Supporting integration of social accountability processes in family planning and contraceptive service provision

A resource for policy-makers and programme managers
Supporting integration of social accountability processes in family planning and contraceptive service provision: a resource for policy-makers and programme managers

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The development of this resource to support Policy makers and programme managers in integrating Social Accountability (SA) in family planning and contraceptive service provision went through several steps. After doing a needs assessment, approval to develop was obtained and a WHO working group and contributor group were established. Considerations to be included in the resource were identified by the groups and an assessment and gap analysis on the scope of evidence synthesis were agreed on. The evidence was drawn from several sources. Foremost was primary data on feasibility and effectiveness of integrating SA that already been collected as part of the Community and Provides Social Accountability Intervention (CaPSAI) project, which includes both quantitative and qualitative data. In addition, data was
drawn from existing reviews on crucial topics that were available. In cases where the evidence has not been synthesized, (such as the health system responsiveness) a review was undertaken. The drafting of the chapters was done by four writers, Victoria Boydell, Joanna Cordero, Mary Nyikuri and Petrus Steyn. An evidence synthesis on health system responsiveness was carried out by Masuma Mamdani and Renu Khanna. The document went through multiple rounds of review by contributors and working group members. Two public consultation meetings were done online addressing technical content and assessing clarity, usability, and pertinence. The final version was validated by selected contributors and external reviewers before WHO approvals.

ABBREVIATIONS

CaPSAI  Community and Provider driven Social Accountability Intervention
CSC  community score card
CSO  civil society organization
DMEL  design, monitoring, evaluation and learning
FGD  focus group discussion
FP  family planning
FP/C  family planning/contraceptive
HRP  Human Reproduction Programme
ICA  institutional and context analysis
IPCHS  Integrated People-Centred Health Services
KII  key informant interview
LMICs  low- and middle-income countries
M&E  monitoring and evaluation
OHCHR  Office of the United Nations High Commissioner for Human Rights
PET  public expenditure tracking
RMNCAH  reproductive, maternal, newborn, child and adolescent health
SA  social accountability
SRH  sexual and reproductive health
SRHR  sexual and reproductive health and rights
TFESSD  Trust Fund for Environmentally and Socially Sustainable Development
ToC  theory of change
UHC  Universal health coverage
UNDP  United Nations Development Programme
UNFPA  United Nations Population Fund
USAID  United States Agency for International Development
WHA  World Health Assembly
SECTION 1.
Background and key principles
CHAPTER 1

Introduction

Evidence has shown that when “communities, particularly people that are directly affected, have the opportunity to be meaningfully engaged in all aspects of contraceptive programme and policy design, implementation and monitoring” (WHO, 2014), programmes are more responsive to their perspectives and needs. Furthermore, public engagement through social accountability (SA) mechanisms and processes is crucial to advancing human rights related to sexual and reproductive health.

Governments have recognized participation by community members as a prerequisite for the right to the highest attainable standard of health. The WHO Constitution emphasizes that “informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people”. In the Declaration of Alma-Ata, the Ottawa Charter for Health Promotion, and many other important international consensus documents in global health, WHO Member States have formally endorsed this commitment. The equal right to participate in political and public life is further recognized in international human rights treaties, in particular, Article 25 of the International Covenant on Civil and Political Rights. As part of efforts to develop more people-centred health systems, community members participation in health policies and service delivery has received increasing attention (WHO, 2015), and is expected to lead to improved quality, accountability and equity of health services.
What is social accountability in family planning?

Accountability is fundamental to human rights protection and promotion because it establishes a dialogue between the government and rights-holders. It provides communities an opportunity to understand how governments use power and resources to promote and protect health, and it provides governments the opportunity to explain what they have done and why. Accountability is a dialogue and process that identifies what works, so that it can be repeated, and what does not, so that it can be revised. The mechanisms for this dialogue and methods of participation may vary, but the end goal is to create change for better protection and promotion of rights.

Accountability is central to ensuring that human rights are systematically and clearly integrated into the provision of contraceptive information and services. WHO defines accountability as the guiding principle for:

“...states in putting their legal, policy and programmatic frameworks and practices in line with international human rights standards. Establishing effective accountability mechanisms is intrinsic to ensuring that the agency and choices of individuals are respected, protected and fulfilled. Effective accountability requires individuals, families, and groups, including women from vulnerable or marginalized populations, to be aware of their entitlements with regard to sexual and reproductive health (SRH) and empowers them to claim these entitlements (WHO, 2014).”

A sector as complex as the health sector requires a wide variety of accountability mechanisms to review the important and difficult decisions made within it. There are five broad types of accountability mechanisms – judicial, quasi-judicial, administrative, political, and social – and these can be found at the national, regional, sub-national, community, and international levels.

Social Accountability (SA) comprises “citizens’ efforts at ongoing meaningful collective engagement with public institutions for accountability in the provision of public goods” (Joshi, 2017). SA can be an important transformative process by which community and health system actors work together to change values, norms, and behaviours and expand people’s rights to high-quality contraceptive information and services.

It is important to distinguish accountability from related concepts of advocacy and activism. Accountability encourages decision-makers to be answerable to what they are committed and obligated to do under law, policies, or regulations and to be responsible for remedies when they fail to do so (Brinkerhoff, 2004). Whereas advocacy focuses on influencing the decisions made by power holders (Fox, 2022).

The contraceptive service challenges that social accountability aims to address

Despite global strategies, commitments and frameworks aiming to address barriers to attaining the highest possible sexual and reproductive health, populations in high-, middle- and low-income countries continue to experience a range of problems, including:

“lack of service availability to limited access; poor quality of services to ethical infringements, gender-based discrimination and rights violations; commercial exploitation to collusion and corruption; rigid bureaucratic norms; to inadequate measures or processes and rules for accountability. Patients often experience inappropriate provider behaviour, including disrespect, abuse and inattention, and outright denial of care, much of which never gets reported through formal channels or mechanisms” (Khan et al., 2021).

Ensuring that women and girls have access to high-quality family planning/contraceptive (FP/C) infor-
mation, services and commodities is fundamental to their right to health (OHCHR, 2014). Expanding access to contraception and ensuring that the need for FP is fulfilled are essential for universal access to reproductive health care services, as called for in the 2030 Agenda for Sustainable Development (Kantorová et al., 2021). However, many potential bottlenecks can prevent these commitments from translating to real progress in FP/C access, quality, and rights.

Common bottlenecks include diversion of funds due to competing priorities, delays and leakages of resources, limited contraceptive choice, poor-quality service provision, and inadequate protection of women’s rights (Sully et al., 2019). Furthermore, limited resources and other disincentives often limit government efforts to monitor and address these problems. Inadequate FP/C services and information remain a global challenge. Often, FP/C services and reproductive health supplies remain inaccessible as they are unavailable or unaffordable. Many individuals are unable to access FP/C services due to challenges such as informal fees, disrespectful staff, or an insufficient variety of methods offered (Castle and Askew, 2015).

Evidence supporting SA for FP/C services is limited but slowly growing. SA has been identified as a high-impact practice in FP based on current evidence that shows these processes leading to localized improvements in service delivery and client-provider relationships (HIP, 2022).

Lessons from a Ugandan study shows that SA contributes to improving health services, with much promise for addressing women’s barriers in contraceptive care (Boydell, 2020). A study in Malawi by Gullo et al. (2017) found that participation in a community score card process could result in an estimated 57% increase in FP use. Similarly, Björkman and Svensson (2009) found a 22% increase in FP use in Uganda after a report card process. Loewenson et al. (2004), in an assessment of the impact of health centre committees on service performance, found that clinics with health committees, on average, had more staff, higher budget allocations, greater drug availability, and better health statistics.

This manual: purpose and target audience

This is not a step-by-step guide, but a resource aimed at supporting national- and local-level policy-makers and programme managers in integrating SA processes in the provision of FP/C services. It is based on the most recent evidence available and builds on guidance provided in *Ensuring human rights in the provision of contraceptive information and services: guidance and recommendations* (WHO, 2014). A related resource has been developed for implementers. The *Community and provider-driven social accountability intervention for family planning and contraceptive service provision* (WHO, 2021) aims to provide practitioners and civil society organizations (CSOs) with guidance for designing, implementing, and monitoring programmes that initiate or support the integration of SA in the provision of FP/C information and services (WHO, 2021).

This manual details how to enable or implement SA programmes that stimulate active community member engagement and health system responsiveness and on how to monitor interventions to ensure progress, sustainability and scale-up.

Following the World Health Assembly resolution (WHA69.24) in 2016, this manual provides concrete technical support aimed at Member States, to realize the Integrated People-Centred Health Services (IPCHS) framework, particularly how to develop and implement programming that strengthens health systems to better promote and protect people’s health rights and provide for their health.
This manual is divided into three sections.

1 **Section one** provides an introduction (Chapter 1) and familiarizes readers with theoretical, practical and contextual underpinnings of SA (Chapter 2). It outlines the importance of the interplay between the law and the accountability system in the context of FP/C, highlighting sexual and reproductive health and rights in legal and policy contexts (Chapter 3).

2 **Section two** focuses on how policy-makers and programme managers can support social participation (Chapter 4) and enable responsiveness to SA demands (Chapter 5).

3 **Section three** supports monitoring and evaluation (M&E) of SA programmes (Chapter 6) and planning for sustainability and scale-up (Chapter 7).
References


2.1 Introduction

SA is a complex, socially embedded and context-driven process with many different community and health system actors interacting in several ways – raising awareness around entitlements, jointly setting priorities, deliberating solutions and ways forward, and following up together to ensure these issues are addressed (Boydell et al., 2019). These interactions take place over time to bring about changes in attitudes and behaviours, quality of health-seeking and overall provision of services.

Because SA is a complex process with many moving parts that respond to local contexts, people can understand SA to mean different things and work in different ways. Therefore it is important to clearly outline how this manual understands SA and to compare it to how others understand and use the term. Developing a clear theory of how SA works will also help with monitoring and evaluation (M&E).

Understanding context is central to initiating, participating, and evaluating SA programmes (Grandvoisinnet,
2015; O’Meally, 2013; Fox, 2015) as it aids identification and leveraging of existing enabling factors as well as adaptation to possible constraints and challenges (O’Meally, 2013; Tembo, 2012; Van Belle, 2018). Context also matters because SA functions within complex and fluid power relationships (WHO, 2021).

Within the contextual reality where SA is implemented, policy- and decision-makers are inherently in power positions and have the ability to influence SA and other social participation processes to an uneven extent relative to other social participation stakeholders (WHO, 2021).

This chapter defines key components of how we understand SA to work. We provide examples of ToCs used in the context of research on SA applied to reproductive, maternal, newborn, child and adolescent health (RMNCAH). We also identify contextual factors that surround SA and those that need to be considered when applying it to RMNCAH, specifically contraceptive service provision.
Why social accountability frameworks are important

SA is a complex, socially embedded and context-driven process.

• Though no single theory of change (ToC) is applicable to all situations, there are three key interrelated components that explain how a particular SA strategy is likely to work for a specific setting, namely information, collective action and corresponding state response and also those responsible for health care provision.

• Policy-makers and programme managers need to take context into account whether they are initiating, participating in, evaluating or supporting SA. Contextual factors may enable or constrain SA processes. Context defines the power relationships of those taking part in the SA process.

2.2 Building a conceptual framework of social accountability

People understand SA to work in many ways. One understanding is as a form of performance management in which service users are consumers who can use the mechanisms to demand improved services (Ringold et al., 2012). At the other end of the continuum are approaches that understand SA as a process whereby service users, as citizens, demand their legal rights and contribute to social transformation (Lopez Franco E, Shankland A, 2018). Another axis for approaching SA is as a tactical intervention; tools are used in a particular time and place compared to more strategic approaches that deploy multiple tactics to combine citizen voice and public sector response (Joshi and Houtzager, 2012).

Given the range of possible approaches, it is crucial to clarify underlying assumptions about how a course of action will bring about a certain change and the conditions necessary for it to happen. This is often communicated through a ToC. A ToC describes how a programme brings about specific long-term outcomes through a logical sequence of intermediate outcomes and includes assumptions about what conditions need to be in place for the process to take hold (Vogel, 2012). This is usually represented in a diagram, figure, or narrative summary.

There are many different ToCs related to SA, depending on how people believe accountability to work, specific contextual factors that need response, sets of actors involved, and types of community and institutional structures engaged. A programme ToC should respond to the specific political, sociocultural, and economic realities that shape interactions between SA actors (O’Meally, 2013; Van Belle et al., 2018). It is important to recognize that decision-making and implementation processes are not predictable or linear and adapt. Therefore, we cannot prescribe a singular theory of how SA will work as it needs to be adapted to the local context. This manual does not provide a single ToC but describes elements that can be used to build your theory and communicate it with others, who can then compare it against their own models or local context.

Key components of a social accountability theory of change

Though no single ToC works in all situations, here we will outline three interrelated components of successful human rights-based accountability. The three components should be included in a conceptual model that explains how a particular SA strategy is likely to work for a specific setting. The components are drawn from the work of Anu Joshi (2014), and map onto existing human rights.

Information – The first component is information, as relates to the right for information and is required for accountability actions. Information can be about official standards, for example, the standards of care...
outlined in the national sexual and reproductive service delivery guidelines, and community members are expected to mobilize and demand performance up to the official standards. Information can also be about perceived differences in performance quality.

**Collective action** – The second component is collective action as it relates to civil rights, such as the right to thought, to speech, to associate and to assemble. Collective action is action taken by a group of people based on a collective decision and can include community member demands for information from governments about budgets and spending, procedures, standards, and performance. Actions can generate information through community member data collection and monitor delivery of public goods, finding gaps between expected and delivered service levels. Actions can also include seeking redress and remedy.

**State response** – The third component is a state response corresponding to the right to seek redress or a legal remedy. Health system responsiveness is “the ability of the health system to meet the population’s legitimate expectations regarding their interaction with the health system, apart from expectations for improvements in health or wealth” (WHO, 2021). Such response can include generating and releasing information, reforming processes, mobilizing resources, advocating for reforms at higher levels and changing behaviour.

**Potential dynamics between component parts of social accountability (Joshi, 2014)**

These components relate to each other through a range of mechanisms, and the relationship between parts is not singular or unilinear, but rather, characterized by multiple interactions between component parts. In some instances, the provision of information will lead to collective action, which will then lead to a state response. In another scenario, collective action could generate information that forces a state response to make the information public.

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Examples of social accountability theories of change

In the context of sexual and reproductive health and rights (SRHR), several SA strategies have had positive impacts on contraceptive service provision. This section outlines the ToCs described in each of these approaches to provide an overview of the diversity of conceptual models and inspiration for developing models for local contexts.

The ToC in Fig. 2 is from the WHO/Human Reproduction Programme (HRP) study Community and Provider Social Accountability Intervention (CaPSAI) that aimed to improve contraceptive care in Ghana and the United Republic of Tanzania. This ToC outlines how engaging community members and health services actors in dialogues to discern challenges and develop action plans can improve service quality, counselling, interpersonal care, staff capacity, and stock management. These, in turn, can then support full, free and informed choice and facilitate more uptake and use of modern contraceptive methods (Steyn, 2020).

The CaPSAI SA process involved community members, health professionals offering FP services at health facility level, and other duty bearers within facilities’ catchment areas working together to understand entitlements and responsibilities and to identify and implement ways to improve the delivery and quality of FP/C services. This process was undertaken in eight gradual steps:

**Step 1:** SA activities were introduced to local leaders to ensure that buy-in and preparations were made, such as training of facilitators and background work on assessing FP/C standards against local service provision.

**Step 2:** Activities focused on community mobilization

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where community members, health service providers and other duty bearers introduced them to the process.

**Step 3:** Activities completed Step 2 and provided training where community members were provided with information on health awareness and education, existing service standards, rights training, good governance, and accountability. Community members then rated the existing services against right-based standards and generated discussions about local priorities.

**Step 4:** Meetings where key issues in FP/C access and use were raised and prioritized by the community, who then collectively scored the issues and set priority areas for action.

**Step 5:** Health sector actors followed the same process as for Step 4, collectively scoring issues and setting priority areas for action.

**Step 6:** Community and health providers met to discuss the respective issues faced and develop a consensus on priority items for collective action that was developed into an action plan.

**Steps 7 and 8:** Action plans were monitored, and progress was assessed at 3 months and at 6 months.

The ToC in Fig. 3 is taken from CARE’s Community Score Card (CSC) to improve reproductive health-related outcomes in Ntcheu, Malawi. This ToC outlines how the community score card process brings together actors according to context, for example, gathering community members, health workers, and local officials to identify barriers in service delivery, prioritize actions to resolve the issues, and monitor improvements. By expanding the space for inclusive dialogue and negotiation, these actions empower both women and health workers and lead to improved health behaviours, increased service use, and higher-quality services and, in the longer term, decrease maternal and neonatal mortality. A randomized control trial of this process found more significant improvements in the proportion of women receiving a home visit during pregnancy and higher current use of modern contraceptives in the intervention sites.

CARE’s CSC consists of five phases where Phase 1 starts with preparation activities, such as understanding the context and barriers both service providers and users face, training facilitators, and engaging different stakeholders (Gullo et al., 2020). Phase 2 focuses on issue generation through focus group discussions with community members separated into groups, such as men, women or youth, to identify service-use issues, prioritize them and develop indicators that can be scored, create a score card, and make suggestions for how to improve the score. In Phase 3, the same process is conducted with service providers to identify the challenges they face in delivering quality services. An interface meeting, where community members, service providers, local government officials and other...
power holders come together to discuss the community and service provider score cards, is the centre of Phase 4. Together, the stakeholders outline solutions to the barriers they prioritized and develop an action plan for improvement. In Phase 5, the action plan is implemented and progress on the indicators is reviewed and monitored. This cycle is repeated every 6 months in “an on-going cycle of problem identification, solution generation, implementation of improvements, and mutual accountability” (Gullo, 2020).

2.3 Types of social accountability methodologies

There are many tools to promote and support SA for contraceptive information and services. The specific activities may vary in form and scope, ranging from participatory mechanisms, such as client charters and participatory budgeting, to watchdog functions such as score cards, but they share the three interrelated components discussed above. Boydell and Keesbury (2014) outline some of the different approaches to promoting SA (see Example 1). These are often combined and are not mutually exclusive.

2.4 Defining contextual factors surrounding social accountability

Broadly speaking, context can be defined as a set of active and unique characteristics and circumstances that surround an implementation effort (Pfadenhauer, 2015). These characteristics and circumstances not only serve as a backdrop of implementation, but also interact, modify, facilitate or constrain. The context describes not only the setting or the physical location in which implementation is taking place but also the roles, interactions and relationships existing within (Pfadenhauer, 2015).

Based on a review of the existing evidence, we define the contextual factors that have been identified as critical for SA. Examples of contextual factors associated with the success or failure of SA programmes are summarized here (see also Annex 1).

In the SA literature, two types of contextual factors have been identified:

Macro-level factors: These refer to the political and economic processes that can support or impede implementation (Joshi, 2013). The factors focus on interests and incentives that drive groups and individuals, distribution of power and wealth, and relationships created (Joshi 2013). O’Meally identified six domains (2013). The main domains are (i) political society, which relates to the patterns of political rule defined by the nature of state actors and the dynamics between institutions, and (ii) civil society, which refers to the arena where people come together to advance common interests. Other domains describe the interactions between and among groups: (iii) inter-elite relations describe the horizontal power relations between the political and economic elites that define incentives for action; (iv) state-society relations define the social contract that dictates what is accepted as entitlements, roles and responsibilities between groups; and (v) intrasociety relations shape the cultural factors that influence the relationships between individuals within and among groups. Finally, (vi) global dimensions may affect SA at the national and subnational levels. Global or transnational actors, such as donors and other international power holders, can shape SA in a positive or negative way.

Micro-level factors: Local issues can also influence how certain SA programmes unfold, even within broadly similar contexts. To understand these micro-contexts as Joshi (2013) defined them, two aspects need to be analysed: (i) the features of the broad individual components of accountability processes and (ii) the causal chains through which SA processes are expected to work. Understanding these components can help identify which strategies are likely to work as they focus on the implicit assumptions underlying particular activities from community member action, public information or transparency and official response,
EXAMPLE 1
Social accountability methodologies
(adapted from Boydell and Keesbury, [2014])

**Participatory budgeting** allows citizens direct participation in all phases of the budget cycle: formulation, decision-making, and monitoring of budget execution. This is intended to increase citizens’ voices in the budgeting process, increase transparency, and improve targeting of public spending. Goldfrank (2006) documents the use of participatory budgeting in Brazil, where it was first used to successfully improve transparency, increase direct citizen participation, and redistribute financial resources. In other countries, such as Bolivia (Plurinational State of), Guatemala, Nicaragua, and Peru, however, participatory budgeting has had mixed effects due to a range of factors, including whether there are municipal revenues to invest in public works or whether there is a tradition of participation by and cooperation within local civil society.

**Public expenditure tracking (PET)** involves civil society in monitoring budget execution by tracking flows of public resources for the provision of public services and goods. PET is a diagnostic tool to identify problems, such as leakages of funds or goods, or service delivery issues, such as staff absenteeism. Sundet’s (2008) review of PET’s application to educational grants from central government to local schools in Uganda showed impressive results. In 1995, only 26% of the cash intended for primary schools made it to its destination, whereas in 2002, after regular expenditure tracking, 80% of funds transferred to schools from the central government were received.

**Citizen report cards** are participatory surveys that solicit user feedback on public service performance. Reports cards are useful for assessing service performance to improve quality, accessibility, and relevance of services, and reduce leakages and corruption. In Bangalore, Ravindra (2004) found that using citizen report cards to assess user satisfaction with service performance increased public awareness of the quality of services and stimulated demand for better services.

**Social audits** engage citizens, service users, or CSOs in collecting and publicly sharing information on available resources allocated for service delivery and public works.

**Community score cards**, a process of community-based monitoring, combine social audits and citizen report cards. Score cards compile information on the demand (user perspectives) and supply (service provider perspectives) sides of a particular service, and the data are then reviewed by all parties in an interface meeting to allow for immediate feedback and action plan development. Dufils (2010) describes how a community score card, or “local governance barometer,” in Madagascar was used to successfully identify blockages in programme implementation and include all parties in designing a practical approach for addressing the blockages.

**Citizen charters** articulate guidelines for the client and provider relationship, providing detail on what standards a client can expect and demand. Charters aim to raise awareness about service standards and client entitlements and share the expectations and standards that providers agree to uphold.

**Health committees** involve civil society and government working together in an institutionalized oversight body to improve health system effectiveness. Health committee structures aim to ensure community participation in decision-making. Loewenson et al. (2004) assessed the impact of health centre committees on service performance and found that clinics with health committees, on average, had more staff, higher budget allocations, greater drug availability, and better health statistics.

**Information sharing or campaigns** are efforts usually led by CSOs to inform citizens and duty bearers about citizens’ rights to services and quality performance standards. These campaigns are intended to increase awareness of services and benefits, service provider performance, and efforts to tackle corruption and fraud. Reinikka and Svensson (2011) describe how a newspaper campaign in Uganda targeting corruption in public education reduced misuse of public education funds and contributed to a positive effect on enrollment and student learning.

**Complaint mechanisms** are formal channels to express dissatisfaction with a service and demand redress. Submitting complaints to a suggestion box or an ombudsman are examples of complaint mechanisms. Maru (2010) found that, in many cases, SA interventions failed to have a positive impact because of a distinct lack of formal complaint mechanisms and redress.
and the dynamic links that connect each component. The central assumption of SA is that transparency or availability of information leads to community member action, such as demands for change, which then prompts and requires an official response. However, in practice the relationship between the three components can be more complicated. Community member action, for example, can influence the availability, relevance and quality of information. Official response may vary in substance and may even be negative. Unpacking the assumptions of SA can help identify contextual factors that need consideration (Joshi, 2013).

**Key contextual factors to consider when integrating social accountability in the provision of contraceptive services**

**Health systems:** For SA applied to health issues, the health system structure needs to be accounted for. Health systems are defined as a complex network of connected stakeholders with varying degrees of influence at different points in service delivery (Boydell and Keesbury, 2014). Two levels have been identified: (i) the systems level, which includes policy decisions and institutional arrangements that affect how human and financial resources are allocated, and (ii) the service level, which is the interface between infrastructure, client and provider that determines the quality of services provided. The relevant policy and legal environments for SRH service delivery are discussed in Chapter 3. The interface level between health providers and clients are addressed in Chapters 4 and 5.

It is also important to note that the state is not the only service provider for contraceptive service provision, and SA frameworks need to explicitly include provisions for influencing non-state actors (Freedman, 2013). This concern is especially relevant as the FP sector moves toward a “total market approach” that recognizes the roles of public, non-profit, and commercial service providers in expanding access to FP services (Freedman, 2013).

**Social norms and values:** Social norms and values, including gender relations, define power relations within health systems and shape health status, inequities in access to health services, and ability to participate in public forums and make demands on state actors at the local and national levels (George, 2019; Balestra, 2018). Sexual and reproductive health decisions, including the use of FP/Cs, are highly dependent on social norms and values (Van Belle et al., 2018; Boydell et al., 2018). Although there has been some resistance toward public dialogue on such sensitive issues, there is emerging evidence that it is feasible for SA processes to be applied and that these may lead to positive outcomes. A study evaluating two SA projects aiming to improve access to quality contraceptive services in Uganda found that in a context where there is social resistance to contraception and limited knowledge and information about contraceptives, the dialogues challenged pre-existing hierarchies and played a critical role in sharing more positive ideas and information about contraception (Boydell et al., 2020). There is limited evidence on navigating gendered norms in SA. However, the study found that using appropriate methods has been shown to support the application of SA in addressing SRHR issues. Working with intermediaries, such as esteemed community representatives, could support and legitimize women’s demands (Boydell et al., 2020).

**Conflicts, natural disasters, and public health emergencies:** Humanitarian crises may contribute to creating hostile environments for SA and sexual and reproductive health. Humanitarian settings can affect health systems in different ways, including weakening health infrastructure (Pieterse, 2019; Schaaf et al., 2020a) and making quality patient-centric care challenging due to a lack of time for consultations to focus on the speed and scale of the response to emergencies (Schaaf et al., 2020a). In these settings, the focus of existing accountability processes that are often dependent on outside funding often shifts toward donor priorities rather than affected populations (Schaaf et al., 2020b). In humanitarian settings, such as the public health emergency to respond to COVID-19, the sexual and reproductive health needs of women and adolescent girls are often overlooked (UNFPA, 2021; Schaaf et al., 2020a) and support for gender-based violence policies are de-emphasized due to weakened health care systems (Schaaf et al., 2020b).

Despite these challenges, there is space for SA processes, which can support responsiveness to...
service users’ needs and an appreciation of the challenges faced by service providers, promote better government-citizen relationships, and provide valuable feedback information about the status of basic service delivery in the local setting (Peiterse, 2019). Considerations do need to be taken into account, such as drawing on lessons learned from experiences of governments and civil society in low- and middle-income countries (LMICs) and nurturing trust among community members in the government response (Schaaf et al., 2020a), and documenting learnings from accountability failures and human rights abuses to build more resilient mechanisms for answerability and remedy (Schaaf et al., 2020a).

Methodologies for identifying and understanding relevant contextual factors
Various methodologies have been developed and used to map and identify relevant contextual factors which are discussed in Chapter 3.

HOW TO ADAPT SOCIAL ACCOUNTABILITY TO LOCAL CONTEXTS

• Respond to specific political, sociocultural and economic contexts that shape and influence the power dynamics between SA actors.

• Use numerous methodologies to map and understand the national or local macro-level and micro-level contextual factors and adapt the SA process to their contexts.

• Actively support enabling health systems structures, as well as collaborate with and create provisions for influencing non-state actors who are expanding access to SRH services.

• Use methodologies that take into account social norms and values that can affect how social accountability processes can be applied to sexual and reproductive health and rights, including FP and contraception use.

• Adapt methodologies to conflict, natural disasters and public health emergencies that may contribute to creating hostile environments for social accountability and sexual and reproductive health. Social accountability processes can be implemented in these contexts and can support responsiveness to service users’ needs and an appreciation of the challenges faced by service providers, promoting better government-citizen relationships.
References


Linking social accountability to legal and political frameworks

3.1 Introduction

As shown in the previous chapter, SA processes do not exist in a vacuum and how they bring about change is embedded in their wider legal and policy contexts. This chapter outlines the importance of the legal and policy contexts, support for SA for FP/C service provision, and understanding of the countless systemic factors and obstacles to accountable governance. **Barriers to accessing FP/C are often rooted in out-of-date or conflicting policies**, and it is important to understand the surrounding policy environment. This includes interrogating: What are the available resources? Is there good governance, management and accountability? Are there supportive social norms, particularly equitable gender norms? We also need to consider the conditions that influence the ability of community members and their organizations to promote accountability for FP/C services, such as their **ability to participate without fear of consequences**. Household power dynamics also play a significant role on SA for FP/C service provision, as some people are permitted and encouraged to speak out, whereas others are not.
It is important to understand the interplay between the law and the accountability system in the context of FP/C because it helps identify which actors or dynamics generate or constrain accountability, and the required change to strengthen or reorient it. Two elements of the enabling environment are considered; first are the legal and policy grounds for SA itself. These include the right to assemble, to participate, and to information; rules and regulations for civil society; and the legal standards and entitlements related to FP/C programming that SA can leverage to increase access to SRHR.

Laws, policies, and programmes better reflect the needs and perspectives of affected populations when members of these populations take part in their development, thus supporting improved health outcomes, quality of health care, governance and health systems (WHO, 2021). Second, linking SA to SRHR is important because national legal and policy frameworks can help policy-makers to support SA in the context of FP/C programmes and support policy-makers and programme managers to meet their SRHR-related goals. Examining links
between SA and legal and policy context can identify structural barriers to participation for certain populations and increase access to decision-making structures for other populations (WHO, 2021). Under CESC general comment no. 14: the right to the highest attainable standard of health (Art. 12), it was agreed that the right to health includes the right to control one’s health and body.

Ensuring that human rights are protected and promoted in the context of contraceptive information and services is operationalized through the principles of nondiscrimination, availability, accessibility, acceptability, quality, informed decision-making, privacy/confidentiality, participation and accountability (WHO, 2014).

Subsequent sections elaborate on what we mean by policies and regulations and what the evidence says about the policies and regulations for accountability for FP/C programming. They also provide resources that can help map this context.
Why linking social accountability to legal and political frameworks is important

SA does not exist in a vacuum. How it brings about change is embedded in the wider legal and policy context in which it happens.

Understanding the policy environment surrounding FP/C can help identify actors or dynamics that generate or constrain accountability, and the required change to strengthen or reorient accountability.
Key terms of policies and regulations

Policies and regulations, grounded in laws, provide the basis for accountability, responsiveness, and sustainable reforms. There are binding rules that govern the rights and responsibilities of governments, health workers, companies, civil society and a country’s population. They define the roles of state, community members, and civil society and what the engagements between them are. These rules make up the legal framework, or legal architecture, for health. The framework formalizes commitment to goals to, for example, universal health coverage and creating a drive for action. To enable cooperation and achieve health goals, people use law to create different organizations (such as hospitals) and relationships (such as contracts for providing health services). In turn, organizations (whether health ministries, private sector or civil society) have mandates, policies and strategies based on legal rules that guide their operations.

Accountability surrounding the health system is complex, with multiple actors from a range of sectors —government, clients/community members, and providers all play a part in strengthening and supporting accountability for political, programmatic and financial commitments. It is helpful to think of an accountability ecosystem, and further details about this approach are provided in Annex 1, in which “the relationship between multiple levels of government, citizen collective action, civil society advocacy, and institutions, wrapped together by a web of social, political, and cultural factors in a given country context” (Chemonics, 2019). The accountability ecosystem for FP is rooted in health and FP strategies and policies and other areas of the law. These include laws that protect, promote and fulfil human rights; laws that establish and protect cadres of health workers; public accountability laws; and laws regulating speech, information dissemination, and civil society. Much of the accountability ecosystem is outlined in law and policy; therefore, it is important to analyse the legal instruments that regulate state action to better understand rights and guarantees established by law. The types of judicial norms vary by legal systems.

Another critical consideration is that each country is territorially divided into national, regional, and local governments with differing forms and characteristics of political and administrative authority. The degrees of decentralization and deconcentration and the corresponding balance of authority have been found to affect responsiveness considerations and will be relevant to discussions about accountability mechanisms in practice.

Learnings from current evidence on legal frameworks for accountability and health

This section outlines the legal grounds and mechanisms for SA. The evidence suggests that enabling policies, laws and governance mechanisms enhances accountability. Reproductive health policies and guidelines and national policies can promote accountability and citizen participation (Butler, 2020).

In this section, we share information available for assessing the (1) legal and policy grounds for SA itself and (2) the legal standards and entitlements related to FP/C programming that SA can leverage to increase access to SRHR. Various resources can be been used to map and analyse different political, institutional, and contextual factors that generate or constrain SA. There are several techniques for this mapping, including environmental and political “scanning”, institutional and context analysis (ICA), and political economy analysis (PEA). Such types of analysis aim to understand political and economic processes and trends – including power dynamics and relationships, between different groups and individuals. These are broadly captured under a rubric of “thinking and working politically” that includes strong political analysis, insight and understanding; detailed appreciation of, and response to, the local context; and flexibility and adaptability in programme design and implementation (TWP, 2015). If stakeholders in your environment have already done such analysis, leveraging existing...
analysis can be useful as an input to thinking about SA processes in your context.

Information about the legal and policy grounds for social accountability itself

The publication Voice, agency, empowerment - handbook on social participation for universal health coverage (WHO, 2021) has drawn out the most effective contribution policy-makers can make towards an enabling environment for social participation, including SA. Fig. 4 details the key elements identified in the handbook; see Chapter 4 for more details.

Based on existing evidence and consultations, the handbook also identifies the actions that can be taken by policy-makers to address barriers for participation. See more information on how policy-makers and programme managers can support participation in Chapter 4.

Documentation for the legal basis for these actions can be found in the following online databases:

- Civil Society Participation, Index: https://govdata360.worldbank.org/indicators/hab8090ea?country=BRA&indicator=28738&viz=line_chart&years=2006,2018

Information about the standards and entitlements relation of FP/C programming

Laws and policies form the basis for the design and implementation of FP programmes; these include the regulations, guidelines, training, financial resources and supplies that need to be in place to deliver a programme. A comparative analysis found that the policy context can shape a young woman’s (age 15–19) access to FP services in Guatemala, Malawi, and Nepal (Rosen et al., 2017). Table 1 presents a useful typology of policies (see Peel and Lipsky (2021)).

Much of this information has already been collected and country-specific situational analysis conducted: United Nations Population Fund (UNFPA) country programme strategies, and FP2030 Costed
Implementation Plans and Global Financing Facility business cases. The Family Planning Effort Index: (Ross and Smith, 2010) provides an analysis of national FP programs that have been conducted seven times from 1972 through 2009. Other resources include:

- http://www.healthpolicyproject.com/index.cfm?id=topics-RepositionFP
- https://www.fpfinancingroadmap.org/roadmap

The existence of policies does not, however, necessarily translate into real world changes, and implementation gaps are a persistent challenge. Policy implementation requires dissemination and training to ensure that subnational decision-makers are aware of the policies, ensuring that service providers understand their roles and FP (non) users are aware of their rights under existing policies. Over time, it is vital to assess whether (and to what extent) policies are implemented, are working as intended and if there are any unintended consequences that require corrective action. SA processes that bring community members and government together in dialogue can help.

**Policy checklist: essential elements for successful family planning policies**, developed by a United States Agency for International Development (USAID)—funded Health Policy Project, draws from lessons learned and best practices in moving from policy to action. It is a guidance document to stakeholders on how the policy environment can be used to operationalize and fulfil FP2030 commitments. The tool allows users to compare current policies with practices to assess whether existing policies need to be revised or better implemented, and whether new policies should be developed.

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### Table 1. Useful typology of policies (Rosen et al., 2017; Hardee, 2013)

<table>
<thead>
<tr>
<th>Type of policy</th>
<th>Policy mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Legal and regulatory policies</strong>&lt;br&gt;establish an individual’s right to health, formalize financial commitments, facilitate the procurement of quality commodities, and regulate and facilitate private sector engagement.</td>
<td><strong>Laws.</strong> Legislation can be an important policy instrument by introducing legally binding commitments to promoting young people’s reproductive health.</td>
</tr>
<tr>
<td><strong>Constitutional provisions, judicial decisions, and executive orders.</strong> Like laws, these are legally binding commitments.</td>
<td><strong>Treaties and conventions.</strong> By signing international treaties and conventions, countries formally express their commitment to addressing issues relevant to FP.</td>
</tr>
<tr>
<td><strong>National and financing policies</strong>&lt;br&gt;and strategies articulate a country’s FP goals and priorities, set minimum standards of quality, outline roles and responsibilities, facilitate coordination, guide resource mobilization, and determine timelines for programme rollout.</td>
<td><strong>Population-based policies.</strong> These encompass broad national or subnational policies that may include language on reproductive health.</td>
</tr>
<tr>
<td><strong>Sector-specific reproductive health policies or strategies.</strong></td>
<td><strong>Operational policies, standards, guidelines, and professional standards of practice.</strong> Typically (but not exclusively) applied to public sector services, such policies influence the actions and attitudes of health workers. They include rules, regulations, guidelines, operating procedures, and administrative norms that governments use to translate national laws and policies into programs and services.</td>
</tr>
<tr>
<td><strong>Standards of practice in professional fields.</strong> These include policies set by national, regional, or local professional bodies, such as associations of doctors, nurses, pharmacists, and teachers. This can include professional accountability (PMNCH, 2019).</td>
<td></td>
</tr>
</tbody>
</table>
HOW TO LINK SOCIAL ACCOUNTABILITY TO LEGAL AND POLITICAL FRAMEWORKS

• Analyse the legal instruments that regulate state action to better understand the rights and guarantees established by the laws.

• Assess systematically the political and legal architecture surrounding community member participation in FP under the rubric of thinking and working politically. This includes strong political analysis, insight and understanding; detailed appreciation of, and response to, the local context; and flexibility and adaptability in programme design and implementation.

• Determine if policies are implemented as intended, working as hoped, and translating into real world changes after developing and passing new policies and providing training and ongoing monitoring of policy implementation. If they are not, the gaps and limitations should be addressed – and SA processes can help in this regard.
References


PMNCH (2019). Professional accountability for women’s, children’s, and adolescents’ health: what mechanisms and processes are used, what works? (https://pmnch.who.int/resources/publications/m/item/professional-accountability-for-women-s-children-s-and-adolescents-health-what-mechanisms-and-processes-are-used-what-works)


TWP Community of Practice (2015). The case for thinking and working politically: the implications of ‘doing development differently’.


SECTION 2.
Supporting social accountability
Enabling social participation in health

4.1 Introduction

Social accountability is a participatory process that entails different health system actors, from community members, service users, and service providers to decision-makers, to interact and to collaborate in identifying service issues and developing an action plan for addressing them. As such, for SA to work, there needs to be support and buy-in from policy-makers and programme managers for participation in health. A key enabling factor for SA is willingness and capacity among state actors and political elites to promote and respond to SA (O’Meally, 2013). Although CSOs often initiate SA, state actors can support democratic and participatory spaces for civil society action (O’Meally, 2013; Van Belle, 2018).

The participation of communities, families, and individuals at all stages of decision-making and implementation of policies, programmes and services is central to global frameworks, guidance, and charters for improving health services and outcomes. It is a cornerstone for sustainable development and the highest attainable standard of health (WHO, 2021; Hone, 2018; WHO, 2014) and for strengthening people-centered health services (Sixty-ninth World Health Assembly resolution WHA69.24 in 2016) and universal health coverage (WHO 2020). Participation is also recognized as one of the nine human rights standards in WHO’s
guideline for ensuring human rights in the provision of contraceptive services and information (WHO, 2014). Despite recognition in global and national-level guidance for participation in health, challenges remain. Participation is not systematically brought into policy- and decision-making (WHO, 2021). In many settings, participation is reduced to extending health service provision to reach marginalized communities, while there is no recognition of the fundamental responsibility and obligation of health actors to engage and work with patients, their families, and local communities (Odugleh-Kolev and Parrish-Sprowl, 2018). Finally, establishing the link between health outcomes and participatory processes has been elusive (Rifkin, 2014). Part of the challenge is the lack of common understanding of who the community is, what participation entails, and its purpose (Odugleh-Kolev and Parrish-Sprowl, 2018; Rifkin, 2014).

This chapter defines key concepts related to participation and the community. We detail current evidence on how policy-makers and programme managers can support and help create an enabling environment for SA in health services, including contraceptive service provision, by supporting and promoting social participation. Some points in this section provide key considerations on how policy-makers and programme managers can help sustain and scale
Key Terms

In relation to participation, some areas require conceptual clarity: (1) what we mean by social participation, (2) what are participatory spaces and (3) what is the community.

Social participation

Defining participation has been dominated by two seemingly opposing views. On one side, participation is seen as a means for attaining health goals by improving service provision and use (Marston, 2013; Rifkin, 2014), and on the other, it is seen as an end in itself or as a key factor in the wider context of understanding and accounting for social determinants of health and health as a human right (Marston, 2013; Rifkin, 2014). The lack of clear definitions of participation and what the community is has resulted in challenges in linking participation and improvements in health status (Rifkin, 2014). Rifkin (2014), as well as other authors (Molyneux, 2012; Marston, 2013), suggests that it would be more accurate to view participation as a process rather than as an intervention, meaning as an intermediary step to longer-term health and social change. Participation ensures that health programmes are responsive to the needs and sociocultural contexts that influence the health of the communities that they serve (Marston, 2013). At the same time, it is a crucial component of democratic systems and essential for improving health equity and increasing public accountability (Marston, 2013).

In this manual, we use “social participation” as a term to encompass the various forms of participation. These include processes that aim to develop relationships and alliances to involve communities in decision-making and planning associated with legitimate governance and processes where groups identify their needs and establish ways of meeting them and are often initiated by the client-group (WHO, 2021). In short, it is viewed as the means through which social actors group their potential to achieve collective good (WHO, 2021). Social participation mechanisms aim to link policy-maker perspectives with the experiences and needs in the community.

Participatory spaces

Instances and channels where community members have the opportunity to act to affect policies, decisions and relationships that affect their lives are often
Learnings from the current evidence

There are a number of ways that policy-makers and programme managers can enable participation by developing and ensuring good functioning of invited participatory spaces, such as health committees (see Example 2: Health facility committees’ potential impact and challenges identified in the literature) and by promoting or supporting participatory spaces created, claimed or chosen by communities.
EXAMPLE 2

Health facility committee potential impact and challenges identified in the literature

Health facility committees are among the most common mechanisms for accountability and participation in public health service (Molyneux, 2012; Lodenstein, 2017). These committees tend to be government-supported and part of the routine health system structure (Molyneux, 2012). They generally aim to improve health system effectiveness, quality and management as well as community involvement (Molyneux, 2012).

Health facility committees have the potential of improving accountability and governance (Mamdani, 2018) and, consequently, creating people-centred quality care (Lodenstein, 2017). In a comprehensive review of health facility committees in west and central Africa – Benin, the Democratic Republic of the Congo and Guinea – Lodenstein et al. (2017) noted that despite the “disabling legal and political context, the health facility committees in the study areas seem to use the limited space or develop the necessary approaches locally to facilitate social accountability”.

However, several challenges have been identified that interfere with the effective functionality of health facility committees (Lodenstein, 2017; Molyneux, 2012). Molyneux (2012) identified three types of barriers related to the selection, composition and functioning of committees:

1. Inconsistencies in running committee meetings, elite groups dominating membership, lack of clarity in roles and lack of incentives for members, and inadequate time and resources for training and supervision have led to unequal implementation of health committees in different settings.

2. For some relationships between committees, health workers and health management systems, imbalances in information and power have led to health workers dominating control of committees.

3. Broader contextual issues such as government contexts and socio-cultural norms and priorities also affect the functionality of health facility committees, at times negatively.
health systems and wider political and sociocultural contexts influence the form and level that the social participation process takes (Draper, 2010). A one-size-fits-all, comprehensive social participation process does not exist, nor is it desirable. In some settings where there are restrictive contextual factors, such as humanitarian or conflict settings, social participation can still work, even in a limited form (Schaaf, 2020). Some authors do warn against tokenism, where there is no real distribution of influence and control (Molyneux, 2012). In a mapping of community engagement tools for quality improvement in RMNCAH service provision, Spencer et al. suggest that, ideally, a comprehensive approach should be taken (Spencer, 2021). This means incorporating participation in all seven phases of the quality improvement framework: establishing a leadership group, situational analysis/assessment, adopting standards of care, identifying quality improvement intervention, implementation, continuous measurement of quality outcomes, and refinement of strategies (Spencer, 2021).

### 4.3.2 Who to involve?

The diversity of communities brings challenges in selection, representation and accountability (Zakus, 1998). Some minority groups may prefer not to, or may not have the capacity or access to, actively participate (Zakus, 1998). Efforts towards a “better understanding of the nature of community and the nature of human social interaction and community participation” must be part of the process (Zakus, 1998). Table 2 provides links to useful tools or approaches for mapping the community and how to look at and address differences in communities.

### Table 2. Examples of tools and approaches for understanding the community and addressing differences

<table>
<thead>
<tr>
<th>Community mapping tool/approach</th>
<th>Example or resources</th>
</tr>
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Ensuring the participation of the following stakeholder groups in sexual and reproductive health services, including FP, has shown positive outcomes:

- **Direct beneficiaries of services** – Involving the people who directly benefit from the services can increase knowledge, utilization, and use of sexual and reproductive health and contraceptive services (Steyn, 2016; Altman, 2015).

- **Young people and adolescents** – The meaningful participation of young people and adolesc-
cents ensures that SRH service provision is safe, rights-based, transparent, informative, voluntary and free of coercion, and respectful of young people’s views, backgrounds and identities (FP2020, 2019). Involvement of young people has demonstrated the potential to increase youth uptake of sexual and reproductive health services (Kesterton, 2010) and trigger community-level SRHR improvements, such as decreased rates of child marriages, adolescent pregnancy, and school dropouts among pregnant girls at the community level (Wigle, 2020). Youth involvement in policy-making has to lead policy changes such as constitutional change to raise the minimum age of marriage to 18 years old and the national rollout of youth-friendly services (Wigle, 2020).

- **Household decision-makers** – Involving parents of young people who can benefit from SRH services has resulted in generating wider community support (Kesterton, 2010). Male partners’ perception of contraceptive use can greatly influence women’s access to contraceptive services (Kriel, 2019). Engaging men in SRHR as clients, equal partners and advocates of change can lead to increased use of services, SRHR awareness, sharing of contraceptive decision-making, and decreasing tolerance of domestic violence (Stern, 2015).

- **Community and religious leaders** – Involving community gatekeepers can be beneficial in dissolving resistance to FP and contraception (Boydell, 2020). Involving community and religious leaders can ensure participatory process’ concurrence with local cultural norms and address the complex social and gender norms that influence fertility preferences and the acceptability of FP and contraception (George, 2015).

### 4.3.3 Factors that enable or support functional and equitable participatory spaces

**Selecting members and who participates**
Ensuring democratic and transparent selection of participants is associated with ensuring equity. The community representation cannot be dominated by a group, such as males or affluent or politically prominent community members (Molyneux, 2012). The formal election of volunteers who were held in high esteem within their local communities or are members of existing community structures has been linked to the good functioning of participatory processes (Molyneux, 2012).

Numerous studies evaluating participatory spaces have shown that these spaces are often dominated by men, older people, community members from higher economic statuses, and dominant ethnic groups (George, 2015). Women, adolescents and young people, those who are less educated, and ethnic minorities are often excluded, and when they do attend activities, they may not actively participate in discussions. (George, 2015). Explicitly supporting the participation of marginalized or vulnerable groups can ensure diverse representation (George, 2015). For example, policy-makers and programme managers can support the meaningful participation of young people and adolescents by: (i) supporting young people’s leadership, (ii) agreeing on roles, responsibilities and expectations, (iii) establishing a clear method for addressing and responding to their feedback, (iv) creating and identifying opportunities where young people can advocate for issues and causes of their choice, (v) supporting sustained engagement and ongoing relationships between young people and the communities that they represent, (vi) building skills and knowledge, (vii) using language and communication methods that are understandable, respectful and accessible, (viii) providing sufficient support and resources, (ix) providing an enabling environment, and (x) promoting gender equality and empowering girls and young women (FP2020, 2019).

**Ensuring a level playing field**
The WHO Handbook has underlined several recommendations for social participation on how policy-makers and programme managers can level the
playing field within participatory spaces (WHO, 2021). These are related to the quality and type of participatory spaces: the use of a broad range of diverse dialogue techniques adapted to the different population groups and where there is transparency about the role and function of the participatory space (WHO, 2021). Participatory space should include regular evaluation, including continuous cross-checking of who is not participating and post-dialogue feedback to those who participated (WHO, 2021). Regular evaluations could also inform subsequent processes to build evidence on what works (WHO, 2021).

Building trust between health actors and community members
Ensuring trust and collaboration between the community and health actor groups is vital for social participation to work. Community input should be incorporated into the various stages of programme development to ensure that there is practical and not just symbolic collaboration (George, 2015). Participatory research or social mapping can, for example, be used to develop consensus between stakeholders and promote acceptability (George, 2015). This can also be achieved by including representatives from community-based organizations, health committees, and discussion forums (George, 2015).

Enabling community and health provider relationship dynamics can also be promoted by increasing links between them where health facility actors and community members work closely and have equal influence in decisions made; this has provided support and helped legitimize the action plans (Steyn, 2016; WHO, 2021). Multiplying participatory avenues can also build health professionals and institutional experience and commitment to community orientation such as institutional boards, advisory groups, health committees and community education programmes (Zakus, 1998).

Transparency and effective communications are needed to ensure that community members are informed about the existence and functioning of participatory spaces such as committees, otherwise there could be mistrust between the two groups (Molyneux, 2012).

Making human and financial resources available for primary health care system and for (independent) participation
Molyneux described a virtuous cycle between the strength of the primary health care system and that of participatory spaces such as health facility committees, with each positively reinforcing each other (Molyneux, 2012). Investing in health worker outreach and primary health care was noted to be an important trigger for this virtuous cycle. In different settings, social participation can only achieve goals of improving health facility service provision and responsiveness if they are given adequate resources and power to make decisions in practice, and where local and national governments are experienced in responding to community concerns (Molyneux, 2012). Health actor responsiveness is further explored in Chapter 5.

Supporting platforms in which community members can engage meaningfully with decision-makers and service providers
Multiplying opportunities for interactions between health actors and community members can reinforce enabling elements for social participation (Butler, 2020; Marston, 2013; Mamdani, 2018). Making efforts to identify and support state-society reform champions and invest in strategic network-building approaches to link state and society and build alliances between different groups within the civil society has been identified as a way of promoting an enabling environment for social participation (O’Meally, 2003; Mamdani, 2018).

Enhancing the power of civil society representatives also strengthens the enabling environment. This can be done through participation contracts, quotas for participation of excluded groups, and investments in capacity-building of different stakeholders on both leadership and reproductive health and rights (Murthy and Klugman, 2004). At the same, it ensures a level of independence of the mechanisms from the duty bearer(s) (Ray, 2012; Garba, 2014; Martin Hilber, 2020).
**Promoting transparency and access to information**

The importance of transparency and open communication in increasing accountability to communities and supporting social participation has been underlined time and again (George, 2015). Ensuring the availability and accessibility of information regarding the official standards and performance is critical for social participation processes such as SA. It provides community members with information on what they can mobilize and demand action on (Joshi, 2013). In the context of FP programming, these may include information about their sexual and reproductive health rights and right to access contraceptive service provision. Additionally, the nature and quality of the information provided should also be carefully considered. Joshi posed the following questions to ask when providing information (2013):

- Is the information provided clear, understandable, and actionable? Is the information meaningful and tangible for target audience?
- Is the source of information credible, meaning is the information accurate and reliable? When information used in accountability demands is generated through a process involving both providers and users, it has more legitimacy among stakeholders.
- Is the information about official standards or is it about performance in relation to other similarly placed comparators?

Information about performance of interventions can be catalysed to support social participation actions by showing where there are differences in quality and performance of services (Joshi, 2014). Transparency should also apply to the functioning of invited participatory spaces. Insufficient information regarding roles and responsibilities were commonly stated barriers to effective participation of community members (George, 2015).

**EXAMPLE 3**

**Using health facility charters or patients’ rights charters to promote transparency**

The use of charters, which are guidelines that provide information on standards of care that patients can expect to receive and demand as a basic human right, is an example of an accountability mechanism (Molyneux, 2012). In examples analysed, Molyneux et al, found that staff and managers were often positive about the charter and its ability to motivate staff and generally the potential in providing community members with a standard for negotiating quality of care with providers at their facilities was recognized (2012).

In an example from Kenya, community members from the poorer districts and relatively more constrained facilities appreciated that health facilities displaying the service charter, even in its limited form with minimum information displayed (available services and related costs) (Atela, 2015). Information included in the charter was fragmented and, at times, selective. Nevertheless, the presence of a service charter was perceived to be a sign of transparency and accountability, symbolizing the facility management’s commitment to government standards (Atela, 2015).

Several challenges have been identified regarding the use of facility and rights charters. There have been reports of charters creating strains in the relationships where providers felt that patients’ expectations were unrealistic, and that health workers’ own stresses and challenges were not considered (Molyneux, 2012). These resulted from the imposition of the charters and inadequate inclusion of health providers with field experience in decision-making, and inadequate support to local-level understanding and adaptation of the charter (Molyneux, 2012). Development of charters without community input, and where they are introduced in a context where civic structures tend to exercise political patronage rather than play active roles on behalf of civil society, can also contribute to interventions failing (Molyneux, 2012).
HOW TO ENABLE AND SUPPORT SOCIAL PARTICIPATION IN HEALTH

• Take into consideration that the varying participation needs of the actors in the health systems and wider political and sociocultural contexts influence the form and level that the social participation process takes.

• Involve or engage not only women, girls, men and boys who access services, but also all community stakeholder groups that impact SRHR-related norms and decision-making.

• Ensure functional and equitable participatory spaces by:
  - Ensuring that marginalized and vulnerable groups are represented and that there is democratic and transparent selection of participants;
  - Using a broad range of technics to account for power and level the playing field within participatory spaces;
  - Building trust between health actors and community members;
  - Supporting platforms in which community members can engage in meaningful with decision-makers and service-providers;
  - Promoting transparency and access to information.


5.1 Introduction

In this chapter, policy-makers and programmers will gain insights on how they can meaningfully engage and respond to the community demands that are raised through the SA processes and help to ensure effective contraceptive service delivery and provision. Health system actors and duty bearers are equally important in determining whether SA achieves its intended outcomes and, therefore, should not be seen as the target of blame. Duty bearers are understood as health care providers, health officials, managers, or policy-makers.

Social accountability rests on the assumption that public officials and duty bearers will respond to citizen action and make improvements (Joshi, 2017; Lodenstein, 2013; Lodenstein, 2017). These official responses can vary considerably, including generating and releasing information, reforming processes, mobilizing resources, advocating for reforms at higher levels and changing their own behaviour (Joshi, 2017). They could also initiate investigations of wrongdoings and sanction those responsible. On the negative side, they could instigate reprisals and ignore reputational taints.

This chapter outlines definition of key terms, learnings from the current evidence around health system responsiveness and activities, that policy-makers and programmers can undertake to strengthen responsiveness.
Why enabling responsiveness is important

Successful SA is dependent on health system actors and duty bearers meaningfully engaging and responding to community demands and claims.

Health system actors also need support to foster SA.

Key terms

There can be confusion around some key terms, and here we offer clarification:

**Health system** is the organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations (WHO, 2007). Health systems include not only the institutional side of the health system but also the population. Therefore, there is not a neat distinction between community and health systems – communities are an integral part of health systems.

**Health system responsiveness**: WHO defines health system responsiveness as “the ability of the health system to meet the population’s legitimate expectations regarding their interaction with the health system, apart from expectations for improvements in health or wealth (WHO, 2007).”

**Duty bearers** are understood as health care providers, health officials, managers, or policy-makers. But in a health system, there are many shifting accountability relationships – a person may be a duty bearer in one relationship but be a rights holder in another situation. Many duty bearers do not have decision-making authority to change the issues that are raised.

Learnings from the current evidence

There is little understanding as to why officials might take certain actions and how health system responsiveness works (Mirzoev and Kane, 2017; Khan et al., 2021). Many health system actors have limited receptivity to
concerns raised by patients and the broader public (Lodenstien, 2013; Khan et al., 2021). Community mem-
bers struggle to engage with the system about their problems and to secure appropriate responses; this is
particularly true for minority groups (Khan et al., 2021).

Several studies have identified the factors that can help support health system actors respond to issues
raised through community:

- Duty bearers believe and have the capacity to respond, influence and make changes (Lodenstein, 2017; Joshi, 2017; Frost and Pratt, 2020);
- Attitudes of health workers, for example, they may self-identify as activists’ health providers and/or be motivated by public service (Mirzoev and Kane, 2017; Lodenstein, 2017; Joshi, 2017);
- Organization and management of the health system shape the internal accountability of service providers to actors other than service users (Mirzoev and Kane, 2017);
- Duty bearers are receptive to and value people’s expectations (Mirzoev and Kane, 2017; Lodenstein, 2017; Joshi, 2017);
- Duty bearers see citizen groups as providing personal and professional support to health providers (Lodenstein, 2017a);
- Duty bearers care about their reputations (Joshi, 2017).

A recent review found that there are several mechanisms and interventions to enhance health system
responsiveness; there are both formal and informal mechanisms (Khan et al., 2021). The current evidence
focuses on the type of mechanism, how it works and how it is implemented rather than on how these mecha-
nisms are acted upon or how the system responds.

5.3.1 Formal mechanisms

In particular, the mechanisms are formally mandated or institutionalized ones, such as: community monitoring;
complaint management procedures; incident reporting; intersectoral action or collaboration; health facility
committees and hospital boards; medico-legal cases; ombudsmen; patient charters; satisfaction, experience,
or quality of care surveys; social audits; score cards or report cards and complaint systems (IAP, 2021).

5.3.2 Informal mechanisms

Recipients of health services or other social actors may informally and organically provide feedback on service delivery issues. These may include direct verbal and non-verbal expressions (usually expressions of gratitude) and indirect feedback transferred through intermediaries such as family members (Lodenstein, 2018). There are also collective informal mechanisms such as public “buzz” (Lodenstein, 2018). This is when health workers hear about feedback in conversations in public spaces rather than from specific individuals (Lodenstein, 2018).

What to do?

There are activities that policy-makers and programmers can undertake to strengthen responsiveness. But we recognize that policy-makers and programme managers may not have the power to make any changes. Therefore the activities to strengthen responsiveness will vary depending on the structure and process of deci-

Power is central to the working of accountability strategies in contraceptive care and shapes responsiveness. Sen et al. (2020) argued that we need to assess the interactions of different stakeholders based on their social position, material interests, and voice and examine what types and sources of power they wield both within formal and informal mechanisms.
HOW TO ENABLE AND ENSURE HEALTH SYSTEM RESPONSIVENESS

• Facilitating SA for contraceptive services is an ongoing process and not something that is triggered when there are problems to be dealt with.
  • Ensure that activities to strengthen responsiveness consider the structure and processes of decision-making in the local health system and recognize the constraints on the decision-making power of different health system actors.
  • Map the existing formal and informal mechanisms that can facilitate and foster SA.
  • Consider what “responsiveness” outcomes you want to achieve when thinking about activities.
Another common form of informal feedback was via social media, the studies being primarily descriptive, often relating to the potential for user experiences (or complaints) to be fed through social media to service engagement.

5.3.3 Health system responsiveness outcomes

Whether improvements occur in quality and performance of health providers depends on the willingness and ability of health providers to respond to societal pressure for better care. Lodenstein (2017) provides a useful outcome of responsiveness of the health system at facility level outlined in Table 3 below.

<table>
<thead>
<tr>
<th>TABLE 3. USEFUL OUTCOMES OF RESPONSIVENESS OF THE HEALTH SYSTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcomes area of health system responsiveness</strong></td>
</tr>
</tbody>
</table>
| ‘Receptivity’ of health care provider – this is improved attitudes between providers across different levels of the system and/or towards citizens groups or increased awareness of challenges in service delivery | • Articulate and demonstrate stakeholder commitment rights holders and/or duty bearers as appropriate.  
• Work through partnership structures to ensure that all stakeholders can participate.  
• Focus on finding solutions, not allocating blame.  
• Identify and implement appropriate solutions that address the identified issues.  
• Establish and use feedback loop involving both rights holder(s) and duty bearer(s).  
• Give appropriate consideration to all affected subgroups. |
| ‘Responsiveness’ – changes in health care providers’ behaviour and actions leading to improvements in health service delivery based on citizens’ articulations | • Provide positive incentives for action.  
• Implement consequences for inaction.  
• Monitor the extent to which the mechanism contributes to action taken to address standards and entitlements.  
• Establish and use feedback loop involving both rights holder(s) and duty bearer(s). |
| ‘Accountability’ – measures resulting in better relations and interactions, including mutual respect between health providers and communities | • Develop national and local ownership of the mechanism.  
• Ensure sustained change to process(es).  
• Monitor the extent to which the mechanism contributes to action being taken. |
EXAMPLE 4

Social accountability and health system responsiveness

A qualitative study of two SA projects that focused on contraceptive care in Uganda found that SA improved health system responsiveness amongst other outcomes (Boydell et al., 2020). Through participating in SA, health system actors were actively supported to overcome their own bias about contraception and about community engagement. Through this engagement process, those health system actors with decision-making power listened to the community needs and preferences. As a result, new health care providers were recruited and changes in provider behaviour were observed (for example, wearing of uniforms and posting of duty rosters). Dialogues lead to alliances between communities and health system actors who worked together to negotiate with higher authorities to effect change. Health system actors increasingly valued community members’ input and sought their participation in districts and at local planning and budget meetings. In both sites, however, project participants worked with local officials and health sector actors to raise their awareness about contraception, to actively value concerns coming from the community as well as to improve their knowledge about the health system and their own roles in it.
References


Frost L, Pratt BA (2020). Literature review on how accountability platforms, mechanisms, actions, or activities carried out by stakeholders (public, private, or partners) impact systems performance, health outcomes, and/or health-relevant SDG outcomes in countries. Report for the UN SG’s Independent Accountability Panel for Every Woman, Every Child, Every Adolescent (IAP).

IAP (2021). The health of women, children and adolescents is at the heart of transforming our world: empowering accountability (https://iapewec.org/reports/iap-2021-final-report/)


SECTION 3. Supporting monitoring, evaluation, sustainability and scale-up
Supporting monitoring and evaluation

6.1 Introduction

In this chapter, programme managers will gain a better understanding on how to monitor and evaluate SA interventions. This can support greater learnings on implementing and studying SA. Such learning can support adaptations to SA interventions that are more likely to be embedded, scaled up, and institutionalized to support more responsive health systems and provide communities equitable access to quality care (MCSP; 2019). Knowledge about what does and does not work in scaling up needs to be harnessed through M&E, knowledge sharing, and training. M&E should assess not only the impact of an intervention but also the factors that contribute to determining possible scale-up pathways (drivers and spaces). Effective M&E is a critical component of an effective scale-up pathway (Cooley and Linn, 2014).
Designing monitoring, evaluation, and learnings for social accountability can be challenging because accountability initiatives are often abstract and complex, existing of dynamic interactions between social actors. It also involves multiple types and levels of actors and groups who interact in different configurations of power relations (Holland, 2009; Paina et al., 2019; Boydell et al., 2019). *Nevertheless, M&E efforts to increase accountability are essential to better understand the effectiveness of accountability interventions.*

This chapter summarizes some existing M&E methods that can be applied to SA in the context of contraceptive services. We conclude with some key considerations for policy-makers and programme managers in their contribution to/use of M&E of SA in contraceptive services.
Why monitoring and evaluation is important

Knowing whether a SA initiative is working as planned is important in providing government officials, development managers, and civil society with a means to make course corrections to improve service delivery and planning and allocating resources; demonstrate results as part of accountability to key stakeholders; and garner learnings for future programming.

• It can generate learnings that are essential to embedding, sustaining and scaling up SA.

• Through M&E, policy-makers and programme managers can identify excluded voices and the marginalized and therefore create avenues that lead to their inclusion and presence at the centre of decision-making.
6.2 Key terms

In the context of SA, monitoring and community monitoring can get confused. By monitoring we mean monitoring of the activities by the project implementers as part of day-to-day management practice and generally focuses on the question “Are we doing things, right?”. It provides a robust foundation for evaluation and learning (Joshi A, Houtzager P (2012). Whereas community monitoring is part of the SA itself and aims to monitor ongoing activities of public agencies. Often community monitoring is used to ensure ongoing performance in the public sector (focused on observable features, for example, teacher or doctor attendance, quality of construction in facilities) or that appropriate procedures are followed. Community monitoring has been useful in bringing to light instances of corruption or diversion of public resources (Joshi, 2012). Here we focus on monitoring to understand if and how SA intervention is achieving what it is supposed to achieve, that is, effecting change in, for example, power spaces, community member engagement and accountability. Monitoring is often conducted at the community level.

Evaluation is a longer-term dynamic learning process and generally focuses on the question “Are we doing the right thing?”. Evaluation’s focus is to identify what works, for whom, in what respects, to what extent, in what contexts, and how (Lopez Franco E, Shankland A, 2018). Evaluation is a piece of research, but not all research is evaluation. The purpose of evaluation (example Realist) is about how a programme/intervention works as well as whether it works to improve it and form the basis for decision-making. Evaluation seeks to find out how well it works, while research aims to find out how it works (Levin-Rozalis, 2003).

It is important to note how evaluation differs from monitoring. Monitoring involves ongoing measurement of performance, examining parameters such as cost efficacy and assessing whether things are going well. Ideally, these measurements are conducted and reviewed locally by the intervention team and can lead to improvements throughout the implementation stage. Evaluation, on the other hand, is focused on proving impacts rather than improving interventions. However, evaluation is a more detailed and time-consuming activity and is thus conducted less frequently. Organizations therefore often rely on monitoring information to identify potential problems that require more detailed investigation via evaluation.

6.3 Learnings from the current evidence

There is little consensus regarding the M&E of SA, yet there have been several studies to better understand how SA has been evaluated (Marston et al., 2020). Most of the evidence comes from research not on M&E (Marston, 2020; Fox, 2015 Paina, 2019). There is increasingly recognition that evaluation of SA interventions using exclusively randomized controlled trials with quantitative data on their own will not help understanding if and how SA works (Fox, 2015; Paina, 2019; Joshi, 2014; Cant, 2015; Lopez Franco E, Shankland A, 2018). To address these issues, theory-based evaluations have been recommended, outlining and specifying their assumptions about how and why change happens and shifting questions from what works to how and why a certain approach makes a difference in a particular context (Boydell V, Keesbury J, Wright K, 2014; Van Belle et al., 2018; Paina, 2019; Lopez Franco E, Shankland A, 2018).

An early attempt to evaluate an SA intervention using an experimental study design was a 2009 paper presenting the evaluation of community-based monitoring of public primary health care providers in Uganda by Bjorkman and Svensson (2009). Other study designs include Realist evaluation, experimental designs, including randomized trials, quantitative surveys, qualitative studies, participatory approaches, indices and rankings, and outcome mapping (Gaventa and McGee, 2013). Table 5 shows some of these with
examples of where they have been applied. Choice of a study design should be guided by the study questions, purpose of the evaluation, status of current conceptualizations of SA, nature of existing evidence, and resources available.

Other possible research approaches include process/outcome tracing, harvesting, developmental evaluation (embedding someone in an organization to help it adapt over time), case study, community-based participatory research, or a mix of methods (Squires, 2020; WHO/HRP Meeting Report 2018).

There are different types of monitoring in SA programming, including at process, output, and outcome levels. We provide examples of both process-level indicators in Example 5 and outcome-level indicators in Example 7 that have been used in other studies (Lopez Franco E, Shankland A, 2018; Fassiotti and Rajaelison, 2020). Programme managers and policy-makers’ should focus on processes to understand what is and not working in a particular context.

### Table 4. Study designs and examples of their application

<table>
<thead>
<tr>
<th>Study design</th>
<th>Example of its application</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Realist evaluation</strong></td>
<td>Evaluation of the citizen Voice and Action for Government Accountability and Improved Services: Maternal, Newborn, Infant and Child Health Services project funded through the World Bank’s Global Partnership for Social Accountability (GPSA) programme. The aim of the project was to improve maternal, newborn, child health, and nutrition (MNCHN) services, and specifically to achieve “Improved quantity and quality of midwives and District Health Office’s Services for MNCHN” in the three districts.</td>
<td>Ball and Westhorp (2018)</td>
</tr>
<tr>
<td><strong>Experimental designs</strong></td>
<td>Randomized field experiment on increasing community-based monitoring. As communities began to monitor the provider more extensively, both the quality and quantity of health service provision improved. One year into the programme, there are large increases in utilization, significant weight-for-age z-score gains of infants and markedly fewer deaths among children.</td>
<td>Björkman and Svensson (2009)</td>
</tr>
<tr>
<td><strong>Participatory community monitoring</strong></td>
<td>CARE’s CSC was assessed in a cluster-randomized trial in the catchment areas of 20 health facilities in the Ntcheu, Malawi.</td>
<td>Gullo et al. (2018)</td>
</tr>
<tr>
<td><strong>Outcome mapping</strong></td>
<td>Building a civil society collective to realize quality, respectful maternal health care in Madhya Pradesh, India.</td>
<td>Dasgupta (2011)</td>
</tr>
<tr>
<td><strong>Multicase study design using a theoretical replication</strong></td>
<td>Assessed Structural and Community Change Outcomes of the Connect-to-Protect Coalitions: Trials and Triumphs Securing Adolescent Access to HIV Prevention, Testing, and Medical Care.</td>
<td>Miller et al. (2017)</td>
</tr>
<tr>
<td><strong>Multicase study design using a theoretical replication</strong></td>
<td>Examined whether and how establishment and scale-up of HIV services influenced mechanisms of accountability within the primary service domain and, as a result, service quality and responsiveness.</td>
<td>Topp et al. (2015)</td>
</tr>
</tbody>
</table>
Process-level monitoring

Process monitoring refers to the monitoring of the modalities under which the activities take place. Modalities or processes are often established before the SA activity is implemented. These should be formed based on the local context and participant needs. This type of monitoring helps to answer questions such as: Was the SA activity implemented on time? Were the participants well informed on the time, space, and scope of the SA activity? Are people (other than participants) aware of the selection process? Was the place in which the activity took place safe for participants? How long did participants have to wait before the activity started? Was the targeting inclusive? Example 5 gives examples of process-level indicators from the design, monitoring, evaluation and learning (DMEL) guidelines for SA programs by Carlotta Fassiotti and Sederé Arnaud Rajoelison (Search for Common Ground, 2020).

**EXAMPLE 5. process-level indicators**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Examples of Indicators</th>
<th>Data collection tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training in the specific SA initiative (for example, community score card, citizen voice and action, health facility committees)</td>
<td>% of participants who have knowledge of SA principles and theory</td>
<td>Pre- and post-test</td>
</tr>
<tr>
<td>Community perception of score cards</td>
<td>% of score card participants who have knowledge about their rights and entitlement</td>
<td>Audits, surveys, focus group discussions (FGDs), key informant interviews (KIs), post-activity surveys, etc.</td>
</tr>
<tr>
<td>Meetings between health service users and health service providers</td>
<td>% of participants who have knowledge of SA principles and theory</td>
<td>Post-activity survey</td>
</tr>
<tr>
<td>Face-to-face, constructive engagement with service providers, facility managers, and local government</td>
<td>% of participants who have skills to facilitate the SA initiative process</td>
<td>FGD or KII with service users and providers</td>
</tr>
<tr>
<td>Number of project-supported organizations that introduce independent monitoring by CSOs</td>
<td>% of project-supported organizations that use feedback provided by independent monitoring</td>
<td>KII or FGD with service users and providers</td>
</tr>
<tr>
<td></td>
<td>% of monitoring committees (for example, school management committees) trained in participatory monitoring</td>
<td>Satisfaction surveys</td>
</tr>
</tbody>
</table>
Outcome monitoring

Outcome monitoring should inform whether expected changes are happening and to what extent. The changes to be tracked should be based on the programme’s ToC and on the expected changes that the different activities are expected to bring about. Example 7 gives outcome indicators although they are not specific to FP/C.
HOW TO SUPPORT MONITORING AND EVALUATION

- Decide on what information you need to collect considering your ToC.
- Link M&E to other related initiatives, for example, quality assurance or improvement efforts by the government.
- Focus on process-level monitoring to understand what does and does not work.
- Assess the various factors that contribute to determining possible scaling up pathways (drivers and spaces).

- Purpose to map out the social, gender, and institutional norms of the context, how they change over time.
- Combine different data sources to gather a more thorough insight.
- Build and sustain partnerships between communities and providers.
- Create and sustain partnerships between the community members, civil society, and government, being context-appropriate, clearly defining roles, standards, and responsibilities of every actor.

### Example 7. Examples of outcome-level indicators

<table>
<thead>
<tr>
<th>Reference</th>
<th>Intervention</th>
<th>Outcome area</th>
<th>Thematic reference indicator</th>
<th>Outcomes reported by providers</th>
<th>Outcomes reported by clients/communities</th>
<th>Intermediate outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boydell and Keesbury (2014)</td>
<td>IPPF/western hemisphere region • Budget tracking in Mexico, Peru, and Bolivia (Plurinational State of) (budget analysis and advocacy activities by a consortium of national civil society partners)</td>
<td>Revenue mobilization</td>
<td>Financial statements of accounts made available Citizens can study the books of accounts and offer choices and priorities among budget items</td>
<td>Community boards Community websites Focus group discussions</td>
<td>N/A</td>
<td>Increased funds for state implementation of adolescent SRHR policy</td>
</tr>
<tr>
<td>Malawi Gullo et al. (2017); Gullo et al. (2018); Gullo et al. (2020)</td>
<td>CARE Community Score Card using cyclical process, every 6 months over 2 years with community members (men, women, youth, vulnerable groups, power holders), health providers and power holders, including District Health Medical Team (1) meetings (community and providers separately) to identify barriers/facilitators to service use and delivery, and develop measurable indicators (that is, score cards); (2) interface meetings to develop plans</td>
<td>Citizen participation</td>
<td>Number of citizens that are better informed and co-determine development activities and budgets in their localities</td>
<td>Knowledge, attitudes, and practices (KAP) surveys Statements from focus group discussions</td>
<td>From Gullo et al. (2018)</td>
<td>Community members have increased ability to express needs and participate in dialogue with health actors • Equity (inclusion of marginalized groups) and quality of CSC meetings and processes • Community action group or safe motherhood committee exists • Solutions are implemented and collectively monitored, with adaptations as needed • Perceived positive changes in health services</td>
</tr>
</tbody>
</table>
References


MCSP (2019). Monitoring and evaluation of evolving social accountability efforts in health: a literature synthesis


Supporting and enabling sustainability and scale-up

7.1 Introduction

In this chapter, programme managers and policy-makers as duty bearers and at times as rights holders in both public and private sectors will understand their roles in the scale-up, sustainability and institutionalization of SA. They will gain insights from examples of efforts to scale-up SA and lessons learned from them.

Sustainability of SA is potentially beneficial depending on the extent that SA processes and gains such as citizen control are systematized and integrated into the relationships between citizens and governments via CSOs (UNICEF, 2018). While scale-up is of significant interest, there is also a strong association between approaches to scale-up and how sustainable an intervention may be over the long term.

There is a scarcity of information on how improved accountability can be sustained, institutionalized, or scaled up (Boydell and Keesbury, 2014; Squires, 2020). Most of the mechanisms described in the literature stop short of institutionalization, and many acknowledge this as a shortcoming (Martin Hilber, 2020). However, there are different examples of characteristics of a possible sustainable/scalable SA which will vary depending on the context and the programme objectives.
(Bennett et al., 2020). This underscores the need for practitioners to customize interventions to what is most feasible and acceptable in the local context. The World Bank has scaled up SA through country-based experimentation. In Madagascar they initiated modest pilot projects supported by a Trust Fund for Environmentally and Socially Sustainable Development (TFESSD) grant using community score cards in the health sector and participatory budgeting in local governments.

These pilot activities led to scale-up of SA to other sectors and integration of a national SA programme in the Country Assistance Strategy (Agarwal, Heltberg, and Diachok, 2009). Another lesson from the World Bank’s pilot approach to scale-up is that the successful integration of SA in World Bank–funded projects can be achieved but requires concentrated efforts at all levels – national, sectoral, and project/local – as evidenced from cases in Honduras and Nicaragua (Agarwal, Heltberg, and Diachok, 2009).

**Sustainability of SA has been and can be achieved when communities and state actors at all levels own and support each other** (Martin Hilber, et al., 2020). This can be through information-sharing, capacity-building, and duty bearers seeing themselves as rights holders.
Why supporting and enabling sustainability and scale-up is important

- It leads to improvement of the effectiveness of SA mechanisms.

- It brings about sustained changes to norms, perceptions and/or practices.

- It can make the crucial difference in ensuring access to services for marginalized groups, such as women.

- It leads to the creation of inclusive spaces for community participation, whether institutional or informally established, which can reduce 'asymmetrical power relations' between local service providers and community members.
7.2 Key terms

There is little documentary evidence of how SA becomes institutionalized, and the robustness of that institutionalization to deliver transformative change and greater accountability within health systems, but the definition used here draws from the Simmons and Shiffman (2007) framework. It is applicable to SA from the perspective of policy-makers which stipulates that scale-up is predominantly an organizational, managerial, political policy, legal, budgetary or other health systems change (https://expandnet.net/PDFs/WHO_ExpandNet_Practical_Guide_published.pdf).

It defines scaling up as “deliberate efforts to increase the impact of health service innovations successfully tested in pilot or experimental projects so as to benefit more people and to foster policy and programme development on a lasting basis” (WHO, 2011). This framework links the SA to be scaled up with four other elements: a resource team to promote it, a user organization to adopt the SA, a strategy to transfer it, and an environment in which the transfer takes place. The framework’s intention is to facilitate the strategic planning and management of the scaling up by unpacking the scale-up process, identifying the conditions for success, supporting strategic decision-making, and pinpointing actions that support success and sustainability (Simmons and Shiffman, 2007). The framework is presented in Fig. 5.

Simmons and Shiffman (2007) suggest four primary scale-up strategies: (1) vertical scaling up, (2) horizontal scaling up, (3) diversification, and (4) spontaneous scaling up. These strategies are not mutually exclusive and different types of strategy, especially vertical and horizontal scaling up, are likely to be required for sustainability (Simmons and Shiffman, 2007).

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The innovation refers to a set of health service interventions that is being scaled up, such as the score card programme health committee. The user organization refers to the institutions or organizations that seek or are expected to adopt and implement the innovation on a large scale, such as community members and health providers of FP. The resource team or organization refers to the individuals, such as programme managers, service providers, community representatives, reproductive health advocates, and policy-makers and organizations that seek to promote and facilitate implementation of the SA. The environment is the social, cultural, political, and economic context in which scale-up of SA is taking place. The scaling strategy is how the innovation is communicated, disseminated, transferred, or otherwise promoted.

Scale-up requires (i) the innovation that is SA as a health innovation for contraceptive service provision to ensure a rights-based approach to quality improvement, people-centred care...but have not been scaled up; (ii) successfully tested and promising practice that is SA processes supported by CSOs for other health programmes, or by donor-initiated studies/programmes with short-term successes in different contexts; (iii) an enabling environment – SA scale-up cannot work without health system responsiveness at higher levels – as seen in other chapters (legal and policy environments); (iv) funded policy and programme development on a lasting basis; and (v) policy-makers and programme manager actions to carry out institutional capacity-building, sustaining scale-up, political support, managerial structures, and human and budgetary resources.

7.3 Learnings from the current evidence

The different types of scale-up described here do not function in isolation.

Table 5. Type of scale-up and examples of its application

<table>
<thead>
<tr>
<th>Type of scale-up</th>
<th>Explanation</th>
<th>Case example</th>
<th>Sustainability achieved?</th>
<th>Role of policymakers and programme managers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous diffusion</td>
<td>An innovation moves from individual to individual or from an innovative programme setting to other environments</td>
<td>mHealth call centre to advise volunteer doctors (VDs) and a self-diagnostic tool for use by villagers and VDs aim to enhance the quality of care provided by untrained VDs (Bennett et al., 2017)</td>
<td>As originally designed, proved unsustainable due to low demand, and lack of willingness of for-profit company to continue to provide services given low revenues from the scheme</td>
<td>(Government policies very supportive of e-health) Support the ways to organize the process; assess costs; and mobilize resources, monitoring and evaluation</td>
</tr>
<tr>
<td>Expansion/replication</td>
<td>Also referred to as horizontal scaling up</td>
<td>Population Foundation of India intervention to expand access to FP services that started as a pilot in 36 districts in nine states and expanded nationally with support from state and national governments</td>
<td>Sustainability ensured through local ownership with district and state working groups bringing champions together to capitalize on local knowledge, develop plans and implement advocacy strategies</td>
<td>Support the development of human resources and appropriate training and educational strategies for achieving quality of care</td>
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</table>
A key lesson about successful scaling up is the importance of designing and testing innovations with implications for scale-up in mind, rather than leaving them as an afterthought once a pilot project is completed (WHO, 2011). In addition, Fox (2015) noted that there should be:

- Identifiable scalable ‘active ingredients’ or mapped out what works in what context through political economy analysis and process mapping (Boydell et al., 2019);
- Political acceptability of an approach that ultimately seeks to challenge power between the disadvantaged and the privileged (this can be through links to local government through municipalities. This support will facilitate access to the necessary resources (financial and human) to institutionalize an SA initiative within government);
- Capacity for embracing error, learning with the people, and building new knowledge and institutional capacity through action (Korten, 1980 p. 480).

Opening the black box, the contextual drivers of social accountability (Grandvoisinnet, Aslam, and Raha, 2015) defines some of the main elements of a sustainable SA intervention as: strong political will (at the national and local [municipal] levels); identification of sustainability strategies at the outset of the project, such as long-term funding arrangements (ideally from government); good entry points for broader post-project institutionalization; engaged partners and consensus building; systematic technical assistance to state and society; and professional knowledge of SA and simple systems, procedures and management incentives linked to performance.
HOW TO SUPPORT AND ENABLE SUSTAINABILITY AND SCALE UP

• Create awareness of power and build capacity of community on SA process including resource mobilisation for action.

• Advocate at the subnational level to create interest and ownership, partnerships between CSOs and governments, concerted efforts to address community members’ concerns, and recourse mechanisms to affirm people’s faith in the public health system.

• Encourage CSOs to continue until resilient SA infrastructure is built and fully institutionalized.

• Discern when community champions may need to be identified, nurtured and (their activities) funded to help ensure local ownership and sustainability.

• Support community committees by national policy/legislation framework and link them with local government structures.

• Ensure that all actors, rights holders, and duty bearers work together to sustain the interest by higher-level power brokers.

• Apply results from monitoring and evaluation, what is being learnt? This requires that M&E is not only functional, but also sustainable with a data management system integrated across all levels.

• Develop guidelines for institutionalization although this needs to be responsive to the context.

• Encourage member countries to report on the state of implementation at regional and international levels (Sarkin, 2019).
References


Boydell V, Keesbury J. (2014). Social accountability: what are the lessons for improving family planning and reproductive health programs?


## ANNEX

### Tools and approaches for analyzing context

<table>
<thead>
<tr>
<th>Type of tool or approach</th>
<th>Examples or resources</th>
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<tbody>
<tr>
<td><strong>Environmental and political “scanning”</strong></td>
<td>This can include a SWOT (strengths-weaknesses-opportunities-threats) is or PEST (political-economic-social-technological) analysis. (<a href="http://apps.who.int/iris/bitstream/handle/10665/310886/9789241514514-eng.pdf?sequence=1&amp;isAllowed=y">http://apps.who.int/iris/bitstream/handle/10665/310886/9789241514514-eng.pdf?sequence=1&amp;isAllowed=y</a>)</td>
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<td>Type of tool or approach</td>
<td>Examples or resources</td>
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<tr>
<td>Accountability ecosystem approach</td>
<td>An accountability ecosystem approach incorporates the diverse levels of actors who have a range of roles, responsibilities and interactions and the formal and informal paths toward and influences accountability mechanisms. This approach of defining context also accounts for the multiple accountability strategies and mechanisms that exist, influence each other and change over time.</td>
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