

SOCIAL ACCOUNTABILITY: OVERVIEW OF APPROACHES AND CASE STUDIES

VHT demonstrating how she uses a Rapid Diagnosis Test for malaria Photo: IRC/Morukileng

I. Introduction

Social accountability refers to “an approach towards building accountability that relies on civic engagement, i.e., in which it is ordinary citizens and/or civil society organizations who participate directly or indirectly in exacting accountability” (Malena et al., 2004:3). It encompasses a wide range of approaches, tools, and methods, from information dissemination about user rights and entitlements to client exit interviews and participatory budgeting exercises.

This briefing paper provides an overview of these approaches and key factors to consider when designing a social accountability intervention. It also includes case studies from within and outside the International Rescue Committee to illustrate how the approaches have been used in practice, as well as the key lessons learned from these experiences.

A number of resources have been developed by the Policy and Practice Unit that provide both a theoretical background to social accountability and more practical guidance on the design of specific methodologies.¹ This paper aims to serve as a bridge between these resources and stimulate greater understanding of social accountability tools and methods.

II. Overview of approaches

Social accountability approaches, while all centered on civic engagement, represent a broad grouping of interventions with diverse characteristics. They can be initiated by a wide range of actors from community members and civil society organizations (CSO) to gov-

ernment ministries, parliamentarians and media organizations. Interventions such as the community scorecard methodology can take place at village or community levels, while participatory policy formulation exercises tend to be more focused at national level. Social accountability initiatives can rely on diverse strategies, including monitoring, civic education, research, media coverage, advocacy, and coalition building. They can be focused on the development of policies and plans, monitoring of budgets and expenditures or oversight of service quality. Lastly, they can employ different forms of formal and informal sanctions like public shaming, judicial enforcement and public exposés in the media (McNeil and Malena, 2010:6).

One useful way to categorize these tools and processes is according to whether they increase transparency, foster greater civic voice and participation in service delivery or support efforts to monitor performance and hold service providers accountable. Many social accountability approaches can target more than one objective. For example, community scorecards can increase transparency (through access to information about entitlements), strengthen citizen voice (through the scorecard process and interface meeting) and support user monitoring and oversight (through the development and monitoring of joint action plans). Similarly, support for health user management committees can not only serve to mobilize user voice but also support oversight of drug stocks and health facility budgets. The table on the following page summarizes the contexts in which these objectives would be prioritized, as well as examples of social accountability tools to achieve them.

¹ See ‘Social Accountability: An introduction to civic engagement for improved service delivery’, Policy and Practice Discussion Paper (May 2015) [here](#), ‘Local accountability in service delivery: The Tuungane Community Scorecard Approach’, Policy and Practice Briefing Paper (May 2015) [here](#), and ‘Citizen Engagement and Social Accountability in Health programs’, Policy and Practice Guidance Note [here](#).

Objective	Context	Examples of Social Accountability Tools
Increase transparency	In many contexts, information campaigns may be useful in informing people about their rights and entitlements, improving transparency and identifying leakages in funds. This applies in contexts where a new policy has been introduced (e.g. the introduction of free healthcare for children under 5 years), where there might be a lack of awareness about service performance, where there is weak management of public funds or corruption is an issue. Efforts aimed at not only disseminating, but also demystifying, information may also be necessary.	▪ Patient charters are often disseminated in health facilities, detailing patient rights and entitlements, the service delivery standards that clients should expect, and ways in which they can access redress mechanisms if these standards are not respected. ▪ Budget literacy campaigns are aimed at increasing public understanding of and participation in local government budgeting exercises. ▪ Public announcements can be used to communicate changes in education policy or water tariffs through posters and community radio. ▪ School report cards can be used to assess and rank local schools according to key performance indicators, with the results disseminated within the community and to education authorities (see Case Study #1).
Strengthen voice and participation	Strengthening the voice and participation of service users enables them to voice their needs and preferences, provide feedback on their experience with service provision and engage actively in the delivery of services. This allows service users to better align service delivery to their needs and play a part in decision-making about how resources are allocated and managed.	▪ Exit interviews are conducted with users of health facilities to gauge service quality and patient satisfaction with services (see Case Study #5). ▪ Participatory budgeting exercises are aimed at stimulating civic participation in the formulation and monitoring of public budgets. ▪ User committees like PTAs, health management committees and WASH committees are elected, trained and mentored so they are better able to defend users' interests and advocate for service improvements on their behalf (see Case Study #2 and #4).
Strengthen monitoring and accountability	Strengthening monitoring and accountability can be effective in contexts where there is weak accountability (which may be manifested by high absenteeism and poor quality services), fraud and corruption. User monitoring and oversight of service delivery and resource management can be effective in exposing or preventing mismanagement. By providing citizens with a channel for reporting errors, fraud and corruption and seeking redress, they are empowered to hold service providers accountable for service delivery.	▪ Social audits can, for example, determine how resources are used by a district education department to achieve education outcomes. ▪ Public expenditure tracking is a quantitative survey that tracks the flow of public funds to determine the extent to which resources actually reach the target groups. ▪ Community scorecards are an approach to community monitoring that empowers users to provide feedback to health personnel and receive immediate response (see Case Study #3). ▪ Complaints handling processes include hotlines and complaint boxes that allow service users to communicate their grievances to service providers and seek redress (see Case Study #6).

III. Key considerations when introducing social accountability tools²

Purpose: Social accountability tools and methods remain instruments of broader processes of social mobilization, voice, engagement and negotiation in the public sphere. As such, clarity on the purpose they will serve and the objectives to which they will contribute need to be established from the start. This requires a thorough understanding of the nature of the problem at hand, the underlying causes, the social, political and cultural setting in which the tool or method needs to be applied, the functional relationships between stakeholders, and the most appropriate entry point to achieve change.

Technical Complexity: Social accountability initiatives vary greatly in their complexity and the level of technical expertise required. The choice of tool can be further narrowed based on the capacity and experience among stakeholders, especially citizens themselves. Public displays and reporting of information is usually not technically complex. On the other hand, budget tools — such as independent budget analysis, input and public expenditure tracking, and procurement monitoring — require a fairly sophisticated analysis of budgets and contracts. Stakeholder capacity to implement the tool is not the sole consideration; more complex tools generally require greater financial and management resources, and may pose more challenges to achieving the desired results.

Civic Participation: Some social accountability tools require much greater levels of civic participation than others. For example, disseminating information to service users usually does not require users to take any specific action themselves to make the information available. On the other hand, most tools for consultation and monitoring require active civic engagement, although the burden on citizens may be reduced through the involvement of CSOs and the media. Differential demands on people's time, education and literacy levels and differential power relations all have an impact on participation, particularly for women and traditionally marginalized groups. The number of individuals that need to participate also varies greatly, even with the same social accountability tool. For example, participatory budgeting can mean engaging a few user committee members with budget decision-making authority, or it can mean tens of thousands of people participating in public budgeting assemblies.

Government Cooperation: Most initiatives are highly dependent on government cooperation because of the need for access to government information. Social accountability tools for participation, for example, usually require governments to share decision-making responsibilities such as participatory budgeting and planning exercises, or to delegate authority such as in community management of services. Beyond cooperation, government capacity to respond to claims made through various social accountability tools and processes must also be considered.

Cost and time considerations: Social accountability tools vary widely in the amount of time and resources required to implement them. Cost and time is affected by whether the tool is applied once, periodically, or continuously. In addition to the time and participation costs for citizens engaging in social accountability initiatives, it is important to consider whether the resources to properly staff and manage them are in place, as a lack of resources may constrain the choice of tool or its breadth of application.

Monitoring and Evaluation: Given the experimental nature of many social accountability interventions, particular attention should be paid to monitoring and evaluation, particularly at design phase. An immediate investment in developing a strong theory of change — and identifying progress markers or performance indicators that can be tracked over the lifetime of the intervention — can facilitate monitoring and evaluation efforts. Key indicators that may be useful to monitor include: changes in the capacities and willingness of public officials to engage in social accountability processes, the degree to which citizens understand service delivery arrangements, improvements in interface and interactions (e.g. shifts in the nature of transactions between citizens and service providers from indifference or hostility towards greater collaboration), improvements in service provider responsiveness and improvements in service delivery. By building in opportunities for learning about the changes elicited by these initiatives, the pathways through which they occur, and the contextual factors contributing to their success or failure, implementers are able to better understand how social accountability interventions operate and make more informed decisions regarding their replication, scale-up and sustainability.

Sustainability: In order to be effective and sustainable in the long run, efforts should be made to build a constituency and capacity for implementation of social accountability initiatives among government officials and civil society. They also need to be institutionalized (embedded) within existing civil society, service provider or 'hybrid' institutions and, whenever possible, linked to existing service delivery channels and accountability processes within the service provider system. According to Fox (2000:1), "civil society demands for state accountability matter most when they empower the state's own checks and balances." It is also important to consider the relevance of repeated exposure to social accountability tools and processes and how they might interact with one another to achieve impact given the interdependence of the institutions, actors and processes targeted by these interventions. For interventions that are embedded in service provider institutions, long-term planning can also ensure that ongoing investments of staff time to implement, monitor and follow up on activities are identified, incorporated into recurrent budgets and sustained over time.

The following section presents six case studies that demonstrate the use of various social accountability tools and methods. They provide some background on the context in which they have been introduced, describe their roll-out and achievements, and share key lessons learned from each intervention.

² This section is drawn from Agarwal and Van Wicklin III (2011), Ringold, Holla et al. (2012) and the World Bank Social Accountability Sourcebook.

Case Study 1: Kenya National Taxpayers' Association's experience of fostering accountability in the education sector through the School Report Card

Background

The Kenya National Taxpayers' Association (NTA) is an independent and non-partisan Kenyan organization created in 2006. It emerged out of interest among citizens for greater government accountability regarding the use and collection of their taxes. Following the introduction of Kenya's free primary education policy, NTA noted decreased parental involvement in schools which resulted in decreased demand for accountability from parents and fewer incentives on the part of teachers and district education officers to improve accountability to parents. As a result, NTA sought to encourage parents to take a more active role in education while holding teachers and school management to account for improving the quality of education in their local primary schools. In 2009, NTA began an innovative partnership with the Ministry of Education (MoE), Kenya Primary School Heads Association and the Kenya National Union of Teachers to introduce the School Report Card (SRC) methodology in 18,560 schools across the country.

Methodology

The School Report Card process unfolds over a period of 11 months in each school. The first step in the process is the organization of sensitization meetings with District Education Officers, District Quality Assurance Coordinators and other Ministry of education officials. Two parents, one female and one male, are trained in every school to lead the SRC process. They then hold meetings with parents to evaluate their schools in 10 areas, based on the existing benchmarks provided by the MoE. These are: school safety and protection, school facilities, access to textbooks, continuous assessment, water and sanitation, roles of children at the school, management of instructional materials, performance of the School Management Committee (SMC), homework assignment and marking, and parental responsibility. Parents then score school performance using a rating scale of 1-10. They agree on areas of weak performance and come up with action plans which are shared with the head teacher, SMC and District Education Officers. The latter are required to review each SRC from schools in their respective districts and take necessary action. NTA has supported the development of district ranking posters based on the scores allocated by parents in each school. These are also disseminated through radio shows. Parents conduct visits to schools after one year to take stock of achievements and identify other areas of improvement.

The School Report Card process is supported by one NTA staff in each region (covering 400 schools). In addition to receiving training support, SRC committees are provided with tools to carry out the exercise, including SRC guidelines, meeting attendance forms and scoring sheets. NTA use aggregated scores as an evidence base for their advocacy work with the MoE.

Key results/achievements

- Over 30,000 parents were trained and provided with tools to implement the school report card in the first two years of the program.



NTA Programme officer discussing School Report Card results with parents in Kenya
Photo: NTA/Mganga.

- The SRC has increased parents' awareness of their role in school management and provided them with an opportunity to discuss and address other issues affecting education in their schools. For example, parents in one school decided to buy sanitary towels for the girls and had them stored by a female teacher for girls to use in case of an emergency.
- The SRC has also provided new sources of information to MoE staff on school performance, offering an external perspective on the quality of education and supporting more objective decision-making.
- The results of the SRC exercise have served numerous advocacy efforts including NTA's ongoing engagement with the Teacher Service Commission to revise the teacher code of conduct, particularly with regard to teacher absenteeism and violence against the girl child. Based on the findings of the SRC, NTA made recommendations to the MoE task-force to strengthen the SMC structure in terms of its composition and mandate and these have since been adopted in the 2013 Basic Education Act. NTA is also currently engaging the parliamentary committee on education on the capitation grant to schools with a view to opening the disbursement process up for public scrutiny.

Lessons learned

- Stakeholder engagement:** NTA has invested in formal partnerships and engaged a wide range of stakeholders, including MoE officials from national to sub-county levels and teacher and school head unions. Their support of the School Report Card initiative has been instrumental in its success, both at school level and in terms of influencing county and national policies.
- Parents' participation:** Parents in rural areas, where more underperforming schools can be found, have shown greater interest and commitment to the report card initiative than their counterparts in urban areas. However, lower literacy levels in rural areas pose a challenge to the quality of parental participation. NTA has invested in translating the report card into Kiswahili in order to maximize parents' interaction with the tool.
- Teachers' lobby:** NTA initially underestimated the impact

that the Kenya National Union of Teachers (KNUT) could have on its initiative. Despite extensive negotiations, efforts to include teacher attendance and performance/time on task among the SRC performance indicators were systematically rejected by the Union. NTA has since decided to undertake this type of assessment separately from the SRC, and in partnership with the Teacher Service Commission.

- **Implementation strategy:** NTA has had to align the SRC work plan with the school term and exam schedule, as well as adapt to periodic calls for industrial action on the part of KNUT, over pay. Changes in the education sector brought about through the new constitution have also led NTA to realign its strategies in order to remain relevant and ensure sustainability, including scaling down on the number of schools targeted and expanding training opportunities to include newly appointed county education officials.

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Case Study 2: Participatory Learning and Action in the Environmental Health Sector in Pakistan

Background

The Khyber Pakhtunkhwa (KPK) Region of Pakistan, close to the border with Afghanistan, has had a restive history, ever since the soviet invasion of Afghanistan. Instability and violence continue to affect the region, contributing to the lack of development that causes the Khyber Pakhtunkhwa Region to have the second-lowest Human Development Index out of all of Pakistan's provinces, at 0.607.³ Local governments have the mandate to improve water and sanitation coverage in rural areas, but in effect very little is done outside the municipalities. Almost all water and sanitation access is the result of families paying for installation of their own private services; naturally this limits access for the poor.

With funding from the Australian Government, the IRC is conducting Environmental Health programming in rural villages in the Khyber Pakhtunkhwa Region, aiming to increase access to water and sanitation, improve hygiene practices, and enhance the environmental health and disaster preparedness of the communities through Participatory Learning and Action (PLA).⁴ The program is implemented in a context in which there are many obstacles to rural women's participation in decision-making. In rural Pakistan in general and particularly in the Khyber Pakhtunkhwa Region, women's access to the space outside the home is very circumscribed, without the company of a male family member, in accordance with the culture of *pardah*, or seclusion.

Methodology

The IRC's engagement in each village takes place over the course of about a year. Initially, in accordance with the government's sanitation policy, the program commences with Community Led Total Sanitation (CLTS) triggering in the village.



Community Meeting in Pakistan. Photo: IRC/Begum

This process is designed to trigger a strong perception of the need for change in the village, and mobilize the villagers to take responsibility for driving this change.

The IRC team then works with village leaders to identify a female and a male village activist. These activists are often members of the same family, such as a brother and sister or husband and wife. Under the leadership of the activists, male and female village WASH committees are recruited. Under this process, the team tries to strike a balance between broad inclusion of the village as a whole, while also trying to ensure that male and female participants are drawn from the same families. Including members from the same families makes it easier for women to attend meetings, and provides an avenue for family members to discuss issues outside of the meetings.

Activists are trained by IRC staff to lead the roll-out of a PLA curriculum in each village. Through the different modules of the PLA process, the committees use participatory tools to explore the conditions of their village, and discuss and prioritize feasible improvements. Each module has a different theme. Between each module, PLA Activists gather to provide feedback to IRC staff, and undergo further training for the next module. Ultimately, the committees develop action plans which allow them to implement concrete changes in the village using project funds and the communities' own resources, as well as through local government support.

Although the male and female committees meet separately, the Activists lead the process of cross-presenting the viewpoints of each committee throughout the process, and family members are also encouraged to discuss together in their homes. This approach presents a new level of engagement in decision-making by female community members. Ultimately, the different priorities of the male and female committees are reconciled to produce a unified action plan.

³ World Bank Pakistan Growth and Export Competitiveness (PDF).

http://www-wds.worldbank.org/external/default/WDSCContentServer/IW3P/IB/2006/05/23/000012009_20060523095241/Rendered/PDF/354991PK0rev0pdf.pdf (Accessed September 2014)

⁴ Participatory Learning and Action (PLA) is an approach for learning about and engaging with communities. The approach can be used in identifying needs, planning, and monitoring or evaluating projects. Whilst a powerful consultation tool, it offers the opportunity to go beyond mere consultation and promote the active participation of communities in the issues and interventions that shape their lives. (Thomas, S)

Key results/achievements

- By the end of 2015, the PLA process was completed in 60 villages out of the 130 targeted in the four-year project.
- The outcomes of the planning processes have been surprising in many cases. At the outset of the project, it was assumed that water resources and sanitation would be key needs. In many cases the communities have prioritized environmental improvements, such as tree-planting and measures to reduce disaster risks, especially from seasonal flooding which is common in the area. Fortunately, the project design is flexible enough to respond to this shift.
- The project has also provided a good entry point for local government officers to engage with communities. The manner in which the KPK government has embraced the process has been a key success of the project to date. A Project Oversight Committee meets regularly to monitor and support the progress of the project. District government representatives attend some meetings in the villages, and each action plan is reviewed and endorsed by the District Commissioner. While it is not yet clear whether the components of the plan assigned to local government will be implemented fully or in part, government authorities have welcomed this process of highlighting needs and prioritizing needed improvements, and there are signs of closer synergies emerging as a result of the increased interaction between office bearers and communities.
- Through the advocacy efforts of activists and community members in some villages, small offices have been established for male as well as female committees. This occurred spontaneously in three out of the initial 10 villages. These offices are used for meetings and development of action plans, as well as follow-up of plans. These villages plan to continue activities beyond the PLA process, and IRC has agreed to support them in registering as Community Based Organizations with the Department of Social Welfare.

Lessons learned

- Stakeholder engagement:** Because IRC staff are not present at most of the PLA sessions, leadership of the process is necessarily passed to the Activists and the community members themselves.
- Flexibility:** Community members have a variety of commitments in their daily lives, and the project must be flexible enough to accommodate harvest seasons, religious festivals, market days and so on.
- Time to build trust:** While the communities are not hostile to NGOs, they are dubious about the benefits they bring. The community engagement process at the beginning of the PLA curriculum was extended in order to give the community time to understand the IRC's 'agenda,' before pressing ahead with the analysis and planning process.
- Respect of cultural norms:** IRC team are careful to follow the *Pardah* system and the female team members were successful in engaging local females in establishing their own female committees as well as small scale offices for future sustainability. Women and men both provide respect to the IRC female team and appreciate IRC's efforts.

Case Study 3: Fostering local accountability in the education and health sectors in DR Congo through the Community Scorecard approach



Background

In 2007, the IRC began implementing a Community-Driven Reconstruction (CDR) program in the Democratic Republic of Congo in partnership with CARE and with funding from the UK Department for International Development (DFID). *Tuun-gane*, meaning Let's Unite, seeks to empower more than one thousand communities in four eastern provinces (North Kivu, South Kivu, Maniema and Katanga) to have greater voice and control over their own development. Since 2010, the program has strengthened and built on its community-driven approaches by fostering greater linkages between community members, frontline service providers, line ministries and nascent decentralized local government structures. These efforts have built foundations in the medium term for improved accountability in state-run service delivery. These linkages were fostered, in part, through the implementation of a social accountability tool in the health and education sectors: the community scorecard (CSC).

Methodology

Each community elected a Village Development Committee (VDC) to oversee public decision-making and implementation of a block grant for the construction/rehabilitation of basic social infrastructure. Following election of the VDC, the CSC was implemented through the following steps:

- Training of VDC members and service providers on the CSC and data collection process:** The two-day training provided them with the skills and knowledge to analyze and monitor the performance of service providers.
- Input tracking Matrix:** At the local level, objective data on the priority sector (e.g. health or education) were collected by VDC members in collaboration with user committee members, and were recorded in a systematic manner using an input tracking matrix which compared available inputs against the Congolese standards.
- Community Generated Performance Scorecard:** A minimum of 60 community members, the VDC and user committee members, as well as village leaders, collaboratively generated the scorecard. They were organized into three focus groups (divided into women, men, and the elderly/youth), and at least one third of the community members participating were women. Each focus group scored their service according to their own indicators for service delivery performance and also four standard indicators: access to services, quality of services, engagement

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Tuungane community scorecard meeting in South Kivu, Democratic Republic of Congo. Photo: IRC

of the user committee in financial management, and equal treatment. They scored each indicator using a five-level qualitative scale.

4. **Service Providers Self Evaluation Scorecard:** Service providers went through a similar, but separate, exercise to carry out a self-evaluation of the quality of basic services they offered.).
5. **Interface Meeting:** A meeting to discuss service quality, identify gaps in service provision and manage expectations with regard to service improvements was organized for VDC, village leaders, user committee members, services providers, and representatives of each focus group.
6. **Joint Service Improvement Plan (JSIP):** The collaborative space of the interface meeting allowed community members and service providers to work together, negotiate and mutually agree on an action plan to improve services.
7. **Community endorsement of the JSIP:** A general assembly was called during which the wider community was given an opportunity to become acquainted with the plan, to propose amendments if needed, and ultimately to approve it.
8. **Line Ministry and local government endorsement of the JSIP:** Once approved by community members, the JSIP was also shared by VDC members with all relevant local stakeholders, including local government officials and line ministry staff.

The VDC was responsible for overseeing the implementation of the JSIP using Tuungane and community resources (community members' time and labor). Two reviews of the CSC were conducted, at intervals of approximately six months, to gauge progress on the implementation of the JSIP and the scorecards. Two Tuungane staff facilitated the process in each community, working through the first review in close collaboration with VDC members who took the lead for the second review of the CSC.

Key results/achievements

1. **The CSC approach was implemented in 720 communities.** Over 7,200 community members and 3,600 service providers were trained and provided with an opportunity to hold interface meeting where they collectively addressed service delivery problems.

2. **Through the CSC process, user committees became more dynamic and transparent, and demanded greater transparency from service providers.** Community members also became more active in the management of health and education services. For example, they began ensuring that classrooms were clean and started attending general assembly meetings in greater numbers.
3. **Access to services increased** in many communities, primarily because of changes in user fee policies and a reduction in bribes requested from users. In some cases, user committees' members and frontline service providers advocated for increased oversight from line ministry staff to ensure that service provider salaries were paid regularly and to dissuade service providers from demanding bribes.
4. **Community members reported that service providers were more willing to listen and more respectful in their dealings with users.** This increased communication and helped to create a more welcoming atmosphere for users at the health and education facilities.

Lessons learned

- **Champions of change:** The CSC approach inevitably challenged local power dynamics and had the potential to trigger conflict among local actors. It therefore required highly skilled facilitation on the part of program staff as well as VDC members. In addition to providing them standard training, the IRC made the decision to invest in a small team of experienced staff who could be deployed across program sites to reinforce the facilitation skills of their colleagues by providing on-the-job support. These 'champions of change' played a critical role in the successful implementation of the scorecard activities and ensured that certain community members were not at risk of victimization by powerful interests.
- **Monitoring and Evaluation:** Given the experimental nature of many community scorecard interventions, particular attention should be paid to monitoring and evaluation, particularly at the design phase. It is important to invest in developing a theory of change and identifying progress markers or performance indicators which can be tracked over the lifetime of the intervention. By building opportunities for learning about the changes stimulated by these initiatives, the pathways through which they occur and the contextual factors contributing to their success or failure, implementers are able to better understand how social accountability interventions operate and make more informed decisions regarding their scale-up and sustainability.
- **Cost and time requirements:** The scorecard process required two staff members each dedicating fifteen days of labor in each community (over the 12-15 months of the project cycle). This represents a considerable staff investment given the scale at which the scorecard was implemented.

More on the Tuungane Community Scorecard can be found in the IRC Policy and Practice Briefing Paper, [Accountability in Local Service Delivery: The Tuungane Community Scorecard Approach](#). For more information, please contact Guillaume Labrecque, Governance Technical Advisor at Guillaume.Labrecque@rescue.org.



Community members in Myanmar participate in a focus group discussion on Accountability, Equity, and Inclusion (AEI) for Maternal and Child Health. Photo: Aung Minn Thein

Case Study 4: Accountability, Equity, and Inclusion (AEI) for Maternal and Child Health in Myanmar

Background

The IRC is implementing a maternal and child health (MNCH) project in two conflict affected states in Myanmar (2014-2016). The Accountability, Equity and Inclusion (AEI) practices integrated with MNCH project was first piloted in Chin State, one of the least developed areas in the country, which is largely populated by the Chin minority group. Telecommunications are poor, education levels are low, and access to villages is extremely difficult. Each state is divided into districts, which are further divided into townships. The township health department is responsible for management and supervision of health facilities in its catchment area. Accountability, Equity and Inclusion provides an opportunity for mutual understanding and collaborative problem solving between the Township Health Department, health facilities, village health committees and service users.

Methodology

The Accountability, Equity and Inclusion cycle is a bottom-up and dynamic process which starts at the community/village level and links to the Township level. IRC, working with partner CBOs, facilitated a series of discussions with the Village Health Committee (VHC), the service providers at the Sub Rural Health Centre (SRHC) that serves the area in which the village is located, and the Township Health Department (THD) about users' experiences.

The cycle has five steps:

1. IRC-facilitated discussions with the Village Health Committee about key health, accountability, equity and inclusion issues faced by health users in the target village;
2. IRC-facilitated discussions with service providers at the SRHC to gain their perspectives on the same issues;
3. Support for quarterly SRHC meetings between providers and Village Health Committees during which they share information on the issues raised during their respective discussions;
4. Dissemination of meeting outputs to the Township Health Department for action;
5. Feedback meetings with the Village Health Committee in

the target villages on actions taken by SRHC and THD.

Key results/achievements

- Providers and Township Health Departments jointly agreed on immunization outreach dates and these were communicated to village health committees and community members.
- In the pilot villages 100% of targeted children were immunized, greatly increasing coverage.
- Villagers developed more positive attitudes toward health staff and became more engaged in all health activities.

Lessons learned

- **Community ownership:** AEI supported the ownership of the process by VHC members and service providers, notably by having them facilitate community meetings and receive feedback on priority health service needs from community members / clients at the village level.
- **Improved communication can lead to increased engagement:** In the pilot, communication difficulties between the Township Health Department and health facility resulted in unresponsive services and low coverage for immunization. When this changed, users perceived increased responsiveness on the part of providers and changed their attitude and engagement in all health activities.
- **Transparency and sensitization:** It is essential to advocate for user participation and explain the entire process, procedures, objectives, expected results, and benefits of AEI not only to service users and providers, but also other stakeholders such as the Township Health Department before starting the process.
- **Conflict sensitivity:** If conflicts arise during the process it should be paused and additional explanation of the process should be conducted before restarting. It requires patience and conflict sensitivity.
- **Time requirements:** The cycle should not be started if the community and service providers do not have adequate time to first understand and conceptualize the AEI process. The time needed may vary from one community or service provider to another.

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Case Study 5: Patient Exit Interviews in DR Congo, Sierra Leone and Uganda

	DRC	Sierra Leone	Uganda
Questionnaire	- Mostly focused on patient satisfaction - Compares information on drugs received with drugs prescribed to see if changes were made - Includes consent request	- Focused on patient satisfaction - Recently introduced naming of specific drugs to track drug stock-outs - Open responses	- Focused on patient satisfaction, defined as: clinical improvement, humanity of care, organization of care, environment and overall impression - Use of Open and closed questions; consent requested
Interviewer	HMCs	CBOs – paid a small amount by IRC each month	HMCs and IRC staff
Methodology	- Interviews conducted in households (to encourage openness) - Pilot with three HMCs	Interviews conducted at health facilities	- Interviews conducted at health facilities - Mean of client scores used to attribute the satisfaction score for the health facility
Client selection process	Random selection of curative consultations (every 12th person in the patient register)	Random selection of patients leaving antenatal clinic (ANC) or maternity	Random selection of 12 patients leaving each target health facility
Frequency	Monthly but later extended to quarterly	Monthly	Annually
Analysis & Response	- HMC members trained to do the analysis but found this challenging (low literacy levels) - Results discussed with providers at the monthly meeting for action, and presented at the zonal level meeting of nurses and management team to ensure additional accountability and support.	- Monthly analysis conducted by CBO - Results presented to health facility staff at monthly meeting for action.	- Satisfaction scores: poor (<50%) to excellent (>85%) - Results shared with HMCs, district health teams and other stakeholders - Action taken by providers during monthly health facility meetings and by implementing partners supporting health facilities.

Background

The IRC has piloted exit interviews in a number of different settings, with the aim of improving services based on user feedback. They serve as a quality control measure (respect for fee policy, appropriateness of prescriptions), as well as a way of gauging client satisfaction regarding issues such as waiting time, hospitality of health workers and cleanliness of facilities. CBO or health management committee (HMC) members often conduct the interviews and provide feedback to providers and/or local authorities.

Methodology

Above are some examples of how exit interviews have been conducted and analyzed in three countries.

Key results/achievements

- In one facility in the DRC, the nurse was unaware of the problem with keeping men and women in the same observation room until it was raised by users through exit interviews. She subsequently invited the health committee to help clean out an unused room to allow for separate observation rooms.

- In another health facility, it emerged from the interviews that some health personnel were taking advantage of a stock-out of official receipts to charge users informal fees. The health zone was able to make the receipts available and curb this practice.
- Through the exit interviews conducted in Uganda, stakeholders were alerted to the lack of confidentiality displayed by health personnel regarding patients' HIV status, which directly affected demand and adherence to HIV/AIDS services. Implementing partners supporting the health facilities have since committed to strengthening providers' awareness and practice with regard to patient confidentiality and privacy.
- In one district in Uganda, complaints about staff absenteeism resulted in further investigations which highlighted the fact that absenteeism was associated with lack of accommodation and water in remote health facilities. The local government has since committed to installing/repairing water harvesting systems in health facilities and to target those with accommodation challenges for future construction opportunities.

Lessons learned

- **User awareness of rights:** Without an investment in raising users' awareness about their rights and entitlements, it can be difficult for them to understand the value of social accountability initiatives like exit interviews and to stimulate their participation.
- **Stakeholder engagement:** Health district authorities and healthcare providers may not be motivated to make changes if they are not engaged from the beginning of the process or do not face sanctions for inaction. Engagement by local authorities is particularly challenging.
- **Motivation and costs of conducting interviews:** Without payment the time burden can prove too costly for health committee members to be motivated to continue the work.
- **Improving communication:** Some problems arising from lack of information sharing between providers and users or providers and district level authorities can be resolved fairly easily.
- **Growing space for user voice in health systems:** Initiatives like exit interviews are relatively uncommon in developing countries. However, they are starting to gain ground, alongside the growing recognition of the value of soliciting user voice as part of health systems strengthening.

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Case study 6: Building trust and strengthening local government responsiveness through ICT in Zimbabwe

Background

There is growing interest and investment in information and communication technologies (ICT) as a tool for strengthening social accountability in many parts of the world. While the jury is still out as to how effective this technology is in stimulating and sustaining social accountability initiatives, it is clear that it offers a new (virtual) space through which citizen voice can be heard and acted upon, and dialogue between citizens and their institutions can be fostered. Zimbabwe is one country where such spaces are particularly restricted and where trust between citizens and their institutions is very low. The political and economic crisis that has gripped the country in the past two decades has resulted in countless human rights violations and the near total collapse of basic service delivery. The decline in the population's social and economic welfare has affected the government's overall legitimacy and threatened the ruling party's monopolistic hold over political power.

Recognizing the need to meet the basic socio-economic rights of the population, the Government of Zimbabwe has bolstered efforts to improve public service delivery and expand citizen engagement at the local level, including through its e-government program which focuses on modernizing government systems and processes through the use of information and communication technologies.



Distribution of City Council refuse bins branded with a SMS number in Zimbabwe.
Photo: IRC/Makonese

Methodology

The IRC and its local partners, through the Mutare City Dialogue and Technology for Accountability (M-DATA) project, have seized the opportunities created by these initiatives to support greater local government accountability for service delivery and rights abuses while working within Zimbabwe's constricted human rights environment. Through the establishment of a Citizens' Short Messaging Service (SMS) platform, residents of Mutare City in Manicaland province are able to easily and anonymously address their service delivery complaints and suggestions to Mutare City Council (MCC). These are then managed through a cloud database which allows local government officials to escalate concerns to the appropriate departments. Upon receipt of an SMS, the platform instantaneously sends an acknowledgement with a system generated ticket (reference) number for tracking purposes. Once addressed, residents receive a follow-up SMS message before the case is closed. Residents associations have been trained to monitor messages and related action taken by the MCC. Most of the complaints concern burst water pipes, refuse collection, sewage treatment and road maintenance.

Key results/achievements

- The project has shown that there is real demand for spaces like the one created through the SMS hotline (approximately 550 users in the first 3 months of operation) and that, once opened, these spaces offer opportunities for citizens to voice their needs and concerns about a wide variety of issues. In addition to submitting complaints about service delivery, residents have also used the SMS platform to raise concerns about the lack of transparency in the management of the local government budget, to report cases of police harassment and abuse of power, as well as cases of gender-based violence. There have even been reports of MCC employees using the hotline to complain about their remuneration.
- While resource constraints have meant that the MCC has been slow to address concerns over road maintenance,

Residents Associations have noted that response times in repairing burst water pipes have been vastly reduced and that City Council refuse trucks which were previously broken down have been repaired and refuse collection has improved.

- Beyond the formulation of complaints, an increasing number of SMS received also contain suggestions for how the MCC could improve its relationship with residents and better address their needs.
- Through the work of the Residents' Associations, the operations of City Council has been demystified and residents now have a better understanding of how their concerns are managed and some of the constraints faced by the MCC.
- The SMS platform has been upgraded since the end of the project: residents can now communicate with City Council via WhatsApp, at no additional cost. They are also able to send images, videos and audio clips related to the issue they are reporting. These enhancements are likely to improve uptake of the platform.

Lessons learned

- **Capacity building investment:** Working on both the demand and supply sides when building mechanisms for local government accountability is an effective approach, but it requires significant investment in capacity building.
- **Building trust and stimulating responsiveness:** In a context where partisan politics has permeated every aspect of society and dictates both how citizens engage with the State and how the State does or does not respond to citizen demands, inclusive, apolitical and transparent interface mechanisms like the SMS hotline are critical to building trust on both sides and fostering responsiveness to residents' concerns.
- **Expanding space for dialogue:** Ultimately, the project has opened up space for dialogue on issues that are generally deemed to be too sensitive to discuss publicly in the Zimbabwe context, and shown that it is possible to make progress even in highly politicized and restrictive environments.

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