“Closing the Gap”: Preliminary Lessons on Implementing Social Accountability for Family Planning and Reproductive Health (FP/RH) in Uganda

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March 7, 2016

This paper is being presented in Session 99: Contraceptive Delivery: Innovations and Issues, at the Population Association of America Meeting, Washington D.C. March 31-April 2, 2016.
Introduction

Social Accountability in Family Planning and Reproductive Health (FP/RH)

Social accountability as a process that promotes engagement between citizens and service providers/officials has the potential to become a key catalytic approach for improving the delivery of family planning and reproductive health (FP/RH) services. Social accountability approaches in FP/RH consist of processes that address key health system and governance issues through civic education, citizen-led identification of gaps and problems, citizen-led monitoring activities, ongoing citizen engagement with service providers and health officials to create action on key issues, and continued monitoring and follow-up led by citizens.

Lessons from other health sectors show that independent citizen/community-led monitoring of the implementation and performance of public sector health policies and programs has had positive effects on staffing, quality, funding disbursements and allocations, and on strengthening oversight and monitoring of health services (Fox 2014; Joshi 2013; Ringold et al 2014). In some cases, there have been significant increases in both uptake of services and in satisfaction with service provision in the communities where activities are implemented.

However, these findings are not specific to the FP/RH sector. A 2014 review of the literature found only 16 case studies that describe single or multiple FP/RH social accountability interventions.¹ These studies represent geographically diverse populations, covering Latin America, South Asia, and Africa. All studies included FP as a health service component that the social accountability approaches sought to improve, although many programs were framed as broader RH or maternal health activities. The bulk of these papers were found in the grey literature and consisted primarily of project reports or other deliverables. The vast majority of the activities reviewed were of limited quality, with untested chains of causation, low methodological rigor, numerous implicit assumptions, and little information on actual implementation.

Emerging Evidence on Social Accountability in FP/RH

Two forthcoming studies demonstrate the impact of social accountability on a range of outcomes, including FP/RH. Both of these studies assess the use of community monitoring with scorecards. Simavi in India compared scorecards in 16 health facilities over a two-year period. Eleven facilities showed increased contraceptive method mix, and all facilities started to include counselling on family planning as a standard part of the outreach package. The study in India found a 90% increase in contraceptive use and a 10% decrease in women who did not know any method of contraception. The second study comes out of a two-year randomized control trial of community scorecards conducted by CARE in Malawi. The findings show a 20% increase in community health worker (CHW) prenatal home visits, and a 6% increase in CHW postnatal home visits in the intervention villages, as compared to control villages. Overall service satisfaction also improved, as did the availability and accessibility of FP/RH information.

These new impact studies provide promising findings on the effect of incorporating social accountability approaches into FP/RH programming, but neither focuses on the mechanics of implementation. These positive findings add to the urgency to better understand whether the chain of causation within social accountability approaches occurs through civil society’s efforts to increase citizens’ awareness and articulate citizens’ voices to affect change and reform of the public sector. Building on these impact results, there is a need for a deeper understanding of how the implementation of social accountability mechanisms improves the provision and access to services and of the key variables that hinder or help. These factors are part of an often complex and evolving political process that operates over long timeframes, in the nuanced and ‘lumpy’ reality of social relations.

Retrospective Case Study of the Healthy Action Project in Uganda

Implementation science is a useful approach for better understanding the context of project implementation, including which factors will support and inhibit interventions in the real world. All projects take place within complex social and political landscapes, with pre-existing capacities, incentive structures, and informal and formal institutions. Implementation science places activities within the local landscapes and describes the dynamics that shape how the project is executed.
In response to this knowledge gap about social accountability approaches in FP/RH programming, the Evidence Project undertook a retrospective case study of the Healthy Action Project. The Healthy Action Project was a “proof of concept” social accountability project implemented by DSW (the German Foundation for World Population) and Reproductive Health Uganda (RHU) over a 36-month period between 2009 and 2011 (with an extension to March 2013) in five districts in Uganda. An impact evaluation conducted by independent evaluators for DSW found that district-level outcomes included increased budget allocations for FP services in some districts, while other districts gained new medical staff and an operating theatre. The village-level service outcomes in some districts included an increase in delivery beds, additional commodities supplied, and increased mobile services and blood donations. Some project activities have been sustained, as consultations with communities on health matters are purportedly now included as part of the district work plans.

The Healthy Action Project provides us with a natural experiment in the sense that the same project model was implemented in different sites in Uganda. The Evidence Project’s retrospective case study, conducted two years after project implementation, compares the accounts of the implementation across three of those sites and helps draw out key issues and variables in the implementation of the social accountability for FP/RH programs, and may shed light on sector-specific characteristics of social accountability.

This paper begins by presenting the study methodology, then presents research findings from the case study. The paper concludes with a discussion of how the implementation of social accountability mechanisms improves the provision and access to family planning and reproductive health programs.

**Methodology**

The overall aim of this case study was to understand how the Healthy Action Project’s community-led monitoring mechanisms in FP/RH programs were implemented and how they subsequently affected users’ access to services at the district level in Uganda. This research aimed to 1) identify the formal and informal drivers, barriers, and motivations of different actors; 2) explore the varying perceptions of the activities by different stakeholders (project staff, project stakeholders, and other local actors); and 3) compare the implementation process and outcomes across sites. The retrospective case study design compiled an
existing Political Economy Analysis (PEA) and reviewed the project documentation alongside in-depth interviews in the project sites.

Site Selection

The findings are drawn from three sites where the Healthy Action Project was implemented. Partners received subawards to implement similar strategies in each site. The strategies were based on the parent project’s training to 1) increase citizen access to information; (2) build civil society and community coalitions at district level; (3) enable project staff to undertake civic education of local communities; and (4) train local community members in holding dialogues with public officials.

The sites were selected based on areas the Health Action Project claimed to have improved the voice of community and civil society in local decision-making about FP/RH. By comparing the three districts and sub-counties, we can gain insights into the contextual and geographic differences and the variables emerging in implementation.

The first site was Wakiso, Central Uganda, one of the most populated districts, located in the outskirts of Kampala, Uganda’s capital city. The Healthy Action Project supported the Uganda National Health Consumers Organization (UNCHO) and Communication for Development Foundation Uganda (CDFU) to hold orientation meetings with youth advocates; to hold district-level dissemination meetings and district-level community dialogues; and to support civil society organizations (CSOs) and advocates to participate in the planning and budgeting process. The second site was Mukono, a fast growing district in Central Uganda on the Jinja highway. The Healthy Action Project supported the Uganda Media Women’s Association to generate and disseminate a budget analysis at district- and sub-county level to guide planning processes, host dialogues of young people with district leadership, CSOs, communities, and other stakeholders, strengthen youth participation, and raise the awareness of district and sub county leadership of the importance of youth friendly services. The third site was Kamuli district, a more remote district in Eastern Uganda, where Healthy Action supported the Action Group for Health, Human Rights and HIV/AIDS (AGHA), Muvubuka Agunjuse Uganda, and Naguru Teenage Information and Health Centre Uganda to undertake awareness campaigns directed at in and out of school adolescents, host regular lobbying meetings with district leadership, and host radio talk shows on adolescent sexual and reproductive health, HIV/AIDS, and maternal health.
Methods and Analysis

Data collection for the case study was conducted between June and December 2015 and included a review of project documentation, a review of an existing Political Economic Analysis, and 50 semi-structured interviews with a range of project stakeholders, including project staff, local officials, health officials, beneficiaries and local actors who were not directly involved in the project. Interview participants were selected through a combination of purposive sampling and snowball sampling.

The interviews were translated, transcribed, and then coded using Atlas.ti software. Two levels of coding were applied – the responses were first coded by question and then by emerging themes. The thematic coding framework was not pre-determined but based on the emerging themes. After coding, the thematic codes were organized by stakeholder group (beneficiaries, officials, and project staff) and analyzed by site. The sites and the stakeholder groups were then compared. Data reliability and validity were checked through triangulation of data from project documentation, interviews, and the PEA.

There are some limitations with this methodology. Firstly, because the study was retrospective in nature, it took longer to identify and recruit respondents. The number of similar projects and activities taking place at the individual sites meant that data collectors had to spend extra time with the respondents, verifying that they participated in this specific project. Given the respondents’ participation in the development projects and evaluation activities, the respondents may have been responding positively in order to resume the project activities, resulting in respondent bias. The activities ended three years before the interviews were conducted, and this delay could have introduced recall bias. In addition, it was difficult to corroborate the results found in the interviews with the service and budget data collected, as there was no formal baseline or endline data collection during the project, and no counterfactuals in place to verify if the recorded and reported changes were attributable to these activities or other activities at the same sites.

Results

Healthy Action Project activities were managed by national staff members of two organizations, DSW and RHU, and delivered through a coalition of national non-
governmental organization (NGOs) that received standardized training in advocacy, fundraising, and civic education. National NGO partners competitively applied for sub-awards to undertake activities at district- and sub-county levels; the activities were then usually implemented by smaller CBOs and community health workers, known in Uganda as Village Health Teams (VHTs). In each district, project coordinators undertook budget analyses of spending on FP/RH, prepared a locally specific policy brief, mapped the district landscape, created community groups, and targeted decision-makers to make changes to improve services. Decision-makers included both political actors (district councilors and the social service committee) and technical actors (the district health technical team, the district health officer, and district stakeholder forums). Another set of activities supported awareness raising and micro-consultation at the village and sub-county levels to engage community members and service providers.

The formal Theory of Change as outlined in project documents proposes that building the capacity of CSOs in advocacy and civic education will strengthen networks and coalitions. With these improved capacities, CSOs can then catalyze communities to pro-actively interact with decision-makers and positively influence pro-poor health policy formulation, budgeting, and resource allocation at various levels of decision-making. A key assumption is that when community members share their health concerns, they can provide input that influences decisions at district, national, and other decision-making levels. Civic education supports community members to voice their concerns, increases their knowledge of and rights to specific services available, and demands accountability from service providers. Civic education for health service delivery was needed to help citizens identify their own role in policy planning, their responsibility for monitoring service delivery, and opportunities to interface with decision-makers to persuade them to prioritize reproductive health issues. Then, through a series of activities at the community level (e.g. edutainment sessions and village consultative dialogues), communities were empowered to identify health challenges, formulate health priorities, make recommendations, and demand accountability.

2 The civic education training module was especially developed by Institute for Empowerment and Development Kenya. The modules included: (1) unity of purpose among NSAs and communities of making collective demands from elected leaders; (2) share information and knowledge on management and administration of health services in the respective countries; (3) empower citizens to connect health issues with other aspects of development; (4) to inform citizens of the existing facilities and services monitoring of service provision, and (5) mobilize citizens to support policies that target the vulnerable groups in society e.g. youth, disabled and women. Each partner was received the civic education module and encouraged to disseminate it with their partners. The impact evaluation quoted participants that said: ‘We have already been able to apply the same principles in our work on advocacy for HIV positive women’ (NACWOLA). ‘Having had the opportunity to participate in advocacy with communities and community leaders was very helpful in making what we learnt in the training become very practical (AGHA, Uganda).
The project documents report that the concept of civic education was relatively new in Uganda and had been limited to elections. However, a recent mapping suggests that the Healthy Action Project activities were not unique in Uganda, instead paralleling a spate of NGO and CSO demand-side accountability activities in the country (Mazzo xxxx). The main social accountability activities undertaken by these other projects, which were not related to FP/RH, tended to focus primarily on two types of social accountability activities: monitoring service provision and hosting public/citizen hearings.

The first year of the Healthy Action Project focused on improving participating CSOs’ advocacy capacities and starting dialogues between CSOs and policy makers at both the central and national levels. The second year continued to build the capacity of the CSOs, strengthen the networks to ensure coordinated input into local health policy, and scale up dialogues and community participation at the district and community level by integrating health advocacy into civic education.

Six key findings were drawn from the accounts of the 50 interview participants of Healthy Action Project activities in the three sites:

1) **Perceptions of Family Planning**

The activities described by the respondents were clearly related to an FP/RH program. Respondents had very positive views of the value of family planning and, taking into account respondent bias, there was an evangelical undertone in how people talked about family planning. Family planning was seen as a tool for improving yourself and your family, as a “rescue” and “savior” that will help people move from an “ancient” way of thinking to a “good culture” or a “modern way of thinking” (KAM 11), and improve one’s health and wealth. Respondents said that not using family planning led to earlier pregnancies and unsafe abortions, or too many pregnancies in quick succession that weaken the mother and child. Participants generally believed that people were not using family planning now because of “ignorance” and poor service delivery.

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Ignorance was described as high fertility expectations due to a desire for large families, competition between co-wives in polygamous marriages, a preference for male children, and the intention to extend the lineage and secure the inheritance of land. Young people were seen as “morally” uncontrollable and in need of direction, and there were rampant myths about family planning causing sterility, fetal abnormalities, cancer, and so forth. Participants saw the remedy to “ignorance” as spreading the “right” information, which would lead to change in behavior.

Many officials discussed the challenges of providing services: untrained, absent, and/or abusive staff; limited and lack of stocks and long lines that drove people to use private facilities and drug shops at great personal expense. In addition, people who experienced side effects which affected their work and personal life (such as low libido, headaches, or continuous bleeding), were not being properly counseled on side effects and were discontinuing use.

2) Local contextual issues

There were several cross-cutting contextual factors identified in the responses from all three districts. The first related to husband and wife dynamics around contraception. These gender dynamics were perceived to affect peoples’ participation in the activities in the community, including sensitization or outreach services. Men were perceived as being opposed to or disinterested in contraception, while women were characterized as wanting to use FP and often doing so without the knowledge or permission of their husband. The threat of violence from male partners because of contraceptive use was a repeated theme.

A second contextual factor that was repeatedly remarked on was the number of NGOs providing programs, including services and advocacy activities, in all three communities. The NGO-provided programs brought funding, training, staff, and other benefits to the community and made up part of the local political economy. Local health officials reported “integrating” the different NGO outreach programs with public programs, including FP, immunization, bed nets, dentistry, and circumcision activities, to increase coverage and to use resources effectively. This meant that stakeholders were often unable to distinguish which NGO was doing what and when. For instance, in Mukuno, three NGOs had three different referral forms on top of the referral form of the public sector. Once the NGOs leave, the project activities and sensitizations stop, supplies and outreach stop, quality drops, and there are
gaps in staffing and training. One respondent describe NGO projects as being like “water which boiled but is not ready i.e. it brings bubbles so it is in the middle.” This reported reliance on NGO programs for extending public sector outreach programs illustrates the extent to which NGOs form part of the local political economy.

In the Ugandan administration, in order to implement a project, the project implementers have to inform and get the formal approval of county-level local officials ahead of starting any project activities. Often, the same local officials determine the sub-counties where the activities will be implemented, and it is unclear whether the sub-county selection is based on political favor or increasing program coverage in the district. Local leaders see themselves as “gatekeepers” of the community and as critical to the success of a project. However, discussions with respondents revealed that the role of local officials is not so clear cut and the relationships are not so straightforward. They noted that alongside the elected and politically appointed officials, Uganda also has the additional formal institutional structure of Kingdoms, each with their own resources, administrative systems and public services (Bugandan Kingdom, 2007). These kingdom structures often have similar or greater political pull with local citizens, and their participation, political patronage, or lack thereof may strongly affect citizen participation in projects. Though the local government officials position themselves as “gatekeepers” to the community, their reach in the community was mediated by outreach programs of the VHTs and NGOs.

3) Outcomes and facilitating factors

The respondents reported a range of outcomes from the activities (Table 1). Beneficiaries reported more outcomes and tended to focus on personal benefits, such as self-efficacy, as opposed to the institutional, collective, or organizational gains reported by officials and project staff. The two most frequently reported types of outcomes were those related to health and those related to civic engagement. Of particular interest are those related to increased community participation in health facility management through health committees, improved physical infrastructure, staff being more respectful, changes in fees, bribes, and informal payments, and improved provider-patient relationships.
There are some parallels between what was reported by the respondents and what was captured in the project’s impact evaluation, such as improved confidence in health services, improved relationships between the service providers and the community, and decision-makers addressing issues raised by the community. In Kamuli, participants specifically articulated the engagement of cultural leaders and religious leaders, and in Wakiso, participants mentioned the integration of the youth friendly program activities in the district workplan.

Interestingly, respondents did not remark on the financial commitments made by district government. This contrasts with the changes in the local budget reported in the project documents, thanks to the project activities. This included the 8 million shillings in the district budget to mainstream family planning by the Mukuno local government, and 516 million shillings secured for the district budget in Kamuli for reproductive supplies and equipment.
There was little to no recollection of the budget changes, which suggests a disconnect between the village/sub-county activities and the district level activities.

Across the three sites, participants were asked about activities, processes and people that facilitated the implementation or success of the Healthy Action Project. Three facilitating factors were identified. First, when the civic education element of the project was combined with more traditional mobilization activities (such as organizing sports events and music, dance, and drama activities) it tended to increase people’s knowledge about family planning and services. Second, in addition to the community sensitization activities, the project also provided free outreach services in the form of health workers stationed at sports venues or at music, drama, and dance events to provide services during the sensitization. This project feature emerged from a request for services as part of mobilization at a community dialogue in Mukuno. Finally, the activities created new “spaces” and associations where people talked and worked with new people, learnt new skills, and gained confidence.

4) People’s understanding of the interventions

The descriptions of the Healthy Action Project interventions tended to be one of two types. The first type described activities related to community sensitization and awareness-raising for family planning and reproductive health in order to “spread the word,” and mobilization of community members to use the outreach services provided. This is a fairly typical model for family planning outreach programs. It is more pedagogic in nature, as it aims to inform and educate people, and assumes that the “right” information will drive people to change their behavior. The second type described activities related to community empowerment and dialogue to support citizens to raise their voices and discuss their needs with officials. This is more typical of civic education and democratization activities. It is more dialogic in nature and focuses on creating spaces and conversations between different stakeholders. The assumption is that talking, listening, and dialogue will drive people to change—this assumption was confirmed through some participant’s articulation of dialogue as a “catalytic” part of the change that occurred through the Healthy Action Project.

Generally, across the three sites, the beneficiaries of the project were least aware of the project’s civic education and social accountability components, and described the activities as more of an outreach program. Officials across the board saw the activities as containing elements of both standard outreach and civic education and community engagement to ensure community views in local planning process. Project staff were the most articulate.
regarding the project’s formal Theory of Change, and most likely to use project terms such as “advocacy”, “accountability”, and “civic education”. The Theory of Change states that after sensitization, local villagers would question their leaders, the leaders would listen and make commitments, and changes would then result.

In Wakiso, the stakeholders appeared to be less familiar with the formal Theory of Change of the project model they were implementing, and described a traditional mobilization and outreach program. However, Wakiso respondents also reported the most impact in terms of service outcomes and in terms of creating political capabilities. The activities were seen to have a very strong outreach and sensitization element, and there was no mention of rights or civic education. However, the officials involved reported they were more responsive to community demands. They characterized the project activities as “closing the gap”, where the “gap” is perceived or actual social or political space between citizens and officials or service providers. They also reported that the project activities created mutual understanding, since local officials attended the outreach events and “people could bring their complaints” to the leaders in their own communities. The activities created new spaces for interaction and created new forms of association. These new associations often developed formal structures and spaces for new types of solidarities between community members.

In Kamuli, all groups of participants articulated two distinct routes to achieve project outcomes. Despite these distinct articulations of “pathways to social accountability”, in Kamuli, there was some conflagration of the pedagogic and dialogic project models. The first route was about increasing community members’ ability to make demands, and terms like “brave,” “confident,” “not sit behind government,” and “engage ourselves in government activities” were used. The second route was about listening, in the sense that community members learnt about the constraints faced by health workers and the constraints they face. Dialogues were not about “fault finding,” but sharing. In Kamuli, there were more examples of beneficiaries applying new civic capacity to other areas, such as making public the informal fees charged for the removal of implants, ARTs, or facility-based deliveries. Kamuli is an example where there is reportedly ongoing civic education and voicing of community demands, but they also reported less follow through on the demands by officials. Based on reports, it is unclear if a youth center was built, if budget lines were added or not, or filled.

In Mukuno, the opposite happened. The language was very much about civic education and engagement (project model two); however, further analysis shows that local officials kept their distance from the communities. Often, the officials and decision-makers did not attend
the local dialogues, and the VHTs acted as interlocutors between the communities and officials.

The accounts clearly show that there are ways of combining a typical family planning outreach project modality with civic education activities, to tailor governance and accountability work to the family planning sector. However, the degrees of comprehension of the project, the demands made and responses in each site, and the disconnect between the inputs and outputs suggest the importance of context and pragmatic implementation issues when examining expected outcomes from social accountability approaches.

5) Pathways

There are several pathways of change in social accountability interventions. Change can be affected through more confrontational activities between communities and decision-makers, change can occur when providers respond to information, change can come about through pressure from community representatives or supervisors, or change can be achieved through collaborative action (Ho et al 2015). Comparing the responses from the three sites, a range of accountability pathways emerged. The project staff in all three sites recounted the official institutional blueprint of accountability relationships – the project must work through officials, because people want to hear and are led by their political leaders. The project staff, the respondents who were most articulate on the project’s official Theory of Change, were most concerned about working through local government to ensure buy-in and about addressing the formal accountability relationships. They were less aware or concerned about other accountability relationships that were reportedly at play in a community.

In Wakiso, the most notable commentary on accountability pathways was from the officials and the beneficiaries. Beneficiaries noted a change in their relationship with the health workers, as well as with officials – they felt more assertive and used phrases such as “I am a leader,” “I make decisions,” “we learn to speak and behave,” “open,” “confident,” and “bold.” In response to this, officials talked about the community being hard to satisfy, while also saying that the dialogues were important for gaining the community’s empathy and increasing community awareness of the constraints on the health system, and to get community inputs on government processes – that is, for “closing the gap.” This is not totally one way; there was a surveillance element as well, since officials could see who was not attending these events.
In Wakiso, people expressed that they were learning about political relationships and processes, particularly through the establishment of youth committees with the formal structures of chairperson, secretary, and treasurer, and the convening of youth assemblies with formal dialogues. Respondents described how they learnt to speak, to be taken seriously, and how to “behave”; this was confirmed by the officials’ accounts. Through the different groups established – Nsangi Youth Club, Kirangi Dancers, Nsangi Peer Educators, and Shoe Maker – people were making new connections and working together in different ways.

In both Kamuli and Mukuno, officials had very top-down descriptions of accountability – local leaders didn’t go to the community to get feedback, and often worked through lower tier officials and VHTs; local leaders only got involved if there was a very big incident. Village committees could only engage officials through letter writing and there were no face-to-face occasions for complaints and grievances. The groups created by the project made engagement easier because they grouped people for service providers to reach, provided a channel to share information on behalf of the District Health Office, and acted as an early warning system for complaints for the leadership, so there were no surprises.

There were questions about the incentives of leadership, and whether local leaders supported activities to get more votes or to take credit for the work of others. Leadership were reluctant to go to the community level; in all three sites, we see officials working through mediators.

In all sites, community members were reluctant to engage with health workers and local leaders, instead going through VHTs, writing down thoughts during the meeting, or writing letters to officials. This could be part of the culture of deference, in which people do not think they can demand services, but rather that the leadership or health committee should be proactively providing them (Mamdami 1996; Golooba-Mutebi 2004). There were several examples of people opting out of the accountability system and instead using other facilities, private facilities, or drug shops.

6) Limitations of the project

There were similarities across sites in the reported limitations of the Healthy Action Project. First, the activities were seen to have created demand, but staff and stocks were insufficient to respond to this increased demand. A respondent explained: “What we did unintentionally
was to create a lot of demand which could not be met by the health service delivery.” (MUK 02) Another reported limitation was that issues identified through the community dialogue process were not addressed, due to financial constraints or to lack of political will. People were “educated” and mobilized to make demands, but were left feeling that their demands and complaints made no difference. The end-of-project evaluation found that community participation in planning and budgeting was undermined by bureaucratic decision-making, which meant that recommendations from the communities were not easily taken forward.

The respondents identified four types of barriers. First, there were barriers related to beneficiaries being able to participate in project activities. This included the opportunity costs of participation, poor scheduling of activities, lack of incentives and benefits (such as food), lack of equipment, transport costs, and poor compensation for the array of local partners. Another set of barriers related to the way in which project partners implemented the activities, including getting permission from officials, the turnover of trained participants, the limited spaces for meeting with leaders, and the incentives for health workers and mobilizers. Other barriers were the end of activities and the feeling that targeting activities to young people excluded others who may have also benefited.

Discussion:

Drawing on the findings, several lessons emerge that can help us better understand the implementation of social accountability approaches for improving family planning and reproductive health programs.

One of the most compelling features of these social accountability approaches is the innovative combination of traditional family planning outreach activities with a civic education component. This appears to have the effect of embedding ideas like civic education and health rights within an accepted health education methodology. The project documents refer to the integration of civic education into health advocacy and education, and project partners noted that delivering the civil education message through partners who provide services (e.g. the Naguru Teenage Centre) enabled them to reach more people and has increased their credibility among community members.

Combining civic education with health education can help address any possible tensions between the personal nature of FP/RH services and the public nature of many social accountability interventions. The interest in maintaining privacy and confidentiality in FP/RH
services can conflict with the inherently public nature of social accountability: FP/RH decisions are personal, and many people may not feel comfortable discussing those choices or their service experiences with others, or with their leaders (Boydell et al. 2014). In addition, FP/RH programs may not enjoy widespread community support, and this may complicate efforts to engage citizens. Most examples of successful social accountability interventions are from sectors in which communities express widespread support for the targeted activity, such as decreasing maternal mortality, improving education, or offering curative health services (Boydell et al. 2014). In this context, mobilizing support for FP/RH social accountability interventions poses a particular challenge. However, incorporating social accountability activities into the “integrated” health outreach activities may reduce resistance and create spaces for engagement.

In the reports from respondents about the Healthy Action Project, VHT workers were noted as central to the interaction between the different stakeholders. The VHTs educated the community on behalf of the NGOs, health workers and local officials, they facilitated interactions between service providers, officials, and communities, and they collected and brought the demands of the community to the attention of the leadership. Across the responses, VHT workers were seen as a semi-formal liaison between communities and the health system – they educated the community about their rights and entitlements and they represented community concerns to the local health facility. This is an area that warrants more investigation—much like the role the VHTs play in Uganda, Community Health Workers (CHWs) around the world play a unique and central role to the relationships between the community and the health system, probably because they are answerable to the both. The positive role of CHWs as a mechanism of change in social accountability approaches requires further investigation.

The accounts of the community-based accountability activities focused on sharing information, but also about creating new spaces for participation. The activities promoted participation at two levels. The first was supporting communities and CSOs to engage in existing processes of village and district development and to participate in budget planning meetings, mostly through NGO partner representation. This is citizen participation with authorities in “invited spaces” (Cornwall 2002). But the activities also created spaces through sensitization and community dialogue that were outside of the formal arena for community participation, such as the village level consultation and the consultations alongside the community mobilization and outreach activities.
These social accountability activities also appear to have fostered the creation of stronger associations between community members and service providers. Community members reportedly created new relationships based on common pursuits, gained critical consciousness, learnt skills (such as how to speak and behave in a way that garnered the attention of officials), and gained more confidence from their collective associations to change how they interact with service providers, enabling them to be more assertive in asking for services or reporting abuses. This increased consciousness and confidence also led to community members taking on roles in the formal arenas of “invited spaces” such as the Health Unit Management Committees (HUMC).

In all three sites, there was a repeated theme of the activities being seen to “close the gap” and make space for people to interact with officials from the District Health Office or health workers at the facilities. The outreach dialogues created new spaces for engagement, particularly as there appeared to be limited spaces for engagement between the community, service providers, and officials in the institutionalized, state-sponsored arenas.

Yet there is a reported difference between how officials and health workers participated in the outreach dialogues. Officials tended to work through mediators like VHTs and NGOs, whereas health workers were physically part of the outreach and had direct interaction with the communities. This direct interaction appears to have created a sense of responsibility among both the communities and the health workers - they were “joined in the race.” Communities reported that they learnt about the constraints faced by health workers, and that this helped manage expectations. In turn, health workers got more accurate information about needs, quality, and coverage from communities to inform planning and logistics.

Given the health service focus of the exchanges, the issues prioritized at the outreach dialogues almost exclusively related to issues in provider-client interactions, like untrained, abusive, or absent staff, and the lack of or limited types of supplies. In turn, the relationship with health workers was the most improved outcome, including better treatment by staff and elimination of informal fees. These are issues that are in the power of the health workers to address. Issues such as supplies and equipment, however, would require budgetary changes and a higher level of authority to approve them, and the complex approval systems between local and national levels appear to limit the influence of community-led demands in those areas. This could be related to the continued distance between communities and officials, who reportedly remain reachable only by letters and through VHTs.
The extent of the changes described above was limited. A similar study of social accountability interventions in Uganda found that there was limited impact on civic education - few formal meetings were held, the meetings were seen primarily as an opportunity to gain information, and officials were unable to enforce any decisions (King 2014). Like that study, participants in the Healthy Action Project were unclear as to whether the identified priorities had made it into development plans and budgets and, if so, had been implemented. This may also be due in part to the limited political space in Uganda where localized change is feasible. The respondents we spoke to did not mention the wider informal patronage systems of resource allocation, the centralized nature of resource allocation, the importance of party politics and electioneering, or the very real power relationship between smallholders and dominant landholders. Community-based monitoring may not easily change these real structural limitations.

These accounts also make it clear that social accountability activities are not happening in a vacuum, and that these activities are building on legitimate and accepted existing structures, such as community health workers and banking associations. No project is discrete or working in untouched territory – they each take advantage of pre-existing capacities, incentives, and motivations. Care is needed to not view activities as isolated or discrete “projects,” but rather in the context of local political dynamics that shape how the project is implemented and rolled out.

Conclusion:

The experiences of social accountability approaches within a FP/RH program collected through this study describe how changes occurred as a result of health workers learning about the community’s concerns, pressure from community representatives, particularly VHT workers, and improved collaboration between health workers and communities. A critical part of this was providing a space and opportunity for interaction between community members and the health system, which allowed community members to share their opinions directly or through an intermediary, and close the information gaps for both users and health workers. This was seen to improve the quality of care that was received, specifically increasing access to and uptake of services and strengthening patient-provider relationships.

These findings provide important insights into the implementation of social accountability for FP/RH in Uganda. The findings from this case study highlight two key features of applying social accountability to FP/RH programs. For decades, FP programs have used outreach
programs and community health workers to reach and serve populations. The social accountability activities applied in the Healthy Action Project built on this existing programmatic infrastructure. First, there was a clear attempt to combine civic education into the health education methodologies used in community mobilization and outreach services. Second, according to respondents, the VHTs (the community health workers) played a central yet muted role as interlocutor between the project stakeholders and communities. This suggests that to reach the full potential of social accountability, we cannot simply “cut and paste” social accountability interventions from other sectors, but rather we should start with more sector-specific approaches, identify desired outcomes within a defined Theory of Change, and then assess social accountability’s relevance to those outcomes.

The evidence presented here supports a body of literature that argues that social accountability is a long-term endeavor that consists of building people’s ability to engage with the state and institutional processes. The changes documented in this case study relate to the incremental nature of political capabilities, learnings of associations, and some changes in the patterns of representation (Williams 2004). As an official in Kamuli noted, “at the first dialogues no one said anything. They would just look at you and nothing comes out, but when they [Healthy Action] left, at least people are now opening up.” (KAM 05) The support to create associations and new dialogue spaces appears to have facilitated negotiation and collaboration, created spaces for collective problem solving, fostered new kinds of relationships, and built new skills of monitors and trainers through community mobilization and advocacy (King 2014). In this way, NGOs have a positive role in fostering coalitions, supporting organizational development and training activities, securing access to information, brokering relationships with decision-makers, and, in the longer term, supporting local associations to make claims and create their own spaces for participation and engagement.

Insights from other accounts of NGOs in rural Uganda suggest that this might be what is realistic in the constricted political context of that country (King 2014). With these structural limitations, only certain strategies may achieve meaningful outcomes, particularly where they support new relationships between stakeholders and reshape perceptions and relationships between groups (in this case between health workers and the communities they serve). This includes the power of face-to-face interaction in bringing about behavior change and recognizing that the disconnects may not be between communities and health workers, but between those groups and higher level authorities, which would require the use of different types of social accountability approaches, depending on the targeted stakeholder (Ho et al 2015).
This has implications for measurement of social accountability. Given that some of these outcomes are longer-range, it is critical to have realistic expectations of the outcomes social accountability interventions can achieve within limited timeframes. For example, shorter timeframes can show changes in service uptake, performance of providers, and so on, but longer timeframes are required to assess changes in broader health and governance outcomes. Programs, and their evaluation strategies, must be aware of these realities at the design phase, in order to ensure that expected outcomes are appropriate and measurable within the project timeframe.
References:


Ho, L. G Labrecque, I Batonon, V Salsi and R Ratnayake. 2015. Effects of a community scorecard on improving the local health system in Eastern Democratic Republic of Congo: qualitative evidence using the most significant change technique. Conflict and Health 9:27.


