Chapter 3

Research design

This chapter presents the research questions, research approach, substudies, methods and settings. The chapter ends with a section on research validity.

Research questions

Our central research question is formulated as follows:

*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?*

As mentioned in the introduction, social accountability has become an important issue in maternal health care but it is still largely unknown what social accountability entails, how it works in practice, for whom and under which circumstances. The conceptual framework proposes the key actors and features of social accountability processes and hypothesises the relationship between these processes, outcomes and contextual factors. The central research question is formulated in such a way that it allows an empirical exploration of the phenomenon of social accountability, its purpose and significance at the frontline of service delivery (part 1 of the question) and a theoretical reflection on how it can contribute to responsiveness and better maternal health care in particular contexts (part 2 of the question). For the theory building part of this thesis, a realist approach to social science is used that advises on a particular analytical method to studying complexity and that adds to the ‘how’ (can it contribute) question ‘for whom’ and ‘under which circumstances’ (see also research approach).

In order to answer the main research question, we formulated seven subquestions that are clustered around three themes: local social accountability relations and practices; accountability context; and, provider responsiveness to social accountability initiatives (see also Table 3.1).

**Local social accountability relations and practices**

As a first step towards understanding social accountability relations, this thesis examines how the processes of information, dialogue and consequences currently work in practice between citizens and health providers in their local context. In the conceptual
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framework it is postulated that social accountability relations operate in informal and formal ways, both of which are explored through the following research questions:

1. **What is the role of informal social accountability relations in monitoring and promoting responsive maternal health services?**
2. **How and to what extent do health facility committees facilitate and formalise social accountability relations and practices?**

The aim of the first question is to understand what social accountability as a process of on-going and daily interaction looks like at the local level of service provision, who constitutes the ‘forum’ in the immediate environment of health providers, and what channels and strategies are used by the forum to hold health providers to account. Question 2 aims to explore one particular social accountability interface within the local web of accountability relations: the health facility committee \(^1\) (HFC). Historically, HFCs have been part of the governance landscape in many health systems in low-and middle-income countries. A key assumption in this thesis is that, because of their formal position within the health system and their closeness to the frontline realities of health service delivery, health facility committees have the potential to address poor performance of maternal health services, either through direct engagement with providers or through the activation of bureaucratic accountability institutions.

**The accountability context**

As suggested in the conceptual framework, social accountability relations at the micro-level should be understood within their context to assess their relevance and potential to enhance health provider responsiveness. Beyond capturing the functioning of social accountability relations between citizens and providers, the aim of this thesis is to understand the broader accountability culture, the prevailing notions of responsibility, rights and accountability in policy discourses and practice. These themes are addressed in three questions, applied to the case of Malawi. Question 3 focuses on the role of traditional leaders in defining, monitoring and sanctioning men’s and women’s responsibilities in maternal health care and questions 4 and 5 address, respectively, the influence of gender norms and global and national maternal health policies on local level accountability relations:

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1 In this thesis, health facility committees (HFCs) refer to formally constituted structures with community representation that have an explicit link to a health facility and whose primary purpose is to enable community participation, improve health service provision and health outcomes. HFCs exist at different levels and have different names, depending on the context: village health committees, community health committees, health centre management committee, health facility board, health advisory committee etc. The term health facility committee (HFC) is used as an umbrella term throughout this thesis.
3. How do traditional leaders mediate accountability relations in maternal health care at the local level?
4. How do gender norms influence relations of responsibility and accountability in maternal health care?
5. How do global and national maternal health care policies affect local accountability relations?

Answers to these questions will provide a basis for understanding the place of social accountability in the wider accountability landscape. They will also contribute to understanding the role of power and gender in accountability, and the implications for women seeking maternal health services.

**Provider responsiveness to social accountability initiatives**

Given the central interest of this study in health provider responsiveness and the factors that influence provider responsiveness, we also need to know what these informal and formal relations and interactions mean to health providers and what makes them respond to social accountability initiatives and under which circumstances. This leads us to the sixth and seventh question:

6. How do health providers perceive, and respond to, local social accountability initiatives?
7. What makes health providers receptive and responsive to social accountability initiatives?

With question 6 we aim to evaluate the types of responses of health providers to social accountability initiatives. This will help to explore outcomes associated with social accountability defined in the conceptual framework. Question 7 emphasizes our interest in understanding how, why and when change happens, rather than whether it does so and to what extent (Maxwell, 2012). Hence, the purpose of this question is to critically reflect on why social accountability makes a difference, in particular for health providers, and under which circumstances. This theoretical reflection is needed in order to define the potential of social accountability and entry points for strengthening the opportunities for women, community structures and health providers to engage.

**Research approach and methods**

This research emphasizes the relational nature of health systems and social accountability processes and highlights the complexity of studying social accountability due to its different definitions, purposes and practices. Above all, the research concurs with the idea in complexity theory that organizational practices are often spontaneous and unorganized rather than subject of control. Qualitative research allows for
the exploration of the many dimensions of the social world, including the texture of
everyday life, the perceptions, experiences and meanings of research participants and
the ways in which social processes, institutions and relationships work (Mason, 2002).
A qualitative approach is most appropriate to develop a better understanding of the
functioning of social accountability relations in practice in maternal health care and
the types of changes social accountability can bring about, as well as the perceptions
on, and dimensions of, responsiveness rather than to assess or measure pre-defined
responsiveness outcomes.

The research design developed inductively in response to new information and chang-
ing circumstances (availability of study sites, actual study sites, access to data and
relations with study partners, participants and colleagues) as common in qualitative
research (Maxwell, 2012). This research is not based on one particular philosophical
perspective or paradigm; the complexity of studying social accountability requires the
use of different perspectives. The researchers’ understanding of social accountability
at the frontline of service delivery gradually increased by consulting scholarship from
political science, organizational sociology, in particular Lipsky’s concept of ‘street level
bureaucracy’ as developed by Hupe and Hill (2007), as well as theories on collective
action (Booth, 2012) and gender studies. The researcher also used scholarship that
contextualizes the concept of accountability in an African or low-and middle-income
country context (Berlan & Shiffman, 2012; Booth, 2012; Lindberg, 2009; Tembo, 2012).

The research subquestions were investigated by employing five substudies (see
Table 3.1). The first four studies are empirical studies conducted in the sub-Saharan African
countries of Malawi, Benin, Guinea and the Democratic Republic of Congo while the
fifth study is a knowledge synthesis study of social accountability initiatives in low-and
middle-income countries.

All empirical studies used a qualitative data collection and analysis method that
allowed richness and in-depth knowledge on social accountability processes, their
context and complexity (Mason, 2002). Each empirical study also included an effort to
reveal, test and develop concepts and theories in order to support analytical gener-
alizability beyond the particular settings of the cases (Polit & Beck, 2010). Therefore,
the empirical studies were each preceded by a review of existing knowledge on the
particular topic and the development or refinement of (parts of) the initial conceptual
framework. The different stages of data collection further refined the research ques-
tions of each substudy. As a result, each study had its particular objective, research
questions, methods, participants and focus. Overall, the studies iteratively and ac-
cumulatively build our knowledge of social accountability from the local and specific
(one single setting: Malawi) to the contextualization of the specific (multiple cases
across different settings in sub-Saharan Africa and low-and middle-income countries).
Studies in this thesis

Among the five substudies, study 1 focuses on daily accountability relations between individual citizens, organized citizens and health providers. Studies 2 and 3 focus on the ways in which health facility committees facilitate and formalise the social accountability process. Study 4 examines the political and gendered context of accountability relations in maternal health care and the role of traditional authorities in processes of accountability while study 5 assesses the effect of social accountability initiatives on health provider responsiveness.

For an in-depth and contextual understanding of social accountability relations at the frontline of maternal health service delivery, research in one setting for a prolonged period was deemed necessary. Studies 1, 2 and 4 represent the results of fieldwork conducted in Northern Malawi between 2015 and 2017. Study 3 was conducted in three other countries (Benin, Guinea, Democratic Republic of Congo) over a shorter period. Study 5 is based on a review of case studies from 14 low-and middle-income countries. In the following we provide further details on the individual studies.

**Study 1**, “Informal social accountability relations in maternal health service delivery in Northern Malawi” is an exploratory study on the daily interactions between citizens and health providers around the performance of maternal health services. It aims to describe the ways in which citizens provide feedback to health providers and how health providers experience social pressure and feedback in their local work environment. Through semi-structured interviews with 32 nurses and 19 clinicians, 155 accounts of citizen feedback were collected, including both instances of appreciation and complaints. The study aims to answer subresearch question 1: What is the role of informal social accountability relations in monitoring and promoting responsive maternal health services? At the same time, this study serves as an introduction to the next study by giving a broad overview of accountability relations in rural Malawi.

**Study 2**, “Approaches to social accountability by health facility committees in Northern Malawi”, focuses on the forum represented by HFCs, or health centre advisory committees (HCAC) in Malawi. These committees emerged as important formal social accountability structures in study 1 and study 2 aimed to further explore to what extent they formalise the information-dialogue-consequences process and how that affects health workers’ perceptions and practices. The study is based on documentary analysis and semi-structured interviews with 40 health workers, 22 HCAC members and 7 district authorities.

**Study 3**, “Social accountability in primary health care in West and Central Africa: exploring the role of health facility committees” consists of a synthesis of case studies on HFCs in three other countries: the Democratic Republic of Congo (DRC), Guinea
and Benin. Through comparative analysis of 11 cases (HFCs), the study identifies factors that shape HFCs accountability role and outcomes. At the same time it serves as input to contextualize study 2 on Malawi. Studies 2 and 3 jointly respond to the subquestion: How and to what extent do Health Facility Committees facilitate and formalise social accountability?

**Study 4**, “Gendered norms of responsibility: reflections on accountability politics in maternal health care in Malawi” serves to contextualize the findings of studies 1 and 2 by illustrating how citizen-provider accountability relations are embedded in a broader web of accountability relations, gender norms and power dynamics. The chapter is based on data from document search, observation, case studies, 35 semi-structured interviews, 19 focus group discussions (FGDs) with female maternal health service users, male community members, health workers, traditional leaders, local officials and health committee members. It focuses on the role of traditional and local authorities in defining responsibilities in maternal health care and in mediating accountability processes. It also provides a critical assessment of the gendered nature of these processes and their effects on women’s reproductive health rights and gender equality. The study serves to answer subquestions 3, 4 and 5: How do traditional leaders mediate accountability relations in maternal health care at the local level? How do gender norms influence relations of responsibility and accountability in maternal health care? How do global and national maternal health care policies affect local accountability relations? The findings illustrate how gender norms can influence (social) accountability relations and lead to unintended negative effects of maternal health programmes. They thereby inform our theories on how structural contextual factors can shape citizen-provider relations and health provider responsiveness to women’s concerns, linking with study 5.

**Study 5**, “Health provider responsiveness to social accountability initiatives in low- and middle-income countries” includes a realist review of social accountability cases. This is a particular qualitative method for research synthesis. Primary cases are analyzed according to a predefined protocol for data extraction, analysis and synthesis. The review has a descriptive (identifying types of initiatives, actors involved and outcomes) and an explanatory goal aiming to understand how social accountability initiatives achieve change. The latter results in a programme theory on health provider’ responsiveness to social accountability initiatives. Using a realist approach, retroductive analysis and triangulation of methods and sources are performed to construct Context–Mechanism–Outcome configurations that explain potential pathways to provider responsiveness. The initial protocol and the actual synthesis are presented in two different chapters (8 and 9, respectively).
Some elements of this programme theory are also addressed in the empirical studies (studies 1-4). The actor of interest across the studies are health providers in terms of their experiences with, and perceptions on, social accountability initiatives, in particular initiatives of health facility committees, and the influence of such initiatives on provider practices. All empirical studies include this provider perspective to some extent, hence allowing them, in combination with study 5, to contribute to answering subquestions 6 and 7: How do health providers perceive, and respond to, local social accountability initiatives? What makes health providers receptive and responsive to social accountability initiatives? Hence, answers to these questions are grounded in both empirical and secondary research.

Table 3.1 provides an overview of the studies and their relation to the research questions and chapters. The chapters are presented in three parts that correspond to the three themes presented in 3.1: local social accountability relations and practices (part I); the accountability context (part II); and provider responsiveness to social accountability initiatives (part III).

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<td>2 How and to what extent do health facility committees facilitate and formalise social accountability?</td>
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<td>7 What makes health providers receptive and responsive to social accountability initiatives?</td>
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Study sites and research teams

Malawi was chosen as the site to explore in-depth the local context of accountability relations. The particular study site, Northern Malawi, was selected in the context of a university-NGO partnership between the VU and the Dutch NGO Simavi who had implemented a maternal health rights project in the area, in collaboration with a Malawian NGO, the Foundation for Children’s Rights (FCR)\(^2\). Overall, the number of externally supported social accountability initiatives in Malawi has increased over the past decade in multiple sectors. Although most development projects in Malawi are concentrated in the Southern and Central Regions, the researcher expected stakeholders and participants in the Northern Region to be familiar with community participation and accountability discourse and interventions.

Benin, Guinea and the Democratic Republic of Congo were selected as part of a UNICEF funded study on the role of HFCs in social accountability in francophone countries\(^3\). In those West and Central African countries, HFCs have been part of the health system for more than 30 years and the funder, policymakers and partners had a keen interest in exploring the evolution of the role of HFCs in the governance of rural health facilities.

The governance and maternal health context of the four countries are somewhat similar. They all have poor maternal health status and weak health systems, while services are largely public.

In all four countries, the research was carried out at primary health care level in rural districts, supported by the fact that the majority of the population lives in rural areas and thereby the majority of women receive maternal health services at the level of primary health care and, in the study countries in particular, in rural areas.

For all the studies in this thesis, the author was the main researcher, who collaborated with researchers from Benin, Guinea, DRC, Malawi and the Netherlands. The responsibility of the author was in conceptualizing and designing the research approach and coordinating the development of the research protocols, data collection and analysis tools and processes. The author was also responsible for data analysis, synthesis, and reporting and led the writing process for all articles. The author was not part of the data collection teams in study 4 (Benin, Guinea, DRC), allowing some distance\(^2\) Campaign for increased access to quality health care services among rural women and children in Mzimba district that included components to strengthen capacities of health centre advisory committees, area development committees and traditional birth attendants.

\(^3\) The research project entitled ‘Le rôle d’interface des comités de santé en Afrique de l’Ouest et du Centre’ was funded by UNICEF/WCARO’s Muskoka Fund to strengthen the achievement of MDGs 4 and 5 in Francophone and West African countries.
between the research and implementation and a role in facilitating joint analysis, synthesis and writing.

**Ethical considerations**

Ethical approval was obtained for all the primary data collection as explained in each of the individual chapters. The initial research proposal was approved by the Scientific Research Committee of EMGO in Amsterdam. Ethical approval for studies 1, 2 and 4 was granted by the National Health Science Research Committee of the Ministry of Health in Malawi (NHSRC#15/03/1398). Approval for the research in Benin, DRC and Guinea was obtained from ethical review boards at the Department of Sociology, Anthropology of the University of Abomey, Benin, the School of Public Health in Kinshasa, and the Ministry of Health in Guinea in 2013. In each study, strategies were employed to mitigate risks for participants engaged in the interviews. They include measures to ensure confidentiality and anonymity of data, informed consent and training of researchers, assistants and support staff.

**Research validity**

Throughout this thesis, a variety of strategies was employed to minimize bias and preserve the internal and external validity of the results of both the qualitative empirical research and the review.

**Internal and external validity of the results of the qualitative empirical studies**

In qualitative research, internal validity refers to the question how far the constructions of the researcher are grounded in the constructions of those being researched (Flick, 2009), also referred to as trustworthiness and credibility of research conclusions. We used several approaches to enhance the validity of the research conclusions.

All empirical substudies were designed through collaborative processes involving multiple researchers and peer review. For example, the protocol for the multi-country study on HFCs was developed by a group of six senior researchers from four different countries and diverse backgrounds to ensure critical reflection and a joint assessment of preconceptions and potential bias arising from them. The studies in Malawi were designed in collaboration with practitioners (NGOs and district officials). In all protocols, measures for internal team reflection, member checks and validation sessions (where data and interpretations are tested with research participants) were organized (Gray, 2014).

For the analysis stage, we used three types of triangulation to enhance the reliability of the findings. We used investigator triangulation (multiple researchers involved in data collection and analysis). Two or more researchers tested codebooks indepen-
dently and disagreement on code definitions and selection were solved in research teams. We used methodological triangulation (use of multiple methods to collect data, including documents, interviews, focus group discussions, and field notes) and source triangulation (use of a diverse range of respondents sharing their views on social accountability). Reliability is enhanced through systematic coding and data analysis using qualitative data software; in most studies MAXQDA (versions 11 and 12) was used.

Researchers need to adopt a ‘reflexive stance’ through which they critically and repeatedly reflect on their influence on the research process (Hall & Callery, 2001). Throughout the research, this was achieved by keeping a project journal to make observations and note thinking on what was expected, seen and heard during field work. Observations and notes were regularly discussed with supervisors, to check how original ideas moved on during the research and when and how the focus shifted. Insights gained through literature guided reflection during the implementation of the empirical research by mirroring empirical findings with ideas from the literature and broader theory attending to external validity.

**Validity of findings obtained from the realist review**

Literature reviews apply the same principles of internal validity as described for empirical studies. It is important during data extraction to check on a regular basis the abstracted data against the data and arguments in original articles to ensure that the analysis does not deviate from the original intent of the authors (Jackson et al., 2009). Realist review, in itself, is a methodology to establish external and construct validity because of its theory-based nature. We attempted to ensure the validity of the results of the realist review by focusing the review questions on a particular set of outcomes and target groups, health providers. Furthermore, the search strategies, data extraction and analysis steps were outlined in a peer-reviewed protocol and documented as the review progressed. Moreover, at least two researchers evaluated each study for inclusion, and analyzed the included studies separately.

The overall validity of this thesis relies on the cross-checking of findings and conclusions in light of existing published literature and among the studies of this thesis. This will be addressed in the synthesis and conclusions chapter (Chapter 10).

**Embedding of the PhD research**

This study was conducted in the context of the Global Health Policy and Health Systems (GHPHS) research programme funded by the Netherlands Organization for Scientific Research (NWO). In 2012, the Athena Institute of the VU University Amsterdam and its partners (Royal Tropical Institute, l’Institut National de Santé Publique
in Burundi, l’Ecole de Santé Publique in the Democratic Republic of Congo) started the implementation of a multi-country research programme that aimed to contribute to building the evidence-base to inform the conceptualization and policy-making regarding social accountability in maternal health services in sub-Saharan Africa. The programme consisted of four subprojects involving intervention research in Burundi (subproject 1) and the Democratic Republic of Congo (subproject 2), case studies in other sub-Saharan countries (subproject 3), and a comparative study to develop an integrated conceptual framework for social accountability in maternal health (subproject 4). The focus of all research projects was on maternal health services at the primary health care level where health facilities provide antenatal, birth and postnatal care. This thesis concerns the results of subproject 3 that was implemented between November 2012 and April 2017.