Scaling social accountability for health: Leveraging public policies & programmes

11/05/2021

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The puzzle

UPTAKE **EFFECTS**

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> WHAT WORKS FOR SOCIAL ACCOUNTABILITY? FINDINGS FROM DF

What works for Social Accountability? Findings from DFID's Macro Evaluation

Jeremy Holland | Publisher: Itad and DFID | 2017 | Brief

A wide-ranging evaluation of the UK Department for International Development's (DFID) support to social accountability initiatives has found that service delivery is improved when local citizens are informed and learn about their rights and entitlements and have the opportunity to engage in dialogue with service providers. This briefing summarises the main findings from the evaluation which looks at what works best and highlights key lessons learned.

DFID supports social accountability across many countries and contexts. Social accountability processes are supported either as standalone projects or as components of broader sector or governance reform projects. In 2016, DFID commissioned a macro evaluation of its social accountability portfolio looking at evidence across 50 different projects. This evaluation tested a number of hypotheses and generated key findings about what works in social accountability, for whom and in what contexts. The evaluation was designed primarily to inform policy and practice within DFID and secondarily to contribute to the debate on social accountability with other development actors.

3ie International Initiative for Impact Evaluation

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Participation, inclusion, transparency and accountability (PITA) to improve public services in low- and middle-income countries: a systematic review

Systematic review

Author: Hugh Waddington, Jennifer Stevenson, Ada Sonnenfeld, Marie Gaarder
Region: All Low and Middle Income Countries
Sector: Public Sector Management
Equity Focus: Differently-abled, Elderly, Ethnic Minorities, Gender, Indigenous Groups, Orphans and Vulnerable Children, Poverty, Refugees, Sexual minorities, Vulnerable groups
Review Type: Effectiveness review
Status: Review

Tools

Link to source

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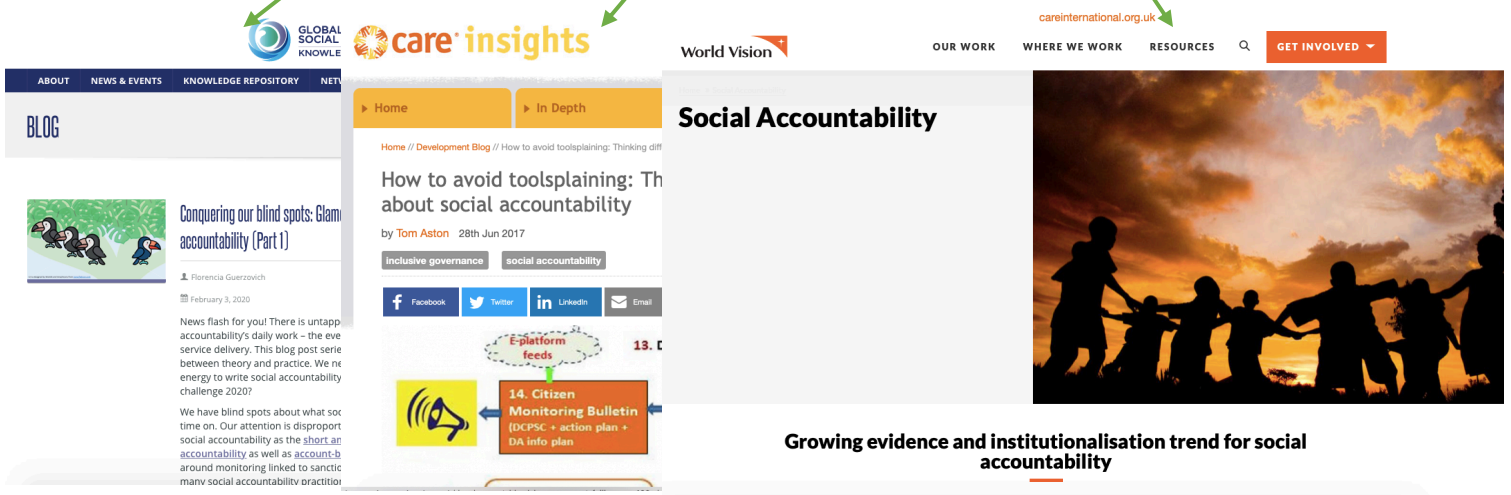
Generating transferable knowledge on scaling up

- What do we know about what works in social accountability?
- What do we know about scaling up?

Learning, evaluation, practice, research



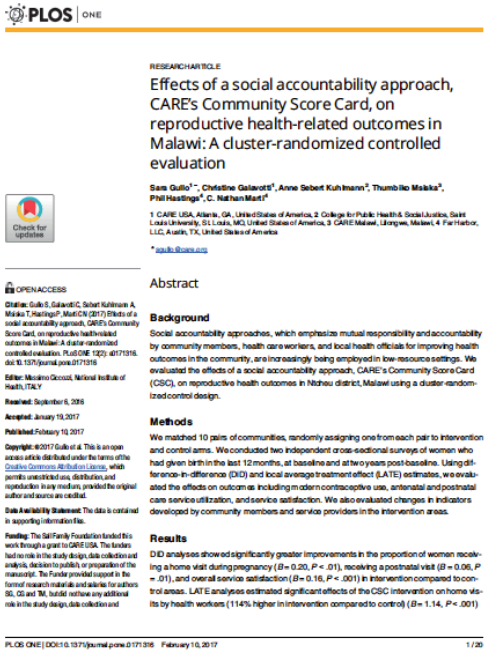
*Two pager insert here

Rocha Menocal and Sharma, 2008; Gaventa and Barrett, 2010; McNeil and Malena, 2010; Hanna *et al.* 2011; McGee and Gaventa, 2011; Fox, 2014; e-Pact, 2016; Molina *et al.* 2017; Waddington *et al.* 2019; Tsai *et al.*2019; Kosec and Wantchekon, 2020

Best practice in Malawi

- Strong **correlation between rigorous evaluation** (i.e. evidence) and **scaling** (Kremer *et al.* 2019: 3)
- Innovations **including "development economics researchers**…six times *more likely* to scale than those that did not."

CARE RCT on scorecards in **10 facilities** in Ntcheu district **shows positive results**



PLOS ONE

RESEARCH ARTICLE

Effects of a social accountability approach, CARE's Community Score Card, on reproductive health-related outcomes in Malawi: A cluster-randomized controlled evaluation

Sara Gullo[1]*, Christine Galavotti[1], Anne Sebert Kuhlmann[2], Thumbiko Msiska[3], Phil Hastings[4], C. Nathan Marti[4]

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OPEN ACCESS

Abstract

Background

Social accountability approaches, which emphasize mutual responsibility and accountability by community members, health care workers, and local health officials for improving health outcomes in the community, are increasingly being employed in low-resource settings. We evaluated the effects of a social accountability approach, CARE's Community Score Card (CSC), on reproductive health outcomes in Ntcheu district, Malawi using a cluster-randomized control design.

Methods

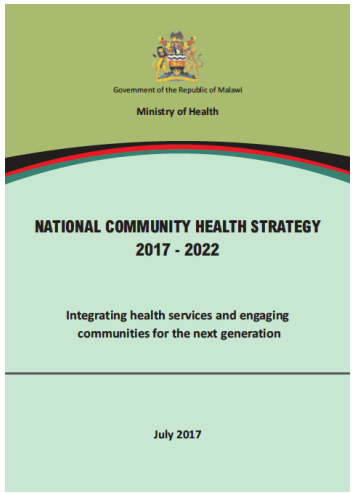
We matched 10 pairs of communities, randomly assigning one from each pair to intervention and control arms. We conducted two independent cross-sectional surveys of women who had given birth in the last 12 months, at baseline and at two years post-baseline. Using difference-in-difference (DID) and local average treatment effect (LATE) estimates, we evaluated the effects on outcomes including modern contraceptive use, antenatal and postnatal care service utilization, and service satisfaction. We also evaluated changes in indicators developed by community members and service providers in the intervention areas.

Results

DID analyses showed significantly greater improvements in the proportion of women receiving a home visit during pregnancy ($B = 0.20$, $P < .01$), receiving a postnatal visit ($B = 0.06$, $P = .01$), and overall service satisfaction ($B = 0.16$, $P < .001$) in intervention compared to control areas. LATE analyses estimated significant effects of the CSC intervention on home visits by health workers (114% higher in intervention compared to control) ($B = 1.14$, $P < .001$)

PLOS ONE | DOI:10.1371/journal.pone.0171316 February 10, 2017 1 / 20

National "**rolling out enhanced social accountability** mechanisms at community level (e.g., scorecards)."



Government of the Republic of Malawi

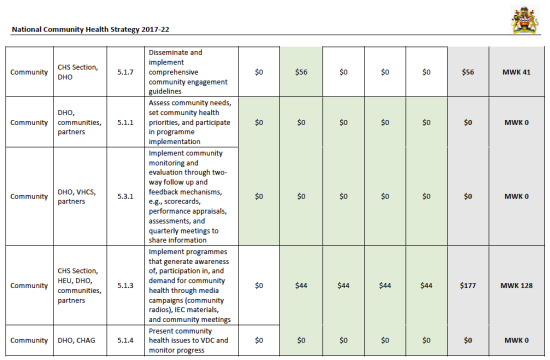
Ministry of Health

NATIONAL COMMUNITY HEALTH STRATEGY 2017 - 2022

Integrating health services and engaging communities for the next generation

July 2017

Government **allocates $0 to community monitoring**



National Community Health Strategy 2017-22

Community	CHS Section, DHO	5.1.7	Disseminate and implement comprehensive community engagement guidelines	$0	$56	$0	$0	$0	$56	MWK 41
Community	DHO, communities, partners	5.1.1	Assess community needs, set community health priorities, and participate in programme implementation	$0	$0	$0	$0	$0	$0	MWK 0
Community	DHO, VHCS, partners	5.3.1	Implement community monitoring and evaluation through two-way follow up and feedback mechanisms, e.g., scorecards, performance appraisals, assessments, and quarterly meetings to share information	$0	$0	$0	$0	$0	$0	MWK 0
Community	CHS Section, HEU, DHO, communities, partners	5.1.3	Implement programmes that generate awareness of, participation in, and demand for community health through media campaigns (community radios), IEC materials, and community meetings	$0	$44	$44	$44	$44	$177	MWK 128
Community	DHO, CHAG	5.1.4	Present community health issues to VDC and monitor progress	$0	$0	$0	$0	$0	$0	MWK 0

2019: Sub-national scale in 5 facilities in Ntcheu district only

The model by the numbers

- **4.5** years (from November 2016 – February 2020)
- **5** health facilities
- **7** rounds of the CSC process
- **7** community generated indicators
- **77,000** community members reached, of which **37,000** were women of reproductive age
- **40,000** new family planning users
- Engaged **42** CSOs, **8** departments and ministries to respond to CSC identified issues and needs

Resistance in Uganda

Leveraging adversarial "countervailing power" from civil society through multi-pronged campaigns (sometimes supported by govt. insiders) puts **pressure** on govt. (e.g. through "naming and shaming") to scale up (Gaventa and McGee, 2010; Fox, 2016; Joshi, 2017)

Gaps documented included a staff shortfall. Sub-county *baraza* insisted to fill vacant positions.

Journal of Human Development and Capabilities, 2017
https://doi.org/10.1080/19452829.2017.1411894

Leveraging Communities' Capabilities to Increase Accountability for Health Rights: The Case of Citizen Voice and Action

DAVID WALKER

District's Chairman: "*We took up the issue [of staffing] at the District and resolved to ensure we get medical workers, especially midwives, and we wrote to the Ministry of Health and Public Service*." **Staffing increased**

Window of opportunity > strategy pivot. **Human Resources for Health (HRH) campaign** (cord. by White Ribbon Alliance & World Vision)

IBP INTERNATIONAL BUDGET PARTNERSHIP Open Budgets. Transform Lives.

UGANDA: WINNING HUMAN RESOURCES FOR HEALTH

Case study (Full) | Jillian Larsen | December 2015

Citizens' SMS to parliamentarians "***We are watching you:*** *Refuse to pass the budget unless it includes the increase you promised.*"

Govt. **allocates additional UGX 18 billion, incl. UGX 900 million to retain and recruit** an additional 1,020 health workers (promised UGX 49.5 billion & 6,172 staff)

Section 3: Health Sector

Outcome 1: Increased deliveries in health facilities			
Vote, Vote Function Key Output	2012/13 Approved Budget and Planned outputs	2012/13 Spending and Outputs Achieved by End Dec	2013/14 Proposed Budget and Planned Outputs
Vote Function:0852 Human Resource Management for Health			
Output: 085201	**Health Workers Recruitment services**		
Description of Outputs:	1020 Health Workers recruited.	Arising from the 26th March 2012 advert, the HSC recommended 6 Health Managers to H.E the President for appointment and appointed into Health Service 172 Health Workers. Handled 168 other Human Resource for Health cases which mostly included confirmation	800 Health Workers recruited. All regular submissions processed within one month of reciept. Selection Exams Division and E-recruitment System rolled out.
Performance Indicators:			
No. of appointments made	1020	172	800
Output Cost (UShs bn):	*0.900*	*0.198*	*0.479*

"**Pyrrhic victory** because [CSOs'] role, and the role of MPs in terms of budget oversight and advocacy, had declined as a result of changes carried out by the executive immediately following the campaign's budget victory."

Staff **absenteeism campaigns** required

February 2021
Number 8

Accountability Working Paper

Bottom-up Accountability in Uganda: Learning from People-centered, Multi-level Health Advocacy Campaigns

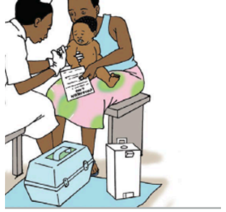
Angela Bailey
Vincent Mujune

with a Preface by Prima Kazoora

Annex 6. Summary of 18 campaign statements and rating of government responsiveness (as of June 2019)

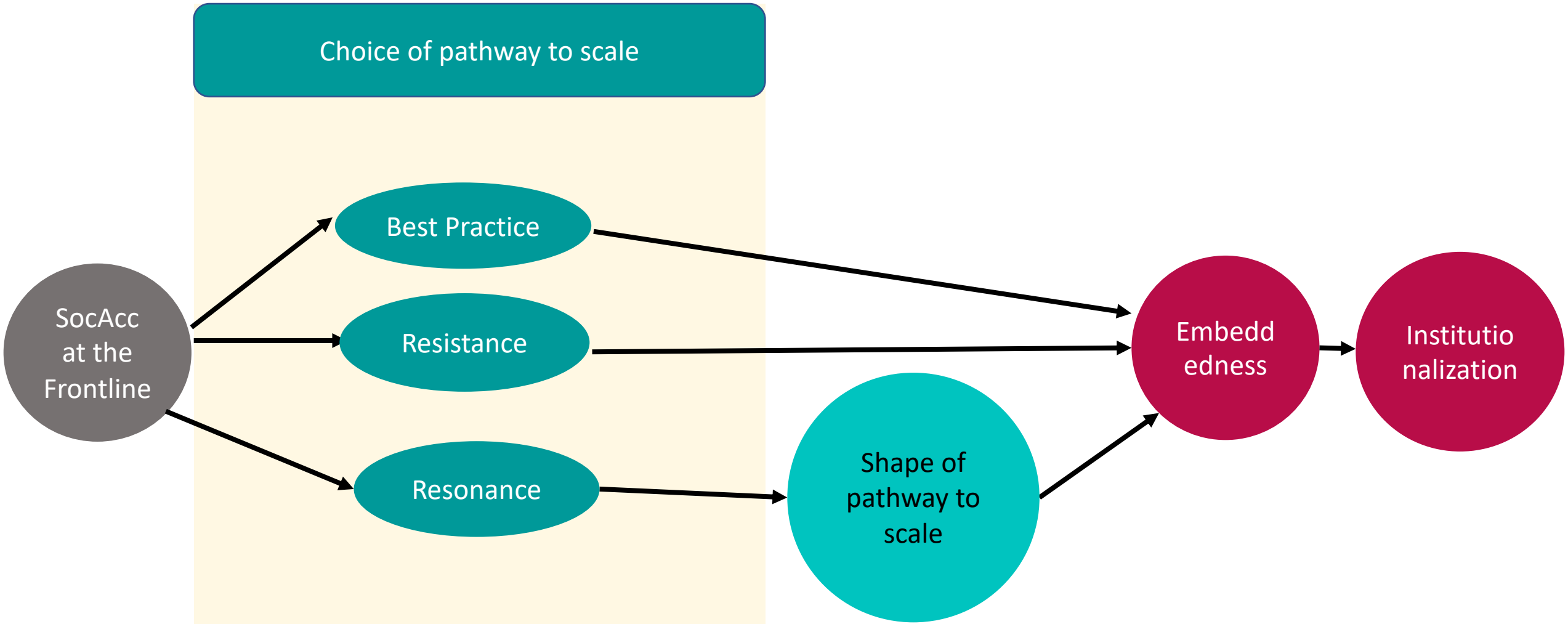
#	District	Issue	Campaign Statements as Written by Community Advocates	Rating
1	Agago	Staffing	Patients visiting HCIIs and HCIIIs in Agago District are not fully attended to or miss treatment because many of the assigned health workers have either left, died, retired, or were posted but never reported, and have not been replaced.	PURPLE
2	Mubende	Absenteeism	People in Mubende District do not access health services because health workers are consistently absent from work or do not work the prescribed working hours.	YELLOW
3	Omoro*	Absenteeism	Health worker absenteeism and tardiness.	GREEN
4	Tororo	Absenteeism	Patients from Mwello, Were, Maundo, Makawari, Morikiswa HCII, do not fully access health services because health workers do not work the prescribed working hours (8:30am—5:00pm).	GREEN
5	Apac	Absenteeism	Patients in Apac District do not receive services at government health centers because staffs come late for work.	YELLOW
6	Bukedea	Absenteeism	Lack of adequate houses in HCIIs of Kidongole, Malera and Kachumbala sub counties in Bukedea District has led to late-coming, absenteeism and neglect of duty by the health center staff resulting to long waiting time, complications and death of some patients.	PURPLE
7	Bundibugyo	Absenteeism	Patients spend a lot of time at in the health center of Ntandi, Bubukwanga, Buhanda, Bukangama and Bupomboli waiting for treatment because medical workers report late for duty and leave early before the time the government recommends.	GREEN
8	Gulu	Absenteeism	Many patients are not getting treatment because health center staffs are coming late and leaving early from duty.	YELLOW
9	Kabarole	Absenteeism	Patients spending a lot of time at the health center waiting for treatment because medical workers report late for duty, leave early before the time the government recommends, and most times they are absent from duty.	PURPLE
10	Kagadi (Kibaale)	Absenteeism	Absenteeism and late-coming of staff that has caused overcrowding and long waiting time of patients at the health centre hence some going home without treatment.	YELLOW
11	Kakumiro (Kibaale)	Absenteeism	Patients wait for long; others go back without receiving treatment because health workers report late at the HC and many others don't even report for work.	YELLOW
12	Katakwi	Environmental Degradation	Environmental degradation due to lax enforcement of district laws.	YELLOW
13	Kitgum	Staffing	Patients wait for long hours at the facility to get medical treatment because the health workers report late for work and depart early from work, others absent and or abscond them-selves from work without approved permission.	RED
14	Lamwo	Absenteeism	Patients in Lamwo District are not getting treatment effectively as required because medical staff start work late and close early, others absent themselves from duty, and other facilities have the name of staff in the staff register but the staff have never been seen at the facility, therefore the number of medical staff to attend to patients in those health facilities are not always enough. the staff have never been seen at the facility, case of Ogako Health Centre II where there is a name Owot.	YELLOW
15	Lira	Absenteeism	Patients from Barapwo HC III, Anyangatir HC III, Barr HC III, Ongica HC III, Akangi HC III and Aromo HC III in Lira District waited for long hours to get treatment and some miss treatment because 85% of HC staffs arrive late and leave duty early on average at 10:34am and depart at 4:23pm so we lose 3hrs 21mins.	YELLOW
16	Manafwa / Namisindwa	Lighting/ Infrastructure	In the six health centers of Nabitsikhi, Bunambale, Butiru, Bukhabusi, Bubutu and Bukewa HCIIs, there is no lighting because the installed solar panels are not functional.	GREEN
17	Nakaseke	Absenteeism	Patients wait long hours and some miss treatment because health workers absent themselves from duty during working hours.	RED
18	Pader	Absenteeism	Late-coming, leaving work before time and absenteeism by health workers is responsible for patients going without treatment and overcrowding of patients at the health centers in Pader District.	GREEN

Source: GOAL Heat Map



Accountability Research Center

Alternative pathways to scale

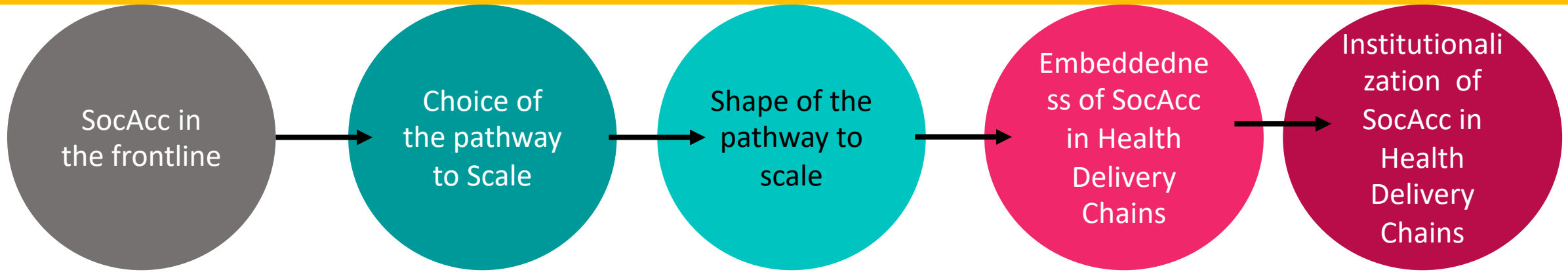


Key challenges of each pathway

<table>
<tr><td rowspan="3">Perceived opposition</td><td>High</td><td colspan="2">Resistance</td><td></td></tr>
<tr><td>Medium</td><td></td><td></td><td rowspan="2">Resonance</td></tr>
<tr><td>Low</td><td>Best practice</td><td></td></tr>
<tr><td></td><td></td><td>Low</td><td>Medium</td><td>High</td></tr>
<tr><td></td><td></td><td colspan="3">Role of social learning</td></tr>
</table>

Additional slide for discussion

What we know?



Most evidence is focused at the frontline.

There is relatively high **consistency in empirical findings.**

There is a **gap** between collaborative aspects of interventions prioritized by practitioners and researchers.

Currently, **zero-sum battle between 2 dominant pathways.**

These are **presented as universally applicable**, despite lack of evidence.

Alternative paths are not entertained by current theories.

Tacit knowledge and some initial **probing of the assumptions in a handful of evaluations.**

Dominant theories of change tend to focus on binary outcomes **wholesale adoption vs. failure.**

Evidence focused narrowly on civil society models and whether these are included in full.

Blindspot on government's own efforts.

Most evaluations' **time horizons are short**: assumes **conjunctural processes** and/or **long durée** are at play.

Research on participatory processes, combining theory building, process tracing, and comparative method has made inroads to specify time in the middle.