Chapter 2: Theoretical perspectives

In this chapter we present the theoretical perspectives that guided our study. Maternal health inequities, as evident from Chapter 1 (Section 1.1), constitute complex problems that can be attributed to a wide range of factors operating beyond the individual bio-medical level. Successful efforts to address such disparities would require targeting the etiological factors situated at different levels of influence, which demand more understanding of these factors and the mechanisms that link them\(^1\). Clarity about these etiological factors and their mechanisms of influence will improve our understanding of the influence of social accountability mechanisms on maternal health inequities, including if and how social accountability mechanisms address them.

We therefore used two perspectives in this study to explore and analyze the influence of social accountability on maternal health: i) the social determinants of health and health inequities, to explore etiological factors of maternal health inequities and their mechanisms of influence, and ii) functional aspects of accountability and social accountability in the health sector in relation to maternal health services, to understand the influence of accountability and social accountability on the factors influencing maternal health inequities.

2.1 Social determinants of health and health inequities

The WHO Commission on Social Determinants of Health’s (CSDH) framework explains the causal processes underlying health inequities as interactions between two sets of determinants: a) structural determinants, or social determinants of health inequities; and b) intermediary determinants, or social determinants of health\(^3\). Structural determinants broadly constitute socioeconomic and political contexts and structural mechanisms that generate, configure and maintain social hierarchies in terms of differential socioeconomic positions, where populations are stratified according to class, gender, race/ethnicity, income, education, occupation and other characteristics\(^3\). The structural determinants then operate through a set of intermediary determinants, such as biological factors, behavioral factors, psychosocial circumstances, health systems, etc., to produce differential health-compromising conditions or health outcomes. The CSDH stressed that any serious effort to reduce health inequities requires clear distinctions between the two sets of determinants.

The CSDH framework also emphasizes power as a critical factor shaping social hierarchies and thus conditioning health differences among groups\(^3\). Efforts to reduce health inequities require the redistribution of power within society to the benefit of disadvantaged groups, by regaining control over the factors that determine their own health, which is achieved through their empowerment.
2.2 Accountability and social accountability in health sector

Prior to understanding the influence of accountability and social accountability on maternal health inequities, it is necessary to clarify these concepts in our study contexts. Accountability and social accountability have various definitions\textsuperscript{4–8}. We primarily use the institutionalist and collective action paradigms among the four paradigms identified by van Belle \textit{et al.}\textsuperscript{7} for accountability in the health sector; the other paradigms are rights-based and individual choice. The institutionalist paradigm aims at improving health sector performance through the use of formal procedures, rules and instruments, particularly in hierarchical organizational/institutional settings. The collective action paradigm sees accountability as a product of the collective action of citizens. Nevertheless, as the paradigms are not mutually exclusive, we also often use concepts from the rights-based paradigm. This paradigm rests on the premise that citizens delegate power and authority to public sector institutions, which in turn are accountable for the progressive realization of citizen’s rights and entitlements\textsuperscript{7}.

\textit{Accountability}

Accountability is the obligation of an individual or agency to provide information, explain and justify their conduct to other actors, along with the imposition of sanctions for non-compliance and/or inappropriate behavior and reward for good behavior\textsuperscript{9–11}. It entails two major aspects: i) answerability or the obligation to answer questions regarding decisions and/or actions, which can be of two types, i.e. simply information or description, and justifications or explanation or reasons; and ii) enforceability or the availability and application of sanctions and rewards based on actions/behaviors.

Accountability necessarily involves two parties – one that is held accountable or the \textit{accountor}, and the other who holds the other accountable or the \textit{account-holder}\textsuperscript{9}. The World Bank identifies the stakeholders of a service delivery based on their roles and responsibilities as: clients/citizens, or individual or group service users; state/politicians/policymakers, or service delivery actors authorized by the state to discharge its legislative, regulatory and rule-making responsibilities; organizational providers or public, private non-profit or private for-profit entities that actually provide service; and frontline service providers, those who come in direct contact with the clients\textsuperscript{12}. In the health sector, usually patients, communities and civil society organizations (CSOs) constitute the \textit{account-holders}, while frontline healthcare providers, organizational providers and state/politicians/policymakers constitute the \textit{accountors}.

Based on the nature of the conduct or purpose being held accountable, accountability can be financial, performance-based, political, etc.\textsuperscript{8,11}.

Public sector accountability is crucial in governance since the primary mandate to provide services to everybody, including health services, lies with the public sector. This is achieved by the delegation of authority or power to the public-sector authorities usually through political processes such as
elections and legislation. Citizens delegate authority to elected politicians or executives to carry out tasks to serve their interests and priorities on their behalf, thus making them principals and agents, respectively. The executives further delegate the authority to public officials down the chain of command. However, in this ‘principal-agent’ relationship, the citizens hold the rights (making them the right-holders) to hold the agents or duty-bearers to account for their decisions and actions. Thus, accountability in the public sector is essentially a relationship of power that involves rights on the part of the citizens and obligations on the part of the public-sector authorities. Accountability, as a part of governance, aims to prevent misuse of the delegated power by the public-sector authorities and to protect the interests of the citizens.

Social accountability

Accountability in the institutional paradigm, i.e. public sector, is generally ensured in two ways: i) horizontal accountability – mechanisms within the state with which one state actor holds the other state actor to account by internal checks and balances between different branches of government; and ii) vertical accountability – mechanisms through which non-state actors take part in holding the state actors to account. Vertical accountability is also often referred to as ‘social accountability’, ‘citizen-led accountability’, or ‘demand-side governance’. Citizen-led accountability involves citizens (including civil society organizations) engaging in exacting accountability from public sector actors such as politicians, policy-makers and service providers. The citizens may use different structures, tools, activities/processes, etc. to voice their needs, expectations and concerns and hold the public sector authorities to account for their decisions and actions. These include elections, advocacy campaigns, popular protests, citizen monitoring and evaluation of public service delivery, etc. through which citizens can participate directly or indirectly in exacting accountability of the public sector.

For social accountability, we refer first to the World Bank’s framework that offers a description on actors, relationships and routes of accountability in a public delivery system. Social accountability in the public health sector operates through two routes, according to the World Bank (Fig. 1): i) short route, as citizens can hold the healthcare providers accountable directly through client-power; and ii) long route, as citizens exercise voice over politicians, the politicians have compacts with organizational providers, and the organizations in turn manage frontline providers. Thus, in the long route, social accountability mechanisms aimed at frontline healthcare providers trigger horizontal accountability, which operates through compact and management.
Social accountability is increasingly highlighted as a promising initiative to improve the health sector’s performance\textsuperscript{4,6,12,18–22}. In maternal health, social accountability mechanisms can improve the quality of, access to and use of maternal health services\textsuperscript{6,12,18,19,21,22} by all groups of women, including the disadvantaged ones, and thus contribute to reducing maternal mortality. The mechanisms of influence or the processes by which these outcomes are achieved by social accountability interventions, however, are still unclear as the literature on social accountability often has a different focus – for example, community empowerment\textsuperscript{19}, health provider responsiveness\textsuperscript{4}, voice and accountability\textsuperscript{23}. The World Bank framework also does not clearly indicate the mechanisms of influence, particularly in terms of addressing power asymmetries between various health sector actors.

At the grassroots level, from the collective action paradigm, social accountability in maternal health is concerned with citizen action, especially by the disadvantaged groups, and health sector accountability and responsiveness. We therefore refer to the conceptual frameworks by George on confronting unequal power through information, dialogue and negotiation\textsuperscript{19}.

George explains that social accountability mechanisms specifically address issues of power asymmetries between the health sector actors and the citizens through the empowerment of the latter. This is a political process involving collective actions on the part of citizens or the disadvantaged groups. In maternal health, it normally starts with information about maternal healthcare and entitlements that enhance critical consciousness among women to make the right choices and decisions about maternal healthcare\textsuperscript{6,19,21}. The empowerment process involves individual women or groups with common interests coming together and discussing the reasons behind their deprivation and social exclusion as group(s) leading to critical consciousness\textsuperscript{6,19}. Thus, it enhances change in their
mindsets to see themselves as citizens with a right to maternal healthcare and entitlements rather than just accepting the provided health services as a kindness. The group approach also triggers a sense of agency among the women to organize for collective actions for their mutual benefit.

The sense of agency stimulates women collectively to confront better the unequal power relations with the health sector through dialogues and negotiations. Such dialogues and negotiations can change the mindsets of the health sector actors to recognize the women as entitled citizens, and therefore increase the likelihood of providers becoming receptive and responsive to their demands. The social accountability mechanisms therefore enhance transformation through the change in the mindsets of both the citizens and the health sector actors.

The overall study is conducted under the premise that social accountability interventions empower citizens to engage in and/or elicit public health sector accountability, resulting in the desired health sector responsiveness.
References


11. Brinkerhoff DW. Accountability and health systems: toward conceptual clarity and policy


