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Review

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Health provider responsiveness to social accountability initiatives in low- and middle-income countries: a realist review

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Abstract

Social accountability in the health sector has been promoted as a strategy to improve the quality and performance of health providers in low- and middle-income countries. Whether improvements occur, however, depends on the willingness and ability of health providers to respond to societal pressure for better care. This article uses a realist approach to review cases of collective citizen action and advocacy with the aim to identify key mechanisms of provider responsiveness. Purposeful searches for cases were combined with a systematic search in four databases. To be included in the review, the initiatives needed to describe at least one outcome at the level of frontline service provision. Some 37 social accountability initiatives in 15 countries met these criteria. Using a realist approach, retroductive analysis and triangulation of methods and sources were performed to construct Context–Mechanism–Outcome configurations that explain potential pathways to provider responsiveness. The findings suggest that health provider receptivity to citizens' demands for better health care is mediated by health providers' perceptions of the legitimacy of citizen groups and by the extent to which citizen groups provide personal and professional support to health providers. Some citizen groups activated political or formal bureaucratic accountability channels but the effect on provider responsiveness of such strategies was more mixed. Favourable contexts for health provider responsiveness comprise socio-political contexts in which providers self-identify as activists, health system contexts in which health providers depend on citizens' expertise and capacities, and health system contexts where providers have the self-perceived ability to change the system in which they operate. Rather than providing recipes for successful social accountability initiatives, the synthesis proposes a programme theory that can support reflections on the theories of change underpinning social accountability initiatives and interventions to improve the quality of primary health care in different settings.

Keywords: Citizen participation, health providers, health rights, health services, low- and middle-income countries, realist review, responsiveness, social accountability

Key Messages

- The evaluation of the effect of social accountability on health service providers has been challenging. A range of citizen actions is associated with the general concept of social accountability and citizen–provider relations are context specific. In order to address this complexity, a realist approach for the review of evidence was applied.
- The findings provide insights into the perspectives, reasoning, agency and abilities of health providers to respond to citizens' concerns and hence provide a more nuanced picture of the potential of social accountability for the improvement of health services. The authors emphasize the need to evaluate intermediate effects, such as attitudinal or behavioural change of participants, of social accountability initiatives.
- This review suggests a programme theory that may help practitioners and policymakers to identify social accountability strategies that are likely to work in their contexts. It is a preliminary theory that could be further explored through existing and new empirical studies.

Introduction

Citizen participation in health policies and service delivery is receiving increasing attention as part of efforts to develop more people-centred health systems (Sheikh *et al.* 2014; WHO 2015). Citizen participation is expected to lead to improvements in quality, accountability and equity of health services. Collective action by citizens who demand greater accountability for failures in public social services is often referred to as 'social accountability' or 'external accountability' (Cornwall and Gaventa 2000; Cleary *et al.* 2013). The concept of social accountability has its roots in political science, theories of public administration and development studies, including rights-based approaches and participatory governance. In health systems literature, social accountability is seen as a means of strengthening community participation (Molyneux *et al.* 2012). It implies that political and governmental actors, including public service providers, are held to account for their actions and decisions by citizens. Public providers are thereby expected to actively respond to citizens' demands, requiring a behavioural change towards more openness towards discussing poor performance and willingness to improve the power of service users and accountability, and eventually to adapt service delivery practices (McNeil and Malena 2010; Molyneux *et al.* 2012; Joshi 2013). Social accountability is more likely to achieve such behavioural change when use is made of rewards and (the prospect of) sanctions, such as public shaming, in the process of demanding improved services (McNeil and Malena 2010). Social accountability can be distinguished from 'internal' or 'bureaucratic' accountability referring to mechanisms such as supervision and performance discipline within the health system (Wild *et al.* 2012; Cleary *et al.* 2013). Studies of human resources for health argue that monitoring and feedback from both external actors (patients, citizens and communities) and internal actors (managers, supervisors and colleagues) is a key determinant of health worker motivation and performance (Franco *et al.* 2002; Willis-Shattuck *et al.* 2008). Social accountability is considered to be particularly relevant to contexts where regulation through internal accountability measures is weak or where formal political and judicial channels are inaccessible to the majority of citizens, in particular the poor (Shukla *et al.* 2013; Fox 2015).

Recent literature reviews have provided useful insights into the internal functioning of citizen groups and their impact on community empowerment, state and government responsiveness, human development and health outcomes (Gaventa and Barrett 2010; Gaumer *et al.* 2011; McLoughlin and Batley 2012; Croke 2012; Molyneux *et al.* 2012; Ringold *et al.* 2012; Joshi 2013, 2014; Rifkin 2014). A few studies consider the effect of social accountability on health service providers (e.g. Berlan and Shiffman 2012; Joshi 2014; Fox 2015) but reaching conclusions is challenging because of mixed results and the context-sensitivity of such initiatives. The existing literature identifies three broad contextual domains that influence health provider responsiveness to societal demands. First, health system factors have a significant impact on responsiveness. These factors include the nature of competition between health providers, the level of provider autonomy, the relative importance of community priorities *vis-à-vis* funder or national priorities and the relative importance of social accountability *vis-à-vis* internal accountability (Gaumer *et al.* 2008; Berlan and Shiffman 2012; Wild *et al.* 2012; Cleary *et al.* 2013; Batley and Harris 2014). For example, provider responsiveness to the public may be constrained if professional careers depend on the goodwill of direct supervisors or political connections in the recruitment processes (Acosta *et al.* 2013; Therkildsen 2014). Second, broader contextual factors have an influence on social accountability and provider responsiveness, including histories of citizen-state engagement and experiences with activism or contestation and conflict (O'Meally 2013). Third, some authors highlight the local level context of social accountability initiatives, such as the presence and quality of 'voice' of citizens, the local politics of participation, as well as providers' attitudes to and resources for citizen engagement (McCoy *et al.* 2012; Cleary *et al.* 2013). For example, health providers' understanding of the role of citizen groups or their perspective on service monitoring by non-professionals may make them more or less receptive to citizen initiatives (Berlan and Shiffman 2012; Cleary *et al.* 2013; George *et al.* 2015). Joshi (2014) stresses that components of social accountability initiatives, such as information collection, demand articulation and presentation, can influence responsiveness differently. Responsiveness of health providers to citizens' concerns is thus the result of a combination of the broader governance and health system context, features of the social accountability initiative and motives and perceptions of providers at a particular point in time. Hence, social accountability is increasingly recognized as a complex phenomenon leading researchers, practitioners and policymakers to stress the need to clarify 'pathways to change' and to unpack the 'black boxes' of outcomes of social accountability (Fox 2015; Grandvoinnet *et al.* 2015).

This article aims to contribute to understanding of how social accountability initiatives, in different contexts, influence health provider responsiveness to citizens' demands. It is based on a theory-driven review of cases of collective citizen engagement and advocacy in low- and middle-income countries. It takes a new perspective on the evaluation of social accountability, complementing other recent reviews (McNeil and Malena 2010; Acosta *et al.* 2013; Cleary *et al.* 2013; Joshi 2013; Fox 2015; George *et al.* 2015; Grandvoinnet *et al.* 2015). The insights can help researchers, policymakers and practitioners reflect on the theories of change of social accountability initiatives.

Review methodology

For this study, a realist approach to review of literature was used. Realist review represents an approach to diversify and mix methods of systematic review in order to respond to an increasingly varied set of policy questions in international development. It is a theory-driven approach focused on the underling programme theory and mechanisms driving interventions (Snilstveit *et al.* 2012). Our study is based on a protocol (Lodenstein *et al.* 2013) and guided by realist synthesis publication and quality standards and training materials (Wong *et al.* 2013a, b; RAMESES Project 2014) and other examples of reviews (Rycroft-Malone *et al.* 2012; Jagosh *et al.* 2014). This section outlines the rationale for using a realist approach as well as the methods used for data searching, extraction, analysis and synthesis.

Rationale for using a realist approach to review

Our choice of synthesis methods was informed by our study questions, the purpose of the synthesis, the status of current conceptualizations of social accountability, and the nature of existing studies and evidence (Pawson *et al.* 2004).

Based on a first scoping exercise of existing primary and secondary studies on social accountability, the authors identified two main questions for the review: what are outcomes of social accountability initiatives at the frontline of service provision? And how, and under what conditions, do these outcomes come about? In order to respond to these questions, the authors adopted a mixed methods approach to literature synthesis with an emphasis on the realist approach. Our first research question was expected to describe the types of social accountability initiatives and outcomes that are reported in literature. Our second question is more analytical and aims to explore explanations for outcomes including contextual factors and health providers' reasoning and behaviour *vis-à-vis* social accountability initiatives. Such subtle behavioural dimensions would remain hidden in standard methods of systematic review. Realist review is one of the approaches to systematic review that goes beyond questions on effectiveness. Rather than judging the effect of programmes ('what works') such as in traditional systematic reviews, realist review aims to develop understanding and explanation. It is an interpretative approach that supports the unpacking of causal pathways of complex interventions or phenomena by asking the question 'what works for whom under which circumstances?' (Pawson *et al.* 2004; Jagosh *et al.* 2014).

As outlined in the introduction, social accountability initiatives are complex: they do not directly lead to outcomes in health service delivery. From a realist point of view, it is rather the health providers' response to the incentives, resources or persuasion strategies provided by citizen groups that triggers change. A realist approach supports the identification of such *mechanisms* of human reasoning and behaviour. These mechanisms are further influenced by the broader context in which the initiatives take place. Therefore, it will be difficult to transfer lessons from one context to the other, unless patterns in the production of outcomes are identified. Researchers try to identify the link between 'contextual factors' (C) and 'mechanisms' (M) that, together, contribute to 'outcomes' (O). By analysing multiple social accountability initiatives, we aimed to identify such patterns (CMO-configurations) that constitute tentative mini-theories of change informing decisions and actions (Pawson *et al.* 2004; Blamey and Mackenzie 2007; McCormack *et al.* 2013). So, rather than providing a list of potential outcomes or contextual factors to take into account in social accountability, our purpose was to produce concrete theories that would help policymakers and practitioners reflect on how their particular initiative could be successful in their particular context.

A final consideration is the fact that, because of its multidisciplinary use, there is no generally accepted definition of social accountability; descriptions of the concept include broad notions of social movements and citizen participation as well as more narrowly defined interventions, such as patient complaint boxes and community scorecard projects. Also, research findings on social accountability are reported in both academic and grey literature, representing a range of research paradigms and methodologies. A realist approach can support the synthesis of complex evidence from different initiatives and a diversity of sources because it takes CMO configurations as units of analysis rather than programmes, interventions, activities, contexts or types of studies (Pawson *et al.* 2004; Snilstveit *et al.* 2015). Hence, it is able to acknowledge and build upon the diversity of theories, concepts, disciplines and research methods in the social accountability literature. The choice of a realist review methodology has implications for data searching, extraction, analysis and synthesis methods. These are well described and compared with systematic review methods by Pawson *et al.* (2004).

Articulation of a programme theory

As a first step in realist review, we developed a programme theory that makes explicit the components, actors and ways of working of a social accountability initiative. Through a scoping exercise and preparatory sessions with the authors and external experts, we explored the assumptions that underpin social accountability initiatives. We developed a rough programme theory, a description and diagram that helped to guide the review, adapted by further evidence as the review progressed. Our initial theory comprised one main CMO (see Figure 1) whereas the eventual programme theory comprises multiple CMO configurations and linkages.

Search strategy

The review aimed to cover the breadth (review question 1) as well as the depth (review question 2) of social accountability initiatives. Therefore, a systematic search was combined with purposive searches of the literature. After an initial scoping period and the collection of academic and grey literature from websites of social accountability networks, we conducted a systematic literature search of four databases: Medline, Sociological Abstracts, International Bibliography of Social Sciences and Web of Science. The search was conducted in September 2014 with the assistance of a research librarian. Search keywords combined terms related to social accountability initiators [e.g. committees, civil society organizations (CSO), movements], the health sector and the country. Annex S1 (supplementary file S1) provides the detailed search terms used for the Web of Science that were adapted to other databases, depending on the specific database requirements. Publication dates from 2003 to 2014 were selected. The emergence of the topic of accountability in service delivery is often associated with the appearance of the 2004 World Development Report, published in the year 2003 (World Bank 2003). Therefore, we took that year as the starting point. Figure 2 presents the steps of study identification, screening and inclusion.

Screening and study selection

Titles and abstracts were screened to meet the following criteria: the study needed to (1) examine or describe an intervention,

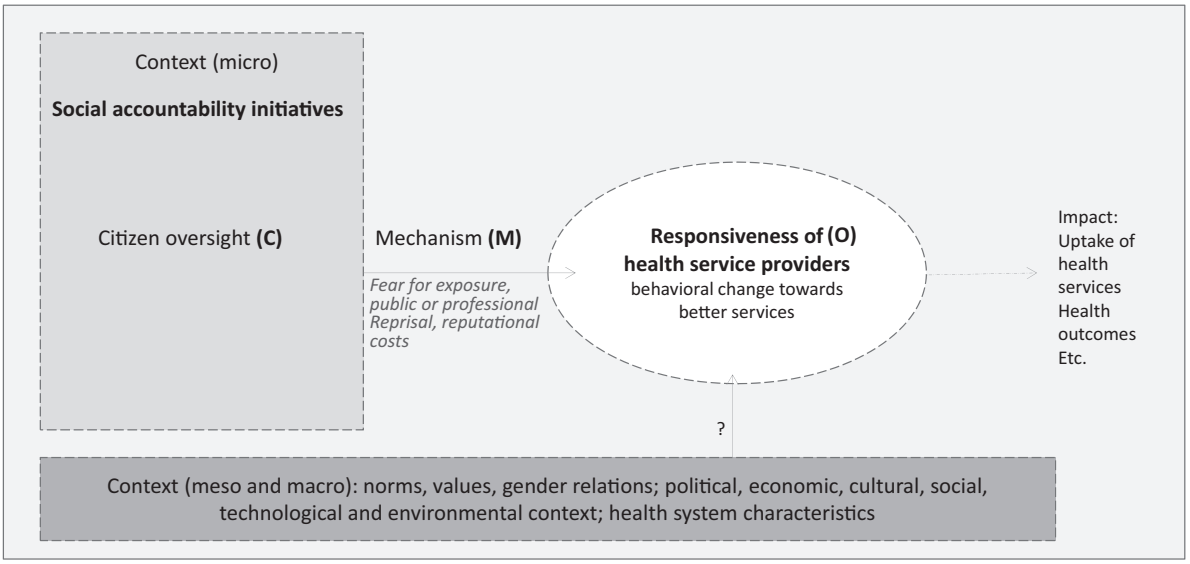

Figure 1. Initial programme theory.

Explanation of visual programme theory: 'Citizen engagement, backed by formal accountability measures and oversight (including enforcement and credible sanctions) by civil society, media, the judiciary or governmental actors (C), can shift incentives for providers by fear for exposure, public or professional reprisal and reputational cost of being sanctioned (M) leading to provider responsiveness (O).' Responsiveness is defined as the actual implementation of changes to service delivery. We also assumed that citizen engagement without additional oversight mechanisms would not lead to responsiveness or would lead to a minimum level of responsiveness ('receptivity') at best. This initial hypothesis (see also Lodenstein *et al.* 2013) was based on insights from several authors (e.g. McGee and Gaventa 2011; McLoughlin and Batley 2012; Acosta *et al.* 2013; Joshi *et al.* 2013; Fox 2015).

reform or case that explicitly aimed at strengthening collective citizen engagement (rather than cases of individual patient empowerment) to address weaknesses in health policies or services in the public sector (rather than improving health seeking behaviour); (2) be written in English (because of time constraints); (3) be located in low- and middle-income countries; and (4) be primarily empirical. The papers that met these criteria were read in full; one author read all of them and the second and third authors read every third and sixth paper. We divided the primary research papers into two categories: those that reported on responsiveness outcomes of providers, policymakers or other 'public' or 'state' agents or on relational outcomes (category A) and those that did not report relevant outcomes but were expected to provide evidence on context or mechanisms (category B). An inclusion decision in either of the categories was based on consensus between two authors or three in the case of doubts. In total, 87 articles reported responsiveness outcomes at different levels of which 40 reported on outcomes at service provision level. These 40 sources form the basis of the synthesis in this paper. The remaining papers were added to the second set of papers (category B), and some of them were used in later stages of the review to explain outcomes. Each of the 40 papers described one or more social accountability initiative, and some papers discussed the same initiative, covering a total of 37 initiatives. Papers describing initiatives (category A) were published in scientific journals ($n = 23$) or in book chapters and working papers ($n = 17$). Study designs included case studies (both descriptive and analytical), randomized control trials, longitudinal descriptive studies (including ethnographic studies), participatory-action research reports and evaluations. Rather than formal before-and-after evaluations, many authors used retrospective analysis of experiences and lessons learned with regard to the implementation of an initiative or policy.

Quality appraisal

In realist review, articles and papers are judged on their relevance and methodological rigour (Pawson *et al.* 2004). Relevance pertains to the presence of evidence to further inform the initial theory. Papers are not expected to provide full evidence; some papers may emphasize outcomes, others context, and others processes and mechanisms. Data from one study can be used to make sense of a pattern in another, and other sources may be used to build explanations (Pawson 2006). Given this approach, we purposefully included all types of studies, including from grey literature. Grey literature sources are very valuable in realist review because they usually contain more contextual richness than peer-reviewed journal articles (Booth *et al.* 2013). We assessed methodological rigour for grey literature and book chapters by judging the credibility and coherence of the methods, sometimes contacting authors or relevant websites for information about peer review procedures. In some papers, particularly in non-evaluative studies, it was not clear whether associations between actions and outcomes were based on empirical data or on author's opinions. In these situations, we did not discard the papers but triangulated the content with other empirical studies to support such interpretations. Reflections by authors sometimes also enriched our explanations. When such studies are used in the results section, they are distinguished from primary evidence.

Data extraction and analysis

The objective of data collection was to (1) identify the features of social accountability initiatives, (2) identify the outcomes associated with the social accountability initiative and (3) configure the explanation of how and under which circumstances these outcomes come about. Data related to objectives 1 and 2 were extracted with the

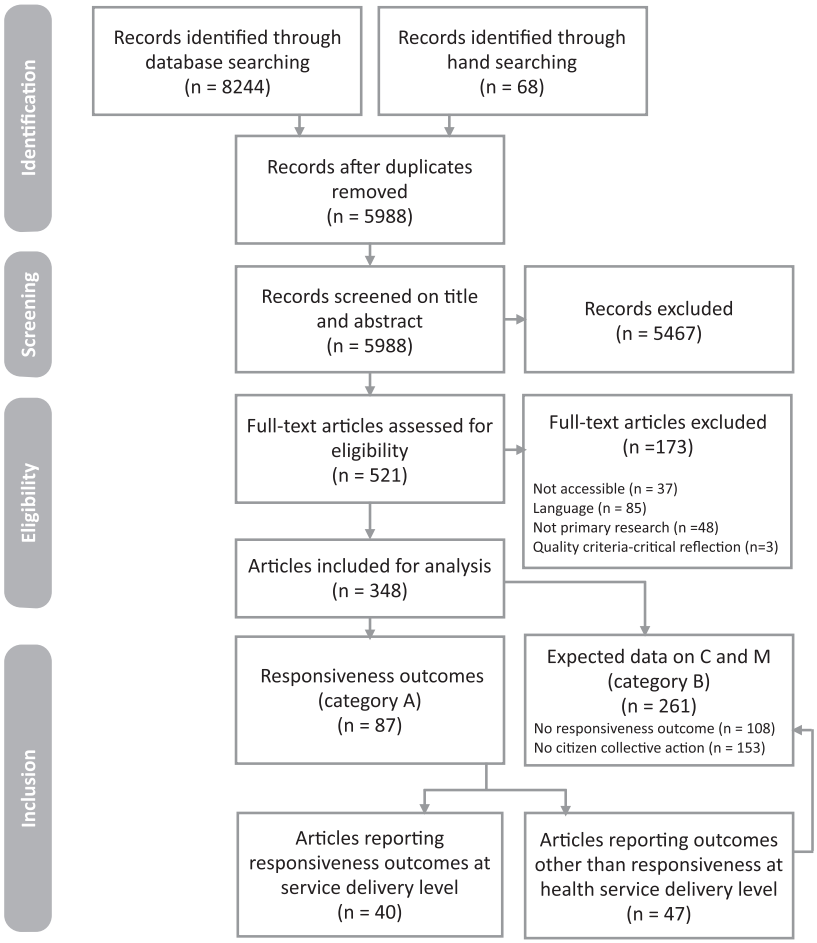

Figure 2. Diagram of the search, screening, selection and inclusion process.

use of qualitative coding software, MaxQDA. For objective 3, data extraction was guided by a coding framework that provided definitions and examples of Cs at micro-, meso- and macro-levels, and examples of Ms and Os with 'responsiveness' as the main outcome of interest (see Table 1). These guiding definitions were refined as data extraction progressed.

A word table was used in which all CMO passages were extracted, either as full CMOs or as individual Cs, Ms or Os. For each paper, data extraction and commenting were done independently by two authors. The authors compared and discussed their findings, and tried to reach consensus on the most important evidence presented in each paper. The initial programme theory (Figure 1) was used as a tracer CMO to which associated or new CMOs were added.

During analysis, the outcomes served as starting points for configuring CMOs through retroductive analysis whereby the circumstances under which a concept (e.g. responsiveness) occurs are identified in a backwards approach (Meyer and Lunnay 2013). This allowed the formulation of multiple CMOs. Patterns in CMOs called 'demi-regularities' were identified and built as evidence by data triangulation from different papers and by triangulating analytical methods. Retroduction was complemented by downstream and midstream analysis whereby respectively contexts and mechanisms were taken as starting points (Tilly 1999). Cross-validation between positive and negative outcomes was also done. Six CMOs were selected for synthesis and presentation in the Results section, based on the richness of, and patterns in, available evidence.

Results

The Results section first presents an overview of the features of the social accountability initiatives as well as the responsiveness outcomes. This is followed by six sets of explanations (CMOs) that appear critical to the outcomes identified. At the end of this section, the findings are summarized and compared with our initial theory to develop a new programme theory.

Features of social accountability initiatives

Social accountability initiatives with responsiveness outcomes are presented in Annex S2 by name, health domain, country, type of actions and outcomes (see supplementary file S2). Figure 3 provides a summary of some of these features. The majority of the initiatives are located in South Asia and East Africa. Social accountability actions occur in different health domains and the majority addresses problems in primary health care. The others focus on reproductive health care, including maternal health services or HIV/AIDS, nutrition and mental health. There are six types of social accountability initiators including health committees, district health boards, non-

Table 1. Coding framework

	Context	Mechanism	Outcomes
Definitions used in realist inquiry	'Features of the conditions in which programmes are introduced that are relevant to the operation of the programme mechanisms' (Pawson and Tilley 2004, p. 7). 'Anything that can trigger and/or modify the behaviour of a mechanism' (Jagosh *et al.* 2011, p. 7).	Reasoning of participants prompted by the provision of resources, opportunities and constraints. Reasoning in the sense of logic-in-use, cognition, values, emotions (Westhorp 2014).	Outcomes are either intended or unexpected, and defined as either intermediate or final (Jagosh *et al.* 2011).
Definitions used in this review (adapted from Lodenstein *et al.* 2013)	Three levels of context (1) Micro-level: social accountability initiatives: type and features of initiator, type of actions and practices (2) Meso-level: structure, culture and practices of the health system, including accountability actions of authorities, interventions of other parties, local political alteration, health system reforms (3) Macro-level: the legal and historical context of citizen engagement, social norms and values, political ideology, economy	The precedents of provider responsiveness. The cognitive, pragmatic, emotional responses of health providers who (are invited to) engage in a social accountability initiative. Descriptions of interpretations, perceptions, feelings, acts with regard to social accountability initiators and actions (micro-level) and other meso- and macro-level contexts.	Responsiveness: the extent to which a health provider demonstrates 'receptivity' to the ideas and concerns raised by citizens and to which he/she (intends to, or actually) 'implements changes' to the decision-making or management structure, culture, policies or practices or by 'changing behaviour' at the point of service. (Not: a dimension of quality of care, patient-centeredness or the quality of patient–provider interaction at a more individual level). Responsiveness outcomes can be both positive and negative (no response or negative response). Health providers can refer to both individual health workers as well as the organizations that provide services in a public health facility at the local level.

governmental organizations (NGOs) and CSOs and their networks. In this article, the term CSO will be further used to refer to both NGOs and CSOs. In eight cases, community groups were newly established to facilitate a social accountability project. In many cases, actions are initiated in partnerships between organizations, also including governmental actors.

There is wide variation in the types of social accountability strategies used by citizens. These strategies can be categorized according to key steps in accountability: information collection and analysis, presentation to officials or providers, action planning or negotiation, and follow-up where there has been an unsatisfactory outcome of the previous phases. Table 2 presents the type of actions within each of these steps. The actions are further classified on the basis of their approach (dialogue, advocacy), locus of action (local or subnational), initiating group (CSOs, NGOs or community-based groups, such as health committees) and target groups (frontline service providers, political and policy actors).

Actions at the health facility level often use a dialogue or participatory approach in which data collection occurs through observation, quality scoring in group discussions or interviews, problem analysis in participatory action research, and action planning at interface meetings between citizens and health providers. At that level, the main social accountability 'targets' are health workers and managers. Some initiatives (right column) use an advocacy approach in which citizens present their evaluation or claims in public hearings, demonstrations, or media reports. At that level, initiatives tend to target multiple public actors, such as providers as well as policymakers and politicians.

The categories of action, action levels and targets are not mutually exclusive. Some initiatives use a combination of methods and operate at multiple levels. A CSO in Bangladesh, for example, conducts daily quality monitoring in the hospital. This monitoring is complemented by visits to the hospital by municipal representatives, and their observations of service failure and success are regularly covered by the media (Mukhopadhyay and Meer 2004). In the case of Shukla *et al.* (2013), multi-level accountability is integrated into the design whereby the unresolved issues of local public hearings are discussed at higher-level public hearings where health authorities are present. In addition to facilitating dialogue or engaging in lobby and advocacy, some citizen groups provide health services. In this study, the level of action, approach, types of initiator and target group are considered to be micro-contextual elements.

Overview of responsiveness outcomes

The papers report three types of responsiveness outcomes at service provision level of which the majority is positive. Table 3 provides definitions and examples of outcomes for each of these categories. Increased 'receptivity' (O^1) is observed in changes in attitudes of providers towards citizen groups or in increased awareness and recognition of service challenges. 'Responsiveness' (O^2) translates into changes in health provider behaviour, involving concrete action to improve service provision in line with citizens' concerns. Negative outcomes refer to ignoring citizens' demands resulting in continued poor access or quality. The third category is concerned with changes in 'accountability relations' (O^3) between communities and service providers. The negative outcomes in this category are usually formulated as 'continued tensions between communities and health workers'. The three types of outcomes are closely linked but distinct in terms of the 'object' of change (O^1 and O^2 concern health providers, O^3 concerns changes in both providers and communities) and in the 'content' of change (O^2 concerns changes in access and quality of services, O^3 concerns changes to governance or accountability relations).

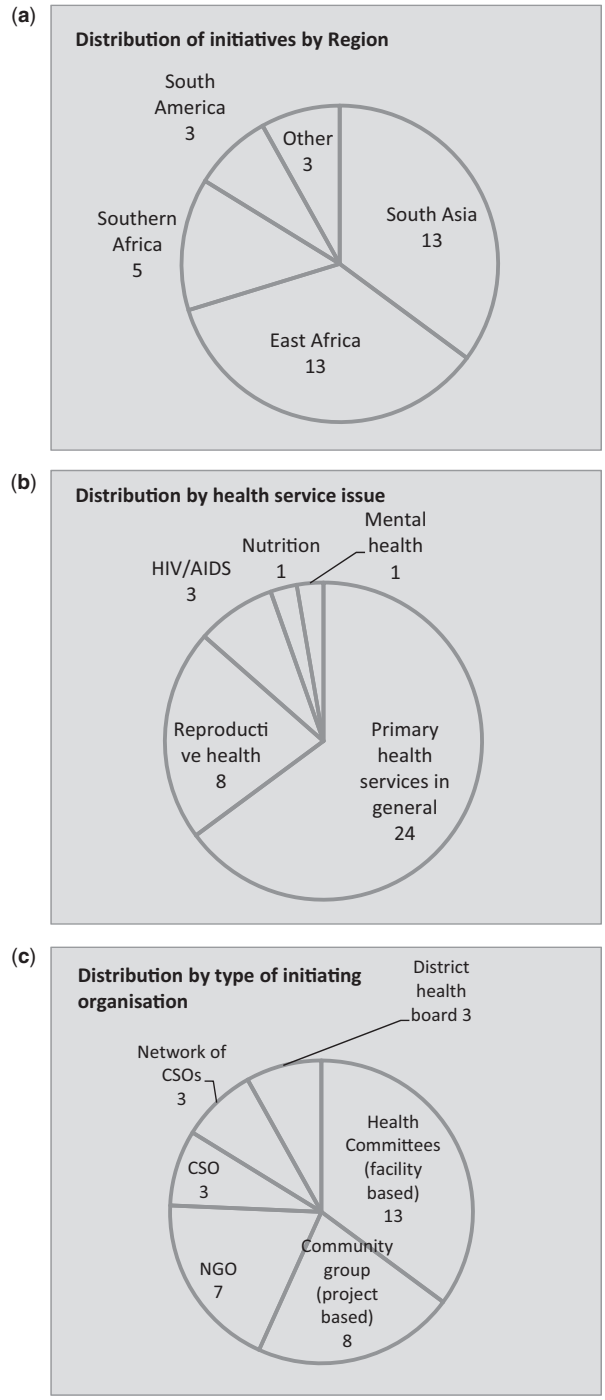

Figure 3. Features of the included social accountability initiatives.

Contexts and mechanisms influencing responsiveness outcomes

In the next section, we offer an explanation for outcomes by proposing links between contexts, mechanisms and outcomes. The evidence is presented under six themes which refer to the main mechanisms at play. Each theme is introduced by a synthesized CMO configuration, followed by supporting evidence and links to quotes. In most cases, it was difficult to disaggregate the evidence per category of outcome because the papers do not specify conditions under which attitudinal, behavioural or relational outcomes occur. This is why some CMOs include multiple Os that are formulated in Boolean (and/or) terms.

Provider's perceptions and expectations of health service users

CMO1. Many social accountability initiatives operate in health systems that are characterized by a power asymmetry between providers and service users (C). This influences providers' expectations of the role of service users in the monitoring and oversight of health services (M) and hence their responsiveness to groups engaging in social accountability initiatives (O^1, O^2, O^3).

The responsiveness of providers is likely to depend on whether they perceive users of health services as patients, recipients, beneficiaries, clients, consumers, citizens or holders of rights (Dasgupta 2011; Coe 2013). For example, in the context of free healthcare in Bangladesh, providers tend to view users as recipients (Mahmud 2007). This view is strengthened by the 'common belief in society that not everyone has equal rights; and, concomitantly, denial of rights is accepted as the natural order of things' (Schurmann and Mahmud 2009, p. 541). Jones *et al.* (2007) report that both providers and community members in health committees in India see themselves, respectively, as experts and beneficiaries. Rutebemberwa *et al.* (2009) explain how such perceptions in Uganda express existing power relations as illustrated by this quote from a community member: 'It is us, the patients, who should bend low for the health workers because it is them who went to school, they know where life is and they are the people God gave the gift of saving people' (p. 151). In such contexts, communities and providers often expect patients to be grateful for services, regardless of perceived quality. Wendland (2010) notes that in Malawi, clinicians are aware of the power asymmetry between them and their patients but they interpret it in two ways. On the one hand, providers acknowledge that feelings of superiority may harm patients. On the other hand, they suggest that their position allows them to defend voiceless patients *vis-à-vis* the health system and the government. Furthermore, expectations of the role of patients reflect the perception of providers that the oversight of health services is not a community responsibility but rather a responsibility of health managers or government (Macwan'gi and Ngwengwe 2004; Mahmud 2007; Ngulube *et al.* 2004; Ruano *et al.* 2014; Curry *et al.* 2012). Providers' perceptions of health service users as patients are likely to influence their attitudes to citizen groups and social accountability.

Providers' perceptions of the legitimacy of citizen groups

CMO 2. Citizen groups engaged in social accountability actions may generate provider receptivity (O^1) if providers perceive them as legitimate (M). Accorded legitimacy depends on the way providers perceive and value (M) the formal mandate, capacities, internal consensus and genuine concern of groups, and citizen groups' role in service delivery (C).

Some papers consider legitimacy in terms of laws that provide citizen groups with formal powers to call public officials and workers to account. Where governments provide a legal status for citizen mobilization and monitoring, as well as procedures for grievance redressal, health workers and officials are more likely to respect citizen groups' decisions and respond to their actions (Mukhopadhyay 2003; Ngulube *et al.* 2004; Jones *et al.* 2007; Mahmud 2007; Misra and Ramasankar 2007; Schurmann and Mahmud 2009). Other authors refer to legitimacy of citizen groups in terms of 'reputation' (Mukhopadhyay and Meer 2004), 'credibility' (Papp *et al.* 2013), 'trust' (Goodman *et al.* 2011) or

Table 2. Types of social accountability actions

Steps in accountability↓	Approach: dialogue	Approach: advocacy
Information collection	Facility co-management meetings (11–14,16,20,21,26,29,33,35) Monitoring in health centres/specific services (1,2,3,6–8,17,26,27,29,31,34,35) Scoring/evaluation in groups (7,10,24,27,28,31) Collection of user complaints (4,14,15,19,20,26,35,37)	Large-scale surveys (5,10,23,25) Maternal death audits (8) Collection of testimonies (5)
Presentation/negotiation	Training of health providers (21) Joint problem analysis with providers and other stakeholders (1–4,9,10,18,19,21,24,28,30–32,34–36) Joint planning with providers and other stakeholders (10,18,28,32)	Independent analysis—formulation of statements and claims (5,23,25) Radio broadcasting (29) Presentation in public hearings, demonstrations, protests, media reports (1,5–8,23,35)
Follow-up/enforcement		Involvement of political or administrative parties (1,5,23)
Other characteristics	Initiator: community groups/committees Locus: health facility Target: frontline service providers providers	Initiator: CSO/NGO Locus: sub-national Target: providers, policymakers, politicians

Table 3. Definitions and examples of positive (+) and negative (-) responsiveness outcomes

Receptivity (O^1)	Responsiveness (O^2)	Relations (O^3)
Changes in attitudes of providers towards citizen groups.	Changes in behaviour by taking concrete action to improve service provision in line with citizens' concerns.	Changes in (accountability) relations between communities and service providers.
+ Reduced hostility towards health watch groups + Recognition of discrimination + Awareness of performance gaps + Apologies or intentions and promises to improve + Acceptance of alternative treatment practices – Lack of consideration of health committee members opinions	Access: + Reduced provider absenteeism; increased outreach + Decrease of informal payments + Reduced drug stock-outs Quality: + Improved provider–patient communication through involvement of translators or traditional health practitioners + Better queue management and increase in consultation rooms – Persistence of corruption and poor quality; particularly for poor women	Relations in general: + Improved links and reduced conflicts between communities and health workers + Mutual respect; interaction between commonly disparate groups Accountability tools: + Introduction of a grievances and complaints system, suggestion box, quality of care committees, transparency measures, expansion of public hearings – Concealing medical evidence on maternal deaths; barring entrance to facility – Arbitrary and frequent audits of CSO by government

'representative legitimacy' (Ngulube *et al.* 2004). Four attributes of citizen groups are identified that determine this type of legitimacy.

First, the perceived poor capacities of health committee members are often cited as barriers to good collaboration with providers. In some contexts, individuals are nominated because of their socio-economic or political status rather than on their affinity to health care. Providers perceive such individuals as not sufficiently knowledgeable, interested, competent or professional to take decisions on health issues and service delivery (Macwan'gi and Ngwengwe 2004; Williams 2007; Leppard *et al.* 2011; Meier *et al.* 2012; Jones *et al.* 2013). This appears less applicable to some CSOs with a subnational coverage, with long-standing experience, and which providers perceive as specialists in the field (Mukhopadhyay and Meer 2004). Health providers and authorities may value the expert knowledge of these organizations, including knowledge about marginalized groups that providers often lack themselves (Spicer *et al.* 2011). Second, apart from capacity and experience, the genuine concern of citizen groups appears crucial for providers' levels of responsiveness. This applies to both poor and 'uneducated' members (Goodman *et al.* 2011) and to members that belong to economically privileged groups (Williams 2007). Third, providers' receptivity to citizen groups' claims depends on the level of internal consensus or 'unity' among group members. Spicer *et al.* (2011) describe how the competition for scarce resources and the lack of ideological consensus lead to rivalry among CSO leaders in a HIV/AIDS coalition in Georgia. This makes health officials less willing to engage with them: 'There were reported examples of heated, public exchanges, often in the presence of government officials, which reaffirmed their [government officials'] caution about working with civil society' (p. 1753). Fourth, citizen groups themselves sometimes engage in the provision of health services in addition

to monitoring and advocacy work. In some cases, providers value and accept CSOs as partners in service provision because they fill a capacity or knowledge gap. This partnership, then, offers opportunities for CSO advocacy, helping CSOs to put issues on the government agenda (Gómez-Jauregui 2008; Evensen and Stokke 2010; Spicer 2011). At health facility level, health committees often have the official mandate to support health service delivery, including the monitoring of the quality of care. The advocacy role of health committees, however, is often loosely defined and interpreted while the service delivery role tends to be emphasized. For example, soon after the installation of health committees in Zambia, district health authorities reiterated that the committees' key role is to work with health centre managers to solve local problems (Ngulube *et al.* 2004). For committee members themselves, according to Jones *et al.* (2007), 'effective monitoring is considered a more demanding task in the context of perceived social and professional superiority of health workers. Providing auxiliary services becomes the safe option' (p. 222). Hence, compared with CSOs operating at a larger scale, health committees' strong contributions to service delivery may not strengthen their legitimacy or opportunities for more oversight or advocacy roles.

Providers' feelings of support, safety and appreciation

CMO 3. Social accountability initiatives may generate provider receptivity (O^1) and improved relations (O^3) when providers feel supported and appreciated and when they experience the discussion platform as safe (M). This is most likely to occur in actions that emphasize information sharing and dialogue between communities and health providers, that are void of open public critique, and that provide the opportunity for providers to defend themselves and to address their own concerns as well (C).

From the perspective of health providers, initiatives that use information sharing and dialogue approaches appear effective in several ways. First, when data collection and analysis of health services are rarely done within the health system, providers welcome these initiatives. They appreciate the identification of gaps in performance to improve their health facility (Papp *et al.* 2013). Health managers, in particular, appreciate citizen monitoring as it supports them in their control over staff. They hope that citizen groups can transform the social skills of health workers and reduce the reliance on transfers to remote areas as an extreme solution to deal with poorly performing workers (Ngulube *et al.* 2004; Golooba-Mutebi 2005). Second, providers are more likely to participate when their priorities and worries about working conditions are listened to and addressed (Mukhopadhyay and Meer 2004; Williams 2007). To make sure their issues are addressed, some providers prefer to be involved in agenda setting for the monitoring exercise or data collection (Mahmud 2007; Williams 2007). Third, providers are more likely to engage in social accountability initiatives when the approach protects the facility and its staff from public critique. For this reason, a CSO in Maharashtra, India, transformed 'public hearings' into 'public dialogues' in which they discouraged speakers from 'making unsubstantiated allegations' and from using 'derogatory and abusive language' (Shukla *et al.* 2013, p. 18). In one Indian case, providers and authorities would only engage in a social audit if working principles were agreed upon upfront, including an assurance that there would be no retributive action against frontline staff if service inadequacies were exposed (Swain and Sen 2009). Health workers in Uganda also wanted to be able to respond to issues brought forward. For example, social accountability initiatives that use radio shows to discuss hospital performance without inviting health workers to explain and respond are considered inappropriate (Rutebemberwa *et al.* 2009). Finally, some initiatives congratulate providers publicly for their good performance and for following up on community demands; this kind of appreciation and social reward is likely to enhance responsiveness (Ngulube *et al.* 2004; Shukla *et al.* 2013).

Providers' fear of repercussions from influential third parties

CMO 4. Social accountability actions may generate provider responsiveness (O^1 and/or O^2) when these initiatives trigger providers' fear of repercussions for the poor performance of health services (M). Citizen groups are not likely to generate this mechanism on their own; they require the involvement of influential third parties (C) that each trigger a particular mechanism of fear of repercussions (M).

Papers report on the involvement of three types of influential third parties to increase pressure on providers: politicians, media and health authorities. These groups of actors mediate provider responsiveness in different ways.

With regard to *politicians*, Mukhopadhyay and Meer (2004) demonstrate that a CSO invites elected representatives to regularly monitor the hospital which 'acted as a pressure in ensuring that women received better quality care, and resulted in improved hygiene and cleanliness … based on the power of 'public mandate' that elected representatives bring with them' (p. 126). Few other cases report on the use of political capital to strengthen the social monitoring of services. Jones *et al.* (2007), for example, found that health committee leaders who have links with political authorities use these relations for personal access to health care rather than for collective calls for the improvement of services. Political affiliation can also have the reverse effect in India or Uganda. In these cases, poorly behaving health workers do not change behaviour because they are protected by a powerful politician who might also have facilitated their appointment (Golooba-Mutebi 2005; Shukla *et al.* 2013).

Women's rights organizations in India use the *media* to share testimonies of poor women who are denied health services (Dasgupta 2011) or to enhance the coverage and credibility of their social accountability efforts (Papp *et al.* 2013; Shukla *et al.* 2013). In Bangladesh, the involvement of journalists is particularly useful in generating responsiveness of providers (Mukhopadhyay 2003; Mukhopadhyay and Meer 2004). Journalists provide media coverage of new agreements and norms set up by monitoring groups and providers, and they are also present at meetings and in hospitals and can broadcast their observations of corruption and misbehaviour. This improves the professional behaviour of the doctors 'since anyone violating the norms risked exposure and public embarrassment' (Mukhopadhyay 2003, p. 50). The set-up of public hearings in India has a similar effect as media coverage: it creates mass attention and therefore creates popular pressure on providers (Papp *et al.* 2013).

The involvement of '*health authorities*' occurs most often in situations where initial citizen action has no effect. Health authorities are the only institutions reported as being able to sanction health workers. Cases from Zambia, Malawi, India and Bangladesh report on the transfer of misbehaving health workers or health workers who are regularly absent or refuse to work by district health authorities (Macwan'gi and Ngwengwe 2004; Dasgupta 2011; Barpanda *et al.* 2013; Jones *et al.* 2013; Shukla *et al.* 2013). In these papers, transfers are presented as results; there is no evidence of the mechanism 'fear of the threat of transfer' leading to responsiveness. Some authors believe that this fear is either non-existent or an insufficient incentive in contexts where postings, transfers and the discipline of health workers are characterized by patronage or corruption

(Macwan'gi and Ngwengwe 2004; George *et al.* 2005; Dasgupta 2011).

Health provider responsiveness may hence be mediated by the relative power of social accountability initiators *vis-a-vis* other powerful groups. Some social accountability initiatives purposefully involve different third parties simultaneously, each for a particular purpose (Mukhopadhyay and Meer 2004; Papp *et al.* 2013; Shukla *et al.* 2013). Most cases, however, did not describe the strategic considerations for involving third parties.

Providers' feelings of moral obligation

CMO 5. Social accountability actions may generate provider responsiveness (O^1 and/or O^2) when these initiatives are able to trigger providers' feelings of moral responsibility or obligation (M). Citizen groups are likely to be able to trigger such feelings when they use frames that correspond to providers' frames (C).

Some citizen groups use frames to strengthen citizens' claims in the public discourse on health and health services. Frames are used to describe behaviour, social accountability objectives, and ideologies or paradigms.

A CSO in Bangladesh involves a member of parliament (MP) in its campaign to improve the quality of health services. It is not just the presence of the MP that puts pressure on the health providers but also the framing of behaviour of health providers. Providers are sensitive to the rhetoric of the MP who, in one of his statements, describes doctors as 'ungrateful' (educated on public money but refusing to serve the people), 'arrogant' (demanding to be addressed as 'Sir'), and 'extortionist' (asking for informal payments), exerting moral pressure (Mukhopadhyay and Meer 2004, p. 127).

The framing of the objectives of social accountability also appears to play a role. Providers and authorities in an Indian case agree to a social audit if it is aimed at identifying systemic failures, at informing the public of the services available and at capacity strengthening of cadres, rather than at monitoring the performance of frontline staff (Swain and Sen 2009).

In the field of reproductive health, the importance of framing is also underscored. Carino *et al.* (2008) observe that providers in Uruguay are more willing to advise women on safe abortion if abortion is framed from a professional 'do-no-harm' perspective, rather than from the perspective of rights. In Peru, Coe (2013) established that health authorities were initially receptive to CSO demands to introduce legal abortion because their own frame of women's human rights reflects the CSO's feminist frame.

Providers' self-perceived capacity and identity

CMO 6. Many social accountability initiatives operate in health systems that are characterized by a strong internal hierarchical organization (C). This context influences providers' perceptions on their capacities to achieve change (M). Social accountability initiatives in these contexts may generate responsiveness outcomes and improved relations (O^1 and/or O^2 and/or O^3) if providers identify with the citizen group and its ideals or claims (M). This is likely to be facilitated when social accountability initiatives (C) build on/are embedded in large-scale societal and political change (C).

The professional hierarchies in many health systems appear to influence the degree to which different categories of health providers are able to respond to citizen's initiatives. Cornwall *et al.* (2006) describe how active participation of health worker representatives in health councils often contrasts with managers' lack of commitment and respect for council members. It is often lower-level (e.g. community health workers) or younger health workers who are delegated with the task of attending community meetings. Even when they are dedicated to participation, such health workers are reserved in meetings, not due to poor technical knowledge or experience but due to a lack of decision-making power (Ngulube *et al.* 2004; Cornwall 2007; Nair and Campbell 2008). The fact that many local health workers are on short-term contracts also prevents them from investing in building effective community relations (Bowyer 2004; Golooba-Mutebi 2005; Cornwall 2007) and from speaking out for fear of dismissal (Cornwall 2007). Wendland (2010) describes how Malawian medical students have strong ambitions to fight the injustices in the health sector but that they feel it is politically dangerous to engage in collective action. Health workers feel that they have to be diplomatic in their communication with superiors, preventing them from reporting grassroots' views to their seniors and limiting the possibilities for responsiveness to communities (Cornwall 2007; Nair and Campbell 2008).

In some circumstances, the institutional culture of a health system is challenged, as illustrated by cases from Peru, Brazil and South Africa. In these countries, due to large societal and political change, providers are likely to develop a high self-perceived capacity to achieve change (Delgado-Gallego and Vazquez-Navarrette 2009). In Peru, Coe (2013) observes that health authorities and CSOs find a strong common ground in their shared history of political activism against authoritarian rule and in their current resistance to the new liberal government. As a consequence, health authorities are supporting coalitions for reproductive rights, including those advocating for safe abortions. Cornwall (2007 2008) and Cornwall *et al.* (2006) find that many providers in Brazil have affective bonds with activist movements because they were part of them themselves and, therefore, identify with citizen members in some health councils. These providers experience the failures in the system and have loyalties to patients and communities. They consider that health councils are opportunities for them to demonstrate their passion for politics. Evensen and Stokke (2010) and Campbell and Ballantyne (2004) describe a similar 'identification' mechanism in their cases in South Africa. Some health providers were formerly activists in the Treatment Action Campaign, a CSO founded in 1998 to campaign for access to treatment for AIDS. These providers share the conviction that ARV treatment is a human right and that exclusion from access to treatment is a new form of 'Apartheid'. They are of the opinion that, as a powerful actor in society, they have the ethical responsibility to challenge the *status quo*. In both Brazil and South Africa, this translates into providers bypassing governments' restrictive policies by distributing or administering inaccessible drugs, thereby being responsive to citizens' demands, in particular to the poor (Biehl 2004; Campbell and Ballantyne 2004). Campbell and Ballantyne (2004) find in their study, however, that it is only some providers who consider themselves as advocates. Others comply with the *status quo*. Rather than spending time on advocacy, providers learn to cope with the unavailability of some (HIV/AIDS) interventions and concentrate on services that are available. This coping mechanism is also found in other cases that describe resource-constrained settings such as Niger and Malawi (Jacob *et al.* 2009; Wendland 2010). Faced with a lack of resources and poor working conditions, most clinicians still opt to offer the minimum of services, rather than to leave the facility or engage in collective protests. In under-resourced settings in Peru, Bowyer (2004) describes health providers being unreceptive to greater inputs from community because new demands cannot be integrated or followed up, even if providers wanted to.

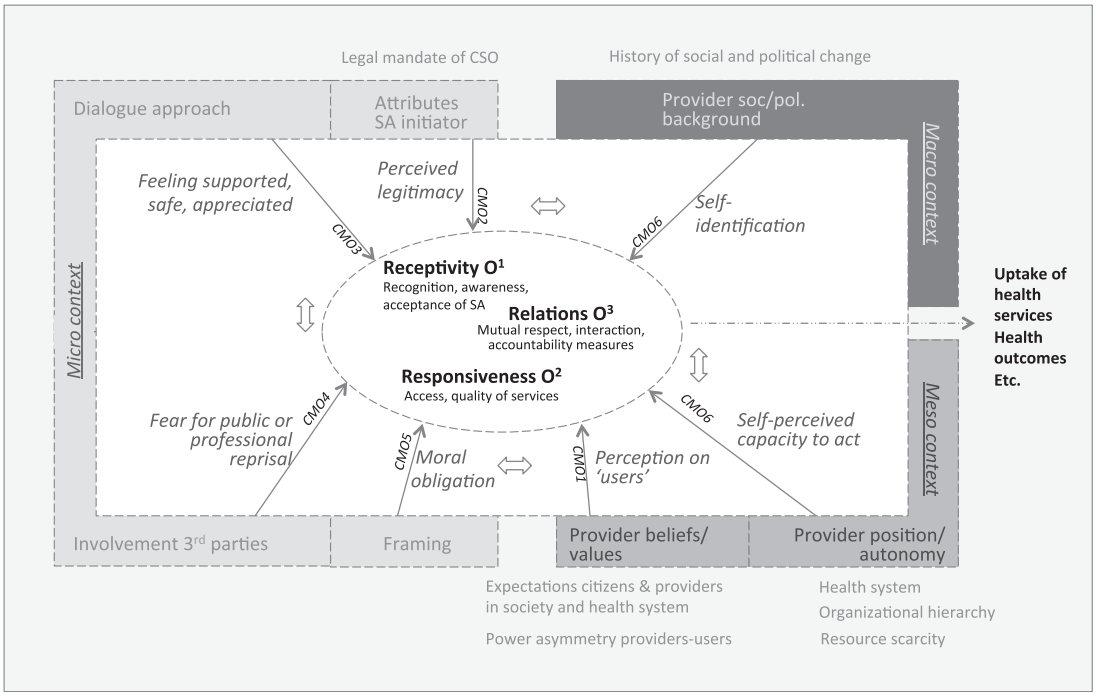

Figure 4. Visual representation of proposed programme theory.

Proposed programme theory for provider responsiveness

The six CMOs previously presented are summarized and visualized in a causal diagram in Figure 4. The arrows towards the outcomes represent the six CMOs: potential pathways to receptivity and responsiveness departing from the micro-context (social accountability initiatives), meso-context (health system context) or macro-context (broader social and political context). At the centre, the outcomes are variable; through an interaction of multiple contexts and mechanisms, they can be (temporarily) present or absent, or change from one to the other.

The micro-level pathways generated by information sharing and dialogue approaches to social accountability and by the involvement of third parties inform our main initial hypothesis. The evidence illustrates how information sharing and dialogue approaches can contribute to provider receptivity. The evidence demonstrates further nuances on how enforcement through third parties works by specifying the variations and effect of 'fear of reprisal'. Framing and its mechanism of moral obligation as an aspect of social accountability approaches emerged as a new element to our initial hypothesis. The meso- and macro-pathways help to make concrete what it is in the broader contextual features that matter for social accountability initiatives.

The evidence presented in the previous sections suggests that attributes and approaches of citizen groups, as well as health system and societal features, can each trigger certain mechanisms leading to outcomes. The CMOs in the diagram, however, should not be read in isolation. Contexts and mechanisms may be complementary (e.g. perceived legitimacy, feeling supported) as well as contradictory (e.g. high self-identification, low self-perceived capacity), taking place simultaneously, sequentially or not taking place at all. The interaction between mechanisms (represented by the arrows between CMOs) may explain the variation in responsiveness outcomes (receptivity vs responsiveness and/or relational outcomes) as well as the variation of responsiveness among categories of providers. The diagram does not present the time dimension that would further show the dynamics of change: CMOs may be relevant at one point in time but less in another.

In view of the findings, and as a textual interpretation of the diagram, a revised programme theory is formulated starting from the micro-level up to the meso- and macro-levels, and taking the mechanisms as main points of interest:

> health providers are likely to be receptive to (O^1) and/or act upon (O^2) citizens' demands for better health care if health providers perceive the social accountability initiative as legitimate (M), and/or if they experience the social accountability approach as safe and supportive to their personal and professional needs (M), and/or if they feel appreciated for their work (M) and/or if the approach appeals to their feelings of moral obligation (M). The involvement of specific third parties can generate additional pressure in the form of fear for public or professional reprisals (M). Additional favourable contexts for health provider responsiveness are socio-political contexts in which some providers self-identify as activists or citizens (M), identify health service users as citizens (M) and/or health system contexts in which some health providers depend on citizens' expertise and capacities and/or have the self-perceived ability to change the system in which they operate (M).

Discussion

The findings of this review contribute to the literature on social accountability in low- and middle-income countries in three ways.

First, the findings focus on the effect of social accountability at the frontline of service provision. This is the level where health

providers frequently experience demands from societal actors and where change towards more responsive healthcare is supposed to occur. The findings suggest a more nuanced view of the 'other side of the equation' (Gaventa 2004), the individuals or groups that are targeted in social accountability initiatives. By analysing provider perspectives, reasoning, agency and abilities, one might gain a more complete picture of the potential of social accountability. Second, the findings present a range of social accountability initiatives and a range of possible outcomes, including improved quality, accessibility and governance of health services. This review contributes to ongoing efforts to assess social accountability initiatives and their effects. Rather than judging whether or not social accountability initiatives work, this review aims to understand the processes that lead to responsiveness outcomes and how broader factors interact with these processes and outcomes. This is the third and main contribution of this article. By putting mechanisms centre stage, the paper operationalizes the commonly mentioned contextual factors influencing health provider responsiveness. Although the proposed programme theory is preliminary and non-exhaustive, it provides a new analytical tool to understand the dynamics of many different approaches that fall under the umbrella term social accountability and to understand the interaction between contextual factors.

The available evidence in this review informs the commonly held assumption that citizen-led accountability initiatives work through 'soft' pressure (McGee and Gaventa 2011) by generating feelings of support and safety or by triggering moral or ethical values in providers. These mechanisms may lead to providers' receptivity or openness to engage with citizen groups and to awareness on service users' perspectives and needs. The reliance of citizen groups on soft methods of persuasion, for example, through dialogue, is often considered a weakness of social accountability (McNeil and Malena 2010). Without the threat of sanctions by political or bureaucratic authorities, social accountability is difficult to sustain in the long run and only able to address superficial service delivery challenges (Joshi 2013; Berlan and Shiffman 2012; Acosta *et al.* 2013; Freedman and Schaaf 2013). Rather than emphasizing the limits of social accountability, we suggest to rethink expected impact or outcomes of such initiatives. What is superficial or significant depends on context and time as illustrated by examples.

Social accountability initiatives in South Africa and Brazil derived much of their transformative power from wider changes in health system policies and legislation, and from an intensive period of democratic transition in society as a whole. This allowed cross boundary alliances to emerge between civil actors and state reformists, which O'Meally (2013) calls 'pro-accountability coalitions'. However, as time passes, the effectiveness of civil society in bringing about change may also change. For example, according to Jonsson and Jonsson (2012), HIV/AIDS activism in South Africa has become more reactive and less pro-active since the advent of majority rule. This careful interpretation of outcomes is equally important in other governance settings.

Many of the cases in this review are located in contexts where citizen groups have fewer opportunities for multi-level coalition building, where providers have less experience with organized feedback from citizens, or where regulatory capacities of the health sector are weak. In such contexts, basic outcomes like 'presence, or more respectful behaviour of health workers' or 'increased job motivation' can still be quite significant. Also, the 'relational' outcomes that we identified can be read as signs of a transformation of health governance, albeit at localized sites and for an unknown period of time. Tembo (2013) concludes from a study in six sub-Saharan African countries that 'soft' approaches, involving informal incentives, may provide a basis for building trust and for joint problem solving of unsatisfactory performance. He states that without a basic level of trust, more formal enforcement approaches, including sanctions, will be ineffective (Tembo 2013). Knox (2009), one of the authors of a study in Bangladesh, considers trust-building approaches at the micro-level particularly relevant in settings characterized by political instability or poor trust among citizens. This argument is also advanced by other scholars comparing constructive and fault finding or distrust-based approaches to social accountability (Freedman 2003; Joshi and Houtzager 2012; Joshi 2013; Acosta *et al.* 2013; Grandvoinnet *et al.* 2015). In any governance setting, it is argued, over-reliance on one or the other approach is not likely to promote systemic change (George *et al.* 2005). Thus, apart from the need to evaluate the potential of social accountability initiatives in their context, we argue that it is important to acknowledge intermediate outcomes, including receptivity of providers and other target groups of citizen advocacy. This aligns with calls of other researchers to evaluate intermediate steps in the causal chain of social accountability (Rocha Menocal and Sharma 2008; Joshi 2014).

Strengths and limitations of methods and findings

To our knowledge, this is the first realist review applied to social accountability initiatives in the health sector. The approach allowed the accumulation and valorization of knowledge generated from a range of sources, study designs and data in order to build plausible theories. However, like other reviewers in the field (e.g. Joshi 2013) we were confronted with the challenge of comparing cases and assessing the quality of studies. With regard to comparative analysis, for example, only 3 of 40 papers provided explicit definitions or measures of outcomes, whereas the others provided narrative descriptions of outcomes, sometimes only implicitly linking outcomes with social accountability strategies. Hence, our evidence suggests three types of outcomes that are difficult to link to a particular strategy or 'intervention component'. With regard to the assessment of quality of individual papers and data, our approach was iterative. We did not want to miss relevant papers by excluding them *a priori* based on methodological rigour. Therefore, the appraisal of methodological quality came after having established the relevance of papers. The relevance of papers, in turn, could sometimes only be assessed after multiple papers had been read. Our initial criteria for methodological rigour (credibility and coherence of methods) were also further defined as the review progressed. For example, for papers that did not include a detailed methods section, or that were retrospective and written by initiators themselves, we decided that an important methodological criterion should be 'author reflexivity', meaning that in at least one instance, authors should critically reflect on the initiatives and their outcomes, for example, in the discussion sections. This leads to the exclusion of three papers. We used inter-reviewer reflexivity as much as possible in the process of appraisal and configuring evidence. We did so by keeping track of important discussions and decisions in a logbook. Hence, like other realist reviewers (e.g. Jagosh *et al.* 2014), we used existing guidelines for realist synthesis as well as our own experience with the material to define and customize our review methods. We are aware that, based on critical decisions during the process, and in order to focus the review, important themes and evidence were disregarded. They may constitute material for separate syntheses. Also, we are aware that broader consultation with practitioners and experts towards the end

of the synthesis process could have enriched or validated the evidence. It is important to note, however, that, in the light of available data and data types, realist review is a pragmatic approach that does not aim to be comprehensive or to provide stable conclusions. The value lies in understanding analytically defined mechanisms rather than in the exact content of initiatives and outcomes that are contingent on temporal changes in the context (Pawson and Tilley 1997). The paper should hence be considered as a complementary effort to understand complexity in evaluation in such broad fields as social accountability.

Most social accountability initiatives in our review are facilitated by formal, established or institutionalized NGOs, CSOs or health committees. This is partly due to our search strategy and inclusion criteria, and partly to the availability of documented evidence. Our main focus was on the effect of organized citizen action on health service providers, not on the preconditions needed for voice and social accountability to emerge. Therefore, these cases are located in contexts where a minimum level of organization and voice is present, and accessible for documentation. We further suppose that formal citizen engagement or funded social accountability programmes are more likely to be documented than more informal or temporary forms of citizen advocacy. Therefore, our results probably do not do justice to the broad scope of initiatives led by grassroots or self-help groups (also beyond the health sector), *ad hoc* protest groups, or campaigns through social media. The insights presented here could provide a useful perspective on more informal forms of citizen engagement as we consider that the mechanisms we have identified may also be applicable to informal processes.

We further encountered a definitional, geographical and reporting bias in the material. Many studies referred to health facilities or health providers in general terms without specifying the categories of health workers or whether they were considered as individuals, groups or organizations. This limits the scope of the findings. Regarding geographical coverage, there is a striking gap in cases from West and North Africa or the Middle East. This may be due to our search strategy that focused on English-language literature. Most cases are located in relatively stable governance settings, which may limit the transferability of elements of the programme theory to, for example, conflict-affected countries. Although many mechanisms may be common to other settings, a wider range of societal, historical and health systems contexts might have led to the identification of more specificity and strengthened the evidence base. This, in combination with the fact that we found very few instances of counterproductive effects or no effects, limited the possibility to cross-validate our CMOs.

Implications for practice, policy and research

The ideas advanced in this review constitute a new avenue for building understanding of the complexity of social accountability. The findings can support reflection and decision-making of researchers, practitioners, evaluators and policymakers.

First, people involved in designing and implementing social accountability initiatives can use the proposed programme theory to interpret their own context, pathways to change and possible outcomes. This type of reflection, in combination with their own experience and insights, will help to refine and tailor their social accountability strategies to their unique contexts and hence generate best-fit, rather than best-practice approaches (Leininger 2014). Second, the findings demonstrate that health systems policy and research needs to recognize that health systems are social institutions, shaped by human agency (Sheikh *et al*. 2014). Programme designers in governmental quality improvement programmes, HR departments and NGOs should take into account the perspectives of those at the frontline of service provision, including the mechanisms leading to the acceptance of new ways to assess service delivery performance. Third, efforts to build responsive health services require a synergy between institutional structures and external initiatives, such as the ones described in this review. For policymakers in public institutions, it might be useful to reflect on how this synergy can be enhanced, for example, by assessing the complementarity between internal and external accountability strategies in how they contribute to responsive health services. Finally, regarding implications for research, we suggest to further develop the proposed programme theory by enriching and validating it with existing theories and by testing parts of it with empirical research. Further research could, for example, focus on particular health service characteristics (e.g. Batley and Harris 2014), social accountability initiators such as health committees, local media or more informal citizen actions or on regions not covered in this review. This will help in further conceptualizing the constructs of, and associations between, social accountability, receptivity and responsiveness in the health sector. As this review has shown, such scholarship could benefit from perspectives from political science, organizational sociology, philosophy and social psychology.

Conclusion

This study brings together the knowledge generated from 37 social accountability initiatives. The evidence demonstrates the contribution of local-level social accountability initiatives to the acceptability and quality of health services, key values and immediate goals of public health systems. This contribution is based on an ability to influence the values, perceptions, logic, expectations, and feelings of providers towards citizen groups and their demands that are, in turn, mediated by the larger health system and societal context. By focusing on the provider perspective on citizen collective action, this review covers an important gap in the social accountability literature and contributes to thinking about interventions to improve the quality of primary health care more generally.

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Supplementary data

Supplementary data are available at *HEAPOL* online.

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