THE ROLE OF SOCIAL ACCOUNTABILITY IN IMPROVING HEALTH OUTCOMES:

Overview and Analysis of Selected International NGO Experiences to Advance the Field

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Abstract

The 1993 World Development Report (WDR), Investing in Health, deemed strengthening accountability as one of the core elements of health sector reform. Engaging communities and community-based workers in the process of measuring health status of children, in assessing causes of deaths, in defining high-risk groups, and in measuring changes in mortality over time will enable governments to achieve levels of under-5 mortality according to their commitments. Models involving International NGOs that used a social accountability approach in various sectors and at different levels including community, district, and national level, were reviewed as part of this paper and are presented regarding the processes undertaken to increase accountability and improve health outcomes. This paper presents common themes, challenges, and recommendations to expand and bring this approach to scale in the context of health and development.

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Acronyms and Abbreviations

ANC	Antenatal Care
ADPS	Area Development Programs
CBPM	Community Based Performance Monitoring
CBO	Community Based Organization
CSC	Community Score Card
CVA	Citizen Voice and Action
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MDGs	Millennium Development Goals
NGO	Non-governmental organization
RCT	Randomized control trial
PDQ	Partnership Defined Quality
QITs	Quality Improvement Teams
USAID	United States Agency for International Development
WDR	World Development Report
WRA	White Ribbon Alliance
WV	World Vision

Contents

Executive Summary

The 1993 World Development Report (WDR), Investing in Health, considered strengthening accountability as one of the core elements of health sector reform. This begun a movement to incorporate participation and accountability as part of the planning process for health sectors among state and non-state actors globally.

Governments with high maternal and child mortality made commitments to invest in maternal child and newborn health programs to accelerate the rate of mortality decline to contribute to achieving Millennium Development Goals (MDGs) as well as A Promise Renewed – a vision of ending preventable child deaths by 2035. Engaging communities and community-based workers in the process of measuring health status of children, in assessing causes of deaths, in defining high-risk groups, and in measuring changes in mortality over time will enable governments to achieve levels of under-5 mortality according to their commitments.

Three models using a social accountability approach in various sectors and at different levels including community, district, and national level, were reviewed and are presented regarding the processes undertaken to increase accountability and improve health outcomes. These include: 1) Citizen Voice and Action, implemented by World Vision; 2) Partnership Defined Quality, implemented by Save the Children; 3) and the Community Score Card, implemented by CARE.

Common themes among the organizations included: preparation and planning as a key step; involvement of marginalized populations and the poorest of the poor; identification of barriers from civil society and governmental/public sector; interface meetings between civil society and governmental/public sector; a focus on accountability and health outcomes measurement; strong facilitation and use of guides; and rigor of evaluation of interventions.

Notable highlights in different approaches among models are presented, which include established presence for entrée; the value of a score card in measuring services; repeated cycles for institutionalization of the approach; and community capacity as a central measurement.

Other CORE Group members' approaches are discussed including the White Ribbon Alliance, GOAL, and Future Generations.

While a variety of social accountability approaches are available and have been implemented globally, it may be challenging for international organizations or local partners to choose what would work best given their context. In addition, questions still remain unanswered regarding aspects of social accountability

approaches in health and development. Recommendations are provided to address some of these issues as part of this analysis.

Greater social accountability can allow for civil society to engage meaningfully in public policy and in-turn public good. Organizations including the World Bank and other international NGOs have contributed greatly to efforts to promote social accountability. This paper presents some of those efforts, challenges, and recommendations to expand and bring this approach to scale in the context of health and development.

Introduction

The 1993 World Development Report (WDR), Investing in Health, deemed strengthening accountability as one of the core elements of health sector reform. This ignited a trend to incorporate participation and accountability as part of the planning process for health sectors, and has been reinforced by various players in civil society, bilateral and multilateral donors, and governments towards a vision of a more effective, efficient and equitable access to health care[1].

According to the World Bank, there are factors, which are critical to any social accountability program[2] : 1) opportunities for information exchange, dialogue and negotiation between citizens and the state; 2) the willingness and ability to seek government accountability among citizens and civil society; 3) transparency and open information sharing, attitudes, skills and practices supporting listening and constructive engagement among service providers and policy makers with citizens; and 4) an enabling environment, within the policy, legal, and regulatory spheres for increased civic engagement. Figure 1 illustrates the critical factors associated with social accountability[3].

Enabling Environment

Legal factors

Demand Side
Willingness and capacity of citizens/ civil society to demand

Bridging Mechanisms
- Information
- Voice
- Influence
- Sanction

Supply Side
Willingness & capacity of government to account

Political factors

Economic factors

Socio-cultural factors
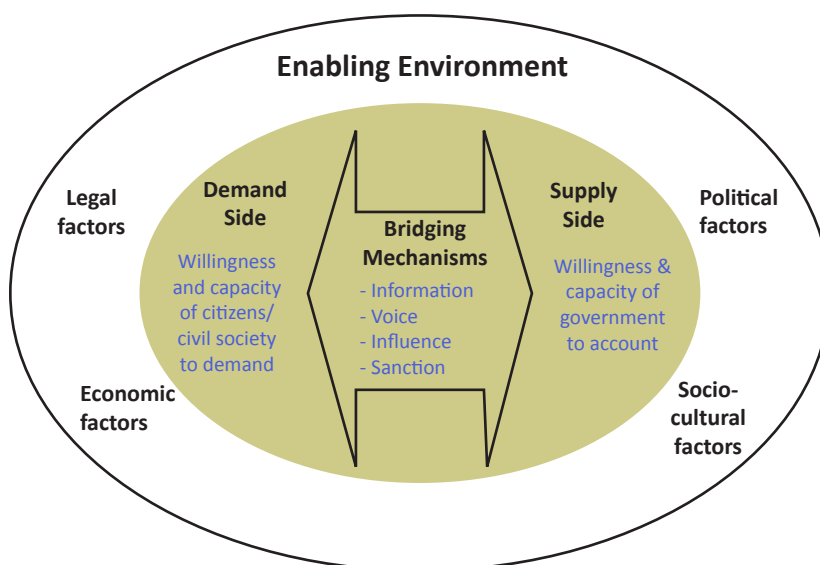
Figure 1:
Critical Factors for
Social Accountability

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[1] Social Accountability Sourcebook. Chapter 4: Social Accountability in the Health Sector. Participatory Public Expenditure Management at the National Level. World Bank. 2002.
[2] Ibid
[3] Social Accountability Sourcebook. Chapter 2: Social Accountability in the Health Sector. What Does it Mean for the World Bank? World Bank. 2002.

Opportunities for information exchange, dialogue, and negotiation between citizens and the state can include the introduction of new tools for citizen-state interaction or reforming existing mechanisms. Willingness and ability to seek government accountability among citizens and civil society can include technical capacity building as well as mobilization, coalition-building, negotiation, and advocacy. Transparency and open information sharing, attitudes, skills, and practices supporting listening and constructive engagement with citizens may utilize incentives, rewards, and sanctions to promote transparent and responsive behavior. An enabling environment can include policy, laws, and a regulatory atmosphere that fosters civic engagement; type of political system, how much political freedom is granted, and a tradition of open pluralistic debate; economic basis and financial viability of different forms of civic engagements; and values, norms and social institutions present in a particular society that support or inhibit open and pluralistic debate and critical but constructive engagement.

Democracy, human rights, and good governance are fundamental objectives in and of themselves, and essential foundations for sustainable socioeconomic development[4]. The social accountability agenda has developed within a background of broader democratization and decentralization movements; leading to the development and refinement of instruments in response to the broader changes[5]. Social accountability initiatives often interface with varying agencies and divisions of government. Some international non-governmental organization (NGOs), for example, participate in programs and activities to support the involvement of national NGOs and citizens in social accountability processes to strengthen capacity bringing together government and nongovernment actors. Other civil society organizations include advocacy and campaigning, while at the community level, examples exist of local groups enhancing citizenship through awareness of rights and increased capacity for political participation, while social movements have successfully pressed for state receptiveness to citizens' rights and agendas. The United States Agency for International Development (USAID) emphasizes the importance of participation and inclusion of citizens in governance and prioritizes this within the USAID Strategy on Democracy, Human Rights, and Governance, with a strong focus on citizen engagement and accountability[6].

Social accountability, health equity, and the post 2015 agenda

The concept of equity is firmly embedded within the right to health. "Health equity is both the improvement of a health outcome of a disadvantaged group as well as a narrowing of the difference of this health outcome between advantaged and disadvantaged groups —without losing the gains already achieved for the group with the highest coverage[7]." The achievement of health equity is an objective of many NGOs that work with underserved populations. These health programs address power and structural dynamics that determine policy and underlying social determinants of health.

The concept of equity is embedded within the 1946 Constitution of the World Health Organization (WHO), defining health "as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" and furthermore mentions that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political

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[4] USAID Strategy on Democracy, Human Rights, and Governance. June 2013.
[5] Reflections on Social Accountability, United Nations Development Programme. 2013.
[6] USAID Op. cit.
[7] Checklist for Health Equity Programming, MCHIP.

belief, economic or social condition." The Alma-Ata Declaration (1978) further discusses equity in its second principle: "The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries." The right to the highest attainable standard of health is a human right acknowledged within global leadership over the past twenty years along with states' obligations regarding the health of their citizens. These global policy commitments provide a framework for the state's obligations in respecting, promoting, fulfilling health care obligations (preventive and treatment services), and addressing the underlying necessities for health for all people, free of discrimination. They also provide a means for NGOs to assist the state in clarifying policies, establishing programs, and holding governments accountable[8].

Accountability is a prominent theme of the U.N. Every Woman Every Child campaign. Governments with high maternal and child mortality made commitments to invest in maternal child and newborn health programs to accelerate the rate of mortality decline to contribute to achieving Millennium Development Goals (MDGs) as well as A Promise Renewed – a vision of ending preventable child deaths by 2035. Engaging communities and community-based workers in the process of measuring health status of children, in assessing causes of deaths, in defining high-risk groups, and in measuring changes in mortality over time will enable governments to achieve levels of under-5 mortality according to their commitments[9]. The post-2015 agenda will presumably change its approach to measuring results and provide many opportunities for strengthened accountability mechanisms that involve citizens in varying capacities[10].

Overview of Selected International NGO models

Social accountability involves ongoing, collective action by civil society groups, which includes NGOs, to hold public officials and service providers to account for the provision of public goods[11]. Several models that use a social accountability approach in various sectors and at different levels including community, district, and national level, were reviewed and are presented below.

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[8] Considerations for Incorporating Health Equity into Project Designs: A Guide for Community-Oriented Maternal, Neonatal, and Child Health Projects. MCHIP. September 2011.
[9] Perry, Henry. Ensuring Accountability to Deliver Results The Role of Community-Level Data and Information in Ensuring Accountability. A Promise to Keep: Global Child Survival Call to Action, Given on 15 June 2012, Georgetown University, Washington, DC. Department of International Health, Johns Hopkins Bloomberg School of Public Health
[10] Reflections on Social Accountability, United Nations Development Programme. 2013.
[11] Joshi, A. and Gurza Lavalle, A. Collective Action Around Service Delivery 'How social accountability can improve service delivery for poor people'

These include: 1) Citizen Voice and Action, implemented by World Vision; 2) Partnership Defined Quality, implemented by Save the Children;   3) and the Community Score Card, implemented by CARE. The CORE Group solicited input from partners regarding those using social accountability approaches in their programmatic work. Methods of data collection included key informant interviews among partners and a review of documents shared by partners, which is available in the references section. Common themes and notable highlights are presented, along with key elements and examples of its implementation by the organizations. Recommendations are provided based on the analysis of the interviews and documentation.

Description of the Approaches

World Vision's approach: Citizen Voice and Action

Origins: Citizen Voice and Action (CVA)[12] was adapted by World Vision, with key support from World Bank staff. Originating from work in The Gambia by the World Bank and an initial participatory scorecard developed by CARE in Malawi, CVA is now applied by 405 of World Vision's programs in 42 countries in Fiscal Year 2014[13]. The name was changed from Community Based Performance Monitoring (CBPM) to Citizen Voice and Action in 2008.

Focus: World Vision's model seeks to improve the relationship between communities and government, in order to improve services, such as health care and education, which impact the daily lives of children and their families. Their view is that each citizen has the right to communicate with, and have a relationship with, their government. Active citizenship and engagement with government helps governments to work effectively and to provide quality services[14]. The approach catalyzes an alliance between community members and government officials, based on those officials who are willing to participate, as World Vision experienced varied interest and will among government officials. Figure 2 is the framework for CVA, and Appendix 1, Table 1, provides the key elements and activities.
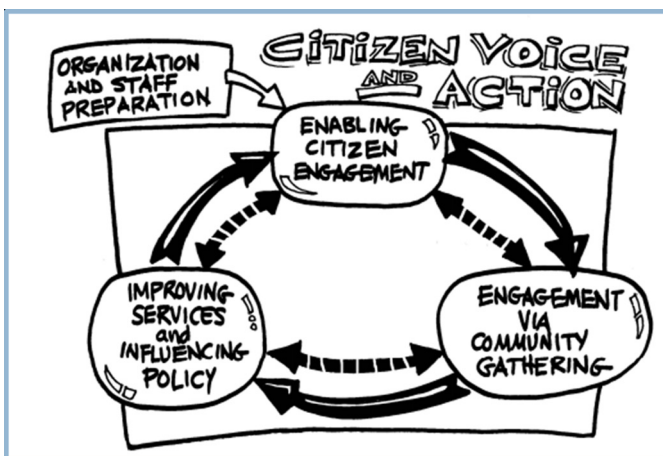
Figure 2: World Vision: Citizen Voice and Action

Where applied: The approach should be based at a facility, clinic, or school, and expanded from there. One criteria includes that the site must be a place where the government is providing services. World Vision found that because their organization is so large, organically communities would come together and were able to identify patterns of government failure. The score card and social audit data used in CVA can be aggregated to show how services may be failing at the

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[12] See citizenvoiceandaction.org
[13] Citizen Voice and Action: Civic Demand for Better Health and Education Services. World Vision International.
[14] Ibid.

district, provincial, or national level. World Vision is currently undertaking a quasi-experimental research project called the Child Health Targets Impact Study (chTIS), in partnership with Johns Hopkins University. This project will rigorously measure the impact of CVA and its contribution to the Every Woman Every Child Campaign[15].

Sectors the process has been applied: CVA is an agenda-neutral process and has been applied in a variety of sectors including education and health, HIV/AIDS, water and sanitation, and is now expanding into the private sector. Focal areas for the CVA process are determined locally with the stakeholders. Currently CVA is operating 405 programs in 42 countries. WV focuses on one facility at a time, therefore, for example, in education it takes a long time to reach all the schools in that catchment area. In health it tends to take less time as there are fewer facilities in each catchment area. WV is in the process of expanding out to all of the 1,800 programs worldwide across programmatic sectors; specific sector issues are locally determined, usually by the community.

Citizen Voice and Action: Characteristics
• Constructive evidence based dialogue in order to improve government services, government performance, and relationships
• Catalyzes alliances between community and key government officials
• CVA encourages collective action, driven and managed by civil society
• Embedded within Area Development Programs
• Ability to leverage ongoing work for greater impact
• Existing relationships provide groundwork for institutionalization of programming

Who should use it and who is involved: World Vision builds the CVA process into its existing Area Development Programs (ADP). Each ADP is a 15 year commitment to the program area. There are currently 1,800 ADPs in 95 countries, each serving a population of 25,000 to 50,000 and up to 100,000 people when operating at full capacity. World Vision staff within the ADP may facilitate the community development with the objective of handing over all the work over to local partners. World Vision identifies an existing group and equips them with the tools needed to carry out CVA, .e.g. a local CBO, village committee, etc. As World Vision's programs are 15 years in duration, they provide capacity building where needed. Two to three people are needed to facilitate the CVA phases, usually a local partner organization.

How it increases social accountability: CVA equips citizens to engage in evidence-based dialogue with health workers and local government in order to improve the accountability of health services. Specifically, CVA equips citizens with an understanding of the standards that government has set of the performance of the facilities they use every day. Citizens learn about the number of health workers, vaccines, equipment, and materials that should be present at their health center. Next, using an adaptation of the "social audit", citizens work constructively with health workers and local government to objectively, quantitatively measure the facility's compliance with government standards.

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[15] For more information on chTIS, visit http://www.wvi.org/health/chtis

Using a "community score card", all stakeholders also rate the facility according to criteria that they themselves generate. Equipped with this evidence, citizens convene an interface meeting among civil society, government, and service providers at which all stakeholders review the documentation and commit to an action plan to improve services.

Financial considerations: Costs range per program, per year. Costs decline significantly over time as citizens drive the bulk of the process. Costs include staff for any program management, materials, translation, awareness raising about entitlements, and lunches for the CVA meetings. Printing and awareness raising, project management are the main upfront costs by World Vision, however, World Vision feels the community can sustain the process on their own regarding meetings, flip charts, etc.

Monitoring and evaluation: Evaluation is built into the design of the ADPs. Most recent evaluation indicators focus on: improved services; increased engagement between citizens and government; and improved relationships. Government and community action outcomes are linked closely to facility based indicators focused on access and quality. WV uses randomized control trials (RCTs) to measure outcomes when possible. Three exist from Uganda: education outcomes and collective action; accountability in education; and an SMS accountability intervention. Oxford University has carried out the RCTs, whilst WV is the implementing partner. One of these RCTs has been published; two others are currently under peer review (see results under "Examples of Successes at Different Levels").

In the absence of RCTs, WV relies upon participatory monitoring and evaluation to measure CVA's effect. WV's M&E framework for CVA includes 3 elements. First, WV measures the degree to which the program adheres to the CVA model as outlined in guidance materials. Second, WV measures the changes in the quality of services and. Communities themselves generate the data on service quality through the "social audit" and "community score card" processes. For citizens, this information is useful for advocacy; for WV, this information is useful to measure changes in service quality over time. WV also seeks to better understand the causal mechanism behind service quality changes through focus group discussions with key stakeholders. Third, WV measures citizen engagement, using a 10-point scale called the "influence and engagement matrix". Level zero on this matrix indicates that Communities report they have no meetings or engagement with government, whereas level 10 indicates that there is evidence of a policy or sustained practice change as a result of input from the community.

Challenges or barriers to implementation: The enabling environment is the key to implementation. In some cases, governments at various levels may not inform local officials that they should participate, so there may not be a true willingness to engage. Lack of rights to information in the preparation phase or lack of a collaborative government partner can be an impasse. If political will is nonexistent, the process will not work; changes in health outcomes may not be possible. In the absence of some minimal level of political will, CVA functions as a strong awareness raising program.

Examples of successes at different levels

Sustained improvements in health indicators: In 2004 a pilot project using citizen report cards was developed based on a response to perceived weak health care delivery at the primary level in Uganda.

The main objective of the intervention was to strengthen the provider's accountability to citizen-clients by introducing a process, using trained local actors (CBOs) as facilitators, which the communities could manage and sustain on their own. The study used an RCT design. Regarding quality of care, one year after implementation, health facilities in treatment villages as compared to comparison villages experienced a 12-minute reduction in average wait time and a 13% reduction in absenteeism. Regarding health outcomes, one year after implementation, health facilities in treatment villages as compared to comparison villages showed: a 33% decrease in under-five mortality; a 58% increase in the use of skilled birth attendants; a 19% increase in number of patients seeking prenatal care; and the results were sustained four years after the project was initiated[16]. WV was not the implementing partner in this research project, but has modeled its practice to closely reflect the intervention studied.

Increased collective action in education: In Uganda, an RCT was developed by Oxford University and World Vision to examine the effect of the CVA Score Card in100 Ugandan primary schools. School Management Committees (SMC) in all the schools were trained and supported to use a school scorecard, however, in the participatory site, the CVA model was used and SMC members were engaged in the development of the scorecard. After one year, the study found that in the schools using the CVA score card that test scores rose by an average of 9%, pupil attendance increased by 8-10%, and teacher absenteeism decreased by 13%[17]. These results can have an influence on national education policies[18]. Where accountability is low, and where test-based incentives may be costly, information-for-accountability interventions provide a cost-effective alternative[19]. In addition, this study provides evidence that this type of participatory approach can lead to substantial increases in collective action.

For additional case studies, please see Appendix 1.

Save the Children's approach: Partnership Defined Quality (PDQ)

Origins: Save the Children originally launched the "Community Defined Quality" (CDQ) initiative in 1996 to document results of community involvement in efforts to increase quality and the availability of health services. As Save the Children learned from field experience, providers and communities had different definitions and priorities for quality of care, hence CDQ was renamed "Partnership Defined Quality" (PDQ) in 1996[20].

PDQ was tested and expanded and piloted in Nepal, Haiti, Pakistan, Uganda, Rwanda, Azerbaijan, the West Bank, Georgia, and Ethiopia. In January, 2003 Save the Children published the PDQ manual: Partnership Defined Quality: a tool book for community and health provider collaboration for quality improvement, designed as implementation guide and tool kit for field use. The CORE Group supported the development of a facilitation guide.

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[16] Bjorkman, M and Svensson, J, 2009. Power to the People: Evidence from a Randomised Field Experiment on Community Based Monitoring in Uganda. Quarterly Journal of Economics.

[17] Zeitlin, Andrew. Management and Motivation in Ugandan Primary Schools: Impact Evaluation Final Report (2011).

[18] Please see World Vision case study: https://www.smore.com/w5xy-citizen-voice-and-action

[19] Barr, A. et al. Information and collective action in the community monitoring of schools: Field and lab experimental evidence from Uganda. Draft, 2012.

[20] Partnership Defined Quality – A Tool Book for Community and Health Provider Collaboration for Quality Improvement. Save the Children. January 2003.

Overview: PDQ aims to improve quality and accessibility of services, allowing more involvement of the community in defining, implementing and monitoring the quality improvement process. This includes the recognition that quality may be defined from different perspectives among clients and providers. It focuses providers and clients working together as allies to address problems and work to overcome any possible blame. Appendix 1,

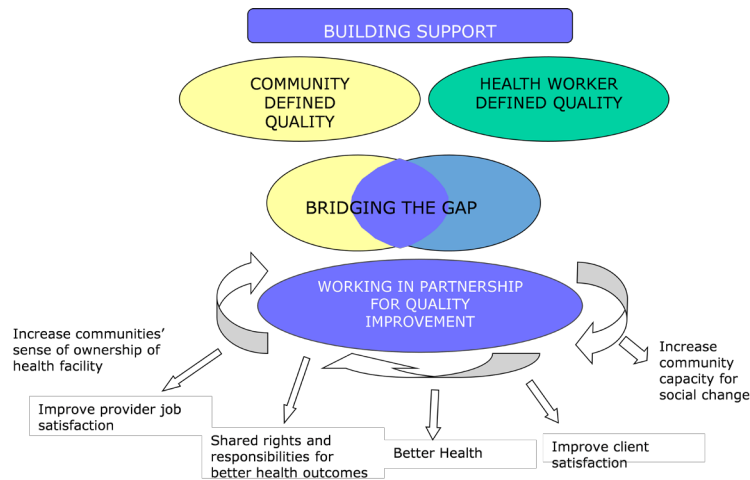**Figure 3: Save the Children's PDQ Framework**

Table 2 shows the key phases, elements and activities of the PDQ model. PDQ aims to promote action, not merely information sharing, through the following steps: 1) Building support; 2) Exploring quality on both sides; 3) Bridging the gap, inviting NGO/MOH partners to the discussion, defining parallels in perceptions between community and providers; and 4) Working in partnership through a Quality Improvement (QI) team which develops and implements and action plan. Figure 3 provides the framework for PDQ.

Where applied: The PDQ approach is most appropriate in projects with a duration of two years or more, with enough staff and budget to adequately support the PDQ process as related to the size of the catchment area involved. The four steps in the PDQ process (up to preparing the Work Plan) typically require about three months to complete. The process works best at the community level in the catchment area around a health post or health center, however, it could also be used at district level. In Pakistan, the PDQ process was carried out at the district level; it is important to note that if PDQ is implemented at the district level, there has to be a link between the specific provider that corresponds to a specific community. If this link is not clear, the answers from the PDQ process will not be specific to the community. Often in decentralized settings, district officials are involved at the community level.

Sectors the process has been applied: The PDQ model has been used in the health sector and has been adapted in education (including non-formal education), youth, adolescent sexual and reproductive health, and HIV/AIDS. In addition, the PDQ manual was modified to be more user friendly for practitioners working specifically with youth. There must be clear identification of two "partners," meaning a clear group that uses a service, and a clear group that is has the responsibility to provide that service. PDQ has been adapted for low literacy audiences. For example, in Bangladesh, the poorest of the poor were involved, with limited literacy and a Bangla user-friendly implementation module of PDQ was drafted, reviewed and finalized to use with this audience[21].

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[21] PDQ Application in Bangladesh: "Involving the poorest community members in quality improvement efforts". Monograph from Save the Children/CORE Group's joint Technical Advisory Group on Partnership Defined Quality

Parternship Defined Quality: Characteristics
• Community based solutions with community resources, with limited external financial support and outside solutions, for social change
• "Duty bearers" – rights based work
• Quality Improvement Teams (QITs) are a key component
• Builds on community capacity, organically grows as the PDQ process is carried out in the community
• As quality has very different meanings, quality is defined by the partners in the context of their community setting, e.g. what keeps people from going to the health center?

Who should use it and who is involved: PDQ is intended to be led by project staff members who are working to improve the quality of services in order to achieve project outcomes. While there isn't any formal professional preparation, staff members who have experience leading meetings and facilitating discussions might find it easier to implement. Staff members should be trained in PDQ, or have an in-depth understanding of the PDQ manual. It is desirable that their cross cultural skills and monitoring and evaluation skills are solid. At least 30% of participants need to be from marginalized groups or else their voices will not be heard; this is relevant when the community seeks members of the Quality Improvement Team. This is one of the most difficult aspects but makes a significant impact in terms of outcomes. Some health providers, who may be used to leading and managing meetings, will need to give up some control in order to favor equity in participation with community members. This empowers disadvantaged groups but may require a real "ideological shift" on the part of the providers.

How it increases social accountability: Save the Children sees the increase in social accountability as a natural output of the PDQ process. PDQ is intended to improve quality at the community level from the perspective of the consumer (client) and more than anything, the marginalized client. Marginalized members address duty bearers. PDQ builds confidence in the clients to stand up to providers and hold them accountable to provide services they should be providing at a quality level that is demanded from the community. Community and health provider perspectives often change after the "bridging the gap" activity, and it is realized that they all want the same thing – the provision of quality care. The community takes ownership to improve health using existing resources, and client satisfaction and provider performance increases together with overall health status.

PDQ creates a mechanism for rapid mobilization around health priorities. Engaging the community in quality improvement dialogue can also increase demand for services.

Financial considerations: The PDQ process intends to use local solutions to community-provider challenges. While costs can range depending on the context, many of the PDQ programs have used local resources as a result of this process. For example, in Afghanistan, as a result of the PDQ process it was discovered that women were embarrassed to deliver at the health center because of crying during childbirth. The

partnership developed a solution: to build a back door to the health center so women could discreetly enter and give birth without being seen by men. In Armenia, after the Republic was established, health centers were substandard. Through the PDQ process, citizens came together to donate their skills to improve the health center. Three years later, the quality of services at the health center had improved, and a spillover effect occurred: communities realized they could create social change; after completing their action plan, they sought to make other improvements in their community, including building a kindergarten.

Monitoring and Evaluation: The Partnership Defined Quality Monitoring and Evaluation Toolkit provides a set of tools including supervisory checklists, mapping tools and an exit interview to support the implementation of PDQ[22]. Some examples of indicators monitored include: client satisfaction; standard measures of the quality and availability of health services; utilization of health services and promoted health behaviors; and improved equity in health services delivery[23]. Although there has been operations research, participants in various settings that have been part of the PDQ process have noted anecdotally that utilization rates of health services have increased, as well as an improvement in overall quality of services, including, client satisfaction and provider performance. In a more rigorous operations research project, intervention and comparison groups in Pakistan and Nepal provide supporting evidence.

Challenges or barriers to implementation: The PDQ process is intensive and time consuming. Frequent transfers in health staff, lack of political will and commitment to the PDQ process can deter successful implementation. Laws may exist that prevent providers from being able to provide additional services that may come out of PDQ process. Sometimes there can be a lack of investment in the community, mostly due to self-interest and in the case when people involved are not from that particular community, or if providers are not interested in their communities. Save the Children finds that 75% of the barriers are not clinical, rather they are societal and cultural in nature. Providers may only be interested in improving their own health center, and the PDQ process requires involvement of communities as well to determine health facility challenges. If communities are not engaged, the providers tend not to listen. Regarding empowerment, youth may not feel comfortable to share their thoughts among adults or providers, perceiving this group as "authoritative". To address this, Save makes sure that other adults that can encourage and coach youth to express what they want to say are present; the same holds true with communities and providers. Lastly, among specific populations, such as commercial sex workers, there may be stigma involved, which may prevent a joint meeting between providers and communities, and adaptations would have to be made to ensure the community's privacy such as analysis of the group's inputs by facilitators as opposed to an interface meeting.

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[22] Partnership Defined Quality Monitoring and Evaluation Toolkit with Youth Annex. Save the Children, February 2010.
[23] Outterson, B. et al. Partnership Defined Quality for Youth. A Process Manual for Improving Reproductive Health Services through Youth-Provider Collaboration. Save the Children, 2008.

Examples of successes at different levels

Community improvements with national recognition: In Afghanistan, where communities experienced low coverage for safe motherhood services, the PDQ model was used to increase access to safe motherhood services and enhance quality of safe motherhood services[24]. Ministry of Public Health and NGO staff were involved in the preparation and planning process, and community mapping identified areas with low coverage. A two day workshop involved community shuras, religious leaders, teachers, and community representatives, the PDQ process was carried out, and action plans with clear indicators and roles and responsibilities were developed. Results from implementation of the action plans included: an increase in ANC coverage from 45% in 2004 to 62% in 2006; an increase in deliveries by skilled birth attendant from 19% in 2004 to 25% in 2006; an increase in postnatal care from 29% in 2004 to 41% in 2006; and increase in DPT3 coverage from 43% in 2005 to 77% 2006; PDQ has been recognized as national quality assurance standard; the ACCESS/HSSP project scaled up to 5 provinces and plans to expand up to 13 provinces.

National PDQ focus: The PAIMAN project in Pakistan, a 92 Million USAID funded six year project implemented by a JSI- led consortium, focused on maternal, newborn, child health and family planning with a health system strengthening approach, along the 'Household to hospital continuum of care' model. The project was implemented at national scale, involving 23 districts. In addition to PDQ initiatives, other activities were carried out, including women's support groups, male health committees and awareness raising events and meetings such as Health Camps, seminars with district assemblies, and theater performances. From January 2008 to June 2009, PDQ districts experienced more ANC visits, child immunizations, and a higher client satisfaction as compared to non PDQ districts. Next steps involved institutionalization of quality improvement teams and support to the Ministry of Health, NGOs and development partners for replication of PDQ- PAIMAN.

For additional case studies, please see Appendix 1.

CARE's approach: Community Score Card

Origins: CARE Malawi developed the Community Score Card (CSC) in 2002 as part of a project aimed at developing innovative and sustainable models to improve health services. CARE has over a decade of experience implementing the CSC in a wide variety of contexts and sectors. The CSC approach brings together community members, service providers, and local government to identify service utilization and provision challenges, and to mutually generate solutions, and work in partnership to implement and track the effectiveness of those solutions in an ongoing process of quality improvement.

Overview: The CSC is an approach that brings together community members, service providers, and local government to identify service utilization and provision challenges, and to mutually generate solutions, and work in partnership to implement and track the effectiveness of those solutions in an ongoing process of improvement[25].

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[24] Partnership Defined Quality (PDQ) Implementation in Afghanistan. Power point presentation [missing date]
[25] Please see wiki page for more information and additional documentation: http://governance.care2share.wikispaces.net/GPF

CARE's Governance Programming Framework Theory of Change is the high level 'theory of change' that guide and underpin CARE's governance work, including CARE's CSC work: If citizens (i.e. health service users) are empowered, if power holders (i.e. health providers and government) are effective, accountable and responsive, if spaces for negotiation are expanded, effective and inclusive, then sustainable and equitable development (i.e. improvement in health care coverage, quality and equity and improved health outcomes) can be achieved. Change needs to take place and be sustained in all three domains to achieve this impact.

The Community Score Card is part of the CARE process and is conducted at micro/local level and, focusing on the community as the unit of analysis, and generates information through focus group interactions and enables maximum participation of the local community. Figure 4 is an overview of the process. Appendix 1, Table 3 provides the key elements and activities of the process.

Figure 4: Community Score Card Process
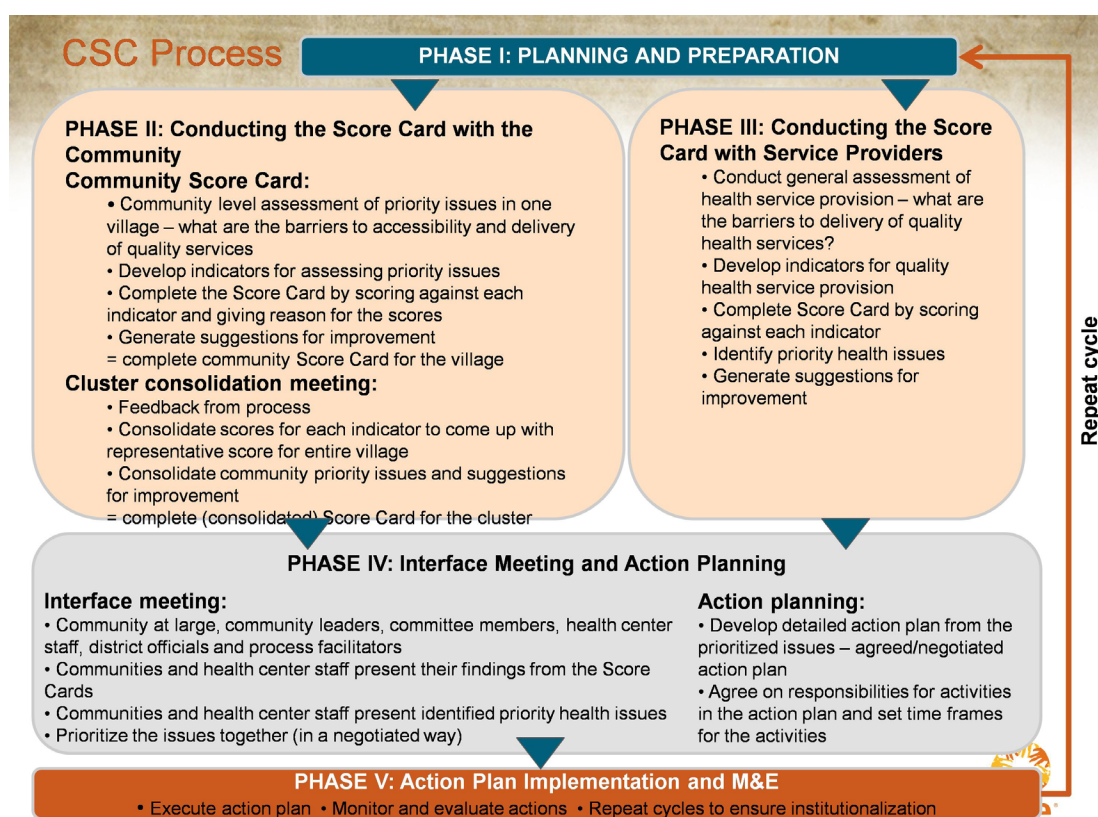
Where applied: The CSC process is used at the local level to address local-level barriers; the score card is implemented at the intersection between the community and health facility; however, in other sectors this can vary. Evidence from the CSC can be used to take uncovered issues to a higher level. District government are involved throughout the entire CSC process. They help with the preparation and planning, and really are the co-implementers. Higher levels of government are involved when service delivery bottlenecks stem from more systematic reasons, and where decentralization has not been fully rolled out. For example, respectful care from providers at the community level can be directly addressed through the execution of the CSC and the development of a joint action plan between the community and service providers, while issues such as

unreliable availability of supplies at the local level may be harder to solve at a local level.

Sectors the process has been applied: The approach has been implemented in areas including food security, education, health, HIV/AIDS, infrastructure, agriculture, water and sanitation, gender based violence and others. In addition, CARE uses the approach as an internal or forward accountability mechanism; prior to implementation in communities/districts, CARE receives feedback on their own accountability from communities. This can lead to governmental partners coming on board due to the fact that they see that it can actually improve programs and benefits.

Community Scorecard: Characteristics
• CARE's Governance Programming Framework reflects a theory of change, grounded in both the literature and practical experience in social accountability • Underlying principles for a rights based approach include Participation and inclusion of voice; Accountability and transparency; Equity; and Shared responsibility and obligation • Community Score Card (CSC) is also used as an internal or forward accountability mechanism to gain feedback on CARE's accountability from communities • CSC repeated measurement: continuous feedback loop for monitoring and evaluation every six months and institutionalization of process

Who should use it and who is involved: Participants in the CSC process is dependent on the focal issue and the improvements and/or changes anticipated, e.g. youth, reproductive health, maternal health, etc. Facilitators are a very important group in the process. CARE ensures effective CSC facilitation through the following elements: choosing facilitators (what are the characteristics a CSC facilitator should ideally possess); training facilitators (what should CSC facilitator training include? What training methods should be used? What CSC training materials currently exist?); and facilitation tips (What are helpful tips for ensuring strong facilitation through the different phases of the CSC process?)[26] There is still a debate regarding who can be included in facilitating the process to create a neutral process, whether or not the process should be facilitated by the government or other local partners. To ensure full representation and empowerment of marginalized and vulnerable groups, the community is divided into different focus groups to ensure wider participation and that their voice is heard.

How it increases social accountability: If citizens are empowered; if power holders are effective, accountable and responsive; if spaces for negotiation are expanded, effective and inclusive; then sustainable and equitable development can be achieved. The score card process is critical, everyone has a voice and participates. The CSC approach can be used to facilitate good governance through promotion of participation, transparency, accountability and informed decision-making[27].

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[26] Community Score Card Implementation Guidance Notes: Recommendations from CARE CSC Experts.
[27] For more information on case studies that discuss domain and dimensions of change that the CSC facilitates, please visit: http://governance.care2share.wikispaces.net/Social+Accountability

Financial and human resource considerations: This is dependent upon what unit the score card is done at, e.g. one facility in a catchment area, and what part of the process, e.g. preparation and planning or issue generation, will depend on how many staff members are needed to facilitate. The amount of time the different steps will take is dependent on the size of the facilitation team. The cost of a CSC cycle varies depending on the scale and the scope of the CSC project. The only cost is facilitating the process.

Monitoring and evaluation: The CSC is ultimately used to improve access, utilization, and quality of service delivery. The CSC process focuses on improved services as an outcome, and improved human development as an impact. CARE also ensures measurement of governance outcomes, including improved decision-making, transparency, and accountability[28]. The governance outcomes act as enablers for improved services[29].

The community score card is just one piece of data; community members and health providers create indicators that they work jointly to improve and track over time. Some of these indicators can focus on access, utilization and provision of services; often they are reviewed every six months for challenges and action items to be implemented Indicators at the community level are grouped into themes based on the lists generated through the score cards. These repeated cycles of the Score Card help institutionalize the practice.

In order to systematically measure changes, CARE has developed and tested measures for Sexual Reproductive and Maternal Health Government projects based on their Governance Programming Framework TOC. These measures can be used in the evaluation component of CSC projects- population based surveys of women and also health provider surveys (baseline and end line).

Challenges or barriers to implementation: From the community perspective, issues can include: whether or not community members think their participation would lead to change; the value of the process, the focal topic and relevance to their situation; self-efficacy to participate in the process; and fear of negative fallout. From the health provider perspective, issues can include: possible additional workload; fear of negative fallout; and possible lack of supervisory support after changes and actions are discussed. Among government/power holders, questions arise regarding whether the process is beneficial or damaging to them, the amount of time allotted to the process, as well as understanding the benefits of the process. NGOs and civil society may be weary of participating in this process based on perceptions that the process could lead to adversarial relationships with the government. In addition, CARE has found challenges in linking the process at the district/sub-national to the national level so that some of the higher level service

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[28] Final Community Score Card Guidance Notes. CARE. 2013
[29] For further information, please see: Towards Better Governance Monitoring and Evaluation of Governance Programmes: Guidance Note. October 2001. http://governance.care2share.wikispaces.net/file/view/Governance%20 ME%20Guidance%20Note%207%2010%2011.pdf/263533248/Governance%20ME%20Guidance%20Note%207%20 10%2011.pdf

issues are addressed, and to create responsibility at the national level. CARE is working in several countries to try and address some of these challenges. Because it is context specific and is requires flexible facilitation, it relies heavily on a very clear understanding of the context, and being able to adapt and change the process as necessary.

Examples of successes at different levels

Community ownership of CSC: In Malawi, CARE Malawi implemented the SMIHLE project (2004 – 2010), which focused on strengthening food security service delivery and mainstreaming HIV/AIDS and gender[30]. The CSC was presented in 2007 to improve communication between community members and CARE Malawi staff. As part of the SMIHLE exit strategy, 10 community members in Group Village Headman (GVH) Mwaphira were selected and trained to function on the Score Card Committee. Their role was to continue facilitation of the CSC process after the completion of SMIHLE. Two years after SMIHLE finished, the Score Card Committee in GVH Mwaphira led the community in the continued use of the CSC. It engaged numerous power holders with the CSC, including teachers, the School Committee, agriculture extension workers, health surveillance assistants, chiefs, district government officials, and NGOs. The community applied the CSC in non-traditional ways related to cultural and family behaviors. Results of this project are being submitted as a manuscript for publication to a peer reviewed journal.

Ongoing research: CARE is using a cluster-randomized control design to evaluate the effectiveness of the CSC in Malawi. Health centers (and surrounding catchment areas) are randomly assigned to treatment or comparison groups, with 10 intervention and 10 comparison clusters. The evaluation includes a women's survey, a health worker survey and a medical chart review at baseline, 2012, and end-line, 2015. The goal of the research is to identify widely applicable strategies, approaches and methodologies for systematically improving implementation of evidence-based reproductive, maternal and newborn health (RMNH) interventions using the Community Score Card. Research outcomes include: women's and communities' empowerment to participate in quality improvement efforts, and access and utilize RMNH services; health workers' empowerment and their responsiveness, effectiveness, and accountability to communities' needs; and RMNH coverage, quality and equity. CARE is also researching the sustainability of the CSC, as well as how context affects the effectiveness of CSC.

For additional case studies, please see Appendix 1.

Common themes across models

Several common themes emerged from the models, including themes pioneered by the World Bank. Organizations may use different terminology to refer to the same element, or some elements may not be clearly mentioned in a model's description, yet they are included implicitly in all of them. The text boxes highlight notable elements that may be more salient in certain organizations, but exist in an adapted manner among other organizations.

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[30] The Sustainability of the Community Score Card and its Effects in Dowa, Malawi. CARE Malawi.

Preparation and planning: As part of preparation and planning, context analysis or political economy analysis to understand potential challenges that may happen in the process, and development of processes that can mitigate potential conflict among partners and power dynamics. This includes understanding public policy, building networks and coalitions, identification of intervention areas, selection of facilitators, and securing cooperation of relevant service providers and/or government leaders and civil society. This is a critical step among all the models, leading to an enabling environment for the activities to take place.

<div style="background-color:teal; color:white; text-align:center; font-weight:bold;">

Established Presence for Entrée

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Established presence for entrée: World Vision's Area Development Program is their process of implementing long-term (15 years), local programming that contributes to the sustained well-being of the population. The approach supports local advocacy. World Vision incorporates CVA directly into the Area Development Programs where trust and alliances may already exist due to World Vision's presence. Save the Children also seeks to implement PDQ in communities where long term programming is established. This includes communities with child sponsorship funding, where Save the Children is typically in a community for 10-15 years. The reason this is effective is that the implementing NGO (in this case Save the Children) becomes a trusted partner for long term change. Save the Children has adapted PDQ for use with adolescents in many of its sponsorship communities worldwide. CARE incorporates the CSC into its projects and programs.

Involvement of marginalized populations and the poorest of the poor: World Vision considers CVA an extension of their regular programming, which involves marginalized groups. CARE and World Vision use their community score card models specifically with marginalized populations. Save the Children, based on prior experiences, has a goal to ensure that 33% of the participants are from marginalized groups. CARE uses focus groups to ensure involvement of marginalized and poorest of the poor.

Identification of barriers from civil society and governmental/public sector: Through a variety of quantitative and qualitative methods, including score cards and focus groups, bottlenecks and challenges are defined separately by government partners and civil society. World Vision and CARE use score cards to identify and rank these issues, while Save the Children explores community and health worker defined quality as defined by these groups through checklists, focus groups, and interviews.

Interface meetings between civil society and governmental/public sector: The government/public sector and civil society are brought together to compare perceptions from the problem identification phase. These issues are often disaggregated for marginalized groups. These meetings provide an opportunity for a facilitated discussion wherein participants can present their issues to the larger audience. Both groups work together to prioritize activities through various methods of action planning, defining of roles and responsibilities, and a shared vision for monitoring activities and follow up.

Phase V, Action Plan Implementation and M&E, CARE plans a repeat score card cycle ahead of time to institutionalize the practice, which takes time. For example, some changes may be more challenging such as relationships, which are not one-time engagements. The information collected needs to be used on a sustained basis, i.e., to be fed back into the service providers current decision-making processes as well as its M&E system.

Focus on accountability and health outcomes measurement: Indicators are developed and measured that focus on accountability such as collective capacity, collective action, community empowerment, budget changes, social cohesion, and social capital. Alongside social accountability indicators, sector specific indicators are developed and measured including access to and quality of health services, primary school enrollment, utilization of health services and promoted health behaviors.

Value of a Score Card in Measuring Services

CARE developed the community score card; World Vision adapted the score card in its CVA approach, and PDQ uses another method of scoring. A score card allows for both users of public services as well as providers of public services to use a simple method of assessing the performance of service delivery and offering proposals to improve the quality of service. The score card data is usually collected through focus group discussions among particular interest groups, e.g. women, men, youth, children, community leaders, PLWH/A, health center committee, etc. The score cards help develop a set of indicators for monitoring and evaluation, and can also serve as a baseline for service improvement. The scorecard can be used as a tool to generate issues to advocate for to help integrate some solutions into local policies and systems for sustainability of results. In addition, community member's health behaviors and actions can be evaluated.

Facilitation and guides: Skilled facilitators with negotiation skills is critical for these activities to succeed. Facilitators need to have respect for citizens, be trusted by the community, have knowledge of the local language and culture, as well as CSO and NGO context, must not foster a vertical relationship, and not be in a position of power or authority within the community. The facilitator must know how to encourage involvement and participation. Toolkits and field guides exist for partners in the field to adapt when implementing the activities; facilitators should be very familiar with the activities involved in each step.

Rigor of evaluation of interventions: All three organizations have undertaken a level of rigor in evaluating various outcomes of their respective interventions. World Vision, in partnership with Oxford University, is carrying out randomized control trials (RCTs) in Uganda focused on education outcomes and collective action, accountability in education, and an SMS accountability intervention. World Vision's approach aligns

Save the Children has been testing the use of community capacity indicators in several countries as a community's attributes are associated with its health and social outcomes. These community capacity indicators have been linked to the PDQ process. Examples of these indicators include: participation; social cohesion; sense of ownership; collective efficacy; resource mobilization; information equity; and critical thinking. A recently published peer reviewed article found support for incorporating community capacity building as a central component of health communication and health promotion practice . Carried out as part of a health communications project implemented by Save the Children in Zambia (2004-2009), the goal of the three-phase research study was to develop and validate community capacity indicators so that they could be applied to the evaluation of the project. The study is one of the first to measure and assess pathways through which community-based projects focused on capacity building can influence health outcomes.

closely with the randomized field experiment regarding community-based monitoring of public primary health care providers in Uganda by Björkman and Svensson, which showed a 33% reduction in child mortality[31]. Through CARE's Maternal Health Alliance Project, (MHAP), a cluster-randomized control design is underway (2012 – 2105) to evaluate the effectiveness of the CSC in Malawi. Save the Children carried out several operations research studies to determine if PDQ leads to quality improvement. An example is an experimental intervention-control study carried out in Nepal to assess the PDQ intervention in relation to improvements in quality of health services, improvements in utilization of health services, and what solutions are initiated by the community as a result of the process. PDQ sites showed a significant improvement relative to the control sites in the number of sick children presenting for care and the PDQ intervention was associated with an increase in utilization of health services by adults, with a decrease control sites, among other outcomes.

Other Initiatives from CORE Group Members

White Ribbon Alliance

The White Ribbon Alliance for Safe Mother-hood (WRA) is a network of advocates for maternal health focused on mobilizing people to demand sustainable change. The White Ribbon Alliance has thirteen affiliated networks, called National Alliances, mostly in Africa Asia. WRA has recognized and advocated that even though Governments have the plans and policies to prevent [maternal and child] deaths, proper implementation is needed[32], which includes a focus on government accountability. WRA uses a variety of tools to promote social accountability, including: participatory budgeting; social audits; participatory planning;

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[31] Björkman, M. and Svensson, J. Power to the People: Evidence from a Randomized Field Experiment on Community-Based Monitoring in Uganda.

[32] Quoted from Aparajita Gogoi, National Coordinator, White Ribbon Alliance for Safe Motherhood India

public expenditure tracking surveys; citizen report cards/community score cards; budget analysis; citizen-based vigilance committees; public hearings; checklists; and verbal autopsies[33].

Numerous WRA National Alliances have utilized social accountability approaches under several initiatives to increase accountability and improve health outcomes. The following is a description of the models and attributes of approaches utilized by WRA India and WRA Uganda.

Social Watch – India: WRA India is using a Social Watch approach to promote accountability for safe motherhood. Social watch is a 'people-centered' strategy that mobilizes civil society to hold governments accountable to their commitments[34]. Social watch techniques mobilize citizens and engage them to hold duty bearers accountable for transforming maternal and newborn health commitments and policies into improved access to quality services. WRA-India's social watch processes are aimed at generating demand, leveraging intermediaries, and sensitizing leaders and health providers to the demands of women, and thus offer a mechanism to overcome barriers to implementation.

The social watch campaigns primarily include three elements: 1) gathering information and evidences to develop and share tools to monitor the state of maternal health and progress on policy implementation; 2) spreading awareness, to make sure that civil society and community has essential information regarding the maternal health situation, a woman's right to high-quality healthcare, and government policies; and 3) speaking out, wherein citizen groups are given a chance to share their findings and their stories, and demand change from decision makers. Within these three elements, various social watch techniques are used: tracking policy implementation through use of checklists; verbal maternal death autopsies; national campaigns; community feedback through scorecard and public hearings. The public hearings present an opportunity for broad community mobilization and offer a rare occasion for women to assert their power through collective action. The checklists used at facility level study assists in identifying systemic gaps that hinder delivery of quality maternal health services. Verbal death autopsies are undertaken to understand in-depth the range of complications experienced by the women leading to maternal deaths and identify the gaps in access to and availability of services.

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[33] Social Accountability: People-centered approach to rights realization. Presentation by Betsy McCallon, Executive Director, White Ribbon Alliance. February 6, 2014

[34] Promoting Accountability for Safe Motherhood. The White Ribbon Alliance's Social Watch Approach. http://www.healthpolicyinitiative.com/Publications/Documents/1282_1_Social_Watch_WRA_HPI_FINAL_acc.pdf

In 2006, WRA/India developed health facility level checklists to monitor the facilities and measure the progress of MNCH policies against the set standards. The checklists were to be used by elected local government representatives and NGO representatives in the rapid assessment of the maternal health services and situations in local health facilities. Social watch studies were implemented using the checklist from 2006–20012 in a number of districts in many states. The checklists tracked implementation of key policies and programs including rural health, reproductive and child health, and access to high quality health care. In 2009, WRA-Orissa used the checklists as part of the "Deliver Now for Women and Children" campaign supported by the Partnership for Maternal, Newborn & Child Health to assess if WRAI's advocacy and mobilization efforts contributed to improved community awareness and if social watch efforts contributed to improvements in service delivery.

Of the 204 sub-centers and 102 primary health centers assessed under the Deliver Now campaign, results included: an increase in postnatal visits by auxiliary nurse midwives to new mothers and their babies from 15 to 25 percent; and a significant increase in community awareness of current MNCH policies and appropriate care were visible, according to the checklist results based on responses from community leaders and women. WRA India follows the strategy of collecting evidences for fact finding rather than fault finding.

A peer reviewed study showed that at a programmatic and systemic level, social accountability efforts within this approach are creating a positive impact on women, intermediaries, service providers and government leaders[35]. Social accountability initiatives, such as the public hearing, are offering new ways for women to jointly express their concerns and demands in a supportive manner. These efforts are helping service providers and government leaders gain a better comprehension of gaps in the system, which increases opportunities for improved service delivery. The study also found that subtle mindsets play a large role in the success or failure of social accountability.

Participatory Health facility assessment, Uganda: In 2013, WRA Uganda launched a campaign to hold the Government accountable to its commitment to provide basic emergency obstetric and newborn care (EmONC) at all health centres and comprehensive emergency obstetric and newborn care (CEmONC) at 50% of health centre IVs. As part of the campaign efforts, WRA- Uganda, in partnership with the Kabale, Lira and Mityana District Local Governments, organized participatory Health Facility Assessments using checklists to evaluate the provision of Emergency Obstetric and Newborn Care Provision (EmONC).This process allowed district officials, health care providers, community members and the media to jointly conduct the assessments and identify critical gaps in the provision of EmONC.

Equipped with this information the assessment teams have been able to address immediate concerns while also advocate for increased budget at the district and national level in order to fulfill the Government's commitment. Local and district official described the assessments as "eye-opening" and more comprehensive and useful than institutionalized processes. The participatory approach was also applauded for avoiding the blaming culture often associated with facility assessments. The assessment teams will continue to lead local advocacy in WRA's campaign and will re-evaluate the health facilities to monitor change in the provision of EmONC. As a follow-up WRA Uganda has developed a community score card and a District Health Team Score Card. Both will be used to ensure the citizen hold the local government, their local MPs accountable.

[35] Susan A. Papp , Aparajita Gogoi & Catherine Campbell (2012): Improving maternal health through social accountability: A case study from Orissa, India, Global Public Health: An International Journal for Research, Policy and Practice, DOI:10.1080/17441692.2012.748085

In addition, the citizens will be encouraged to play their part. We have also use citizen's voice in form of video and audio recordings to inform leaders about the poor state of EmONC services.

<table>
<tr><td>**Practical solutions recommended by WRA**</td></tr>
<tr><td>Ensuring upfront investment; accessible information made available to citizens (not just donors); direct feedback and communication loops; value placed on local data and evidence; and institutionalization of social accountability approaches into formal mechanisms.</td></tr>
</table>

Critical factors and challenges: WRA has found in their approaches that having civil society and/or an NGO role is critical. It does take resources to train, mobilize and follow up, and social accountability is an on-going process for continuous improvement, not a single standalone activity. WRA has found the enabling environment to be the biggest challenge in implementing models promoting social accountability. Currently, an internal working group within WRA is focused on gathering evidence for lessons learned in social accountability to apply within their programs, in collaboration with partners. Presently WRA does not have a specific toolkit or field guide used for implementation of these models.

GOAL

In 2012, GOAL Uganda started Accountability Can Transform Health (ACT Health), a governance (social accountability) program for the health sector on a pilot basis in Eastern Uganda. The approach is based on a theory of change which encompasses three elements contributing to increased accountability and responsiveness: changes within society (empowerment of individuals); changes within state (inclusive and responsive institutions); and changes at state and society interface (space for participation and collective voice). ACT Health focuses primarily on changes in the state-society interface by creating structured opportunities (space) for evidence-based interaction between community members and health service providers. ACT Health began with a survey of over 5,900 households to develop the citizen report card (CRC). One distinguishing characteristic of the CRC approach is the use of standard government (Ministry of Health indicators) as the basis for the household surveys[36]. The survey collected information from households rating medical staff attendance at government health centers, as well as actual medical staff attendance at government health centers on the day of the survey. Other questions on the CRC included: utilization patterns; how health centers pattern compare to other facilities, and district and national data; community's utilization of antenatal care, immunization and family planning services; and services in general (attendance community perception and day of the survey). Implementation teams (staff of partner organizations) facilitated CRC sharing in a series of meetings at the community level: 1) health

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[36] The term "citizen report card" is often commonly interchanged with "community scorecard." While the two are similar, the community scorecard approach focuses more on community-defined indicators of satisfaction.

worker dialogue, 2) community dialogue, and finally 3) an interface meeting between the two groups where action plans were developed based on the results of the CRC. Over 2,700 individuals were involved in the action planning. In addition to the baseline and endline (scheduled for July 2014) which do offer statistically significant quantitative data in intervention communities, ACT Health incorporates a robust qualitative monitoring technique: Most Significant Change (MSC). MSC stories help explain and describe why and how changes have occurred in the lives of participants over the course of the program. MSC can also highlight unexpected outcomes from program implementation; provide rich context for quantitative data; track outcomes noted in the ACT health theory of change that cannot be measured quantitatively; and facilitate community involvement in the tracking and documentation of changes in the targeted programmer areas.

Most Significant Change stories are collected in the following way: Stories are collected through interviews with a number of program participants including community members, community leaders, health workers, and village health team members, among others. The analysis of MSC stories categories each story into one of four domains: 1) changes in service quality (for example reduced waiting time, polite health workers); 2) changes in relationships between service providers and community members (for examples better communication between health facility staff and community) ; 3) changes in health outcomes (for example, HUMC members supervise the health facility, or an increase in the number of community members visiting the health facility); and 4) other changes.

Example of Most Significant Change Story
Name of storyteller: Kagoya Rebecca , May 2013

Improved client care for mothers!

"I raised the mother's concerns and they were captured in the action plan. This meeting allowed us present these issues directly to the health workers who were present. The midwives have since improved the way they handle mothers and stopped asking for money. This has increased the number of mothers delivering at the health centre. This story is significant to me because the number of mothers delivering at the centre has increased."

Scale-up: GOAL Uganda is scaling up the ACT Health program across Uganda in 16 districts, 367 health facilities, and in conjunction with a randomized control trial (RCT) to answer the following research questions:

• Does the ACT Health Program lead to greater access to services and an increase in health seeking behavior? Are the results sustained over time?

• Does the ACT Health Program contribute to downwards accountability among duty-bearers within the line ministry levels (from mezzo to micro) for health services?Future Generations

Future Generations

Future Generations provides technical support to a model of social accountability that has been incorporated into the government health system and is scaled up to one-third of all primary health care (PHC) facilities in Peru (2189 out of about 6500 health centers and smaller health posts). Future Generations operates in Peru with the following two hypotheses: 1) Effective improvement of PHC requires fundamental changes in management mechanisms (for financing, human resources management and community involvement); and 2) Political sustainability of more modern management mechanisms (for financing, human resources and community involvement) requires an effective operational model of PHC that links health services with communities to improve impact on health.

In 1994, Future Generations began working with a new government program called the "Shared Administration Program" which provided for the creation of CLAS (Local Health Administration Committees) as private non-profit civil associations that share legal responsibility for administering public funds for one or more primary health care facilities in collaboration with the government. The goals of CLAS under the Shared Administration Program are to administer public resources with transparency and accountability for more efficient and effective impact of primary health care services on the nation´s health with the participation of elected community members, thereby also building citizenship, agency, and empowerment.

Future Generations supported and strengthened the co-management of primary health care by developing and testing an operational model that articulates community involvement in financial and human resources management with: an operational model linking health services with communities; a modular training system that supports health promotion for behavior change – including counseling in health facilities by health personnel and in homes and communities by CHW; a model for orientation of community leadership to plan for and support maternal, neonatal and child health; and pathways for involvement of district municipalities in the financing and co-management of health promotion – leveraging municipal resources. In addition, Future Generations led and supported efforts for legal stability of CLAS in the context of health reform through development of a new law and regulations.

Prior to the Future Generations intervention, improvements in productivity and cost efficiency were already observed higher in CLAS-managed health facilities versus non-CLAS facilities[37].

Also, where both CLAS and non-CLAS health centers received the same training interventions, health personnel performance was better in CLAS-managed health facilities versus non-CLAS facilities in service areas including: family planning, prenatal visits, and prenatal care follow up[38]. As a result of the process implemented by Future Generations, significant improvements were shown in outcomes of key maternal and child health and hygiene practices in the home and reduction in chronic child malnutrition.

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[37] Altobelli, L. and A. Sovero (2004) Cost-Efficiency of CLAS. Lima: Future Generations. (Data from Integrated Insurance Program, 2002).
[38] USAID Quality of Care Project. Implemented by Chemonics International. 2013. Peru.

Seen through the lens of a Theory of Change: SEED-SCALE Methodology. The development of PHC Approach in Peru focuses on three "scales", described in the box below:

Development of PHC Approach with Social Accountability in Peru Applying the SEED-SCALE Methodology[39]

Scale One – Ideally functioning local system	Scale Squared – Use the Scale One system to teach others	Scale Cubed – Policy Environment
• Establish a SCALE-One Center: create a "Model CLAS" to demonstrate how CLAS helps to strengthen the quality of PHC with sustainable links to health promotion in communities • Develop the "Model CLAS" building on successful strategies from earlier pilot PHC programs during the previous decade in the country	• Use the "Model CLAS" as an Experimental Observation and Training Center to scale up the new model of enhanced PHC linked to communities with focus on health behavior change. • Continue to innovate • Develop other "Model CLAS" with local adaptations • Promote visits to Scale-Squared Centers	• SEED-SCALE concepts initially used to develop a national program for primary health care (PHC) with community involvement (Shared Administration with CLAS) • Strengthen SCALE-Cubed with a stronger legal instrument – a Law on CLAS • Disseminate strategies and results, advocate for policy continuation & improvements

Source: Altobelli, L. and Cabrejos, J. Future Generations Peru. Presented at CORE Group Global Health Practitioners Conference. Washington, DC. May, 2014.

Future Generations has noted several challenges in the policy environment, and as well has found ways to influence the policy environment. Some challenges include: confusion in decentralization laws; health sector financing issues; weak leadership in role clarification within levels of the Ministry of Health; opposition of interest groups to CLAS, such as the Medical Federation; and health promotion viewed as a non-priority. Several groups have been identified to work with, and initiatives have been developed, to influence the policy environment, including: involvement of government partners at every step of the project; creation of an interest group on CLAS; participation on several oversight and policy advocacy groups, including the National Health Council – Committee on Health Services; the Initiative Against Child Malnutrition; and the Roundtable to Articulate the Fight Against Poverty (quasi-government oversight entity). Future Generations was also the lead civil society organization working with the Peruvian Congress and MOH to achieve a new Law on CLAS and regulations to the law.

Recommendations

A variety of social accountability approaches are available and have been implemented globally. However, it may be challenging for international organizations or local partners to choose what would work best given their context. In addition, questions still remain unanswered regarding aspects of social accountability ap

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[39] Taylor, Daniel and Taylor, Carl E. (2002) Just and Lasting Change: When Communities Own Their Future. Baltimore: The Johns Hopkins University Press in collaboration with Future Generations
[40] Social Accountability E-Guide, World Bank: https://saeguide.worldbank.org/monitoring-and-evaluation-me

proaches in health and development. The following is a list of recommendations to address some of these issues based on discussions with key informants and a review of the documents.

Expand existing evidence base: There is a growing demand for practitioners to deliver empirical reporting of results[?]. While partners are continuously strengthening the rigor of their monitoring and evaluation of social accountability interventions, more evidence is needed regarding the effectiveness of different interventions at the community, district, regional, and national levels. RCTs and other experimental designs, where appropriate and feasible, should be explored to offer more rigorous outcomes. The World Bank also suggests third-party non-State monitoring to provide an independent perspective on project or government performance.

Clarify financial and human resource inputs: Partners indicate that costs can vary based on a variety of factors. It would be helpful if partners could formally cost out essential elements in programs for other practitioners and host countries interested in adapting or applying these social accountability interventions. These costs should include possible fluctuations, e.g. based on resources available and the scale of the program. These processes can take a considerable amount of time and commitment from partners and the government. A clear understanding of financial and time commitments for each phase of the process may foster greater partner buy-in. This would also assist communities and other organizations with respect to the types of inputs they may be accountable for during implementation.

Identify barriers to scale up: State actors are involved in each of these models, however, once action plans are implemented and evaluated, what further involvement should the government have to ensure more sustainable outcomes? What are the existing barriers beyond these models that impede scale up and further social accountability at a sub-national or national level? Can regional/national policies and or laws support changes at the district level or do existing policies impede change? How does the level of decentralization hinder or support scale up? An emphasis on identification of these barriers could help develop solutions for more effective scale up. This includes a better understanding of the influence of the larger social, economic, and when applicable, external donor relationships.

Consider critical factors in achieving successful outcomes: At all levels within the State, policies, laws, changes in standards of care, and financial commitments to health can have an influence on the feasibility of sustaining accountability and health outcomes as a result of these processes. Each country context differs in levels of decentralization, workforce capacity, socio-cultural aspects, among other factors. As Save the Children has found, a majority of barriers at the clinic level are societal and cultural in nature. As previously discussed, four critical factors for successful approaches in social accountability include the following: 1) citizen-state bridging mechanisms; 2) ability and willingness of citizens—and their representatives/civil society organizations (CSOs)—to engage in effective social accountability and demand government and service provider accountability; 3) ability and willingness of the state—politicians and bureaucrats—and service providers to be accountable and responsive to the public and civil society; 4) and presence of a broader enabling environment[?]. These must be considered in any social accountability intervention.

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[41] How To Notes: How, When and Why to Use Demand-Side Governance Approached in Projects, World Bank, 2011. [pdf]
[42] For more information, please see:
https://saeguide.worldbank.org/glossary-social-accountability-tools-and-approaches

Highlight the importance of community owned progress: Social accountability interventions based in the community may address specific issues in that community, but may not be generalizable on a larger scale; while building community capacity at the local level allows for community ownership, the data generated may not be significant at a national level. However, it is very important to those communities implementing the changes to identify their role in ongoing, measureable improvements in outcomes in order to continue their involvement and ownership of the process.

Develop similar definitions and a central location for well-known social accountability approaches in health and development: Organizations are implementing very similar activities: planning, gathering of stakeholders' perceptions on issues, joint meetings, and action planning and monitoring and evaluation of outcomes. However, there are various names and some distinct components for each of the processes among the organizations. It may be helpful to create a database of terms as the World Bank has done in their glossary of Social Accountability Tools and Approaches[?]. It may be beneficial to develop an information repository that contains such a glossary, as well as the evidence-based articles, theoretical and practical tools available among organizations for practitioners. For example, organizations including World Vision have crowd maps available where social accountability projects are being implemented; a map showing the levels of engagement among organizations, e.g. community, district, national, may be a useful resource in preventing the replication of activities, allowing for an opportunity to build synergy, and harnessing a repository of lessons learned.

Explore highlights among different models for promising practices: Each model reviewed by this analysis is comprised of unique elements that merit further exploration. To the extent possible, these elements should be analyzed further for their effectiveness and sustainability. For example, elements may include World Vision's ability to bring the CVA approach within area development programs, CARE's repeated score card process for institutionalization, and Save the Children's focus on tested indicators for community capacity.

Conclusion

Among the most fundamental problems, including in developing democracies, are the continued barriers to widespread participation and inclusion[?]. Social accountability interventions have proven to be critical to enabling meaningful participation among all citizens. The value of social accountability is that the government should be open to its citizens, that citizens have the right and with an enabling legal environment the power to hold their government responsible. Greater social accountability can allow for civil society to engage meaningfully in public affairs and contribute to the public good. Organizations including the World Bank and other international NGOs have contributed greatly to efforts to promote social accountability. This paper presents some of those efforts, highlights, challenges, and recommendations to expand and bring this approach to scale in the context of health and development.

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Appendix 1: Case studies

World Vision

Batnes is an Indonesian village just a few miles from the border of East Timor where citizens are using the "Citizen Voice and Action" approach to transform their local clinic. The services at the Oeolo clinic in Batnes have dramatically improved – so much so that the clinic won a prize for the best service in the province. Oeolo clinic is now in the running for national recognition.

"Now people understand their rights and can remind government of their responsibilities," says Yuliana, a CVA facilitator from Batnes.

Using the "Citizen Voice and Action" approach, citizens begin by learning about their basic human rights, like the right to health. But they also learn how these abstract rights are articulated under their own local law. For example, under Indonesian law, each village is entitled to have a midwife at their clinic.

Next, communities work with government to measure whether their clinic is complies with these government standards. Communities also have the opportunity to generate their own criteria for good health services, and compare reality against that ideal. Finally, with this evidence in hand, communities convene a collaborative, town-hall style meeting where citizens have the opportunity to engage their governments, identify problems, and design a plan of action to improve their health services.

The community in Batnes followed this process. They also reinvigorated a local planning process called "Musrenbang". In Indonesia, the Musrenbang is a forum designed to solicit community input for government planning. In Batnes, the Musrenbang existed, but had little effect, because citizens did not have an organised way to present their petitions and challenge government's shortcomings.

Using "Citizen Voice and Action" the people of Batnes leveraged the Musrenbang process to greatly improve the quality of health care in their village. Through CVA, community members discovered that, under local law, their clinic should have a midwife, a doctor, and village ambulance service for

Transparency - the Batnes community now records basic community health and service indicators in the waiting room of the clinic.

patients. But these staff and services were absent prior to the CVA exercise. Equipment (such as scales, office supplies, notice boards, height measuring tools, chairs, desks) was also absent. The Batnes "clinic" was

really no more than a couple of empty buildings. The community brought this evidence, and its impact upon them, to the attention of the government, using the Musrenbang forum.

A transformed clinic

Today, after advocacy by the community, the government has fulfilled its commitments. A new doctor and midwife now serve children and their families. The clinic equipment has been delivered, and the ambulance delivers patients to the clinic from far flung rural areas. And, in response to a grave problem underweight and undernourished children, Community Health Workers now provide advice to parents to help them use local products to improve the nutrition of mothers and children.

Thanks to improved services, the community reports just 2 under-nourished children, down from 25 just 2 years ago.

The impact on children

CVA facilitator Yuliana Opat has two children. Her oldest, Yova (now 7), was a baby, she needed regular treatment because of a rare infection. Because the clinic in Batnes was not functioning, Yuliana had to travel more than an hour from the nearest functional medical facilities, "We had to spend a lot of money just on accommodation and transportation," says Yuliana. Prompted by this experience, and equipped with the CVA tools, Yuliana's children can now count on local medical services just a short walk away. Yova says she wants to be a midwife when she grows up – perhaps inspired by the friendly staff at the Oeolo clinic.

Government supportive

When asked, local government officials attribute the changes in Batnes to the "action plan" that the community developed during the Citizen Voice and Action process.

CVA facilitator Yuliana Opat with her daughter, village head, Thomas Laka and his son in Batnes village

"Citizen Voice and Action has added value to our government system, especially health care," says Thomas Laka, head of the Oeolo clinic. "Community input provides a good control mechanism. Now, we have a better idea about what people need and where gaps exist".

Government officials and citizens may disagree on many things. But they are often united by a desire to see their children thrive. As in many other places where World Vision supports the Citizen Voice and Action approach, local government officials and community members often depend upon the same health services for the well-being of their children. In Batnes, the positive changes at Oeolo clinic benefit everyone.

Save the Children

Rigorous evaluation to measure PDQ's relationship to improved health quality: In Nepal, an experimental intervention-control study carried out focused whether or not PDQ leads to improved quality of Health services and improved utilization of health services as well as what community initiated solutions resulted from the process[1]. From October 1999 to March 2000, the PDQ approach was introduced and the QI team was formed and formalized (pre-intervention); from May 2000 to July 2001 the QI team implemented their action plans and activities for the PDQ initiative; and from October 2001 to March 2002 results were evaluated post-intervention. Intervention areas included 34 Village Development Councils (VDCs) composed of 4 Health posts and 30 lower level Sub-Health posts, and non-intervention areas included 28 VDCs composed of 3 Health posts and 28 lower level Sub-Health posts. To assess the changes in the utilization of the Health facilities, utilization data were collected in the intervention and non-intervention facilities. Among indicators measuring facility function in intervention and control areas highlights include: in intervention areas, the number of facilities where all health workers were present in the PDQ sites increased from 30% to 97% from pre to post intervention, while it remained unchanged in the control sites from 50% to 52% (p=0.056); in intervention areas, the number of facilities where biohazard waste was disposed of properly in the PDQ sites increased from 10% to 91% from pre to post intervention, while it declined in the control sites from 33% to 0% (p<0.005). Regarding health worker behavior, politeness and provision of clear information improved significantly in intervention areas ((p=0.018); (p=0.049) as compared to control sites from pre to post intervention.

> **Significant results (p < 0.005) include: PDQ sites showed a significant improvement relative to the control sites in the number of sick children presenting for care; the PDQ intervention was associated with an increase in utilization by adults, with a decrease control sites; improvements in visits by ongoing oral contraceptive (OC) users in PDQ facilities was greater than that in the control sites; and improvements in distribution of OCs in PDQ sites was greater than in the control sites.**

Community driven scale up: In Armenia, 5-year health initiative (2004 – 2009) focused on increasing the use of appropriate and safe Reproductive Health/Family Planning, Maternal and Child Health services and practices in rural areas of Armenia[2]. The PDQ model was adapted for Armenia: Community Partnership for Health (CPH) was based on building partnership among healthcare providers, community leaders and local authorities, involving and empowering communities in quality improvement. The pilot project (Prime II) from 2003-2004 covered one province with 20 rural communities and was very successful with substantial impact on the communities, leading to project expansion to the national level aiming to cover all 10 provinces of Armenia in five years. Key outcomes included: increase access to primary healthcare services in rural communities; 6-fold increase in utilization of primary healthcare services for antenatal and postpartum care; 2-fold increase in the quality of health services at Health Posts; increased knowledge among residents about key MCH practices and free services (48% vs. 30%); and partnerships

> **As a result of the project, 120 Health Action Groups were established and 120 Health Posts were rejuvenated. Almost 30,000 people were reached with key MCH messages, and the project built the capacity of 20 staff from 7 local NGOs.**

[1] Evaluating Partnership Defined Quality in Nepal: Save the Children. Power point presentation [missing date]
[2] Iren Sargsyan, MD, MPH: Innovative Approaches to Engage Communities in Quality Healthcare. PDQ Technical Advisory Group Meeting. Washington DC, May 27, 2008. Power Point Presentation

established between key stakeholders for sustained quality operations of Health Posts, including local government, community nurses, supervisory healthcare facility and community leaders.

PDQY and improvements among youth: In Kapilvastu, Nepal, where Save the Children works in 21 health centers, the progress of the QITs has led to increased strength of health facilities to serve adolescents. As part of the PDQ process, the QITs explored options for adolescent friendly space, renovated unused space in health facility to build an adolescent friendly counseling room, and established "Youth Corner" with information, education and communication materials on adolescent and sexual reproductive health (ASRH). The number of new adolescents empowered to visit and access health services at Health Service Delivery Points increased almost six fold from 4,193 in 2012 to 23,641 in 2013. Adolescents now identify their sexual and reproductive health needs, demand quality services, and conduct orientation classes for their peers. They also engage in community mobilization and street dramas to raise awareness on ASRH. Married Adolescent Groups are included as vulnerable group

member of the QITs. Because of their involvement in PDQY process, adolescents are able to identify their needs and demand quality services. Their voices are also being heard in QITs and the action plans are developed together with health providers trained in Adolescent Friendly Health Services. One adolescent said, "I was married three years ago. Initially, I used to feel shy in front of my friends and other older people and thus it was very difficult for me to go outside of home. I used to go to school with my brother. However, after being involved in Married adolescents group (MAG), I am feeling more comfortable now. I go to school with my friends."

CARE

Community resilience and stronger government collaboration: The HIV/AIDS epidemic in Ethiopia has placed considerable stress on both the state and traditional community based safety net mechanisms. In 2009, an estimated 1,162,216 adults and children were living with HIV and AIDS, with women disproportionately affected by infection (Federal Ministry of Health of Ethiopia). Infection rates were significantly higher in urban areas, where prevalence reached over 12 percent compared 2.6 percent in the rural areas; centres such as Addis Ababa experienced an infection rate of over 15 percent. In 2009, the number of orphans due to AIDS alone stood at 855,720. The Ethiopian Government regards HIV and AIDS as a key challenge to socio-economic development, and has worked to implement a multi-sectoral approach to the prevention and control of the disease (Ethiopian Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response of 2004-2008). The Getting Ahead project (GAP) was designed to support existing government strategies for HIV/AIDS control, focusing in particular on women, orphans and vulnerable children (OVC), in highly affected areas within Addis Ababa and Bahir Dar. GAP used a rights based approach; it employed

the use of social accountability mechanisms as a means of a) improving community members' awareness of their rights and responsibilities in relation to service providers, and b) building confidence for community members to approach service providers on non-delivery of entitlements, and c) creating mechanisms to allow for service improvement through dialogue with providers. CARE took a largely supportive role in the CSC implementation process, working in partnership with CBOs and local government to select CSC facilitators from within target communities themselves. Enabling factors included: a National decentralization policy which provided a promising legal framework to lower government levels on which GAP was able to build; and local government responsibilities, wherein as part of the decentralization process, Kebeles have been given responsibility for organizing and mobilizing communities around HIV and AIDS-related issues; local government actors proved highly supportive of the CSC process and its outcomes. Thus, in spite of common issues of limited local government capacity, GAP was nevertheless aligned with existing local governance trends relating to HIV and AIDS.

GAP ran from 2007 to 2010 with co-financing from the EU and CIUK. CARE Ethiopia was responsible for implementation, having signed an agreement with the HIV/AIDS Prevention and Control Secretariat office. CARE worked with local partners to manage the impact of HIV/AIDS on 132,000 women and OVC in twelve of the most vulnerable kebeles (districts) of Addis Ababa and Bahir Dar. In addition to promoting social accountability mechanisms, CARE provided training in areas such as business management, employment creation mechanisms and income generating activities; 62 percent of evaluation respondents cited this as the most effective support offered by GAP.

Strengthening the capacities of national and regional civil society networks: Peru has extremely high levels of inequality. Despite its status as a high-middle income country, approximately one in two people are still living in poverty. Underlying this duality is a series of inequities in access to basic services, particularly for indigenous women. Access to health care and high maternal mortality rates are a major concern. The main underlying causes of this situation are discrimination and inadequate or poorly implemented public policies, which fail to respond to marginalised citizen's needs. The Participatory Voices project recognises that sustainable change can happen only when poor and marginalised citizens are actively engaged in designing and shaping public policies. It was therefore conceived to strengthen the participation and advocacy capabilities of civil society networks in the oversight of health services at local level and district, and leveraging this learning to influence policy (re)formulation at national level.

Since 2008, CARE has trained citizen monitors (vigilantes) in Piura, Puno and Huancavelica to oversee the quality of healthcare provision in their local area. The vigilantes visit health centres and generally carry out around 2 visits per week, each of roughly 5 hours. They observe healthcare provision, discuss issues with female patients in their native language and produce regular reports of service quality. The most frequent problems vigilantes detected are: an incomplete number or no drugs delivered; mistreatment (disrespect); discrimination; under-the-table payments; and a lack of cultural appropriateness. In order to foster dialogue and negotiation between providers and users and to agree commitments to improve health services' quality, these reports are analysed monthly with the regional Ombudsman's office, CARE Peru and ForoSalud members. Mechanisms are then in place to monitor commitments.

In partnership with ForoSalud, CARE Peru has made efforts to influence decisions in district and national-level policy spaces. The project has developed the capacity of citizens to participate in the formulation of health-policy proposals, by bringing their voice to policy design and public debate via the construction of bottom-up approaches. More than 10 policy proposals have been presented in public dialogues in most of the country's 23 regions, and in diverse national and regional "invited spaces" in which ForoSalud has succeeded in including several proposals in regional health policies. CARE has used this as a basis for national-level advocacy and has been actively involved in these spaces in the capital.

The third main component of the project is to provide technical assistance to the Ministry of Health (MoH) to improve maternal and neo-natal health provision. CARE has worked with the Neonatal Health Collective to formulate strategic plans to reduce neo-natal and maternal mortality, for example in the Cuzco region, and also designed publications such as guides for pregnant women and new born children for health staff and on the integral care and nutrition for pregnant women and new born children for community health agents, adapted to different regional contexts.

Key lessons learned include:

Choose the right partners: CARE Peru recognized that to build its legitimacy at local level, it had to change its way of working. CARE identified like-minded actors and decided to ally with ForoSalud as they shared CARE´s rights-based approach to health and had a broad-based constituency at local levels. This partnership has been key for both citizen monitoring and advocacy on health rights.

Focus on HR: Some health personnel did not recognize any problems in terms of mistreatment, disrespect, discrimination, lack of privacy, lack of respect for indigenous culture. They mentioned only the lack of medicines as a problem, one that was out of their hands, and they do "as best they can," given the circumstances. This calls for earlier interventions to improve the training of medical staff and in generating performance-related incentives for staff to improve the quality of treatment for patients.

Dialogue, not naming and shaming: Key to the success of citizen monitoring in Puno was creating spaces for dialogue with health providers, ensuring that both positive and negative aspects were highlighted in meetings and discussing options openly with providers rather than attacking them.

Following up commitments: Given the lack of authority within the health ministry to impose sanctions, commitments made in the audiencias are difficult to follow up on. There needs to be a clearer and more systematic follow up of commitments made. And in the case of under-the-table payments, for example, the Ombudsmen has asked to be informed so that it can follow up on cases in health facilities.

Appendix 2: Key elements and activities among the social accountability models

Table 1: World Vision Citizen Voice and Action Model

Elements	Activities
Phase 1: Enabling citizen engagement	
Understanding public policy	Learn about public policies; decide which policy to focus on; understanding policy in detail; Raise awareness of working group/ facilitation team in public policy identify government standards in relation to local service delivery; build networks and coalitions
Prepare local materials and resources	Deciding on local materials and resources needed; translate key terms and phrases from the general Guidance Notes; encourage local participation and ownership of development
Citizen education and mobilization	Conduct assessment of the situation; plan and initiate citizen education; plan and initiate citizen mobilization
Build networks and coalitions	Identify other agencies or organizations doing similar work; identify complementary processes or systems that are in line with CVA; identify groups or organizations that may take the lead in facilitating CVA, especially the Community Gathering
Establish relationships and connections	Meetings with service providers, relationships formed; meetings with other key stakeholders including local government officials and district sector staff, relationships formed; interest expressed and commitments made to participate in the Community; gathering by both government and community
Phase 2: Engagement via Community gathering	
Initial meeting	Introductions, purpose, explanation of processes
Monitoring standards	Comparing government standards with reality, lots of flip charts
Community scorecard	
Interface meeting	Opinion of service users and service providers about the services they are providing via focus groups, disaggregated for marginalized groups, smiley scale for rating, voting, facilitated by a minimum of three people
Action planning – SMART objectives	Participants from monitoring Standards and Score Cards sessions brought together in a meeting to present outcomes of sessions, discuss and build together an action plan to improve the delivery of the public service
	Transfer of agreed proposals to action planning sheet with: action to be taken; expected results; who is responsible; who will monitor; timeline
Phase 3: Improving services and influencing policy	
Doing action plan	Strategy to achieve the action plan decided; mobilize stakeholders; carry out plans; monitoring and support
Building networks and coalitions	Identify potential organizations, agencies or groups to build networks or coalitions to support achievement of action plans; build actions together
Advocate and influence	Identify duty bearers and power holders; build plan of action to advocate and influence; carry out

Table 2: Save the Children's Partnership Defined Quality (PDQ) Model

Elements	Activities
Phase 1: Building Support	
Determine Who to Contact	Uses map from design phase, list of key people to be involved
Decide How Best to Present PDQ	
Present PDQ to Potential Partners	Provide an overview of what can be achieved by the process
	Explain why it is beneficial, why they should be willing to participate
Phase 2: Exploring Quality	
Health Worker Defined Quality	Reflection, role playing, small/large group discussions, identifying current standards, problem identification for quality, rights and responsibilities for quality
Community Defined Quality	
Preparation for Bridging the Gap	Facilitated group discussion, role play, market scenario, overview of PDQ to community
	Categorize information, integrate for presentation, analyze the gaps confirm findings, bridging the gap
Phase 3: Bridging the Gap	
Team Building	Tour of community/health facility
Developing a Shared Vision	Venn diagram with illustration of discussions
Problem Identification	
Select QI Teams	Small group identification of quality elements and any associated problems through exploratory dialogue with community members and health workers
	Discuss who will be on the team, where and when they will meet should be discussed among the participants
Phase 4: Working in Partnership	
The QI Action Cycle	Drawing of QI action cycle diagram
Tools for Problem Analysis	Fishbone, tree analysis to identify root causes of problems
Solutions and Strategies	
	Development of action plan with Problem, contributing factors, Solutions, Action, Who is Responsible, Resources/materials needed and when, status
Reviewing Progress	
Tools for Self-Management	
	Creation of tracking table including problem, what should be (quality standard), proof of change (indicator), how it will be measured, how good is good enough (benchmark)

Table 3: CARE's Community Score Card Model

Elements	Activities
Phase 1: Planning and Preparation	
Carried out by the CSC practitioners in coordination with key stakeholders	Uses a social map to ensure inclusion of all groups in community
	Identify sectoral scope and intended geographic coverage of exercise, identify facility/service input entitlements for chosen sector, identify and train of lead facilitators, make introductory visits to local leaders to inform them of plans
	Involve other community partners, contact and secure cooperation of the relevant service providers, identify relevant inputs to be tracked, identify main user groups in the communities serviced by the focal facility or service, develop work plan, create list of necessary materials (i.e., flipchart, markers, notebooks to record the process, pens) for process, and develop budget for the full Score Card exercise
Phase 2: Conducting the Score Card with the Community	
Organizing the community gathering Developing an Input Tracking Matrix Developing the community's Score Card Preparing for joint dialogue	Community level assessment of priority issues in one village for CSC: what are the barriers to delivery of quality services
	Develop indicators for assessing priority issues
	Complete the Score Card by scoring against each indicator and giving reason for the scores generate suggestions for improvement = complete (consolidated) Score Card for the village
	Cluster consolidation meeting: Feedback from process; consolidate scores for each indicator to come up with representative score for entire village
	Consolidate community priority issues and suggestions for improvement = complete (consolidated) Score Card for the cluster
Phase 3: Conducting the Score Card	
Starting the service provider Score Card Developing the service provider Score Card	Conduct general assessment of health service provision (barriers to delivery of quality health services); develop indicators for quality health service provision
	Complete Score Card by scoring against each indicator; identify priority health issues; generate suggestions for improvement
Phase 4: Interface Meeting and Action Planning	
Conduct joint interface meeting	Community at large, community leaders, committee members, health center staff, district officials and process facilitators
	Communities and health center staff present their findings from the Score Cards; Communities and health center staff present identified priority health issues; Prioritize the issues together (in a negotiated way)
Joint action planning	Develop detailed action plan from the prioritized issues – agreed/negotiated action plan; Agree on responsibilities for activities in the action plan and set time frames for the activities (appropriate people take appropriate responsibility – community members, community leaders, health center staff, government staff and community committees and process facilitators
Phase 5: Action Plan Implementation and Monitoring and Evaluation (M&E)	
Execute action plan	Compile report on Score Card process including the joint action plan.
Monitor and evaluate actions	Use outcomes and action plan to inform and influence any current plans concerning delivery of concerned service
	Monitor the action plan implementation
	Plan a repeat Score Card cycle ahead of time and inform both service providers and communities

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