SOCIAL ACCOUNTABILITY SOURCEBOOK

CHAPTER 4

SOCIAL ACCOUNTABILITY IN THE HEALTH SECTOR

HOW TO READ THIS DOCUMENT

Welcome to the World Bank's Sourcebook on "Social Accountability: Strengthening the Demand Side of Governance and Service Delivery"!

There is growing recognition among governments, donors and civil society that citizens and communities have an important role to play with regard to enhancing accountability of public officials, reducing corruption and leakage of funds and improving public service delivery. As a result, Social Accountability has become an attractive approach to both the public sector and civil society for improving governance processes, service delivery outcomes, and resource allocation decisions. Over the last decade, numerous examples have emerged that demonstrate how citizens can make their voice heard and effectively engage in making the public sector more responsive and accountable.

In an effort to capture the diverse experiences from across the world and make them available in one single place, the World Bank began developing a Sourcebook in 2005 on these approaches for reference, familiarization and inspiration. Practitioners and decision makers in the World Bank and in client countries constitute the primary audience for the Sourcebook.

The Sourcebook was originally developed as an interactive resource for use on-line or via CD-ROM. In order to cater for readers with limited web/ computer access "downloadable" file versions of the main Sourcebook chapters have been made available (http://www-esd.worldbank.org/sac/).

This document is part of the larger Sourcebook on Social Accountability. It constitutes one of the main chapters of the Sourcebook, originally written as content of web pages and later converted into a comprehensive text.

The entire Sourcebook is organized in several main chapters:

- A Conceptual Chapter ("Social Accountability: What Does it Mean for the World Bank?") providing an analytical framework of social accountability, and an overview of the main concepts and definitions.
- Tools and Methods, that are most frequently used as part of social accountability approaches such as participatory budgeting, citizens report cards and social audits;
- Social Accountability in the Regions provides access to case examples of social accountability in different regions.
- Sectoral and Thematic Applications: Social Accountability in Public Expenditure Management, Decentralization, Education and Health;
- Social Accountability in Bank Operations provides guidance, case examples and lessons learned from the implementation of social accountability in Bank operations, including investment and development policy loans. It also provides guidance on how to conduct analytical work on social accountability and access to examples of analytical studies on the topic.

- Knowledge and Learning Resources: access to knowledge and learning materials on social accountability, including case studies, publications, website links, power point presentations, manuals, etc.

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List of Acronyms

LIST OF ACRONYMS

CBO	Community Based Organization
CIET	Centro de Investigacion de Enfermedados Tropicales
CHAK	Catholic Health Association of Kenya
CMP	Community Management Program
CNS	National Health Council (Peru)
CPPIH	Commission for Public and Patient Involvement in Health (UK)
CRS	Catholic Relief Services
IDASA	Institute of Democracy in South Africa
KIM	Key Informant Monitoring
MDG	Millennium Development Goal
MoH	Ministry of Health
MHO	Mutual Health Organization
NSHIF	National Social Health Insurance Fund
NSMP	Nepal Safe Motherhood Project
PAC	Public Affairs Center (Bangalore)
PETS	Public Expenditure Tracking Survey
WDR	World Development Report
WHO	World Health Organization
	Programs Supported by the World Bank

1. INTRODUCTION

The 1993 World Development Report (WDR), *Investing in Health,* described strengthening accountability as one of the core elements of health sector reforms. Since then, both participation and accountability have become increasingly popular and part of strategic plans for developing and transitioning countries' health sectors. This popularity has been reinforced by pressure from civil society, bilateral and multilateral donors, and governments in the quest for more effective, efficient and equitable access to health care. The WDR 1993 suggested competition, decentralization, community financing and oversight mechanisms as ways of strengthening accountability. However, a recent paper analyzed these suggestions and concluded that none of these initiatives had enhanced health service accountability and that participation and accountability in the health sector need rethinking.[1]

Social accountability approaches operationalize and strengthen direct accountability relationships between citizens (the users of health services), policy-makers and service providers. They help to overcome significant challenges such as weak citizen's voice and oversight, and lead to better informed policy decisions, responsible management and leadership, and more efficient and responsive investment decisions. The Millennium Development Goals (MDGs) for health will succeed only if the business as usual strategy is changed and the right to demand health, as well as the capacity and willingness to respond to them, is strengthened.

This chapter provides an overview of, social accountability mechanisms in the health sector. The first section presents the rationale and conceptual framework for analyzing social accountability. With reference to the WDR 2004 framework, this section also addresses decentralization in the health sector and how that affects social accountability relationships. Section two illustrates five main entry points[2] for introducing social accountability in the health sector. It provides examples of how these entry points have been used. Section three discusses the critical supply side (government) and demand side (citizen) factors that facilitate or impede social accountability, and looks at pre-conditions in the broader legal and political enabling environment for these approaches. Section four contains a checklist on how social accountability mechanisms can be incorporated into the health sector. Section five lists additional resources including case studies, a bibliography, website links to training manuals and resources institutions, and more project examples.

1.1 Relevance and Conceptual Framework

Two of the four MDGs that directly refer to better health, namely reducing child mortality and improving maternal mortality, have been difficult to achieve due to a number of factors which include:[3]

- elite bias and top-down processes in public health planning,
- poor targeting and leakage of resources for health,
- lack of incentives for health service providers,

[1] Murthy and Klugman (2004)

[2] An entry point is a particular conducive setting for the application of social accountability mechanisms that respond to the felt needs and demands of stakeholders, and aims at increasing accountability, inclusiveness, transparency, responsiveness and development effectiveness.

[3] See www/siteresources.worldbank.org/GLOBALMONITORINGEXT

- insufficient implementation capacity of service providers and citizens, and,
- insufficient public oversight and feedback from end users.

This is partly caused by due to lack of citizen's participation towards social accountability in health shown in the following examples.

- In Nepal, neonatal mortality decreased by 30 percent through participation of women in health service provision.[4]
- In Kenya, malnutrition has been significantly reduced through community participation and capacity building of service users.[5]
- In Burkina Faso, community participation in primary health care clinics increased immunization coverage, the availability of essential drugs, and the percentage of women receiving ante-natal care.[6]
- In Peru, good governance in primary health care was associated with improved quality of services and decreases in staff absenteeism and waiting times.[7]

This suggests that participatory mechanisms not only contribute to better health outcomes, but also help define policies which correspond more closely to the needs of citizens. Participatory mechanisms can help reduce leakages and corruption, and often change the orientation of service providers towards inclusion of marginalized groups.[8] In order to be effective, accountability initiatives must contest power relations and include health issues marked by social inequalities and stigma. Thus, reference to and inclusion of specific health areas[9] and/or population groups[10] can be a litmus test indicating the presence, depth and scope of social accountability in the health sector.

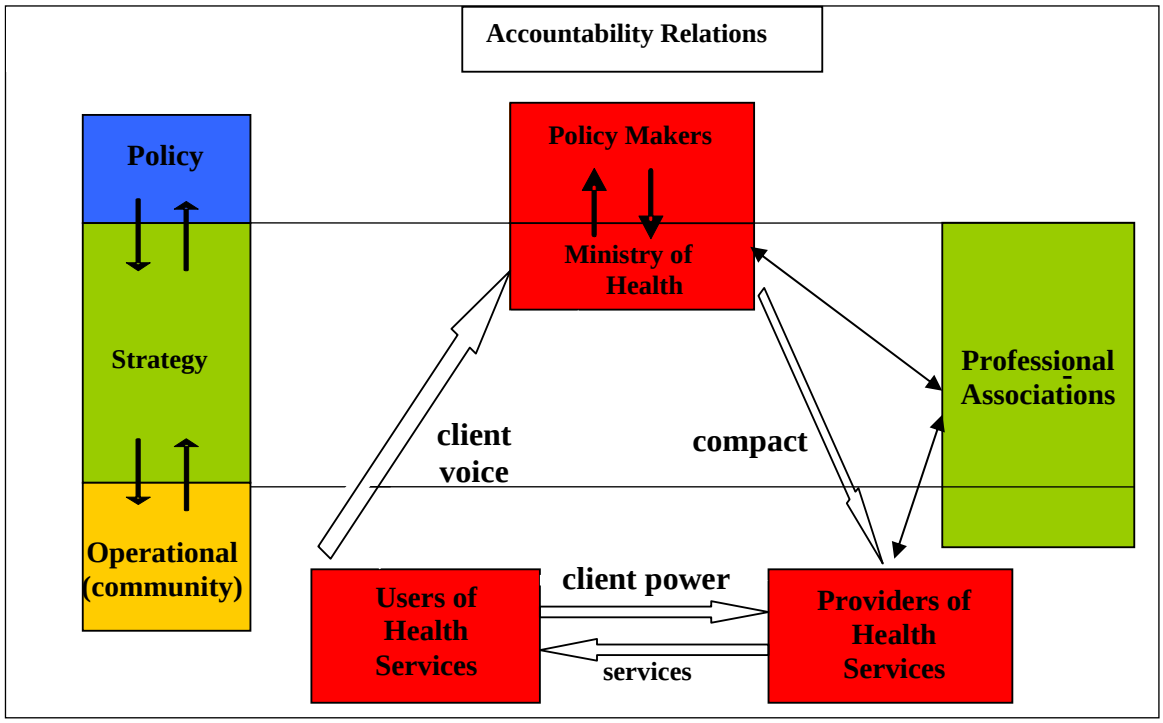
The link between development effectiveness and social accountability is becoming particularly relevant as donors, politicians and academics alike are striving to achieve and document better development outcomes. Social accountability is a powerful tool for monitoring and evaluating programs. However, social accountability is one set of tools, works under certain conditions, and cannot solve the problems of health sector performance by itself. For example, civil society groups working in the health sector, including patients' associations, are often weak and disorganized, and they frequently lack the organizational capacity and the financial resources to expand and become more professional. Among their future challenges will be building closer relationships with government and professional medical associations, promoting greater access to public information, and building closer relations with the media for information dissemination and enforcement of laws. Social accountability is usually most effective when used in conjunction with government accountability measures.

[4] Manandhar et al. (2004)
[5] Government of Kenya (2004)
[6] Eichler (2001)
[7] World Bank (1999); Ewig (2003)
[8] George (2003)
[9] For example, mental health, and sexual and reproductive health and rights.
[10] For example, people living with HIV/AIDS and people with disabilities.

To analyze accountability relationships in service delivery more systematically, the WDR 2004 offers a widely accepted conceptual framework. Three different sets of accountability breakdowns are identified between the policy makers, service providers and clients. Figure 1 depicts the three mechanisms by which accountability relations between the actors can be improved: client voice and client power, i.e. the two broad ways in which citizens can influence patterns of service delivery, and the compact between providers and policy-makers.

- *Client Voice* is the "long route" of accountability, through which *citizens* provide mandates and/or their preferences to *policy-makers (the state)* to design services that respond to citizens' needs.
- *Client Power* is the "short route" of accountability, which denotes forms of direct client feedback, co-management and/or client choice related to *services provided*.
- *Compact* is the more or less formalized relationship through which *policy makers (the state)* provide policy directives and incentives to the *health system and providers*.

Figure 1: Client Voice, Client Power and Compact (centralized system)



1.2 Decentralization and the Health Sector

In the last two decades, health sector decentralization has been implemented throughout the developing world, usually as part of a broader process of political, economic and technical reforms.[11] It has usually been argued[12] that the benefits of such reform policies include:

- improved efficiency in budget allocations by allowing the mix of health services and expenditures to be shaped by local user preferences

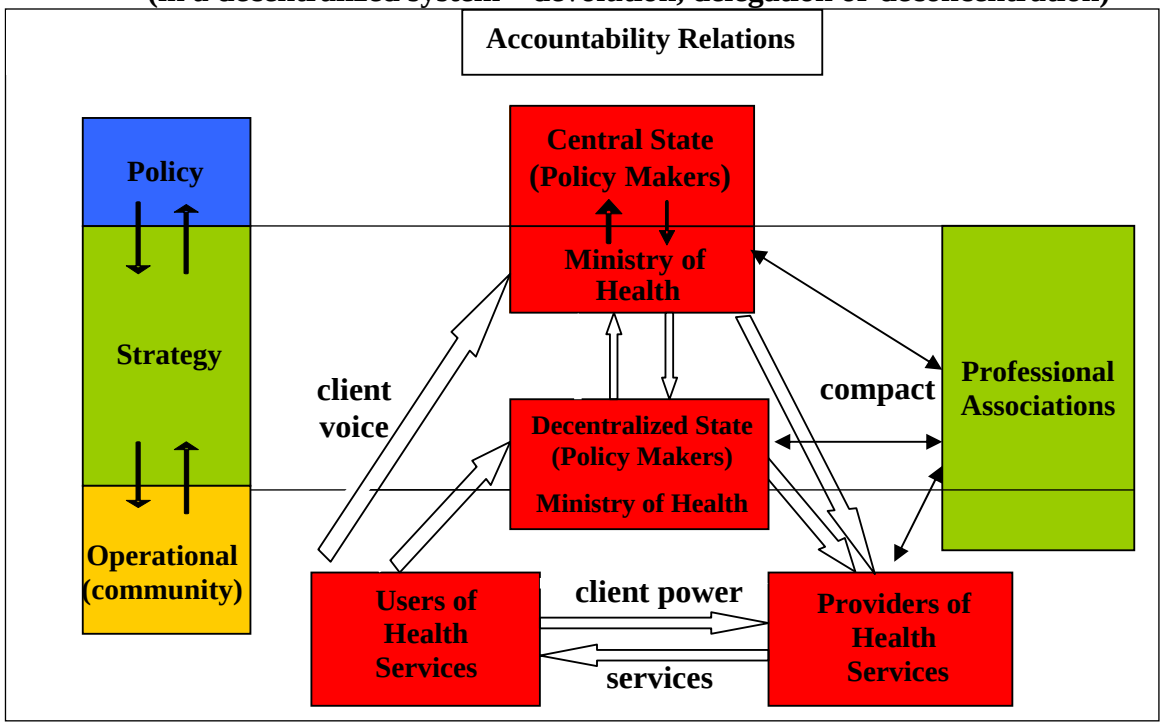
[11] Litvack, Ahmad and Bird (1998). Unless stated otherwise, this chapter equates decentralization with devolution.
[12] Bossert and Beauvais (2002); Catholic Relief Services (2003) p.81.

- improved technical efficiency through greater cost awareness at the local level
- health service delivery innovations through adaptation to local conditions
- greater equity via resource distribution of towards marginalized regions or groups
- improved quality, transparency, accountability, and legitimacy owing to user oversight and participation in decision making.

Decentralization in the health sector has been fueled by new efforts at democratization through promoting accountability and introducing competition and cost consciousness in the health sector. The state's role has shifted from being an implementer of health service delivery, to a regulator creating enabling environment[13] The degree to which this has been successful depends on whether fiscal, administrative, ownership and/or political authority for health service delivery is delegated from the central Ministry of Health to the local level and on the capacity of local level staff to manage such tasks.

Figure 2 shows the WDR 2004 framework modified to illustrate the accountability mechanisms in a decentralized setting. This conceptual differentiation is important as it captures the re-positioning of actors, mandates and authorities in the decentralized service delivery system. The so-called *intermediate route of accountability* refers to client *voice* and the *compact* mechanisms relating clients to public officials and service institutions at the sub-national government level.[14] A decentralized framework multiplies the entry points for social accountability initiatives.

Figure 2: Client Voice, Client Power, and Compact
(in a decentralized system – devolution, delegation or deconcentration)



[13] In this context, the state refers to politicians and the Ministry of Health at the central level.
[14] Assuming devolution. [15] Emanuel and Emanuel (1996)

2. ENTRY POINTS AND SOCIAL ACCOUNTABILITY MECHANISMS

Notions of accountability in the health sector are more than descriptions of current health care systems: they are also normative guides that determine the institutional structures for health service organizations and the type of health service delivery. As in other public sector contexts, health care systems contain political, financial, administrative, legal and social accountability relationships. Social accountability is about affirming and operationalizing direct accountability relationships between citizens, the state and service providers. Social accountability refers to (i) the broad range of actions and mechanisms (beyond voting) that citizens can use to hold public officials to account, as well as (ii) actions on the part of government, civil society, media and other societal actors that promote or facilitate these efforts. Social accountability approaches are not intended to replace, but rather to reinforce and complement, conventional (political, administrative, financial and legal) mechanisms of accountability.

2.1 The Components of Accountability

To help elucidate the concept of social accountability in the health sector, it is useful to consider the different components of the accountability relationship – the who, what, and how – by defining the actors that can be held accountable, the issues for which they can be held accountable, and the appropriate mechanisms for social accountability.[15]

The first question is *who* is accountable to *whom*, that is, *the locus of accountability*. Many different parties can be held accountable or hold others accountable, such as individual students, individual teachers, schools, professional associations and so on. To understand the locus of accountability, it is important to understand power relationships between actors. These relationships can be unpacked through stakeholder or structural analysis which has proven useful not only at the operational level but also at the strategy and policy levels.[16]

The second question is *what* a particular actor is accountable *for,* that is, the *objects of accountability*. Different types of accountability focus on different issues (e.g. financial management, proper conduct or performance). An accountability object can be any issue which an actor can legitimately be held responsible for and called on to justify or change its action.

The third question is *how* these actors account for their actions, that is, *the procedures for ensuring accountability*. Some of the most common approaches and mechanisms for social accountability are described in the Methods and Tools chapter. Beyond answerability, rewards and sanctions are indispensable elements of accountability. Social accountability approaches, which often operate from outside the public sector, mainly work through building up public pressure or awareness, influencing public opinion, or partnerships with the public sector or other actors. The practical application of social accountability mechanisms are shaped by in-country factors such the political willingness and capacity of state and civil society stakeholders; the particular organizational, structural, financial, planning and implementation systems in place; and broader socio-economic, political and cultural factors.

[16] Veneklasen and Miller (2002)

Entry points for social accountability can usefully be categorized at the policy, strategy or operational level. The policy level (macro government) formalizes the political priorities of government, such as equal access to quality services. The sector strategy level (usually the Ministry of Health) operationalizes overall policies via strategic planning, implementation and monitoring of reform packages. The operational level (health providers and management) implements and monitors government policies and strategies to ensure effective and efficient coverage of quality services.

Social accountability entry points at each of these three levels include the following concerns.

At the *policy level* social accountability is usually concerned about issues such as:

- Are the public policy priorities the right ones? For example, emphasis on curative compared to preventive/promotive health services and exclusion of marginalized groups, such as children with disabilities and women exposed to violence.
- Is the vision behind public policy prescriptions understood and widely shared? Are the underlying values and norms acceptable? Are the preferences of citizen and service users publicly articulated and discussed?
- Do the policy prescriptions achieve the desired outcomes? Are they on the right track?
- Is monitoring information on policy goals publicly available and discussed?

At the *strategy level* social accountability often deals with the following concerns:

- Are the policy prescriptions adequately translated into budget allocations, legal and regulatory mechanisms, institutional reforms, investment programs, and so forth?
- Are sectoral policy reforms implemented as planned? Do they achieve their expected outputs and outcomes?
- Is disbursement of public expenditures in line with allocated budgets for health? To what extent do resources transferred from the central level reach end-users? Do leakages occur? Are resources mismanaged?

At the *operational level* social accountability frequently examines:

- Health care service delivery – its accessibility, availability, effectiveness, efficiency, standards, and outcomes.
- Monitoring of health performance and oversight of the service delivery chain, both by civil society and by self-regulatory bodies (e.g. professional medical associations).

Table 1 provides an overview of accountability issues in the delivery of health services.

Table 1: The Eight Dimensions of Effective Health Service Delivery

Dimension	Key Questions
Physical Accessibility	Are health facilities or outreach services available and sufficiently accessible for the poor to make use of them?
Availability of Human Resources	Are human resources available at health facilities that target the poor? Are services geographically accessible or in short supply part of the time?
Availability of Material Resources	Are material resources, especially medicines, accessible at the prescribed standards?
Organizational Quality	How are health care services organized, such as hours of operation, quality of services, gender-balance of health care staff, and requirement of 'unofficial' hidden payments?
Relevance of Services	Does the sector provide services that are relevant to the diseases that affect the population, especially the poor?
Timing and Continuity	Are services provided in a timely and continuous fashion (for some services, such as tuberculosis treatment or immunizations, continuity is a vital determinant of efficacy)?
Technical Quality	Are services provided to the poor at lower technical quality compared with those provided to the better off? Is a basic service of reasonable quality available to all? How are health care providers' skills and qualifications kept current?
Transparency and Management of Financial Resources	How transparent is financial management at the health facility level? Are directors or administrative staff accountable to citizens and communities? What forms of co-decision making and public oversight exist?

Social accountability initiatives can be found in most of the important dimensions for service delivery provided in Table 1. Many successful or interesting social accountability examples are presented in the following section, structured according to the different levels in the health sector introduced above. Despite these promising initiatives a note of caution has to be reiterated. Social accountability approaches are not intended to substitute conventional (financial, administrative, political, etc.) accountability mechanisms, but rather to complement and reinforce them. They have proven their value where conventional mechanisms were not effective, or where service users and civil society organizations felt that their direct engagement was needed to raise an issue, improve the situation or expose inefficiencies or leakages.

2. 2 Policy Level

Meaningful citizen engagement in the policy making and planning phases of health care service delivery can improve prioritization and allocation of resources and lead to structural changes. However, as several of the examples given below show, successful citizen engagement in health policy and planning must go beyond the involvement of beneficiaries and focus on the interface between citizens and service providers. A prerequisite is that information on entitlements and obligations is available to citizens.

The examples below are cases of participatory planning and policy formulation and do not fully meet the definition of social accountability, but they represent an important step towards social

accountability. Because the agenda is still in its infancy and very few, if any, examples of social accountability at the policy level have been documented, these examples have been included.

In the 1990s, the government of Brazil reaffirmed the role of the state in guaranteeing citizen rights to health and created a network of health councils at the national, state and local levels to facilitate citizen participation in the public health care system.[17] A report by the Brazilian Center of Analysis and Planning examined the experience of municipal and district health councils in Sao Paulo. The councils created an opportunity for debate among social groups who would otherwise have been excluded from discussion of health policy. Districts with social mobilization and enthusiastic health councils did not have the sharp social inequalities and unequal provision of services prevalent elsewhere. This indicated that improved service delivery could take place through the participation of active health councils. Important factors for success were the commitment of civil society and state actors and their willingness and ability to guarantee clear rules of political representation and processes that could give voice to excluded groups.

In China, the Basic Health Services Projects I and II involved key stakeholders at all levels in the design phase ensuring that the health master plan responded to the diverse needs of the beneficiaries and therefore contributed to its long term success.[18] The project design included "nationality" as a variable in the health planning baseline survey. This provided unprecedented comprehensive and comparative analysis of issues for minority nationalities. The follow-up survey and stakeholder involvement also ensured that institutional arrangements were realistic and in line with the needs and demands of the local population.

The Christian Health Association of Kenya has been a key stakeholder in health policy dialogue and development.[19] This advocacy role was reaffirmed in various forums to advocate support among trade unions and members of parliament for the National Social Health Insurance Fund (NSHIF). By the end of 2004, the NSHIF bill had been passed by parliament and presented to the president for approval. The NSHIF was soon to become a crucial health financing mechanism in Kenya. Unfortunately, this initiative was taken over by politics resulting in the promise of "free health care" for all Kenyans. A later analysis showed that the scheme would merely have benefited the better-off and would have disempowered people employed in the formal sector by transferring their medical allowances from their job benefits to a centrally controlled fund.

2.3 Strategy Level

2.3.1 Health Budget Formulation and Review

Provision of health care has often been more closely linked to the cost of services than to citizen engagement or a sense of social responsibility. However, independent budget analysis and citizen input into budget formulation have helped to open up officials and other responsible parties to greater scrutiny. This has resulted in increased financial allocations to health services at more local levels and contributed to improved health outcomes. Health outcomes depend on what information is sought, by whom and for what purpose.

[17] See www.id21.org/society/s8cvc1g1.html
[18] Kuehnast (2001)
[19] Christian Health Association of Kenya (2005)

IDASA's (Institute of Democracy in South Africa) AIDS budget unit has undertaken a ten country HIV/AIDS budget study in Africa and Latin America.[20] The budget analysis helps monitor government commitment to the Abuja Declaration which states that 15 percent of any government's total budget should be allocated to health and that an adequate portion should be given to HIV/AIDS, TB and related infectious diseases. IDASA analyzes decision-making processes and helps build civil society capacity by providing budget information and showing where and how civil society can participate in budget processes. IDASA is also conducting a multi-country study on HIV/AIDS budget tracking in Africa (Kenya, Mozambique, South Africa and Namibia) to find out:

- How much is budgeted for HIV/AIDS?
- How does the HIV/AIDS budget compare with other parts of the health budget?
- Is the government response to HIV/AIDS improving?
- Are resources being allocated equitably?
- Is donor funding monitored? To what extent do donor funded programs and projects correspond to national priorities?

In South Africa, the allocation for implementing the National Disability Program has remained fairly constant at 0.07 percent of the total health budget since 1995, but expenditures have decreased since 2000. This led IDASA to analyze budget allocations to children with disabilities to assess whether they have the same or better access to services. The work focused on government's legal obligations and on budgets and expenditures in the health and social development sectors including programs for children with disabilities. It gave them the opportunity to speak about their life experiences. To shed light on the issues they highlighted, IDASA published budget and technical information to ensure access to resources for children with disabilities.

In Mexico, FUNDAR, a center for analysis and research on budget issues, evaluated the extent to which public resources were allocated for the reduction of maternal mortality.[21] FUNDAR collaborated with local groups that had substantial experience working on maternal mortality and reproductive health issues. The study found that basic health services were insufficient to face the challenge of reducing maternal mortality among the poor. This study was used in an advocacy campaign that had several positive results.

- In 2002, the federal government earmarked a substantial amount of decentralized health resources to programs specifically targeting maternal health. The budget of the maternal health program, "Arranque Parejo en la Vida," increased by almost 900 percent.
- Comparing money allocated to maternal and reproductive health with other areas of spending was important. Furthermore, the increasingly effective sharing of information between different stakeholder groups helped form partnerships between civil society groups and FUNDAR. All sides benefited from the development of a shared perspective and from understanding what they can offer each other.

[20] See www.idasa.org.za
[21] See www.idasa.org.za

2.3.2 Expenditure Tracking in the Health Sector

Health service provision may be affected by leakage of resources, corruption in contracting and procurement, and staff absenteeism. This can result in poor service quality and coverage. Therefore, tracking the flow of government spending and public resources is important. Tracking can be initiated by government or civil society. The specific examples here refer to tools such as public expenditure tracking, input tracking, and social audits.

Published work on public expenditure tracking describes wide variations in leakages across countries. Figures vary from 20 percent of non-wage transfers reaching frontline facilities in Ghana to 59 percent in Tanzania. In Tanzania, the Essential Health Intervention Project disseminated the results of expenditure tracking and provided evidence that services increased partly due to the application of social accountability mechanisms.[22] In Georgia, prominent posting of the fee schedule in the children's hospital in Tbilisi contributed to curbing excessive payments and significantly increased hospital revenues.[23]

The "Observatoire" in Senegal is a national watchdog organization that critically examines the multi-sector response to HIV/AIDS.[24] It has been tracking HIV/AIDS expenditures by using the National Health Accounts framework for measuring total (public, private and donor-funded) health expenditures and comparing this with what is actually spent on HIV/AIDS.[25]

As a follow-up to the 1995 baseline study on performance and perceptions of health services in Uganda, the 1998 National Integrity Survey was conducted by CIET (the Portuguese acronym for the Center for Tropical Disease Research) at the request of the Ugandan Inspector General.[26] It found that citizens were less likely to pay extra fees if they knew the facts about procedures for public services and what to expect. A social audit mapped out what information people needed. As a result, every district in Uganda now has follow-up workshops to discuss action plans. Asked what communities could do to counter corruption themselves, many community members said they could refuse to pay bribes. "There is no receiver if there is no giver" one man said in a focus group discussion. Extensive media coverage of the audit results helped reinforce this message. Each social audit finishes with a workshop process where evidence is shared and solutions are developed jointly. Follow-up surveys measure the impact of these reforms.

In Bangladesh, a social audit commissioned by the government showed that more than a fifth of those who visited government health facilities made an extra payment to the health worker, and nearly a third paid an unofficial registration fee. Extra payments for supposedly free services were a disincentive for many who should use government health care. Of those who did use the services, 13 percent said there was no health worker present when they arrived at the facility.

[22] See www/web.idrc.ca/en/ev-8331-201-1-DO_TOPIC.html
[23] World Bank and IMF, 2005, pp.129, 130.
[24] Alliances (2004)
[25] Loewenson (2003)
[26] See http://www.ciet.org/welcome.html

2.4 Operational Level

2.4.1 Management of Health Services and Outcomes

Service delivery is increasingly co-managed by service providers and users. This effective engagement responds to the needs and demands identified by communities themselves. In addition, it requires change in service users and professionals, institutions, and most importantly, changes in decision-making procedures. It also requires enhancing the capabilities of communities to exercise their new rights and responsibilities. Gibbon calls this a responsible partnership.[27] It includes:

- agreement on a shared vision,
- transparency of information and resources,
- agreed roles and responsibilities,
- all interests represented, and,
- agreed mechanisms for conflict resolution.

In Burkina Faso, the essential drugs program is managed at the health center level as a public-private partnership between the Ministry of Health and civil society. Health Center Management Committees are established to ensure the day-to-day operation of the program. The Ministry of Health manages the supply chain of drugs from the central to the district level and provides medical personnel for prescribing drugs. The Health Center Management Committees are responsible for logistics and for the management of the health center pharmacy. This interaction between civil society and the public sector has generated understanding within civil society for prescription standards and for the value of subsidizing drugs aimed at increasing public health. It has also helped public health officials to improve and be accountable for their prescription practices.

In Kenya, the NGO World Vision, the Community Based Nutrition Program (hosted in the Department of Social Services) and the Ministry of Health have established a partnership between health service users and providers. The partnership takes place through the village development sub-committee on health at the village level, elected dispensary and health center committees at the health facility level, and elected health boards at the district level. This interaction has significantly increased revenues for district and sub-district health facilities, increased drug availability and contributed to higher immunization rates for children.[28]

An alliance between the Government of Brazil and NGOs established the implementation of the National HIV/AIDS Control Program.[29] The leadership of the government's national HIV/AIDS program led to the development of this cooperation. An NGO Liaison Office was created within the national HIV/AIDS program to expand participation of civil society in the struggle against the epidemic and to ensure inclusion of marginalized groups. It was this NGO office that was instrumental in creating the legislation for compulsory HIV testing of blood donations, home based care programs, HIV support groups and educational campaigns. Five NGO representatives now serve on the National AIDS Council that monitors Brazil's AIDS

[27] Gibbon (2000)
[28] Personal communication, project medical officer, Coast Province, Kenya.
[29] Boyd and Garrison (1999)

policies. This was possible due to a good relationship between NGOs and the government, and an enabling environment.

Senegal's Mutual Health Organization (MHO) has implemented another approach.[30] MHOs are autonomous, nonprofit organizations based on member-solidarity and are democratically accountable to members. The aim of MHOs is to improve members' access to quality health care through risk sharing based on their financial contributions. In some cases, these organizations are supported by private donors such as religious organizations and local hospitals. MHOs have internal and external stakeholders that include the Ministry of Health and local government. There were 19 functioning MHOs in 1997 and 136 by 2003. This rapid expansion and community participation in MHOs was assessed by the Partnership for Health Reform*plus*. The main findings were that although the structures of the MHOs do result in active participation and collaboration by different stakeholders, participation tends to diminish with time. Trustworthy leadership and decentralized management structures appear to be key elements for sustainability. The importance of political, moral, and logistical support of external stakeholders should not be underestimated as they play a key role in ensuring the viability of the MHOs. The last important element for MHO success is the capacity of MHO management to perform their intended roles.

2.4.2 Performance Monitoring, Audit and Oversight

Citizen participation in standard setting and the inclusion of public oversight mechanisms can play a powerful role in helping to reduce corruption and nepotism, enhance equity, and provide redress of complaints. This can take place at the national, sub-national or local levels. Different mechanisms are used at different levels. The most commonly used tool at the national level is the citizen report card and at the community level—the community scorecard. The attraction of these tools is that they often produce immediate results which may include a change in institutional behavior that eventually can lead to changes in health outcomes. The following tools are described in this section: citizen report cards and community scorecards, public hearings, social audits, objective recruitment systems and promotion processes, and voucher schemes.

Citizen report cards (surveys) have been used in Bangalore, India by the Public Affairs Center (PAC) to assess services provided by the maternity homes run by the Bangalore Municipal Corporation. These homes are used by relatively low income women. The survey revealed that overall satisfaction with services was low (only 39 percent of the people surveyed received free medicine, and only 53 percent used disposable syringes). The homes were poorly maintained (only 43 percent said that the toilets were useable), and there was widespread corruption. After interviewing four officials about the results, actions were taken on almost all of the report card findings. PAC later collaborated with the management of the maternity homes in implementing a follow-up survey.[31]

In Cameroon, citizen report cards have been used by the Multisector HIV/AIDS Program.[32] As part of the community's self-evaluation system, report cards are a mandatory component of the participatory assessment processes which take place every 6 months prior to communities submitting requests for new resource allocations. The report cards

[30] Franco, Mbengua and Atim (2004)
[31] Ravindra (2004)
[32] Delion, Bela, Naude and Salmen (2006)

test community knowledge and awareness of HIV/AIDS, quality of services provided, access to treatment, management of financial resources, and the performance of the HIV/AIDS committee. The report cards contribute to reducing stigma by increasing collective responsibility and action. In 2004, some of the local HIV/AIDS committees who had embezzled funds were replaced as a result of the negative opinions expressed through the report card exercise. Community members claim that now they are better informed and have a better understanding of the use of funds related to HIV/AIDS activities.

The Citizen Report Card at the Community Level in Uganda used community based monitoring to improve health service delivery. The project collected quantitative survey data from service users and providers on health service delivery, disseminated this data to health service users and providers, educated staff and service users on patient rights and entitlements, and facilitated discussions between service providers and users to develop joint action plans to improve health service delivery. One year into the program, utilization of general outpatient services was 16 percent higher in project health facilities compared to a control group. Treatment practices, as expressed both in perception responses by households and in more quantitative indicators (immunization of children, waiting time, examination procedures) improved significantly. There was a small but significant difference in the weight of infants and a markedly lower number of deaths among children under-five in the treatment communities.

In Sri Lanka, the Colombo Center for Policy Alternatives administered opinion polls and citizen report cards to determine user satisfaction with four essential services, health being one of them.[33] These surveys took place due to a perceived urgent need to strengthen institutions, build the capacity for good governance, and resolve conflicts. The report cards offered feedback on the quality of health services for the residents of Colombo. The results were used to highlight problems and successes, and to lobby for better quality and access to service delivery. The survey showed the prevalence of long waiting times, inadequate supply of prescribed drugs, and perceptions of ill-treatment by staff. The results were published in the *Sunday Observer*, but so far no policy action has been taken due to a lack of advocacy. Unfortunately, people did not make any official complaints as they felt that they would not gain anything by doing so.

Community scorecards have been used in the Gambia to monitor the effectiveness of the poverty reduction strategy.[34] These score cards were used in a pilot project on health and education among approximately 3,500 stakeholders. Fifteen health facilities were selected across the entire country. The results indicated weak staff capacity with less than a 30 percent satisfaction rating, insufficient availability of resources such as drugs and transportation and poor conditions within the health facilities such as water, sanitation and access to electricity. Recommendations were developed after a meeting between health service provides and users. The process created awareness of the relevance of monitoring and empowered the community.

The World Bank-supported Fifth Health project, Improving the Efficiency and Quality of Provincial Health Services, covers three provinces of Indonesia. This program aims to strengthen the health professional association thereby ensuring greater accountability of health professionals. Health personnel were assisted to develop and deliver in-service training,

[33] World Bank Institute (2005)
[34] Dedu and Kajubi (2005)

networking and communication for members. The project also implemented maternal mortality audits, a mechanism for strengthening provider accountability. The audit explores the reasons for the death and lessons that can be learned to suggest changes in the guidelines for preventing such incidents. Health administrators and hospital physicians at the district level perform the audit. The findings are presented to community groups, midwives and staff from community health centers. A study of audit outcomes in three districts of South Kalimantan Province found that these audits led to improvements in the quality of obstetric care and strengthened community-based responses to emergency obstetric care. At the same time, the evaluation team observed that there was a tendency to blame the village-level midwives, thereby ignoring underlying problems within the health care system. Given the hierarchy within the system, the final recommendations often tended to represent the opinions of the obstetricians. An analysis of widely publicizing audit findings and community involvement in the findings showed that it was difficult for health staff to openly admit to problems in service delivery.[35]

Social audit systems have been further developed in Europe. In Denmark the audit is institutionalized through a process called self-evaluation.[36] This process has been derived from the Total Quality Management System or ISO certification in the private sector. The Denmark case is interesting because implementation is flexible and leaves room for adjustment to local circumstances. The dissemination of results is not public but can include a wide range of stakeholders, from hospital boards to a closed circle of colleagues in the same department or work area. An evaluation of the initiative showed that a supportive enabling environment was the most critical factor for success.

The Ceara Family Health Programs in Brazil, supported by the World Bank, recruited family physicians to follow-up at-risk families and to provide curative care and hospital referrals based on similar models successfully developed in Sao Paolo, Porto Alegre and Niteroi. Infant mortality and malnutrition significantly declined between 1997 and 2001.[37] Strategies were developed to strengthen community leverage over health providers as well as strengthening client voice. The widely publicized election campaign of a large number of community health agents helped to generate support for the program and made service providers accountable.[38] Service outcomes were reported to the public allowing them to monitor performance. Good performance was rewarded with a prize.

In Cambodia, the World Bank earmarked funds for local NGOs and community based organizations (CBOs) which significantly increased the efficiency of HIV/AIDS services.[39] Service delivery NGOs and CBOs are selected through open bidding with the full participation of all stakeholders. Services are implemented using voucher schemes. Fieldworkers and NGOs distribute vouchers to female commercial sex workers at specific sites. The vouchers entitle the sex workers to free services at a private, nonprofit, or public clinic contracted by the voucher agency through competitive bids. Approved providers receive training and must follow a set treatment protocol. Contracts are renewed after each round of voucher

[35] Supratiko et al. (2002)
[36] See www.dsi.dk/frz_publikationer.htm
[37] Victora et al. (2000)
[38] World Bank (2003)
[39] Wilkinson (2005)

distribution and renewal is subject to an assessment of the quality of care. The clinics return the vouchers to the voucher agency who reimburses the provider at an agreed rate. Sex workers were involved in the design of the program and have opportunities to express their preferences and complaints. In each round, ten percent of the recipients were interviewed about their experiences. Initially, sex workers reported that the gatekeepers, such as nurses and receptionists, lacked sensitivity. Training and awareness raising of the providers solved this problem. Although a follow-up study showed that the prevalence of sexually transmitted diseases was only slightly lower than at the beginning of the project, incidence among women who used vouchers decreased more than 65 percent in the first 3 years of the program. Following recommendations by sex workers, they receive vouchers to give to their regular partners and clients. They appreciated the fact that they could choose which clinic to attend and made their choices based on convenience and staff attitudes. The clinics reported that their main benefit was improvement in the technical quality of services and that these lessons were applied to all their clients. Furthermore, clinics felt that their reputation was enhanced by being contracted by a prestigious public health agency.

Table 2 aligns the five social accountability entry points discussed in this section with the role and functions promoted by the health sector, and the information building blocks, at the policy, strategy, and operational levels.

Table 2: Social Accountability Entry Points in the Health Sector

Level	Principal Roles and Functions	Information Building Blocks and Mechanisms	Social Accountability Entry Points
Policy Level **(Macro Government Level)**	Develop overall policy framework and strategic plans for the health sector. Propose, set and review existing policy goals and strategies. Review equity impacts of health sector policy and strategy.	Information on public needs and preferences Information on the sector profile, policies and activities	Health policy and planning
Strategy Level **(Health System or Ministry Level)**	Assess the revenues and resources for investment in the health sector. Prepare health sector plan and budget at the national and sub-national level. Identify implementation systems and priorities, targets and standards.	Information on the resource envelope for health compared to planned activities and priorities	Health budget formulation and review
	Allocate resources for health according to agreed plans and programs.	Information on resources disbursed compared to resources allocated	Health expenditure tracking
Operational Level **(User or Community Level)**	Implementation of health sector strategic plans	Information on quality and access to health services	Management of health care service delivery, outputs and outcomes
	Monitoring and evaluation of health care budget and quality of health care service delivery	Information on accessibility, relevance, timing, quality, and equity of health care service delivery	Health performance audit and oversight

3. CRITICAL FACTORS AND ENABLING CONDITIONS

Social accountability initiatives that improve health care service delivery rely on a broad range of political, institutional, cultural and historical pre-conditions such as:

- political space for citizens or civil society organizations to freely associate and advocate their position;
- institutional arrangements and incentives that favor public debates of policy directions, reform initiatives, budgets and performance in the health sector;
- cultural norms that permit citizens to publicly criticize authorities or service providers about perceived irregularities and shortcomings, e.g. health care staff conduct or absenteeism, secretive management of funds, and low quality construction work; and
- information is accessible to service users regarding their entitlements, national standards in the health sector, and the budget and other resources in their local health facility.

Changing accountability relationships to improve health outcomes is not easy, and does not occur through applying simple technical tools or formulas. The following four elements have proven critical to the success of social accountability initiatives, in general and in the health sector.

- *The introduction or strengthening of citizen-state bridging mechanisms*, i.e. mechanisms for information exchange, dialogue and negotiation between citizens and the state. This can involve the introduction of new tools for citizen-state interaction or the reform of existing mechanisms. Many examples for these bridging mechanisms have already been described in the preceding sections of this chapter.

- The *willingness and ability of citizen* and civil society actors to actively seek government accountability. Capacity development for CSOs is often required, both in technical areas and in mobilization, coalition-building, negotiation and advocacy.

- The *willingness and ability of service providers and policy makers* to account to the public. Transparency and information disclosure, attitudes, skills and practices favoring listening and constructive engagement with citizens are key. Similarly, the use of incentives, rewards and sanctions to promote transparent and responsive behavior is critical.

- The broader *enabling environment*. This includes: (i) the policy, legal and regulatory environment for civic engagement; (ii) the type of political system, how much political freedom is granted, and a tradition of open pluralistic debate; (iii) the economic basis and financial viability of different forms of civic engagements; and (iv) the values, norms and social institutions present in a particular society that support or inhibit open and pluralistic debate and critical but constructive engagement.

3.1 Accountability in Four Models of Health Care

The health status of a population is highly dependent on the political context in which a given health system functions. Consumers, providers and managers of health systems have different

levels of access to information and therefore different abilities to influence the health system and its responsiveness, outcomes and accessibility. The likelihood social accountability mechanisms will be effective is related to the degree of democracy and to basic political and civil rights factors such as functioning enforcement systems. These factors should be carefully analyzed when planning a social accountability initiative because they affect health resource allocation, distribution of resources, and equality of access and care.

For an analysis of the political context, it is useful to consider the following four models of health care: the *professional*, the *economic*, the *political* and the *administrative*.[40] The *professional model* refers to the traditional relationship between the physician and the patient where the physician's actions are directed towards the patient's well-being. Accountability has historically focused on the legal and ethical conduct of the physician. Health care is a professional service and financial remuneration is secondary to the patient's well-being. The main mechanisms for accountability are licensure, accreditation, legal suits and informal accountability to individual colleagues.

In the *economic model*, accountability of the market place is applied to the health sector. In this model, individual patients are viewed as consumers, physicians as providers, and health services as the commodity. Accountability under this model is mediated by the market which means that the consumers exercise choice and the payment for services determines choice. Providers are "punished" for poor performance by losing customers and the government plays a regulatory function in this market. If competition is functioning well and the patients are relatively well informed, the main accountability mechanism is exit or choice.

In the *political model*, the patient and the physician interact within the community. They are both citizens-members and elect representatives to oversee the provision of health care. The goal of the health care system remains patient's well-being, but the precise content and the optimal mechanism for achieving this goal is subject to interpretation by elected citizen-members. In this model, the accountability mechanisms are citizen oversight and "voice".

In the *administrative* or *managerial model*, the focus is between the policymakers and health service providers. Within the public sector, accountability is primarily exercised through contractual relations, when service provision is carried out by independent providers and accountability is exercised via supervision of contracts with organizations or individuals.

One can debate which model of accountability should govern the health system. Diverse approaches embody different values, political views, and goals, and thus seek different ends. The distinctions have important implications for effective health outcomes and inclusion of vulnerable groups. A stratified model of health care that can adapt to changing power and resource considerations seems to be the most realistic.

There are many issues to consider when improving accountability, especially social accountability, in the delivery of health services. Some of the constraints and factors are *supply side driven,* such as level of transparency, access to information, decentralization of health service delivery, and institutional reform. Others are *demand side driven,* such as effective use

[40] Harrison and Bruscini, (1993); Woods (2002)

of information and client voice. And some are related to the *interface,* such as legal and institutional structures for promoting synergy between health service providers and users.

3.2 Supply Side Factors

Critical supply side considerations are health policies, financing, service delivery and regulation in both centralized and decentralized health care systems. Constraints in these factors may have their root in weak local capacity. Other constraints may result from poor management at a higher level. A toolkit the analyzing constraints on frontline service delivery has been developed and includes assessment tools for accountability and enforcement mechanisms).[41]

Attention needs to be given to factors that motivate the performance of health care workers. Under-funded health workers are likely to regard public demands for accountability and greater control as a burden rather than an asset. The capacity of health workers to perform is important. They normally implement their duties according to their knowledge and skills as well as according to decisions made at higher levels. Holding them accountable for provision of poor quality health services is only part of the solution to a deeper problem of insufficient capacity in the health system. Without addressing capacity issues, a social accountability agenda may be futile.

3.2.1 Transparency and Access to Information

A crucial pre-condition for any social accountability initiative is the availability of, and free access to, relevant information on:

- budget allocations at various levels, i.e. health facilities, specific investment and procurement items, and intra- and inter-sectoral allocations
- revenues, expenditures (including major investment and procurement items), and audits
- human and physical resources at individual facilities
- critical performance indicators, e.g. health care service delivery, at the individual facility level, compared with regional and national averages.

Easy access to this information allows service providers and users, professional associations and civil society organizations to constructively engage in health service provision. They can ask questions, engage in independent monitoring, conduct social audits and other forms of public oversight, have more meaningful co-management arrangements and disseminate technical information to the general public.

Publishing information on health expenditures and resource levels disaggregated by district and health facility significantly improves the parameters for transparency and accountability at the various levels. The Ethiopia Protection of Basic Services project supports the government in increasing financial transparency in the education and health sectors. Budget processes and formats will be made public and "de-mystified" to make them understandable to citizens. Budget literacy of local officials, citizens and their organizations will be strengthened. Budget and expenditure information using simplified formats will be widely disseminated at the district level. Schools and health centers will post information on notice boards about available and

[41] See www1.worldbank.org/publicsector/toolkits.htm

expected resources (finances, staffing, equipment, goods provided), service standards and key performance indicators.

Another way for government to become more transparent is to make management structures, roles and responsibilities clearly known and widely publicized. Such information provides an important means of strengthening the political voice of the poor and improving their access to health care resources.[42] Capacity building efforts should involve information on citizen's rights and entitlements. Citizens can demand better services only if they know their rights.

The availability of reliable and timely data, such as information on the minimum number of health staff and their qualifications, and the rights and responsibilities of providers and users, are important for social accountability. Access to information is influenced by status, power, gender and literacy level. This needs to be taken into consideration when planning social accountability interventions. The political context also influences access to information. Access can be particularly difficult in countries with an integrated, publicly operated health system, and can be compounded by weak consumer interest. Legislation on freedom of information may need to be addressed.

In Kenya, the Ministry of Health displayed notice boards, health rules and regulations, agreed fee structure for services, and compared common disease patterns with patient attendance rates and cash flows (see photo below). As a result, drug availability improved, immunization rates increased and staff absenteeism decreased.[43]

Blackboard in a rural health facility in Kenya showing attendance rate, morbidity, income and expenditures.

[42] See http://www.unesco.org/education/gmr_download/chapter6.pdf
[43] Personal communication, provincial medical officer, Coast Province, Kenya.

India's Tamil Nadu Integrated Nutrition Program informed the community about health worker roles, responsibilities and expected performance. This information enabled the community to make health workers accountable and enabled health workers to see how their program was performing.[44] Monitoring was done with the aim of generating timely and good quality data. Special efforts were made to collect data not only for managers, but for frontline workers and their clients. Every month data were collected by the community nutrition workers and were displayed outside the community nutrition centers. These data included information on the number of children who were weighed, malnourished, and receiving supplementary feeding. These data provided the community with an idea of how well the program was progressing.

3.2.2 Decentralization

Many governments have established open and transparent systems for policy formulation and implementation in the health sector (e.g., the Foro Salud initiative in Peru). In many countries, the on-going decentralization process, which usually includes the health sector, may open new avenues for even stronger social accountability processes. If funds are directly channeled to and managed at the level of individual health facilities, that increases the likelihood for them to be spent according to local preferences and for accountability to local constituencies. As a rule, devolution of resources without strict rules, systems, and investment in local level capacities (of local officials, citizens and community based organizations) will probably not result in improved transparency and accountability.

Decentralization to the sub-national level, such as a district, can be particularly problematic. Compared to decentralization to the municipality or facility level, district level officers are further away from the end-users of health services and therefore often feel less accountable. Forms of organization that would allow villagers to collaborate and address accountability issues at the district level are frequently weak or non-existent. At the same time, counselors are more likely to be protected by patronage from the center. District level officers are therefore more likely to commit offenses with impunity.

3.2.3 Institutional Reform

Through institutional reforms, government can further influence the incentive structure in the health sector towards increased responsiveness and accountability. Many health sector reforms aim to provide sufficient numbers of health care workers. Besides this target, it is important to develop a performance based reward system where variable salary elements can influence staff behavior in the desired direction. This often requires the development and setting of performance standards and codes of conduct which help to benchmark facilities and individual behavior. When developing standards and codes of conduct, collaboration with professional associations has often been very useful. Involving them in these processes often helps:

- build ownership and utilize the expertise of the health care profession;
- simplify the code of conduct for service providers and make it more relevant;
- ensure broad dissemination of the code of conduct;
- strengthen independent mechanisms for dealing with complaints; and,

[44] Wagstaff and Claeson, 2005, p. 11.

- integrate issues related to service provider professional conduct into training courses.

3.3 Demand Side Factors

The need for demand side strengthening has emerged due to:

- citizen dissatisfaction with the erosion of basic health rights and standards as well as with the quality of, and access to, care
- increased citizen education and access to information
- growing diversity of service delivery channels
- increased direct care burdens on citizens due to the AIDS pandemic, rise in non-communicable diseases, rising costs of care, and declining service coverage, and
- a growing demand from citizens to hold public office holders responsible and accountable for their performance and the results of their decisions.[45]

3.3.1 Effective Use of Information

Social accountability initiatives are often portrayed as evidence-based advocacy. Effective use of information is needed to build a solid base of evidence to make claims. Frequently this includes accessing and analyzing existing supply side information (e.g. budget/expenditure information, performance/ outcome information etc.), as well as the collection and analysis of demand side information.

Citizens and civil society organizations frequently lack the technical knowledge and skills to read aggregated budgets or perform data collection and analysis. Social accountability initiatives therefore often entail capacity building activities in these areas. Civil society organizations sometimes seek the assistance of knowledgeable research organizations or think tanks for technical tasks. In the context of the first Filipino Citizen Report Card, the technical data collection and analysis work was entrusted to a well-established social research organization (the Social Weather Station), whereas the follow-on advocacy steps were performed by a coalition of NGOs and CSOs with the support of the World Bank. Similarly, the Public Affairs Center in India, the creator of the citizen report card, outsources data collection and analysis to a private sector market research organization.

3.3.2 Client Voice

The scaling-up challenge of the community scorecard approach is symptomatic for supporting the articulation and aggregation of client voice. It is already a challenge to enable citizens and service users, particularly from marginalized groups, to articulate their preferences and feedback. A second, related challenge is how to aggregate the voices of different social groups. Participatory learning and action approaches may be particularly helpful to establish inclusive or group-specific analyses and recommendations, e.g. revealing the differential constraints facing men and women when it comes to health care. The third challenge is how to make their voice heard by decision or policy makers in distant district or national capitals.

Besides relatively expensive participatory policy research programs, e.g. the Ugandan Participatory Poverty Assessments, client voice can be captured and analyzed via quantitative

[45] Cornwall, Lucas and Pasteur (2000), Loewenson (2000), Loewenson (undated).

and statistically representative approaches (e.g. citizen report card, quality of service delivery survey) with public dissemination, debate and direct forms of negotiation with service providers and policy makers to achieve policy influence.

Another way of expressing (and aggregating) voice is through organizations such as patient associations, federations, and professional organizations. Along with institutionalized forums for public dialogue, debate and negotiation, e.g. the Foro Salud in Peru or health sector multi-stakeholder working groups in a number of PRSP processes, user associations and their federations can become a powerful voice for their constituencies. User associations, however, frequently need considerable institutional and capacity development for advocacy.

3.4 Factors at the Interface of Providers and Users

A lesson learned from a review of 18 World Bank project information documents and project appraisal documents on health sector reform initiatives in Asia revealed that building the interface between users and providers of health services is important and can take place both inside and outside the health system. Successful alliances require a participation contract between civil society and government service providers.[46] These contracts must spell out what is expected from different parties and must ensure that each party has an equal say in agenda setting, implementation, monitoring, evaluation, and defining institutional structures (beyond the duration of donor funded projects). The contract should also spell out processes that are needed for ensuring better health outcomes. These processes could include terms of reference for elections and administrative procedures for health service management boards and teams at the local and national levels. It has been shown that such contracts must ensure that at least 50 percent of the participants come from marginalized and civil society groups. Expanding democratic spaces in the health sector and strengthening a culture of claiming user and provider rights seems essential.

[46] Murthy and Klugman (2004)

4. CHECKLIST: SOCIAL ACCOUNTABILITY IN THE HEALTH SECTOR

The following suggestions should be kept in mind when building a social accountability process.

- *Collect system and performance information* such as ease of access, quality of health services, available funds, utilization patterns and effective coverage of the health system. This information gathering should include an analysis of the actors and describe existing forms of decentralization.

- *Assess the accountability challenges* relating to stated accountability goals and vision. This should include an assessment of exist forms of accountability within the system, the reason for the weaknesses in the formal accountability systems, and what needs to be done to rectify the situation.

- *Assess existing social accountability initiatives and their experience.* Map existing social accountability initiatives. Analyze a sufficient cross-section of promising experiences. Contact relevant stakeholders and discuss with them the particular challenges and constraints as well as plans and resources to support future social accountability initiatives. Try to understand how current initiatives have developed strategic influence, and which public debate, negotiation, sanction and enforcement mechanisms were successful. This will be critical in finding an optimum social accountability strategy.

- *Prioritize challenges and determine appropriate entry points.* Appropriate entry points can directly relate to bridging mechanisms between the user, health sector policy makers and service providers. Equally, they can refer to strengthening demand or supply side capacity to engage in social accountability. Or they can support improved access to information and the broader enabling environment for social accountability. Entry points can be found in the policy, strategy, budgeting, operational planning or implementation cycle, at both the national and the health facility level.

- *Design a social accountability strategy*. Carefully consider existing and required capacities within the health sector, citizens and civil society organizations. The strategy often involves a significant capacity building component. Consider a viable implementation arrangement that helps to raise interest, respect and collaboration between actors within the health sector and citizens, clients and CSOs. Consider sufficient steps to increase the policy influence of social accountability initiatives.

- *Implement the strategy.* Who will take the lead on implementing the strategy? How well are the champions or lead agency anchored in their constituencies? Are there enough human and financial resources and capacity to implement it? How are quick gains and demonstration effects achieved? How can risks be managed, particularly early failures, confrontation, and frustration?

- *Build public understanding and support* for these mechanisms. It is important to ensure buy-in from many stakeholders. The more buy-in, the greater the chance of success. Communication strategies should be in place, and planned and tested in advance. It is important to ensure policy alignment so that messages regarding health care priorities and goals are

communicated in a consistent and timely manner and in a language understood by all stakeholders.

- *Monitor and enforce actions*. Taking action is easier from within the health care system. Benchmarking is useful to ensure that the change process is on track. Civil society organizations, community based organizations and other citizen groups can take necessary actions that can help to foster change within the system.

5. ADDITIONAL RESOURCES

5.1 Case Studies

Uganda: The Citizen Report Card at the Community Level

The Citizen Report Card at the Community Level is a pilot project in Uganda that uses community based monitoring to improve health service delivery. The project lasted from May 2004 until December 2005. It involved the application of a "client information and feedback" methodology in 25 dispensaries in rural Uganda and a robust impact evaluation with in-depth health facility and community surveys. The project had four components: (a) collecting quantitative survey data from service users and providers on health service delivery; (b) assembling this information in accessible report cards and disseminating them to users and providers in such a way as to create awareness and invoke participation; (c) providing training and advocacy for CBOs, dispensary staff, and service users on patient rights and entitlements; and (d) using CBOs to facilitate discussions between service providers and users to set priorities and develop joint action plans to improve health service delivery.

The challenge to ascertaining whether community-based monitoring can foster stronger accountability between service providers and citizens is to establish a comparison group which would, in the absence of the project intervention, have had outcomes similar to those exposed to the intervention. To achieve this, the pilot project used a randomized design: 25 dispensaries were randomly assigned to the treatment group (communities in which the citizen report card project was implemented) and 25 were assigned to the control group (communities in which the project intervention was not implemented).

Social Accountability Mechanism. The information dissemination process was conducted in three separate meetings: a community meeting, a dispensary staff meeting, and an interface meeting between dispensary staff and the community. The community meeting was a two-day event with approximately 150 participants drawn from the surveyed villages near the dispensary. Facilitators presented findings from the survey, comparisons with other communities, district and national averages, and the facility resources and budget. The facilitators used participatory methods that enabled community members to make their own conclusions and plans for action and monitoring. The community's suggestions for improvements (and how to achieve them without additional resources) were summarized in an action plan.

The dispensary staff meeting was a one-day meeting with all the staff present. Facilitators presented the results from the dispensary survey, how it compared to other dispensaries in the district and Uganda, and the results from the community survey. The staff discussed the survey results, operation of the dispensary and perceptions about performance, service delivery and quality. They prioritized issues and made suggestions for improvement including institutional arrangements.

Finally, there was an interface meeting with community members and all dispensary staff. The objective of this meeting was to agree on a strategy for improving health care provision based on the action plan developed in the community meeting and the discussions from the dispensary

staff meeting. The community members and dispensary staff made presentations based on the information from their respective report cards on perceptions about the dispensary. They discussed issues raised in the presentations and prioritized issues for action. A role-play was used to disseminate the results from the survey and the community and the staff switched roles. They discussed their rights and entitlements and their roles and responsibilities as patients or medical staff. The outcome was a joint action plan describing how the staff and the community collectively can best improve service delivery within the existing resource envelope. Institutional arrangements are made on how linkages with the communities will be maintained and how information will flow regularly from and to the dispensary.

After a period of six months, the communities and dispensaries were revisited and a mid-term review was conducted. The mid-term review was a repeat engagement on a smaller scale which included a one-day community meeting and a one-day interface meeting. It aimed to track implementation of the action plan and identify new areas for concern. The facilitators presented information followed by focus group discussions on implementation progress. During the interface meeting, the dispensary staff and the community members discussed suggestions on actions for improving or sustaining the progress of the previous action plan. In cases where improvements had not been made, new recommendations were agreed upon and noted in the updated action plan. In cases where improvements had been made, suggestions for sustainability were recorded in the plan. The updated action plan was kept with the community and the dispensary to assist in ongoing work and monitoring.

Impacts of Community-Based Monitoring. Communities were inspired to take action. They discussed dispensary performance during village meetings. They communicated their concerns to the Local Council, to the dispensary, the Health Unit Management Committee, and other decision makers. Communities monitored staff during visits to the dispensary and followed up on issues in the action plan. Monitoring tools—such as duty rosters, suggestion boxes where community members could leave anonymous suggestions or comments, and numbered waiting cards to ensure treatment on a first come-first served basis—were introduced at several treatment group dispensaries. One year into the project, 36 percent of the treatment facilities had suggestion boxes (no control group dispensary had these) and 24 percent had numbered waiting cards (only 4 percent of control group dispensary had these). There are also differences between the treatment and control dispensaries in the extent to which information is posted on free services and on patient's rights and obligations. The enumerators could visually confirm that 68 percent of the treatment facilities had at least one of these "monitoring tools" while only 16 percent of the control facilities had at least one of them.

The community-based monitoring intervention increased the quality and quantity of primary health care provision and resulted in improved health outcomes. One year into the program, utilization of general outpatient services was 16 percent higher in the treatment health facilities than in the control group. The difference in the number of deliveries at treatment dispensaries (albeit starting from a low level) is even larger (68 percent). There are also positive and significant differences in the number of patients seeking antenatal care (20 percent) and family planning services (63 percent).

Treatment practices, as expressed both in perception responses by households and in more quantitative indicators (immunization of children, waiting time, examination procedures) improved significantly in the treatment communities. For example, 54 percent of the households in treatment group households reported that the quality of services provided at the dispensary has improved in the first year of the project compared to 47 percent of the control group households. Similar differences are apparent in household perceptions about the change in staff politeness during the first year of the project, availability of medical staff, attention given to the patient by the staff when visiting the project dispensary, and whether the patient felt he/she was free to express herself when being examined. A significantly larger share of households in the treatment communities received information about the dangers of self-treatment and on family planning than control group households.

There was a small but significant difference in the weight of infants and a markedly lower number of deaths among children under-five in the treatment communities. In treatment communities, 3.2 percent of the surveyed households had suffered the death of a child under age 5 in 2005 compared to 4.9 percent in the control communities. There was no difference in financial or in-kind support from the government, suggesting that the changes in the quality and quantity of health care provision are due to changes in staff behavioral. Furthermore, there is evidence that the treatment clinics started sharing information about treatment practices, availability of drugs, and service delivery in response to the intervention and that the treatment communities began to monitor the health unit more extensively. This reinforces confidence that the findings on the quality and quantity of health care provision resulted from increased efforts by the health unit staff to serve the community in light of better community monitoring.

Benin: The Millennium Development Goals

This case study embraces a functionalist approach to health care delivery where communities actively engage with health care providers, policy makers, international donors and governments to provide continuous feedback on ways to improve the public health care system. The case of Benin demonstrates how organized communities can improve the availability and quality of health services, *inter alia,* as primary stakeholders in the daily operations and financing of primary health care services. Priority was given to reestablishing a direct accountability mechanism between people and health care providers, and between people and the political system. The success of this 15 year project can be attributed to sustained partnerships between the state and civil society organizations, ensuring increased availability of services such as affordable essential drugs and subsidies of the most essential services for women and children. To achieve this, policy makers chose to strengthen communities' power over service providers while balancing this power with sustained involvement at the decision-making level. At the local level, community involvement and the accountability of providers in the planning and management of services, particularly immunization and maternal and child health interventions, have contributed to the project's immunization levels reaching 80 percent coverage.

This initiative, however, has several shortcomings, such as insufficient redistribution of resources to cover the poorest. Other constraints include low maternal literacy levels, weak community and civil society support for preventive and promotive health care, and inability to pay for care. This will require further development of family oriented service delivery and a

strengthening of supply side financing mechanisms – such as poverty funds, exemption cards or micro-insurance systems – to remedy these shortcomings.

Implementation of this project is contingent on the establishment of a direct accountability link between health service users, providers and the state government. This partnership is based on the following principles: decentralizing decision-making and management from the national to the local levels, strengthening the demand side of services by negotiating new activities with donors and the government, fostering opportunities for community cost sharing and co-management of health services, increasing the accountability of local health staff to communities, and ensuring the availability of affordable medicines on a sustainable basis. Community financing of key operational costs bought the communities a "seat at the table" in discussions with policy makers. Benin's approach to improving health care services depended on revitalizing health centers as the primary interface between service users and providers. Dialogue between users, providers and politicians addressed several strategic components of service delivery that required reform.

This approach was gradually scaled up from 40 to 400 health facilities by 2002, when the share of the population with access to professional services reached 86 percent. The government helped redesign national support systems to accommodate these initiatives by developing a legal framework supporting the contractual relationship with communities, cost-sharing arrangements, essential drugs, and community participation. As a result, community management committees were legalized, and became stakeholders in the newly created national Central Medical Store.

Identified Problem	Entry Point for Social Accountability	Solution
Physical access	Management of health services	Revitalize existing health centers, expand the network, and implement outreach by health center staff.
Availability of affordable essential drugs	Management of health services	Implement community owned and managed revolving funds.
Insufficient knowledge of health	Enabling environment, management of health services	Interventions triggered investments in social mobilization of knowledge creation and community based communication to stimulate demand for services such as immunization and basic health education.
Low capacity to pay	Enabling environment, management of health services	Price most effective interventions below those of the private sector through subsidies from the government and donors.
Lack of power of the poor over providers	Health planning, health performance audit and oversight	Develop community participation in the assessment of progress and problems in the most important services, and in the planning, budgeting and monitoring of services.
Lack of monitoring tools	Health performance audit and oversight	Develop legal framework for representation. Set up elected district committees with representation of all stakeholders. Data collected bi-annually, analyzed, results disseminated, and action taken.

Monitoring. Health center staff, community representatives and district supervisors met twice a year and jointly reviewed health center performance. Data was compiled from the health management information system to assess achievements and problems in coverage, analyze the evolution of coverage, and decide on corrective actions.

Results. There is broad evidence that the affordability of services improved. Increased access reduced travel costs and improved drug availability. Prices have been consistently less than alternative treatment sources. Aggregate figures show that 69 percent of service users see price levels as generally acceptable, and 75 percent of the key informants declared being satisfied with the quality of care although 48 percent were not fully satisfied.

A new assessment of current health problems and health service performance revealed that some supply problems remained, mainly the availability of qualified staff in rural areas. The government recently allocated funds from debt relief and external budget support to provide subsidies to community organizations to hire qualified staff on a contractual basis. The evaluation of the experience showed overall improvements in the availability of personnel in remote regions. Benin now faces the challenge of supporting increased demand because of the greater emphasis on household behavior and protection of the poorest and most vulnerable.

Nepal: Safe Motherhood Project

DFID's Safe Motherhood Project in Nepal (NSMP) provides insight into the challenges of reducing maternal mortality in a poor country highly stratified by ethnicity, caste, gender, age, and kinship. During its inception period, a management unit was established and a participatory needs assessment carried out. Phase 1 began in 1998 with implementation in three districts and a formal evaluation in mid-2000. Phase 2 is an expanded and modified version of Phase 1. It operated in 10 districts, covering 15 population of Nepal's population, and ran until mid-2005.

The goal of the NSMP is to increase the availability and use of good quality midwifery and obstetric services. The project has three main goals: policy and program development, service provision and increasing access. It seeks to influence the health reform process at the national level in a number of areas including abortion policy and nurse-led post-abortion care. Regular reporting and periodic inspections improve service provision by ensuring that all NSMP-supported facilities are fully operational. The monitoring covers physical facilities and equipment, waste disposal, maintenance and safe blood transfusions. Monitoring is carried out by staff and partners using a variety of participatory methods. These include knowledge and attitude surveys, recording the performance of emergency fund and transport schemes, and using institutional assessment tools to gauge political support for safe motherhood at the district level. External reviews and specialist studies are also undertaken in specific areas. Project monitoring involves proactive communication with key stakeholders. Follow-up surveys are implemented to assess progress and provide feedback which influence future policy development and provides a strong, community-based voice with which to lobby the government.

Social accountability mechanisms. Key Informant Monitoring (KIM) provides the means to ensure accountability of service providers in the provision of services for ante-, peri- and post-natal care. This affects maternal health outcomes and maternal health seeking behavior. KIM is

based on local women and men collecting information from peers or key informants on their perceptions of how the social environment enables women to access care. The conversations are structured around three themes:

- reduced barriers to obstetric care,
- improved quality of care, and
- improvements in women's social status and mobility.

KIM is a means through which communities can communicate their views and concerns to project staff—in this case NGO support staff—and participate in monitoring relevant social change. The use of the tool allows monitoring of progress towards creating an enabling environment from the perspective of the targeted beneficiaries.

The findings from use of KIM in Nepal highlight barriers to change and help enforce accountability. For example, key informant researchers have recorded instances of health workers discriminating against low caste women, and the functional exclusion of extremely poor women from community emergency fund schemes. Both practices are antithetical to the project and Nepalese government policy.

One of the key aspects of KIM has been its importance as an advocacy and social change tool. Local NGOs have facilitated meetings between key informant researchers and Village Development Committees on the findings and recommendations of the research. The dialogue generated through this process has facilitated changes to improve the quality of service delivery.

Further research on the benefits of KIM is planned. The tool could be used by women to hold service providers accountable. One of the limitations of the application of the tool in Nepal has been its dependence on using local researchers (literate women and men from the community) with the result that the extreme poor and low caste groups are poorly represented. However, participatory ethnographic evaluation and research has been used successfully by non-literate researchers in other contexts.

Peru: Foro Salud

The System for National Coordination and Decentralization in Health was formed in 2002. It is composed of national, regional, and provincial health councils. The National Health Council (CNS) is composed of organizations that promote the health of the Peruvian people and identify health priorities based on analysis of health data.

One major national conduit of client voice in the health sector is Foro Salud. It communicates the voice of social services users of the poor by acting as "interpreters" of their needs rather than directly representing these groups. This forum brings together sector experts, academics, specialized NGOs, professional associations and think-tanks to facilitate national discussions on service quality, new institutional designs and decentralization. It was founded in 2001 and was specifically intended to forge links between development planning and the right of all persons to access health services. Foro Salud has the following objectives:

- Provide an independent channel for the communication of health sector diagnostics and experiences.
- Provide information to the public and private sector in order to allow them to develop opinions on health in Peru.
- Facilitate citizen participation in the formation of policies, management, and evaluation, and in the creation of space for negotiation at the national, department, and local levels.
- Elaborate proposals for dialogue between the state and public/private actors to support campaigns and actions which benefit the population.
- Develop a research plan for health sector institutions and plans for analysis, dissemination and use of public information.

Foro Salud is adapting to the decentralization process by implementing its national model at regional levels in the form of regional forums. So far, Foros Regionales have been created in 17 regions. Regional Health Advisory Committees have also been established with the purpose of elaborating regional health plans. Foro Salud has tried to enable its representatives to become involved in the new regional committees. To date, 67 provincial health advisory committees have been formed. For example, in Ucayali, regional organizations affiliated with Foro Salud – in collaboration with the regional health council, local civil society representatives and citizens of each district – identified eight health priorities in each district and five priorities at the regional level. The priorities were respiratory diseases, water and sanitation, sexually transmitted diseases, malnutrition and anemia, and shortages of supplies and services.

The forum is composed of 15 thematic groups that convene expert working groups to develop programs and policies. The increased presence of Foro Salud in CNS and its influence on the agendas of 19 technical committees increases Foro Salud's potential impact on policymaking but also brings new challenges. Specifically, Foro Salud must now contribute to CNS's technical committees with practical proposals in addition to engaging in general policy debates. According to the president of Foro Salud, the areas where Foro has been most able to contribute are preventative health, medicines, mental health, youth, adolescents, and health investment.

Social Accountability Mechanism. In 2004, Foro Salud organized a regional consultation in Lambayeque to define regional health priorities for the Participatory Regional Health Plan. The referendum took place over two days with 124,000 voters including the military and children 14 years and older. It was supervised by the National Office for Electoral Processes and Defense of the Village. The six areas selected as priorities were:

- water shortage and quality,
- waste and sanitation,
- marginalization of the poor in accessing services,
- mental health,
- malnutrition, and
- maternal health.

According to a decree of the regional government, this referendum resulted in a mandate obliging the government to implement projects addressing these areas as part of its Participatory Regional Health Plan for the next five years.

Reforms. A major challenge for Foro Salud is gathering the perspectives and needs of the poor concerning health services. Foro Salud needs to continue to implement regional consultations, like those organized in Lambayeque and Ucayali, to set the priorities of the regional health plans in agreement with the regional government. Concurrently, Foro Salud could adopt internationally well known social accountability methodologies to monitor the implementation of health policies. Under this mandate, the Foro could organize—on its own or in partnership with academic institutions, think-tanks and NGOs—annual independent analysis and debate on the national budget's social expenditures and health. This analysis offers an excellent opportunity to promote informed debate on the social budget and advocate better allocation of public spending to match the needs and priorities of the population.

Foro Salud may also benefit from tailoring public surveys to users' perception of the performance and quality of health services. With this information—combined with other data collected from the CNS, administrative statistics and other national surveys—Foro Salud could issue a report card on the health sector every year. This report card could contribute to an informed debate on access to health services and distribution of quality standards if disseminated through the media and discussed in workshops involving users, service providers and policy makers.

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Service Accountability and Community Participation:
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5.4 Additional Project Examples of Social Accountability

5.4.1 Policy Level

In Kenya, the recent development of the Kenya National HIV/AIDS Plan II (2005-2010) has involved a wide range of stakeholders from civil society such as patients groups, people living with HIV/AIDS (PLWAs), faith-based organizations, the private sector, bilateral and multilateral donors and several government agencies. These stakeholders conduct joint HIV/AIDS program reviews. This process was initiated at national level and is now being replicated at sub-national levels.[47]

Another example from Kenya is the Community Capacity Building Program. This program has engaged citizens from the village levels to the central levels in a participatory planning, implementation, monitoring and evaluation process over the last 10 years. This has resulted in greater transparency and accountability of service delivery, both of quality and resources, as well as improved development effectiveness. Furthermore, the representation of stakeholders in policy dialogue has given the users of services access to influence policy, such as in the development of the new social sector policy.[48]

Another positive experience is in Benin. Experience has shown that stakeholder involvement and representation at all levels, from community to central, have positive results.[49]

- Citizens are satisfied with the increased availability and the decreased cost of services and drugs.
- Funding for essential drugs is guaranteed because local health committees, not the Ministry of Health, manage cost recovery.
- People appreciate the local control they have over funds.
- The involvement of women is a strong factor in building community support and has raised the status of women as community leaders.

A less positive experience is the Zambia Health Sector Reform project where health center committees were known by only 20 percent of the population. There was a widespread feeling that representation on these committees largely favored certain social groups. These committees, which should have been able to discipline staff, in reality had no power to do so.[50] Although Health Center Committees and Health Boards at District level had been formed through public meetings, the challenging working environment caused these representatives to lose touch with their fellow citizens. Gradually, health center staff took over recruitment for these committees. Lack of guidance and access to information by citizens were the main obstacles.

After the end of the civil war in Guatemala, efforts to improve sexual and reproductive health were impeded by centralized policy decisions and political sensitivity on reproductive health and

[47] Government of Kenya (2005)
[48] Government of Kenya (2005)
[49] World Bank (1996:23)
[50] Ngulube et al. (2004)

rights issues. Advances have been made with the formation of civil society networks and coalitions such as the Women's Network for Building Peace and the Cairo Action Group. Another advance was the promotion of a more participatory process for the identification and analysis of needs and definition of priorities within the health sector. Opportunities have been created for the government and civil society to interact at the departmental level. The result is increased societal awareness about reproductive health and rights.[51]

5.4.2 Operational Level

User surveys in Zambia linked user charges to health service performance.[52] This information was used by joint civil society-local government committees to discuss the measures that should be put in place to enhance service performance. These discussions resulted in guidelines stating that increased user fees must be associated with demonstrable improvements in at least one attribute of community perceptions of quality of care at the local level. This attribute was to be decided at the local health facility in consultation with community representatives.

Cuba and Costa Rica have sustained low infant mortality rates over the last fifty years.[53] This achievement came with the introduction of a community-based health care system, highly motivated staff, access to information and close monitoring and evaluation. Health indicators are publicly disseminated every year with the full involvement of citizens who provide feedback about providers. This feedback can be channeled through clinics, municipal councils, hospitals or the local representative in the Peoples Power Assembly, which is required to respond.

In England, the Commission for Public and Patient Involvement in Health (CPPIH) worked at the national, regional and local levels during 2003 to ensure that the voice of both the public and the patients were heard in health matters.[54] The CPPIH established, funded, monitored and supported Patient and Public Involvement Forums and the delivery of the Independent Complaints Advocacy Services.

In Bangladesh, stakeholder health watch committees in nine thanas (districts) were established in 1999 by the Ministry of Health and Family Welfare. These committees were composed of local residents who are supposed to monitor the performance of government health services at the local level. The activities of these groups significantly enhanced the effectiveness and accountability of implementing NGO's.

In the Burkina Faso Poverty Reduction Strategy Credit, the national health information system was strengthened by integrating information from local management committees and using beneficiary assessments to ascertain citizen perceptions on the efficiency and accessibility of health services, including financial, socio-cultural and geographical barriers to health care.

[51] Merino et al. (2000)
[52] Ngulube (2000)
[53] World Bank (2003)
[54] See www.natpact.nhs.uk