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Monitoring and Evaluation of Evolving Social Accountability Efforts in Health

A Literature Synthesis

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The Maternal and Child Survival Program (MCSP) is a global, $560 million, 5-year cooperative agreement funded by the United States Agency for International Development (USAID) to introduce and support scale-up of high-impact health interventions among USAID's 25 maternal and child health priority countries,* as well as other countries. MCSP is focused on ensuring that all women, newborns, and children most in need have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn, and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment.

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Acronyms and Abbreviations

CBM	community-based monitoring
CBO	community-based organization
CHW	community health workers
CHS	complaints handling survey
COPASAH	Community of Practitioners on Accountability and Social Action in Health
CSC	community scorecard
CVA	Citizen Voice and Action
INGO	international nongovernmental organization
JHSPH	Johns Hopkins School of Public Health
MCSP	Maternal and Child Survival Program
M&E	monitoring and evaluation
NGO	nongovernmental organization
PDQ	partnership-defined quality
PHC	primary health care
PMNCH	Partnership for Maternal Neonatal and Child Health
SA	social accountability
SDG	Sustainable Development Goals
S4H WG	CORE's System for Health Working Group (formerly Community-Centered HSS WG)
UN	United Nations
USAID	United States Agency for International Development

1. Introduction

Social accountability (SA) interventions present various approaches that support citizens' participation, direct or indirect, in dialogue with service providers and other officials with a goal of developing a collaborative relationship to improve quality of service provision. In other words, SA interventions stimulate the engagement of citizens and the responsiveness of public and private authorities (Agarwal et al. 2009, Fox 2015). Many strategies to strengthen SA exist—from local community oversight committees, to participatory planning and budgeting in subnational units, to national advocacy efforts and legal accountability frameworks. Central to many of these strategies is the assumption that bringing stakeholders together to share and create information about a particular service will lead to changes in how community members and health providers engage in the demand and supply of services. Participatory strategies, such as community scorecards (CSCs), can also drive change through the development of ownership and joint planning between community members and health providers. Recently, interest in SA in health in low- and middle-income countries (LMICs) has grown as part of broad interest to better understand how to strengthen governance to reach the Sustainable Development Goals, and universal health coverage in particular (Boerma et al. 2015).

Following several recent debates, researchers and practitioners working in the SA field have acknowledged the existence different types of accountability that can be expressed uniquely across contexts, as well as the importance of "accountability processes that target the systemic and structural drivers of inequity" (Nelson et al. 2018, p. 2) and of intervening within the accountability ecosystems to promote sustainable institutional change (Fox 2015, Fox 2016). Despite this renewed attention and recent reviews of SA interventions, progress on updating or adapting how these interventions are monitored and evaluated has been slow. Consensus is moving toward recognizing that evaluation of SA interventions using randomized controlled trials and quantitative data alone cannot answer key questions associated with how SA relationships form, break, or change over time in a particular political, social, or economic context (Joshi 2014, Cant 2015, Lopez Franko and Shankland 2018).

To address these issues, some authors have recommended theory-based evaluations, through which evaluators elaborate and test their assumptions about how and why change happens, using mixed-methods data and ongoing monitoring (Cant 2015, Van Belle et al. 2018). Such recommendations aim to advance the field of monitoring and evaluation (M&E) of SA, shifting evaluation questions from what works to how and why a certain SA intervention can make a difference in a particular context. There is also greater recognition that the intervention itself, and the pathways through which it acts, may have context-specific implications, as well as different meanings for different stakeholders, including our community of health systems and community health professionals.

We propose that a better understanding of how SA interventions are monitored and evaluated can support greater collective learning on implementing and studying SA, and that such collective learning can support adaptations to SA interventions that are more likely to be embedded, scaled up, and institutionalized to support more responsive health systems, providing communities with equitable access to quality care. Through our literature review, we sought first to summarize how SA interventions are monitored and evaluated. After providing an overview of the literature review methods, we summarize the SA landscape and conclude with key issues related to the M&E of SA that merit further discussion and reflection.

2. Literature Review Methods

Our literature review targeted both peer-reviewed and grey literature. We outline our approaches for searching each of those categories in the following subsections.

Peer-Reviewed Literature

The search criteria for peer-reviewed literature was more relaxed than a systematic review, and was not restricted to following a systematic means of locating articles within a specific date range. The search string, developed with an academic librarian, included key terms such as program evaluation, community health, and social responsibility (see Box 1).

Box 1. Peer-reviewed literature search strategy

We conducted a thorough search on PubMed that included all English-language articles without any time limitations, using the following search strategy:

Evaluation Research[mesh] OR *Evaluation Research*[tw]* OR *Program Effectiveness[tw]* OR *Health Care Quality, Access, and Evaluation[mesh]* OR *Health Care Quality, Access, and Evaluation[tw]* OR *Healthcare Quality, Access, and Evaluation[tw]*

AND

Community Participation[mesh] OR *Community Participat*[tw]* OR *Consumer Participat*[tw]*

AND

Social Responsibility[mesh] OR *Social Accountability[tw]* OR *Social Responsibility[tw]*

Results: 624 hits

The search string initially returned 624 articles. We reviewed the abstracts of this set of articles to eliminate irrelevant or incomplete abstracts. This process returned around 45 articles that appeared related to community-level accountability. Other articles included in the extraction came from reference lists of relevant articles and from systematic reviews related to community participation and SA.

Articles were extracted if they included information about the M&E of SA interventions in LMICs. We excluded articles related to SA in medical school education. Also excluded were articles that did not describe a community or a group of citizens interacting with SA mechanism(s) in some way. For example, we excluded research to gauge community perspectives about health care delivery. This reduced the number of eligible peer-reviewed articles to 25.

Grey Literature

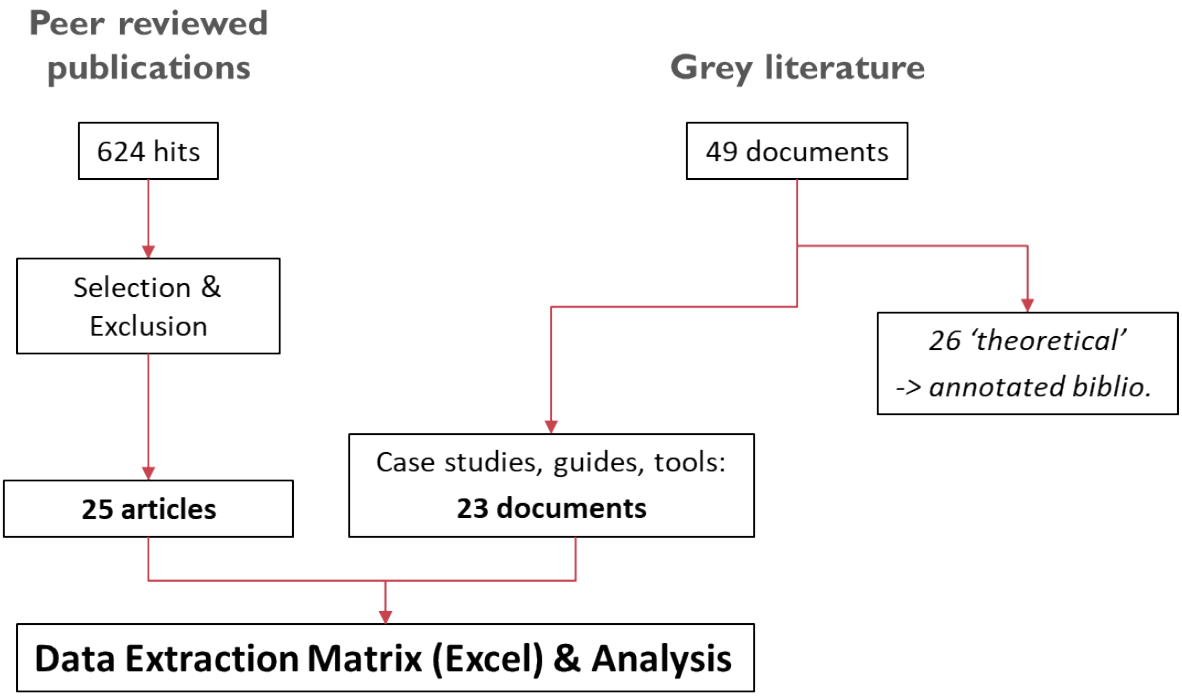
We first compiled grey literature from the team's knowledge of the field and from resources shared during past events.[1] We used a snowballing approach to expand this list and surveyed selected members of CORE Group's Systems for Health Working Group (S4H WG),[2] who sent a few additional resources.

[1] These include several CORE Group Global Health Practitioners' meetings, a 2017 event with Save the Children and the DC Health Systems Board, and MCSP activities and reports.
[2] Formerly known as the Community Centered-Health Systems Strengthening working group.

We divided the literature into three main categories—case studies, guides, and overarching theories. Case studies and guides were included only if they contained a significant discussion of the M&E strategies used, along with a detailed description of the intervention. We limited the search to resources from the past two decades. The more theoretical literature was included if it focused on M&E or SA and contained novel, pertinent ideas. In total, we reviewed 49 pieces of grey literature. Theoretical documents, though helpful, did not fit into the data extraction matrix, which was designed more for case studies and practical guides. They were therefore separated and included in an annotated bibliography, which was then summarized under the following rubrics: general approach to SA, context considerations, indicators, monitoring, evaluation, and theories of change.

Because the literature in this field is constantly growing, we tried to include the most recent reports and peer-reviewed articles in our analysis. However, we were not able to do so consistently after August 2018.

Figure 1. Summary of peer-reviewed and grey literature search results



Data Extraction Process

Both the peer-reviewed and grey literature were included in a Microsoft Excel data extraction matrix. Two of the matrix tabs were devoted to intervention design and implementation, including location, scale, time, and types of mechanisms. Another tab focused on M&E of the intervention, which encompassed methods applied, indicators used, and concepts explored. Complete categories in the data extraction included:

- publication information (title, author, date, country context, and author's definition of SA)
- intervention design (issue/purpose framing, intervention description, donor/leadership, SA mechanism, health focus, and intended and unintended outcomes)
- intervention implementation (scale, implementation design description, and duration of intervention)
- M&E (study type, implementation research objective, research and evaluation methods and data collection, monitoring methods and data collection, relevant conceptual frameworks, key indicators, key SA concepts, and targeted users of the M&E methodology)

We made adaptations along the way to account for information that did not fit into the original matrix. Important information that did not align well with the categories was included in the comments sections of the matrix and in separate documentation. Articles that could not produce enough information for the M&E component were excluded.

Analysis and Synthesis

In the first step of our analysis, we synthesized the data extracted from the two sets of literature separately, following a common outline. In the second step, we identified common themes and aimed to summarize key features of M&E of SA and major gaps.

In addition, we organized a 1-day participatory consultation workshop on November 7, 2018, in the collaborative space of CORE's S4H WG. The purpose of the workshop was to initiate a process to discuss the findings of the literature synthesis, reflect on the gaps identified, and begin to outline a set of critical questions for practitioners planning SA interventions to consider. Dr. Ligia Paina, assistant professor at the Johns Hopkins University School of Public Health, and Dr. Eric Sarriot, chair of CORE's S4H WG and senior advisor for Health Systems Strengthening at Save the Children USA, cofacilitated the workshop.

Workshop participants were selected from applicants to a call for expression of interest. Those selected represented technical advisors with a wide range of experience in implementing, monitoring, and evaluating SA initiatives. Because the workshop was held in Washington, DC, we could only accommodate participants who could fund their own travel. The full list of participants shows a broad range of nongovernmental organizations (NGOs) and academic centers (see Annex 3).

The workshop began with a scene-setting presentation that aimed to highlight the "network of networks" currently contributing to moving the fields of SA and M&E of SA forward. These included:

- Community of Practitioners on Accountability and Social Action in Health (COPASAH)
- EQUINET Africa
- Global Partnership for Social Accountability
- Partnership for Maternal, Neonatal, and Child Health (PMNCH)
- Citizen Led Accountability Coalition, including World Vision, CARE, International Planned Parenthood Federation, and PMNCH
- World Health Organization's Human Resources Development's Community of Practice on Measuring Social Accountability and Health Outcomes
- Swiss Agency for Development and Cooperation's Network on Democratization, Decentralization and Local Governance
- CORE S4H WG

The workshop included a presentation of summary findings from the literature review. Participants then worked in small groups during two sessions, first, using the draft theory of change as a starting point to discuss assumptions and gaps, and second, building on the themes from the first discussion to identify questions that could be useful in considering the design of M&E of SA. The groups were initially formed around the three levels outlined in the literature synthesis (frontline, subnational, and national); however, during the day, distinguishing among these levels lessened in importance as the group deliberated challenges that cut across levels, intervention types, and contexts.

The reflections from the workshop were incorporated in the literature analysis and informed the preliminary list of questions relevant to M&E of SA, as well as concluding sections on key gaps in the M&E of SA and recommendations for next steps.

Search and Analysis Limitations

Our review is limited by not being systematic and by being focused on SA in health only, not being able to incorporate lessons learned on accountability from other sectors. We did not explore other forms of accountability (e.g., bureaucratic or political) and how these can either enhance or deter SA. Additionally, we did not systematically document the specific tools used by practitioners for current M&E efforts (e.g., existing M&E toolkits, specific tools to measure participation and empowerment), unless they were specifically mentioned in the extracted documents. Although we recognize the importance and potential of technology, our literature review did not examine how it is used in M&E, tradeoffs between paper and electronic data collection and synthesis, and whether it aids or hinders SA implementation.[3]

Within the grey literature, few of the case studies mentioned the M&E methods used, and even those studies often devoted only a small section to the discussion. A major limitation to the peer-reviewed literature search and extraction was related to the keyword sensitivity in picking up SA articles. Some articles did not use a term specifically but highlighted community participation approaches in health care demand that fit our definition of SA mechanisms. This rendered the search strategy as a complementary component of the search process rather than an exhaustive, comprehensive resource. We found the most pertinent articles through ad hoc searching than through the search string product. Therefore, difficulty arose in deciding when to halt the search of new articles through reference lists and prominent SA researchers' work. Furthermore, the gaps we identified may be addressed to some degree in practice, but we could only examine what was published and publicly available.

Additionally, although we benefited tremendously from the technical inputs of the participants in the November consultation, we recognize that they represented but a fraction of implementers in a quickly evolving and diverse field.

[3] Which itself might have technology-related elements.

3. Overview of the SA Landscape

In this section, we give an overview of the types of SA interventions encountered in our review. We organize them by main level of implementation into the following three categories:

- **Frontline:** Interventions that directly involve the community interfacing with local health system actors through iterative cycles aiming to strengthen community voice and create bottom-up accountability from the community.
- **Subnational:** Interventions that facilitate interaction between community members or representatives and subnational management and oversight structures of the health system, or local civil government figures who can influence policy at the local level and have a vision to promote frontline responsiveness through official policy.
- **National:** National-level interventions, often by civil society organizations or other groups representing health care consumers and citizens through transparency or advocacy efforts.

Distinguishing between the various levels sheds light on the issue that contexts in which all forms of accountability are weak also exhibit weak administrative capacity, often exacerbated by incomplete decentralization. Examining SA using these levels helps to move us from generic concepts to more practical identification of the various stakeholders that can be engaged and whose power matters in a particular intervention at each level. Ultimately, strategic SA efforts seek to cut across these categories: with time and scale, frontline efforts will seek to influence subnational management decisions; at the same time, subnational SA efforts will aim to impact frontline services. To fully and completely understand SA, we propose examining it from all three perspectives, as well as the continuity between them.

Table 1 summarizes the types of interventions we identified in the literature review, organized by level of implementation, acknowledging that overlaps are inherent in many of them. Figure 2 summarizes the key stakeholders involved (whether through participatory implementation or M&E data collection) by the primary level in the system in which they are implemented. More detailed definitions of each intervention, along with examples, will be provided in the glossary. In general, interventions that use scorecards, such as CSCs, are more popular at the frontline than at the national or subnational levels. Our review did not identify many resources discussing SA at the national level. This may be partly due to the cultural divide within NGOs and United Nations agencies (such as UNICEF), that is, between programs and advocacy. National-level transparency and accountability are more often in the hands of the latter. We allude to linkages among all three levels when possible.

Understanding stakeholders, their power and positions in their health systems, and their role in SA is necessary to fully appreciate a particular context. In this section, we summarize our observations about the stakeholders' perspectives that were engaged through SA and captured as part of the M&E.

At the frontline level, we collected data from community members, health facility administration members, and health providers. The data were often collected through committees, with varying levels of formality or institutionalization and consistency. Some community members might be trained, as part of project operations, to take on facilitation roles, which are often initially (and sometimes indefinitely) held by external implementing partners or NGOs. For example, in Uttar Pradesh, India, World Vision employed its Citizen Voice and Action (CVA) strategy—a combination of information dissemination and interface meetings with local government leaders—to revive village health committees, introduce quality of care refresher trainings, and empower local government to implement the CVA strategy and access untied funds.

Table 1. Summary of interventions by level of implementation

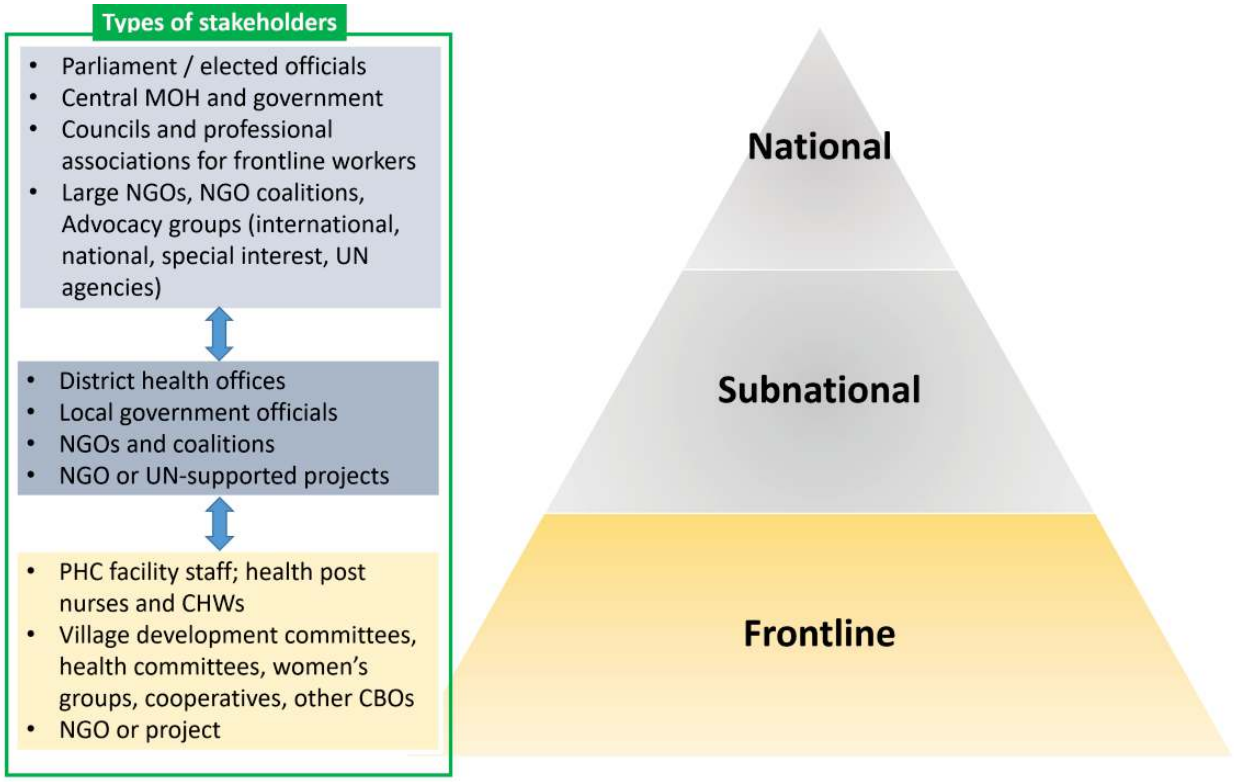
Intervention	Level of implementation		
	National	Subnational	Frontline
Legal accountability	X		
National advocacy efforts	X		
Fairness priority-setting assessment		X	
Priority setting for health programs		X	
Social audits		X	
Maternal death audits		X	
Participatory planning and budgeting		X	
Participatory action research (e.g., Dialogue Model)		X	X
Citizen report card/community monitoring		X	X
Community scorecards		X	X
Citizen Voice and Action		X	X
Partnership-defined quality		X	X
Citizen satisfaction survey			X
Information campaigns for local communities			X
Advisory boards and health facility committees			X
Local community oversight committees			X
Note: The list of interventions was derived from the literature reviewed.			

At the subnational level, SA interventions typically expand the types of stakeholders who are engaged. For example, CSCs that broaden participation of subnational actors would involve meetings that also include local government representatives (Schaaf et al. 2017).The stakeholders engaged in M&E for subnational SA interventions ranged from service users to community members more broadly, as well as to user groups (i.e., civil society organizations and consumer groups), health facility administrators and health providers, district health management teams and local policymakers, to national policymakers, such as members of commissariats, ministry officials, and, as relevant, other public or private parties (Mosquera et al. 2001, Few et al. 2003, Topp et al. 2015, Tromp et al. 2015, Samuel 2016). Sometimes nontraditional actors were engaged in SA. For example, a SA intervention in India leveraged journalists and local leaders to change community perceptions on women's power to overcome barriers to care (Papp et al. 2013). In an intervention to improve compliance to a birth policy in Peru, women leveraged newfound relationships with lawyers to advocate for them to hospital directors when issues arose (Samuel 2016).

Although external actors, such as international NGOs (INGOs) and research institutions, almost always play a facilitation role at both frontline and subnational levels,[4] especially during the pilot phase, their perspectives are not often directly included as stakeholders. Practitioners point to the importance of academia as a key stakeholder that contributes an analytical perspective and adds value to the credibility of SA. Furthermore, although several resources call for INGOs and other types of implementers to be more self-reflective (Crack 2013, Shutt and McGee 2013) or note that reflexivity is a feature of study quality (Van Belle et al. 2018), we identified only a single article that mentioned, without much detail, a research team engaging in a reflexive process (Mafuta et al. 2017).

[4] We acknowledge a possible bias of observation, as efforts not involving INGOs and research institutions would be less likely to appear in the literature.

Figure 2. Stakeholders engaged at various system levels



By engaging actors beyond the community, subnational SA interventions have been able implement action plans based on gaps identified at the frontline level to expand resources or make service delivery infrastructure changes (e.g. local leaders in Peru and Zambia reallocated the budget to increase the allocation of essential drug kits or hire a new midwife (Samuel 2016, Schaaf et al. 2017)).

4. Frequently Used Methods

This section summarizes the M&E methods and approaches at the frontline and subnational levels documented through our review. We did not identify consistent differences between how M&E is documented within the peer-reviewed and grey literature. Among peer-reviewed articles, interventions at the subnational level were most common, whereas the grey literature most commonly documented community-level, frontline interventions. This distinction might rise from the number of resources available to implement SA at the subnational level (generally more than at the community level) and incentives to publish in peer-reviewed journals (more by research teams than by NGO implementers).

Table 2 lists the M&E methods we identified in the review and attempts to categorize them by level of implementation. There is a fair amount of overlap between the M&E methods used at the frontline and subnational levels.

Overall, SA intervention implementers used a **medley of M&E approaches, often in a mixed-methods design**. Document reviews (i.e., committee meeting minutes, monthly reports, project documents), qualitative data from key informant interviews and focus group discussions, and quantitative data, often in the form of questionnaires and facility assessments, corroborated the stories of the health care personnel and users (Mosquera et al. 2001, Few et al. 2003, Uzochukwu et al. 2004, Falisse et al. 2012, Tromp et al. 2015, Abimbola et al. 2016, Blake et al. 2016, Otchere et al. 2017, Balestra et al. 2018, Wetterberg et al. 2018).

The most commonly measured indicators related to service quality, access to care, and participation. A smaller subset of studies also measured coverage, participant knowledge and perceptions, and trust. Some interventions, such as CSCs, simultaneously monitored health workers' performance, access to and quality of services, which can include both technical and perceived quality, and community priorities and perceptions. Monitoring such dimensions was achieved through the iterative implementation of the scorecard, generally on a quarterly or biannual basis. For example, the National Health Records Assessment Tool for Zambian Health Facilities guided an observation exercise and was complemented by notetaking of informal interactions and a review of facilities' paper-based registers (Topp et al. 2015). Some of the interventions documented participant and meeting observation, but this is a monitoring approach seldom used systematically (Blake et al. 2016, Balestra et al. 2018).

A few interventions stood out for applying **unique approaches as part of their M&E**. For example, the *most significant change* technique, a participatory M&E approach that collects stories from stakeholders about the most significant changes and the processes they believe led to them, was used in a couple of instances, such as the Tuungane Community Scorecard project in eastern Democratic Republic of Congo (Ho et al. 2015). Authors noted that the technique's value lay in gathering willing and capable project participants who could speak to not only successes but also any significant change that the intervention produced (Ho et al. 2015). A few of the studies we identified used ethnographic and policy analyses, which complemented interview data and facilitated analyses of accountability that cut across frontline and subnational levels (Béhague et al. 2008, Blake et al. 2016, Samuel 2016, Schaaf et al. 2017).

Table 2. M&E methods by level of intervention

M&E method	No. of studies	Frontline	Subnational
Direct observation of meetings (community, interface)	2	Blake et al. 2016, Balestra et al. 2018	
Interviews	8	Few et al. 2003, Falisse et al. 2012, Papp et al. 2013, Topp et al. 2015, Gullo et al. 2016, Schaaf et al. 2017, Balestra et al. 2018, Wetterberg et al. 2018	

M&E method	No. of studies	Frontline	Subnational
Focus group discussions	10	Mosquera et al. 2001, Few et al. 2003, Uzochukwu et al. 2004, Falisse et al. 2012, Papp et al. 2013, Ho et al. 2015, Gullo et al. 2016, Mafuta et al. 2017, Schaaf et al. 2017, Nxumalo et al. 2018	
Client satisfaction surveys	3	Iwami and Petchey 2002, Few et al. 2003, Goodman et al. 2011	
Facility assessments (infrastructure, equipment, drug availability, cleanliness)	2	Topp et al. 2015, Blake et al. 2016	
Most significant change	1	Ho et al. 2015	
Project document reviews	5	Few et al. 2003, Tromp et al. 2015, Abimbola et al. 2016, Nxumalo et al. 2018, Wetterberg et al. 2018	
Realist review	4	Abimbola et al. 2016, Gullo et al. 2016, Lodenstein et al. 2017, Schaaf et al. 2017	
Ethnographic analysis	2	Béhague et al. 2008, Samuel 2016	
Policy analysis	3	Iwami and Petchey 2002, Blake et al. 2016, Schaaf, Topp et al. 2017	
Local government development framework scores	2		Wetterberg et al. 2016, Wetterberg et al. 2018
Note: As the table shows, there is significant overlap between interventions at the frontline and subnational levels.			

The identified literature rarely included an explicit theory of change, though it is possible that some projects use them but choose not to document and/or publish them. The most common implicit theory was based on the SA intervention stimulating community participation and engagement of health providers, the expression of citizen voice and provider awareness of performance stemming from the development, feedback, and exchange of information. The expression of citizen voice, in conjunction with client perceptions and satisfaction with provider performance, create pressure on providers (directly and through the system more broadly), to increase responsiveness and quality of services. The ongoing engagement on both the community and the provider sides then create desired feedback within a community, through which mutual accountability is maintained, alongside a presumed cycle of continuous quality improvement. Making the theory of change explicit helps to illuminate the specific assumptions made about how SA interventions would work in a particular context and serve as a reference point for an eventual evaluation.

In the literature we surveyed, we identified only a few **applications of theory-driven evaluations**. In one case, authors used theory-driven qualitative design to explore the context, mechanisms, and outcomes of CVA, as implemented in Zambia (Schaaf et al. 2017). In Nigeria, local government performance frameworks engaged citizens to produce annual scores assessing weaknesses in the performance of local actors and incorporating findings in capacity-building plans (Wetterberg et al. 2016). In another set of examples at the subnational level, implementers in Tanzania and Indonesia used theory-based evaluation designs based around the "accountability and reasonableness framework," whereby priority setting is grounded in justice theory with an emphasis on democratic deliberation and evaluated against four criteria: relevance, publicity, appeals and revision, and enforcement (Topp et al. 2015, Tromp et al. 2015). In a recent article, Nxumalo et al. (2018) used accountability mapping in Kenya and South Africa for frontline managers to capture formal and informal accountabilities. Ho et al. (2015) used the most significant change technique to better understand and test assumptions outlined in their project's initial theory of change. Topp and colleagues employed the mechanisms-of-effect framework to study the interactions of hardware and software in health systems, and appreciated how trust and accountability become defining elements of complex adaptive systems (Topp et al. 2015).

As we conclude this summary, it is important to note what we did not often find. Evaluations of both frontline- and subnational-level SA interventions focused on positive outcomes. Although they sometimes documented no effect, they rarely mentioned **negative outcomes and/or unintended effects** of SA interventions. Most of the positive outcomes reported related to increases in expression of citizen voice, provider responsiveness, and equitable access to care, especially in rural communities (Iwami and Petchey 2002, Otchere et al. 2017). Seldom did authors mention negative outcomes, with the exception of the risk of tokenizing the marginalized group representatives invited to committee meetings in Nigeria (Abimbola et al. 2016). In this case, district leads initially were reluctant to include people living with HIV (PLHIV) in health facility committees, but over time they grew to appreciate the opinions of PLHIV. More broadly, the degree to which marginalized people (e.g., PLHIV) were consistently engaged as part of frontline SA efforts was difficult to determine through our review.

Only a few of the articles we identified reflected on the **role of politics and power in relation to SA** efforts. For example, in one case the role of committee member was politicized and thus its functionality and impact were questioned, but the role was not repurposed to legitimatize its meaning (Mosquera et al. 2001). In Benin and Peru, authors noted that an unintended effect of a social audit and a citizen monitoring intervention, respectively, was the reproduction of unequal hierarchies within the health system (Béhague et al. 2008, Samuel 2016). Some articles describing interventions at the subnational level highlighted issues of power and informational asymmetries, noting that these were neither immediately nor completely eradicated after the intervention took effect (Béhague et al. 2002, Papp et al. 2013). Although more users voiced demands for better health care, many were unaware of the existence of health facility committees or their role as advocates for community needs (Few et al. 2003). Unclear delineation of expectations of facility committee members and roles appeared as a recurring challenge in multiple contexts (Mosquera et al. 2001, Few et al. 2003, Abimbola et al. 2016). Additionally, committee meeting minutes in Nigeria illustrated that there was limited incentive to participate, or that committee members did not feel they had the power to make decisions that would produce real change (Abimbola et al. 2016). One article found that a neighborhood health committee struggled with having limited information about existing policies and services at the facility level, and the committee was further hampered by the members lacking advocacy skills to sufficiently deal with setbacks (Topp et al. 2015). Interviews elucidate that training on committee roles is often conducted, but there is need for more. Often committee members are clear on their role in clinics but struggle to execute community outreach (Few et al. 2003, Loewenson 2016).

Overall, evaluations of subnational interventions were explicit about the implication of **contextual factors and dynamic stakeholder relationships** (i.e., trust building). Yet, more work is necessary in terms of elaborating potential negative unintended consequences related to the implementation of SA, identifying and measuring context variables, and understanding how formal and informal accountabilities coexist and are influenced by power and political economy.

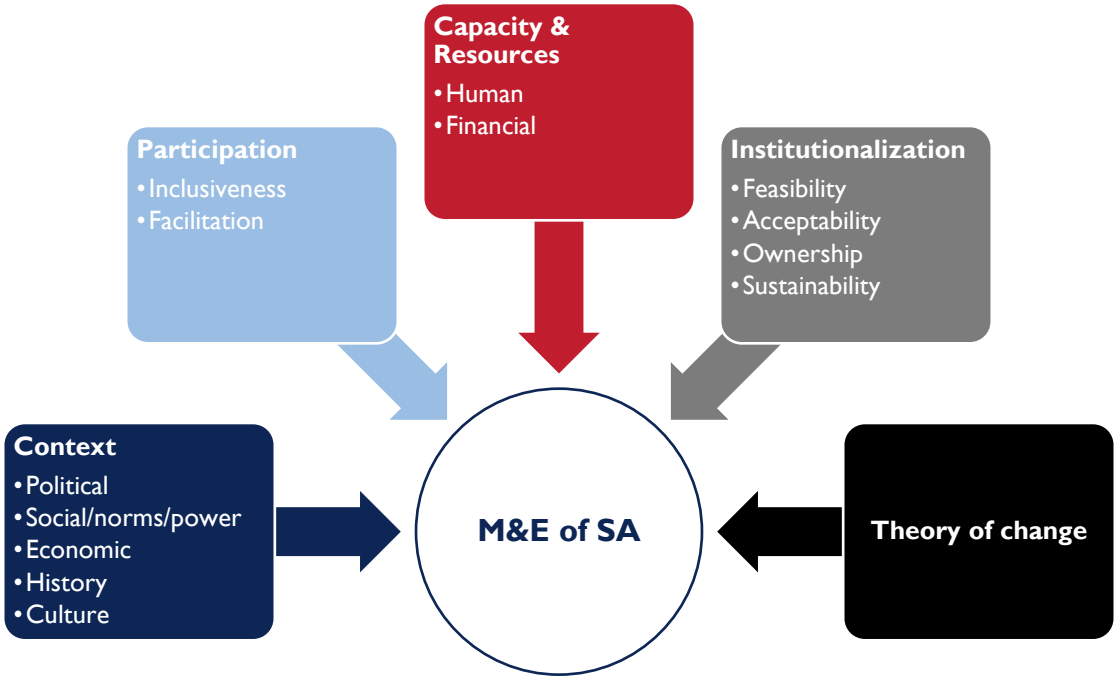
Another gap relates to the **capacity to implement, scale up, and institutionalize SA interventions**, whether at the frontline, subnational, or combination of levels. There is almost no mention in the grey or peer-reviewed literature of program costs and the **role of the implementing agency** (including level of resources and duration of involvement) in influencing the success or lack thereof of SA interventions. More concerning, potential social desirability bias might lead informants to report only positive results to an evaluator, masking some of the underlying capacity and funding needs (Ho et al. 2015)).

We observed that all of the **"unique" applications of M&E were applied in the context of research studies**. Although we do not know whether or how such approaches are used in regular M&E, routine applications are also less likely to be published in the peer-reviewed literature, and, consequently, not captured as part of our literature review. Finally, **monitoring how SA interventions adapt over time**, that is, mapping and documenting how SA is introduced and then implemented, usually in regular cycles, was not identified in our review.

5. Summary of Gaps in M&E of SA

In this section, we highlight key areas related to the M&E of SA that have not been fully elaborated in the published literature. The issues identified here were confirmed through consultation with practitioners, as described in the "Methods" section. We intend these gaps to serve as a foundation for future conversation among SA practitioners and researchers on how to move forward a related learning agenda. Figure 3 summarizes the main domains where we suggest further advancement of practice.

Figure 3. Major domains where there are gaps in M&E of SA



Addressing Context Explicitly

Understanding the context in which SA interventions are introduced and implemented (including power, history, and culture) is important both for the intervention's design and for ongoing learning through implementation and interpreting whether and how an intervention resulted in desired change (Lopez Franko and Shankland 2018, Van Belle et al. 2018). One would expect both an evolution and a proliferation among the contextual elements relevant to protracted implementation of SA, especially for interventions that achieve scale. Although most of the documents we reviewed recognized the importance of understanding the context, few gave details about which contextual dimensions were most relevant and how the authors explored them systematically. Several frameworks could be used to break down context considerations, including Joshi's macro context versus micro context (Joshi 2014), and O'Meally's six dimensions of context (civil society, political society, inter-elite relations, state-society relations, intrasociety relations, and global dimensions).[5] In addition, context analysis strongly features as part of political economy analysis,[6] power analysis,[7] and realist evaluation.[8] When not explicitly mentioned in a public document, the extent to which these or similar frameworks have been applied to date in the design or M&E of SA is unclear.

[5] http://siteresources.worldbank.org/EXTSOCIALDEVELOPMENT/Resources/244362-1193949504055/Context_and_SAcc_RESOURCE_PAPER.pdf
[6] https://www.odi.org/sites/odi.org.uk/files/odi-assets/events-documents/3797.pdf
[7] https://www.odi.org/publications/5529-mapping-political-context-power-analysis
[8] https://www.betterevaluation.org/en/approach/realist_evaluation

Formative research can also help implementers develop a deep understanding of a particular social, political, and economic context, including an appreciation of social movements that have been underway in health or other sectors and which a particular SA could leverage. It also provides an opportunity to apply tools that help to elicit information about how power and accountability unfold in a particular context (e.g., power cube analysis[9] or accountability mapping[10]).

Participation

Who participates and how, and whether and how participation translates to voice and empowerment are not systematically monitored, evaluated, or documented. More specifically, considerations of equity, gender, intersectionality, as well as special considerations for vulnerable or marginalized groups, are not often explicitly studied and documented throughout M&E, even though the vast majority of SA interventions identified through our review relate to women's health and empowerment. Additionally, few of the documented studies describe how SA interventions might reinforce existing social inequalities and barriers to participation among vulnerable and marginalized groups. To better incorporate participation in M&E of SA, several methods and approaches could be used, ranging from qualitative or quantitative observation of SA-related interactions (e.g., CSC interface meetings), to measuring how participation translates into desired outcomes, such as voice and empowerment (e.g., CARE Women's Empowerment—Multidimensional Evaluation of Agency, Social Capital and Relations [WE-MEASR][11] tools), to adopting a participatory M&E approach (several toolkits outline possible methods that can be used[12]).

Institutionalization of SA

Due to the complex nature of accountability, learning from implementation is important, from the design through evaluation and adaptation phases. The documents we examined were largely silent on issues related to scale-up and institutionalization and the learning that projects have built in to facilitate these processes. How SA activities or initiatives fit into the broader accountability ecosystem (including formal and informal accountabilities), the degree to which a SA intervention is embedded in a particular system and/or linked to other related initiatives (e.g., quality assurance or improvement efforts that are initiated by the government), or issues around the implementation of the SA intervention (i.e., feasibility, acceptability, local ownership, sustainability) are not systematically documented. How institutionalization occurs and the degree to which SA is embedded in a local system and perceived as legitimate (e.g., how INGOs work with national partners to design, learn, and adapt for institutionalization) are also underexplored, and we did not identify any examples for which M&E specifically and systematically included such issues. Most publications evaluated whether a SA had an impact on fairly immediate sets of outcomes, not on adaptation of the SA approach over time or its institutionalization. Practitioners and researchers should take advantage of learning through implementation, and of defining and monitoring medium- to long-term outcomes and processes, such as those related to institutionalization and sustainability.

Capacity and Resources Needed to Implement SA

None of the extracted materials documented reflections about the capacity and resources needed to implement and scale up/institutionalize SA interventions. Additionally, insufficient work seems to have been done to test how to scale up a SA intervention from a "proof of concept" pilot to an embedded intervention—particularly if it is to be scaled up from interventions often focused on maternal, sexual and reproductive health, and HIV to address accountability gaps in other health areas—or even to examine positive or negative spillover effects.

[9] https://www.powercube.net/
[10] https://gsdrc.org/document-library/mapping-accountability-origins-contexts-and-implications-for-development/
[11] https://www.care.org/we-measr-new-tool-measuring-women%E2%80%99s-empowerment-health-programs
[12] https://www.betterevaluation.org/en/toolkits/equal_access_participatory_monitoring

Additionally, there is likely insufficient reflection and self-reflection on the role of those who implement SA interventions, their relationships vis-à-vis local stakeholders (e.g., embedded or external, implications of embeddedness within the system that is to be held to account, and legitimacy of the information produced from SA initiatives vis-à-vis other sources of data), and the role they play in relation to future scale-up and sustainability potential. As mentioned in earlier sections, the work of donor-funded international implementers dominates the published literature. As a result, there is limited documentation and understanding of the incentives of local implementers (sometimes invisible), and how power and resources can be transferred between external and local implementers. A related but unique challenge in SA is identifying local capacity for facilitation. Practitioners emphasize that SA processes should be culturally sensitive and adaptable. However, only one document (a slide presentation) discussed the importance of facilitation. Although some manuals have been used to train facilitators, insufficient attention has been given to facilitation's role in enhancing or detracting participation and/or voice, or in terms of ensuring that this function is well supported in terms of resources and capacity—not just in the pilot phase, but also in future work.

Theory-Based Evaluations

Many donor-supported SA interventions "implicitly or explicitly, incorporate a linear theory of change that connects citizens' voice, enabled by SA tools, directly to increased accountability, leading to government and provider responsiveness"(Wetterberg et al. 2018, p. 2). Recent reviews suggest that theory-based evaluations[13] are needed for SA reforms, to allow for a more in-depth exploration and reflection into how change occurred (Van Belle et al. 2018). We identified a few documented examples of theory-based evaluation or intervention design, but found no documentation of an adaptive theory-based design, hinting at insufficient consideration of how intervening at one level (i.e., frontline) is affected by and affects other levels (e.g., subnational) over time. Finally, for purposes of isolating and attributing impact, evaluators often aim to draw rigid boundaries around an intervention. However, in SA the boundaries between where an intervention begins and where it ends are murky. Evaluation frameworks or theories should acknowledge and purposefully study how the process of stakeholder engagement in itself can have its own contribution affecting accountability (e.g., we found one example where the exercise to design a relevant SA intervention improved operations and supervision at the district level (Mafuta et al. 2017)).

[13] In the context of SA, the call for theory-based evaluations suggests the development of a program theory early on. This may or may not be based on an existing theory, or it can be a theory specific to a particular program, the main idea being that the broader context is considered when designing and planning an intervention. Ideally, the theory would be revisited during the monitoring phase and be used in evaluation.

6. Recent Work

SA in health is a quickly moving field and due to rapid growth in efforts to study and understand how SA initiatives can impact health, some reports and peer-reviewed journals have come out since we concluded our review. Most notably, two efforts are particularly important to recognize. We summarize their key findings here.

Lopez Franco and Shankland (2018): Guidelines for designing and monitoring social accountability interventions. Swiss Agency for Development and Cooperation and Institute for Development Studies.

The report presents "a set of principles and general guidelines for designing and monitoring social accountability processes, paying particular attention to the importance of context-specific Theories of Change." The report unpacks key questions and elements about the context in which an intervention unfolds. This resonates strongly with our findings and discussions. Furthermore, it suggests directions for linking information from a context analysis to theories of change and theories of action for SA.[14]

Marston (unpublished 2018): Methods to assess the role of social accountability in interventions for reproductive, maternal, newborn, and child and adolescent health: A systematic review. Preliminary findings presented in October 2018 to the World Health Organization Community of Practice on Measuring Outcomes for Social Accountability in Health.

Marston is preparing a systematic review of study designs and data collection methods published in the peer-reviewed literature and used to assess the role of SA in reproductive, maternal, newborn, child, and adolescent health interventions. Marston's preliminary findings confirm the key gaps that we identified (no further citation available, publication pending for 2019).

[14] Full report found here: https://www.ids.ac.uk/wp-content/uploads/2018/10/Guidelines-for-social-accountability_Final_Sept2018_1.pdf

7. Recommended Next Steps

This literature synthesis seeks to stimulate a broader discussion on M&E of SA interventions, specifically around how program implementers can promote and use M&E for learning during ongoing implementation. In light of our findings, we conclude that there currently is no single resource guiding practitioners on M&E across the thematic areas we have mentioned, although some new and ongoing efforts are helping to move the field in this direction. Based on the literature review and our consultations with practitioners, in particular, we developed a list of guiding M&E questions (see Annex 2).

Through this report and the illustrative questions in Annex 2, we not only aim to summarize the current state of M&E of SA, but also to highlight key gaps for practitioners and academics to address when redesigning SA initiatives with renewed emphasis on improved M&E. The current emphasis of the rich network of agencies, coalitions, partners (and occasional competitors) on SA suggests that we will learn to accelerate progress from the "tactical" to the "strategic," notably through better tested shared references about monitoring our interventions and learning to adapt strategies through better evaluation. We reflect on our key findings and potential next steps, specifically for civil society actors seeking to institutionalize SA mechanisms within responsive, equitable, quality, and people-centered health systems.

- **Routine learning activities should foster development of a systematic understanding of both intended and unintended consequences.** Assuming that SA interventions remain static and can be scaled up in the same form as they were piloted can hinder learning. Understanding factors that reinforce this assumption and identifying ways to relax it, and facilitating candid discussion of system distortions, spill-overs, and other unintended consequences, would prime the way for different approaches to M&E, which would facilitate learning and adaptation. For example, theories of change should be developed and adapted over the course of implementing a SA intervention and could serve as a guide for planning learning activities. Regular reflections and reflexivity among SA implementers could help to document the process of change, information that could also be used to help explain progress toward SA.

- **Evaluations of SA interventions should address spillover effects and feedback loops, while remaining nimble enough to learn from changes in the service indicators that providers and health managers are accountable for.** Our literature review did not systematically review or document evaluation outcomes, how indicators were defined, or the specific tools and guides used to measure them. Future review efforts should further analyze these indicators to document the types of outcomes captured through evaluation (technical service indicators, provider or community perceptions, and health system capacity and governance indicators) and ensure that they reflect the range of dimensions needed to understand how SA changes over time in response to a particular initiative or set of initiatives. In terms of M&E process and methods, we did not review the tools specifically, but note that M&E of SA largely uses traditional M&E methods, although SA interventions both change over time and could have both intended and unintended influence on behaviors that go beyond the health sector, a particular community, or a defined period in time.

- **SA interventions do not always succeed in the first application or pilot; rather, changes in SA take time and must adapt to a particular context and set of actors.** Not recognizing these unique characteristics through the M&E does not do justice to the potential of SA initiatives. Implementers of SA initiatives should use mapping (stakeholders, accountabilities, relationships, etc.), critical events recording, and theories of change early and throughout the implementation process, as well as storytelling/narratives, which might help to identify changes that can signal greater shifts down the line and leverage points.

- **M&E of SA should purposefully map out the social, gender, and institutional norms of a given context, address how they affect health system responsiveness, how they change over time, and whether the window of opportunity for systems improvement expands or contracts.** Knowing when and how to implement or adapt SA requires understanding the context (historical, political, cultural, and social) across multiple segments of society, as well as how SA successes and challenges will affect the context of SA implementation over time. For example, a community's history of civic engagement can be an important determining factor in the success or failure of SA. Additionally, the community's sense of rights and accountability depends on the broader awareness of citizens' rights and collective action beyond health service provision. Political economy analysis can help determine whether and to what extent a community is engaged with or feels accountable to civil society, so the SA initiative can be tailored appropriately. Similarly, accountability mapping can shed light on the balance between formal and informal accountability mechanisms. Norms are generally recognized as important, but they are seldomly explicitly studied.

- **Meaningful participation is a multidimensional measure that should be regularly reviewed. At a minimum, as SA interventions adapt over time, participation should be evaluated.** Defining the participation and engagement desired at every stage of SA design, implementation, and evaluation could be a first step toward acknowledging and prioritizing meaningful participation. Setting practical goals and objectives for participation creates activities that can be monitored and evaluated. Additionally, mapping who participates in various SA processes and interventions—both formal and informal—is critical to understanding barriers and facilitators for successful implementation of SA. Stakeholder and network mapping techniques can help describe the current context; observation checklists could be used by independent observers to track whose voice matters and how decisions are taken; and scales, similar to CARE WE-MEASR,15 can assess participants' perceptions of voice and empowerment. Perceptions (community and provider), participation, and empowerment metrics should be as relevant and central to the M&E of SA as service quality and access, and, as needed, tools and approaches should be adapted to make these elements feasible and robust.

- **It is not enough to "try" or "do" social accountability; implementers need to question and monitor the nature and quality of their facilitation of SA processes.** Facilitation is a critical component in the scale-up and institutionalization of SA, yet it is often overlooked or not given sufficient attention in M&E (i.e., documentation or measurement). For both international and national implementers, facilitation quality is part of the SA intervention's DNA. Typically, facilitators can start by being completely exogenous to a context (i.e., INGOs), endogenous (i.e., a local, community-based organization); or exo-endogenous (e.g., a local NGO reaching out to urban or rural communities). Recruitment of facilitators should consider empathy, language, cultural appropriateness (including gender), and skills and capacity (e.g., community organizing), along with commitment (i.e., estimating the likelihood of turnover overall and an individual's ability to maintain involvement over time). Funders and implementers of SA should consider the needs for ongoing capacity-building, in terms of both refresher training and mentoring (i.e., leadership development). Those overseeing facilitators should be equipped with problem-solving, leadership, and coaching capacity, as well as the ability to engage and potentially negotiate with government officials. For facilitation, as well as for the overall management of the SA initiative, M&E should also pay attention to the resources needed to sustain involvement, which are often in addition to the resources needed to run the SA effort.

- **Last, and admittedly at odds with the previous recommendations, implementers of ongoing, evolving SA efforts, possibly with limited or no external resources, will have to tailor their M&E and learning agenda to address these issues broadly, and focus assessment and measurement efforts at different stages of their implementation.** This may be an area for development of toolkits and ready-to-use guidelines.

[15] https://www.care.org/we-measr-new-tool-measuring-women%E2%80%99s-empowerment-health-programs

8. Conclusion/Parting Notes

Although several resources for supporting M&E of SA exist, it is unclear whether implementers consistently and deliberately ask the right questions at the right time. Furthermore, existing tools for evaluating SA have limitations that are not always recognized (e.g., exit surveys are often used, but they may not be consistently complemented with data collection approaches to capture the perspectives of those who do not access services). And there is seldom documentation of how M&E adapts over time to facilitate learning and adaptation, effectively moving beyond the identification of data and indicators, toward sense-making and translation of data of programmatic and strategic decision-making.

In the medium to long term, it will be important to explore how the gaps identified in this report can be filled and what related resources might be helpful, depending on the nature of the gap. Gaps that are not well defined might call for more exploratory research alongside current implementation of SA interventions; well-defined gaps could open opportunities to apply new M&E approaches or develop and test new tools; gaps where some scattered research exists and conclusions are unclear might call for a more focused systematic or critical review of the literature. Most importantly, there are many learning opportunities within the many ongoing SA initiatives. Increasing practitioner awareness of opportunities to document lessons from existing SA initiatives could make an important contribution to SA practice and theory.

Annex 1: Glossary

A: SA Interventions and Illustrative Examples

Information Campaigns for Local Communities

Information campaigns aim to increase community knowledge and awareness to promote behavior change and use of government health services. Organizations use print, audio, and visual media, and sometimes door-to-door contact, to educate communities and local leaders about the importance and benefits of a health area. Maternal health is a commonly targeted area, with foci such as pregnancy spacing, birth timing, and contraceptive use.

Illustrative application example:

- **India**
  - Otchere, S., V. Jacob, A. A. Toppo, A. Massey, and S. Samson (2017). "Social accountability and education revives auxiliary nurse-midwife sub-centers in India, reduces travel time and increases access to family planning services." Christian Journal for Global Health 4(2): 10–18.

Community Scorecards/Citizen Report Cards

A process by which citizens and service providers rate health facility performance against national service standards, facility assessment data, and pre-identified indicators informed by a community's perception of ideal care quality, usually gathered via a community focus group or survey. Community scorecards (CSCs), in particular, typically involve meetings between community members and providers in an effort to co-develop scores and jointly plan and prioritize a related action plan.

Illustrative application examples:

- **Multicountry**
  - Gullo, S., C. Galavotti and L. Altman (2016). "A review of CARE's Community Score Card experience and evidence." *Health Policy and Planning* 31(10): 1467–1478.
  - Gullo, S., C. Galavotti, A. Sebert Kuhlmann, T. Msiska, P. Hastings and C. N. Marti (2017). "Effects of a social accountability approach, CARE's Community Score Card, on reproductive health-related outcomes in Malawi: A cluster-randomized controlled evaluation." *PloS One* 12(2): e0171316.
- **Democratic Republic of the Congo**
  - Ho, L. S., G. Labrecque, I. Batonon, V. Salsi, and R. Ratnayake (2015). "Effects of a community scorecard on improving the local health system in Eastern Democratic Republic of Congo: Qualitative evidence using the most significant change technique." *Conflict and Health* 9: 27.
- **Ghana**
  - Blake, C., N. A. Annorbah-Sarpei, C. Bailey, Y. Ismaila, S. Deganus, S. Bosomprah, F. Galli, and S. Clark (2016). "Scorecards and social accountability for improved maternal and newborn health services: A pilot in the Ashanti and Volta regions of Ghana." *International Journal of Gynecology and Obstetrics: The Official Organ of the International Federation of Gynecology and Obstetrics* 135(3): 372–379.

Citizen Monitoring

Citizen monitoring aims to improve the quality of government health services by promoting district-level health provider compliance to policies that primarily impact marginalized groups. Volunteers from the marginalized group are recruited and trained to observe and report on health care service delivery in local facilities.

Illustrative application example:

- **India**
    - Samuel, J. (2016). "The role of civil society in strengthening intercultural maternal health care in local health facilities: Puno, Peru." *Global Health Action* 9(1): 33355.

Local Oversight Health Committees and User Associations

Local oversight health committees and user associations are either self-organized or organized by an institution. Community representatives comprise these groups and can be elected or appointed. Roles and objectives vary by national context, but some activities include health facility quality control and collecting community health survey data to inform health service delivery.

Illustrative application examples:

- **Peru (local oversight health committee)**
    - Iwami, M., and R. Petchey (2002). "A CLAS act? Community-based organizations, health service decentralization and primary care development in Peru. Local Committees for Health Administration." *Journal of Public Health Medicine* 24(4): 246–251.
- **Colombia (user association)**
    - Mosquera, M., Y. Zapata, K. Lee, C. Arango, and A. Varela (2001). "Strengthening user participation through health sector reform in Colombia: a study of institutional change and social representation." *Health Policy and Planning* 16 Suppl 2: 52–60.

Advisory Boards/Health Facility Committees

Often established via national policy, committees liaise between communities and the health facility, and sometimes sub-district government, to be responsive to and advocate for community's health needs. Roles vary by national context, but some include oversight of health facility management, promotion of health services to the community, facilitation of feedback to the community, and mobilization of community resources toward development of a health program or service.

Illustrative application examples:

- **Nigeria**
    - Abimbola, S., S. K. Molemodile, O. A. Okonkwo, J. Negin, S. Jan, and A. L. Martiniuk (2016). "'The government cannot do it all alone': Realist analysis of the minutes of community health committee meetings in Nigeria." *Health Policy and Planning* 31(3): 332–345.
- **Tanzania**
    - Macha, J., H. P. Mushi, and J. Borghi (2011). Examining the links between accountability, trust and performance in health service delivery in Tanzania. Ifakara Health Institute.

Social Audits/Maternal Death Audits

A social audit is used to assess clinic performance against national service delivery standards. Some incorporate patient feedback into a health facility's existing clinical audit structure, offering patients the opportunity to rectify injustices experienced when receiving care. Patients are invited to observe the facility, review facility data, and/or give honest feedback in brief, semi-structured interviews, and qualitative data may be bolstered by interviews with health facility personnel, such as administrators and/or social workers.

Illustrative application examples:

- **Zambia**
  - Schaaf, M., S. M. Topp, and M. Ngulube (2017). "From favours to entitlements: Community voice and action and health service quality in Zambia." *Health Policy and Planning* 32(6): 847–859.
- **Benin**
  - Béhague, D. P., L. G. Kanhonou, V. Filippi, S. Lègonou, and C. Ronsmans (2008). "Pierre Bourdieu and transformative agency: A study of how patients in Benin negotiate blame and accountability in the context of severe obstetric events." *Sociology of Health & Illness* 30(4): 489–510.

User Complaints System and Service Charters

A complaints handling survey (CHS), designed and implemented by a multistakeholder forum, aims to empower citizens to advocate for better quality care upon increased awareness of their rights. Problems identified through this survey are fed into a service charter, which is an agreement between citizens and primary health care providers, with delineated provider responsibilities and care delivery areas identified for improvement.

Illustrative application example:

- **Indonesia**
  - Wetterberg, A., J. C. Hertz, and D. W. Brinkerhoff (2018). "Social accountability in frontline service delivery: Citizen engagement and provider response in four Indonesian districts." *Development Policy Review* 36: O564–O585.

Public Hearings

A public hearing, as a standalone intervention, is a regularly occurring forum, usually before, during, and after implementation of a program, that convenes local community members, the media, and elected representatives. The objective is to hold health officials, workers, planners, and policymakers accountable for implementing policies and designed. Hearings also serve as a space for local community members, usually women, to receive information about their entitlements and rights, and to practice agency in demanding change from the more powerful attendees.

Illustrative application example:

- **India**
  - Papp, S. A., A. Gogoi, and C. Campbell (2013). "Improving maternal health through social accountability: A case study from Orissa, India." *Global Public Health* 8(4): 449–464.

Participatory Budgeting

Participatory budgeting is a process through which citizens and policymakers negotiate a municipality's investment priorities and budget allocations. The major outcomes are improved information flows between the two parties, increased ability of policymakers to provide goods and services that align with citizen needs and preferences, and increased accountability, via citizens' frequent checks, among policymakers to deliver on the promised priorities and allocations.

Illustrative application examples:

- **Brazil**
  - Gonçalves, S. (2014). "The Effects of Participatory Budgeting on Municipal Expenditures and Infant Mortality in Brazil." *World Development*, 53: 94–110.
- **Nigeria**
  - Wetterberg, A., D. W. Brinkerhoff, and J. C. Hertz, Eds. (2016). *Governance and Service Delivery: Practical Applications of Social Accountability Across Sectors*. "Chapter 8: Social Accountability in Cross-Sectoral Service Delivery: The Leadership, Empowerment, Advocacy, and Development Program in Nigeria." Research Triangle Park, NC, RTI Press/RTI International.

Citizen Voice and Action

Citizen Voice and Action (CVA) is a SA program intended to increase dialogue and accountability between citizens, public service providers, and government officials to improve service delivery. The program unfolds in three iterative phases, combining community gathering and relationship-building to inform a social audit process, conduct of a community score card, then an interface meeting to discuss findings, address gaps, and create action plans.

Illustrative application examples:

- **India**
  - Otchere, S., V. Jacob, A. A. Toppo, A. Massey, and S. Samson (2017). "Social accountability and education revives auxiliary nurse-midwife sub-centers in India, reduces travel time and increases access to family planning services." *Christian Journal for Global Health* 4(2): 10–18.
- **Zambia**
  - Schaaf, M., S. M. Topp and M. Ngulube (2017). "From favours to entitlements: community voice and action and health service quality in Zambia." *Health Policy and Planning* 32(6): 847–859.

Partnership-Defined Quality

Partnership-defined quality (PDQ) is a methodology applied in communities to improve service accessibility and quality. A pairing of quality assessment and community mobilization, PDQ has four phases: Building Support, Exploring Quality, Bridging the Gap, and Working in Partnership. It has been scaled up in Nigeria, Nepal, Haiti, Azerbaijan, West Bank, Georgia, Ethiopia, Pakistan, and Rwanda.

Key resources:

- Lovich, R., M. Rubart, D. Fagan, and M. B. Power (2005). "Partnership Defined Quality: a tool book for community and health provider collaboration for quality improvement." Save the Children/US Report.

- Outterson, B., et al. (2010) Partnership Defined Quality—Monitoring and Evaluation Toolkit. With Youth Annex. Save the Children/CORE Group/USAID. https://coregroup.org/resource-library/partnership-define-quality-pdq-facilitation-guide-pdq-monitoring-and-evaluation-toolkit/

Illustrative application examples:

- **Pakistan**
  - Amanullah, K. (2009). "Linking Community Mobilization to Quality Improvement in PAIMAN Project: PDQ Application in Pakistan." PowerPoint presented at the Technical Advisory Group Meeting.
- **Rwanda**
  - Community-Provider Partnerships for Quality Improvement in Rwanda. (2009). IntraHealth. Report.

B: Selected M&E Approaches for M&E of Social Accountability

Theory of Change vs. Results Framework, as Linked to Theory-Based Evaluations

A theory of change describes how a program will lead to results and facilitates a critical thinking process throughout design and implementation. Theories of change, results frameworks, and log frameworks are often used interchangeably. Typically, theories of change illustrate and explain assumptions related to how a program might fit in a context and all the various pathways that might lead to change, whether or not they relate to a particular intervention. A results framework or a logical framework hones in on the specific pathways that an intervention might aim to influence change. Log frames are more likely to be displayed as linear and can be tied directly to indicators in an M&E framework. In the context of SA, the call for theory-based evaluations suggests the development of a program theory early on. This may or may not be based on an existing theory, or it can be a theory specific to a particular program, the main idea being that the broader context is considered when designing and planning an intervention. Ideally, the theory would be revisited during the monitoring phase and used in evaluation. The principles of planning, monitoring, evaluation, learning, and feeding back into planning are also common to result-based management.

- Vogel (2012) Review of the use of Theory of Change in international development - https://assets.publishing.service.gov.uk/media/57a08a5ded915d3cfd00071a/DFID_ToC_Review_VogeIV7.pdf
- Rogers (2014) Theory of change – Methodological briefs - https://www.betterevaluation.org/sites/default/files/Theory_of_Change_ENG.pdf
- UNDP 2009 Handbook on Planning, Monitoring, and Evaluating for Development Results - http://web.undp.org/evaluation/handbook/documents/english/pme-handbook.pdf

Most Significant Change

A participatory program monitoring approach that collects stories told by highly engaged beneficiaries on the most significant—not only most successful—changes at the field level due to implementation of a SA intervention (in this example, a CSC), and the stories are compiled by a panel of stakeholders and evaluation staff.

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

Realist Evaluation

An alternative approach to systematic reviewing and understanding SA initiatives that goes beyond judging program effectiveness ("what works") and instead is an interpretive method seeking to unpack causal pathways of complex interventions by asking, "what works for whom under which circumstances" (Lodenstein et al., 2017).

- Abimbola, S., S. K. Molemodile, O. A. Okonkwo, J. Negin, S. Jan, and A. L. Martiniuk (2016). "'The government cannot do it all alone': Realist analysis of the minutes of community health committee meetings in Nigeria." *Health Policy and Planning* 31(3): 332-345.

- Schaaf, M., S. M. Topp, and M. Ngulube (2017). "From favours to entitlements: Community voice and action and health service quality in Zambia." *Health Policy and Planning* 32(6): 847-859.

- Lodenstein, E., D. Marjolein, G. Barend, and J. Broerse (2017). "Health Provider Responsiveness to Social Accountability Initiatives in Low- and Middle-Income Countries: A Realist Review." *Health Policy and Planning* 32 (1): 125–40.

Accountability for Reasonableness Framework

An ethical framework created to define fair priority-setting processes, grounded in justice theory. Priority setting should satisfy the four conditions of relevance (decisions should be based on reasons that stakeholders agree upon and are relevant to the context), publicity (decisions and rationales should be publicly accessible and leaders should take action to disseminate the message widely to the public), appeals and revision (a mechanism for challenge must exist, including the opportunity for revising decisions when stakeholders raise considerations), and enforcement (voluntary or public regulation must exist to ensure first three considerations are met).

- Tromp, N., R. Prawiranegara, H. Subhan Riparev, A. Siregar, D. Sunjaya, and R. Baltussen (2015). "Priority setting in HIV/AIDS control in West Java Indonesia: An evaluation based on the accountability for reasonableness framework." *Health Policy and Planning* 30(3): 345–355.

Participatory Action Research (i.e., Dialogue Model)

The Dialogue Model is a participatory action approach used for M&E design, as it facilitates dealing with complex phenomena, allowing groups to achieve participation when integrating issues among varying stakeholder groups. The Dialogue Model uses six phases: initiation and preparation, consultation, prioritization, integration, programming, and implementation.

- Mafuta, E. M., M. A. Dieleman, L. Essink, P. N. Khomba, F. M. Zioko, T. N. M. Mambu, P. K. Kayembe, and T. de Cock Buning (2017). "Participatory approach to design social accountability interventions to improve maternal health services: A case study from the Democratic Republic of the Congo." *Global Health Research and Policy* 2: 4.

Whitehead and Gray-Molina's Concept of Community-Based Monitoring (CBM)

Whitehead and Gray-Molina posit that pro-poor policies generate resources for political action; Balestra et al. draws on this to conceptualize CBM as a complex, long-term process toward accountability, requiring communities to renegotiate citizenship, rather than as a "widget" (termed by Joshi) that involves short-term technical interventions meant to produce standardized outcomes.

- Balestra, G. L., J. Dasgupta, Y. K. Sandhya, and J. Mannell (2018). "Developing political capabilities with Community-Based Monitoring for health accountability: The case of the Mahila Swasthya Adhikar Manch." Global Public Health: 1–12.

Pierre Bourdieu's Transformative Agency Theory

Transformative agency may occur as a result of a biological crisis; one's illness could cause one to change social position. Social audits, specifically patient feedback interviews, are explored as transformative agency mechanisms that may stimulate change in a patient's social position as well as change the system of social positions playing out in a hospital.

- Béhague, D. P., L. G. Kanhonou, V. Filippi, S. Lègonou, and C. Ronsmans (2008). "Pierre Bourdieu and transformative agency: A study of how patients in Benin negotiate blame and accountability in the context of severe obstetric events." *Sociology of Health & Illness* 30(4): 489-510.

Annex 2: Illustrative Questions

Based on the day's discussions (November 7, 2018, CORE's S4H WG workshop), we developed an initial list of questions that participants identified as critical for M&E of SA (Table A1). The thematic groups discussed participation, context/history, and facilitation; however, many of the questions were in common across most topics.

Table A1: List of illustrative questions on M&E of SA elaborated by workshop participants

List of Illustrative Questions
Design
What are the institutional preconditions for implementing SA?
What are existing mechanisms for redress/retaliation?
What are existing formal and informal accountability mechanisms at different levels of the system and what triggers a response? • What are the push/pull levers or incentives? • Who makes decisions? • What capacity do they have as interlocutors? • How are decisions made/acted upon? • What institutional accountability mechanisms are missing? • What are formal and informal communications channels to support accountability mechanisms? • What are historical grievances that have been addressed through existing systems?
Who are vulnerable and/or marginalized populations? What are existing mechanisms/processes for identifying inequity? Is there data for community engagement?
To what extent are vulnerable and/or marginalized populations included in existing accountability mechanisms? Who is excluded?
What does empowerment mean? And does a population know, practice their rights and how they can be redressed?
What does user-centered SA look like?
What is the program's basic theory of change?
Specific to participation
How are we defining meaningful participation? • Equity in participation • Elite capture How does participation change over time? Who facilitates these processes?
What are risks to citizens who participate in SA (e.g., safe open civil spaces, leveling structures, power dynamics in voting) • What social and gender norms can affect participation? • How do you avoid reinforcing existing, undesirable power dynamics?

List of Illustrative Questions
Specific to context/history
How do health and political structures/systems interact? • What are "power centers"? • What is the space for change/influence? • How do you measure change/influence
What is existing political will for SA? Is there willingness among political champions to expand their political capital? • Who are the thought leaders/champions? • Who is for or against reform/agendas? • Are there catalyzing events? • Is the timing right?
Monitoring
How is information shared? Used for decision-making? • Are you speaking the language of the government/community? • What are functional and/or sustainable features of existing M&E systems (subnational, facility, national level, health management information system)? • Can existing data be disaggregated/collected by appropriate identifiers? • Is citizen feedback digitized/aggregated? • Is the data received/acted upon by the government? • Is media monitoring/proposing pressure?
How can inclusion be monitored at all levels (who is the voice)?
How can power relationships/dynamics be reassessed and how can one observe whether the balance of power is changing?
How are community perceptions/attitudes/behaviors changing (in response) to the intervention?
How are actors/bureaucrats responding (or not) to accountability mechanisms?
Specific to participation
How does one conceptualize critical mass for participation (link to social movements) and whether a project achieves critical mass through their outreach efforts?
What were risks and/or negative consequences for citizens in participation/empowerment (i.e., unintended behaviors from providers)?
What factors contribute or hinder the mobilization of community/participation?
Evaluation
How can you observe and measure changes to social and gender norms?
What was the influence of various intervention components (e.g., informal communication vs. formal communication)?
Are there lasting effects from these approaches (more general participation, citizen engagement, empowerment)?

List of Illustrative Questions
Facilitation
Who facilitates?
What is the role of government actors, civil society organizations, other structures?
Who recruits facilitator (community group should have the ability to recruit, train, manage facilitator)?
Who is asking and defining the questions?
Who is the data for?
What are competencies for facilitation (i.e., needs to know how to work with community and health systems, know community empathy, culturally appropriate language, ability to negotiate with government, clinicians, problem-solving capacity)?
If competencies not met, what kind of training does a future facilitator need (e.g., leadership development)?
How are we assessing quality of facilitation?
General Monitoring and Evaluation
What SA arrangement is feasible based on existing financial and human resources?
What are the M&E models (qual, quant, mix) and resources needed to sustain M&E in various contexts (fragile, pilot, large-scale implementation)? • How can these consider the nature of the data that you can collect routinely (i.e., government) vs. at the citizen level?
When does data collection on participation happen and what are inherent biases linked to this timing/space? • At the end of service (e.g., will miss those who are not using services) • At planning/budgeting
How can you use the Theory of Change to think ahead about what could go wrong within each relationship and start developing scenarios to mitigate?
How can M&E adapt to both capture how an intervention adapts through time, and adjust the intensity and depth of data collection and use throughout pilot, scaling-up, institutionalization phases (and the increasing complexity in the solutions that are identified)? • How do you recognize things as signs of (potential) change that you did not anticipate?
How can practitioners communicate and support M&E for smaller organizations (i.e., M&E that is both balanced and practical)?
Provision and provider performance—systems' response to SA • What triggers provider responsiveness? • What norms, policies, guidelines, budget are necessary, so one moves beyond provider responsiveness? • What are the implicit assumptions about health providers (i.e., information will motivate change; benevolent motivation assumption)?
Feedback/mechanisms of change • How is it packaged? Could it be packaged in a more useful fashion? • How is it used?

List of Illustrative Questions
What are the right approaches, guidelines, and/or tools to address the questions elaborated here?
How can we continue learning from how we do M&E (i.e., continuously question the approaches used, data collected)?

Additional Resources Identified Through the Workshop

Our literature review was not intended to identify and capture the existing tools to measure and evaluate SA, although there are many of these tools and toolkits available. The resources identified through this consultation are listed in Table A2. These were not extracted as part of the literature synthesis, but they reflect additional tools or ongoing efforts that would be important to consider should a guide for the M&E of SA be developed.

Table A2: List of resources crowdsourced from the workshop and their respective links

Resource	Link
CARE WE-MEASR (Women's Empowerment—Multidimensional Evaluation of Agency, Social Capital, and Relations)	https://www.care.org/we-measr-new-tool-measuring-women%E2%80%99s-empowerment-health-programs
CARE Women's and Health Workers' Voices in Open, Inclusive, Communities and Effective Spaces (VOICES)—Measuring governance outcomes	https://onlinelibrary.wiley.com/doi/full/10.1111/dpr.12209
Transparency for Development (T4D) Project	https://ash.harvard.edu/transparency-development
Tanzania Community Scorecard Documentation Report	https://www.slideshare.net/COREGroup1/social-accountability-for-improved-community-health-winch Chima et al. (2016) "MCSP Community Component/Tanzania Community Scorecard Documentation Report
World Vision—Implementation quality assurance tool	https://www.wvi.org/hiv-and-infectious-diseases/implementation-quality-assurance-tool-orientation https://www.wvi.org/hiv-and-infectious-diseases/article/iqa-implementation-quality-assurance-tools

Additional ideas included exploring current social movements (e.g., AIDS Campaign in South Africa, White Ribbon Alliance's What Women Want) and additional bodies of literature that are unexplored (e.g., community organizing literature in the United States, theories on elite capture). No specific resources were identified for these during the workshop, but they should be considered in future discussions.

Annex 3: Participants in the November 7, 2018 Consultation

First Name	Last Name	Organization
Christina	Alexander	International Planned Parenthood Federation-Western Hemisphere Region
Angela	Bailey	Accountability Research Center
Marissa	Bell	International Rescue Committee
Suzanne	Cant	World Vision International
Deborah	Caro	Cultural Practice, LLC
Dennis	Cherian	World Vision International
Matthew	Cruse	Relief International
Blake	Dublin	CARE USA
Allison Annette	Foster	IntraHealth International
Mai-Anh	Hoang	Chemonics
Ochiawunma	Ibe	ICF/MCSP
Kristy	Kade	White Ribbon Alliance
Kristen	Mallory	Children International
Adriane	Martin Hilber	PMNCH (and Swiss Tropical and Public Health Institute)
Tanvi	Monga	Ipas
Thumbiko	Msiska	CSC Consulting Group, CARE Malawi
Ligia	Paina	Johns Hopkins University School of Public Health
Eric	Sarriot	Save the Children
Eileen	Yam	Population Council
Erin	Murray	CORE Group

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