

# Strengthening Social Accountability Process in Community Health Systems: Exploring the Role of Community Actors in Africa and South Asia: Systematic review

Malkia M. Abuga<sup>1</sup>, Wanja Tenambergen<sup>1</sup> & Kezia Njoroge<sup>1</sup>

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## Abstract

**Background:** Despite a growing body of literature on social accountability in health systems, many questions remain unanswered about how community actors interact with health workers and demand accountability. Social accountability is viewed as an empowerment process and a social practice in which communities actively participate in changing the conditions that affect their health. Local factors, such as the role of community actors, influence the effectiveness of social accountability. The purpose of this research was to assess empirical evidence on the role of community actors in social accountability.

**Methods:** Electronic searches were conducted for eligible studies within each of the Pubmed, Medline, Google Scholar and SciELO databases from 2012 to January 2022. Peer-reviewed English language publications describing a social accountability mechanism with a focus on the role of community actors in Africa and South Asia were eligible for inclusion. There were no restrictions on the research design.

**Results:** The review included eleven relevant studies. According to the findings, community actors include Community Health Workers, Health Facility Committees, Community Elected Leaders, and the media, among others. Their responsibilities include monitoring services and health worker's performance, gathering and sharing information, and resolving complaints. Some of the enablers to the role community health actors include diverse committee membership and the legitimacy of community leaders. On the other hand, knowledge and power asymmetry, the lack of a clear mandate, a lack of clarity on their roles and fear of reprisal are among the barriers to their role in Social Accountability.

**Conclusion:** Community actors are part of the community health system, and understanding their role, strengths, and challenges has a practical impact on how they contribute to the overall health system's strength. The findings show that they can exert social pressure through their powerful coalitions, which is critical in Social Accountability activities. As a result, in order to maximize their potential, novel approaches to addressing the limitations identified in this review are required.

**Keywords:** Social Accountability, health systems, community health systems, community actors

## Background

Globally countries are faced with health systems challenges. Most challenges are man-made and cut across institutional, human resources, financial, technical and political developments. In addition a scoping review of research in various countries by Roncarolo et al., (2017), reported that the most documented health system problems are linked to health service delivery (23.8%), human resources (22.3%) and leadership and governance (21.2%). These challenges can be broken down to lack of access to healthcare, weak healthcare systems, healthcare system corruption, poor leadership and administration, poor quality of healthcare services, lack of good resource management, weak training and education of healthcare workers, weak accountability systems among others (Oleribe et al., 2019).

Increased budgetary allocation to healthcare, training and capacity building of healthcare workers, advocacy and increased political engagement, improved health infrastructure, increased collaboration among stakeholders and adequate accountability systems are some of the proposed solutions to health system challenges (Oleribe et al., 2019). Furthermore, community participation has been found to be critical in strengthening health systems by empowering patients and communities to help identify the most pressing needs (Raynes & Maibani 2006; Yutaro Setoya., 2012).

Social accountability (SAC), also known as citizen-driven accountability or bottom-up accountability, refers to strategies, processes, or interventions in which citizens express their opinions on the quality of services or the performance of service providers or policymakers, who are then asked to respond and account for their actions and decisions (Lodenstein et al., 2013). It is a form of community participation. SAC is viewed as a process of empowerment and a social practice in which communities are actively involved in changing the conditions that affect their health (Mafuta et al., 2016).

There is overwhelming evidence that implementing SAC activities or interventions has resulted in the resolving of some health system challenges such as reduced waiting time, absenteeism of health service providers (Björkman & Svensson 2009), increased health facility infrastructure, essential drugs and equipment (Blake et al., 2016; Hoop-Bender et al., 2016), and increased satisfaction with health services and utilization of maternal and child health services (Gullo et al., 2016; Kaseje et al., 2010). The effectiveness of social accountability is influenced by local factors, one of which is the role of community actors.

The term "community health system" refers to a group of local actors, relationships, and processes that are involved in producing, advocating for, and supporting health in communities and households that are not part of formal health structures but exist in relationship to them (Schneider & Lehmann's 2016). This study adopted Schneider and Lehmann's (2016) definition of community actors, which includes household caregivers, a variety of formal, volunteer, and informal health providers working in communities, organizational intermediaries such as nongovernmental organizations and other forms (religious, sport, youth, etc.) of associational life; workplaces, and other government sectors such as housing, education, and social development.

Community participation and inter sector collaboration have been identified as key pillars in strengthening the health system. However there is limited documentation on the role played by the different community actors, their social networks and associations, challenges they face and what are their enabling factors in a format that is easily accessible by the policy makers, and those engaged in development of health innovations. In this paper we thus report the findings of a systematic review whose aim was to identify community actors in SAC, their roles, challenges and enabling factors that were investigated in the peer-reviewed scientific literature from 2012. In this study community actors included all those groups in the community that are directly (for instance Female Community Health Volunteers) or indirectly (for example Self Help Groups) involved in community health work and reforms.

## Methods

### Eligibility Criteria

Our search included all research designs, empirical quantitative, qualitative, mixed methods, randomized controlled trials of published studies on Social Accountability in Africa and South Asia. All studies intervention and non-intervention were included. We included studies published from 2012 to 2022 and in English. We excluded studies which explained health facility intervention for instance use health service charter in Kenya (Atela et al., 2015).

### Information Sources

We conducted electronic searches for eligible studies within each of the Pubmed, Medline, Google Scholar and SciELO databases from 2012 to 5<sup>th</sup> January 2022 as illustrated on the following table 1.1.

Name	Interface/Platform	Coverage Range	Search Executed
Pubmed/Medline	<a href="https://pubmed.ncbi.nlm.nih.gov/">https://pubmed.ncbi.nlm.nih.gov/</a>	2012 to Present	January 5 <sup>th</sup> 2022
Google Scholar	<a href="https://scholar.google.com/">https://scholar.google.com/</a>	2012 to Present	January 5 <sup>th</sup> 2022
SciELO	<a href="https://scielo.org/en">https://scielo.org/en</a>	2012 to Present	January 6 <sup>th</sup> 2022

### Search Strategy

Original, empirical studies published in peer-reviewed journals between 2012 and January 2022 were searched to identify studies in Social Accountability. Search terms included combinations of: Social accountability, social responsibilities, community health systems, health systems, voice, and citizen-led accountability. The search terms were used in combination with the Boolean operators AND, OR. The refined search strategy for Pubmed is presented in table 1.2.

**Table 1.2 Search Terms**

Social Accountability	"social responsibility"[MeSH Terms] OR ("community participation"[MeSH Terms] OR
And	
Health System	("health"[MeSH Terms] OR Health[Text Word]) AND ("drug delivery systems"[MeSH Terms] OR System[Text Word])
Community Health System	"community health planning"[MeSH Terms] OR Community Health System[Text Word]
AND	
Community Actors	Level Actors

### Selection Process

We imported titles and abstracts retrieved by the searches into Covidence systematic review software and duplicates were removed. Two researcher (MA & WT) independently reviewed title and abstracts for the first 60 records and discussed inconsistencies until consensus was obtained. The remaining citations were screened independently by MA. Full-text of all potentially studies was retrieved. A sample of 5 full-text studies were independently screened by two reviewers (MA, WT and KN) until agreement was achieved. The remaining full-text studies were screened by one reviewer (MA). Disagreements or uncertainty about eligibility were resolved through discussion. Citations that did not meet the inclusion criteria were excluded and the reason for exclusion was recorded at the full-text screening.

### Data Collection and Data Items

A data extraction sheet was developed, pilot tested on five randomly selected included articles and then refined. After finalizing the data extraction sheet, one reviewer (MA) performed the initial data extraction for all included articles and second reviewers (WT & KN) checked all proceedings. Data items included Author (year), study site, study design, SAc initiative, outcome measure, key outcomes, enabling and limiting factors, community actor, description of the group and the role played by the community actor. Because we were interested in understanding the roles of the community actors, the actual role verses the expected role were examined.

### Quality Appraisal and Risk of Bias Assessment

We used a modified Mixed Methods Appraisal Tool (MMAT) to assess the quality of the studies in our review (V.2018) (Hong et al., 2019). MMAT was used to evaluate study methodological quality. Although several critical appraisal tools exist, the majority of them focus on a single design type or use an individual component approach, such as Critical appraisal of qualitative research (Hannes et al., 2011) and the Cochrane risk-of-bias tool for randomised trials (Jørgensen et al., 2016). MMAT, on the other hand, covers quantitative, qualitative, and mixed methods research. MMAT was also chosen for its utility (wide range of coverage) and usability (easy learnability and high efficiency) (Hong et al., 2019). Two review authors used the tool independently on each included study, recording supporting information and justifications for risk of bias judgments (Yes; No; can't tell). Any disagreements in risk of bias judgments or justifications for judgments were resolved through discussion between the two review authors to reach consensus.

Table 1.3: Quality Appraisal of MMAT

RefID	First author	Year	Citation	S1. Are there clear research questions?	S2. Do the collected data allow to address the research questions?	1.1. Is the qualitative approach appropriate to answer the research question?	1.2. Are the qualitative data collection methods adequate to address the research question?	1.3. Are the findings adequately derived from the data?	1.4. Is the interpretation of results sufficiently substantiated by data?	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?
1	Hanifi et al., 2020	2020	Hanifi, S. M. A., Hossain, A., Chowdhury, A. H., Hoque, S., Selim, M. A., Mahmood, S. S., & Bhuiya, A. (2020). Do community scorecards improve utilisation of health services in community clinics: Experience from a rural area of Bangladesh. <i>International Journal for Equity in Health</i> , 19(1), 149. <a href="https://doi.org/10.1186/s12939-020-01266-5">https://doi.org/10.1186/s12939-020-01266-5</a>	Yes	Yes					
2	Mafuta et al., 2015	2015	Mafuta, E. M., Dieleman, M. A., Hogema, L. M., Khomba, P. N., Zioko, F. M., Kayembe, P. K., de Cock Buning, T., & Mambu, T. N. M. (2015). Social accountability for maternal health services in Muanda and Bolenge Health Zones, Democratic Republic of Congo: A situation analysis. <i>BMC Health Services Research</i> , 15(1), 514. <a href="https://doi.org/10.1186/s12913-015-1176-6">https://doi.org/10.1186/s12913-015-1176-6</a>	Yes	Yes	Yes	Yes	Yes	Yes	Yes

3	Mafuta et al., 2017	2017	Mafuta, E. M., Dieleman, M. A., Essink, L., Khomba, P. N., Zioko, F. M., Mambu, T. N. M., Kayembe, P. K., & de Cock Buning, T. (2017). Participatory approach to design social accountability interventions to improve maternal health services: A case study from the Democratic Republic of the Congo. <i>Global Health Research and Policy</i> , 2, 4. <a href="https://doi.org/10.1186/s41256-017-0024-0">https://doi.org/10.1186/s41256-017-0024-0</a>	Yes						
4	Feruglio and Nisbett 2018	2018	Feruglio, F., & Nisbett, N. (2018). The challenges of institutionalizing community-level social accountability mechanisms for health and nutrition: A qualitative study in Odisha, India. <i>BMC Health Services Research</i> , 18(1), 788. <a href="https://doi.org/10.1186/s12913-018-3600-1">https://doi.org/10.1186/s12913-018-3600-1</a>	Yes						
5	Hamal et al., 2018	2018	Hamal, M., de Cock Buning, T., De Brouwere, V., Bardají, A., & Dieleman, M. (2018). How does social accountability contribute to better maternal health outcomes? A qualitative study on perceived changes with government and civil society actors in Gujarat, India. <i>BMC Health Services Research</i> , 18(1), 653. <a href="https://doi.org/10.1186/s12913-018-3453-7">https://doi.org/10.1186/s12913-018-3453-7</a>	Yes						
6	Papp et al., 2013	2013	Papp, S. A., Gogoi, A., & Campbell, C. (2013). Improving maternal health through social accountability: A case study from Orissa, India. <i>Global Public Health</i> , 8(4), 449–464. <a href="https://doi.org/10.1080/17441692.2012.748085">https://doi.org/10.1080/17441692.2012.748085</a>	Yes						

7	Lodenstein et al., 2019	2019	Lodenstein, E., Molenaar, J. M., Ingemann, C., Botha, K., Mkandawire, J. J., Liem, L., Broerse, J. E. W., & Dieleman, M. (2019). 'We come as friends': Approaches to social accountability by health committees in Northern Malawi. <i>BMC Health Services Research</i> , 19(1), 279. <a href="https://doi.org/10.1186/s12913-019-4069-2">https://doi.org/10.1186/s12913-019-4069-2</a>	Yes						
8	Hamal et al., 2019	2019	Hamal, M., Heiter, K., Schoenmakers, L., Smid, M., de Cock Buning, T., De Brouwere, V., Bardaji, A., Nepal, C., & Dieleman, M. (2019). Social Accountability in Maternal Health Services in the Far-Western Development Region in Nepal: An Exploratory Study. <i>International Journal of Health Policy and Management</i> , 8(5), 280–291. <a href="https://doi.org/10.15171/ijhpm.2019.05">https://doi.org/10.15171/ijhpm.2019.05</a>	Yes						
9	Kiracho et al., 2021	2021	Kiracho, E. E., Aanyu, C., Apolot, R. R., Kiwanuka, S. N., & Paina, L. (2021). Designing for Scale and taking scale to account: Lessons from a community score card project in Uganda. <i>International Journal for Equity in Health</i> , 20(1), 31. <a href="https://doi.org/10.1186/s12939-020-01367-1">https://doi.org/10.1186/s12939-020-01367-1</a>	Yes						
10	Boydell et al., 2020	2020	Boydell, V., Nulu, N., Hardee, K., & Gay, J. (2020). Implementing social accountability for contraceptive services: Lessons from Uganda. <i>BMC Women's Health</i> , 20(1), 228. <a href="https://doi.org/10.1186/s12905-020-01072-9">https://doi.org/10.1186/s12905-020-01072-9</a>	Yes						

11	Lodeinstein et al., 2017	2017	Lodenstein, E., Mafuta, E., Kpatchavi, A. C., Servais, J., Dieleman, M., Broerse, J. E. W., Barry, A. A. B., Mambu, T. M. N., & Toonen, J. (2017). Social accountability in primary health care in West and Central Africa: Exploring the role of health facility committees. <i>BMC Health Services Research</i> , 17(1), 403. <a href="https://doi.org/10.1186/s12913-017-2344-7">https://doi.org/10.1186/s12913-017-2344-7</a>	Yes						
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## Data Synthesis

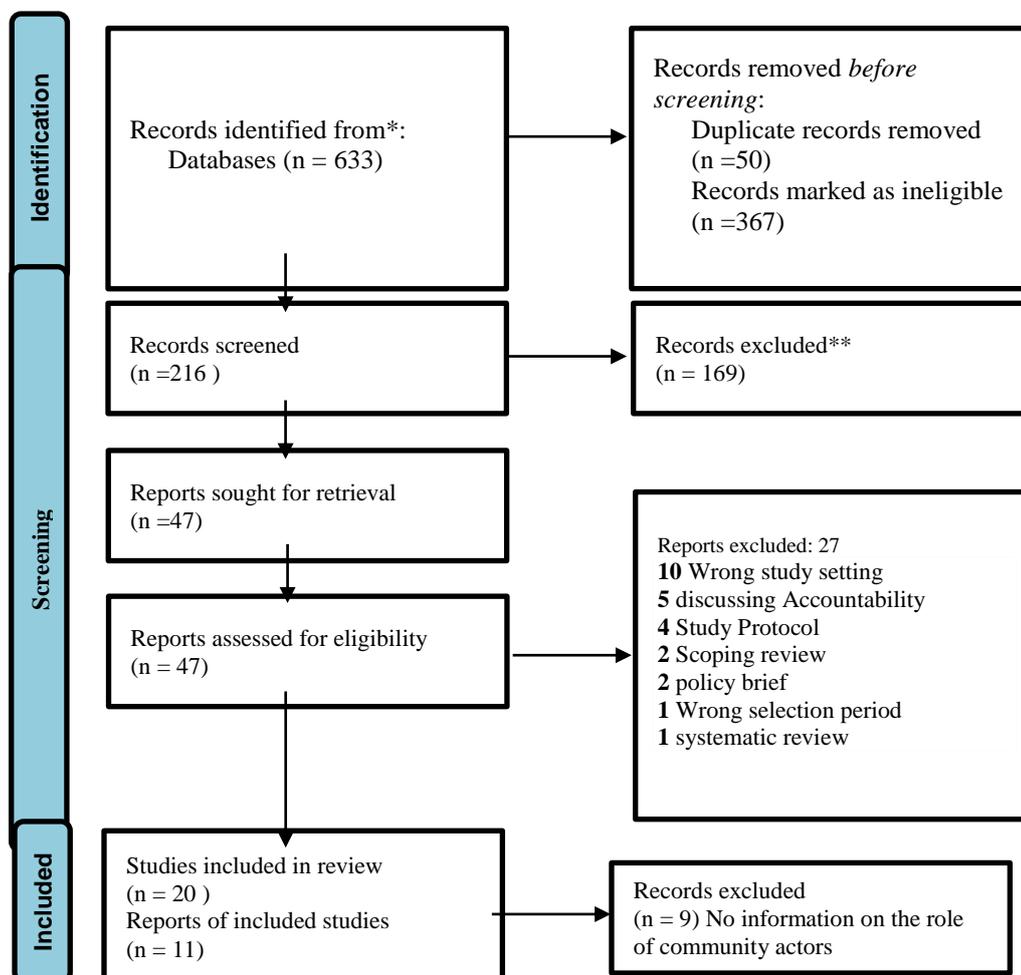
A meta-analysis was not appropriate because the included studies were not homogeneous in design or had data available. All included studies were subjected to a narrative synthesis. We gathered information about the social accountability approach/activity/mechanism, data collection methods, outcome measures (where applicable), enabling and limiting factors, community actors involved and their roles.

## Results

The screening and selection process is outlined in Figure 1.1. The initial search identified 633 potentially relevant papers. 367 papers were removed because they were not describing social accountability in the health sector. 50 papers were removed due to duplication, leaving 216 studies for screening. 169 studies removed because they were not relevant based on the inclusion criteria. The remaining 47 full-text studies were assessed for eligibility. 27 studies were excluded due to irrelevance to the topic or accountability approach i.e., looking at other forms of accountability other than social accountability. Further nine studies were excluded for insufficient information on Community actors.

A total of eleven studies were included in this systematic review. Majority (10/11) of the studies were qualitative and only one was randomized control trial. Studies were conducted in diverse country settings including India (three studies); Democratic Republic of Congo (DRC) (Two studies); Uganda (two studies); one study reported findings from 3 countries that is Benin, Guinea and DRC (Lodenstein et al., 2017) and one each in Bangladesh, Malawi and Nepal.

Figure 1.1: Search, screening, selection, and inclusion process diagram



Source: PRISMA 2020 (page et al., 2021)

**Community Actors**

A wide range of community actors in SAc were described see attachment 1.2. Community actors included community support groups (Hanifi et al., 2020); Community Health Workers (CHWs) /Female Community Health Volunteers (FCHVs), Community Leaders, community based organizations (Hamal et al., 2018, 2019; Mafuta et al., 2015, 2017) Village Health Sanitation Committees (VHSC), Journalists and celebrities, Civil Society, Community Champions, women pressure groups (Boydell et al.,2020; Hamal et al., 2018, 2019; Kiracho et al., 2021; Papp et al., 2013) and Health Facility Committees (HFC) (Lodenstein et al., 2017, 2019)

**Table 1.4: Community Actor’s Role, Enabling and Limiting Factors**

Community Actors	Role	Enabling Factors and Limitations
Community Support Group	Expected role was to takes care of community clinics (CC's) day to day operations, monitoring and evaluation of CC's performance and community participation, coordination with stakeholders and fund generation	<p><b>Enabling Factors</b> Information sharing on CC's empowered the community on services available at the clinics.</p> <p><b>Limiting factors</b> 1. Lack of awareness on the roles and responsibilities among the community clinics committees</p>
Community Health Workers, Community leaders such as a local authority, a village chief, or an administrative chief officer, Community based organization	<ol style="list-style-type: none"> <li>1. CHW- Collecting and presenting women concerns to the health facility</li> <li>2. CBO- Community monitoring through surveys</li> <li>3. Community leaders - Approached by the community because of the perceived influence ( concerns raised through community leaders are more likely to be accepted by the health providers than those brought by women)</li> </ol>	<p><b>Enabling Factors</b> 1. Collection of concerns or complaints during home visits</p> <p><b>Limitation Factors</b> 1. Lack of formal channel that collects information related to the concerns/complaints by the population in the current health information system. 2. Doubt on the ability of CHWs to influence the behaviour or decisions of HPs 3. Women not believing in collective action 4. Community members excluded in monitoring and evaluation 5. Power asymmetry 6. Information/knowledge asymmetry 7. Absence of mechanisms for communicating grievances</p>
CHWs, Community Leaders (Community group representatives (women and men), village notables and administrative officers, religious leaders)	<p><b>CHWs</b></p> <ol style="list-style-type: none"> <li>1. To work as intermediaries by collecting and transmitting community concerns about health services.</li> <li>2. To document population’s complaints and concerns using a formal system of records</li> <li>3. To sensitize population to report their concerns</li> <li>4. To receive from the population concerns, questions and complaints using home visits</li> <li>5. To bring community concerns forward to health providers during dialogue meeting and the health committee meeting</li> </ol> <p><b>Community Leaders</b> Participate in Community Dialogues- Build coalitions of the community leaders in order to build social pressure</p>	<p>Enabling Factors will be:</p> <ol style="list-style-type: none"> <li>1. Training of CHWs and choosing the CHWs through community elections</li> <li>2. To document population’s complaints and concerns using a formal system of records</li> <li>3. To sensitize population to report their concerns</li> <li>4.To make all decision as a group and not individually;</li> <li>5. To build coalition of community leaders</li> </ol> <p>Limitations Lack of financial and technical inputs and poor institutionalization of social accountability mechanisms</p>

<p>Mother Committee (MC), Jaanch Committees (JC), Village Health and Sanitation Committees (VHC), Self Help Groups (SHG)</p>	<p>1. MG- Implementation and monitoring functions. The oversight role tasked with ensuring quality of the food rations distributed at the AWC by being present 2. JCs are tasked with monitoring different aspects of The feeding programs undertaken in AWCs, for instance by overseeing distribution of hot cooked meals and morning snacks which are distributed to women and children enrolled at The AWC. 3. VHSC- Planning, implementing, and monitoring interventions around health, water and sanitation at village level by developing work plans based on village situation and Community priority. Also Financial assistance to individuals in need 4. SHG- Tackle issues identified as priority by the members e.g poverty and lack of purchasing power, long working hours and heavy workload</p>	<p><b>Enabling Factors</b> JC with <b>diverse membership</b> including participants who are not service recipients assisted in breaking the provider/use paradigm, increasing the potential for performance monitoring - Voluntary nature of joining the self-help group with a clear purpose for the members to earn an income enabled the group not to experience challenges of non-participation due to time constraints. - SHG did not work as extension of other committee which increased their autonomy and equal power distribution among them which is an important factor in success of Social accountability activities -Community recognition - Relevance of committee to the lives of those involved -Having a sense by the committee members that they are playing an important role <b>Limiting Factors</b> -Little or no interest of being part of the members (JC) because the selection was based on a criteria of demography and category -Confusion about roles and duties of members especially those in multiple committees -lack of participation in committee meetings -expectations of incentives -hindrance exerted by family members which prevented women from participating -Language barriers that hindered participation of the marginalized -Dependence of committee on frontline workers for their access to health and nutrition, their monitoring potential</p>
<p>Accredited Social Health Activists (ASHAs), Female Health Worker (FHW), Gram Panchayat or Panchayat (Locally elected village council), Village Health and Sanitation Committee (VHSC), Civil Society ANANDI</p>	<p><b>ASHA &amp; FHW</b> 1. Communities share and communicate their concerns and issues about health services to the formal health sector through ASHA &amp; FHW. 2. Provide community with information about health services and government schemes and entitlements through group discussions and home visits 3. Assist women to obtain their entitlements <b>Gram Panchayat or Panchayat</b> 1. Conduct periodic village meetings that serve as main platform for community members to voice their concerns 2. Ensuring the accountability of the public health system 3. Panchayat advises the health authorities at PHC and Health Sub-Centres on issues, such as to refrain from using abusive language in addressing patients. 4. They refer complaints about health services, such as corruption and illegal charges by health facilities, to higher authorities. 4. Create awareness among women and their families to use health services and secure their government entitlements 5. Fighting for government entitlements to include people who do not have below poverty line (BPL) cards. <b>Village Health and Sanitation Committee</b></p>	<p><b>Enabling Factors</b> 1. Formal government structures e.g Accredited Social Health Activists (ASHAs), 2. Promotion of public-private partnership <b>Limitations</b> 1. Even though the ASHAs and FHWs were identified as communicating communities 'concerns to the health system, the discussions with the beneficiaries and women's group members indicated that women approached them mainly about health problems and less often shared concerns about health services. 2. Beneficiaries mentioned not expressing any concerns to ASHAs or anyone else due to lack of awareness about their rights and entitlements or feeling helpless 3. Lack of training, funding and transparency of funds spent by its members 4. Panchayat members are powerless and face threats when they demand government accountability 5. Lack of ownership among the VHSC members even though they are the main formal structure of SAc 6. Lack of clarity about the composition and roles of the VHSC. 7. The VHSCs are not active, and that there is a lack of initiatives on the part of the government and CSOs. They also indicated that government efforts to build their capacities jointly with the CSOs were limited to the initial years and only in some villages 8. Communities have not been able to use these structures to their full potential because they face various difficulties. For example, the VHSC members lack the ownership and capacity to demand accountability and</p>

	<p><b>(VHSC)</b></p> <ol style="list-style-type: none"> <li>1. Inform communities about health services, and government health schemes and entitlements</li> <li>2. Act as an avenue for communities to voice their concerns related to health, address them through periodic health and village meetings, and/or communicate them to Panchayat and health system</li> <li>3. Ensure communities' participation in planning, implementation and evaluation of local-level health plans through adequate representation of all community groups</li> </ol> <p><b>WOMEN GROUPS</b></p> <ol style="list-style-type: none"> <li>1. Women groups discuss issues affecting them and try to solve them collectively and take unresolved issues to the ANANDI, Gram Sabha or other village meeting.</li> <li>2. Group members discuss their issues collectively at ANC clinics with ASHA and FHWs on issues such as lack of care, or making demands collectively at health facilities or at higher levels on issues such as lack of medicines, equipment and supplies.</li> <li>3. Carrying out protests and rallies on issues affecting them</li> <li>4. Raise awareness among women and families about health services and entitlements, monitoring their use of maternal services, etc., contribute to demanding accountability from the health providers.</li> </ol> <p><b>CIVIL SOCIETY (ANANDI)</b></p> <ol style="list-style-type: none"> <li>1. Provides the necessary training and support to the women's groups in conducting these activities through monitoring and supervisory visits</li> <li>2. Identifying communities' concerns, including about health services and making the health system accountable by referring communities' collective voices to the health system and conducting dialogues and negotiations through the women's groups and CBO staff.</li> <li>3. CSOs conduct maternal death reviews (social autopsy) review of maternal deaths for all associated causes including social factors</li> <li>4. Conducting dialogues on issues raised during MDR</li> </ol>	<p>Panchayat members do not feel empowered to hold the government actors accountable</p>
<p>Women, Media (Journalists and celebrities), Civil Society Alliance of organization, Elected officials</p>	<ol style="list-style-type: none"> <li>1. Women were expected to attend the public hearing and share the stories and demand for their rights and entitlements.</li> <li>2. Media supported public hearings</li> <li>3. Media participated in maternal death verbal autopsies, placed maternal mortality on the political and public agenda contributing to an enabling environment for social accountability. E.g highlighting incidents of a mother giving birth in a floor</li> <li>4. Elected official raise the profile of maternal health among their powerful</li> </ol>	<p><b>Enabling Factors</b></p> <ol style="list-style-type: none"> <li>1. Educating women on health issues including maternal entitlements so that they are able to participate in the public hearing</li> <li>2. Civil Society Alliance linked with women self-help groups to train group leaders and spread information about public hearing, maternal health and entitlements to their member's</li> <li>3. Public hearing provided women a safe space and catalytic spark to develop agency</li> <li>4. Public hearing provided women with an avenue for collective action and an opportunity to mobilise the</li> </ol>

	peers.	community to influence the power dynamics <b>Limiting factors</b> 1. Some leaders may be reluctant to openly admit weakness in the system 2. Fear of reprisals- Leaders and health providers could enact reprisals on vocal members of the public hearing 3. Community mistrust- -If improvements are not evident to the community members after the hearing, women may become more discouraged than before. 4. Women lacked agency due to the deeply embedded patriarchal norms, this impeded assertion of rights women which led to poor maternal health outcomes
Health Facility Committees in Malawi are known as Health Centre advisory committees (HCACs)	1. Monitor provision of services through observation 2. Addressing poor performance by engaging with health workers directly, through individual feedback (sitting down) and mediation. 3 Reporting poor behaviour to health authorities when the informal approaches do not lead to changed health worker behaviour or performance or when problems are considered beyond the authority of HCACs.	<b>Enabling factor</b> Availability of HFC as a formal structure  <b>Limitations</b> 1.Lack of training and information, feeling not entitled to monitor health workers 2. HCACs capacities to judge health worker performance and the lack of clarity of roles and responsibilities in upward and downward reporting processes were mentioned as main challenges. 3. HCACs often cannot judge complaints and distinguish between personal frustrations and issues that affect the whole community. 4. Participants reported a lack of clarity on reporting procedures and accountability relations between the HCAC, individual health workers, health centre management (officer in-charge) and the DHMT. 5. The HCAC training manual on complaint management is not clear; it does not specify how, when and for what HCACs should forward complaints to the DHMT. This lack of clarity frustrates health workers as some feel HCACs sometimes report to the DHMT too quickly, without a proper investigation
Mother Groups, - Female community health volunteers (FCHVs), Health Facility Operation and Management Committees (HFOMCs);	1. MGs and FCHVs were perceived as trusted intermediaries, but their functioning was limited to information. 2. FCHVs received complaints from women in the community, 3. FCHVs and MGs communicated the concerns of women to the health sector. 4. FCHVs provided information regarding maternal and child health and health services. 5. FCHVs play a major role in linking communities with the health sector and in convincing them to use the health services. 6. FCHVs prepare a monthly report during the MG meeting, which includes the communities' health service-related concerns 7. HFOMCs were not fully functional	<b>Enabling Factors</b> -Women share their health service concerns in mothers' groups (MGs) and with female community health volunteers (FCHVs) who have the potential to serve as intermediaries between the women and the health sector. <b>Limiting Factors</b> -Poor participation by women -Absence of a mandate especially for MGs and FCHV and limited capacity, including resources -A major gap concerned the lack of responses, especially from the higher levels such as the district and Ministry which was attributed to lack of financial resources -Lack of resources to implement some Social Accountability activities e.g Social audit -poor monitoring of the social accountability activities mainly due to limited personnel.
Local Council Leaders & Village health team	1. Mobilized and called for community meetings to secure community buy-in 2. Provide community feedback that help in designing CSC	<b>Enabling Factors</b> 1. Legitimate community level leaders can play an important role in ensuring that the CSCs are locally accepted and implemented successfully through powerful coalitions with powerful stakeholders at higher levels. <b>Limitations</b> Limited leverage in influencing upstream factors
Community Champions, women's pressure group, male	1. Sensitizing the community on Family planning to dispel the myths during community dialogues	<b>Enabling Factors</b> 1. Capacity building of the various actors equipped them with information and skills to sensitize the community on

<p>role model groups</p>	<p>2. Pressure Groups &amp; Champions led sensitization about family planning in person or at social gatherings. 3. The community groups consisted people with local social stature and strong networks and were strategically leveraged to enhance the credibility of efforts and to help legitimize the demands of those in less socially advantageous positions. 4. Promote family planning with other men, both individually and in groups</p>	<p>SAC 2. Social capital- connection that the local groups had assisted in addressing some issues 3. The social standing of the community representatives played a role in legitimizing women’s demands, and acted as a safe outlet for women who felt social constraints in what they could say and do for fear of social censure. <b>Limiting Factors</b> 1. Divisions among community actors created by indifferent treatments for instance, the community champions received additional training and directly engaged with the officials that the other community groups.</p>
<p>Health Facility Committees</p>	<p>1. Information/data collection through direct observation or through users approaching individual HFC members and supervision in health facilities. 2. Dialogue/forum through direct (HFC meetings) and immediate problem solving or involvement of health authorities</p>	<p><b>Enabling Factors</b> 1. Strong collaboration and partnerships 2. Absence of remuneration does not affect HFC engagement in social accountability. <b>Limitations</b> 1. HFC do not document their interactions 2. In none of the study sites, HFC members pro-actively seek users’ opinions or ask people to share needs, demands, expectations or complaints about health services.</p>

### Role in Sharing and Collecting Information

Four studies conducted in India, Nepal, and DRC discovered that community actors serve as an intermediary by collecting and presenting women's concerns to health care facilities (Mafuta et al., 2015, 2017; Hamal et al., 2018, 2019). Three studies in India, Nepal, and the Democratic Republic of the Congo found that CHWs/FCHVs provided information to the community about health services and educated the population about the importance of reporting their concerns. In India the FCHVs educated the community about government programs and entitlements through group discussions and home visits. FCHVs aided women in obtaining their entitlements in this study. Mafuta et al., (2017) in DRC confirmed that CHWs raised community concerns with health providers during dialogue meetings and health committee meetings.

In addition to the use of CHWs/FCHVs to share information, six studies reported the use of other actors like community leaders, champions, women pressure groups, and to collect concerns from the community and inform the health system. Local authority, a village chief, or administrative chief officers were examples of community leaders. Regular village meetings were held by community leaders, and they served as the primary forum for community members to express their concerns (Boydell et al., 2020; Hamal et al., 2018; Kiracho et al., 2021).

Papp et al., (2013) reported on the use of media actors such as journalists and celebrities in SAC activities. Media supported public hearings and participated in maternal death verbal autopsies, placed maternal mortality on the political and public agenda contributing to an enabling environment for SAC.

### Role in Monitoring Performance and Services

Four studies conducted in Bangladesh, Benin, Guinea and the DRC, Malawi, and India found that various community actors played an important role in monitoring services and the performance of health providers.

Lodeinstein et al., (2019) study in Malawi explored how Health Facility Committees (HFC) also known as Health Centre advisory committees (HCACs) monitor the quality of health services and how they demand accountability of health workers for their performance. The results suggested that the HFC monitor provision of services and address poor health worker performance such as absenteeism, poor treatments and informal payments. They address poor performance by engaging the health workers directly through individual feedback and mediation. When informal approaches of addressing the issues fail, they report poor behaviour to health authorities (District Health Management Team). Some of the limiting factors on HFC role were lack of training and information, lack of clarity on reporting procedures, HCACs capacity in judging health workers performance and the HCACs felt not empowered to monitor health workers. The study concluded that the potential and limitations of HFCs in improving health worker’s performance should be assessed from a broader perspective and in comparison to other efforts to improve the quality of services and address poor performance and illegal actions by health workers.

Feruglio and Nisbett (2018) identified four SAc community actors in India. They included Mothers Committees (MC), *Jaanch* Committees (JC), Village Health and Sanitation Committees (VHSC), and Self-Help Groups (SHG). In terms of monitoring and oversight, MCs were tasked with ensuring the quality of food rations distributed at the *Anganwadi* Centre (AWC), as well as being present during take-home ration distribution and ensuring the timely opening of the AWC and home visits by the *Anganwadi* Workers (AWW). The JC role entailed monitoring various aspects of the feeding programs implemented in AWCs, such as overseeing the distribution of hot cooked meals and morning snacks to women and children enrolled in the AWC. The VHSC role included planning, implementing, and monitoring interventions around health, water and sanitation at village level by developing work plans based on village situation and community priority. SHG tackled issues identified as (individual and collective) priorities and which were important underlying or basic drivers of health and nutrition. For instance poverty and lack of purchasing power, long working hours and heavy workload, gender based violence (often linked to alcohol abuse) and discrimination based on ethnicity and gender.

In Bangladesh, Hanifi et al., (2020) study did not exhaustively discuss the actual practice observed for the community groups and community support groups. However the expected role for community group was to take care of Community Clinic's (CC's) day to day operations, monitoring and evaluation of CC's performance and community participation, coordination with stakeholders and fund generation. The Community support group was to help the Community Group in managing the clinic, to raise awareness about the CC and its services in the community. Findings especially from the control site showed that this role wasn't adequately played as the service utilization remained the same pre and post study.

In Benin, Guinea and Democratic republic of Congo, Lodenstein et al., (2017) established that HFC performed SAc by engaging with health providers in person or through meetings to discuss service failures. This led to changes in the quality of services, such as improved health worker presence, the availability of night shifts, the display of drug prices and replacement of poorly functioning health workers. However, these practices were individualised and not systemic. Therefore, success was dependent on HFC leadership and collaboration with other community structure. The study established that remuneration of HFC did not affect how they engage in SAc. The limiting factors on the role of HFC across the study countries was lack of documentation and passive role of seeking opinions from the health service users.

### **Role in Addressing Complaints**

There was little documentation on community actors' actual participation in addressing community concerns. Nonetheless, depending on the context, the role of community actors in resolving complaints varied. Other community actors' role was limited to sharing information, such as MC and FCHVs in Nepal Hamal et al., (2019), and bringing community concerns to health providers during dialogue meetings and health committee meetings to create social pressure (Mafuta et al., 2017). Locally elected village councils in India fought for the extension of government entitlements to people who did not have below-poverty-line (BPL) cards (Hamal et al., 2018).

In Malawi, HFC addressed poor performance by engaging with health workers directly, through individual feedback (sitting down) and mediation. They also reported poor behaviour to health authorities when the informal approaches did not lead to changed health worker behaviour or performance or when problems were considered beyond the authority HFCs (Lodenstein et al., 2019). HFC addressed complaints in Benin, Guinea, and the Democratic Republic of the Congo through direct HFC meetings and immediate problem solving or involvement of health authorities (Lodenstein et al., 2017).

### **Factors that Enable or Limit the role community actors in Social Accountability**

#### **Enabling Factors**

To promote SAc activities in the DRC, it was suggested that CHWs be trained and selected through community elections (Mafuta et al., 2015). Diverse committee membership, such as the *Jaanch* Committees (JC) in India, and including participants in committees who are not service recipients aided in breaking down the provider/use paradigm, increasing the potential for performance monitoring. Furthermore, groups that are not an extension of health committees, such as Self Help Groups, increased their autonomy and equal power distribution among themselves, which is an important factor in the success of SAc activities (Feruglio & Nisbett 2018).

Legitimate community leaders recognized by formal government structures, such as local council leaders and Village Health Team/HFC members, aided in increasing local acceptance of SAc activities. Their influence resulted in powerful coalitions, which helped in the development of social pressure in the health system, which is critical to the success of SAc (Kiracho et al., 2021; Lodenstein et al., 2019; Hamal et al., 2018). Furthermore, Hamal et al., (2018) found that the availability of public-private partnerships increased the strength of coalitions that promote SAc activities. In India, dialogues and public hearings provided a safe space for the community to express their concerns while also serving as a channel for collective action (Papp et al., 2013).

#### **Limiting Factors**

Four studies found that community actors' lack of awareness on their roles and responsibilities hampered their ability to implement SAc. Lack of awareness was attributed to a lack of training according to Hamal et al., (2018), which contributed to

knowledge and information asymmetry (Mafuta et al., 2015). The asymmetry of power among community actors and health providers hampered community actors' ability to hold government actors accountable. For example, HFC in Malawi and VHSC in India reported a lack of capacity and authority to evaluate health workers' performance and hold them accountable (Hamal et al., 2018, Mafuta et al., 2015, Lodenstein et al., 2019; Hanifi et al., 2020). According to one study, beneficiaries' lack of knowledge about their rights and entitlements prevented them from reporting their concerns to community actors (Hamal et al., 2018).

The absence of a clear mandate for community actors on their role and responsibilities in SAc was identified as a challenge in five articles. These caused members, particularly those on multiple committees, to become confused about their roles and responsibilities, causing some actors to fail to fully implement their responsibilities (Feruglio & Nisbett, 2018; Hamal et al., 2018; Lodenstein et al., 2017, 2019; Mafuta et al., 2015). Lodenstein et al., 2019 reported in Malawi that even with the available HFC complaint management training manual, it was unclear and did not specify how and when the HFC should forward complaints to higher levels. Aside from a lack of a clear mandate, two studies reported a lack of a formal channel for collecting information about complaints (Lodenstein et al., 2019; Mafuta et al., 2015).

Three studies in India, Nepal, and the Democratic Republic Congo found that a lack of financial resources to implement SAc activities had an impact on the role of community actors. Unresponsiveness was also linked to a lack of financial resources, particularly at the higher levels (Hamal et al., 2018, 2019; Mafuta et al., 2017). According to one study, community mistrust was a barrier to their role, which stem from unfulfilled promises (Papp et al., 2013). Community actors reported fear of reprisal as a factor limiting their role (Hamal et al., 2018; Papp et al., 2013). In Uganda, community actor's limited influence over upstream factors was identified as a barrier in implementing SAc (Kiracho et al., 2021).

## Discussion

This study identified community actors in SAc, including CHWs, HFCs, Community Based Organizations, and Community Leaders. Overall, we found that community actors are involved in a variety of activities, including collecting community concerns and presenting them to the health facility and health authority, informing the community about health services and government entitlements, monitoring the performance of health providers, and addressing community concerns. Community actors held health providers accountable by providing forums for communities to express their concerns, as well as monitoring health workers behaviour and availability of essential commodities like drugs. These findings are consistent with previous study on the role of community health committees (Karuga et al., 2022). They discovered that the health committees are involved in SAc by raising community concerns about the quality of care provided and monitoring the management of health facilities.

Enablers and barriers to community actors' success in social accountability were identified in this review. The enablers included diverse committee membership, which included participants who were not service recipients. The diverse membership helped to break the provider/user paradigm, increasing the potential for performance monitoring. Legitimate community leaders also aided in the formation of strong coalitions and increasing local acceptance of SAc activities. The challenges identified included community actors' lack of awareness of their roles and responsibilities, the absence of a clear mandate for community actors on their role and responsibilities, fear of reprisal for speaking up, power asymmetries and lack of financial resources to implement SAc activities. These findings are inconsistent with those of Danhoundo et al., (2018), who discovered that successful social accountability interventions include clear roles and responsibilities for all parties involved in the process, as well as financial and technical support from experienced groups. In their study, they also discovered that fear of reprisal for speaking out, as well as a lack of financial resources, limit social accountability activities. As stated by, Marston et al., (2020) a lack of financial support jeopardizes the sustainability of SAc activities. Karuga et al., (2022) also reported power dynamics as limiting how health committees are selected and involved in the planning and budgeting process.

The limitation of this review was that the search was confined to English language studies, and the literature search included studies published after 2012. There is a possibility of existence of other literature written in other languages e.g Xhosa from south Africa that this study did not look at. The strengths of this review included the systematic approach to searching the literature, selection of studies, analysis and interpretation of the findings was done by two authors. Agreement was used to reach a consensus on the interpretations.

The optimization of community actors' roles in social accountability necessitates capacity building and the establishment of a clear mandate. It is critical that policies and training manuals explicitly state the roles of various community actors. The complaint management system must be clear, particularly about who, what, and where community actors can escalate concerns that cannot be addressed at their level. Documentation on complaints and how they were handled by various actors should be strengthened at the operational level so that the information can be used as a reference point. Governments must devote resources to effectively support social accountability activities such as community score cards and social audits.

## **Conclusion**

Our findings indicate that community actors play an important intermediary role in strengthening health systems by amplifying community voices. However, in order to maximize their potential, they must be trained on their roles and responsibilities, as well as given clear mandates. These will give them the ability to hold health providers accountable, reducing the reported knowledge and power disparities. Furthermore, financial resources are critical to the success of social Accountability monitoring activities such as social audits and community score cards. These insights will assist various implementers who work with community actors to strengthen their SAc activities.

## Abbreviation

AWC: *Anganwadi* Centre

AWW: *Anganwadi* Workers

CC's: Community Clinic's

CHW: Community Health Workers

DRC: Democratic Republic of Congo

FCHVs: Female Community Health Volunteers

HCACs: Health Centre advisory committees

HFC: Health Facility Committees

JC: *Jaanch* Committees

MMAT: Mixed Methods Appraisal Tool

MC: Mothers Committees

SAC: Social Accountability

SHG: Self Help Groups

VHSC: Village Health Sanitation Committees

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**Main Author:** Malkia M. Abuga

**Corresponding Authors:** Wanja Mwaura Tenambergen & Kezia Muthoni Njoronge, Health Systems Management Department, Kenya Methodist University.

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