Summary

In maternal health care in low-and middle-income countries, pregnant women face difficulties in accessing maternal health services that are appropriate, affordable, respectful, of good quality and non-discriminatory. Women’s perceptions on, and experiences with, services related to childbirth are seen as equally or even more critical determinants of care-seeking behavior than commonly recognized barriers, such as cost or distance. In maternal health policies, the strengthening of women’s participation, voice and collective action in service delivery is expected to address access and quality failures in service delivery. Under the banner of ‘social accountability’, interventions are introduced and implemented that support citizens to hold governments and service providers to account for the delivery and quality of maternal health care. In these policies and interventions, however, a significant gap exists between the expectations of social accountability and the empirical evidence of how social accountability is understood, what difference it makes, for whom and under what circumstances.

This thesis aims to increase the understanding of the ways in which service users, citizens and community structures in low-and middle-income countries call health providers to account at the frontline of maternal health service delivery. The thesis aims to contribute to:

• A deeper understanding of the type of actors and processes involved in social accountability initiatives at the local level in maternal health care.
• A deeper understanding of the context of local accountability relations including norms of responsibility, gender and power, and the influence of global and national maternal health policies on local accountability relations.
• The provision of an overview of the features, strategies and outcomes of social accountability initiatives and a deeper understanding of the types of changes social accountability initiatives can generate in health provider practices.
• The development of hypotheses about how social accountability can generate change, for whom and under which circumstances.

In this thesis, social accountability is operationalized as a relationship between an actor (health provider) and a forum (citizens or community structures), in which the actor has an obligation to explain and to justify his or her conduct, the forum can pose questions and pass judgment, and the actor may face consequences. Accountability is inherently about the retrospective evaluation (by the forum) of behavior, decisions or
actions (by the actor) and often concerns instances of poor performance where the actor fails to meet standards and obligations.

The studies in this thesis describe and analyse the interactions between three main groups: health providers (especially the doctors, nurses, health assistants and other professionals who provide maternal health care), citizens (individuals, women and men, users of maternal health services), and community structures that represent citizens in different forms (health facility committees, local governments, traditional authorities, civil society organisations).

The central research question is:

*How can we understand social accountability relations in their context at the frontline of maternal health service provision in sub-Saharan Africa and how can they contribute to improved responsiveness of maternal health services?*

In order to respond to this question, a combination of methods was used: empirical research (chapters 4-7), and a realist review of the literature with a theory-building objective (chapters 8-9). A qualitative research approach was adopted across the studies, allowing for the exploration of the complexity of social accountability processes, their relation to the context, and the diversity of perceptions, experiences and meanings of citizens and health providers on their interactions. The empirical research was conducted in Malawi, Benin, Guinea and the Democratic Republic of Congo while the realist review focused on low-and middle-income countries.

The research was implemented between 2012 and 2017 in collaboration with local NGOs, development partners, health authorities and universities in the Netherlands and in the four countries mentioned above. All empirical study protocols were approved by national research councils or university ethical review boards in these countries. Throughout the research, measures were implemented to protect the confidentiality of information collected from study participants. In the chapters, the participants are not identifiable.

The research findings are presented in three parts that cover, respectively 1) local social accountability relations and practices in Malawi, Benin, Guinea and the Democratic Republic of Congo; 2) the accountability context; and, 3) health provider responsiveness to social accountability initiatives.

**Part 1. Local social accountability relations and practices (chapters 4-6)**

This part looks at informal and formal accountability relations and the role of Health Facility Committees (HFC) as facilitators of social accountability.

Chapter 4 aims to respond to the question: *What is the role of informal social accountability relations in monitoring and promoting responsive maternal health services?* It
is based on a study in Northern Malawi that analyses maternal health care workers’ experiences with citizen feedback on their performance. Data from semi-structured interviews with 32 nurses and 19 clinicians, allowed the identification of four main strategies citizens use to express their opinion and concerns about maternal health services. They include direct expressions of appreciation; indirect expression of complaints (such as on absenteeism and poor interpersonal behavior) via intermediaries such as the health workers’ spouse, co-workers or the health committee; discussing complaints and rumours in public; and reporting complaints to health authorities.

Chapters 5 and 6 address the question: How and to what extent do health facility committees facilitate and formalize social accountability? The chapters, covering research in Malawi, Benin, Guinea and DRC explore the role of health facility committees as social accountability interfaces and analyse how they engage with health providers to address poor performance. For each of the studies, a mix of methods was used including semi-structured interviews, focus group discussions and document reviews. In Benin, Guinea and the Democratic Republic of Congo, an average of 32 individual interviews and 7 focus group discussions were conducted, and in Malawi 69 individual interviews were held. Participants were health providers (nurses and clinicians), representatives from local and district authorities, health committee members, and maternal health service users (female and male). The results suggest that HFCs have multiple roles and responsibilities and participants have diverging expectations as to their function in calling health workers to account. Most committees address quality failures such as absenteeism, poor treatment and informal payments and they report severe misconduct to health authorities, but their approach is rarely formalized, coherent, and inclusive.

Part 2. The accountability context (chapter 7)

Chapter 7 addresses several contextual factors that shape and influence social accountability relations at the local level. These factors are addressed in the following research questions: 1) how do traditional leaders mediate accountability relations in maternal health care at the local level?; 2) how do gender norms influence relations of responsibility and accountability in maternal health care?; and, 3) how do global and national maternal health care policies affect local accountability relations?. The questions are explored through an in-depth analysis of the phenomenon of by-laws in Malawi; these are local rules issued by traditional authorities to increase the uptake of antenatal and delivery care. Findings are drawn from meeting observations, document analysis, 36 semi-structured individual interviews, and 19 focus group discussions with female maternal health service users, male community members, health workers, traditional leaders, local officials and health committee members. A gender and power sensitive thematic analysis was performed on the process of formulation,
interpretation and implementation of the by-laws as well as its effects on women and men. The findings show that these by-laws individualize responsibility for maternal health care and discriminate against women who are held accountable for global maternal health goals. This ‘reversed accountability’ impacts negatively on women’s reproductive health rights and ambitions to empower women through social accountability initiatives.

**Part 3 Health provider responsiveness to social accountability initiatives (chapters 8 and 9)**

This part of the research focuses on health providers’ perspectives on, and experiences with, social accountability initiatives. It is based on a critical review of published data. Chapter 8 presents the initial research protocol, and chapter 9 presents the results. The research uses a realist review approach for the analysis and synthesis of data. This approach represents a logic of inquiry that is theory-driven and that facilitates an explanation of what works, for whom, in what circumstances and in what respects. To identify relevant social accountability initiatives, purposeful searches for cases were combined with a systematic search in four databases, eventually leading to the inclusion and analysis of 37 social accountability initiatives in 15 countries. The findings suggest that health provider receptivity to citizens’ demands for better health care is mediated by health providers’ perceptions of the legitimacy of citizen groups and by the extent to which citizen groups provide personal and professional support to health providers. Favourable contexts for health provider responsiveness comprise socio-political contexts in which providers self-identify as activists; health system contexts in which health providers depend on citizens’ expertise and capacities and where providers have the self-perceived ability to change the system in which they operate.

**Conclusions**

Among the conclusions in the final chapter, the most important ones are:

- Social accountability can make visible the ‘blind spots’ of maternal health care provision at the frontline of rural health service delivery. These spots concern quality and governance failures, such as provider absenteeism, disrespectful behavior, violence and abuse in facilities. These are recognized challenges in health systems in low- and middle-income countries, but they are hardly addressed in maternal health care policies.
- Citizens do raise concerns about quality failures and articulate their demands for improvements. Formal and informal, individual and collective citizen feedback practices show that social accountability can provide important non-material incentives for health workers to carry out their clinical and social responsibilities.
Also, they may be crucial for the socialisation, motivation and retention of maternal health care workers in under-resourced rural settings.

- Social accountability at the frontline of service provision takes place in, but also beyond organized, collective and formal spaces, such as health facility committees. Moreover, social accountability is often exercised in informal interpersonal interactions rather than through formal processes of service monitoring and reporting.
- Trust-based approaches to social accountability are likely more effective than fault finding or control-based approaches, in particular in contexts of resource scarcity, where citizens have few opportunities to organize, where providers have less experience with organized feedback from citizens, or where regulatory capacities of the health sector are weak. Constructive approaches to social accountability are instrumental to collective problem-solving in itself but are also the basis on which further formalization of accountability relations are to be established, including more formal links with other accountability structures to address repeated misbehavior and crime.
- ‘Calling to account’ takes place through other approaches than only retrospective monitoring that focuses on poor performance. It also occurs prospectively by citizens reminding health workers of their mission and moral responsibility or by joint target setting and planning.
- The establishment of effective and inclusive social accountability processes is hampered by limited regulatory support from the health system, including the poor definition of roles, responsibilities and lines of authority between social, professional and bureaucratic accountability structures.
- The emphasis in global and national policies on individual women’s responsibilities, rather than their entitlements in maternal health care, is reflected in local accountability practices. It impedes women’s access to services, and it is problematic for establishing effective and equitable social accountability practices.

**Recommendations**

Among the recommendations in the final chapter of the thesis, the most important ones are:

- Social accountability practices are features of everyday life; external initiatives can be important catalysts towards practices that are more inclusive, collective and organized to effectively contribute to health provider responsiveness and the quality of maternal health care at the frontline of service provision.
- This thesis suggests to break-down the assumptions and theories of change underpinning social accountability initiatives:
  - The purposes of social accountability need to be critically assessed, and approaches should be tailored accordingly. Any initiative needs to start with
a context analysis of the ‘web of accountability’: processes of engagement between citizens, public officials and service providers and the social norms underpinning relations of responsibility and accountability in daily life regarding the provision of public services. Interactive or transdisciplinary research provides an immediate avenue to debate different perceptions, questions and underlying values and to develop relevant theories of change and target interventions.

This thesis reiterates the instrumental value of social accountability at the frontline of service delivery for the co-production of services. In resource-scarce settings, social accountability is about establishing core relationships that are required to deliver a public good. Constructive dialogue serves behavioral improvements of providers, learning, conflict resolution and socialisation and constitutes an essential basis for the institutionalization of feedback and social accountability practices.

Social accountability also has a transformative potential: when geared towards facilitating dialogue and negotiation about rights, responsibilities and accountabilities, social accountability can contribute to challenging relations of power, including gender relations and hierarchies of responsibility. Facilitating such dialogues may not only lead to improved practices but also address inequalities.

- The realisation of the potential of social accountability for transformative change requires the willingness of funders, policymakers and programme designers to go beyond an instrumental view of social accountability and to address systemic obstacles to quality and respectful service delivery. It requires political and gender analysis, and a careful assessment to identify the appropriate forum, intermediaries and alliances to enhance responsive and equitable service delivery.
- Effective local social accountability requires health system adaptations, including links with human resources for health policies, a review of the formal accountability system, integration of social accountability in quality of care policies and vice-versa; and an increase in investments in the institutional capacity, power and incentives of district health management teams.