestataires, puisqu’ils les ignoraient. Cette situation a conduit à suggérer la mise en place des mécanismes de redevabilité sociale plus appropriés prenant en compte les défis identifiés et rencontrés lors de l’analyse de la situation de mécanismes de redevabilité sociales dans les zones de santé rurale de la RDC.

**Formulation, mise en œuvre et évaluation d’une intervention visant la redevabilité sociale dans les services de santé maternelle**

La seconde partie de cette thèse a porté sur les effets de mécanismes de redevabilité sociale en termes de performance et réactivité de services de santé, considérant les défis soulevées dans la première partie. Le Chapitre 8 décrit la formulation d’une intervention de redevabilité sociale. C’est une étude qui rapporte le processus de recherche participative mis en œuvre pour développer une initiative visant l’amélioration de la redevabilité sociale de services de santé maternelle qui pouvait permettre d’adresser les défis contextuels et autres rencontrés lors de l’analyse de la situation des mécanismes de redevabilité sociale en RDC. Dans cette étude, le Dialogue Model a été appliqué pour conduire un processus de consultation et d’intégration
impliquant les bénéficiaires, les représentants du secteur de la santé et les autorités sanitaires locales dans les deux zones de santé. Le Chapitre 9 décrit la mise en œuvre et l’évaluation de cette intervention suggérée par les participants dans le Chapitre 8, en utilisant un modèle d’étude quasi-expérimentale communautaire, comprenant une évaluation réaliste partielle.

Les résultats de ces études ont montré que pour adresser les défis et contraintes soulevées en rapport avec les mécanismes de redevabilité existants, les participants au Dialogue Model ont suggéré une initiative visant l’amélioration de la redevabilité sociale intégrant six composantes: (i) impliquer les relais communautaires et le comité de santé dans la collecte, la transmission et la discussion des préoccupations de la communauté en rapport avec les services de santé; (ii) renforcer les capacités de la communauté en termes de connaissance et information; (iii) impliquer les leaders communautaires par le biais de réunions de dialogue avec le comité de santé et les prestataires; (iv) discuter avec les prestataires de soins leur attitudes à l’égards de la voix et la gestion de la voix de la communauté au sein du service de santé local; (v) impliquer les superviseurs de services de santé en appui aux activités de participation communautaire; et (vi) utiliser les autres mécanismes existants, comme le financement basé sur les résultats et les mutuelles de santé. Cette initiative a été expérimentée comme intervention pilote pendant 12 mois dans les deux zones de santé.

Son évaluation préliminaire a montré que les relais communautaires avaient collectés pendant les visites aux ménages les préoccupations de la communauté comprenant une variété des problèmes allant des problèmes de santé individuels aux problèmes de services de santé, suggérant une amélioration de la voix et du suivi communautaire de services de santé. Cette évaluation a aussi montré que les relais communautaires avaient fourni à la communauté des informations de santé contribuant au renforcement de connaissance et à la sensibilisation de la communauté, contribuant ainsi à l’amélioration de la capacité de membres de la communauté à détecter les problèmes de services de santé et à exprimer leurs préoccupations. Les préoccupations collectées ont été transmises au comité de santé et discutées chaque mois avec les prestataires de soins provenant du service de santé local, qui avaient ainsi l’occasion de fournir des explications et de proposer des actions correctrices, suggérant une amélioration de la justification-réponse des prestataires. Les préoccupations de la communauté ainsi résumées, les explications et actions proposées par les prestataires ont été rapportées dans le compte-rendu de réunions du comité de santé et transmises à l’Equipe cadre de zone de santé.
Résumé

L'amélioration de la justification-réponse des prestataires suggère une augmentation de la capacité de sanction au niveau de la communauté, qui pourrait être expliqué par les ressources apportées de l'intervention, qui combinent la formation des prestataires pour comprendre le rôle et la mission de comité de santé, celle de membres du comité de santé et les relais communautaires pour comprendre leur rôle d'interface et l'appui des autres personnes détentrices d'intérêt dans la communauté locale. L'étude a documenté plusieurs changements mis en œuvre dans les services de santé, en relation avec les préoccupations soulevées par les membres de la communauté, suggérant une amélioration de la réactivité des prestataires de soins aux préoccupations de la communauté. Les mécanismes activés pour cette initiative pour faciliter la voix inclut les relations de confiance entre les membres de la communauté et les relais communautaires et les membres de comité de santé utilisés comme intermédiaires, qui ont la confiance de la femme, le tout ancré dans la protection et appui de la communauté. Les mécanismes activés par l’intervention pour faciliter la justification-réponse des prestataires à l’égard des préoccupations de la communauté incluent la perception de la légitimité du comité de santé comme représentation de la communauté, les motivations financières, la pression sociale et la redevabilité administrative.

L'intervention a permis d’expérimenter l’initiative visant à améliorer la redevabilité sociale des services de santé et les résultats de cette expérience ont suggéré qu'elle a contribué à une modification de relations de pouvoir entre les prestataires et les utilisateurs. Cinq facteurs contextuels ont été trouvés importants pour l’atteinte de ces résultats notamment l’existence de relais communautaires et du comité de santé au niveau local, connus par la communauté, formés dans leur rôle formel, comme édicté par la politique nationale de la santé, et le contexte dans lequel les services de santé sont principalement financé par le payement direct au point de service par les utilisateurs et supervisés par l’Equipe cadre de zone de santé.

Discussion et conclusion

Dans Chapitre 10, les résultats et les leçons apprises sont discutés. Les résultats produits par cette recherche permettent de supporter l’hypothèse de recherche et ont montré que la redevabilité sociale pouvait augmenter la performance et la réactivité des services de santé maternelle que lorsqu'elle permettait aux femmes d'exprimer leurs préoccupations par rapport à ces services et leur offrait des canaux pour faire leurs feedback aux services
d’une part. D’autres part, qu’elle conduisait les prestataires à être ouverts aux feedbacks des utilisatrices, à montrer les dispositions ou être capables d’introduire des changements dans leurs pratiques et comportements en fonction de ces feedbacks. La recherche a également montré que la participation communautaire comme pratiquée actuellement devrait être renforcée de manière à améliorer les aspects liés à la redevabilité sociale de services de santé dans sa réalisation. De manière spécifique, les résultats ont montré que pour améliorer la redevabilité sociale de services de santé maternelle dans le contexte de la RDC, une possibilité consiste à la capacitation de relais communautaires et au renforcement du comité de santé en tant qu’interface entre la communauté et les prestataires de santé, associés à la formation des prestataires de soins et à l’implication des intermédiaires. Une telle intervention a le potentiel d’augmenter la voix de la communauté, de renforcer la capacité de sanction de cette communauté et d’améliorer la justification-réponse des prestataires de services de santé aux préoccupations de cette communauté, étant basée sur une modification de relations de pouvoirs entre les prestataires et la communauté qu’elle induit. Une perception par un prestataire de ces modifications de relations de pouvoir induit par un mécanisme de redevabilité sociale contribue à l’amélioration de sa réactivité et de la performance. Ces résultats soulignent la nécessité de réorganiser et de renforcer la participation communautaire, en termes d’activités centrées sur la communauté, de faciliter les mécanismes de l’expression indirecte de la voix, de coordonner l’initiative de redevabilité sociale en combinant plusieurs composantes, ainsi que l’importance de l’implication des prestataires de soins dans ce processus. Ces résultats soulignent la nécessité des recherches futures pour explorer les effets de mécanismes de redevabilité sociale liés à l’amélioration de la participation communautaire sur l’utilisation de services de santé, sur la connaissance en santé ainsi que sur le renforcement de capacité de membres de la communauté.
Acknowledgements
This thesis has only been possible because of the inspiration, encouragement, support, help and patience from many others. Here, I thank those who directly or indirectly have contributed to my thesis. A few people I would like to mention by name.

First and foremost, I would like to thank my promoter, Prof. dr. Tjard de Cock Buning, and my copromoters, Dr. Marjolein Dieleman and Prof. dr. Therese Mambu Nyangi Mondo. Tjard always supported me, guiding me through the thinking and writing process. His challenging questions, reflections and advice encouraged me to be critical. I especially valued his honesty and creative and stimulating ways of thinking. Through him, I owe my gratitude to Anne-Marie, his wife, for her hospitality and for each story during the meals we shared. Marjolein has been my direct supervisor since the start of the project. I feel fortunate in having a bilingual supervisor who understood me so well; she really helped me by strengthening my capacity to deal with the many obstacles inherent in such a complex process as a PhD. I especially appreciate her timely constructive feedback even while she provided support to other colleagues. Therese was also my direct supervisor. She really supported me in building my capacity in qualitative research and smoothed the entire research process despite her current career leading the Kongo Central Provincial Ministry of Health.

I am very grateful to Prof. Patrick Kayembe who did not hesitate to support me during my work as lecturer in the Kinshasa School of Public Health by integrating me in his research team, helping to align academic activities to social responsibilities. I am very grateful to the members of my thesis committee. Their critical reading and remarks on the original manuscript have made a positive contribution.

I am grateful to all health providers, managers, community health workers and community members who participated in the studies and who helped me to understand better the reality of the relationship between community and health providers in the context of limited resources and underfunded health services. I would like to thank Sr Nadine Bolumbu, Sr Bibiane Ndilu, Louis Kiese, Drs Abanda, Luhengo and Kiyimbi, Catherine Epanzoa and Jean Claude Basile, community health workers, for their support and availability.

The studies in this thesis would not have been possible without the active collaboration of colleagues from partner organizations. Special thanks go to Dr Paul Khomba, former contact
Acknowledgements

person of Cordaid DRC team and Adolphe Malanga, Dr Zioko Francois, representative of Medicus Mundi, Berthys Indebe and his team of AAP Muanda, Henri Muwawa and his team of CGAT Mbandaka.

This research would not have been possible without the financial contribution of the NOW WOTRO programme. The call in 2012 for PhD students to research the effect of social accountability on the improvement of maternal health service performance and responsiveness gave me the prospect to conduct action research in the Democratic Republic of the Congo. I especially appreciate the programme for its willingness to move beyond understanding the relationship between social accountability and maternal health, and that it actually stimulated new types of interdisciplinary and action-oriented research to gain more insight into how to respond to the maternal health problems.

I am most grateful to my colleagues and friends from the WOTRO programme, Elsbet Lodenstein and Prosper Niyongabo. I have really enjoyed their support. My thanks extend to my fellow PhD students at the Athena Institute, Mary, Vibian, Ibukun, Roselyter, Cheick, Mukesh, with whom I shared so many joyful and formative moments.

I am grateful to Cordaid for having supported the travel expenses of Marjolein, my copromotor, and for having provided an opportunity to build the research partnerships necessary for action-oriented research.

The Athena Institute has been a safe haven for me where I found the time to write and focus on the research without the distraction of the practical and logistical aspects of the project in DRC. I thank all the staff who were very kind to me every time I came from abroad, allowing me to discuss my work and learn from their experience, not forgetting the RCMP and AGP courses, and my master student team members. I would like to thank Leon Essink and Lisanne Hogema, who participated as master student and intern in the study in DRC for their contribution to the research that has formed the basis of this thesis. Through the Athena Institute, I am grateful to the management of the Vrije Universiteit Amsterdam, which hosted my PhD programme and supported my progress. Working in this university provided me with an inspiring atmosphere and encouraged me to innovate in research, teaching and community services.
My grateful appreciation to KNET Africa that supported with research dissemination and knowledge translation activities and helped me to involve policymakers, users, and community members. I am grateful to Suzanne, Angela, and David. I have really enjoyed their support. My colleagues and the management of the Kinshasa School of Public Health have also contributed to this work, and through them, I am grateful to all of the professors of the Kinshasa School of Public Health who contributed to my career, and to the authorities of the Faculty of Medicine and of the University of Kinshasa.

I thank my friends and family. First, I am lucky to have friends who shared their time with me discussing my research: Paulin, Pierre, Aimée, Adèle, Steve, Francis, Alex, Nono, Ya Pelagie and Jacques. I am grateful to my father and mother, Daniel and Mathilde, to my brother Théophile and sisters Doris, and Annette. I am grateful to my Yvie. I cannot wish for a better friend and companion and for our five lovely children, Perle, Beryl, Onyx, Grace and Daniel-Eric. A word of thanks to Ruth Yala, Alain and Flore Mahamba, Goethe Makindu, Carine Dibakidi Lubenzo, Frank Boembi, Michel Disonama, Jacques and Mamie Luntezila, and their family. I appreciated your support and friendship, happy that you were ready to help me and to make my frequent travels enjoyable.

Finally, I remembered the Lord for his marvelous works and wonders that he has done for me.

Kinshasa, June 2017
About the author
On 07 May 1975, Eric Musalu Mafuta was born in Gemena in Sub Ubangi where his parents worked as researchers in a goiter research project, in the north of the Democratic Republic of the Congo. He spent his childhood in Gemena and moved in Kinshasa, the capital city in 1986, where he completed his secondary education at the College Pie XII Bonsomi in 1994. He studied medicine at the University of Kinshasa and obtained a Diploma of Medicine, surgery and midwifery in 2003 after 12 months’ internship at Clinique Bondeko in Kinshasa. After graduation, he began his career as a general practitioner in a private hospital situated in one of municipalities of Kinshasa and spent three years there in charge of maternal health. This experience was life-changing, professionally and personally.

In 2005 he made a career shift and applied for a lecturer position at the Kinshasa School of Public Health, University of Kinshasa. He was subsequently enrolled in the Master in Public Health course at the Kinshasa School of Public Health, Kinshasa, in 2006. The Kinshasa School of Public Health and the people at the Institute provided him with many opportunities in research, services to the community and teaching until 2012. He was involved in the design and conduct of studies in the field as a research assistant and then supervisor and assistant investigator, and travelled nearly everywhere in DRC. He gained experience in research in health systems management, applied research methods, health project and program management, economy of HIV-AIDS, health systems research, maternal and child health and in malaria. He worked as Program Officer for the Federation of Regional Drug Supply Centrals called FEDECAME from 2009 to 2011. He became senior lecturer on Health Systems Policy and Management in 2012. He coordinated research on the health expenditure of people living with HIV-AIDS, on the evidence-based Family Planning at Kinshasa and in the Global Early Adolescent Study, in collaboration with the School of Public Health of Tulane University and John Hopkins Bloomberg School of Public Health. He served as the focal person for Africa Hub, Health Alliance project for strengthening the capacities for health systems research of eastern and central Africa Schools of Public Health, in collaboration with John Hopkins Bloomberg School of Public Health through Future Health Systems and Makerere University School of Public Health.

In 2012, he applied for a PhD position in WOTRO Program Improving Maternal Health through Accountability Mechanisms in DRC, and from November 2012 to 2016, he joined the Athena Institute at the Vrije Universiteit Amsterdam as an international PhD student. He carried out
his research in DRC, committed to linking people from both disciplines in understanding each other and working together. Currently, he is working as a senior lecturer in Public Health at the Kinshasa School of Public Health. He is particularly interested in the application of health systems research, realist approach, and qualitative research.