# USAID MEDICINES, TECHNOLOGIES, AND PHARMACEUTICAL SERVICES (MTaPS) PROGRAM

*Improved Access. Improved Services. Better Health Outcomes.*

Engaging Civil Society in Social Accountability to Improve Access to and Appropriate Use of Quality Maternal, Newborn, and Child Health-Related Medical Products: A Discussion Paper
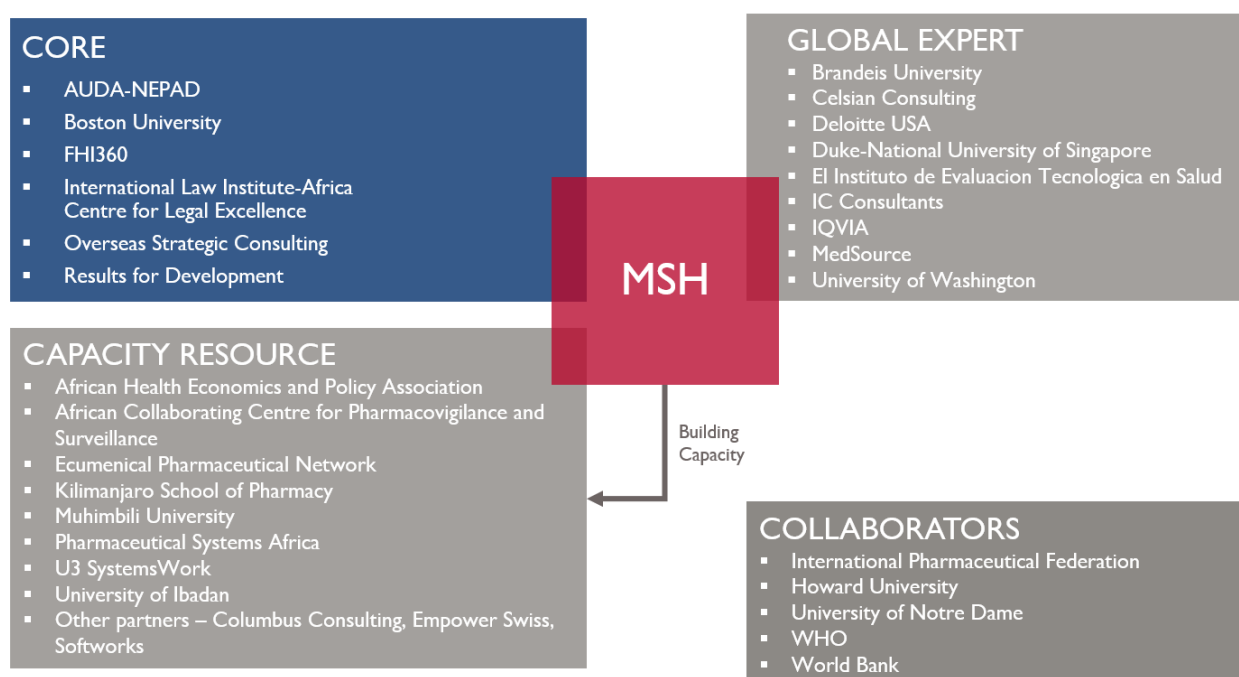
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## About the USAID MTaPS Program

The USAID Medicines, Technologies, and Pharmaceutical Services (MTaPS) Program enables low- and middle-income countries to strengthen their pharmaceutical systems, which is pivotal to higher-performing health systems. MTaPS focuses on improving access to essential medical products and related services and on the appropriate use of medicines to ensure better health outcomes for all populations. The program brings expertise honed over decades of seminal pharmaceutical systems experience across more than 40 countries. The MTaPS approach builds sustainable gains in countries by including all actors in health care—government, civil society, the private sector, and academia. The program is implemented by a consortium of global and local partners and led by Management Sciences for Health (MSH), a global health nonprofit.

## The MTaPS Consortium

### CORE
- AUDA-NEPAD
- Boston University
- FHI360
- International Law Institute-Africa Centre for Legal Excellence
- Overseas Strategic Consulting
- Results for Development

### GLOBAL EXPERT
- Brandeis University
- Celsian Consulting
- Deloitte USA
- Duke-National University of Singapore
- El Instituto de Evaluacion Tecnologica en Salud
- IC Consultants
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Building Capacity

### CAPACITY RESOURCE
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- African Collaborating Centre for Pharmacovigilance and Surveillance
- Ecumenical Pharmaceutical Network
- Kilimanjaro School of Pharmacy
- Muhimbili University
- Pharmaceutical Systems Africa
- U3 SystemsWork
- University of Ibadan
- Other partners – Columbus Consulting, Empower Swiss, Softworks

### COLLABORATORS
- International Pharmaceutical Federation
- Howard University
- University of Notre Dame
- WHO
- World Bank

# ACKNOWLEDGMENTS

# ACRONYMS AND ABBREVIATIONS

CBO        community-based organization

CHW        community health worker

MNCH        maternal, newborn, and child health

MTaPS        Medicines, Technologies, and Pharmaceutical Services

NGO        nongovernmental organization

ORS        oral rehydration salts

PEA        political economy analysis

SRH        sexual and reproductive health

USAID        US Agency for International Development

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# PROJECT SUMMARY

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| **Program Name:** | | USAID Medicines, Technologies, and Pharmaceutical Services (MTaPS) Program |
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| | **Global Expert Partners** | Brandeis University, Deloitte USA, Duke-National University of Singapore, El Instituto de Evaluacion Technologica en Salud, ePath, IC Consultants, Imperial Health Sciences, MedSource, QuintilesIMS, University of Washington |
| | **Capacity Resource Partners** | African Health Economics and Policy Association, Ecumenical Pharmaceutical Network, U3 SystemsWork, University of Ibadan, University of Ghana's World Health Organizations (WHO) Pharmacovigilance Collaborating Center, Kilimanjaro School of Pharmacy, Muhimbili University, Pharmaceutical Systems Africa |
| | **Collaborators** | International Pharmaceutical Federation, Howard University, University of Notre Dame, WHO, World Bank |

# EXECUTIVE SUMMARY

This discussion paper has two aims. The first is to contribute to the knowledge base on lessons learned on social accountability interventions that engage civil society in improving access to and appropriate use of quality medical products and related services for maternal, newborn, and child health (MNCH). The second objective is to propose approaches for designing and implementing social accountability interventions to improve access to and use of MNCH medical products.

Successful social accountability interventions facilitate enabling conditions and the building of coalitions of actors that go beyond the traditional interlocutors for MNCH medical products. For example, human rights activists and investigative journalists at both the national and subnational levels are important stakeholders that social accountability for MNCH should take into account. This also implies that technical arguments around MNCH medical products may not be sufficient to engage these kinds of actors. There is a need to broaden the rationale behind social accountability interventions to engage new actors and encourage the development of wider, more effective coalitions to advocate for change.

Another lesson is that lack of service user knowledge about entitlement to quality services, procedures to provide feedback, and capacity of authorities to respond to feedback are all barriers to effective social accountability for MNCH medical products. Because of these barriers, social accountability interventions for improving MNCH medical products must include specific strategies, actions, and activities to inform and educate users and providers about standards and entitlements for quality medical products and facilitate the creation of spaces for dialogue and shared monitoring and decision making among users of services, frontline providers, and authorities. This paper also summarizes lessons learned about the role of different actors (health providers, authorities, external technical assistance, service users, community health workers, and community leaders) in the success or failure of social accountability interventions.

Several authors argue that evaluating the effect of social accountability on providers to improve the delivery of health care services is challenging because the range of citizen actions associated with the general concept of social accountability and citizen-provider relations are context specific. This means that simple transference of lessons from one context to another is not the best approach. Rather, the aim should be to identify patterns in the production of outcomes.[1] For example, in the realist approach to systematic reviews, researchers aim to identify links between contextual factors and mechanisms that together contribute to outcomes.

This paper posits that there is a need to go beyond the traditional social accountability interventions that focus primarily on strengthening the demand side (users) of health care services at the local level. To achieve this, the paper proposes three main actions. First, there is a need to understand the accountability ecosystem for MNCH medical products. An accountability ecosystem is the set of relationships among multiple levels of government, citizen collective action, civil society advocacy, and institutions. These actors and institutions implement formal and non-formal procedures (e.g., legislation, social norms) to make decisions and implement corrective actions in relation to resources, policies, and

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[1] Lodenstein E, Dieleman M, Gerretsen B, Broerse J (2016). Health provider responsiveness to social accountability initiatives in low- and middle-income countries: a realist review. *Health Policy and Planning*, 32, 125–140.

contracting for public services. The accountability ecosystem influences government responsiveness, which in turn affects whether social accountability interventions succeed and their potential to be expanded and sustained.

The accountability ecosystem in any given context in which projects are planned or implemented must be understood and mapped out. The mapping should include the institutional and sociocultural landscape, including formal and non-formal or sociocultural norms and the key actors and organizations. It should identify the standing of key actors in relation to supporting or opposing policies and strategies that aim to improve access to and use of quality health care services and medical products. Another important consideration is whether key actors (including the constituency body for MNCH medical products) have the power and capability to shape decision making in a way that favors their goals. Some approaches and tools, such as political economy analysis (PEA), can help in this task. Social accountability interventions should take into account the unique normative, social, and political features of the existing accountability ecosystem in their design. Interventions that are predefined without regard to ecosystems are no longer justified.

Building on the better understanding of the accountability ecosystem for MNCH medical products, the second action is to design and implement social accountability interventions that are strategic. These are interventions that focus on disseminating information that is clearly perceived by users as actionable, with measures that actively enable collective action, influence service provider incentives, and share power over resource allocation. Strategic social accountability aims to scale up users' voices and collective action beyond the local arena while bolstering the capacity of the state to respond to those voices. Strategic social accountability involves iterative implementation with adaptation and learning as challenges arise. For practitioners, it means a deeper and continuous engagement with all stakeholders, a continuous reflection and assessment of whether actions and strategies are achieving expected results, detailed documentation of activities, and processes to facilitate learning. For funders, it involves the provision of flexible funding and conditions to enable adaptation and learning.

The third action is to implement interventions that simultaneously and in a coordinated manner address bottlenecks at different levels in the health system. This approach, known as "vertical integration of social accountability," requires implementers to work with national, subnational, and local civil society structures and to build linkages among them to facilitate effective advocacy for systemic change.

When considering social accountability for MNCH medical products, it is worth considering that building a coalition about comprehensive primary care services that include essential medical products may gain the interest of more actors and organizations than attempting to establish a coalition for a narrow subset of services (e.g., postnatal care) or for one specific medical product (e.g., oxytocin). The broad coalition approach would include actors interested in monitoring postnatal care and oxytocin together with actors interested in other primary care services and essential medical products.

There are knowledge gaps around the contribution of social accountability to improving access to and use of quality MNCH medical products, including the fact that published literature on social accountability does not separate medical products from the package of services delivered, whether MNCH, sexual and reproductive health (SRH), or others. There is also a lack of literature on whether

there is a difference in outcomes when social accountability interventions are implemented around a discrete subset of services and medical products versus a wider range of services and products.

There are many social accountability tools and approaches available, but social accountability interventions often fail to reach their full potential. Effective social accountability interventions must be designed for the specific accountability ecosystem in which they operate. By following our three proposed actions, implementers will be more likely to design interventions that are adaptive, promote learning, and are likely to sustainably improve access to and use of quality MNCH medical products.

# 1. INTRODUCTION

To improve MNCH outputs and outcomes, including access to and appropriate use of quality medical products, international development partners, donors, and implementing agencies have supported national governments to develop capacity for delivering essential packages of services and for the planning, budgeting, and procurement of key resources, including medical products. Partners have also supported national and subnational authorities to develop protocols to deliver essential services at the frontline of care. All of the above falls within strategies and actions to strengthen the supply and quality of MNCH services and essential medical products.

Women and caretakers of children who require such services need to be able to identify danger signs during pregnancy, delivery, the neonatal and postnatal period, and the early childhood years. The identification of these danger signs helps to inform their decisions to rapidly seek available services (e.g., treatment for children with pneumonia). Users of MNCH services also need to learn about the preventive services (i.e., immunization, growth monitoring, antenatal care) they need to seek at local health facilities and actions that can be implemented at home to maintain reproductive health and the healthy development of newborns and children. All of these strategies fall within actions to strengthen the demand side of MNCH services.

Successful MNCH programs aim to connect the strengthened supply and demand sides in a virtuous cycle, resulting in improved health outputs and outcomes. However, at times, these efforts are stymied by factors not directly related to the capacity for delivery and uptake of services, such as individual and organizational incentives to perform (i.e., lack of or perverse incentives); political and governance arrangements within public institutions; and historical factors affecting the level of trust among people and cultural, religious, and government authorities at different administrative levels, including health authorities.[2] Some examples of such factors are when frontline workers do not show up to work in peripheral facilities; when a user of services is asked to pay informal charges to receive services; when historical discrimination toward a subpopulation group is expressed through fewer resources and less empathy and care from frontline providers and authorities; and when in national-level priority setting, elected officials break their commitments and ignore the needs and resources required to maintain and improve essential services for women, newborns, and children.[3] Situations like these commonly arise because one or more officials or providers, situated at one or more levels in the system, decide not to follow rules and regulations; the existing rules and regulations contain gaps or loopholes allowing such behaviors; or public officers and authorities may be abusing their vested power because they are unlikely to face consequences.[4] If accountability is the obligation of actors to provide information or a

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[2] World Bank (2004). World Development Report: Making Services Work for Poor People, Washington, DC: World Bank, 2003 Overview chapter.

[3] Gilson L, Schneider H, Orgill M (2014). Practice and Power: A Review and Interpretive Synthesis Focused on the Exercise of Discretionary Power in Policy Implementation by Front-Line Providers and Managers *Health Policy and Planning*, 29 (suppl 3); Uzochukwu et al (2002). *BMC Health Services Research*, 20:884.

[4] Joshi A, McCluskey R. (2017). The Art of 'Bureaucraft': Why and How Bureaucrats Respond to Citizen Voice Research Briefing, Brighton: IDS/Making All Voices Count.

justification for their actions,[5] all of these actors can be held accountable through administrative, legal, or social procedures that reveal poor service delivery and realign incentives to encourage improvement.

Absent or poor accountability in a health system directly affects the possibility of implementing effective MNCH services, including access to and appropriate use of quality medical products. This was first recognized almost two decades ago.[6] From those initial discussions on accountability, it was generally agreed that government agencies—such as Supreme Audit institutions[7] or Parliament—can hold authorities and bureaucrats accountable for the use of public funding and the implementation of rules and regulations (also known as horizontal accountability). The general population, through participation in political elections, also partakes in a means for holding authorities accountable (known as vertical accountability). However, not all public officers and bureaucrats are directly appointed or removed through elections, and some service delivery issues are too locally specific to be addressed at the ballot box. Beyond political elections, there is a need for ordinary people to act to influence public accountability, including for improved and adequate public services. This direct participation of people who are not public officials or other kinds of public authority but who, through collective action, demand accountability from frontline providers and other authorities at different governance levels is generally referred to as "social accountability." Examples include a local women´s group that monitors and reports to higher authorities on health care facility opening hours[8] or a nongovernmental organization (NGO) that monitors and tracks the use of a specific public budget for medical products at the provincial level of government.[9] As these and other interventions have demonstrated promise in improving local service delivery in a variety of areas, technological advances—most notably inexpensive and increasingly feature-rich mobile phones—and the social media revolution have fostered an explosion of social accountability tools and approaches, the theory and practice of social accountability has grown exponentially in the past two decades and still continues to evolve.

This discussion paper aims to contribute to the knowledge base on lessons learned on social accountability interventions that engage civil society, duty bearers, and the community in improving access to and appropriate use of quality medical products and related services for MNCH and other priority health care services, including SRH. It is important to note that most published literature does not separate medical products from the service delivery package monitored through social accountability interventions. Therefore, it is not possible to know the specific effect and impact of the interventions on medical products alone. Medical products are part of a system, so their absence, low quality, or inappropriate use is not evaluated in isolation. However, there may be unique aspects to

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[5] Brinkerhoff D, Wetterberg A (2015). Gauging the Effects of Social Accountability on Services, Governance, and Citizen Empowerment. *Public Administration Review*, Vol. 76, Iss. 2, pp. 274–286.

[6] World Bank (2003). World Development Report 2004: Making Services Work for Poor People, Washington, DC.

[7] Supreme audit institutions are national agencies responsible for auditing government revenue and spending. Their legal mandates, reporting relationships, and effectiveness vary, reflecting different governance systems and government policies. Their primary purpose is to oversee the management of public funds and the quality and credibility of governments' reported financial data. Source: World Bank (2001). *Features and functions of supreme audit institutions*. PREMNote 59. October.

[8] Frisancho A, Vasquez ML (2014). "Citizen Monitoring to Promote the Right to Health Care and Accountability," CARE/Forosalud/COPASAH.

[9] Nosotr@s por la Democracia (2021). Mapeo del desabasto de medicamentos en México. Informe de Transparencia en Salud 2019–2020.

MNCH medical products and their supply chain that could be included in social accountability approaches. This discussion paper takes into account the published evidence to interpret the implications for policy and practice of social accountability interventions seeking to improve access to and appropriate use of quality-assured MNCH medical products and related pharmaceutical services in low- and middle-income countries.

To develop the paper, two main bodies of literature were reviewed. The first source comprised recent systematic reviews of social accountability in health,[10] including papers that were published after these reviews. The second source was literature from the governance, development, and human rights fields (2010–2020) that address sociopolitical factors and other elements of relevance to understand accountability ecosystems and how to apply them to access to and appropriate use of medical products. Both sources included peer-reviewed and grey literature. Key literature suggested by the US Agency for International Development (USAID) staff and the USAID Medicines, Technologies, and Pharmaceutical Services (MTaPS) Program was also reviewed.

The paper is organized into five sections. Section 1 is the introduction. Section 2 presents a summary of the lessons learned about social accountability for MNCH. Section 3 discusses the need for improving the analytical components of social accountability for MNCH medical products. Section 4 presents a proposal for improving the design and implementation of social accountability interventions for MNCH medical products. Section 5 presents the conclusions. Annex 1 presents key concepts around access to and use of medical products, accountability, social accountability, and civil society. Annex 2 presents a mapping of interventions and stakeholders engaged in social accountability. Annexes 3 and 4 discuss social accountability in fragile contexts and social accountability for MNCH medical products, respectively.

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[10] The reviews are: Danhoundo, G, Nasiri K, Wiktorowicz M (2018). Improving social accountability process in the health sector in Sub-Saharan Africa: a systematic review. *BMC Public Health* 18:497; Van Belle S, Boydell V, George A, Brinkerhof, D, Khosla R (2018). Broadening understanding of accountability ecosystems in sexual and reproductive health and rights: A systematic review. *PLoS ONE* 13(5): e0196788; Hilber A, Blake C, Bohle L, Bandali S, Agbon E, Hulton L (2016). Strengthening accountability for improved maternal and newborn health: A mapping of studies in Sub-Saharan Africa. *International Journal of Gynecology and Obstetrics* 135:345–357.

# 2. LESSONS LEARNED ABOUT SOCIAL ACCOUNTABILITY FOR MNCH

In recent years, several systematic reviews of social accountability[11] interventions in health have been published.[12,13,14] This body of evidence is important to understand the impact of such interventions on health outcomes and other essential inputs for service delivery, including medical products. This section aims to distill and summarize lessons learned around the contextual conditions, facilitators, barriers, and institutional capabilities for successful social accountability that have been identified in those systematic reviews and other literature relevant to access to and appropriate use of medical products, including for reproductive health and MNCH.

## 2.1. CONTEXTUAL CONDITIONS FOR SUCCESSFUL SOCIAL ACCOUNTABILITY

In a systematic review of accountability in SRH, Van Belle et al[15] identified specific contextual conditions associated with successfully undertaking accountability for SRH at the national and subnational levels. The authors of the systematic review organize the conditions under broad social structures, governance factors, and core features of the health system (table 1).

**Table 1. Contextual conditions for successful SRH accountability as reported in the literature**

| **Broad social structure** | Societal awareness about rights and social norms (e.g., no fear of stigma for victims of SRH violations) |
| --- | --- |
| | Active civil society and civic culture (advocating for the implementation of SRH through strategic litigation, among other strategies) |
| | Trust in the legal system and institutions |
| **Governance context (overall political and legal framework)** | Democratic space (civil society action is possible) |
| | Recognition of the rule of law and reduced impunity (freedom from reprisal when victims report violations) |
| | Independent judiciary knowledgeable about human rights and SRH |
| | Adapted legal and policy framework |
| **Health system context** | Community participation in the health system |
| | Adequately resourced health system (timely budget allocation, adequate human resources) |
| | Motivated health providers and no blame culture in health facilities |
| | Robust health management and information system |
| | Sound management of the local health systems and health facility leadership |

Source: Adapted from Van Belle et al (2018)

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[11] See Annex 1 for definitions and key concepts related to access to and use of medical products, accountability, social accountability, and civil society.

[12] Van Belle S, Boydell V, George A, Brinkerhof, D, Khosla R (2018). Broadening understanding of accountability ecosystems in sexual and reproductive health and rights: A systematic review. PLoS ONE 13(5): e0196788.

[13] Danhoundo, G, Nasiri K, Wiktorowicz M (2018). Improving social accountability process in the health sector in sub-Saharan Africa: a systematic review. BMC Public Health 18:497.

[14] Hilber A, Blake C, Bohle L, Bandali S, Agbon E, Hulton L (2016). Strengthening accountability for improved maternal and newborn health: A mapping of studies in Sub-Saharan Africa. International Journal of Gynecology and Obstetrics 135:345–357.

[15] Van Belle, S, Boydell V, George AS, Brinkerhof DW, Khosla R (2018). Broadening understanding of accountability ecosystems in sexual and reproductive health and rights: A systematic review. PLoS ONE 13(5): e0196788.

It is important to note that the list in table 1 is not exhaustive because, as noted by its authors, published articles do not regularly provide information on context. However, the conditions distilled from published SRH accountability interventions are useful to take into account for improving access to and use of quality medical products. For example, in relation to health system conditions, MNCH medical products require adequate and timely resources; a strong health management and information system that includes medical products; and the participation of communities to help to identify their needs in relation to MNCH medical products and to contribute to participatory monitoring (e.g., of the availability of essential products such as medicines and oxygen).

## 2.2.  FACILITATORS OF AND BARRIERS TO EFFECTIVE SOCIAL ACCOUNTABILITY

Hilber et al (2016)[16] carried out a structured review to describe the types of maternal and newborn health program accountability mechanisms implemented and evaluated in recent years in Sub-Saharan Africa. The review included 38 peer-review papers published between 2006 and 2016. The authors organized the papers around three types: performance accountability, political and democratic accountability, and financial accountability. In their review, the authors classify social accountability as one mechanism under the political and democratic accountability category. Table 2 summarizes the findings in relation to specific recourse mechanisms and the facilitators of and barriers to effective accountability of maternal and newborn health.

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[16] Hilber MA, Blake C, Bohle L, Bandali S, Agbon E, Hulton L (2016). Strengthening accountability for improved maternal and newborn health: A mapping of studies in Sub-Saharan Africa. *International Journal of Gynecology and Obstetrics* 135: 345–357.

**Table 2. Recourse mechanisms, contributing strategies, and barriers to maternal and newborn health accountability among published studies in Sub-Saharan Africa**

| Accountability mechanisms and approaches | Recourse mechanisms | Strategies and actions contributing to effective accountability | Barriers to effective accountability |
|---|---|---|---|
| <ul><li>Community engagement and civil society advocacy</li><li>National accountability mechanisms</li></ul> | <ul><li>Community support and/or discontent and social reprisal for nonaction</li><li>Negative publicity and threat of legal action</li><li>Health system managerial disciplinary action</li><li>Professional ethics creates normative pressure for improvements in quality of care</li><li>Legal action</li></ul> | <ul><li>Building coalitions of community stakeholders and others such as patient groups, professional associations, human rights activists, and media increases political and social pressure for improvements</li><li>Social action campaigns that combine tactics such as social mobilization, litigation, NGO "shadow reports" to the UN Human Rights Committees, confidential enquiries, and scorecards with community participation to mount political pressure to act on recommendations for improvement</li><li>Strengthening the capacity of activists and the media on how to use human rights-based advocacy to build awareness of problems and support engagement and mobilization</li><li>Community participation in health facility committees is formally and actively engaged in the accountability process and better positioned to seek answerability at the district and provincial levels</li><li>Nationally established commissions strengthen accountability to citizens on the enforcement of laws, policies, strategies, or commitments</li><li>Multisectoral independent expert review groups rule on abuse and track progress commitments and action plans, providing social and political impetus or action</li></ul> | <ul><li>Maternal and newborn health has not received sustained coverage as a social issue</li><li>Women rarely voice their concerns and expectations about health services due to the absence of procedures to express them, lack of knowledge, fear of reprisal, and other social norms limiting engagement</li><li>Feedback systems from decision makers to community members often are not responsive or functional</li><li>Lack of oversight mechanisms limits space for voicing discontent or building coalitions despite many local associations and groups</li><li>Structures for discussion and claiming rights are relatively absent in most contexts</li></ul> |

Source: Adapted from Hilber et al (2016)

Among the strategies and actions contributing to successful social accountability, it is particularly important that the building of coalitions of actors goes beyond the traditional interlocutors for MNCH medical products. Human rights activists and investigative journalists are examples of important stakeholders that social accountability initiatives for MNCH should take into account. The involvement of such actors also implies that technical arguments around MNCH medical products should be communicated in a manner that is understood by nonexperts to engage these kinds of actors. In addition, there is a need to broaden the arguments and rationale to appeal to new actors and draw them in as part of a wider coalition. Annex 4 reflects on considerations related to implementing social accountability interventions around a discrete subset of services and medical products versus a wider range of services and products.

In terms of barriers to effective social accountability, the most relevant for MNCH medical products is the lack of procedures and knowledge to enable service users to provide feedback and for authorities to respond to feedback. Social accountability interventions for improving MNCH medical products must include specific strategies, actions, and activities to inform and educate users and providers about standards and entitlements for quality medical products and ways to verify them and facilitate the creation of spaces for dialogue and feedback among users of services, frontline providers, and authorities at different levels of the health system.

## 2.3.  ROLES OF DIFFERENT ACTORS IN SUCCESSFUL SOCIAL ACCOUNTABILITY INTERVENTIONS

### ROLE OF HEALTH PROVIDERS

Lodenstein et al (2016) did a review of health provider responsiveness to social accountability in low- and middle-income countries. The authors used a realist review, which is an approach to diversify and mix methods of systematic reviews to respond to a varied set of policy questions. Realist review is a theory-driven approach focused on the underlying program theory and mechanisms driving interventions. The authors argue that evaluating the effect of social accountability on health service providers is challenging because the range of citizen actions associated with the general concept of social accountability and citizen-provider relations are context specific. This means that simple transference of lessons from one context to another is not the best approach. Rather, one should aim to identify patterns in the production of outcomes. In the realist approach, researchers aim to identify links between contextual factors and mechanisms that together contribute to outcomes. Through the analysis of multiple social accountability initiatives, researchers try to find such patterns, and these patterns are, in practice, a summary version of a theory of change informing decisions and actions.[17]

An important difference between the Lodenstein et al review and the other reviews presented earlier in this paper is that instead of presenting a summary list of contextual factors and outcomes, the authors present concrete theories that may help development practitioners, policymakers, and funders reflect on how a particular initiative could be successful in a specific context. As a result of their review, the authors identify six themes in which there is evidence of links among context, mechanisms, and outcomes.

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[17] Lodenstein E, Dieleman M, Gerretsen B, Broerse J (2016). Health provider responsiveness to social accountability initiatives in low- and middle-income countries: a realist review. *Health Policy and Planning*, 32, 125–140.

Table 3 presents in the left column a summary version of each of the six themes in the Lodenstein et al review. The right column is our analysis of the implications of those findings for the design and implementation of social accountability interventions for improving access to and use of quality medical products.

**Table 3. Findings from a realist review of health provider responsiveness to social accountability**

| Findings by Lodenstein et al (2016) | Implications for the design and implementation of interventions for improving access to and use of quality medical products |
|---|---|
| *Providers' perceptions and expectations of health service users*: Social accountability initiatives operate in health systems that are characterized by a power asymmetry between providers and service users. This influences providers' expectations of the role of service users in the monitoring and oversight of health services and their responsiveness to groups engaging in social accountability. The responsiveness of providers is likely to depend on whether they perceive users of health services as patients, recipients, beneficiaries, clients, consumers, citizens, or holders of rights. | A key goal of any intervention must be addressing the power disadvantage and information asymmetry faced by users of services through capacity building and facilitating the self-empowerment of users as citizens who are holders of rights. |
| *Providers' perceptions of the legitimacy of citizen groups:* Citizen groups engaged in social accountability actions may generate provider receptivity if providers perceive them as legitimate. Accorded legitimacy depends on the way providers perceive and value the formal mandate, capacities, internal consensus and genuine concern of groups and citizen groups' role in service delivery. Some authors consider legitimacy in terms of laws that provide citizen groups with formal powers to call public officials and workers to account. Other authors refer to legitimacy of citizen groups in terms of reputation, credibility, trust, or representative legitimacy. | Using existing laws and regulations about the role of users of services in monitoring existing facilities is the most important entry point. In case a given country does not have an explicit law or regulation about this role, narratives about the legitimacy of users of services demanding better access to and quality of services can be developed and established. |
| *Providers' feelings of support, safety, and appreciation:* Social accountability initiatives may generate provider receptivity and improved relations when providers feel supported and appreciated and when they experience the discussion platform as safe. This is most likely to occur in actions that emphasize information sharing and dialogue between communities and health providers that are void of open public critique and that provide the opportunity for providers to defend themselves and to address their own concerns as well. | This theory resembles the collaborative engagement as promoted by some agencies, such as the World Bank. Although collaboration is desirable and has been successful in some settings,[18] this may not always be possible if providers are underperforming and refuse to commit to improvements. Experience in different countries demonstrates that in this kind of situation, users of services employ both collaborative and adversarial strategies (such as formal complaints to Parliament, Ombudsman, and the judiciary system or use of the media for naming and shaming) to achieve changes in quality of services.[19] |

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[18] See, for example, https://www.thegpsa.org/about/collaborative-social-accountability
[19] See, for example, Joshi A (2017). Legal Empowerment and Social Accountability: Complementary Strategies toward Rights-Based Development in Health? World Development, 99, 2017; Flores W. Hernández A (2018). Health Accountability for Indigenous Populations: Confronting Power through Adaptive Action Cycles, *IDS Bulletin* 49.2.

| Findings by Lodenstein et al (2016) | Implications for the design and implementation of interventions for improving access to and use of quality medical products |
|---|---|
| *Providers' fear of repercussions from influential third parties:* Social accountability actions may generate provider responsiveness when these initiatives trigger providers' fear of repercussions for the poor performance of health services. Citizen groups are not likely to generate this mechanism on their own; they require the involvement of influential third parties that each trigger a particular mechanism of fear of repercussions. Published research reports on three types of influential third parties to increase pressure on providers: politicians, media, and health authorities. These groups of actors mediate provider responsiveness in different ways. | Interventions with users of services and grassroots organization must also facilitate the engagement of these groups with other influential actors in the accountability ecosystem (e.g., parliamentarians, journalists, recognized advocacy NGOs). Some authors[20] state that such engagement should aim for vertical integration that builds multilevel pro-accountability coalitions that tackle both systemic and frontline bottlenecks affecting access to and quality of public services. |
| *Providers' feelings of moral obligation:* Social accountability actions may generate provider responsiveness when these initiatives are able to trigger providers' feelings of moral responsibility or obligation. Citizen groups are likely to be able to trigger such feelings when they use frames that correspond to providers' frames. Some citizen groups use frames to strengthen citizens' claims in the public discourse on health and health services. Frames are used to describe behavior, social accountability objectives, and ideologies or paradigms. | The explanation of why users of services are pursuing social accountability and the role of service providers and health authorities in responding to users' claims is important. Storytelling methods and tools are important resources to build the arguments and the narrative that should be part of any social accountability intervention. |
| *Providers' self-perceived capacity and identity:* Many social accountability initiatives operate in health systems that are characterized by a strong internal hierarchical organization. This context influences providers' perceptions of their capacities to achieve change. Social accountability initiatives in these contexts may generate responsiveness outcomes and improved relations if providers identify with the citizen group and its ideals or claims. This is likely to be facilitated when social accountability initiatives build on/are embedded in large-scale societal and political change. | Access, including availability, affordability, and quality of medical products at local health care facilities, is influenced by policies and regulations at the national level. Deficiencies at the local level may be the result of a systemic problem that cannot be resolved locally. Therefore, social accountability interventions should aim to facilitate the forging of alliances between frontline providers and users of services so they together place pressure on systemic bottlenecks. |

Source: Adapted from Lodenstein et al (2016) and our analysis

## ROLE OF HEALTH AUTHORITIES AND MANAGERS

In the Hilber et al (2016)[21] structured review to describe the types of maternal and newborn health program accountability mechanisms implemented and evaluated in recent years in Sub-Saharan Africa, the authors conclude that accountability depends not only on how mechanisms are enforced but also on how managers and authorities understand accountability. The authors identified several procedures that

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[20] See, for example, Fox J (2016). Scaling accountability through vertically integrated civil society policy monitoring and advocacy, Brighton: IDS; Aceron J, Fox J (2016). Doing Accountability Differently: A Proposal for the Vertical Integration of Civil Society Monitoring and Advocacy, Issue Paper No. 4, Bergen: U4.

[21] Hilber MA, Blake C, Bohle L, Bandali S, Agbon E, Hulton L (2016). Strengthening accountability for improved maternal and newborn health: A mapping of studies in Sub-Saharan Africa. *International Journal of Gynecology and Obstetrics* 135: 345–357.

facilitated the successful engagement of health authorities and managers. Table 4 presents a summary of those procedures and the implication for social accountability for medical products.

**Table 4. Procedures that facilitate the successful engagement of local health authorities and managers in social accountability for MNCH**

| Successful factors | Implications for social accountability for medical products |
|---|---|
| **Working through local actors** | Procurement, distribution, use, and quality of medical products is a highly technical field, and interventions are generally implemented by specialized NGOs or technical teams. To work through local actors, there is a need to implement participatory strategies to develop the capacity of service users and local organizations, so they engage directly with local authorities and managers (box 1). |
| **Supported by evidence and grounded in the local context** | Nationally or subnationally aggregated data may not be relevant. There is a need to generate specific local data showing gaps in access, use, and quality of medical products in relation to existing protocols and regulations in the country. |
| **Locally presented, with understandable detail** | Take into account that the audience for evidence and reporting is different at different system levels. National-level audiences may expect a technical report, whereas local-level audiences expect a report that explains the situation in their own context and in plain language. Also important is that reports should be presented by local organizations (grassroots or local staff of a national NGO) instead of international or national-level technical staff. |
| **Defined aims for social and political action** | Writing and disseminating a report on access, quality, and use of medical products is not sufficient. There must be concrete advocacy actions and accountability demands by users of services (e.g., demanding solutions to bottlenecks at the subnational or national level so that services are improved at the local level; advocacy for increased resource allocation to primary care facilities; demanding a plan to improve the logistics to distribute medical products from regional warehouses to peripheral facilities). |
| **Engage with multiple stakeholders, each with their respective area of expertise, and define outcomes locally** | It is not sufficient to engage with public officials responsible for procurement, distribution, quality, and use of medicines. There must be engagement with professional associations, NGO providers of services, local media, and grassroots organizations. This engagement should seek to establish dialogue and agreement on common goals and outcome of interest that are relevant for all actors involved. |

Source: Adapted from Hilber et al (2016)

## ROLE OF SERVICE USERS

Service users, organized as local community-based or grassroots organizations, are the heart of social accountability interventions. Grassroots organizations are groups of people pursuing a common interest such as improving the social, cultural, and economic well-being of their families and communities. They largely work on a volunteer and not-for-profit basis. Many are closely linked to communities and local concerns.[22] There are also cases in which users of services attend health care facilities but are not

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[22] Flores W, Samuel J (2019). Grassroots Organisations and the Sustainable Development Goals: No One Left Behind, BMJ 365: l2269, doi:https://doi.org/10.1136/bmj.l2269.

organized to present their needs and demands to providers and authorities. This affects the possibility of agreeing on common issues and demands and engaging in dialogue with frontline providers and authorities. Hence, many social accountability interventions include specific strategies and actions to strengthen the organizing of service users.

It is important to note that service users are not all the same, and they do not have the same opportunity and power to participate in and influence decision making related to health care services. Frequently, women and other socially marginalized groups face structural barriers to participation in the community and social activities that may serve as the locus for social accountability interventions. Therefore, social accountability projects must be aware of and understand the local power dynamics and design and implement interventions that will reduce the barriers to women's and other marginalized groups' participation.

Nazneen and Silva Olivares (2021) reviewed successful interventions that strengthened women´s inclusion in social accountability. The authors identified four factors that were critical to success: building technical and other forms of capacity among women, changing formal rules on women´s inclusion, applying PEA to unpack power dynamics at the local level, and making long-term funding commitments for sustainable change in gender-based norms.[23]

Flores and Samuels (2018) state that successful social accountability initiatives are the product of alliances among grassroots organizations and intermediaries such as NGOs, think tanks, and professional associations. In this alliance, the grassroots organization provides a connection to the population. The intermediaries provide structure and resources, such as training, organizational models, research, or assistance with advocacy to help establish and maintain an initiative.[24] In the role described above, organized users of services play a central role in designing and implementing social accountability interventions. For MNCH medical products, this implies developing communication and training strategies that are inclusive and facilitate basic understanding by service users of access to and use and quality of MNCH medical products and associated key functions.

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[23] Nazneen S, Silva Olivares M (2021). Strengthening women´s inclusion in social accountability. *IDS Policy Briefing*. Issue 174.
[24] Flores W, Samuel J (2019). Grassroots Organizations and the Sustainable Development Goals: No One Left Behind, BMJ 365: l2269, doi:https://doi.org/10.1136/bmj.l2269.

**Box 1. Engaging users of services in monitoring the barriers to access health care in rural facilities**

In Guatemala, a local NGO and a network of indigenous community leaders worked for more than five years to participatively design a strategy to involve users of services in monitoring the availability of medicines, essential supplies, and other issues while accessing health care in rural facilities. They developed an electronic internet-based platform that registers complaints from services users. Trained community leaders (known as Health Defenders) receive verbal complaints from service users about problems at health care facilities, such as not receiving the required medicines, opening hours not being respected, the ambulance service not being available, or a service provider who is disrespectful of or abusive toward patients. The Health Defender obtains as much detail as possible about the complaint and classifies it based on a catalogue of 23 complaint types. Once classified, the Defender sends a coded SMS message to an electronic platform that converts the SMS message into an individual complaint that is geo-referenced on a digital map. Depending on the type of complaint, the defender may also take photographs or video recordings of infrastructure or shelves inside health facilities showing stock-outs of medicines and medical supplies or verbal testimonies from service users about their complaints. By analyzing the complaints received, the Defender identifies whether a recurrent problem is emerging, such as several patients not receiving the required medicines, reports of abuse and disrespect by the same health care worker, or the local ambulance not transporting patients. In coordination with NGO advisors, the recurrent problem is identified, and all evidence related to this problem (individual complaints in the electronic platform and any audiovisual evidence) is compiled in a report to be presented to public officials for resolution. This strategy proved successful to generate a positive response from district authorities for the complaints they have the capacity to resolve at the local level, such as opening hours of facilities, absence of frontline workers, and disrespectful behavior toward users. However, the district level does not have authority on the procurement and distribution of medical products. Hence, these types of complaints were not resolved. The NGO and the network of Health Defenders are currently mapping bottlenecks for medical products, engaging with provincial authorities, and building alliances with national-level NGOs who are experts in public budget monitoring.

Source: Flores W, Hernández A (2018). Health Accountability for Indigenous Populations: Confronting Power through Adaptive Action Cycles, *IDS Bulletin* 49.2.

## ROLE OF ACTORS PROVIDING EXTERNAL TECHNICAL ASSISTANCE AND CAPACITY BUILDING

In relation to actors from cooperation agencies and NGOs, the literature discusses two positions. One is citizen-led social accountability, in which grassroots organizations or affected population groups make decisions on implementation. The role of external actors is focused on providing capacity building, technical assistance, and basic resources.[25] Performing such a role requires longer engagement with the citizen group(s), flexibility in the use of resources, and a multidisciplinary team to respond to citizen needs.

The second position is NGO-led social accountability. In many countries, NGOs are considered legitimate actors in the social accountability arena because they have highly educated elites who are able to mobilize resources. Many NGOs also have the skills to mediate state/citizen relations at the local level, translate popular claim making into formal discourse, and explain complex policies in everyday language.[26] In many cases, social accountability approaches by NGOs emphasize technical aspects of

[25] Hernández A, Hurtig A, Goicolea I, San Sebastián M, Jerez F, Hernández-Rodríguez F, Flores W (2020). Building collective power in citizen-led initiatives for health accountability in Guatemala: the role of networks. BMC Health Services Research 20:416.

[26] King S (2015). Increasing the power of the poor? NGO-led social accountability initiatives and political capabilities in rural Uganda. *European Journal of Development Research* (2015) 27, 887–902.

interventions and use of tools. Several authors state that such approaches fail to address politics and power relations involved in public systems and services.[27] An evaluation on the impact of donor-led accountability for education and health services in Uganda found that the achievements on answerability by authorities were minor and that interventions were isolated and dependent on strategies influenced by donors. Of course, this limited achievement was also partially the result of a context characterized by a lack of political will and power inequalities between a rural poor majority and a politically and economically elite minority.[28]

The above findings indicate that social accountability for MNCH medical products should follow a citizen-led approach. This will require changes and innovations in the way development projects are designed and implemented to ensure that citizens meaningfully lead interventions. Under a citizen-led approach, international NGOs may be able to play a role in facilitating and linking the various levels of civil society to help ensure that interventions are more vertically integrated. There may also be a catalytic role for international NGOs to get accountability interventions started. NGOs may also have an important role to play in working with host country governments to create a more favorable enabling environment within which social accountability efforts can flourish.

## ROLE OF COMMUNITY HEALTH WORKERS

The role of community health workers (CHWs) in social accountability is multifaceted—they are accountable to their communities and may also be accountable to the health system. There are factors that can promote and also undermine CHW ability and interest in fostering health system accountability to the community.[29]

Many CHWs intend to be accountable to their communities, but they help in service delivery and may receive public funding stipends. This makes them part of the frontline providers that many interventions seek to hold accountable. But there are also many CHWs who are volunteers and still help in service delivery, experiencing stress and physical dangers. In these kinds of situations, one can think that health systems are not being accountable to CHWs.[30]

During an international learning exchange on the experiences of CHWs and health system accountability, participants emphasized that CHWs must themselves be empowered to empower communities to engage in social accountability.[31]

Experienced CHWs have insight, information, and understanding about service delivery and medical products that may be relevant to communities. They may also be trusted by communities. However, due

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[27] Joshi A, Houtzager P (2012). Widgets or watchdogs? *Public Management Review* 14(2): 145–162.

[28] King S (2015). Increasing the power of the poor? NGO-led social accountability initiatives and political capabilities in rural Uganda. *European Journal of Development Research* (2015) 27, 887–902.

[29] Schaaf M, Warthin C, Manning A, Topp S (2018). Report on the 'Think-In' on Community Health Worker Voice, Power, and Citizens' Right to Health. Accountability Research Center, Learning Exchange Report 3.

[30] Topp S, Scott K, Schaaf M (2017). "Lackeys or liberators" revisited: Community health workers and health system accountability. International Health Policies. Available at: https://www.internationalhealthpolicies.org/blogs/lackeys-or-liberators-revisited-community-health-workers-and-health-system-accountability/

[31] Ibid

to the multifaceted and contextual variation in CHWs' roles, there should be a careful analysis of their potential role in a given context, including social accountability interventions that target MNCH medical product access and use. For example, in contexts in which CHWs sell medicines as a private income-generation activity, their participation in social accountability for MNCH medicines at local public facilities may not be a good fit due to potential conflicts of interest.

# 3. ANALYZING SOCIAL ACCOUNTABILITY FOR MNCH MEDICAL PRODUCTS

This section will define the accountability ecosystem and address two key themes: understanding the accountability ecosystem for medical products and better mapping of actors and institutions engaged in social accountability for MNCH medical products.

## 3.1. ACCOUNTABILITY ECOSYSTEM

An accountability ecosystem is the set of relationships among multiple levels of government, citizen collective action, civil society advocacy, and institutions. Broadly, the accountability ecosystem refers to formal and non-formal procedures for decision making. Among the formal procedures are laws, norms, and regulations; type of governance of public institutions; and respect for civic voice in the interaction between citizens and state institutions. The non-formal procedures include cultural practices such as social prestige, leading the community by example, and volunteering for the collective good of a community.[32] The accountability ecosystem influences government responsiveness, whether social accountability interventions succeed or fail, and their potential to be expanded and sustained. This understanding is very important to note because early social accountability interventions often took the form of isolated interventions that aimed to deliver information to citizens or promote information transparency without awareness of all the actors, levels of government, and institutions involved. There is a growing body of evidence that social accountability interventions that are embedded within the broad accountability ecosystem have a better chance of positive impact and sustainability.[33]

## 3.2. UNDERSTANDING THE ACCOUNTABILITY ECOSYSTEM FOR MEDICAL PRODUCTS

As stated earlier, the accountability ecosystem influences government responsiveness, whether social accountability interventions succeed or fail, and the potential to be expanded and sustained. Therefore, mapping and understanding the accountability ecosystem for medical products is crucial.

Figure 1 presents a generic representation of an accountability ecosystem for medical products. Ministries of finance, health, and commerce are departments from the executive branch of government that are directly responsible for designing laws, policies, and regulations for procurement, distribution, selling, and use of medical products. These three departments have the same level of authority and influence one another's decisions.

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[32] Halloran B (2015). Strengthening accountability ecosystems: a discussion paper. Transparency and Accountability Initiative. Available at: https://www.transparency-initiative.org/archive/wp-content/uploads/2015/11/Strengthening-Accountability-Ecosystems.pdf
[33] Fox J (2016). Scaling accountability through vertically integrated civil society policy monitoring and advocacy, Brighton: IDS.
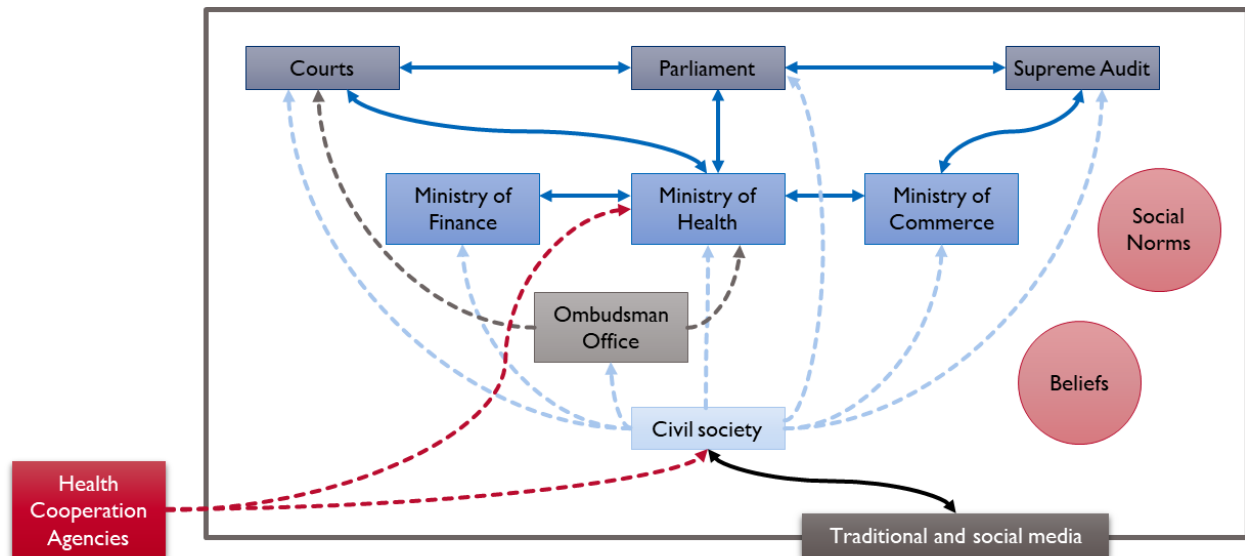
**Figure 1. Generic representation of an accountability ecosystem for medical products**

The Courts, Parliament, and Supreme Audit Institutions[34] are state institutions that have direct authority over the Ministries and can hold them accountable. For example, Supreme Audit may rule that a procurement policy does not follow existing rules and regulations and must not be enforced, therefore affecting the entire supply system of medical products in the country. Similarly, civil society organizations or the Ombudsman Office may approach the Courts to sue against a national pharmaceutical policy that they consider discriminatory to certain subpopulation groups. The Court may rule that the national policy is illegal, thereby forcing the Executive to draw up a new policy. Parliament's role in approving public budgets is a strong instrument for enforcing accountability. Parliamentarians may refuse to approve resources for a Ministry of Health program that may be seen as inadequate to respond to the national needs for access to and use of quality medical products.

The Ombudsman Office (or a similar human rights oversight office) is depicted because in several countries, public human rights defenders have played a key role in influencing policies related to procurement, distribution, access to, and use of essential medical products. This has been the case for HIV-AIDS, tuberculosis, and some chronic diseases.[35] Although Ombudsmen are legal public figures, generally they do not have direct authority over the Executive or any other branch of government. However, their role of independent oversight of public laws and policies is very important.

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[34] Supreme Audit institutions are national agencies responsible for auditing government revenue and spending. Their legal mandates, reporting relationships, and effectiveness vary, reflecting different governance systems and government policies. But their primary purpose is to oversee the management of public funds and the quality and credibility of governments' reported financial data. Source: World Bank (2001). *Features and functions of supreme audit institutions*. PREMNote 59. October.
[35] See, for example, https://hivlawcommission.org/wp-content/uploads/2017/07/Using-Complaints-to-Address-Healthcare-Violations_Draft-7.pdf; https://www.who.int/hiv/pub/prev_care/en/standardsquality.pdf?ua=1

Civil society engages with the Ministries of the Executive, Parliament, Supreme Audit, Courts, and Ombudsman. However, other than at the time of political elections, civil society does not have direct influence over any of those institutions. Between elections, civil society influence is indirect (e.g., through advocacy and building alliances with politicians and authorities inside government that may share similar goals).

The media plays an important role in disseminating information generated by public authorities but also of independent oversight to enhance transparency and accountability. For example, the media may report on the success of a new national medical products policy, but it also can—through investigative journalism—identify corruption or mismanagement in the procurement of medical products that is affecting medical product access and use by the population. Social media can collect and disseminate the individual perceptions and experiences of people that need or use medical products. Perceptions and cases of stock-outs or adverse effects of medicines can rapidly propagate through social media. Although social media is a rapid and relatively inexpensive form of communicating relevant and factual information, it may also become a source of disinformation. Both traditional and social media play an important role in reinforcing or disseminating new social, political, and cultural factors related to medical products.

International health cooperation agencies are situated outside the accountability ecosystem. Although they provide support to countries through capacity building, financing, and other key resources, they do not have authority over any of the actors, organizations, or institutions within the accountability ecosystem. The influence of international health cooperation agencies is generally conveyed through engagement with the Ministry of Health and support from civil society.

Figure 1 shows that the actors in the accountability ecosystem are many and their interrelations complex. Therefore, health cooperation agencies aiming to contribute to improved access to and use of quality medical products may need to target their engagement beyond their traditional practice. Some examples include capacity building and support to parliaments for more effective public policy and funding of medical products, to ministries of finance about innovations in progressive taxation to fund publicly available medical products, to the media for investigative journalism of medical products at the subnational and local government levels, and to civil society so they can become more knowledgeable and proactive in advocating for innovations in public policy related to medical products.

Finally, it is important to note that the national accountability ecosystem has representation at the subnational and local government levels as all entities (e.g., Ministry of Health, Ombudsman, Supreme Audit) have a presence and services at the subnational level. In countries with centralized systems, the subnational and local ecosystems mostly follow the implementation of policies and programs decided at the national level. In those countries with a high degree of decentralization, such as those with devolved functions and resources to municipal governments, the accountability ecosystem is more complex since each devolved government unit has policy, resources, and decision-making functions. This situation creates smaller accountability ecosystems that may be relatively independent from a national-level ecosystem. In summary, it is crucial to map out the specific accountability ecosystem at each level of government.

It is acknowledged that in fragile states, the ecosystem may be somewhat different; Annex 2 summarizes the emerging evidence and considerations for implementing social accountability interventions in fragile settings.

## 3.3. BETTER MAPPING OF THE ACCOUNTABILITY ECOSYSTEM

For the purpose of social accountability goals, it is important to first do a mapping of the specific accountability ecosystem in a given context. In addition to customary institutions, health facility committees, and other core structures, this mapping should include the institutional and normative landscape and the key actors and organizations. The mapping should identify the standing of key actors in relation to supporting or opposing policies and strategies that aim to improve access to and use of quality health care services and medical products. The mapping should also explore power dynamics and whether actors have the strength and capability to influence the decisions toward their goals. Some approaches and tools, such as PEA,[36] can help in this task.

The design of a specific intervention should occur after the mapping and analysis of the accountability ecosystem. For example, it may be possible that the mapping reveals that there is already a coalition of actors that require capacity building and other key resources to advance their goal of improving equitable access to MNCH medical products through social accountability. In this situation, an intervention can be designed to support this existing coalition and expand its capacity to integrate organizations from the local and subnational level to the coalition. In other contexts, the mapping may reveal a gap in terms of regulations and policies to oversee and enforce medical product standards, that there are no visible civil society actors aware of the importance of medical products and leading equitable access, or that elected officials are not using their vested authority to influence better policies and procedures for public procurement of medical products. In such contexts, an intervention should aim to facilitate the enabling of conditions for a more conducive accountability ecosystem by providing technical assistance and capacity building to civil society, parliamentarians, Ministry of Health authorities, and others.

In summary, social accountability interventions should take into account unique normative, social, and political features of the existing accountability ecosystem in their design. Interventions that are predefined without regard to ecosystems are no longer justified.

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[36] For example, see USAID resources on PEA: https://www.usaid.gov/documents/1866/thinking-and-working-politically-through-applied-political-economy-analysis

# 4. IMPROVING THE DESIGN AND IMPLEMENTATION OF SOCIAL ACCOUNTABILITY INTERVENTIONS FOR MNCH MEDICAL PRODUCTS

This section discusses the importance of engaging with the structural factors that influence access to MNCH medical products and an approach to social accountability that is strategic and vertically integrated. The section concludes with an example of the kind of social accountability interventions that may be implemented to effectively improve access to and use of quality MNCH medical products. Annex 4 summarizes some of the key knowledge gaps with regard to the contribution of social accountability to improving access to and use of quality MNCH medical products.

## 4.1. ENGAGING WITH STRUCTURAL FACTORS THROUGH STRATEGIC SOCIAL ACCOUNTABILITY

Most social accountability interventions are implemented at the local level. However, the availability and quality of MNCH medical products in local health care facilities are directly affected by procurement and other policies that are set and implemented at the national level. In addition, bottlenecks may affect the pharmaceutical system at different levels (e.g., from the local to the subnational and national and from the national to the local).

In a meta-analysis of impacts of social accountability initiatives in different sectors and for different needs, including for MNCH services and essential supplies, Fox (2015) determined that those interventions with positive impact are characterized by implementing a strategic approach to social accountability, whereas those with low or mixed impact implement a tactical approach. Table 5 presents the elements included in each of these approaches.

**Table 5. Tactical and strategic approaches to social accountability**

| Tactical social accountability | Strategic social accountability |
|---|---|
| Bounded interventions to a relatively short time implementation (1–3 years) | Multiple, coordinated tactics |
| Citizen voice as the sole driver | Enabling environments for collective action to reduce perceived risk |
| Assumption that information provision alone will inspire collective action with sufficient power to influence public-sector performance | Citizen voice coordinated with governmental reforms that bolster public-sector responsiveness (voice plus teeth) |
| Exclusive focus on local arenas | Scaling up (vertically) and across (horizontally) |
| | Iterative, contested, and therefore uneven processes |

Source: Adapted from Fox (2015)

Interventions that use a tactical approach (e.g., that rely on a single monitoring tool such as scorecards or budget tracking) to improve access to MNCH medical products and/or services have less opportunity to combine information from different sources and implement different advocacy tools. Similarly, interventions that are focused exclusively in local or peripheral facilities may not be able to tackle

bottlenecks occurring at the subnational or national level that have a direct effect on access and quality of local services, including medical products.

Strategic social accountability for MNCH medical products implies the use of several tools that are complementary (e.g., scorecards, budget tracking, campaigns through social media) and promote capacity building and mobilization of users of services (e.g., understanding what essential medicines are and what is involved in improving quality and appropriate use of medical products; providing transport and food subsidies to attend meetings with health authorities). These strategic approaches seek to build alliances and coalitions among users of services, NGOs (both providers of services and think tanks with expertise in medical products), progressive politicians, and decision makers. The actions are ideally implemented at different governance levels (local, subnational, and national) in a coordinated and complementary manner. This is referred to as vertical integration of social accountability actions. The actions can also extend horizontally to further build alliances with other users of services (e.g., between groups working on MNCH and groups working on access to medicines and universal health coverage).

It is important to note that strategic approaches generally do not follow linear implementation and accurate adherence to implementation plans, as expected in most externally funded and time-bound projects, but rather involve iterative implementation with adaptation and learning as challenges arise. For practitioners, this means a deeper and continuous engagement with all stakeholders, a continuous reflection and assessment of whether actions and strategies are achieving expected results, detailed documentation of activities, and processes to facilitate learning. For funders, it involves the provision of flexible funding and conditions to enable adaptation and learning. Several international funders, including USAID, and NGOs are already experimenting with this and similar approaches under the umbrella name of "Doing Development Differently, Adaptive Development in Aid and Thinking and Working Politically."[37]

Published examples of strategic social accountability can be found in the education[38] and natural resources sectors;[39] for health, some experiences are currently being documented in Asia and Latin America. Recently, an experience of strategic social accountability for MNCH in Malawi was published. This research by Butler et al (2020)[40] describes an intervention that was multitool and multilevel to gather data, elevate community voices, and facilitate engagement among citizens and state actors at the community, district, and national levels. Box 2 presents a summary of the intervention.

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[37] See, for example, https://twpcommunity.org and https://odi.org/en/publications/doing-development-differently-who-we-are-what-were-doing-and-what-were-learning/

[38] Aceron J, Fox J (2016). Doing Accountability Differently: A Proposal for the Vertical Integration of Civil Society Monitoring and Advocacy, Issue Paper No. 4, Bergen: U4, August 2016.

[39] Abdulkarim M (2017). Following the Money in Ghana: From the Grassroots to the Hallways of the IMF. Accountability Research Center, Accountability Note 1.

[40] Butler N, Johnson G, Chiweza A, Aung K, Quinley J, Rogers K, Bedford J (2020). A strategic approach to social accountability: Bwalo forums within the reproductive maternal and child health accountability ecosystem in Malawi. *BMC Health Services Research* 20:568.

**Box 2. MNCH social accountability project with multitool and multilevel engagement**

Based on a strategic social accountability approach, UNICEF in Malawi implemented an intervention that was multitool and multilevel to gather data, elevate community voices, and facilitate engagement among citizens and state actors at the community, district, and national levels. The project supported three NGOs to work at the health facility, district, and national levels. Each NGO had different expertise and used a variety of tools, from data visualization, local radio programming, and participatory dialogues facilitated at the community and district levels to budget analysis and tracking and advocating to parliamentarians at the national level. The project achieved outcomes related to the authority's responsiveness. Issues raised at the community level, such as a lack of emergency transport and equipment, inadequate staff, unfriendly workers, shortages of medicines and other supplies, and poor water in sanitation in health facilities, were mostly resolved at the community or district level. Issues that were not resolved at those levels were presented at the national level by community representatives. In general, the intervention was considered a success in relation to achieved outcomes and outputs (as described above). However, the authors report that scalability and sustainability were not achieved since the intervention was not embedded in the existing structures but implemented in parallel. The reason for this was to remain independent of existing structures to avoid the potential for elite capture and advancing in the implementation with the support of external funding. However, a lesson learned was that scaling-up and sustaining interventions requires long-term planning and budgeting and engaging and influencing existing structures.

Source: Butler N, Johnson G, Chiweza A, Aung K, Quinley J, Rogers K, Bedford J (2020). A strategic approach to social accountability: Bwalo forums within the reproductive maternal and child health accountability ecosystem in Malawi. *BMC Health Services Research* 20:56.

## 4.2. VERTICAL INTEGRATION OF SOCIAL ACCOUNTABILITY INTERVENTIONS FOR MNCH MEDICAL PRODUCTS

It is frequently recognized that there are structural factors that influence the availability and quality of health care services, including medical products. However, many social accountability interventions only target local-level issues and a small number of inputs. Professor J. Fox, a leading scholar in social accountability, calls it the low-dose approach in which a medicine (intervention or strategy) with a potential to cure a problem fails because it is administered at a low dosage (too small scale or few inputs).[41] He argues that low-dose interventions only address symptoms and do not tackle the underlying causes of technical and governance failure that are upstream, and they affect availability and quality of public services, including the provision and use of quality medical products. The implication for policy and practice is that widely diffused, low-level or low-dose interventions are unlikely to succeed no matter how broadly they are implemented. The challenge is not really one of scale, but of vertical integration.[42] Achieving successful vertical integration requires interventions to be designed in new ways since implementers often focus on a single level at a time. Vertical integration, in turn, requires implementers to work with national, subnational, and local civil society structures and to build linkages among them.

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[41] Fox J (2019). How can a rethink of lessons from field experiments inform future research in transparency, participation, and accountability? International initiative for impact evaluation.
[42] Fox J (2016). Scaling accountability through vertically integrated civil society policy monitoring and advocacy. Brighton: IDS.

Figure 2 presents a generic example of vertical integration of actions and goals to improve access to and use of MNCH medical products. In this example, the goal is improving access to and use of quality MNCH medical products through independent monitoring by civil society and the support of international and national technical organizations to build capacity of public officials to fulfil performance gaps identified during the monitoring process. The assumptions are:

- International development partners have provided technical assistance and capacity building in supply chain management to national authorities and public officials, managers, and supply chain staff. The country has the basic capabilities to implement an adequate procurement and distribution system. The main gaps are related to poor supervision and a lack of adequate incentives for performance.
- There is an initial exercise of mapping the accountability ecosystem of MNCH medical products in this country.
- There will be a detailed stakeholder mapping. The specific actors involved will be identified through these exercises.
- The intervention will design and implement an electronic platform for monitoring with resources for capacity building, scorecard reports, and data visualization focusing on addressing key gaps identified through a situation analysis, including availability of MNCH medicines, oxygen availability, correct storage of oxytocin, and quality of care. The platform will be open access. Journalists, civil society, decision makers, and the general public will be able to consult the platform. For public with limited digital access, monthly and quarterly reports will be produced and distributed as podcasts through social media and community radio.
- If the analysis of the monitoring identifies that low performance is the result of some gaps in capacity of public officials, required training will be provided by expert international or national organizations.
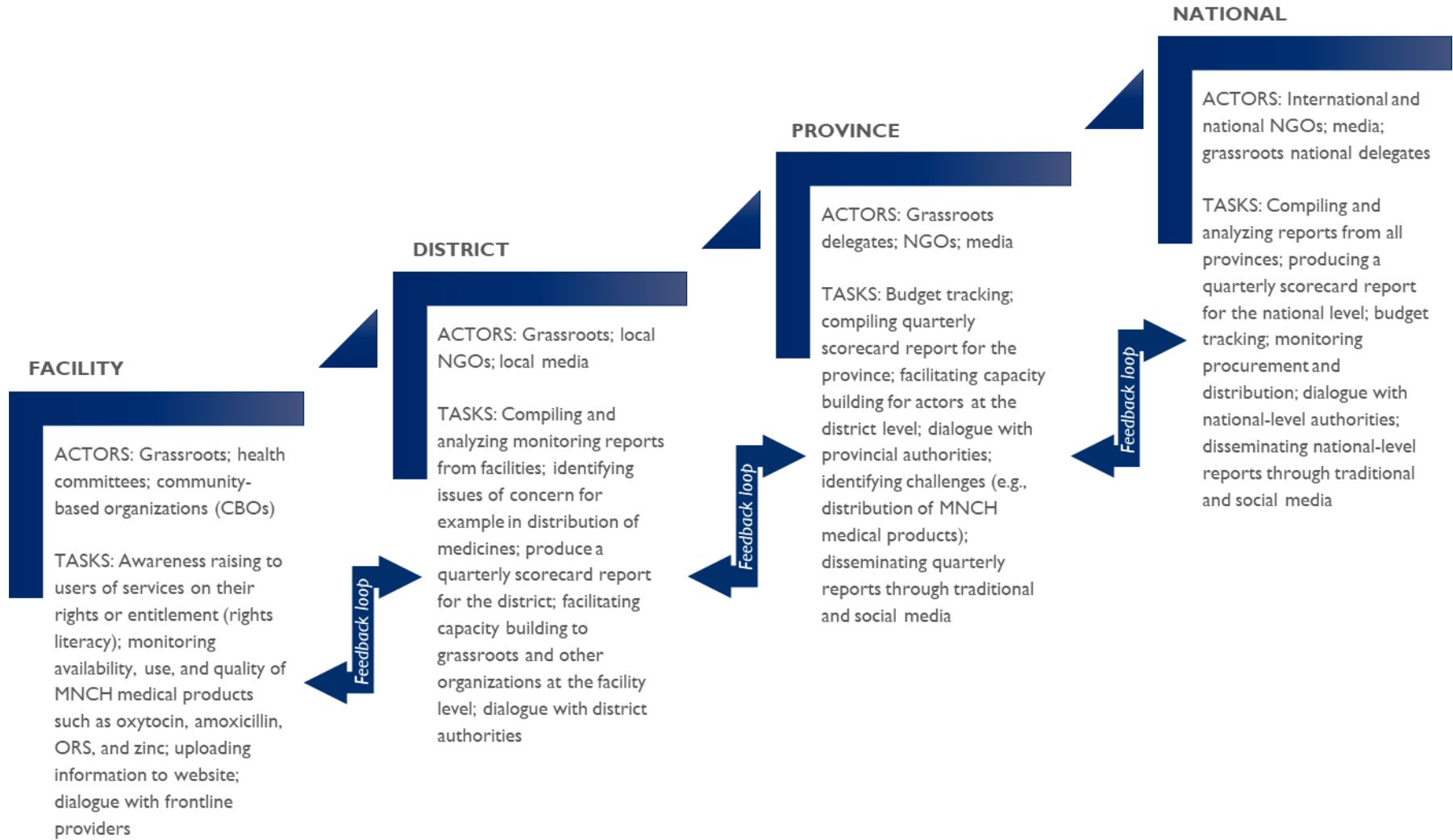
**NATIONAL**

ACTORS: International and national NGOs; media; grassroots national delegates

TASKS: Compiling and analyzing reports from all provinces; producing a quarterly scorecard report for the national level; budget tracking; monitoring procurement and distribution; dialogue with national-level authorities; disseminating national-level reports through traditional and social media

**PROVINCE**

ACTORS: Grassroots delegates; NGOs; media

TASKS: Budget tracking; compiling quarterly scorecard report for the province; facilitating capacity building for actors at the district level; dialogue with provincial authorities; identifying challenges (e.g., distribution of MNCH medical products); disseminating quarterly reports through traditional and social media

**DISTRICT**

ACTORS: Grassroots; local NGOs; local media

TASKS: Compiling and analyzing monitoring reports from facilities; identifying issues of concern for example in distribution of medicines; produce a quarterly scorecard report for the district; facilitating capacity building to grassroots and other organizations at the facility level; dialogue with district authorities

**FACILITY**

ACTORS: Grassroots; health committees; community-based organizations (CBOs)

TASKS: Awareness raising to users of services on their rights or entitlement (rights literacy); monitoring availability, use, and quality of MNCH medical products such as oxytocin, amoxicillin, ORS, and zinc; uploading information to website; dialogue with frontline providers

*Feedback loop* (between Facility and District)

*Feedback loop* (between District and Province)

*Feedback loop* (between Province and National)

**Figure 2. A generic example of vertical integration of actions and goals to improve access to and use of MNCH medical products**

### 4.3. ENTRY POINTS AND APPROACHES FOR CIVIL SOCIETY ENGAGEMENT IN MEDICAL PRODUCTS FOR MNCH

As discussed earlier, detailed mapping of the accountability ecosystem is of utmost importance. A second crucial resource is a detailed diagnosis of the capacities, gaps, and bottlenecks affecting the procurement, distribution, access to, and use of quality medical products for MNCH. This is important because not all problems and bottlenecks existing in a given setting can be resolved through civil society or social accountability strategies. For example, knowledge about planning and budgeting is a key capability for effective procurement. Improving such skills clearly requires technical capacity building. A social accountability intervention will not help. However, if it is known that public officials have these capabilities and that inadequate procurement is affected by a lack of supervision or lack of support from higher-level authorities, civil society engagement in social accountability may be beneficial (e.g., through identifying and making public assessments that show poor performance or by putting pressure on authorities to strengthen supervision and support to public officials in charge of procurement).

Table 6 presents examples of issues for which there may be a role for civil society. The table also identifies the type of organization that may be engaged and examples of interventions. It is important to stress that the entry point has to be based on a perceived problem or issue by civil society and users of services. In social accountability, building a constituency[43] that will be motivated to tackle challenging issues and engaging with authorities is of utmost importance. For example, if families do not perceive as a problem that local services do not have oral rehydration salts (ORS) and zinc to manage diarrhea, there is no readily available constituency for a social accountability intervention. However, many social accountability interventions begin with information campaigns targeting users of services to make them aware of issues and become conscious about their rights and entitlements. Having national standard treatment guidelines is important to support appropriate prescribing. However, these guidelines can also be utilized by service users and other civil society organizations as the standard that will allow them to identify gaps in implementation and demand improvements.

Once the entry point is selected, a thorough design process of vertical integration of social accountability and procedures and strategies should be followed to embed the intervention in the accountability ecosystem.

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[43] A constituency is a group of people sharing similar views and aspirations that invest resources (time, money) to achieve a common goal (Lockyear C, Cunningham A. [2017]. Who is your constituency? The political engagement of humanitarian organisations. *Journal of International Humanitarian Action,* 2:9). In social accountability, a constituency is the group of people that will directly benefit from improved public services, which motivates them to become organized and engaging with providers and authorities.

**Table 6. Examples of entry points for designing and implementing civil society engagement on improving availability, affordability, and appropriate use of quality medical products for MNCH**

| Main issue/bottleneck | Potential role for civil society engagement on accountability | Example of interventions |
|---|---|---|
| Despite improvements in availability of services and medical products at local clinics, users still do not seek services or products such as ORS/zinc due to lack of information and/or lack of trust of frontline providers, the value of the treatment, or quality of the products dispensed or sold | Grassroots organizations are effective in facilitating trust building among communities and local health care services and dispensaries and sharing user-friendly information about products such as ORS/zinc and their importance and proper use | ▪ Spaces for dialogue between frontline providers and users<br>▪ Scorecards to monitor local clinic performance<br>▪ Engagement in developing messaging and user-friendly information to raise awareness on their importance and use<br>▪ Mechanisms to enable providers and users to report problems with product quality |
| Although district and regional warehouses are relatively well stocked, storage requirements for products such as oxytocin are not always adhered to and medical products are not reaching local clinics due to a lack of priority and other decisions from regional authorities, including on funding for distribution to lower levels | Local frontline providers, users of services, grassroots organizations, and local NGOs working at regional levels form an alliance to bring the issue to light and demand improved supervision and procedures for the timely distribution of medical products to peripheral facilities.<br><br>NGOs working at regional and national levels design a campaign to improve oxytocin storage (e.g., funding for refrigerators). | ▪ Audiovisual monitoring of warehouses by stakeholders<br>▪ Producing short audiovisuals with narrative of the problem, its negative effects on people, and the solutions to be implemented<br>▪ Collaboration with media at subnational and national levels (box 3) |
| National procurement agency is slow in including more optimal pediatric formulations such as amoxicillin dispersible tablets in procurement lists | Technically specialized NGOs engage in explaining to decision makers the importance of more optimal pediatric formulations and assist in developing specifications.<br><br>Advocacy NGOs design a campaign for social media.<br><br>Grassroots organizations mobilize to contact elected representatives to support the procurement of more optimal products.<br><br>Overall, increase pressure on decision makers. | ▪ Information campaign<br>▪ Information and capacity building on procurement to established civil society organization with interest to improve issue<br>▪ Campaign with grassroots organizations |

Source: Authors' own analysis

**Box 3. Engaging media in social accountability for MNCH**

In Guatemala, a local NGO and a grassroots indigenous organization have been implementing social accountability to improve MNCH services, including medical products at health facilities serving rural indigenous communities. In 2017, users complained of illegal charges for emergency transport. In a six-month period, almost 100 individual complaints were documented by the organizations with support of the NGO. The grassroots organization presented the complaints to district and provincial authorities and demanded resolution because such charges were corruption and were putting in danger the lives of patients who needed urgent referral. After several meetings and seeing that the authorities were not acting, the NGO and the grassroots organization devised a strategy to engage investigative journalists and national media. They contacted well-known journalists who investigate public corruption and provided access to the database with the documented complaints. The journalists became interested and said they would independently verify the illegal charges to patients. The journalists traveled to rural communities, and the grassroots organization provided contact information for patients who had filed complaints. After two months of work, the journalists produced a full investigative report that was published in the second-largest newspaper in the country. After the publication, provincial and district authorities started acting to resolve the illegal charges by producing new guidelines and enforcing consequences for workers requesting illegal payments. The National Ombudsman Office contacted the grassroots network and offered legal advice and mediating with provincial and national-level authorities.

Source: https://cegss.org.gt/2018/03/24/sistema-de-emergencias/

# 5. CONCLUSION

While the review of published literature carried out for this paper did not identify specific social accountability interventions for MNCH medical products implemented separately from service delivery packages, medical products should be integrated into existing services that then become the target of social accountability. A central lesson learned from this review is rather than focusing on a specific medical product, the potential for effective social accountability increases when interventions and actions are embedded in existing structures and procedures for accountability and coalitions of key actors are established and/or strengthened.

There are important lessons learned from the two decades of implementing social accountability interventions in health and some specifically on MNCH. One such lesson is the importance of facilitating enabling conditions for users of services and communities to become strong constituencies and of building broad coalitions of actors beyond the traditional interlocutors for MNCH medical products (i.e., human right activists, investigative journalists).

The second key lesson is that to enhance the potential of positive impact, social accountability interventions for MNCH medical products must include specific strategies, actions, and activities to inform and educate users and providers about standards and entitlements for quality medical products and facilitate the creation of spaces for dialogue and feedback among users of services, frontline providers, and authorities.

The third key lesson is that the various actors play different and sometimes complementary roles in the success or failure of social accountability interventions. For example, community members, including women and children, who are users of health care services may be able (with appropriate support) to develop knowledge and skills in monitoring local services. With sufficient capacity, motivation, and technical support, users of services are able to lead the implementation of social accountability interventions, which makes the sustainability of interventions more likely. Implementing NGOs (either international or national) can support the capacity building process of users of services while at the same time facilitating the creation of spaces for dialogue and coalition building among grassroots users of services and national NGOs acting at the subnational and national levels. This coalition building would be among actors sharing the goal of improving access to and use of quality MNCH medical products.

Taking into account the above lessons and the fact that the systems that support the procurement, distribution, and appropriate use of MNCH medical products are both complex and interconnected at different levels of the health system, there is a need to design and implement social accountability interventions that respond to that reality. In this discussion paper, we are proposing three actions to design effective social accountability interventions to improve access to and use of MNCH medical products—or any health service.

First, there is a need to understand the accountability ecosystem for MNCH medical products and to do a detailed mapping of it. Once we understand better the accountability ecosystem for MNCH medical products, the second action is to design and implement social accountability interventions that are strategic. These kinds of interventions are characterized by iterative implementation with adaptation and

learning as challenges arise. For practitioners, it requires a deeper and continuous engagement with all stakeholders, a continuous reflection and assessment of whether actions and strategies are achieving expected results, and detailed documentation of activities and processes to facilitate learning. For funders, it involves the provision of flexible funding and conditions to enable adaptation and learning, not only on the effectiveness of interventions but also on the role of contextual conditions, politics, and power.

The third action is to implement vertical integration of social accountability. This requires implementers to work with relevant national, subnational, and local civil society structures and to build linkages among them to facilitate effective advocacy for systemic change.

There are many useful social accountability tools and approaches that may aid the implementation of the three actions mentioned above. By following our three proposed actions, implementers will be more likely to design interventions that are adaptive, promote learning, and are likely to sustainably improve access to and use of quality MNCH medical products.

# ANNEX 1: KEY CONCEPTS USED

## ACCESS TO AND USE OF MEDICAL PRODUCTS

Access refers to availability, affordability, acceptability, and accessibility. Use of medical products refers to the prescribing, dispensing (or sale or supply to the user), and consumption (or end use). Medical products encompass medicines, medical devices, in vitro diagnostics, and other supplies needed to administer medicines.[44]

## ACCOUNTABILITY

Accountability is the obligation of actors to provide information or a justification about their actions in response to another actor with the power to make those demands and apply sanctions for noncompliance.[45] Accountability includes answerability and enforcement. State-centered accountability, which is also called horizontal accountability, refers to institutions that monitor performance and compliance and control abuses by other public agencies and branches of government.[46] For example, parliamentary commission review of the use of public funds by the executive branch of government.

## SOCIAL ACCOUNTABILITY

Social accountability is defined as "an approach towards building accountability that relies on civic engagement, for example, when ordinary citizens and/or civil society participate directly or indirectly in exacting accountability."[47] Since the World Bank proposed the above definition in 2004, social accountability theories, operational interventions, and experimentation have grown within the social and economic development field. Because of this, some authors argue that social accountability is still evolving and is best understood as an umbrella category that includes citizen monitoring and oversight of public-sector performance, user-centered public information, public complaint and grievance redress mechanisms, and citizen participation in the allocation of budgets.[48]

In the specific case of the health sector, social accountability is a form of participatory engagement in which citizens are recognized as service users who are ultimately impacted by health care decisions and thereby can effect change in health policies, health services, or health provider behavior through their collective influence and action. To have such a level of influence, citizens must organize, build alliances with civil society organizations, and aim their actions to different levels of government.

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[44] Management Sciences for Health (2012). MDS-3: Managing Access to Medicines and Health Technologies. Arlington, VA: Management Sciences for Health. pp1.9. Available at: https://www.msh.org/sites/default/files/mds3-jan2014.pdf

[45] Brinkerhoff D, Wetterberg A (2015). Gauging the Effects of Social Accountability on Services, Governance, and Citizen Empowerment. Public Administration Review, Vol. 76, Iss. 2, pp. 274–286.

[46] Ibid

[47] Malena C, Forster R, Singh J (2004). Social accountability: an introduction to the concept and emerging practice. In: Social development working papers series, paper no. 76 World Bank.

[48] Fox J (2015). Social accountability: what does the evidence really say? World Dev 72:346–61.

## CIVIL SOCIETY

This concept generally refers to a broad category of actors that range from private for-profit, worker unions, professional groups, academia, and non-state providers of services to community grassroots organizations. In terms of improving equity and the health of marginalized populations, including access to quality essential medical products and services that support their safe and appropriate use, the direct involvement of grassroots organizations in the accountability of health care services is essential.[49] It is important to note that different civil society actors may have different incentives and goals and sometimes may even oppose one another. Therefore, a concept as broad as "civil society" should further be examined to identify the key actors and organizations that are relevant to the intended goal and their strengths and weaknesses.

Table 7 presents a detailed typology of organizations that are usually engaged in accountability work for improved MNCH services and medical products.

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[49] Flores W, Samuel J (2019). 'Grassroots Organisations and the Sustainable Development Goals: No One Left Behind', BMJ 365: l2269, doi:https://doi.org/10.1136/bmj.l2269.

**Table 7. Typology of civil society organizations engaged in accountability work for improved MNCH services and medical products**

| Type of organization | Main focus | Strengths | Weakness |
|---|---|---|---|
| Grassroots and CBOs (savings and loan associations, water and sanitation committees, health committees) | Improving access to and quality of health services that their families and neighbors use. | Generally perceived as legitimate actors by local and national authorities and the general population; volunteers that do not depend entirely on external grants; capable of mobilizing and carrying collective actions to demand accountability. | Limitations to engage with issues that are very technical or require formal academic training; they face geographical and time barriers to engage in advocacy occurring at the subnational and national levels. |
| NGO providers of services under public contracts or grants (includes faith groups) | Ensuring that they receive medical products and all other necessary supplies to deliver quality health care. | A key ally in the monitoring of services for aspects of access, quality, and appropriate use; they can also train users of services on health rights and entitlements. | Since they provide services, they may be perceived as affected by conflicts of interest in relation to making providers accountable. |
| Private for-profit (corporations and businesses selling medical products) | Some may want to make tendering more transparent whereas others may want to maintain current contract arrangements if they are the main vendors. | Knowledge and expertise to advise transparent procurement; they can also suggest logistics arrangements to deliver acquired products to regional warehouses. | If organizations are benefiting from current contractual arrangements, they may be less interested in working to increase transparency in procurement. |
| Professional health associations (doctors, nurses, pharmacists) | Improving and implementing the standards for access to and appropriate use of quality medical products. | Because they are placed in frontline delivery, they can have a direct positive impact. They can also advocate for the adequate provision of training and other resources to cadres responsible for medical products at the national, subnational, and local levels. | Some associations may perceive the improved standards as additional work and responsibility for their affiliates. Hence, they may implicitly or explicitly oppose it. |
| Research/think tank, academic | Designing and implementing research related to accountability. | Producing evidence of success and/or failure of interventions; understanding and engaging with complex technical topics related to medical products. | Limitations to communicate with nonexpert audience. Sometimes the research is sponsored by interested parties, limiting its objectivity. |
| NGOs doing advocacy (either international or national) | Improving access to and quality of services and medical products for marginalized populations or as a universal health coverage goal. | Can use research evidence to design national advocacy campaigns; depending on capacity, they may also engage with technical topics related to medical products. | Many only work at the national level and have few connections with grassroots organizations. |

Source: Authors' own analysis

# ANNEX 2: SUMMARY OF MAPPING OF SOCIAL ACCOUNTABILITY INTERVENTIONS AND STAKEHOLDERS

A summary mapping of social accountability interventions in health that were identified in the literature is presented in table 8. This annex also includes key stakeholders that are engaged or targeted through social accountability and the relevant system level of implementation (table 9).

**Table 8. Summary of mapping of social accountability interventions implemented in the health sector**

| Intervention | Description | System level | | |
|---|---|---|---|---|
| | | Local | Subnational | National |
| Community scorecards | Participatory monitoring and evaluation tool that requires dialogue and agreement between users and service providers | X | X | |
| Citizen voice and action | A process of participatory dialogue between providers and users to set targets and assess performance | X | X | |
| Information campaigns for local communities | Provision of information and key messages about local services and user entitlements | X | | |
| Health facility committees | Local organization of health care users aiming to establish dialogue with frontline providers to improve quality of services. Users may be appointed by health authorities or elected by their own communities. | X | | |
| Community oversight committees | Local organization set to review performance and complaints related to local health care services | X | | |
| Legal accountability | Users of services approach courts, Ombudsman, or other state agency in charge of the legal enforcement of standards ensuring access to and quality of health care services | | | X |
| National advocacy efforts | Campaigns and other advocacy actions aiming to influence national-level decision making. In general, implemented by international and national NGOs. | | | X |
| Social audits | A form of participatory monitoring implemented by a user of services | | X | |
| Citizen satisfaction survey | A tool for users of services to provide feedback on expectations and experience while using health care services | X | | |
| Participatory planning and budgeting | A participatory process in which users of services and health authorities discuss and agree on plans and allocation of resources to facilities | | X | |
| Citizen report cards | A tool to assess performance of services based on user expectations | X | | |
| Patient charters | A written document establishing rights and obligations of patients and a code of conduct for service providers. This document may be understood as a standard so users of services and authorities can monitor its effective implementation. | X | | X |

Source: Adapted from Paina et al (2019)[50] and Danhoundo et al (2018)[51]

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[50] Paina L, Saracino J, Bishai J, Sarriot E (2019). Monitoring and evaluation of evolving social accountability efforts in health. Maternal and Child Survival Program and coregroup.
[51] Danhoundo G, Nasiri K, Wiktorowicz M (2018). Improving social accountability processes in the health sector in Sub-Saharan Africa: a systematic review. *BMC Public Health* 18:497.

It is important to note that most interventions listed in table 8 are very similar in the sense that they:

- Select a standard from a service protocol, policy document, or as agreed between user and service provider
- Collect information (through either surveys or routine information systems) to assess the performance of the service against the agreed standard
- Produce a report with the findings
- Establish a dialogue among users, frontline providers, and authorities to agree on ways to improve assessed services

The difference among these social accountability interventions is the emphasis on human-rights based approaches and whether interventions such as citizen scorecards build their actions on the legal rights and entitlements of citizens. Some interventions design and implement an intervention (e.g., scorecard) without reference to the legal rights and obligations of the actors involved. Another key difference is whether the engagement of service users is meaningful. Some interventions are designed by technical experts, and users have a marginal participation in data collection, analysis, and decision making. Experts analyze and write the reports, and users attend meetings with authorities. There are interventions in which service users are engaged in the entire process—such as participatory planning and budgeting. Whether implementers use any given emphasis usually depends on the country context and how funders and implementers understand the role of social accountability and users of services/communities in the wider accountability ecosystem (see definition below in this section).

Table 9 describes the actors commonly engaged and targeted by social accountability interventions and the system level in which this occurs. The arrows indicate that information and actions related to monitoring and decision-making flow upward and downward.

**Table 9. Type of stakeholders and system levels engaged or targeted by social accountability**

| Stakeholders | System level |
|---|---|
| ■ Parliamentarians and other elected officials<br>■ Central Ministry of Health and government departments<br>■ Health related professionals' associations<br>■ International NGOs and NGO coalitions<br>■ National and international advocacy groups | National |
| ⇕ | |
| ■ District health officers<br>■ Local government officials<br>■ NGO providers of services | Subnational (provincial or district-level government) |
| ⇕ | |
| ■ Public health care facility staff: health post nurses and CHWs<br>■ Village development/health committees<br>■ Women´s groups, cooperatives, and other CBOs<br>■ Specific projects implemented by NGOs | Local or frontline |

Source: Adapted from Paina et al (2019)

Other sources for interventions, methods, and tools in social accountability include:
■ Manual on social accountability: concepts and tools (https://www.cbgaindia.org/wp-content/uploads/2016/04/Manual-on-Social-Accountability-Concepts-and-Tools.pdf)
■ Glossary of Social Accountability Tools & Approaches (https://www.worldbank.org/content/dam/Worldbank/Event/MNA/yemen_cso/english/Yemen_CSO_conf_glossary_SA_ENG.pdf)
■ Social Accountability Resources and Tools (https://www.mcsprogram.org/resource/social-accountability-resources-tools-2/)

# ANNEX 3: SOCIAL ACCOUNTABILITY IN FRAGILE CONTEXTS

Recent years have seen an interest in and experimentation with social accountability interventions in settings that are fragile, under conflict, postconflict, or affected by violence. Implementing interventions in these settings is challenging because there is limited state capacity, institution instability and corruption, low levels of social cohesion, and a lack of a widely agreed social contract between the citizens and the state.[52] Knowledge and evidence from ongoing programs and initiatives are currently emerging. For example, a multicountry research program (Mozambique, Nigeria, Egypt, Pakistan, and Myanmar) published its learning summarized in several key messages. One of the messages is that in fragile settings, opportunities for accountability exist but not in the usual way that implementing organizations recognize them. Engaging in those contexts requires different entry points, beyond business as usual (e.g., working with non-formal actors and customary structures). Another lesson is that working in fragile settings requires an adaptive and flexible approach. Finally, the program learned that understanding the highly complex and political issues affecting fragile settings requires new tools for PEA[53] (e.g., tools for assessing the social aspects of fragility and facilitating rapid iteration of analyses).

Recently, the World Bank led the implementation of pilot projects in several fragile setting countries (Guinea, Niger, and Tajikistan). Although the pilots were on service delivery, none were specifically on health care services. The report states that projects were able to establish multistakeholder dialogue and collaboration. This was possible because the approach was flexible and adapted to each specific context.[54]

In Sierra Leone, a small study comparing the effects of different social accountability interventions on improving health care delivery was carried out. All four interventions (community monitoring, nonfinancial awards, participatory monitoring and evaluation, and mixed methods (two or more of the previous interventions) showed some effect on reducing absenteeism of frontline workers and improvement in patients' awareness of entitlements, patients receiving medicines, use of available services by users, and spaces for dialogue between health care workers and users. However, the participatory monitoring and planning showed a larger effect. The author concludes that although the study was small and short, it indicates that social accountability is possible in fragile settings.[55]

For the purpose of social accountability of MNCH medical products in fragile settings, the appraised literature indicates unique challenges and the need to use new or alternative research and implementation methods. The reviewed literature describes initiating with pilot projects. Such an approach may be advisable for initiatives that focus on MNCH medical products.

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[52] Nixon, H, Buffardi A, Wales J, Pasanen T (2017). Supporting accountability in fragile settings. Overseas Development Institute, London.
[53] Gaventa J, Oswald K (2019). Empowerment and accountability in difficult settings: what are we learning? Key messages emerging from the action for empowerment and accountability programme, Brighton, IDS.
[54] Poli M, Meknassi S, Thindwa J, Kumagai S, Cavatore M, Jespersen A (2020). Collaborative social accountability in fragile settings: Lesson from Guinea, Niger, and Tajikistan. Governance Notes No 24. World Bank Group.
[55] Pieterse P (2019). Citizen feedback in a fragile setting: social accountability interventions in the primary healthcare sector in Sierra Leone. Disasters 43(S2):S132-S150.

# ANNEX 4: SOCIAL ACCOUNTABILITY AND MNCH MEDICAL PRODUCTS

IMPLEMENTING SOCIAL ACCOUNTABILITY AROUND A SUBSET OF SERVICES AND MEDICAL PRODUCTS OR A WIDER RANGE OF SERVICES AND PRODUCTS

One recurring question relevant to considering social accountability for MNCH medical products is whether there is evidence of different outcomes when social accountability interventions are implemented around a discrete subset versus a wider range of services and products. During the review, we did not identify any specific research that undertook such a comparison. However, this question can indirectly be addressed through the evidence on facilitators for effective social accountability. Table 2 summarizes a key facilitator as: "Building coalitions of community stakeholders and others such as patient groups, professional associations, human rights activists, media, increases political and social pressure for improvements in services." One can anticipate that building a coalition about comprehensive primary care services that include essential medical products may have more actors and organizations interested than attempting to establish a coalition for a narrow subset of services (e.g., postnatal care) or one specific medical product (e.g., oxytocin). The broad coalition approach would include actors interested in monitoring postnatal care and oxytocin together with actors interested in other primary care services and essential medical products.

An additional inference from the literature is a need for balance between issues that are relevant for local actors (i.e., a specific medical product) and systemic issues that may be of interest for actors at the subnational or national level. Effective coalitions implement strategies and advocacy campaigns that maintain the interest of all actors at different levels in the health system.

KNOWLEDGE GAPS AROUND THE CONTRIBUTION OF SOCIAL ACCOUNTABILITY TO IMPROVING ACCESS TO AND USE OF QUALITY MNCH MEDICAL PRODUCTS

During the appraisal of available and retrieved literature, we were able to identify five main knowledge gaps:

1. As stated in a previous section, published literature on social accountability does not separate medical products from the package of services delivered, whether MNCH, SRH, or others. Therefore, it is not possible to know the specific effect and impact of social accountability approaches and tools on the availability of, access to, and/or use of medical products alone. However, if we take into account the lessons learned on the importance of building broad coalitions of actors for effective social accountability, one can say that social accountability that promotes medical products separately from service delivery packages may face challenges to raise the interest and engagement of diverse actors. It would be more relevant to document strategies that include medical products as specific targets of social accountability interventions with potential for impact and sustainability. This is also a gap that should be addressed.

2.  There is a lack of publications of research or case studies that follow up successful interventions for a period longer than an initial development project funding cycle (three years or less). What happens to those experiences in the mid- and long-term? Are they sustained? Do actors maintain their motivation and commitment? Do new challenges appear? What adapting and learning strategies are implemented? Research that addresses these kinds of questions is important and would contribute to inform the design and implementation of social accountability MNCH medical products with a vision for the mid- and long-term.

3.  There is inadequate reporting in most published literature about the sociopolitical context in which social accountability interventions are implemented. In the few articles with context information, this is usually presented in the background section without explicit analysis of its contribution to the observed outcomes or linkage to accountability mechanisms.[56] This is a major gap if we are to learn the most favorable contextual conditions for effective and sustainable social accountability and effective strategies to influence contextual conditions toward more enabling environment for effective social accountability.

4.  There is a lack of literature addressing whether there is a difference in outcomes when social accountability interventions are implemented around a discrete subset versus a wider range of services and products. For funders and implementing organizations, it would be helpful to know whether they should aim for a very concrete service and specific medical product or if instead they should aim to support interventions that target a wide variety of services and products.

5.  Finally, there is a lack of evidence on the role and characteristics of different types of key actors. As presented in this paper, there is plenty of evidence on the characteristics of frontline providers and authorities that facilitate or hinder social accountability. However, there is little information on characteristics of users of services. As stated in a previous section, people who use available services should be at the center of social accountability. Despite this, there does not seem to be a similar amount of published literature on service users as compared to the information available about other actors. The second key actor is NGOs. There are many types of NGOs (i.e., international, national, subnational), and they engage in social accountability from different entry points (e.g., international aid contractor, human rights observer, faith practitioner). However, literature on the most constructive role of NGOs to foster effective social accountability interventions is scarce. An initiative to document the roles of NGOs associated with successful and failed experiences may be a good starting point to filling this knowledge gap.

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[56] Van Belle, S, Boydell V, George AS, Brinkerhof DW, Khosla R (2018). Broadening understanding of accountability ecosystems in sexual and reproductive health and rights: A systematic review. PLoS ONE 13(5): e0196788.