Chapter 10

Synthesis and conclusions

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 in the field of maternal health care. The thesis does so by assessing accountability relations and practices, the features, strategies and outcomes of social accountability initiatives and by theorizing how social accountability initiatives and contexts influence provider responsiveness.

This chapter presents the conclusions of the thesis. Chapters 4 to 9 each contribute to answering the central research question, which guided the research:

*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?*

The central research question was broken down into seven subquestions (see also table 3.1) that are answered and discussed in the first part of this chapter in line with the three themes that structured the research findings. This is followed by conceptual reflections and implications for policy and practice. The chapter ends with a section on research strengths and limitations and recommendations for future research.

Conclusions

Local social accountability relations and practices

In part 1 of the thesis, we explored how social accountability relations work at the micro-level of rural health centres through three studies. All studies used Bovens’ (2007) operational definition of an accountability relation as outlined in chapter 1 and considered these relations within their local context. The results of the realist review in part 3 support the contextualization of the empirical findings in part 1. The combination of insights led to the formulation of four main conclusions as to the objects and spaces of social accountability at the local level.

*Conclusion 1: Social accountability speaks to the ‘blind spots’ of maternal health care at provision and policy level. From a broader health policy perspective, we suggest, along with Sen and Govender (2015), that building social accountability can*
strengthen a direct and early focus on different dimensions of quality and governance of care beyond the quantitative expansion of skilled birth attendance and financial accessibility which is a major focus of the current Universal Health Coverage agenda.

Social accountability relations in maternal health care at the frontline of rural service provision, evolve around non-material aspects of quality of care, rather than material, clinical or technical aspects of quality of care. Accounts in all our studies confirm that citizen concerns include health worker absenteeism, late coming, disrespect as well as informal payments for services and drugs, but also more severe misbehavior such as drug theft and illicit sale of drugs, alcohol abuse and physical violence committed by health personnel. These issues are widely reported to occur in maternal health care facilities as documented in a large number of recent studies on disrespect and abuse in maternal health care globally and in sub-Saharan Africa (Bohren et al., 2015; Rosen et al., 2015, Abuya et al., 2015). This extends to the quality of primary health care in general since maternal health care is often integrated in primary health care in low-and middle-income countries.

While it is generally recognized that the non-material or non-technical issues matter to women in their ratings of the quality of maternal health care and their choice of place of delivery (Kruk et al., 2009; Kumbani, Chirwa, Malata, Odland, & Bjune, 2012), these issues are least addressed in maternal health care policies or in health system regulation. For example, supply-side (bureaucratic or internal) accountability mechanisms, such as licensing and accreditation, financing and payments schemes and quality assurance policies, do include elements of quality of care from a clients’ perspective. These elements, however, are often reduced to a set of standard ‘client satisfaction’ indicators (Bleich et al., 2009). Also, most existing measures of quality of maternal health care are developed for higher level facility-based care, or they focus on access to care; they tend to exclude primary health care clinics, representing 44% of women in sub-Saharan Africa (Dettrick, Gouda, Hodge, & Jimenez-soto, 2016; Kruk et al., 2016). While there is certainly a need to include standard objective quality indicators in formal assessments, we argue that the potential of social accountability lies in its ability to make visible the blind spots of maternal health care provision at the frontline of health service delivery. Social accountability interventions that are based on participatory techniques to discuss perceptions and definitions of ‘good (maternal) health care may constitute an appropriate complement to existing quality of care measurement models and standardized tools.

**Conclusion 2:** Given the information asymmetry and the fact that health workers are formally accountable for technical aspects of care to their supervisors, we conclude that the potential of social accountability interfaces, such as HFCs, lies in mediation,
information brokering and expectation management around technical processes of care on a daily basis.

We found that local social accountability initiatives are less focused on the monitoring of the technical aspects of quality of care, as suggested elsewhere (Cleary et al., 2013). This is usually explained by the information asymmetry between service users and providers. The technical dimensions of quality of care such as choice of treatment, decisions to refer, and appropriate medication are more difficult to monitor without essential knowledge and judgement capacity (Harris, Batley, & Wales, 2014). Also, many tasks in health care (and other sectors, such as education) involve high levels of discretion, questioning the possibility of monitoring by citizens and others, even if capacities were present (Batley & Harris, 2014). Information asymmetries can work to the advantage of health providers as they may support their professional autonomy. They can, however, also lead to a situation in which citizens negatively judge health worker performance; it can create suspicion and lead to unrealistic expectations and poor relations between users and providers (Harris et al., 2014; Hupe & Hill, 2007). This was seen in chapter 4 where confusion about referral processes led to citizens accusing health workers of incapacity or neglect to deal with complicated deliveries.

HFCs can play a mediating and brokering role between citizens and health services. Community scorecards have been found instrumental in this as they often create mechanisms for health professionals to explain technical issues to the public (Harris et al., 2014). This brokering role mainly serves the purpose of managing and bridging different understandings of the technical quality of care, rather than to call health workers to account for their clinical performance (Joshi, 2013).

**Conclusion 3:** Social accountability at the frontline of service provision, takes place in, but also beyond organized, collective and formal spaces, such as health facility committees.

HFCs are heterogeneous structures; their mandate, composition and roles vary across contexts. They have in common that they are formally established through health policies and that they play multiple roles in health facilities of which the facilitation of social accountability is one. The studies found that the effectiveness of HFCs as social accountability interfaces varies; HFCs offer a social accountability forum to assess, question and judge health worker actions and behavior and to enforce change through linkages to authorities. Although they are effective in addressing cases of poor performance, their efforts are not always coherent, authoritative and inclusive. In most accountability literature, and the cases reviewed in chapter 9, intermediaries are often defined as established formal organizations such as civil society organizations, the media, elected parliamentarians, and HFCs. Findings in chapters 4, 5 and 6, however, underline the importance of a range of other influential actors who call
health workers to account, including informal structures or individuals in the private and professional sphere of health providers. It is essential to recognize the diversity and effectiveness of indirect routes, both formal and informal, that citizens use individually and collectively to approach health providers to express concerns and dissatisfaction.

**Conclusion 4:** Our research suggests that formal social accountability structures function through informal interpersonal interactions and it strengthens the evidence that in health systems, informal relations, structures and processes significantly interact with formal processes and structures.

The majority of cases in the realist review (chapter 9) reported on organized and facilitated social accountability initiatives, either by participatory action learning projects, advocacy organizations at the subnational level, and health committees. The role of health committees is further explored in chapters 5 and 6. The studies confirm that at the level of frontline service provision, citizens and social intermediaries address poor quality of services mostly through personal and informal dialogue with health providers, in particular where it concerns social and interpersonal aspects of quality of care. Although HFCs in all four study countries are the formal interface structure, most of them act in informal ways too, responding to incidents as they occur (chapter 5 and 6) and through individual and personal approaches of feedback to health workers and mediation (chapter 5). A minority of HFCs used formal and documented approaches for service monitoring and reporting, in particular for observable issues (absenteeism, prescriptions and bills). These observed accountability dynamics align with Hupe and Hills’ theory that accountability at the ‘street level’ of frontline service provision is often exercised in interpersonal interactions (Hupe & Hill, 2007).

**The accountability context**

This thesis recognizes that social accountability relations are embedded within wider institutional, organizational, cultural and political settings. In the introduction, we proposed that social accountability relations are complex and that processes and outcomes are determined not by single causes but by multiple causes that can interact in both complementary and non-complementary ways (Byrne, 1998). Each of the studies addressed the structural context of social accountability relations to some extent. In part 2 (chapter 7) the focus was specifically on context related to gender norms, values and relations of power, that we assumed in the introduction to be central to an accountability relation and to health systems in general. Rather than producing exhaustive theories on social accountability, this thesis generates specific knowledge on particular aspects of context that shape social accountability relations and outcomes. In the following, we present four main conclusions that emerged from individual and combined studies.
Conclusion 5: 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 and bureaucratic accountability structures.

In the different chapters, we identified health system factors that influence local social accountability relations and health provider responsiveness to citizens’ concerns. They can be perceived as the ‘hardware’ of health systems (Sheikh et al., 2011). They include the formal mandate of health workers and facility managers and in particular the extent to which health worker responsibility towards citizens is formally defined. For example, job descriptions in Malawi do not include a dimension of social responsibility or responsibilities beyond clinical tasks. Supervision tools in Malawi also do not cover this, meaning health workers are not held accountable by their hierarchy for engaging with citizens. Similarly, the lack of a formal mandate of HFCs to monitor service delivery and report to authorities negatively affected HFCs legitimacy and provider responsiveness (chapter 9). Human resource shortage and high workloads have been brought forward by providers as well as HFCs as factors explaining the deterioration of interpersonal relations in maternal health care and a potential lack of responsiveness to citizens’ concerns (chapter 5, 6, 7, 9). Several studies on HFCs in low-and middle-income countries highlighted that HFCs functionality can be severely hampered by poor organizational support from the health system (George, Scott et al., 2015) and capacity and willingness of health authorities to support accountability. Although not recognized as such in much literature on health systems regulation, a fundamental responsibility of health policymakers lies in the clarification of roles, responsibilities and lines of authority between social and bureaucratic accountability structures. In its absence, HFCs will develop governance arrangements themselves, which may work, but which depend heavily on individual leadership in the HFCs, interpersonal relations and may exclude views of marginalized groups (chapter 6). The creation of HFC officers, community liaison officers or ombudsmen at the district level in Malawi and elsewhere can dramatically improve linkages between social and bureaucratic accountability (Goodman, 2011; Boulle et al., 2008).

Conclusion 6: Gendered perceptions and expectations regarding behavioral norms, rights and responsibilities in maternal health care are at the core of (social) accountability processes.

In chapter 9 we hypothesised that the responsiveness of health providers to citizens’ concerns is likely to depend on whether they perceive health service users as patients, recipients, beneficiaries, clients, consumers, citizens or holders of rights. The Malawian case study (chapter 7) further exposes how gender norms shape such perceptions. It appears that people in authority such as local government officials,
traditional authorities and senior health professionals construct women as subjects of accountability, rather than ‘agents’ or ‘rightsholders’, both formally (in written by-laws) and informally during the process of accountability. Health providers, but also other actors, seem to externalise blame and attenuate personal responsibility for maternal health services and outcomes and may instead hold women accountable for failures in maternal health service delivery (chapter 7, 9). The emphasis on women’s responsibilities rather than their rights is common in SRHR; it hampers women’s access to services, and it is problematic for establishing effective social accountability practices. As suggested in chapters 7 and 9, and in support of others (e.g. Cleary et al., 2013), such dynamics influence the agency of both women and health providers to engage in social accountability relations as women may have low expectations regarding their health care entitlements and providers may not see that they bear a responsibility and may be less likely to be held responsible for engaging with women as citizens. They may find it inappropriate for women to be involved in facility monitoring and they may resist such efforts (Cleary et al., 2013). From this perspective, we argue, in line with Grandvoinnet et al. (2015), that a primary goal of social accountability could be to expose and change (gendered) norms and perceptions of responsibilities of service providers and others as well as the perceived entitlements of different groups of citizens. A social accountability process, ideally, focuses on encouraging joint responsibility and creating a dynamic of entitlements and accountability and addresses ‘blame-games’ as they occur (Aveling, Kayonga, Nega, & Dixon-Woods, 2015).

**Conclusion 7:** Social accountability processes are influenced by the wider politics of national and global maternal health care policies and competing accountability demands in which power relations play a significant role.

Chapter 7, in combination with studies on HFCs (chapters 5 and 6), also points to the co-existence of competing and sometimes contradictory demands for accountability, as suggested in the introduction. For example, while HFCs want (and are mandated) to ensure acceptable behavior of health workers vis-à-vis women seeking maternal health care (chapters 5 and 6), local authorities are encouraged to reduce maternal death by ensuring women and communities attend health services (chapter 7). Although these are all valid purposes, what purposes are pursued in practice, depends on how responsibilities and accountabilities are attributed and prioritized (Newell & Bellour, 2002). In the case of Malawi, national donor-funded policies clearly provided a push for the prioritisation of women’s accountability by engaging with traditional authorities and pressuring them to increase the number of facility-based deliveries, rather than any other performance measure such as equity and quality. The international development agenda provides opportunities to address gender equality, governance and accountability in an integrated way, also in the health sector. For
example, the 2030 agenda for Sustainable Development includes targets related to
gender equality (SDG 5) and governance (SDG 16). Similarly, WHO calls for the moni-
toring of the status of underlying barriers to the realisation of health rights and it calls
for longer-term funding for social accountability. These are promising commitments
that can translate into universal access to sexual and reproductive health services for
women and men provided that social and political dynamics are taken into account
in programming.

**Conclusion 8:** Unequal accountability processes and outcomes can be contested and
changed. In each institution or space there are ‘change agents’ who might disagree
with the way service failures are handled and with the way responsibilities and ac-
countabilities are distributed.

The findings in chapters 7 and 9 suggest that unequal accountability processes and
outcomes are not a given and they can be contested. Chapter 7, as well as the other
chapters, underline how people introduce, produce and reproduce norms about
acceptable behavior and judgements on what is sanctionable or forgivable for any
actors in their behavior towards others, whether it concerns women, health workers
or authorities. The fact that responsibilities and accountabilities are constructed and
negotiated on a daily basis means they can be changed. Some actors, such as lower-
cadre health workers, contested the unfair practices and outcomes of the by-laws
(chapter 7). This category of health workers was also found to be particularly inter-
ested in community participation and accountability in chapter 9. Also, HFC members
differ in their position towards acceptable behavior of women or health providers
(chapter 5). When identified and mobilized, these change agents could constitute
collective ‘alarms’ needed to address multiple possible sources of service and institu-
tional failures and poor or unfair accountability practices.

**Responses of health providers to social accountability initiatives**

All studies confirm that health workers are operating in a dense network of account-
ability relations with actors that assign responsibilities to them that are often assumed
and not formalized but to which they need to respond. Chapters 4-6, complemented
by chapter 9, provide a detailed picture of the range of health provider responses to
citizen feedback and social accountability initiatives based on primary and second-
ary research. Two main conclusions regarding health provider responsiveness can be
drawn:

**Conclusion 9:** Social accountability initiatives can provide important non-material
incentives for health workers to carry out their clinical and social responsibilities and
may be crucial for the socialisation, motivation and retention of maternal health care
workers in under-resourced rural settings.
Due to choices made and the availability of data for the realist review, chapter 9 focused on positive outcomes that we categorized as receptivity and responsiveness. Receptivity was associated with attitude change and responsiveness with behavioral change or adaptations to service delivery. The empirical studies found similar (perceived) outcomes: intentions and agreements to improve, settlements of conflicts, compensation and redress (chapter 5), explanations of behavior (answerability) and apologies for absenteeism and poor interpersonal communication (chapters 4-6) as well as a recognition of the importance of interpersonal relations in care (chapter 4). The daily accountability relations, including those facilitated by HFCs, often contribute to provider responsiveness and immediate problem-solving in contexts where the provision of public services is severely challenged. In chapter 5 we showed that the relations ensure a minimum level of functioning and acceptability of services. In the words of Crook & Booth (2012), this is because they are “locally anchored in established forms of social obligation” (p. 98).

Opposite reactions were however also observed: indifference to citizen feedback or denial of complaints, the concealing of medical evidence or information, demotivation, intention to leave, and persistence of poor quality (chapters 4 and 9). Hence, social accountability may contribute to ensure that health providers carry out their clinical and social responsibilities, it is no guarantee that they do so. As concluded in chapter 9, social accountability is just one possible pathway to provider responsiveness to citizens’ concerns; it works under some circumstances for some health providers. This is consistent with the point that Rosen et al. (2012) raise in theories on accountability. The studies in this thesis show that social accountability by itself has limitations for addressing severe health provider behavior and systemic failures in service delivery.

**Conclusion 10:** Citizens or their intermediaries have an important signal function to activate formal accountability structures in cases of severe provider misconduct and abuse.

Social accountability initiatives, especially those relying on informal interactions and arrangements are insufficient to deal with health providers who do not respond to demands (chapter 5, 6), cases of fraud in financial management (chapter 6) and cases of repeated misbehavior, alcohol or physical abuse (chapters 4, 5, 6), denial of care and discrimination (chapter 7). Such failures need follow up through formal investigation and sanctions to protect patients from potential harm as well as to the maintenance of professional standards (Aveling et al., 2016). For these cases, formal enforcement capacity is required, by more systematic evidence collection and local regulation (chapter 6 and 9), by reporting to district health authorities (chapters 4, 5, 6) and by leveraging other powerful actors such as local governments (chapters 5 and 6) or
experienced CSOs or networks of CSOs at the (sub)national level (chapter 9). Major shortcomings were observed in links between health facility committees and the formal accountability procedures (chapters 5 and 6). As a result, health facility committees and other actors do not know the right approach for activating the right level of authority for the right issue.

**Conceptual reflections**

The findings and conclusions in this thesis present a fraction of a whole range of practices and factors characterizing the interaction between citizens, HFCs and health providers in low-and middle-income countries, and they contribute to a further understanding of the concept of social accountability. In the introduction, we referred to social accountability as a complex concept. It is defined in different ways, depending on the assumptions and objectives of its proponents. It is concurrently defined as a dimension of governance, a goal and an outcome, an intervention, process, initiative or action or a relation. We also presented the view that, in international development, social accountability is often approached from an interventionist perspective, as a tool or mechanism that can be initiated and facilitated by external actors. In this thesis, we took the perspective that social accountability is relational: that it is about human relations, on-going interactions and feedback loops rather than short-term activities. In the substudies, we used several perspectives: social accountability as a relation of daily feedback (chapter 4), as a process that can be facilitated by an interface structure, the health facility committee (chapters 5 and 6) and as a gendered relation of power (chapter 7). In chapters 4-6, the relationship between citizens and health providers was the central theme, and we described how the social accountability process works in practice at the frontline of primary health care of which maternal health services are a crucial component. Chapters 8 and 9 focus on the same relation and set of actors but it mainly assesses organized and formal social accountability initiatives. The relational perspective on social accountability adds awareness to the field of social accountability that the issues people care about and the way they (some of them) interact about them in daily practice at the local level may be very different from the actors, content and processes that are expected from social accountability interventions or projects.

The in-depth contextualization of social accountability relations in each of the chapters in this thesis confirms the complexity of social accountability (and accountability in general) but at the same time helps to make sense of itconceptually and theoretically. By adopting a relational perspective on social accountability and exploring micro and structural level contexts, we gained valuable insights regarding the relevance of four elements in the initial framework for which we propose adaptations. They relate
to the purpose and outcomes of social accountability, the separation of the actor and the forum, the role of social intermediaries and, the retrospective focus of social accountability.

**Conclusion 11:** Constructive approaches 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 mechanisms to address repeated misbehavior and crime.

In the introduction (2.3), we explained why we focused on health provider responsiveness as one of the outcomes of social accountability. As the research progressed, we identified co-production, relationship building, and conflict management (chapters 5, 6, 9), provider motivation and retention (chapter 4) as possible additional purposes of social accountability. We argue that they fit the purposes and context of low-and middle-income countries for a number of reasons.

First, in many countries in sub-Saharan Africa, health systems are under-resourced. There may not be sufficient resources to make formal accountability mechanisms work, including hierarchical/bureaucratic accountability mechanisms. In the context of limited feedback by superiors or peers, constructive, support-based relations are important for the socialization, motivation and retention of maternal health care workers in rural settings, as seen in chapter 4. Providers may lack systems to support them and may have other priorities in their daily work. Especially in these areas, the complementarity that can be brought about by citizen engagement and local problem-solving is indispensable. Confrontational approaches to citizen-provider interactions are less appropriate in such a context, and will not contribute to longer-term objectives of sustained service delivery. Constructive approaches are particularly relevant in settings where social relations and networks have been damaged by political or social conflict. Conflict might leave a legacy of mistrust, fear of others and feelings of powerlessness vis-a-vis state actors (Haider, 2011). In post-conflict situations, social accountability is about rebuilding interactions among citizens and between citizens and providers or other state actors. But also in relatively open democracies, constructive local social accountability relations are relevant in the context of mistrust and suspicion inherent to information asymmetry between citizens and providers. By channelling concerns, local intermediaries can mitigate the negative collective “buzz” around health centres described in chapter 5. Also, with the increase of the use of social media to expose service failures, scapegoating of individual health providers has become commonplace in the press, for example in Malawi. With rising expectations of health care, among others in the context of UHC and increased access to social media, the emergence of “accountability as a spectacle” competes with the establishment of a culture of accountability based on trust (Newell & Wheeler, 2006b). The grounding
of accountability relations at the local level is essential in this context. At the same time, the observation that constructive relations already exist in our study settings, does not mean they do not need strengthening, they need to be more inclusive and coherent by focusing not only on practical and daily issues in service delivery but also on underlying perceptions on, and negotiation over, responsibilities and entitlements.

Conclusion 12: Prospective approaches to social accountability are a condition for the enabling of retrospective accountability. Prospective accountability is often conceived as a ‘tangible’ process of target setting and budgeting. Based on the insights from this study, we would define it as a process to interactively discuss and construct norms and values regarding the quality of care, and the responsibilities and accountabilities that come with upholding them. In this way, prospective accountability sets the stage for more inclusive social accountability processes and a possibility to start changing perceptions on roles, rights and responsibilities.

Accountability is inherently about the retrospective evaluation of decisions or actions, associated with control and compliance. Most forms of accountability evaluate performance ex-post facto such as political accountability (whereby citizens have the opportunity to reward or sanction politicians through elections after a certain period), financial accountability (checking the accounts ex-post), or legal accountability (judgement after the fact). In our conceptual framework and studies we also approached social accountability as a retrospective review of the performance of health providers that is activated when services fail, when health providers do not fulfil expectations or basic responsibilities in care. We have seen in this study that monitoring and retrospective evaluation of health worker performance (e.g. through complaint management) is just one aspect of citizen engagement; calling to account also occurs prospectively by citizens reminding health workers of their mission and moral responsibility or by anticipating, joint planning and establishing governance arrangements. This seems particularly the case for HFCs who combine multiple service delivery functions and who build constructive relations through other approaches than only monitoring and feedback on poor performance. Hence, while the retrospective approach to social accountability was emphasized in the initial framework, insights from this research reiterate the value of a prospective and interactive approach to social accountability at the local level.

Conclusion 13: Based on the studies in this thesis, we would give the social intermediaries a more central position between the forum and the actor, and we would position HFCs as one of the intermediaries among others who can represent either the forum or the actor or both. Interlocutors need a range of abilities, capacities and skills to be(come) relevant for health providers.
Initially, our study considered citizens and providers as separate realms. But our studies question whether the “forum” and the “actor” are separate entities in practice, given the web of accountability relations in which they operate. The analytical separation between the forum and the actor seems too simplistic, just like other dichotomies in accountability literature such as principle-agent, state-society, public-private, rights holders-duty bearers. In daily life, people are connected through other relations, and identities change and interact. In line with Fox (2007), we suggest a more nuanced view of individuals or group vis-à-vis the (proposed) accountability relation and not take a homogenous view. Such view would do justice to the multiple identities citizens and health providers represent, as suggested in the previous section. Rather than categorizing actors on one side or the other, it is more relevant to explore the diversity of spaces in which people interact and which persons or groups of persons in those spaces can best engage in dialogues with health providers and leverage the change envisaged by strengthening social accountability.

Tembo (2010) developed the concept of “interlocutor” in the context of social accountability in sub-Saharan Africa. In the following, the concept will be used to discuss the circumstances under which intermediary structures, such as HFCs, can be relevant for citizens, providers and their interactions. An interlocutor refers to a “particular agent of change that works with or alongside ordinary citizens in engaging with state actors at various citizen–state interfaces” (Tembo, 2012: 6). An interlocutor is a person or a structure that brokers citizen-state relations, or more locally, citizen-provider relations. An interlocutor can be located in civil society, the private sector as well as the state, either in bureaucracies, politics or decentralised structures (Tembo, 2010; Tembo, 2012). According to Tembo & Chapman (2014), interlocutors have some characteristics that make them effective in bridging actors’ interests and providing political leverage when they:

- Are willing to act on the community’s or particular marginalized groups’ behalf.
- Can bridge information gaps by organizing the details of the required information and setting of standards for an accountability process to be well informed.
- Take part in conversation and dialogues; they interrogate (“interlocution process”).
- Strengthen citizenship by articulating rights and obligations for citizens and states, increasing citizens understanding of the workings of institutions in the particular context; they manage expectations and enhance citizens’ ability to negotiate multiple identities and representations.

The findings of the studies in this thesis provided additional insights into the conditions for interlocutors to become relevant for health providers (rather than for citizens and communities). Interlocutors are more likely to be effective at the frontline of service delivery when they have/develop:
• A genuine affinity and interest in health care (chapter 9).
• The ability to identify gaps in service delivery and solve problems at the health centre instantly (chapters 4, 5).
• The knowledge and competency to judge the quality of services (chapters 6, 9) including competencies to ensure confidentiality, impartiality, good evidence (chapter 5).
• The ability to appeal to moral responsibility of providers (chapters 5, 4, 9).
• The ability and capacity to appeal to providers’ priority to improve service delivery and efficiency, and in particular, to fill a providers’ knowledge, capacity, social or authority gap. The introduction of ‘foreign’ health workers in local community customs is a strategy to support providers’ social and authority gap.
• The ability to engage in ‘preventive’ accountability: inform communities about the availability of services to increase uptake and, at the same time, prevent complaints by explaining the shortcomings of the facility, defending performance gaps and by receiving patients at the health centre (chapters 5, 6, 9).
• The ability to avoid escalation or more public exposure through social or traditional media (chapter 5) and to solve issues ‘as friends’.
• Capacity to leverage authority informally (chapter 5) and through reporting to authorities.

Health facility committees (HFC) were the central intermediary institutions analyzed in this thesis. Most HFCs (chapters 5 and 6) were able to facilitate an interlocution process, whereby they sometimes speak for service users and sometimes for health providers (chapters 4, 5, 6, 7), playing an essential role in relationship building between communities and providers. The formal character of HFCs, their close relationship with health providers, and embeddedness in local communities may be strengths and obstacles at the same time. Whereas many social accountability interventions are time-bound and externally introduced, HFCs are, at least in policies, permanent structures in many health systems. This allows them to develop the interlocutor role in the longer term. On the other hand, HFCs were found to be unrepresentative and performing poorly with regard to consultation with, and counter-feedback to, the wider community, questioning their accountability towards their constituencies. The informal character of interactions may cause important concerns to be overlooked, and responsiveness may be partial and biased towards certain groups.

In our studies, we have seen that some HFCs have more social and political capacities and abilities to perform a role of interlocutor, depending on, for example, their level of training, experience, leadership and composition. We have also seen, however, that there is a wide variety of potential other interlocutors, that each come with their particular power and networks and their importance is relative to context. Pre-defining ‘effective’ interlocutors or excluding others (e.g. HFCs) for social account-
ability actions is problematic. Tembo & Chapman (2014) argue that the interlocutor role is not necessarily defined beforehand and can develop with other intermediaries, citizens and state actors. Also, some interlocutors may need to grow into this role through capacity development strategies. According to the studies in this thesis, this would certainly apply to HFCs, but also to local government officials, religious and traditional leaders and community health workers.

**Implications for policy and practice**

We have learned that informal social accountability relations and initiatives are features of everyday life; they are ordinary daily events as part of regular interaction and conversation between people. Interactions are more or less overt or explicit, depending on the context, but they are not necessarily ‘introduced’ or ‘created’ by external organizations. Collective, organized and inclusive demands for accountability are not ordinary events, however, and external interventions can be important catalysts towards the institutionalization of social accountability practices. Following Tembo (2013), we suggest to regard social accountability projects as: “Policy and practice experiments in a given governance environment, where the main focus is on establishing core relationships that are required to deliver a public good” (Tembo, 2013, p. 87). Where a basis of these relationships already exists, such as in our study settings in Malawi, projects will be about strengthening them and creating an environment for them to become more effective, inclusive and, eventually transformative.

As stated in the introduction, the function of social accountability is often not well thought through, and theories of change, underlying assumptions and the influence of contextual factors are often not made explicit (Brinkerhoff, 2004; Joshi, 2013). This thesis generated lessons for strengthening social accountability at the frontline of service provision, but also provided hints as to how links with the broader context can be made. We recommend five points of reflection for policymakers and practitioners for the design of social accountability initiatives. We focus on external initiatives supported by international organizations and NGOs. They may however also apply to policymakers committed to strengthening the quality of care and health worker performance.

**Prioritize understanding of formal and informal political and power relations**

Our findings clearly support the need to “think politically” about social accountability. We reiterate that the construction of accountabilities, including the definition of rights and responsibilities is inherently a political process, structured by relations of power, including gender relations, and resulting in a hierarchy of norms of responsibility (Batley, et al., 2012; Newell & Bellour, 2002). It is important for social accountability policymakers and practitioners to critically examine the drives for accountability and
the way standards are set for, and by, different actors within the “web of accountability”.

At the local level, the starting point of any intervention has to be an understanding of the process of engagement between citizens, groups of citizens, public officials and service providers regarding a particular service delivery issue. Rather than taking the initiative or project as a starting point, incentives towards addressing a specific service failure (e.g. concerning access, quality, governance) for a specific group (e.g. women) should guide the context analysis.

A politically informed context analysis pays attention to the way negotiation about responsibilities and accountabilities occurs in daily life and the power imbalances involved. Awareness of relations of power, including gender relations, will enable a more explicit definition of what needs to change, where and in whom these changes are needed and who can facilitate those changes.

Given the context-sensitivity of accountability relations, this analysis should be done on a case-by-case basis. It is also important to consider how global calls for results and accountability by global funding agencies shape local accountability relations and gaps and how global, national and local level institutions shape or reinforce perceptions of gender roles in society and determine men’s and women’s access to rights and resources. Although grasping the international drivers of local social accountability relations is difficult, the case in this thesis and related literature provide relevant pointers for reflection.

**Rethinking the purpose and approaches of social accountability in rural frontline service delivery**

As discussed in the first paragraph of this section, a social accountability project should start with exploring what it aims to change. While its overall aim may be to improve the provision of services, this can happen through *establishing*, *strengthening* and, or, *transforming* social accountability relations, depending on the context and ambitions of policymakers and programmers. In addition to thinking through these levels of change, it is useful to further reflect on the purposes of different elements of social accountability (information, dialogue, consequences) and how strengthening them individually and collectively could add value to the provision of services. As discussed above, data collection can address the blind spots in the quality of health care if that is a particular objective of initiatives. Dialogue can have multiple purposes, including ‘calling to account’ but also support, learning, conflict resolution and socialisation, all relevant for the co-production of services. When the dialogue focuses on the exploration and questioning of norms, values and power in communities and the health profession, it may not only lead to improved practices but also uncover
inequalities in health governance and accountability relations. This may eventually involve shifts in perceptions of the responsibilities of providers as well as entitlements of citizens, increased opportunities for women’s voice and citizenship and changes towards gender equality.

**Interactive approaches to programme design**

Qualitative research, such as conducted for this thesis, may be an appropriate way to perform the analysis previously suggested and to think through the theory of change. We believe, however, that interactive (or transdisciplinary) research provides an immediate avenue to debate different perceptions, questions and underlying values on responsibilities and accountability and to identify target interventions. The process of collective questioning and articulation of a theory of change by citizens, providers and other stakeholders in the prospective initiative offers opportunities for negotiation and contestation over rights and responsibilities and definitions of ‘good’ care, ultimately delivering a more relevant, workable and sustainable initiative (Mcgee & Gaventa, 2011).

**Identifying participants and interlocutors**

There is a risk in pre-defining participants in a social accountability initiative, especially when that is done by categorizing the forum and the actor as separate groups. As suggested before, unexpected groups can emerge as change agents, depending on the issue and context and not every health committee is likely to advance the interests of women, in particular marginalized women. The existence of a forum or an interlocutor is not necessarily leading to change; based on the issue, interlocutors can draw in other relevant actors to address the problem, forming what Fox (2015) calls ‘coalitions of pro-accountability forces’. As suggested previously, allies, ‘change agents’, can be identified at any level, for any issue, in any professional, political or social group. Citizens, their representatives and health providers, in particular at the local level, are linked through other relations than only those implied in health service delivery, for example through the mechanism of identification with specific causes, groups or ideologies. Alliances between service users and service providers who are attempting internal reforms are a crucial resource for both parties in promoting state accountability and responsive service delivery (Goetz & Gaventa, 2001).

**Seeking complementarity with other approaches to enhance provider performance and health service delivery**

For social accountability to contribute to changes in service delivery and health systems, actions in the frontline need to be complemented with other strategies, including the coordination with governmental reforms that bolster public sector responsiveness. Addressing the issue of health worker performance, the study has
close connections with the field of human resources for health. Shortage of health workers is a major global concern and a continuous threat to the availability and quality of care. Our study shows that social support at the micro level constitutes an essential factor that needs to be recognized in human resource policies on health worker retention. It also suggests that stronger links can be made between citizen-driven dialogues and health system interventions to strengthen constructive accountability relations. Health provider training on human rights, the development of moral leadership in health facility management, and team collaboration are crucial enablers for the emergence of value-based organizations and teams (Aveling et al., 2016) and need to be included in human resource policies and management action. This includes making more explicit in job descriptions and supervision guidelines health workers’ responsibilities in citizen engagement and social accountability.

**Research strengths and limitations**

A major strength of the research is the use of three types of triangulation in each empirical study: methodological triangulation, through the combination of different types of data collection methods and source triangulation using different groups of respondents. The involvement of multiple researchers assured investigator triangulation. Researchers with a variety of disciplines, such as sociology, public health and medicine, were involved in the development of research protocols, data analysis and write-up for each study. This allowed critical discussions and reflections on concepts, interpretation of data and developing conclusions, and as such addressed potential bias, enhancing internal validity.

Another strength is the transdisciplinarity of the research which included the involvement of NGOs and district officials in protocol design and discussion of research results.

In light of answering the overall research question, the researchers repeatedly reflected and discussed the research results in the context of published literature on social accountability, various theoretical frameworks and across the empirical studies of this thesis. This enhanced external validity.

Some limitations were also noticed: the fact that the main researcher (EL) was not native to the context of the research, might have led to cultural misinterpretations. Although this was addressed by involving local researchers and practitioners, this cannot be completely ruled out. This thesis consisted mainly of case studies and mostly from Malawi, and these are inherently limited in the generalization of results. Although we gained important insights in social accountability from the empirical studies, it is pertinent that the findings are also investigated in other contexts.
Furthermore, we studied the concept of social accountability mainly from a health system’s and providers’ perspective. Women’s experiences with maternal health care and channels for the expression of their concerns were explored to some extent, but insights on the ‘voice’ side of social accountability and on what works for (different groups of) women under which circumstances are limited. For example, the research drew attention to women who want and can use maternal health services but less to the factors that obstruct other women from accessing care and accountability forums. Also, a gender analysis of accountability relations was not part of the research from the start, which may have led to the oversight of discriminatory practices and inequity in social accountability interventions and outcomes.

Moreover, the research in relation to responsiveness focused mainly on attitudinal and behavioral changes or adaptations to service delivery. The research did not investigate if any changes occurred in service utilization and care-seeking behavior as a result of social accountability.

**Recommendations for future research**

This thesis represents a social science approach to health systems and policy research with intersections between the fields of public administration, rights-based development, and social anthropology. We suggest the study of social accountability remains informed by these multiple perspectives to enable an understanding of the complexity of social accountability and governance in health more generally.

**Understanding the voice side of social accountability**

As mentioned above this thesis focused on health systems’ and providers’ perspective on social accountability, and in particular on how they related to organized groups (HFCs in chapters 5 and 6, CSOs and NGOs in chapter 9). Chapter 7 suggests how accountability relations are gendered and may work differently for different groups of women (married, single, young, older). This study provides just one case study of gendered accountability relations in maternal health care that merits more attention in future research, also beyond the health sector. Therefore, research to gain insight into the voice side, and particularly the gendered norms and values underlying social accountability is highly relevant.

**Social accountability in the private sector and urban areas**

This study, and many other studies in the field focus on (social) accountability in the public sector (public or not-for-profit), assuming that this sector generally functions poorly and requires most efforts to address quality failures. However, the regulation of private clinics is a huge challenge for governments in low-and middle-income countries as well. The only – hard to manage – instrument is accreditation that usually does
not include perceived quality and that is steered by national policymakers. Research could explore the role of social accountability in the private sector and the ways in which citizens can call private health providers to account. Similarly, performance issues and social accountability dynamics in urban health centres and hospitals are different from those in rural areas but only rarely studied; future research could address this gap.

**Social media**
Information and communication technology offers great potential to increase the information to users and the voice of users towards health providers (Olmen, 2012). However, more research is needed in this area to gain an in-depth understanding of working of these media for social accountability and how this can be used in a formative and constructive way.

**Comparative analysis**
This research concentrated on maternal health care. Future research needs to develop a more comparative approach, considering in what way the type of health services (in combination with other contextual factors) influence the incentives and relative power of providers and service users and how social accountability initiatives implemented in different contexts leads to different outcomes in terms of changes in service providers’ behavior, service delivery, service utilization and care seeking behavior.

**Social network analysis**
A new research strategy in social accountability and policy analysis is social network analysis. It is a tool relevant to explore the diversity of spaces in which people interact and which persons or groups of persons in which spaces can best engage in dialogues with health providers and leverage the change envisaged by strengthening social accountability.

**Scaling of local social accountability practices**
This thesis focused on social accountability practices at the frontline of service delivery and on initiatives that are locally bounded. Such initiatives often remain localised, and they rarely spread horizontally or integrate vertically, by linking with civil society advocacy and reforms at higher levels (Fox, 2015). It is this type of scaling up (rather than replicating or multiplying local social accountability initiatives) that may contribute to systemic change. We suggest researchers and evaluators develop insights on how broadening social accountability initiatives can generate more social and political clout and strengthen policymakers’ and providers’ responsiveness.