Chapter 2

Theoretical background

This chapter presents the key concepts and theories associated with social accountability, as well as the conceptual framework used in this research.

Maternal health care and health systems in low- and middle-income countries

Maternal health care refers to a range of services provided to women during pregnancy, childbirth and the postpartum period. Some definitions include newborn and child health care and pre-pregnancy care (Kerber et al., 2007). The care consists of clinical care (e.g., obstetric care assisted by skilled birth attendants, the prevention of maternal to child transmission of HIV), outpatient and outreach services (e.g., antenatal care, family planning, and immunization) and family and community care (e.g., education, healthy home behaviors for pregnant women). The content and availability of these services vary by country, context and health system (Kerber et al., 2007). Overall, low- and middle-income countries have low levels of coverage of most services. Although there have been improvements in the past decades, for example in the area of immunization, many services remain unavailable or inaccessible. For example, antenatal care coverage in sub-Saharan Africa is weak and inadequate and only eight countries in the region have an average of 80% skilled birth attendance, the rate required to significantly reduce maternal mortality (World Health Organization, Regional Office for Africa, n.d.,a). The basic interventions or ‘packages’ required to ensure good maternal health care are known, accepted, fairly simple and cost-effective, but large parts of the world’s women do not benefit from them (Freedman et al., 2005; Kerber et al., 2007).

Maternal health care services are provided in the context of a broader health system. The provision of care is one of the most visible functions of health systems. Effective provision requires the availability of a combination of financial resources, staff, equipment and drugs as well as leadership, governance and management structures, procedures and incentives (World Health Organization, n.d.), all essential and inter-related elements of health systems. Explanations for successes and failures in service delivery in low- and middle-income countries have focused on the availability of resources and technical capacities (the ‘hardware’ of health systems) but increasingly take into account the values, norms and relationships that shape health systems and
services and their outcomes (the ‘software’ of health systems) (Sheikh, George, & Gilson, 2014). From the latter perspective, health systems are not mechanical structures but social, cultural and political institutions that govern human interactions and behavior (Gilson, 2003; Olmen, 2012). They are perpetual processes, a dynamic, on-going, moving set of relationships, including relations of power. They are spaces of contestation as well as spaces of collaboration between actors in the system or the sector and between them and external (non-health) actors. Hence, health systems not only produce health care but they also reproduce, communicate and enforce wider societal norms and values (Freedman, 2005; Gilson, 2003).

Academic research has begun to examine the ‘software’ of health systems, how it interacts with the ‘hardware’ but also how actors, institutions and relations influence whether and how basic services are provided and to whom (Batley, McCourt, & McLoughlin, 2012; Olmen, 2012). The current research is strongly influenced by the perspective of maternal health services as social institutions and is interested in the informal and formal accountability relations and interactions that shape the way in which services are delivered.

**Accountability**

Most authors recognize that ‘accountability’ originates from political science and public administration where it is seen as one of the methods to constrain power (Lindberg, 2009). The definition by Brinkerhoff and Wetterberg (2016) represents a well-known definition of accountability, based on Schedler (1999): “Accountability concerns the obligation of one actor to provide information about and/or justification for his or her actions in response to another actor with the power to make those demands and apply sanctions for non-compliance” (Brinkerhoff & Wetterberg, 2016, p. 275).

This definition emphasizes the relational aspect (social interaction between two or more actors) of accountability characterized by an asymmetry of power in favour of those who have the right to demand answers to those who have an obligation to respond (Mulgan, 2003). The definition also implies that accountability is primarily ‘retrospective’; in the public sector, it is about opportunities to demand officials to explain their conduct after policies have been developed and outcomes have been observed (Grandvoinnet, Aslam, & Raha, 2015; Harlow & Rawlings, 2007). Accountability assumes the prior definition of a technical, political, social or moral responsibility and tasks to implement this responsibility. Accountability is about the (failure to) fulfilment of basic responsibilities rather than superior or exceptional performance (Brinkerhoff, 2004).
Two other elements are key in an accountability relation: ‘answerability’ and ‘enforcement’. Answerability refers to the right to get a response and the obligation to provide one, and enforcement refers to the capacity to ensure an action is taken, and the access to mechanisms for redress or sanctions when answerability fails (Newell & Wheeler, 2006a). It is argued that answerability is about ‘calling to account’ while enforcement, and in particular, the ‘possibility’ of sanctions – not the actual imposition of sanctions – constitutes the actual ‘holding to account’ beyond the non-committal provision of information and explanations (Bovens, 2007). Answerability without enforceability (sanctions) is often considered to be weak accountability, unable to deal with illegal or inappropriate actions and transgressions in behavior (Brinkerhoff, 2004).

Bovens (2007) is one of the scholars who questions whether accountability requires all these elements for a relation to work in practice. Only the stages of information and debate might be sufficient to qualify a relation as an accountability relation (Bovens, 2007; Joshi, 2013). Also, accountability is not necessarily a formal obligation or agreement, it may also be more intangible or voluntary where an actor feels a moral obligation to explain and justify his conduct to some significant other (Meijer & Bovens, 2005). Accountable behavior is then encouraged without procedures and the threat or application of sanctions.

Scholars agree that accountability can take a number of forms, depending on the actors and institutions involved. In public accountability literature, at least five types of accountability are distinguished: administrative, professional, political, legal and social accountability (Bovens, 2007).

‘Administrative’ (or ‘internal’ or ‘bureaucratic’) accountability refers to mechanisms such as regulation, supervision and performance discipline within the health system hierarchy (Cleary, Molyneux, & Gilson, 2013; Wild, Chambers, King, & Harris, 2012). This form of accountability is mainly interested in whether providers meet procedural and quality standards (Brinkerhoff, 2004). Administrative accountability works through self-regulation, the introduction of rules and measures of control and sanctions for non-compliance. ‘Professional’ accountability refers to mechanisms where peers hold each other accountable, for example through vocational associations (Hupe & Hill, 2007). ‘Political’ accountability refers to elected officials and legislatures overseeing ministers and public agencies but also to citizens calling politicians to account on electoral promises and performance through regular elections (Brinkerhoff, 2004). In ‘legal’ accountability, civil and administrative courts judge and sanction deviances based on detailed legal standards or precedent (Bovens, 2007).

‘Social’ accountability, the focus of this thesis, refers to actions by ‘social actors’, citizens and civil society to demand public officials, politicians and civil servants, answers
for, and reports on, their actions. Social accountability is often used as an umbrella term to describe all forms of downward accountability of ‘the state’ to citizens or users. It is also referred to as the ‘demand-side’ of accountability (Brinkerhoff & Wetterberg, 2016), ‘bottom-up oversight’ (Croke, 2012) or ‘citizen-led accountability’ (Gaventa & McGee, 2013). In the field of service delivery, it generally refers to citizens seeking accountability from providers with regard to the relevance, accessibility, quality and equity of the services they provide (or fail to provide) (McNeil & Malena, 2010; Joshi & Houtzager, 2012; Olmen, 2012). Several authors emphasize that it is important to conceptually differentiate this type of citizen engagement from community participation in the sense of information, consultation, co-production of services and mobilization to attend clinics (Murthy & Klugman, 2004). It is also different from the citizen participation agenda of the 1990s that aimed to strengthen citizen voice in the ‘front-end’ of policy and planning processes. Social accountability focuses on the empowerment of citizens through downstream citizen monitoring and oversight (Gaventa, 2016).

Social accountability is approached from two main perspectives. From a normative perspective, providing spaces for citizen engagement and social accountability is a desirable goal in itself. Arguments for social accountability, then, are based on the assumptions that social accountability: (1) increases empowerment and voice, (2) leads to the inclusion of marginalized groups, (3) the transformation of power relations, and (4) respect of human rights (Cornwall, 2011; Newell & Wheeler, 2006b). From an instrumental perspective, social accountability serves as a means to (1) improve service delivery and efficiency (by taking into account citizens views), (2) compensate for the weaknesses in government oversight and regulation and contribute to improved performance of public services, and (3) improve the perceived quality of care and hence increased demand for health services (Wetterberg, Brinkerhoff, & Hertz, 2016). From a systems perspective, the different perspectives are complementary; (social) accountability may have both instrumental and intrinsic values and some purposes may be more relevant to some contexts than others (Hupe & Hill, 2007).

Social accountability is increasingly seen as having a function for societal learning and dialogue (Brinkerhoff & Wetterberg, 2016) and the development of an accountability culture (Newell & Wheeler, 2006b). Social accountability actions, then, support the development of new skills of citizens and citizen groups for monitoring and advocacy, elevating citizens from voting in periodic elections and simply providing feedback to promoting change. Similarly, through social accountability, government officials and civil servants develop new skills to better incorporate citizens’ needs and demands in service delivery and policies. The purpose of social accountability, then, is to increase service delivery fairness, equity, transparency, responsiveness, constructive dialogue
and dispute resolution (Brinkerhoff, 2004). Related to this position is the idea that social accountability could lead to improved relations of trust between citizens and the state, a necessary dimension of state building, in particular in fragile settings (Earle, 2011).

The ways in which social accountability is pursued depends on the purpose of citizen engagement with state actors. Social accountability can work through confrontation and contestation. Citizen protests, petitions and media campaigns, for example, can provide naming and shaming mechanisms to ensure public awareness and to impose reputational costs to trigger political action (Acosta, Joshi & Ramshaw, 2013; Heidelberg, 2015). It can also work through collaborative and constructive approaches. Social accountability with the purpose of learning and co-production, for example, is not about contestation or control, but about the power of mutual responsibility and cooperation.

The different types of accountability co-exist: public institutions are confronted with many eyes applying different criteria to hold them to account for different issues (Bovens, 2007). In health systems, health ministries, insurance agencies, public and private provider organizations, health professionals, legislatures, finance ministries, regulatory agencies, professional associations and health facility committees or boards are all connected to each other in networks of control, oversight, cooperation and reporting (Brinkerhoff, 2004). Important in low-and middle-income countries is the presence of international donors who often play an important role in establishing accountability mechanisms in the context of aid funding. In addition to these formal institutions, informal, indigenous forms of accountability exist. Traditional leadership in sub-Saharan Africa, for example, often determines accountability structures and processes at the local level. Although it remains a minor strand of scholarship, researchers are increasingly interested in the role of informal accountability structures as well as the informality of formal governance structures (Leininger, 2014).

Scholars acknowledge the complexity of accountability relations because of the multiplicity of actors, responsibilities, competing demands and power dynamics. In the health sector, for example, the responsibility for the achievement of health system goals such as equitable access to quality care lies largely with state actors (World Health Organization, 2000). However, achieving them requires the active engagement of many actors (Brinkerhoff & Bossert, 2014). The distribution of responsibilities is one of the most complex issues in accountability because responsibility (for example in maternal health care) lies in many hands, not only in those of the state or health providers. That is, different actors contribute in many different ways to decisions, policies and implementation, which makes it difficult to identify who should be held accountable for what (Thompson, 2014). Moreover, the conception of responsibility and
accountability structures and processes may not reflect local power dynamics on the ground (Freedman & Schaaf, 2013). A primary task of researchers and policymakers, then, is to unpack different purposes of accountability relations and to explore, through empirical research, who is held accountable for what and by whom.

Studying social accountability

In most analyses and social accountability initiatives, the variety of purposes and goals of social accountability as well as their interactions with other forms of accountability and service delivery reforms are underemphasized (Brinkerhoff & Wetterberg, 2016). Social accountability, then, is often translated into interventions and tools, usually promoted by the international development community. Examples of social accountability tools are illustrated in Box 2.1.

Project or tool-based approaches to social accountability are sometimes criticized for not reflecting the political realities of governance in most low-and middle-income countries (Booth, 2012; Joshi & Houtzager, 2012). Similarly, evaluations and case studies on social accountability interventions rarely recognize the complex nature of accountability relations and the fact that they take place within a wider governance and accountability context. From such perspectives, social accountability should be understood as an on-going dynamic relationship between public officials and citizens, not merely a one-off activity or individual intervention. Furthermore, they should be understood as part of an accountability ‘ecosystem’ (Halloran, 2015), ‘culture of accountability’ (Newell & Wheeler, 2006b), ‘micro-network’ of accountability relations, including professional and bureaucratic relations (Hupe & Hill, 2007). As a result of these insights, scholars increasingly call for political, context-sensitive and complexity informed approaches to study social accountability (Hickey & King, 2016; Joshi, 2013).

The primary focus of this thesis is on social accountability relations at the frontline of maternal health service provision between, on the one hand service users, citizens and community structures and on the other hand, health providers. The thesis however also addresses their interaction and co-existence with other types of accountability (bureaucratic, professional, traditional) that are part of the web of accountability.

### Box 2.1. Examples of social accountability tools or actions

- Civic education
- Social audits
- Watchdog NGOs
- Participatory budgeting
- Citizen-provider committees
- Public expenditure surveys
- Citizen/community scorecards
- Complaint and redress mechanisms
- Service or patients’ charters
- Right to Information campaigns
- Protests and demonstrations
- Public litigation
- Investigative journalism

Source: Wetterberg et al., 2016
Against this background and the theoretical concepts outlined in the previous chapter, an initial conceptual framework was developed for the study, visualized in Figure 2.1.

In this thesis, we use four main concepts that demarcate the scope of the study: users’ and citizens’ demands for better maternal health care, social accountability relations between citizens and providers, provider responsiveness, and context.

**Users’ and citizens’ demands for better maternal health care**

We apply our analysis to the case of maternal health care in rural settings, in particular to the level of primary health care. Citizen demands for service improvements are likely related to the availability, accessibility, acceptability and quality of health services and providers (Global Health Workforce Alliance, 2017). The latter two concepts include notions of respect, non-discrimination and dignity as defined in the Charter on respectful and safe maternal health care (White Ribbon Alliance, 2011). Accountability assumes that these objectives and principles, are not, or partially, met.

**Social accountability relations**

In line with our perspective of health systems as relational, we emphasize in our research the often-overlooked nature of social accountability: that it is (like all accountability relations) about human relations, interactions and feedback loops. Rather than
taking particular tools or mechanisms, such as citizen report cards, community scorecards or social audits as entry points for analysis, we take the accountability relation between actors as entry point to study social accountability, aided by the following operational definition of Bovens (2007) of an accountability relation: “A relationship between an actor and a forum, 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” (p. 447).

The locus of these relations is at the ‘micro-level’, around primary health care centres in rural settings. Translated to the micro-level of analysis, then, the ‘actor’ refers to health providers (health professionals, including doctors, clinicians, nurses, auxiliary staff and community health workers). In this thesis the terms ‘health provider’ and ‘health worker’ are used interchangeably. The ‘forum’ refers to citizens or citizen groups (female and male service users, associations, committees or civil society organizations). This thesis focuses on the accountability relation between citizens and health providers but they will be analyzed in the context of other forms of accountability and in their interaction with other accountability actors.

As can be seen in the figure, the relation at the micro-level entails an engagement of participants in three steps: information, dialogue and consequences (or the ‘possibility’ of imposing positive or negative consequences). In accountability literature, the relevance of these steps varies according to the type of accountability. In social accountability relations, citizens generally do not have the direct power or authority to apply sanctions to providers; this power usually resides in internal (bureaucratic) or judicial institutions (Bovens, 2007). Therefore, we hypothesise that citizens rely to a large extent on dialogue, engagement, forms of social pressure and positive consequences to influence provider performance and responsiveness (Hupe & Hill, 2007; McGee et al., 2010). We further hypothesise that when citizen actions are backed by, or can activate, formal accountability or oversight institutions such as bureaucratic, professional or judiciary accountability mechanisms, providers might be more responsive to citizens (Peruzzotti, 2011). As Paul (1992) argues: “the only way the behavior of service providers can be made more responsive to the public is through signals from the hierarchical control (e.g. monitoring and incentives) of the agency” (p. 1048). So besides engaging directly with health providers (horizontal arrows in the figure), citizens can actively use, and push for the activation of formal accountability institutions and sanction mechanisms (Peruzzotti, 2011). The possibility of using or activating these institutions both shapes and influences citizen actions and has implications for the accountability process as well as the responses of health providers.

By adopting the perspective of social accountability as an on-going dynamic relationship between citizens and providers, it is assumed that the interactions between a
forum and an actor can be organized, structured and/or collective, but also informal, spontaneous, individual and/or unorganized (Hupe & Hill, 2007; Hossain, 2009).

**Responsiveness**
This thesis focuses on the intermediary outcome of ‘responsiveness’ at the level of health providers, aiming to understand how health providers react to citizens’ feedback on performance or calls to account for poor services. In development literature, responsiveness is defined as “the extent to which a public service agency demonstrates receptivity to the views, complaints, and suggestions of service users, by implementing changes to its own structure, culture and service delivery patterns in order to deliver a more appropriate product” (Goetz and Gaventa, 2001, p. 6). Molyneux, Atela, Angwenyi, & Goodman (2012) confirm this for the health sector by defining responsiveness as: “changes made to the health system on the basis of ideas and concerns raised by, or with, community members through formally introduced decision-making mechanisms” (p. 542). Joshi (2007) asserts that responsiveness is also about the capacity to manage competing claims. These definitions emphasize the change that responsiveness is supposed to bring: changed attitudes, behavior and performance, service improvement or adaptation and better quality of care at the frontline of service provision. Improved responsiveness may also result in better (perceived) quality of care, enhanced satisfaction of service users, and ultimately in increased utilization and improved health outcomes, such as reduced maternal mortality and morbidity. In this thesis the main interest is in the intermediate changes in responsiveness at service delivery level, rather than outcomes and impacts further down the results chain.

**Context**
We distinguish three interrelated levels of context relevant for the forum, the actor and for their accountability relationship: the individual, micro-level, and structural context.

Individual context: most studies agree that social accountability and participatory governance work best when one main condition is met: the willingness and capacity of key actors to engage (Speer, 2012). Whether or not individual citizens actively engage in a social accountability relation depends on their perceptions on the quality of care and their willingness and capacity to demand accountability. More specifically, social accountability initiatives can work only if people know what they want, know what they are entitled to, and are frustrated about not getting it. Social accountability further requires an ability to articulate and voice concerns, and a willingness to invest time and effort into changing the status quo (Lee, 2011). Adapted to the context of maternal health care, it is particularly the willingness and capacity of women, as key
users of services, to express concerns and engage with health providers directly or indirectly.

Also, individual health providers’ willingness, capacities and resources to engage with citizens, beyond their clinical tasks, is considered an important determinant of the functioning of the interaction (McCoy, Hall, & Ridge, 2012; Cleary et al., 2013). Health providers’ understanding of the role of citizen groups, their recognition of citizens’ claims, or their perspective on service monitoring by non-professionals may make them more or less receptive to citizen initiatives (Berlan & Shiffman, 2012; Cleary et al., 2013; George, Scott et al., 2015). If this awareness and recognition is not there, social accountability will not produce responsiveness (Dasgupta, 2011).

The micro-level context refers to the local politics of participation and representation that shape accountability relations. Local power dynamics define who is invited and involved in what stage of the process and how power differences are played out. Although Figure 2.1 could be interpreted as portraying the forum and the actor as having equal influence and power, this is not the case. The degree of power and authority among the two main actors differ substantially, whereby it is generally assumed that providers hold more power (based on discretion, information and expertise) than citizens (Brinkerhoff, 2004).

Structural context: adopting a context-sensitive approach to study social accountability, we posit that social accountability relations are embedded within wide institutional, organizational, cultural and political settings (Brinkerhoff and Bossert, 2008). The existing literature identifies a range of broader contextual factors that shape, and are shaped by, social accountability initiatives. O’Meally (2013) identified political and cultural ‘domains’ that matter for social accountability. They include civil and political society, inter-elite relations, state-society relations, the history of citizen mobilization and experiences with activism or contestation and conflict, and global factors, including international aid (O’Meally, 2013). Many of these identified contextual factors apply to social accountability in general but they vary according to the theoretical underpinnings of social accountability and across time and place. We integrated in our framework the factors specifically related to social accountability in (maternal) health care.

As explained above, the potential of social accountability initiatives to address service performance partly depends on their ability to lever formal (bureaucratic, professional, political, judicial) accountability institutions and the media (see section 2.2). This assumes, however, that these institutions are accessible and of sufficient quality (e.g. effective regulatory systems, including civil service systems, oversight and management of human resources) and that officials are willing to support social account-
ability efforts (Brinkerhoff & Wetterberg, 2016). External interventions, such as the introduction of a social accountability tool or project are also considered part of these ‘third parties’; they can constitute facilitators (when effectively used or activated by local actors) as well as barriers to local accountability relations.

Other health system factors that can influence the functioning and outcomes of social accountability processes are the nature of competition between health providers, the type of revenue source, levels of decentralization and availability of space for citizen engagement (Berlan & Shiffman, 2012). The under-resourcing of many health systems and understaffing of health facilities in low-and middle-income countries are well known explanations for poor health worker behavior and limited interest of providers to engage with citizens (Bohren et al., 2017).

Other structural influences over interactions between forums and actors, and their consequences, include the norms and values that define responsibilities and rights, duties and obligations that are central to an accountability relation (Cleary et al., 2013). They may include formal (as translated in policies and regulation) as well as informal norms about what is important in maternal health care, who bears responsibility, and about what is considered acceptable and unacceptable behavior on the part of health providers and other actors in the web of accountability relations (Aveling, Parker, & Dixon-Woods, 2016; Newell & Bellour, 2002). As such, norms are socially constructed and they are inherently about power. Power relations include gendered patterns of norm setting, prioritization and decision-making. The potential of social accountability in maternal health care specifically, depends on the opportunities it provides to women and girls and the way in which it addresses gender relations in the definition of norms and the operation of the accountability process (Bradshaw, Linneker, & Overton, 2016). Although power relations are studied in the context of social accountability, attention for gendered power relations has received less attention. The risks of reproduction of unequal power and gender relations through accountability initiatives has been conceptualized elsewhere (Heidelberg, 2015; Newell & Bellour, 2002), but empirical evidence of how it works in practice is limited. Addressing it in research could improve our understanding of why social accountability may not always bring about the change it had hoped for (Waylen, 2014).

Our conceptual framework presents an overview of the main actors, processes and expected outcomes of social accountability initiatives and a selection of individual, micro-level and structural contextual factors that could influence any of these elements. The framework should not be interpreted as a causal theory of change that can be read from the left to the right and that will be tested and revised during the research. It should be seen as a representation of potential factors and pathways that shape social accountability and provider responsiveness. Systematic research on
contextual factors and effects on social accountability processes and outcomes has only recently emerged (Brinkerhoff & Wetterberg, 2016; Grandvoisin et al., 2015; Joshi, 2014) and it has not generated conclusive findings on whether and how different contextual factors influence the functioning or outcomes of social accountability processes.

The research on which this thesis is based recognizes the complexity of social accountability. Complexity refers to the number of potential actors, the range of contextual factors and the causal complexity of social accountability relations that are only visible in Figure 2.1 to a limited extent. The functioning and effect of accountability on provider responsiveness and service delivery is hard to isolate from other factors and mechanisms that influence service delivery (Leininger, 2014). The mechanisms offered by different approaches to social accountability run in parallel or in combination with other initiatives that are designed to address poor performance (Wetterberg et al., 2016). As the figure suggests, responsiveness of health providers to citizens’ concerns can be the result of a combination of structural factors, micro-level factors and individual motives and perceptions. Furthermore, the different steps involved in a social accountability relation (information, dialogue, consequences) can influence responsiveness differently (Joshi, 2014). Also, the relation between the forum and the actor is a two-way relationship whereby the actor can stimulate responsiveness, but responsiveness can also encourage the forums’ willingness to voice concerns by showing that engaging with the actor makes a difference (Tembo, 2010). Similarly, a lack of enforcement or haphazard enforcement may undermine citizens’ confidence that providers and health systems are accountable and responsive to the public and generate a sense of apathy (Brinkerhoff, 2004). In conclusion, the nature of processes and outcomes are determined not by single causes but by multiple causes that can interact in both complementary and non-complementary ways (Bryne, 1998).

Recognizing that this study cannot produce complete, context-independent theories on social accountability, it presents context-specific knowledge on particular aspects of social accountability relations and initiatives.