Chapter 1

Introduction

The under-provision of essential primary health care, including key maternal health services is impeding development in sub-Saharan Africa and obstructing the realisation of health rights for all. One part of this problem concerns the governance of provision at subnational levels. Frontline public services, such as health clinics, are the sites where service providers and citizens interact. The quality of those interactions influences user satisfaction, utilization, citizen’s trust in government and ultimately service and governance outcomes (Bratton, 2007). In maternal health care (the focus of this study) in low-and middle-income countries, for example, it is increasingly recognized that the perceived poor quality of care, including discrimination and disrespect in health facilities, is an equally or even more important barrier to care-seeking than commonly recognized barriers, such as cost or distance (Bowser & Hill, 2010; Shiferaw, Spigt, Godefrooij, Melkamu, & Tekie, 2013). Interpersonal quality, the processes of care and human rights have been the ‘blind spots’ in maternal health care research, policies and efforts to strengthen health systems (Kendall, 2015; Van Lerberghe et al., 2014).

Health system responsiveness and accountability to citizens’ concerns is increasingly on the international development agenda. The 1993 World Development Report, ‘Investing in Health’, deemed strengthening accountability as one of the core elements of health sector reform. The 2004 World Development Report, again, put forward accountability failures as key barriers to improved quality and responsiveness of basic services, in particular for the poor. According to that report, health providers lack guidance on performance standards and incentives, lack monitoring and supervision and pressure from their superiors, peers or society and hence engage in poor and disrespectful care practices. Recent studies on disrespect and abuse during childbirth have also taken up the suggestion to improve supervision (Sando et al., 2014) and increase audit and feedback, including from women (Bohren et al., 2015).

Worldwide, a host of initiatives have been undertaken to improve the accountability of public health service provision through ‘supply-side’ measures, for example through results-based financing and incentive-based systems, quality improvement programmes, supervision and training of health providers. ‘Demand-side’ accountability has gained ground over the past few years in development thinking, including
the health sector, often under the banner of ‘social accountability’. The Partnership for Maternal, Newborn and Child Health, for example, suggests to “develop safe spaces in which women, children and adolescents can give their inputs openly and be heard with respect and dignity, adding their voices to the process of collective accountability” (PMNCH, 2015, p. 7). They suggest using parliamentarians and citizens’ hearings as one of the ways to channel women’s voices to officials and providers in maternal and child care. The UN's Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030), also, suggests that “the whole community, including adolescents, should be engaged in shaping health services for people of all ages” and to “participate in defining their health needs” (UN, 2015, p. 60). It proposes to foster active citizenship, advocacy and collective action and it emphasizes the need to hold governments and duty bearers to account for the delivery and quality of maternal health care. What is meant by citizenship is not defined, however, and the notions of community participation are closely associated with the promotion of health literacy, positive behavior such as breastfeeding and comprehensive sexuality education.

The concept of accountability has a long tradition in political science, but it is increasingly used in the broader community of scholars in public administration, development, business ethics, international cooperation and democratization. Lindberg (2009) speaks of an ‘explosion’ of studies on accountability in its various forms over the past two decades resulting in a myriad of meanings and dimensions associated with accountability (Lindberg, 2009). With so many concepts, ideas and practices, it is sometimes unclear why accountability matters and for whom. This also applies to the field and study of social accountability that suffers from conceptual confusion (Croke, 2012; Joshi, 2014; Fox, 2015). There exists a major gap between normative positions promoting social accountability, often by the donor community in international development, and the empirical evidence of what difference citizen engagement strategies make to achieving stated goals (Berlan & Shiffman, 2012; Gaventa & Barrett, 2010). In order to build responsive (maternal) health services and systems, it is crucial to understand how social accountability matters, for whom and under what circumstances it operates (Newell & Wheeler, 2006a).

The overall aim of the thesis is 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 in the field of maternal health care. The thesis does so by assessing accountability relations at the frontline of service delivery, the features, strategies and outcomes of social accountability initiatives and by theorizing how social accountability initiatives and contexts influence provider responsiveness. The knowledge generated in this thesis draws on cases of social accountability in low-and middle-income countries, with a focus on sub-Saharan Africa, and specifically Malawi.
Introduction

The cases provide insights about the nature and diversity of social accountability initiatives and about the changes social actors can bring about in their critical engagement with health providers. The study provides three specific insights. First, it helps us to understand the type of actors and processes involved in social accountability initiatives at the local level in maternal health care. The study informs in particular about informal and formal accountability relations and the role of health facility committees (HFCs) as facilitators of social accountability. Secondly, the study helps to understand the types of changes social accountability initiatives can generate in health provider practices. Thirdly, it generates hypotheses about how social accountability can generate change, for whom and under which circumstances. Such hypotheses help us clarify expectations about social accountability and identify possibilities for social accountability to emerge and to improve the quality and responsiveness of maternal health services.

The field of social accountability spans various disciplines and is interpreted in different ways. Researchers and practitioners propose a variety of definitions, aims, claims and assumptions to support, study and evaluate social accountability. There is a need and call for organizations that aim to strengthen social accountability to make efforts to consciously and explicitly articulate theories of change of their interventions (Tembo, 2013). The theory-building dimension of this study supports this endeavour. The evidence developed through this research can inform theories of change on social accountability, health worker performance and the contextual factors mediating each of these aspects.

Beyond the field of social accountability, the study addresses an important gap in health systems literature. Governance and accountability are considered ‘blind spots’ in the health sector (Yazbeck, 2009), and midwifery and maternal health care in particular (Stones & Arulkumaran, 2014). This thesis aims to address these blind spots and provide a fresh view on social accountability by assessing the ‘real governance’ of service provision in different contexts.