USAID'S HEALTH EVALUATION AND APPLIED RESEARCH DEVELOPMENT (HEARD) PROJECT

ASSESSMENT REPORT

ASSESSING THE NATIONAL SYSTEM FOR SOCIAL ACCOUNTABILITY IN HEALTH

APPLYING AN ASSESSMENT TOOL TO MEASURE MATURITY AND PERFORMANCE OF NATIONAL SOCIAL ACCOUNTABILITY SYSTEMS IN HEALTH: RESULTS OF A PILOT STUDY IN RWANDA AND MALAWI

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This report was produced for review by the United States Agency for International Development. It was prepared by the HEARD project and was authored by Allison Annette Foster (WI-HER), Thumbiko Wachizma Msiska (co-investigator for Malawi), Cassien Havugimana (co-investigator for Rwanda), Adriane Martin Hilber (USAID HEARD/CUNY). Early contributions on the design and testing of the tool were received from Beth Outterson (Consultant), Kristen Mallory (Children International), Ligia Paina (JHU), and Eric Sarriott (GAVI).

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CONTENTS

ACRONYMS

CBHI	Community Based Health Insurance
CSC	Community Score Card
CSO	Civil Society Organization
CVA	Citizen Voice and Action
CUNY	City University of New York
FGD	Focus Group Discussion
GoM	Government of Malawi
GoR	Government of Rwanda
HEARD	Health Evaluation and Applied Research Development Project
HSSPII	Health Sector Strategic Policy
HSWG	Health Sector Working Group
JADF	Joint Action Development Forum
JHU	John Hopkins University
KIIs	Key Informant Interviews
MDGs	Millennium Development Goals
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn, Child Health
MoH	Ministry of Health
NGO	Non-governmental Organization
NQAP	National Quality Assurance Plan
NSASH	National Social Accountability System in Health
NSASHAT	National Social Accountability System in Health Assessment Tool
PHC	Primary health care
QA	Quality Assurance
QM	Quality Management
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SA	Social Accountability
SDG	Sustainable Development Goal
TWG	Technical Working Group
UNICEF	United Nations Children's Educational Fund
URC	University Research Co. LLC
USAID	United States Agency for International Development
UHC	Universal Health Coverage
WHO	World Health Organization
WI-HER	Women Influencing Health, Education, and Rule of Law

EXECUTIVE SUMMARY

This paper presents the results of a pilot testing of an assessment tool that will provide country governments a snap shot of the status of their national Social Accountability in Health. Social accountability is a critical element of good governance, and a foundational component of universal health coverage and the path toward ensuring healthy lives and promoting well-being for all (Sustainable Development Goal #3). Localized projects, using tools such as Community Score Cards (CSC) that engage rights holders or health system beneficiaries in assessing and improving their health services, have been effective at strengthening the responsiveness and accessibility of primary care services, namely reproductive, maternal, newborn, and child health services (RMNCH). Leveraging these project successes, governments have begun to institutionalize social accountability (SA) through national policies and strategies and integrate SA structures and practices throughout their health system. The National SA System in Health Assessment Tool (NSASHAT), tested in Rwanda and Malawi, guides national governments and their stakeholders and partners, through the five key domains of SA in health, and provides a scoring process for each domain to highlight gaps and strengths. The scores will inform plans to improve their SA in health and strengthen the collaboration of rights holders and duty bearers toward improving RMNCH outcomes through accessible, responsive primary health services.

The NSASHAT is based on an Accountability Measurement Framework developed by Martin Hilber et al (https://pubmed.ncbi.nlm.nih.gov/32494815/) that aims to help practitioners assess how local and national accountability mechanisms are developed, implemented and institutionalized over time. The framework provides a roadmap on how accountability can be integrated into programs and policies, including the stakeholders who should be involved, the data that needs to underpin the SA system, and the review and feedback loop (consequences for inaction), that create accountability in the system. The framework indicates how accountability mechanisms, once embedded and institutionalized can be transformative within the health system creating answerability to rights holders for the quality of the services or policies implemented.

Through 24 questions, the NSASHAT assesses the level to which countries have designed and implemented policies and strategies (Structure) that establish a system for accountability (Function) and have operationalized that system (Sustainability) through system constructs, human and financial resources, and oversight mechanism that will enable it to be accessible and inclusive for rights holders (Effective) to collaborate with duty bearers and influence improvements in RMNCH services (Transformation).

Methods

The framework has been adapted and shaped into an assessment tool through which countries look at five domains of the social accountability system: structure, function, sustainability, effectiveness, transformation. Then across these five domains, a scoring process, providing a score from zero to three, assigns a level of development maturity (with zero representing the lowest score, and three the highest) of the country's social accountability in health. Data for the scoring process is collected through 1) a rapid desk review and key informant interviews (KIIs) and focus group discussions (FGDs). Documents for the rapid desk review include national and sub-national plans, strategies, demographic health data, job descriptions and other program documents; development project reports; and peer reviewed literature. KIIs and FGDs are convened with both duty bearers (those in public positions responsible to provide quality health services), and rights holders (those who hold rights to access quality health services provided by the state). KIIs and FGDs provided additional information to supplement the scoring and also explored the user experience with the SA mechanism and their perceptions of its performance.

Conclusion

The maturity framework of Martin Hilber, et al adapted successfully to an assessment framework that gives an accurate scoring and useful snapshot of the status and maturity level of the SA system and points decision makers to where they need to investigate gaps and leverage opportunities to expand and improve their social

accountability in health. Upon testing the NSASHAT in Malawi and Rwanda, key improvements will be incorporated, adding questions and criteria that address 1) government funding levels; 2) government and stakeholder capacity for self-reliant implementation of NSASH functions; 3) mechanisms that mitigate corruption or rights holder influence on results; and 4) consistency of forums held for collaboration; 5) consistency and accessibility of feedback communication; and 6) inclusiveness of sub-population groups. In addition, guidance for applying the instrument will be included to ensure that the sample of country administrative documents are large enough to be sufficiently representative, and the KIIs and FGDs include specific groups that are traditionally marginalized and are also carried out across the country's states, regions, or provinces to be representative of the diverse populations of the country. Finally, two overall improvements will be made to the NSASHAT. First, the language around the reporting will be targeted to systems for social accountability, as it was discovered that national programs for social accountability may not be defined as such, but rather integrated across a collection of complementary policies and programs. Therefore, the instrument was labeled a National Social Accountability System in Health Assessment Tool (NSASHAT). Second, key FGDs and KIIs responses will also be coded to enhance the accuracy scores under each domain, namely effectiveness, sustainability, and transformation; and the respondents will also be invited to make recommendations and suggestions for improvement, thus incorporating this instrument into the NSASH itself. The NSASHAT, to be applied every five years, will become an integral piece of the sustainability domain.

INTRODUCTION

Social Accountability (SA) is defined as the broad range of actions or mechanisms, which citizens, civil society, and media can use to directly or indirectly hold officials to account to fulfill their obligations as duty bearers to their citizens and rights holders.[1] SA activities or formalized programs can be initiated and supported by the state, citizens, or both. When functional, accountability systems provide a platform through which citizens may submit grievances, demands, recommendations, and inputs, thereby ensuring community participation of rights holders in claiming their rights to accessible quality care.[2]

Social accountability is an important element to achieving universal health coverage goals and to progressing toward Sustainable Development Goal (SDG) #3: "Ensure healthy lives and promote well-being for all at all ages." SA systems allow rights holders to hold duty bearers to account for meeting their commitments and upholding their responsibilities as public servants to the populations they serve.[3] SA incorporates monitoring and reporting processes through which citizens: a) understand the obligations of the system; b) have a way to report where and when the system is failing to meet those obligations; and c) includes a response process or feedback loop through which the duty bearers must recognize claims and report back to the rights holders on their performance.[4] In this way, SA engages citizens in the process of strengthening the system so that services are more responsive to clients' needs. SA is therefore intended to promote equity, accessibility, and quality of health services for all.[5, 6, 7, 8]

Guidance and support from the World Bank, the United States Agency for International Development (USAID), and other development agencies have led to the growing consensus that social accountability (SA), as "an approach toward accountability that relies on civic engagement"[9] is a cornerstone for good governance and essential for responsive health service delivery. Some countries, including Columbia, Malawi, Pakistan, and Rwanda, have established national programs for social accountability. These programs or national SA mechanisms have developed either from the ground up, scaled from SA interventions introduced at community level as pilot projects, or have been initiated from the top down, wherein governments, motivated by global targets such as the Millennium Development Goals (MDGs) or Sustainable Development Goals (SDGs) and supported by global partners, build a national SA program as part of advancing good governance practices and better health systems.

As more and more countries embark on the establishment of national SA programs or scale up community programs that support citizens to claim their rights and entitlements at the national level, their experiences can inform other national and sub-national efforts to institutionalize and sustain SA processes as part of their health systems. To date, there has not been a framework nor common metrics (even less evidence) for assessing whether a SA program is accomplishing its intent. As countries advance in self-reliance in their health systems and continue to sustain progress and improvements in social development, it will be important that they have frameworks and tools for assessing their progress and guiding development efforts. Further, a common measurement will allow countries to compare their progress and continually share learning on progress towards making heath systems more responsive to their citizens.

In 2020, Martin Hilber et al. developed an Accountability Development and Measurement Framework and Tool for Global Health[10] to help practitioners understand how local and national accountability mechanisms should be developed, implemented and institutionalized over time. The framework provides a roadmap on how accountability can be integrated into programs and policies, including the stakeholders who should be involved, the data that needs to underpin the mechanism, and the review and feedback loop (consequences for inaction) that create accountability in the system. The framework indicates how accountability mechanisms, once embedded and institutionalized can be transformative within the system, creating answerability to rights holders for the quality of the services or policies implemented. The Framework was based on the best available evidence of successful accountability interventions. In this report, however, it is noted that while there is considerable evidence on efforts to create greater accountability, particularly through social accountability tools like scorecards,

or performance accountability via clinical performance audits, too little is known about what happens when SA mechanism go to scale and become institutionalized. Questions remain on their functionality, quality, responsiveness and sustainability, leaving practitioners insufficient information to measure whether SA can be truly transformative for a health system.

The National SA System in Health Assessment Tool (NSASHAT) was designed to fill this evidence gap. Like that framework, NSASHAT focuses on **five domains of an institutionalized SA system: structure, functionality, sustainability, effectiveness, and transformation**. A score between zero (lowest) and three (highest) denotes the level of maturity to which a country has arrived effectively institutionalized SA in the health system. Definitions of each of the domains, and the criteria involved in their scoring are explained in further detail in the Methodology section. This paper reports on the testing of the NSASHAT that was carried out in Rwanda and Malawi.

In Rwanda, the national SA mechanisms to improve health services were initiated at the national or central government level and borne out of decisive post-war reconciliation and transformation efforts to establish good governance. The post war environment facilitated the creation of a more accountable health system. Efforts were further advanced through the global MDG and SDG campaigns that emphasized devolution in the health system and greater engagement of community members, or rights holders, in health system planning and service delivery improvement decisions. In Malawi, initial pilot projects and community initiatives spearheaded by CARE Malawi, World Bank, and other international partners, showed such promise that the government of Malawi incorporated social accountability practices and structures in its quality assurance and community health improvement to achieve increase accountability in health for the population.

The NSASHAT was pilot tested in these two countries. Results of the testing will provide the government and partners important information to focus attention and guide planning to strengthen their SA mechanism in health. Such improvements can help to achieve responsive, inclusive health services that improve primary health care services and advance RMNCH outcomes.

This study reports on a pilot testing of the NSASHAT in Malawi and Rwanda. These countries were selected based on the following criteria: 1) The country has a national policy to establish a SA program in health; 2) the national SA program has been active for at least 18 months; and 3) published reports are available documenting the SA program in country.

Assessment Design

As mentioned previously, the tool has been adapted from a broader accountability assessment tool and framework (see Introduction). It specifically reviews the strength and sustainability of the national social accountability system across five domains: **structure, functionality, sustainability, effectiveness and transformation**. For each domain, a series of questions are explored and assessed based on a criterion for each (See Assessment Instrument in Appendix 1). Based on the scores, an aggregated quantitative score indicates the development maturity of the SA program at national level. Disaggregated scoring of each domain provides insight into opportunities for exploration and improvement.

An initial rapid desk review provided a synthesis of available documentation describing the national health system, policies related to SA, and implementation structures for social accountability across the five domains. The desk review provided data for scoring in each domain. Additional qualitative data collected through focus group discussions (FGDs) and key informant interviews (KIIs) enriched information gathered from the desk review and filled information gaps needed for the final scoring. Importantly, qualitative data from interviews also shed light on the program's strengths and weaknesses from the perspective of the providers (duty bearers) and users (rights holders) of primary care and RMNCH services.

Methodological Process

The concept for this assessment was submitted to USAID and received final approval in September of 2020. The HEARD project worked in partnership with Wi-Her, an international NGO, on the pilot study, who additionally sub-contacted local researchers in Malawi and Rwanda to do the data collection in country. The assessment design and implementation were conducted from October 2020 through May 2021. After funding was awarded, **preparation** and **inception** were carried out between October to November 2020. In both countries, a study protocol was produced and submitted for national ethical approval which was obtained by the local researchers before the start of data collection.

Data collection, carried out between February and May 2021, included a rapid desk review and field assessment, including KIIs and FGDs at national, sub-national, and community level. The rapid desk review collected relevant data from: 1) available published peer-review journal articles of the last 10 years from international and local researchers; 2) open-source data provided by the World Bank and other global agencies and government policies, strategic plans, laws, budgets where available, and other relevant government documents or reports; and 3) reports and studies from civil society organizations, donors, and implementing agencies.

Field assessment interviews began in March 2021 and continued through May 2021, with some delays due to COVID 19 government office closures and meeting postponements. Respondents included decision makers and managers (duty bearers) and beneficiaries (rights holders), and interviews were carried out at national, subnational and community levels of the health system. KIIs and FGDs were carried out either face-to-face or virtually. Field interview guides were used as prompt in a flexible fashion for the qualitative questions to be contextualized with local language and custom. This facilitated interviewees to raise additional or complementary issues, while remaining structured and controlled for consistency.

Before conducting KIIs and FGDs, information letters, and oral or written consent forms were obtained from all the participants. Consent form contents were explained verbally, including the purpose of the study, its funding, and the use of the data. All study participants were informed that their participation was voluntary, that no remuneration would be provided, and that all responses were confidential and anonymous. FGD participants were directed to respect the confidentiality of other group participants and to refrain from sharing participant names or responses outside of the group. Data collectors explained that KII and FGD participants had the freedom to decline participation, decline to respond to any specific question, or withdraw from the interview at any point during the KII or FGD. They were also invited to interrupt at any time to ask questions or request clarification. All the KIIs and FGDs were audio-recorded in the participants' preferred language, which was either English or local language, and transcribed and translated.

The sampling was purposive. The assessment team identified: a) key government informants from national, sub-national, and community (or district) levels government with knowledge of Rwanda's health system and the existing platforms of SA; b) global and bi-lateral agencies working in health and social accountability; c) project implementers identified by USAID or CSO stakeholders; d) CSOs working with community youth and women who use primary health and RMNCH services; and d) community members who were identified per their availability, based on support from CSOs working with youth and women in the targeted districts.

In Malawi and Rwanda test countries, the sampling was limited. As the countries were serving as pilots, the application of the tool was intended to be abbreviated; COVID-19 restrictions further limited access to respondent groups of both rights holders at community level and duty bearers at government offices. In Rwanda, four districts were identified, where 34 respondents were interviewed in 12 KIIs and 3 FGDs. The Kicukiro and Nuarugenge districts of Kigali city, the Nyaruguru district from the Southern Province, and the Rusizi of the Western Province. These were selected to provide a broad sampling of rural and urban locations, varied populations, and locations where there was information readily available on the social accountability activities. In Malawi, two districts were targeted: districts of Lilongwe and Ntcheu districts, both of the Central Region, where 49 respondents were interviewed through 14 KIIs and 10 FGDs. [See individual country reports for detail sample size information].

Scoring

Interview questions have multiple choice answers linked to Likert values to provide quantitative scores. From the questions, a score is assessed for each of the five domains. The scores ranked conformity to the question. Overall, **a score of zero** denotes that structures do not exist, that there is no evidence available, or that the answer is unknown. **A score of one** is used when minimal data or evidence that the structure/processes exist (e.g. a program exists on paper but there is no evidence of it as operational); **a two score** signifies that structures or processes partially conform (e.g. a program is in place but is not fully functional); **a score of three** reflects that the structure or processes fully conform to the purpose at all levels (e.g. program is in place and is functional as a social accountability mechanism at national, sub-national, and community levels). With each increasing score, there is evidence, through the desk review or through interviews, that these structures exist at each level of the three health system administrative levels defined for this analysis: national (or central), sub-national (province), and community (district

and below). [See **Table 1** for Domain definition and questions scored for each domain.] Determination of the score is drawn from documentation and key stakeholder opinion when there is no documentation. Additional input from stakeholders is used to add insights and guide further exploration for understanding barriers but rarely reflects the scoring unless it clearly addresses the criteria. Bias is mitigated through triangulation of the responses received when possible.

Findings

Upon testing the NSASHAT in Rwanda and Malawi, the tool was seen as useful in providing a snapshot assessment of the maturity level and gap areas of the national social accountability system in health. Standard scores across five domains, enhanced with perspectives from both duty bearers and rights holders provides a robust assessment that can be implemented by national governments as well as partners. Several areas of improvement were identified, namely 1) adding questions specifically on social inclusion to address the participation of women and historically marginalized groups; 2) adding a separate domain with questions on performance to include recommendations from respondents for improvements; 3) incorporating additional questions in each domain that will provide greater insight; and 4) clarifying questions that might have suggested redundancies. These findings are reflected in the discussion section of the report.

Table 1: Assessment Tool domains and definitional criteria for scoring

Domain	Questions	Definition
Structure	1. Has the country established a policy to institutionalize social accountability at the national level? 2. Are there policies and legal constructs in place to establish the institutionalized social accountability program or system? 3. Do the subnational and community levels of government include a social accountability process in their strategic plans? 4. Are there social accountability bodies or structures (committees or social action groups) at each administrative level identified in question #3 to ensure participation of rights holders and continuing communication and inclusion between duty bearers and rights holders? 5. Are there processes for interaction between the social accountability bodies or structures (committees or social action groups) at each of the relevant administrative levels listed above? (Note: By interaction, it is meant two-way sharing of information or feedback loops) 6. Does an accountability platform for registering grievances exist? 7. Is there a national policy that protects rights holders, stating that anyone who submits a grievance will not suffer retribution?	'Structures' refers to national policies that codify a social accountability intention so it can be institutionalized and programs that define how that policy will be applied. For this assessment only countries that had some sort of SA program or policies in place for at least two years were eligible. Also included in 'Structures' are strategic plans (or strategies) with processes that translate intent into an implementing framework whereby policies may be operationalized. Fourth, an essential structure for an accountability program or SA system are feedback loops

continued

Table 1: Assessment Tool domains and definitional criteria for scoring continued

Domain	Questions	Definition
Functionality	1. Does an M&E process exist (i.e., a process for data collection of and reporting on a set of standard national indicators)? 2. Is the national social accountability program or system budgeted? 3. Is the redress system accessible to all rights holders?	The Functionality of the national SA program or system in health refers to what extent the existing social accountability platforms are functioning to ensure active participation of citizen and other key stakeholders to improve health systems in Malawi. To ensure the functionality of the government social accountability structures, the functionality score assesses if: 1) there are monitoring and evaluation processes in place; 2) budgets exist to support the SA systems in the country; and 3) the system is accessible to all rights holders.
Effectiveness	1. Does performance criteria for staff include the fulfillment of SA responsibilities that respond to rights holder needs? 2. Are M&E findings on the performance of the SA system (i.e., the duty-bearers' responsiveness to rights-holder complaints) shared back with the community (i.e.: on public platforms such as the MoH website; or through other public communication mechanisms)?	By the term "Effectiveness" we refer to the extent to which SA system is positioned to achieve SA objectives. For example, the level to which duty bearers respond to rights holders' needs and complaints should be reflected in their performance reviews. Rights holders must be held accountable and have incentive to be responsive and steer the accountability of the system. In addition, the SA system's performance should be monitored with reports on the average response time to grievances, number of grievances that were solved, and changes or improvements that were made as a response to grievances or service delivery improvements that were accomplished.
Sustainability	1. Are the M&E processes for the SA program/ system institutionalized (or mainstreamed/ normalized within the institutions)? 2. Is there a mechanism for the rights holders to approve of and/or participate in the development of the social accountability strategic plan objectives? 3. Does the budget fund at least one person to be responsible for managing the SA process? 4. Do budget line items support the SA system activities and materials in three health administrative levels (national level, sub-national level, and community level)? 5. Is the responsibility for M&E of the SA system assigned to an MoH staff member and included in his/her job description?	The Sustainability domain explores factors that position the SA program/ system in health to continue autonomously through its being institutionalized by laws and regulations and supported by funding. This measurement requires that the structure not only exist, but that some type of legal or regulatory framework must be in place to enforce common standards. This 'Sustainability" domain also goes a step further than the 'Functionality" domain with regard to financial autonomy. For example, it requires that there be not only budgets for programmatic support, but that there be budget line items to support staff assigned to drive the national SA structures. Monitoring and evaluation must be not only functional, through a structure for and process of data collection

continued

Table 1: Assessment Tool domains and definitional criteria for scoring continued

Domain	Questions	Definition
Sustainability continued	6. Are annual trainings held for participating staff (MoH) and stakeholders (MoH, NGO, and/or CSO) on the principles and practices of the SA system? 7. Do job descriptions of all duty bearer staff at all levels include a statement or description of their responsibility to rights holders?	and evaluation, but also sustainable with a data management system that is integrated across all levels, with capacity for consistent dissemination of information and transparency of results.
Transformation	1. Is the SA program/system self-sustaining (demonstrating self-reliance through both national commitment and national capacity)? (This question addresses both technical and financial sustainability.) 2. Have Provider performance indicators improved? 3. Have health service indicators improved? 4. Have rights holders' satisfaction with the health system improved? 5. Have population level RMNCH health outcomes improved?	The Transformation domain discusses potential markers of lasting change in Malawi's health system and health outcomes as a result of SA programs and policies. It goes beyond sustainability, which stems from institutionalizing practices and providing resources to sustain them and extends to incorporate shifts in attitudes of rights holders and duty bearers and the self-reliance of SA within health governance systems. The transformation domain also looks at whether the system is self-reliant, to which questions were asked about capacity and will. The transformation domain also looks at the results of the national accountability system, asking if services and health outcomes have improved.

***Note: For detail scoring criteria under each of the questions within the domains, please refer to the NSASHAT and /or the country reports*

COUNTRY LEVEL FINDINGS

The pilot study produced country level finding on the status of the SA mechanism or systems. It also provided critical input for the improvement of the tool. Below we describe learning from each country pilot study and then reflect on key improvements needed to strengthen the tool as an assessment instrument.

Malawi

Malawi's NSASH scored **50 out of a total possible score of 72, or a 69% development maturity score**. (See **Appendix 2** for full Malawi Report). Despite policies, strategies, and budgeted processes that clearly define and enable both the Structure and Function of Malawi's national SA system, Malawi struggles with the system's Effectiveness and Sustainability. Effectiveness is thwarted by three primary drivers: 1) the lack of a monitoring data; 2) political agendas at the national level that resist the purpose of the NSASH, while political ambitions aim to centralize influence and hide problems rather than resolve them; and 3) decreasing level of consistency and follow-through on service complaints and performance reports to reach regional and national levels. These challenges highlight the need for stronger incentives within the accountability system, and transparency of data. The most critical threat to sustainability is SA system's heavy dependence on NGO support.

Disaggregated by domain, Malawi scored highest in the **Structure** of its SA system (**95%**). The assessment found that policies, strategies and structures to implement SA at all three health administrative levels (national, sub-national, and community) were in place. Malawi's National Decentralization Policy and the Local Government Act of 1998[11] brought decision-making closer to the level of care and strengthened the health system's responsiveness to local needs and the constituency it served. This context set the stage for the development of the National Quality Assurance Plan (NQAP, 2005), which was put in place in 1998 to improve service quality in the health sector. This was followed by the National Quality Assurance Policy in 2005.

The **Function** of Malawi's NSASH also scores fairly high at **89%**, reflecting processes in place that support the implementation of policies, such as budgeting, accessibility for use by rights holders, and an M&E function to monitor progress. M&E is one of the three sections of governance under the Quality Management (QM) Directorate and has the role to assess the impact of quality initiatives and effectiveness of supervision. The national M&E plan includes formal M&E structures at national and sub-national level. At community level conflicts and resolutions around quality of service delivery are monitored through a variety of M&E processes and mechanisms, including Community Score Card, Citizen Charter and Citizen Voice and Action (CVA), that feed into the SA program. There is a liaison officer within the five QM satellites across the country, and staff are tasked with monitoring data to ensure implementation and documentation of quality overall.[12] However, the M&E processes do not consistently track and record the number of complaints, the rate of responses or average response time. Importantly it does not link improvements to rights holders' demands with system performance or health outcome improvements.

High maternal and newborn mortality rates in Malawi (as registered by their population health and MNCH indicators) have improved dramatically over the last two decades. During the same period, governance was decentralized, the National Quality Assurance Policy and then the Quality Management Policy was put in place, and Malawi's community health system was strengthened. Citizen participation in health system planning and service quality demands have increased. Indeed, rights holder respondents report that they have seen provider performance improve. However, there are no national level processes or institutionalized measurements that relate improvements in health service indicators or health outcomes in Malawi directly to its national SA processes.

The **Effectiveness** of the Social Accountability Structure ranked lowest (**33%**). This score is somewhat misleading; across all three levels (national, sub-national, and community), both rights holders and duty bearers were able to describe the effectiveness of the SA processes and give examples. However, the scoring instrument was designed to look at elements of the program required to be effective. Elements that were designed to assess this domain are: 1) whether the

performance standards of rights holders, or Ministry of Health (MoH) staff, include requirements to be responsive to duty bearers and to concerns expressed through the SA program; and 2) if the results of the SA program, made available through the M&E processes, are reported to (or accessible to) the duty bearers. This 'higher level' of effectiveness was difficult to achieve and may be aspirational—a point that should be considered in the next adaption of the tool.

Performance reviews and guidelines were not available for management staff or providers. Job descriptions of providers, district managers and MoH employees should incorporate specific performance expectations for SA activities of all duty bearers, and performance reviews should incorporate incentives for compliance. In addition, KII and FGD respondents felt that stronger advocacy around the importance of collaboration between government and community is needed to achieve greater awareness and sensitivity among duty bearers related to their mandate and responsibility to hear the voices and act of the needs of rights holders.

With regard to accessibility of M&E reports, there was no evidence that the practice of using the M&E processes has been institutionalized. No evidence was found of improvements in feedback, nor is the link between the SA system and improved services or outcomes documented. However, it is hoped that Malawi's Digital Health Strategy (2019-2022) will enable the implementation Monitoring, Evaluation and Health Information Systems (M&E/HIS) Strategy, initiated in 2017 (2017–2022), will standardize tools and progress indicators across the health system, including the tracking and analysis of the SA program .

Despite the low **Effectiveness** score, rights holders reported their satisfaction with the SA system and their ability to voice grievances and influence change. They were able to provide examples of improvements in RMNCH, such as in the area of respectful care. A common complaint of rights holders with the SA system was the length of time required to receive feedback regarding improvements that require systems changes or where engagement with higher-level decision-making was needed, beyond community and sub-national administrative levels.

In the domain of **Sustainability** (**62%**), Malawi shows a potential to sustain and strengthen its national SA structures and functions. Buy-in and participation of local civil society organizations, such as through district civil society networks and youth networks, have been successful in convening rights holders, disseminating information, and providing peer to peer support and collaboration among rights holders and community and district level duty bearers. The biggest challenge is Malawi's struggle with self-reliance. Malawi's dependence on donor funding and continued technical assistance thwart the potential of Malawi to sustain the SA program. Donors are requested to support strengthening the country's economic development, by further developing capacity in the health system for resource mobilization and private sector investment. Such actions are currently underway and include building the capacity of sub-national and national CSOs to steer the SA system themselves. Further, leadership and steering capacity needs to be further developed to strengthen Malawi's good governance and overcome corruption, commit to the social and economic development of the country, and guide the necessary improvements to advance prosperity. Finally, researchers noted that although the Citizen's Score Card was the most common intervention of rights holders at community level, there is flexibility across communities that allows rights holders to carry out their own form of engagement and structure for grievance registration and feedback. This flexibility has reinforced rights holder ownership of the SA process. As the SA system continues to mature, it may be useful to standardize these processes, particularly as digitalized M&E practices are institutionalized and consistency is required.

Even though Malawi's effectiveness scores are low, the **Transformation score** (**50%**) is higher. This discrepancy reflects the need for more attention by the GoM on addressing the gaps in functionality and effectiveness through oversight mechanisms, civil society and professional society reprimand functions, public employee performance links to responsiveness and SA redress duties, and improved documentation of health system and service improvements related to the SA system. Despite the weaknesses of the SA system itself, government will and rights holder engagement have shifted perceptions and transformed expectations in that duty bearers at every level recognize the government's obligation to be responsive to and collaborative with rights holders. At the same time, rights holders are active in voicing grievances and participating in public discourse with health system representatives, or duty bearers, to address challenges and improve the quality of service delivery. The establishment of a sustainable SA structure that has been expanded, and further developed over recent years suggests a commitment to engaging rights holders in collaboration for

improved health services. It also suggests a commitment to responsiveness to needs and concerns of beneficiaries of the system, linking community governance systems with health system mechanisms in a coordinated, collaborative social accountability process.

The commitment of community members and civil society rights holders to continue the score card process and the participation in social accountability systems at facility and district level, also suggest a transformation that has already occurred and the positioning of democratic principles that have taken hold. However, perceived limited commitment at the higher national level, despite institutionalized committees and staff positions responsible for social accountability in health, stem from corrupt political influences and lack of financial self-reliance. Inputs from USAID, and other government and international development agencies are helping to build capacity, but progress is slow; however, community level capacity and demand for improved government accountability continues to grow, as demonstrated by a variety of SA methods being implemented by communities.

Rwanda

Rwanda scored a 71% out of 100% on the maturity level of its SA system, indicating a strong structure and sustainability, its functionality above average, and its effectiveness and transformational domains needing the improvements. Disaggregated, Rwanda, like Malawi was the strongest in **Structure** (**86%**) and **Functionality** (**67%**). Rwanda, **Effectiveness** (**50%**) with respondents describing their agreement with the program's effectiveness and their satisfaction with both the way the SA Program was implemented and with the RMNCH services they received. Rwanda scored reasonably well in **Sustainability** (**71%**) and less well on **Transformation** (**60%**). (See **Appendix 3** for full Rwanda Report).

The Assessment Score for **Structure** of the National Program for Social Accountability for Health is overall at **86%**. Similar to Malawi, Rwanda's national social accountability system stems from a policy of decentralization and the development of the community health system, including the community based health insurance (CBHI) scheme. These mechanisms include stakeholders or rights holders at national, sub-national and community (district and below) level, bringing them into sub-national and national planning through technical working groups (TWGs); and at national and District level through the JADF (Joint Action Development Forum).

The **Functionality** score of Rwanda's NSASH was 6 out of a possible 9, or **67%**. KII policy makers, sub-national management teams, and community level CSOs respondents reported that budgets are defined for SA activities to enable the process to function adequately. Sub-national budgets were not available for review by researchers. Evidence of sub-national budgets that dedicate resources to SA activities would have resulted in a higher score. Social contracts *(Imihigo)* ensure that M&E processes are utilized and encouraged through competition at every level. Access to redress process is also made available at all three levels through both an institutionalized process of National Dialogue *(Umushyikirano)* as well as a contextualized local process (through which individuals can complain or express their opinion at the community level). Respondents did report greater consistency of utilization of the SA system needed to be encouraged. While rights holders in some areas were active in their participation, other's feedback or input on service quality was scarce.

Rwanda's SA system scores low on the **Effectiveness** domain (**50%**). The low scores are attributable to the absence of performance reviews, or at least to the accessibility of these reviews. Although there are no reports to demonstrate consistent implementation of standardized M&E processes, there is increasing accessibility of health performance information at all levels. Updated information is published on national electronic platforms through MoH and the Institute of Statistics of Rwanda. Subnational and community level access to data has improved through Rwanda's m-health systems for community-level input through Community Health Workers (CHWs), expanded facility access to internet, and linkage to Integrated Health Management Information System (IHMIS). In addition, community members continue to have access to non-electronic feedback loops through community dialogues with district, subnational and national duty bearers, through which they may lodge grievances, have their voices heard, and receive updates on resulting actions or improvements. Respondents expressed their satisfaction with the performance of the SA system itself, and even cited examples of resulting changes in service quality. Even so, the respondent input was not included in the criteria so the score remained low. Using the improved scoring process, through which further respondent qualitative data will be incorporated into the scoring, will improve the accuracy of the scores and the insights into strengths and gaps of the NSASH.

Expanded sample will also increase accuracy and application nationwide.

Rwanda's **Sustainability** score is relatively low at only **71%** (given Rwanda's traditional accountability mechanisms which remain in place). This score was surprising in that social traditions in Rwanda have long been characterized by rights holder engagement and participation in public institutions.[13] Further, Rwandan system for SA in health are well-entrenched through policies and strategies. The Rwandan Constitution, Article 21 states that all Rwandans have the right to good health; and in Article 45, it elaborates that the state has a duty to mobilize the population for activities aimed at good health and to assist them in the realization of those activities.[14] In addition, avenues for funding of the SA system are clearly defined, including the establishment of the community based health insurance system, and results-based funding strategies that strengthen the accountability of the health system by rewarding performance.

Rwanda's sustainability score for its SA system is due the lack of documentation of how the SA system is being sustained at all levels. Budget line items that support SA activities were not apparent at sub-national and community levels, and respondents reported that convening of rights holders to participate in planning, receive updates and SA progress reports, or to submit and discuss complaints are still heavily dependent on donor funding and support. M&E reports were not available, despite the clear guidelines for M&E. Third, job descriptions, which need to include roles and responsibilities related to SA, are often not written or unavailable; thus, managers and providers lack clear mandates for guiding and sustaining SA processes.

Rwanda's score for the **Transformation** domain was slightly above average at **60%**. This score is somewhat misleading because it does not consider the historical transformation of Rwanda's health system post-genocide or the improvements in population health outcomes that coincide with strengthened SA processes.[15] The low score, however, results from the lack data linking service and health improvements to the SA system, making attribution not possible.

Rwanda and Malawi are similar in the development scores, and despite contextual differences, they face many of the same challenges to the sustainability of their SA systems. Both countries, (though particularly Malawi), must emphasize autonomy and self-reliance over the next decade to truly own and sustain a health system that is accountable and consistently responsive in the services they deliver. Resources must be not only budgeted, but also obligated at each level to enable consistent implementation of SA program activities. Both Rwanda and Malawi need to continually strengthen the capacity of duty bearers to implement SA activities and follow through with improvements that respond to grievances. Capacity building on roles and responsibilities related to accountability, reinforced by job descriptions and performance reviews that incentivize responsive care and engagement in SA activities would strengthen accountability of their health systems. Both countries need stronger and consistent documentation processes, particularly with reporting that monitors and evaluates SA activities, and that links systems, service, and health outcome improvements to rights holder involvement and engagement in SA.

DISCUSSION

A key aim of this research was to test the assessment instrument. The first-time application of this instrument demonstrated the strengths and limitations of the scoring component for each domain. A great deal of relevant and reflective information has been captured through the application of the tool. For example, data captured through the KIIs and FGDs provided color and context that reinforced the quantitative findings. Other times, however, the qualitative data provided nuanced exceptions, caveats or conditions that should have shifted the quantitative score higher or lower. This gap in the monitoring instrument limited the ability of the quantitative scoring to accurately prioritize areas for improvement or point to opportunities for strengthening the SA system or for strengthening the health system. However, this understanding will inform the next iteration of improvements in the assessment instrument so that it will remain useful and provide more specific insight.

This assessment instrument is intended to provide a high-level snapshot. Therefore, the tool was purposefully of limited length with the scoring component for each domain having only 2 to 7 questions. Researchers tested these questions during the development of the assessment instrument to ensure they utilized indicators and scoring criteria that would be most effective, while at the same time not becoming too cumbersome or lengthy. It will be useful to adapt the assessment instrument to incorporate a limited number of additional questions to reveal nuanced insights to capture common themes that were revealed in the interviews. For example, the tool did not capture disaggregated information on who participates in the SA system, the frequency of their participation, and whether the needs and concerns of more marginalized and vulnerable members of the communities are heard and addressed.

Qualitative scores are used to validate the quantitative score, and when there is a discrepancy or divergence, a measured assessment of the triangulated was used to modify the results to a higher or lower score – in balance with all the data that is available. To further improve the utilization of the assessment instrument, additional respondent perspectives will be incorporated into the scoring component of the instrument so that their experience on the performance of the NSASH and their own assessments of the gaps in the NSASH will contribute directly to the scoring result. This will be achieved by the following:

Respondent Input Integrated into Domain Scores

Adding several questions under each domain that provide a list of pre-determined responses from which the respondent selects. These selections will be linked to the scoring between 0, representing the lowest level of development maturity to 3, representing the highest level. These questions will incorporate additional insights of both duty bearers and rights holders who use or participate in the NSASH into the scoring.

In the ***Functionality*** domain, one question will be scored to understand how often both duty bearers and rights holders participate in SA activities. Respondents will be asked to rate with a score between 0 (never) to 3 (at least 4 times a year) in SA meetings.

In the ***Effectiveness*** domain, five questions areas will be added, with source data to be collected from FGDs with rights holders.

- At least one question will score the rights holders' perception of the effectiveness of the NSASH. The lowest score will be assigned when rights holders are not satisfied; the highest score will be assigned when responses are returned in a timely manner, progress toward closing priority gaps is shared, and consistency is observed by the rights holders.
- Two questions will be asked to rights holders and duty bearers regarding the level of competence (0 being none, and 3 being a high level of competence) they feel the 1) duty bearers and 2) CSOs have in steering and implementing SA activities.
- One question will be scored for accessibility, asking both duty bearers and rights holders to rate on a score from 0 (lowest) to three (highest) how easily they participate in SA activities.
- Duty bearers will be asked to rate how well-defined their responsibilities are around accountability to their clients/

beneficiaries/ or rights holders. A score of zero (0) will be attributed if they response is that their roles and/or responsibilities are unclear. A score of one (1) will that they understand their role or responsibilities but they are not specified in their job descriptions. A score of two (2) will be attributed if they are in their job descriptions. And a score of three (3) will be if they are in their job descriptions and included in performance reviews.

In the ***Sustainability*** domain, four questions will be scored to enhance the findings.

- Rights holders and duty bearers will be asked at least one question regarding dependence on donor funds. Scoring will also be assigned to whether the duty bearers have a plan in place to become self-reliant in resourcing the NSASH, with a probe requesting an explanation.
- Duty bearers will be asked to rate on a score between 0 (not at all) to 3 (well prepared and trained) on whether or not they are capable to implement SA activities.
- Rights holders will be asked to rate how well the NSASH send information and evidence back to them on whether action has been or will be taken in response to recommendations or to complaints. Zero (0) will mean no information; while a score of three (3) will mean that information and evidence are received consistently and timely.
- Rights holders will be asked if the NSHAA includes performance reviews of the duty bearers, with a low score (0) meaning that rights holders believe there are not performance reviews, and a high score (3) meaning that rights holders have opportunity to contribute to those reviews.

The ***Transformation*** domain will also include scoring from rights holder and duty bearer responses on the degree (0 to 3) to which they agree that the NSASH has contributed to health systems improvement with a second question asking the same regarding the NSASH contributing to broader cultural or social shifts. Probes will ask for an explanation and examples of related shifts in attitudes of duty bearers, consistency of quality of service, engagement of rights holders, and social or cultural norms. These probes will facilitate the respondents' understanding of the question and feed into the 'recommendations' areas when evaluating strength areas. Scores should highlight where weaknesses in the M&E system fail to link improvements to the NSASH.

Two specific questions on oversight protections that will be included in scoring for Transformation:

- Both rights holder and duty bearer respondents will be asked to rate now independent CSOs are from government influence in their ability to facilitate and/ or advocate SA processes? A score of zero (0) will mean that local CSOs are seen to be dependent upon government and thus not independent to carry out social accountability activities that reflect accurately or advocate on behalf of the needs, rights or complaints of rights holders. A score of one (1) will mean that despite dependence on government for licensing or funding, local CSOs are seen to be independent in their ability to report accurately or advocate on behalf of complaints or needs of rights holders. A score of two (2) will mean that there are regulatory or legal protections in place that are meant to protect independence of CSOs that work with SA system activities. A score of three (3) will mean that there are protections in place, they are seen as independent, and that they do represent rights holders' needs, rights, and complaints.
- Both rights holder and duty bearer respondents will be asked to rate on a score from 0 (not at all) to 3 (effectively) how well the media exposes bias or corruption in influencing outcomes of the NSASH.

Elimination of Redundancies

There are several questions in the scoring component of the assessment tool which are similar. While, appreciating nuanced differences, questions need to be more clearly differentiated so as to eliminate redundancies. For example, a question about the M&E processes are part of both Functionality, and the Sustainability domains. While the context of the questions change slightly, and these differences are important, it can be seen by the reader as redundant. Therefore, the improved assessment instrument will differentiate these questions, with the Functionality domain looking at 1) whether there are standard indicators at each level to track the performance of the NSASH; and 2) whether there are guidelines for how to carry out M&E functions at each level.

The ***Sustainability*** domain will continue to score M&E processes but clarify the questions to understand 1) if reports are consistently generated as evidence that the M&E activities at each are being carried out, and 2) if the M&E

documentation and monitoring are carried out through a digitalized or electronic process rather than a paper process. A digitalized M&E process will score higher, indicating an institutionalization of M&E practices, and a standardization how those practices are carried out, and integrated within larger system frameworks and infrastructure. There will also be an added question to the ***Sustainability*** domain as to whether aggregated provider performance reviews of providers are published.

In the ***Transformation*** domain, the first question, which is a combined question on self-reliance, will be split into two questions. The first question, "Is the SA program self-sustaining (demonstrating self-reliance through both national commitment and national capacity)? (This question addresses both technical and financial sustainability.)." The two questions that will replace this question are: 1) 'Is the NSASH financially self-sustaining? (demonstrating self-reliance through both national commitment and national capacity)'; and 2) 'Is there a strategy to mobilize resources to continue and/or expand the NSASH? (demonstrating self-reliance through political commitment)'

'Performance' Domain

To provide a complete snapshot of the NSASH, governments need first to know the level of satisfaction that rights holders report having in the services they receive. Therefore, a Performance domain will be added. Several questions will be asked of both rights holders and duty bearers to rate and score satisfaction in RMNCH, Adolescent health, HIV, or other service areas, depending on country health priorities. Probes will provide insight as to where or why service areas are poor or performing particularly high, and recommendations will be solicited about how to improve services and the effectiveness of the NSASH in helping to improve services. Respondents will also be asked to rate how much or little they believe that service quality improvements is seen to have been initiated or improved in relation to the SA processes. These insights, in a well-functioning NSASH will match the reports from the SA program's M&E processes; and where they diverge, those systems may be improved.

Marginalized Groups

Rights holder respondents should represent the population of the province or region from where they are selected, and should include disaggregated groups of pregnant women, youth and adolescent girls/boys, traditionally marginalized populations, as well as community adults that include village leaders.

They will also be asked specific questions as to how strongly they believe their voice is counted as compared to those of other groups. This addition will be important in promoting equity and inclusiveness in the health system.

Adding these elements to the scoring component will enable the aggregated score of the maturity level to be more accurate and will most effectively guide planning and resources toward improvement priorities.

Assessing NSASH in other regions

Good governance is a priority area of USAID and a cornerstone for global advancement of the SDGs. Accountable systems in health that engage rights holders and enable agency and voice in assessing health system performance is an enormous advancement in good governance. Additional country assessments will offer great learning potential. For example, Columbia has invested resources in establishing a national program which has struggled to maintain a consistent responsiveness. Further, the unique ethnic populations that may have different needs and expectations from an SA system will provide insight into how national programs can be institutionalized and remain accessible to all communities when the populations are widely diverse. Pakistan may also offer important insights into promising practices for scaling and institutionalizing SA programs as SA was introduced and advocated in Pakistan through global donor development support, which evolved and expanded. Since 2011, Pakistan has implemented policies and programs to expand a national SA program, with specific application in the health sector.[16] Both countries have established national social accountability systems and applying this assessment instrument with their governments would allow leadership and learning to support improved health among countries in these strategic regions.

CONCLUSION

Observations and learnings from applying this assessment instrument provided useful insights to consider in supporting national social accountability systems in health to expand and grow.

In both Malawi and Rwanda, decisive government action set the stage for a national program to be functional and sustainable. However, the national government's leadership from each of the two countries stemmed from quite different contexts. Malawi was incentivized by the Millennium Development Goals and the Sustainable Development Goals to invest political will and resources toward lowering the maternal mortality rate through more accessible services and more responsive accountable care. The government, with significant support from international donors, defined clear structures and processes to steer a comprehensive effort to facilitate responsive person-centered care. At the same time, the Malawi government was influenced from the bottom up, as community social accountability efforts had shown promise and created rights holders expectations. The expansion of community level SA initiatives, led by local donors, provided a pathway to focus service improvements on quality assurance and community voice. Further, the successful community level SA, allowed the Malawi government to embrace an existing structure and link it to the national and subnational systems.

Rwanda's context is very different. The post-war Reconciliation period in Rwanda created an environment where the government was motivated to establish responsive, person-centered services and institutionalize collaboration and inclusiveness as part of the restoration of trust in good governance and cohesiveness in the social fabric. Decentralization, as part of the Rwandan advancement of accountable governance, brought decision-making and monitoring closer to the point of care and where rights holders experienced greater ownership in the health system and the care they received. The social and cultural transformation that came prior to the SA program's initiation in Rwanda enabled a program, emanating from the central government level to successfully put the leadership and agency at the community level and build a national program driven by rights holders.

Rwanda scored a 71% out of 100% on the maturity level of its SA system, showing its structure and sustainability strong, its functionality above average, and its effectiveness and transformational domains needing the strongest improvements. Malawi scored a 69% overall, with strong scores in function and structure, a very poor score for effectiveness (33%), and a need for improvement in sustainability and transformation.

The experiences of Malawi, Rwanda and other countries that implement this tool, identify their gap areas, and move to improve, will inform other countries as they begin their journey to establish and operationalize national systems for social accountability in health. A common measurement will allow countries to compare their progress and to continually share learning on progress toward accountable governance, engaged citizenry, and more responsive health systems.

These two cases provide insights on the potential of community based advocacy for accountability as a means of influencing the provision of quality services through increased support from duty bearers responsible for the health system. It is not only possible but imperative that social accountability structures and processes are integrated into national governance systems. More importantly, mechanisms must be in place that ensure that community voices and the agency of rights holders do not get lost in bureaucracy or silenced by comely or opaque institutional mechanisms. While such SA systems may score high on domains such as 'structures in place for SA', and even the improved health outcomes that would suggest a strong SA program, they may not offer sufficient transparency, communication, evidence, and consistency in responding to the rights and demands of the rights holders.

These case studies also demonstrated that SA efforts, to be sustainable and meaningful throughout the system, must be accompanied by a willingness and a commitment to long-term reform. Accountable health systems should not only address immediate user grievances to fix a problem; rather, decision makers and duty bearers must monitor and evaluate grievances in service gaps to identify and address longer term systemic problems or cultural norms

that drive problems. Gaps may stem from poor commodities management where contraceptives consistently do not reach facilities; or poor provider training, incentives or from bias against the poor or persons with disabilities. Deep economic deficiencies may burden low-resourced areas with consistent lack of service access or quality. In Malawi, several district level managers implementing SA activities reported that that they felt challenged in the role of reprimanding providers when grievances were lodged against provider performance or service quality. They expressed that many of providers are short staffed, working long hours in low resourced environments, which obstruct both quality and access, or compromise provider incentive and commitment. The grievance process should be used to inform systems improvements, such as work environments and staffing.

Decisions need to not only address immediate performances, but also resolve root causes that may drive those gaps. Engagement of rights holders in these long-term strategies will be beneficial in advancing program objectives and national health goals.

The findings and conclusions of this research fill a gap in knowledge of the factors or domains necessary to sustain SA systems that have been institutionalized by governments. Closer reflection and assessment of national level social accountability mechanism can help governments face growing global scrutiny on the meaningful engagement of rights holders at every level and remain responsive and accountable—through both action and evidence—to the needs and rights of the people they serve.

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APPENDIX 1

ASSESSING THE NATIONAL SOCIAL ACCOUNTABILITY SYSTEM IN HEALTH

MALAWI

This report was produced for review by the United States Agency for International Development. It was prepared by the HEARD project and was authored by Allison Annette Foster (WI-HER), Thumbiko Wachizma Msiska (co-investigator for Malawi), Adriane Martin Hilber (USAID HEARD/CUNY), Adriane Martin Hilber (USAID HEARD/CUNY). Early contributions on the design and testing of the tool were received from Beth Outterson (Consultant), Kristen Mallory (Children International), Ligia Paina (JHU), and Eric Sarriott (GAVI).

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APPENDIX 1 CONTENTS

ACRONYMS

ADC	Name of traditional leaders' group
CAC	Community Action Cycle
CHAG	Community Health Advisory Group
CHAM	Community Health Assoc. of Malawi
CHT	Community Health Team
COVID-19	Coronavirus Disease- 2019
CSC	Community Scorecard
CSO	Civil Society Organization
CQMO	Chief Quality Management Officer
CVA	Citizen Voice and Action
DC	District Council
DHO	District Health Office
DHS	Demographic and Health Survey
EHP	Essential Health Package
E4A	Evidence for Action
FGDs	Focus Group Discussions
GDP	Gross Domestic Product
GoM	Government of the Republic of Malawi
HCAC (or HAC)	Health Center Advisory Committee
HDI	Human Development Index
HEC	Health and Environment Committee
HIV	Human Immunodeficiency Syndrome
HSA	Health Surveillance Assistant
HSSPII	Health Sector Strategic Policy
HSWG	Health Sector Working Group
ITN	Insecticide Treated Nets
J2SR	Journey to Self-Reliance
KIIs	Key Informant Interviews
MANASCO	Malawi Network of AIDS Service Organizations
MDGs	Millennium Development Goals
MDHS	Malawi Demographic & Health Survey
MHEN	Malawi Health Equity Network
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn, Child Health
MoH	Ministry of Health
MOLGRD	Ministry of Local Government and Rural Development
NGO	Non-governmental Organization
QA	Quality Assurance
QI	Quality Improvement
QIST	Quality Improvement Support Team
QM	Quality Management
QMD	Quality Management Directorate
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SA	Social Accountability
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
TFR	Total Fertility Rate
UNICEF	United Nations Children's Educational Fund
USAID	United States Agency for International Development
UHC	Universal Health Coverage
VDC	Village Development Committee
VHAG	Village Health Advisory Group
VHC	Village Health Committee
WHO	World Health Organization
WITs	Work Improvement Teams
ZHSOs	Zonal Health Support Offices

EXECUTIVE SUMMARY

Increasingly, communities, activists, and ordinary citizen rights holders are holding duty-bearers to account for their commitments to improve and or deliver reproductive, maternal, newborn, child and adolescent health (RMNCAH). Over the past two decades, rights holders have organized themselves to demand respect for their right to health care services, particularly maternity services using social accountability approaches. And increasingly, government duty bearers are heeding their call by putting place accountability mechanisms at community, facility and system levels. In some countries and contexts, these mechanisms have become established and even institutionalized within the health system.

In 2020, Martin Hilber et al. developed an 'Accountability Development and Measurement Framework' and tool for global health initiatives (https://pubmed.ncbi.nlm.nih.gov/32494815/) to help practitioners assess how local and national accountability mechanisms are developed, implemented and institutionalized over time. The framework provides a roadmap on how accountability can be integrated into programs and policies, including the stakeholders who should be involved, the data that needs to underpin the mechanism, and the review and feedback loop (Consequences for inaction), that create accountability in the system. The framework indicates how accountability mechanisms, once embedded and institutionalized can be transformative within the system creating answerability to rights holders for the quality of the services or policies implemented.

The final step and sustainability of the process lies in the institutionalization of the accountability mechanism. There is little documentary evidence of how social accountability becomes institutionalized, and the robustness of that institutionalization to deliver transformative change and greater accountability within health systems. To better understand the process of institutionalization in countries, an adaption of the tool was developed and piloted in 2 countries- Rwanda and Malawi.

In each country, social accountability mechanisms were institutionalized using a variety of different formats, platforms and tools to create a national system of social accountability (SA) in health. This study pilots the use of the adapted social accountability assessment instrument, to assess the development maturity of a country's SA system in health. It also attempts to evaluate the SA system's performance according to the experiences of those who use it. This paper describes the application of the tool to assess how at community level involvement in the health system links with government responsiveness to the delivery of social good for the population focusing on health service delivery. Use of the adapted tool can facilitate governments and partners to recognize strengths and gaps in national accountability mechanisms and make informed decisions on investments for improvement.

Methods

Researchers conducted a rapid desk review of available literature, including national and sub-national plans, strategies, demographic health data, job descriptions and other program documents; development project reports; and peer reviewed literature to collect quantitative and qualitative data to inform the scoring component of the assessment. The scoring component ranges from zero to three and measures the level of development maturity (with zero representing the lowest score, and three the highest) of a national social accountability mechanism—in this case the Malawi's national mechanism for SA in health. The scoring assessed five domains: structure, functionality, effectiveness, sustainability, and transformation. Key informant interviews (KIIs) and focus group discussions (FGDs) with both duty bearers (those in public positions responsible to provide quality health services), and rights holders (those who hold rights to access quality health services provided by the state) were conducted. KIIs and FGDs provide qualitative information on the relative functionality of the SA mechanisms informed the scoring by providing user experience with the SA mechanism, and perceptions of its performance. The assessment instrument will provide a benchmark for improvement of Malawi's national SA mechanism to strengthen the responsiveness of the health system and the quality of RMNCH and other primary care services. Further, it can provide a comparison

from which other countries may develop, assess and improve their national programs or systems for SA in health.

Findings

Malawi's total development maturity score was 50 out of a possible score of 72, or 69%.

This result suggests Malawi is on its way to good governance in the health system with service delivery that is accountable to its constituency. Although 69% cannot be considered particularly strong, we recognize that there were some questions in the instrument for which no data were available, thus lowering the overall score. We also acknowledge that the rating might be higher were the information available, a point noted for the revision of the scoring of the instrument.

Data collected through the desk review and field interviews reflected an overall positive experience of community members using the SA mechanisms. These varied at community level and across different facilities. They included Community Score Cards, and Citizen Voice and Action (CVA), as well as community agreements called Citizens Charters and *Bwalos*, which are citizen dialogue circles or forums held at both subnational and community levels to address primary health care and RMNCH issues.

Malawi, like Rwanda, does not have a specific 'Social Accountability (SA) Program or System' for health, but rather has developed complementary policies and strategies to: 1) engage rights holders, or service users, in decisions and improvement strategies to strengthen the health system; and 2) establish a formal process through which rights holders submit complaints or grievances, receive feedback, and resulting response or improvements based on their claims. Together, a system of policies, strategies, resources, and activities achieve Malawi's SA in health. Malawi's SA system is rooted in Malawi's Quality Management Policy (QMP), which aligns with, and supports the effectiveness of the National Community Health Strategy 2017-2022. The QMP defines and budgets a role for staff to monitor quality management at national, subnational and community (below district) levels. The strength of Malawi's social accountability successes has been the result of early community level SA projects, initiated originally by civil society organizations (CSOs), such as the Malawi Network of AIDS Service Organizations (MANASO), and externally funded international non-government organizations (NGOs) such as CARE Malawi, and UNICEF, which introduced the globally tested and recognized Community Score Cards and CVA. Multiple community level SA projects have empowered community members to participate in their public health system by raising awareness and providing tools and practices through which community members have learned to speak out for their right to accessible, quality health services. Community level SA mechanisms, including the Bwalo, or community forums, and the community score card, have been applied at sub-national, and even national level, in recent years through Malawi's Ministry of Health (MoH) as part of their efforts to establish a continuum of rights holder engagement, and communication between duty bearers and rights holders across all administrative levels. Within Malawi's national QMP policy and the National Community Health Strategy, international NGOs still play a large role in supporting the implementation of SA activities, both through technical assistance and financial support; so, while the MoH leads the national social accountability system in Malawi, there is still progress to be made toward enabling a sustainable country-led and country-funded SA system in health.

Despite high maternal and newborn mortality ratios, Malawi's population health indicators, and reproductive, maternal, newborn, child and adolescent health (RMNCAH) indicators specifically, have improved dramatically over the last two decades. Citizens have increased knowledge of and voice around their rights to quality services, and respondents report that they have seen provider performance improve. However, there are no national level processes or institutionalized measures that correlate improvements in health service indicators or health outcomes in Malawi directly to its national SA system. The Ministry of Health's plan for a digitalized platform of health information may enable data collection through ongoing donor- and CSO- led community level SA activities to be incorporated and cross-tabulated with national and sub-national data and provide an opportunity for attribution.

This assessment instrument will provide a snapshot of the current status of the SA system to highlight areas where Malawi can explore improvement strategies and direct resources to address gap or challenge areas in the SA system. It is expected that scores across the five domains will guide prioritization and inform next steps toward achieving a health system that remains consistently accountable to all rights holders and reflects their input in improvement strategies. This instrument allows governments to evaluate the critical components of an effective SA system, and will inform improvements in health systems and services so they are inclusive, accessible, responsive, and effective.

1. INTRODUCTION

Social accountability in health is a critical element toward achieving universal health coverage goals and to progressing toward Sustainable Development Goal (SDG) #3: "Ensure healthy lives and promote well-being for all at all ages." SA mechanisms are those which allow rights holders to hold duty bearers accountable for meeting their commitments and upholding their responsibilities as public servants to the populations. When a SA mechanism is institutionalized within the health system, it incorporates engagement mechanisms by which citizens or rights holders can: a) participate in the planning discussions of the health management; b) understand the obligations of the system c) report where and when the system is failing to meet those obligations; and c) receive a response through a communications process or feedback loop through which the duty bearers must recognize reported gaps and report back to the rights holders on their performance. In this way, SA engages citizens in the process of strengthening the system and improving service quality so that services are responsive to citizen needs. SA is intended to promote equity, accessibility, and quality of health services for all.[1, 2, 3, 4]

Experience from World Bank, the World Health Organization, and other development donors have led to the growing consensus that social accountability (SA), as "an approach toward accountability that relies on civic engagement" is a cornerstone for good governance and essential for responsive health service delivery.[5] Some countries, including Columbia, Malawi, Pakistan, and Rwanda, have established national programs or systems for social accountability. These national SA systems have developed either from the ground up, scaled from SA interventions introduced at community level as pilot projects, or have been initiated from the top down, wherein governments, motivated by global movements such as the Millennium Development Goals (MDGs) or Sustainable Development Goals (SDGs) and supported by global partners, build a national SA system within their health system as part of advancing good governance practices and better health systems. Malawi, facing critical maternal and child mortality, initiated reforms to improve health at community level. Concurrently, global partners were introducing social accountability pilots, training community members to use Community Score Cards and community discussion forums to monitor and report on the services received in their facilities.

As more and more countries embark on the establishment of national SA systems or scale up community programs that support citizens to claim their rights and entitlements at the national level, their experiences can inform other national and sub-national efforts to institutionalize and sustain SA processes as part of their health systems. Currently however, there has not been a framework nor common metrics to assess whether a SA system is accomplishing its intent. As countries advance in self-reliance in their health systems and continue to sustain progress and improvements in social development, it will be important that they have frameworks and tools for assessing their progress and guiding development efforts. Further, a common measurement will allow countries to compare their progress and continually share learning towards making heath systems more responsive to their citizens.

Measuring progress on institutionalizing social accountability: a framework and tool.

In 2020, Martin Hilber et al. developed an Accountability Development and Measurement Framework and Tool for global health[6] to help practitioners assess how local and national accountability systems are developed, implemented and institutionalized over time. The framework provides a roadmap on how accountability can be integrated into programs and policies, including the stakeholders who should be involved, the data that needs to underpin the system, and the review and feedback loop (consequences for inaction), that create accountability in the system. The framework indicates how accountability systems, once embedded and institutionalized can be transformative within the system, creating answerability to rights holders for the quality of the services or policies implemented.

In the development of the Framework, it became increasingly clear that there is little documentary evidence of how social accountability becomes institutionalized, and the robustness of that institutionalization to deliver transformative change and greater accountability within health systems.

To better understand the process of institutionalization in countries, an adaption of the framework was developed and piloted in two countries, Rwanda and Malawi. The adapted instrument used in this research aims to assess the status of the national accountability program or system, looking at the development maturity level and the perceived performance of SA in health. Like that framework, this assessment instrument focuses on **five domains: structure, functionality, effectiveness, sustainability, and transformation**.

The United States Agency for International Development (USAID) supported the testing of this adapted instrument in two countries, Rwanda and Malawi, with the intent of updating and strengthening the original framework and its application for better understanding of what it takes to create truly accountable health systems. In addition, results of this assessment offer a baseline for Rwanda and Malawi from which they can further strengthen, and measure progress of their SA system. Further, learnings gained from applying this instrument in Rwanda and Malawi will inform improvements in the assessment instrument that will then be made available to support governments in their effort to better monitor and improve their national SA programs or systems in health.

Assessing institutionalization of social accountability systems.

The assessment process begins with an initial rapid desk review, which provides a synthesis of available documentation describing the national health system, policies that advance social accountability in health and the implementation of the SA program or system across the five domains. A Likert scoring process, using zero to three, looked at the level of development maturity (zero being the lowest and three being the highest) that the country's social accountability system has attained across the five domains. The scoring system of the assessment instrument allows governments to measure progress and compare strengths and weaknesses of their systems with those of other countries. Additional qualitative data collected from key informant interviews (KIIs) and focus group discussions (FGDs) further informs the scores in each domain and sheds light on the system's strengths and weaknesses from the perspective of those that participate in the SA system and use RMNCAH services. Information gained from both the desk review and the interviews highlight contextual and environmental factors that may facilitate or hinder the SA system's expansion. Further description of the scoring is provided in the methodology section below.

1.1 Country Context

Malawi, a country of 18.6 million[7] residents located in southeastern Africa, where 85% of the population live in low-resourced rural areas.[8] With a small percentage of the wealthiest households are concentrated in urban centers, over half of Malawi's population lives in poverty.[9] Agriculture is the key employment sector for both men and women (59% and 44% respectively), followed by unskilled manual labor (20% and 25%, respectively),[10] yet 63% of women and 81% of men are unemployed (2015-16).[11]

Multiple development challenges perpetuate poverty and thwart the health and social development of Malawi's people. Malawi's population continues to grow and is expected to double by 2038,[12] where almost half the population is under 15 (48%), and the youth population is growing at a rate of 2.8%.[13] Internal social and governance risks also make Malawi vulnerable. Corruption remains high, with an international corruption ranking of 123/180 in 2019.[14] Despite health governance reforms, investment in health—even with a growing population—remains very low at 9.8%.[15] The education sector is also challenged with low levels of secondary school attendance or completion, and commensurate low literacy.[16] Malawi's Human Development Index (HDI) value for 2019, despite recent gains, remains low at 0.483, leaving Malawi well below the average of 0.547 for countries in Sub-Saharan Africa and at a global ranking of 174 out of 189. This makes Malawi one of the poorest countries in the world.[17]

1.2 Malawi's Health System

Over the last two decades, Malawi was one of a few sub-Saharan African countries that achieved the Millennium Development Goal (MDG) for child survival by 2015.

Malawi has achieved significant has achieved dramatic gains in maternal and child health as well between 2000 and 2019:

- *Infant mortality rate. IMR* decreased from 99.8 deaths per 1,000 live births (LB) in 2000 to 30.9 in 2019.[19]
- *Under-5 mortality ratio.* Under-five deaths decreased from 112 to 63 deaths per 1,000 LB, and neonatal mortality remained at 27 deaths per 1,000 LB.[20]

Service indicators have also improved:

- *Antenatal Care (ANC).* The percentage of women 15-49 who had 4 or more antenatal visits by a skilled provider went up from 46% to 51% from 2010 to 2015.

- *Births attended by skilled birth attendants.* Births assisted by a skilled provider were sustained at 95% between 2010 and 2015.
- *Institutional deliveries.* Facility births increased from 73% in 2010 to 91% in 2015.[21]
- *Sexual and Reproductive Health Services.* The contraceptive prevalence rate increased from 42 percent in 2010 to 59 percent in 2015.[22]

Despite these improvements, RMNCH remains a critical concern for Malawi, (See **Table 1**: RMNCH gaps facing Malawi). Malawi still faces challenges that make social development fragile and require stronger systems to enable further sustainable advances.

Malawi struggles to strengthen its health system and improve services in rural and remote areas. To meet the needs, Malawi will need 7,000 more community health workers (CHWs) than currently exist. Currently, the existing CHWs are unevenly distributed, inadequately trained, and poorly supervised. The extremely poor suffer the greatest, with stockouts of medicines in remote locations commonplace and service delivery unevenly and inequitably distributed.[35] 48% of households have no or poor sanitation. Children under age 18, 12% are orphans or have only one parent, and one in five is not living with neither biological parent.[36] COVID-19 added a greater burden, with unreliable documentation of cases and deaths, and inadequate response.[37] Direct RMNCH service effects have not been published, early studies show that

Table 1. RMNCH Gaps facing Malawi

Maternal Mortality Ratio	439 maternal deaths per 100,000 live births[23]
Total Fertility Rate (TFR)	4.4 children[24] (3.0 in urban areas; 4.7 in rural areas)
Unmet sexual and reproductive health need among married women	19% (2015-2016)[25] Unmet need of married women spans from a low of 16% among women age 45-49, to a high of 22% among women age 15-19.
Modern contraceptive use	59% of married women, aged 15-39 have used any method of contraceptives (63.1 in urban areas; 58.5 in rural areas); and 58% use modern methods (61.4 in urban areas and 57.5 in rural areas) 44% of sexually active unmarried women of the same age range have used any contraceptives, and 43% use modern contraceptive methods[26,27] The difference between urban and rural sexually unmarried women who use any contraceptive is slight, at 45.6% and 44% respectively.[28]
Adolescent Pregnancies	29% of adolescent women age 15-19 are mothers or pregnant with their first child. 22% have had a live birth.[29] In rural areas, 31% of women age 15-19 have begun childbearing, compared with 21% in urban areas.
Infant mortality ratio	42 deaths per 1,000 live births[30] (Infant mortality data is not disaggregated by urban/rural, though under-five mortality ratio is noted below)
Under-five mortality	63 deaths per 1,000 live births[31] (77 deaths per live 1,000 births in rural areas; 61 deaths per 1,000 live births in urban areas).
Malnutrition, stunting and wasting	37% of Children under-five are stunted 37% (25% in urban areas; 39% in rural areas); 3% are wasting; and 12% are underweight.[32]
Vaccination	76% of children 12-13 months have received all age-appropriate vaccinations (77% in urban areas; 70% in rural areas).[33]
HIV Prevalence	8.8% (higher among men at 10.8% versus women at 6.4%). Twice as high in urban areas than in rural areas (14.6% versus 7.4%).[34]

COVID-19 did interrupt primary care services due to increased staff shortages and decreases in HIV testing and notification and referrals for Tuberculosis.[38, 39]

Responsibilities at the **national level** of the health system include policy making, standards setting, quality assurance, strategic planning, resource mobilization, technical steering, national level monitoring and evaluation (M&E), and coordination of international partners and donors. With the overall steering role at national level, the health system's primary oversight and guidance functions are decentralized to **sub-national level**, through five Zonal Health Support Offices (ZHSOs). The ZHSOs help guide planning, service delivery, workforce and quality supervision, and overall monitoring of health services. Below the ZHSOs are district management teams in 29 district health offices overseeing services provided in, and outside of the district hospitals. The Ministry of Local Government and Rural Development (MOLGRD) is responsible for health care service delivery at **community level**. Budgeting flows from the central level to the zones and then to the districts; district level assemblies are responsible for planning, budgeting, procurement, and service delivery oversight at both district and community levels. At the community level, as outlined in the Malawi National Community Health Strategy 2017-2022,[40] community engagement and participation is linked with higher levels of the health system through traditional leadership, or traditional authority (TA), the Area Development Committees (ADCs) and the community health teams. Representatives from the Villages participate in these committees and primary health care providers are supported by community health worker cadres. (See **Figure 1**. The Decentralized Malawi Health System)

There are several cadres of CHWs including Health Surveillance Assistants (HSAs), Senior HSAs (SHSAs), Community Health Nurses (CHNs), Community Midwife Assistants (CMA), and Assistant Environmental Health Officers (AEHOs). HSAs and SHSAs alone make up over half of the MoH's 17,000+ health workers, working out of health posts, dispensaries, maternity clinics, health centers and some working out of community hospitals. Each HSA and SHSA are responsible for approximately 1,000 people, providing health promotion and preventive services through door-to-door visitations, support to community level facilities, and facilitation of integrated community case management (iCCM).[41, 42] Health centers offer primary RMNCH services, usually serving a 10,000-catchment area.[43]

The secondary level of care consists of MoH district referral hospitals which are equivalent to the community hospitals with some additional services, such as lab and x-ray, and provide both in-patient and out-patient services.

The tertiary level consists of central hospitals. They are intended to provide specialist services at the regional level, professional training, and research, and referral services to district hospitals. Despite their role in delivering tertiary and specialty care, over half of the services that the central hospitals provide are either primary or secondary services, as clients often go directly to hospitals, bypassing local health centers.[44]

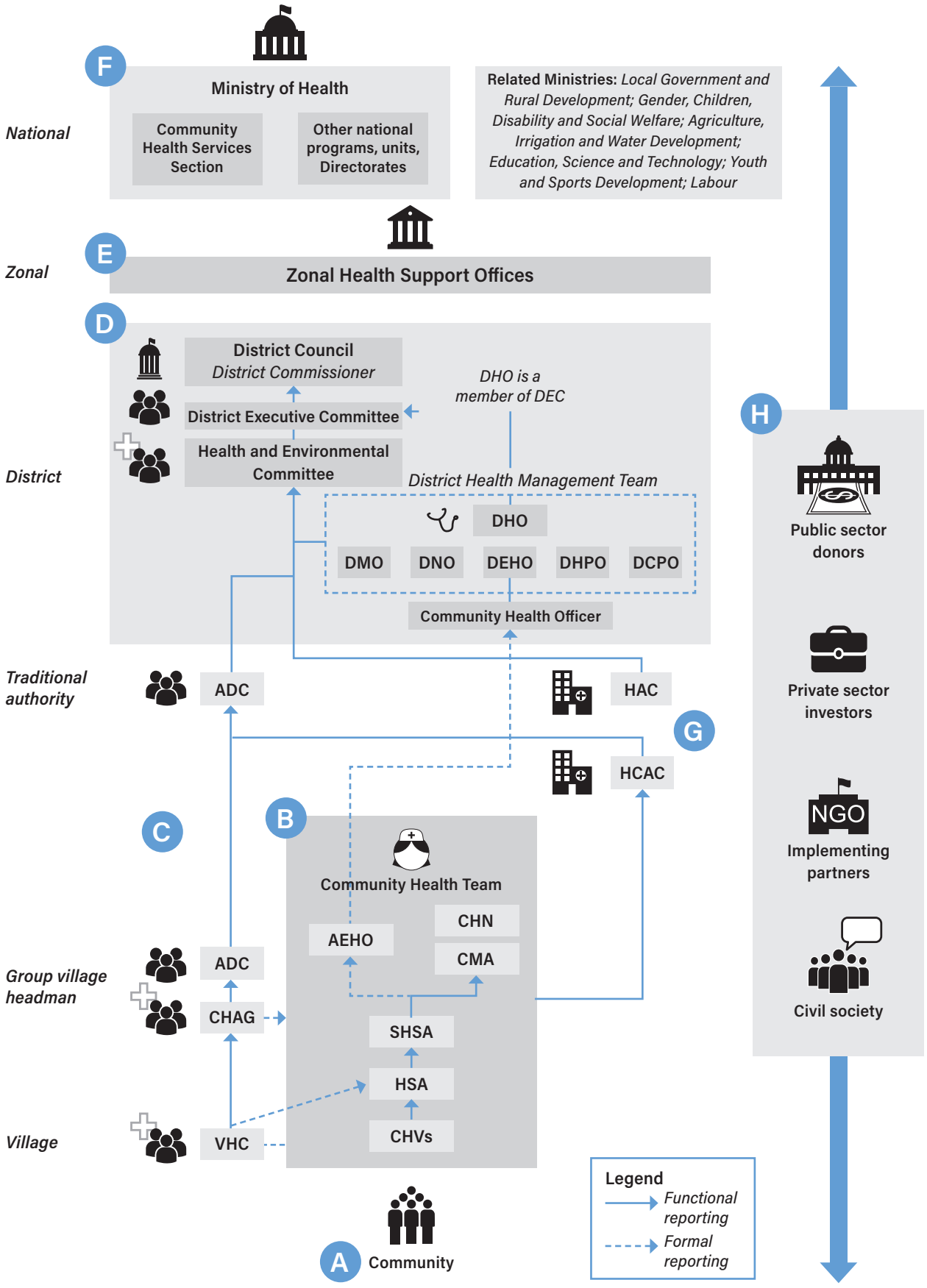
Health services in Malawi are supplied by public and private, not-for-profit providers. Health services in the public sector are free-of-charge at the point of use. 86% of Malawians use the national public health services, while 12% use services provided by the Christian Health Association of Malawi (CHAM). A small fraction of the population receives health services through private hospitals and clinics for a nominal fee.

1.3 Malawi's National SA System

Since 1998, Malawi has had a decentralized government structure, with administrative decision-making devolved to local governments through district and local (municipal or city) based on the National Decentralization Policy and the Local Government Act of 1998.[45] Local councils are comprised of elected officials, local chiefs, local CSO representatives, and special interest groups. Administrative responsibilities are carried out through Directorates, one of which is the Directorate of Health and Social Services.

In the early 2000's, as part of the GoM's broader government reforms and its commitment to attaining the Millennium Development Goals (MDGs), a National Quality Assurance Policy was put in place for the health sector in 2005.[46] Despite this effort, and related strategies toward quality assurance, rights holders, particularly at community level, were not adequately engaged, and policy still left gaps in achieving accountable quality services that are responsive to the health needs of the population.[47, 48] Responding to that gap, in 2017, the MoH created the **Quality Management Policy for the Health Sector**[49] with a **Directorate of Quality Management (QM)** within the MoH to ensure quality of care at all levels.[50] The Directorate of QM is responsible for strengthening sub-national and local governance and promoting community

Figure 1. The Decentralized Malawi Health System



engagement through accountability structures initially laid out through the **National Community Health Strategy (2017-2022)**.[51]

Under the Directorate of QM, an **Ombudsman function** was established as a paid government staff position at both national and sub-national levels to act as a liaison with health service users at service delivery points. Later a staff member was designated in every facility to act as an ombudsman. Aligning with and strengthening these activities, the National Community Health Strategy established a national level Community Health Section and local community bodies, such as the district and local council health staff and the members of the Area and Village Development Committees (ADC and VDC), to guide SA practices at community level. The community score cards, a preferred method of community oversight for facility service delivery performance, regularly scheduled meetings with the Ombudsmen, and representation in the local councils all promote constructive dialogue between citizens and providers and facilitate responsive, people-centered care.[52] These mechanisms also serve to inform, promote, and protect the rights of rights holders, such as the right to respectful maternity care as outlined in Malawi's Reproductive Health Service Delivery Guidelines of 2014[53] and guaranteed by the Respectful Maternity Care (RMC) Charter,[54] which was adopted by the GoM in 2019 and further adapted and elaborated in 2021.

As defined in **Malawi's Community Health Strategy (2017-2022)**, [SA] structures enable community members to play an active role in monitoring services through facility-focused bodies, which serve as a link between the health center and the community. These include:

- Village Health Committees (VHCs): The village health committee (VHC) is a group of 10 people, half of which are required to be female and four adolescents, that are chosen by people in the village to be responsible for the health of their community. Among other responsibilities, the VHCs are tasked to ensure that pregnant women have access to ANC visits; they are also tasked to meet monthly to review and report health-related challenges to the Village Development Committee (VDC) and the Community Health Action Group (CHAG) and liaising with Hospital Advisory Committees (HAC) through quarterly meetings. They also encourage village members to participate in health system activities.[53]
- Community Health Advisory Groups (CHAGs): The CHAG also supports its designated VHCs, to ensure the committees are operational and functional. For technical guidance, the CHAG also coordinates closely with the CHT and the HCAC. To ensure strong representation, each village is part of one CHAG, and one person per village serves as a member. They convene quarterly with VHCs and health centre advisory committee (made up of community members and health providers, and supervisors) for two-way sharing between community and health system and for review and discussion of service monitoring data.[56]
- Health Center Advisory Committees (HCACs): Each health center has a Health Center Advisory Committee which works to ensure communities receive the service they expect. Members include the community members and facility staff to collaborate in support and management of quality health services.[57]

At the same time, the **Quality Management (QM) Policy for the Health Sector**[58] was developed, incorporating the system's responsibility to be accountable at every level for the delivery of quality, responsive care. Operationalized by the **Health Sector Strategic Plan (2017-2022)**,[59] the purpose of the QM Policy for the Health Sector in Malawi is to provide a framework for Quality Assurance (QA) and Quality Improvement (QI) that establishes a role for rights holders as participants, collaborators, and influencers in that framework at national, sub-national, and community level. Further, this policy mandates that health system and service decisions engage the voice of rights holders.

At national level, the Directorate of Quality Management has been established within the Ministry of Health and is supported by the national level Health Sector Technical Working Groups (HSWG) along with various subject related committees, to provide overall oversight to the implementation of the QM Policy and to coordinate with the sub-national and community level bodies the sub-national technical working groups (QM TMGs). The QM TMGs are structures through which both duty bearers and rights holders come together to monitor and address gaps in access and quality of services and impact of initiatives meant to improve services.[60]

QM Policy quality management units have been established at the national hospital level and staffed with QM officers who work with teams across the hospital. These are not

community led efforts but do provide a structure through which information is captured through teams in each department and tasked with oversight. They identify gaps in person-centered quality care, and in response to inputs and grievances provided through the working groups.

At the sub-national level, non-government hospitals, run by the Christian Health Association of Malawi (CHAM hospitals), exist at central, sub-national, and community level. All are required to have a designated hospital QM Coordinator and QM structures that are staffed with hospital staff and support teams made up of representatives from all departments of the hospital. Further, five Chief Quality Management Officers (CQMOs) are positioned in five sub-national level QM offices across the country and are responsible to drive feedback loops, guiding information from the sub-national and community levels to the working sub-national and central level groups to inform them of decisions and/or actions that need to be taken, and to manage communications from the national level to the lower administrative levels with regard to responsive quality improvement actions in response.

At the community level, through the health facility, the QM Policy establishes a QM Focal Person to coordinate collaboration between the health center and community groups and to monitor and document progress in resolving complaints and addressing gaps in quality services. Health Center Advisory Committees (HCACs), which are comprised of community members, service providers, and members of the Community Health Team (CHT), act as a crucial link between the community to the facility and are tasked with informing community members of their rights and raising awareness about quality and access; receiving disputes and resolving them; reporting progress on disputes that are taken to a higher level in the SA process, and mobilizing resources as relevant. The Community Health Team (CHT), comprised of several cadres of CHWs, links the community health system with other key community health structures to engage community members more closely with services and to mobilize them in service positions.[61]

With the National Decentralization Policy as a foundational cornerstone, the health system has brought decision-making, management responsibilities, financial resources, and monitoring closer to the point of care and rights holders. With that devolvement, the GoM established complementary policies and strategies, including the National Quality Management Policy and QM Strategy for the Health Sector, the National Community Health Strategy, and the National Health Strategic Plan to form a Social Accountability system. Operationalizing these complementary policies, the strategies have institutionalized bodies at national, sub-national, and community level with SA responsibilities to promote and facilitate community engagement, collaboration, communication and oversight.[62]

2. METHODOLOGY

2.1 Assessment Design

Malawi was selected as one of the two countries to participate in the research according to three criteria:

1. The country has a national policy to establish a social accountability system in health;
2. The national social accountability system has been active for at least 18 months; and
3. Published reports exist and are available on the social accountability system.

As mentioned previously, the tool has been adapted from a broader accountability assessment tool and framework (See Introduction). It specifically reviews the strength and sustainability of the national social accountability system across five domains: **structure, functionality, sustainability, effectiveness and transformation**. For each domain, a series of questions are explored and assessed based on a criterion for each (See Assessment Instrument in Appendix A). Based on the scores, an aggregated quantitative score indicates the development maturity of the SA system at national level. Disaggregated scoring of each domain provides insight into opportunities for exploration and improvement.

An initial rapid desk review provided a synthesis of available documentation describing the policies, strategies, structural framework, staffing and resourcing and implementation, including monitoring, reporting, and feedback loops. This review provided data for scoring in each domain. Additional qualitative data, collected through focus group discussions (FGDs) and key informant interviews (KIIs), filled in gaps in information from the desk review and added deeper understanding of the in the quantitative scoring, where data was unavailable through the rapid desk review. More importantly, qualitative data shed light on the system's strengths and gaps from the perspective of the providers (duty bearers) and the users (rights holders) of primary care and RMNCH services. The qualitative component also captures information on environmental factors that may facilitate or hinder the system's expansion.

2.2 Methodological Process

The concept for this assessment was submitted to USAID and received final approval in September of 2020. The assessment design and implementation were conducted from October 2020 through May 2021.

Preparation and inception was carried out between October to November 2020.

A study protocol was submitted to the Malawi Social Sciences and Humanitarian Committee for ethical approval in November 2020, and approval was received in February 2021.

Data collection was carried out between February and April 2021.

The rapid desk review was completed in February 2021, using (1) available published peer-review journal articles of the last 10 years from international and local researchers, (2) open-source publication of World Bank and global agency data, and government policies, strategic plans, laws, budgets where available, and other relevant government documents or reports, and (3) reports and studies from civil society organizations and other international organizations.

Field assessment interviews began in March 2021 and continued through May 2021, after formal ethical approval for the study was received. Guidance was provided from USAID/Malawi on key stakeholders to interview and interview questions to be included. Field data collection was carried out at the central level, and at subnational and community levels in the two districts of Lilongwe and Ntcheu with representatives from local CSOs, international development agencies and implementing partners, government representatives, and community members.

Field interview guides were used as prompters in a flexible fashion to allow the qualitative questions to be contextualized with local language and custom, while remaining structured and controlled to allow for interviewees to raise additional or complementary issues. KIIs were held with key stakeholders in Ministry of Health (MoH) and the international NGO and donor community. FGDs were held with local CSOs, and

Table 2. Sampling: List of Focus Group Discussion and Key Informant Interviews

Type of Stakeholder	Target Group	KII	FGD	Total Respondents	Level and Reason for Sampling
Public Institutions: National Level Government	Ministry of Local Government	1		1	Purposive sampling among those working on setting up priorities for local authorities
	Ministry of Health representatives — Community Health Department	1		1	Selected from the departments of Community Health and planning
	Quality Management Department (QMD)	1		1	Purposive sampling from people working on Quality Assurance
Public Institutions: Sub-National Level Government	District Health Management Team – Director of Health and Social Services – District Environmental Health Officer	2		2	Purposive sampling from those responsible for overseeing the quality of health care services in the above-mentioned 4 targeted sample districts.
Facility Providers	Facility Health Management Team	1		1	Purposive sampling only 1 representative delegated representative of the health facility in the target district
Development Partners	USAID Malawi	1		1	Purposive sampling for those working in health systems strengthening
	FCDO	1		1	Funding Social Accountability in health
	World Bank	1		1	Health financing
Civil Society Stakeholders	Management Sciences for Health — ONSE	1		1	Implementing Social Accountability interventions in Health
	Malawi Health Equity Network	1		1	Civil Society Network representative of civil society voice in the health sector
	Family Planning 2020 Focal Person	1		1	Coordinating Civil Society engagement with donor and government in Family Planning work
	PACHI	1		1	Local Civil Society promoting local health systems strengthening in Malawi
	District Civil Society Network		1	5	Group of CSOs at District level promoting coordination and accountability
	District Youth Network (male and female)		1	5	Youth-Led Network of Youth Organizations and Clubs Championing interest of Youths in the district
Rights Holders: Youth/girls association	Nsipe Youth Group (mixed male and female)		1	5	Implementing Community Score Card in Ntcheu District
	Nsiyaludzu Community Health Action Group (female)		1	5	Community structure working on various programs — recently facilitated dialogues sessions in Maternal and Neonatal health
Rights Holders: Community Leader	Paramount Chief Gomani	1		1	Lead Chief actively involved in youth and community engagement in Sexual and Reproductive Health
Rights Holders: Community Members	Women's Group		2	5	Community members who utilize various health services and also involved in community health activities
	Youth Group		2	5	Community members who utilize various health services and also involved in community health activities
	Men's Group		2	5	Community members who utilize various health services and also involved in community health activities
TOTAL		**14**	**10**	**49**	

community and government participants in SA systems. KIIs and FGDs were audio-recorded and transcribed.

Before conducting KIIs and FGDs, information letters were provided, and oral or written consent forms were obtained from all the participants. Consent form contents were explained verbally, including the purpose of the study, its funding, and the use of the data. All study participants were informed that their participation was voluntary, that no remuneration would be provided, and that all responses were confidential, and anonymous. FGD participants were directed to respect the confidentiality of other group participants and to refrain from sharing participant names or responses outside of the group. Data collectors explained that KII and FGD participants had the freedom to decline participation, decline to respond to any specific question, or withdraw from the interview at any point during the KII or FGD. They were also invited to interrupt at any time to ask questions or request clarification.

Data Analysis was conducted in May 2021. The scoring component of the assessment was informed primarily from the findings of the desk review and confirmed or completed through the responses provided in the FGDs and KIIs. A score was then assessed for each of the five domains, and a total score was calculated to provide guidance on how to further progress in advancing SA initiatives.

For the qualitative component of the assessment, KIIs and FGDs were conducted to capture information from a variety of stakeholders, including rights-holders and duty bearers to provide evidence on the performance of the SA system in health, based on the experience of its beneficiaries. Thus, questions for the qualitative component enabled triangulation of data for the quantitative component, while providing insight into effectiveness of the SA system from the perspective of its key users. Prospectively, rights holders described their perceptions and experiences of the national, sub-national, or community levels of the national social accountability system, and provided insights, through describing their own experiences, into whether the SA system is or is not functional, effective, sustainable and transformative.

Based on the submission and review of the Malawi and Rwanda reports in November 2021, a manuscript will be prepared for peer-reviewed publication.

2.3 Sampling

The sampling was purposive, identifying duty bearers with knowledge of Malawi's health system and the existing platforms of SA and community beneficiaries of the health system. Specific recommendations were provided from USAID, government stakeholders, and from CSOs working with community women, men, and youth who use primary health and RMNCH services. A total of 14 KIIs and 10 FGDs were conducted, totaling 24 interviews and 49 respondents. See **Table 2** for sampling detail.

2.4 Gender Representation

Data collectors disaggregated data to lend any additional insight into opinions that might be common or different among males and females. (See **Table 3**) Commonality of responses, however, suggest that differences were probably slight. Particular efforts were made to convene rural community members and to achieve representation of women and youth (both male and female), who are historically marginalized groups. Had a broader sample of respondents participated in the assessment, including persons with disabilities or other historically marginalized groups, variance could, possibly have been observed, particularly with regard to RMNCH issues. A greater number of women who are users of RMNCH services would have provided insights as to whether and how much the SA systems were accessible, responsive, and effective in relation to their needs. These points are acknowledged and noted for the further improvement of the tool and the process.

Table 3. Gender Distribution of Respondents

	Male	Female	Total
Community Level	16	19	35
District Level	3	1	4
National Level	5	5	10
Total	**24**	**25**	**49**

2.5 Data Analysis and Scoring

Data Analysis and scoring was conducted in May 2021. Each domain consists of questions, and a score criteria for assessing the factor. Scoring of the assessment was informed primarily from the findings of the desk review and confirmed through the responses provided in the FGDs and KIIs.

Table 4: Assessment Tool domains and definitional criteria for scoring

Domain	Questions	Definition
Structure	1. Has the country established a policy to institutionalize social accountability at the national level? 2. Are there policies and legal constructs in place to establish the institutionalized social accountability program or system? 3. Do the subnational and community levels of government include a social accountability process in their strategic plans? 4. Are there social accountability bodies or structures (committees or social action groups) at each administrative level identified in question #3 to ensure participation of rights holders and continuing communication and inclusion between duty bearers and rights holders? 5. Are there processes for interaction between the social accountability bodies or structures (committees or social action groups) at each of the relevant administrative levels listed above? (Note: By interaction, it is meant two-way sharing of information or feedback loops) 6. Does an accountability platform for registering grievances exist? 7. Is there a national policy that protects rights holders, stating that anyone who submits a grievance will not suffer retribution?	'Structures' refers to national policies that codify a social accountability intention so it can be institutionalized and programs that define how that policy will be applied. For this assessment only countries that had some sort of SA program or policies in place for at least two years were eligible. Also included in 'Structures' are strategic plans (or strategies) with processes that translate intent into an implementing framework whereby policies may be operationalized. Fourth, an essential structure for an accountability program or SA system are feedback loops
Functionality	1. Does an M&E process exist (i.e., a process for data collection of and reporting on a set of standard national indicators)? 2. Is the national social accountability program or system budgeted? 3. Is the redress system accessible to all rights holders?	The Functionality of the national SA program or system in health refers to what extent the existing social accountability platforms are functioning to ensure active participation of citizen and other key stakeholders to improve health systems in Malawi. To ensure the functionality of the government social accountability structures, the functionality score assesses if: 1) there are monitoring and evaluation processes in place; 2) budgets exist to support the SA systems in the country; and 3) the system is accessible to all rights holders.
Effectiveness	1. Does performance criteria for staff include the fulfillment of SA responsibilities that respond to rights holder needs? 2. Are M&E findings on the performance of the SA system (i.e., the duty-bearers' responsiveness to rights-holder complaints) shared back with the community (i.e.: on public platforms such as the MoH website; or through other public communication mechanisms)?	By the term "Effectiveness" we refer to the extent to which SA system is positioned to achieve SA objectives. For example, the level to which duty bearers respond to rights holders' needs and complaints should be reflected in their performance reviews. Rights holders must be held accountable and have incentive to be responsive and steer the accountability of the system. In addition, the SA system's performance should be monitored with reports on the average response time to grievances, number of grievances that were solved, and changes or improvements that were made as a response to grievances or service delivery improvements that were accomplished.

continued

Table 4: Assessment Tool domains and definitional criteria for scoring continued

Domain	Questions	Definition
Sustainability	1. Are the M&E processes for the SA program/system institutionalized (or mainstreamed /normalized within the institutions)? 2. Is there a mechanism for the rights holders to approve of and/or participate in the development of the social accountability strategic plan objectives? 3. Does the budget fund at least one person to be responsible for managing the SA process? 4. Do budget line items support the SA system activities and materials in three health administrative levels (national level, sub-national level, and community level)? 5. Is the responsibility for M&E of the SA system assigned to an MoH staff member and included in his/her job description? 6. Are annual trainings held for participating staff (MoH) and stakeholders (MoH, NGO, and/or CSO) on the principles and practices of the SA system? 7. Do job descriptions of all duty bearer staff at all levels include a statement or description of their responsibility to rights holders?	The Sustainability domain explores factors that position the SA program/ system in health to continue autonomously through its being institutionalized by laws and regulations and supported by funding. This measurement requires that the structure not only exist, but that some type of legal or regulatory framework must be in place to enforce common standards. This 'Sustainability" domain also goes a step further than the 'Functionality" domain with regard to financial autonomy. For example, it requires that there be not only budgets for programmatic support, but that there be budget line items to support staff assigned to drive the national SA structures. Monitoring and evaluation must be not only functional, through a structure for and process of data collection and evaluation, but also sustainable with a data management system that is integrated across all levels, with capacity for consistent dissemination of information and transparency of results.
Transformation	1. Is the SA program / system self-sustaining (demonstrating self-reliance through both national commitment and national capacity)? (This question addresses both technical and financial sustainability.) 2. Have Provider performance indicators improved? 3. Have health service indicators improved? 4. Have rights holders' satisfaction with the health system improved? 5. Have population level RMNCH health outcomes improved?	The Transformation domain discusses potential markers of lasting change in Malawi's health system and health outcomes as a result of SA programs and policies. It goes beyond sustainability, which stems from institutionalizing practices and providing resources to sustain them and extends to incorporate shifts in attitudes of rights holders and duty bearers and the self-reliance of SA within health governance systems. The transformation domain also looks at whether the system is self-reliant, to which questions were asked about capacity and will. The transformation domain also looks at the results of the national accountability system, asking if services and health outcomes have improved.

Interviews were audio-recorded, transcribed, and translated when carried out in local languages and dialects. Each transcription was given an ID number that was used for analytical purposes. Field notes taken during interviews facilitated the analysis. The National co-investigator and a data collection assistant coded the data to recognize the patterns and links between the concepts highlighted by the participants. After the development of the preliminary set of codes, the team reached consensus on the identification of codes and the subsequent definition of each code as related to the five domains. These codes provided the basis for qualitative analysis.

Specifically, qualitative data from the KIIs and FGDs provided context for the scoring, providing a snapshot of the SA system's functionality, effectiveness, sustainability and transformative properties. Questions were also asked to determine rights holders' experience regarding the quality of primary health care services they received and service responsiveness to their needs and concerns, focusing on RMNCH services. A development maturity score was then produced for each of the five domains, and a total score informed scoring of the development maturity level of the SA system.

Scores were assessed for each of the five domains, ranking conformity to the question. Overall, a score of zero denotes that structures do not exist, that there is no evidence available, or that the answer is unknown. A score of one is used when minimal data or evidence that the structure/processes exist (e.g., a program or system exists on paper but there is no evidence of it as operational). A two score signifies that structures or processes partially conform (e.g., a program or system is in place but is not fully functional). A score of three reflects that the structure or processes fully conform to the purpose at all levels (e.g., program or system is in place and is functional as a social accountability mechanism at national, sub-national, and community levels). With each increasing score, there is evidence, through the desk review or through interviews, that these structures exist at each level of the three health system administrative levels defined for this analysis: national (or central), sub-national (province), and community (district and below). Determination of the score is drawn from documentation and key stakeholder opinion when there is no documentation. Additional input from stakeholders added insights and guided further exploration for understanding barriers, but rarely were reflected in the scoring unless it clearly addresses the criteria. Bias has been mitigated through triangulation of the responses received when possible.

2.6 Limitations

COVID-19

The COVID-19 pandemic created delays and other obstacles during the assessment. Malawi's experienced two waves of infections and related 'lockdown' restrictions during the data collection period. COVID-19 contributed to delays in IRB approval, access to government offices and documents, access to interview respondents, and alteration and delays of the interview implementation plan. 80% of the interviews were conducted virtually. Most interviews that were planned to be conducted face-to-face were carried out over the phone, which required the country co-investigator to search and pursue home phone or cell numbers of respondents. It also required multiple attempts to reach respondents and posed challenges to achieve adequate band width or telephone connection for communication to complete the interviews. Virtual interviews also were often subject to interruptions and divided attention of the respondents, who were often answering from home, which prolonged the interviews and delayed completion of the data collection. Virtual data collection also limited the interviewer's ability to probe deeper on some questions or read body language for further inquiry.

Although some of the FGDs were carried out face-to-face, COVID-19 restrictions required the country co-investigator and his team to rely on CSO partners in the field to convene small groups of beneficiaries because they were unable to travel.

Resources

Limited available funding confined the number of people interviewed and the representation of the sampling. Malawi's health system is diverse and decentralized, and the SA system implementation is not standardized at the community level. Therefore, it is important to note that the perceptions represented do succeed in providing valuable information related to testing of the assessment instrument, as well as insight into the maturity of the development and performance of the national SA program or system in health but must consider that this represents only a small snapshot of what is happening in country.

3. FINDINGS

The findings have been drawn from synthesized data from the desk review, KIIs, and FGDs. The social accountability assessment tool includes five domains assessing the institutionalization of social accountability in the health systems of Malawi including the structure, the functionality, the sustainability, effectiveness and the transformative of the social accountability structure. Qualitative analysis of FGD and KII responses also provided insight into the enabling environment, barriers and connecting factors characterizing Malawi's national social accountability system; and into rights holders' experience regarding the quality of RMNCH and primary care services received.

A mixed method of analysis was used to provide quantitative scores in each of five domains, giving insight to the level of development maturity of the SA system. Scores were calculated on a scale of 0 to 3, with three representing the highest level of maturity, through which the system had expanded to all three levels (national, sub-national, and community) and offered mechanisms to achieve the greatest relative ease of accessorily and participation in the SA process. Scores were gained primarily through the desk review, and justifications were provided. Additional qualitative data from the desk review and interviews with duty bearers and rights holders enriched the quantitative score with respondent perceptions and experiences.

3.1 Structure

The development maturity score for the Structure domain of the National System for Social Accountability for Health is 20/21 (95%)

The purpose of the Structure domain is to identify if structures have been established on which a national SA system or system may function. 'Structures' refers to national policies that codify a social accountability intention so it can be institutionalized and programs that define how that policy will be applied. For this assessment, only countries that had some sort of SA policy or policies in place for at least two years were eligible. Also included in 'Structures' are strategic plans (or strategies) with processes that translate intent into an implementing framework whereby policies may be operationalized. Fourth, an essential structure for an accountability system are feedback loops, so the 'Structure' domain asks if vehicles (platforms, practices, or processes) for communication between rights holders and duty bearers. Fifth, Structures must be bodies, such as a division or agency within the government and civils society groups that are linked across the three levels of government (national or central; sub-national, which in Malawi include provinces and districts; and community, which are structures below the district level, such as sectors, cells, and villages. For a national accountability system to be put in place, bodies that implement the system must be established at each of the three levels and must have a process and platform for collaborating and coordinating. Finally, the 'Structure' looks at whether a platform has been established through which community members can register grievances.

There were seven questions in the quantitative instrument that addressed structure.

1. **Has the country established a policy to institutionalize a social accountability program or system within the health system at the national level?**

Score: 3/3

Score	Criteria
3	Yes, a policy has been in existence for at least five years with information accessible through a public platform, such as an MoH website.
2	Yes, a policy has been in existence for five or more years with no publicly accessible information (website; published and disseminated reports, etc.).
1	Yes, a policy intended to institutionalize a social accountability process at national level has been in existence between 2 to five years.
0	Yes, a policy intended to institutionalize a social accountability process at national level has been in existence for less than two years.
0	N/I = No information
0	N/A = Not applicable

Justification: Yes, the GoM has established several policies that institutionalize a national social accountability system in health. Building on the foundational National Decentralization Policy of 1998, the Ministry of Health has brought decision-making, management responsibilities, financial resources, and monitoring closer to the point of care and to the duty bearers. With that devolvement, the GoM has established complementary policies and strategies, including the National Quality Management Policy for the Health Sector that institutionalizes a Social Accountability system. These policies were initiated in 2017, building on the earlier quality assurance policies established in 2005. Information on the policies is accessible to the public.

2. **Are there policies and legal constructs in place to operationalize the institutionalized social accountability program or system?**

Score: 3/3

Choices for the Respondent:

a. A written national social accountability policy exists.
b. The national health strategy includes steps for operationalizing the social accountability policy.
c. Written guidelines or legal constructs to support implementation exist.
d. Guidelines specifically direct the implementation of the redress mechanism.

Score	Criteria
3	3 = Yes to all four (a, b, c, d)
2	2 = Yes to a, b, and c
1	1 = Yes to a and b
0	0 = Yes to a
0	N/I = No information
0	N/A = Not applicable

Justification: The written national policy (QM Policy) is aligned with the National Quality Management Strategy and with the National Community Health Strategy. There are specific written guidelines at every level and avenues for each administrative level (community, subnational, and national) to feed information and data into the next level and provide communication to rights holders through a feed-back loop.

3. **Do the subnational and community levels of government include a social accountability process in their strategic plans?**

Score: 3/3

Score	Criteria
3	Some Districts (or woreda, parish, or similar) and/or community strategic plans incorporate social accountability processes.
2	The social accountability system processes are part of the national and sub-national plans (provincial, regional, county, or other sub-national administrative level).
1	The social accountability system processes are part of the national strategy but not included in the sub-national plan (provincial, regional, county or similar) strategies.
0	The social accountability system is not yet incorporated at national level.
0	N/I = No information
0	N/A = Not applicable

Justification: Community level strategic plans incorporate SA processes, especially those that address effectiveness. Two examples of such processes are the Community Scorecard and the National Health Budget Consultation, Analysis and Advocacy, which include community members in assessing performance of duty bearers.

4. **Are there social accountability bodies or structures (committees or social action groups) at each administrative level identified in question #3 to ensure participation of rights holders and continuing communication and inclusion between duty bearers and rights holders?**

Score: 3/3

Three administrative levels considered are:

- national
- sub-national (provincial, state, municipal)
- community (all levels from district/parish or below)

Score	Criteria
3	There are communication and interaction structures at three or more different levels that ensure continuing communication feedback loops between duty bearers and rights holders.
2	There are communication and interaction structures that ensure continuing communication feedback loops between duty bearers and rights holders at two different levels. (national and sub-national, sub-national and community, or community and national).
1	There are communication and interaction structures at only one level (national or sub-national or community) that ensures communication feedback loops between rights holders and duty-bearers.
0	There are no interaction or communication bodies /structures at any administrative level that would allow for feedback loops between duty bearers and rights holders.
0	N/I = No information
0	N/A = Not applicable

Justification: At each level there are structures (CQMOs) positioned in QM offices around the country who are responsible for managing communication through feedback loops from the subnational and community SA structures to the national level and then back from the national level through the sub-national structures to the community levels.[65] As per the QM Policy, every health facility has a designated Ombudsman, who is housed at district level and is tasked to carry out monthly visits to assigned health facilities to solicit feedback from patients and to bring responses back from earlier complaints. Ombudsmen report community feedback to QM teams that is synthesized and shared with relevant authorities at each level for decisions on system changes or service improvements. As per a 2013 study, carried out by the Norwegian Agency for Development Cooperation, most districts across Malawi had posted an Ombudsman,[66] and as of August 2021, the GoM has announced that it will assign one staff in each facility to act as an ombudsman in that facility.

5. **Are there processes for interaction between the social accountability bodies or structures (committees or social action groups) at each of the relevant administrative levels listed above? (Note: By interaction, it is meant two-way sharing of information or feedback loops.)**

Justification: Malawi's SA system includes processes for interaction (two-way sharing of information; feedback loops) across all three administrative levels (national, sub-national, and community). This is an intentional process that is described in detail in section 1.3 above.

6. **Does an accountability platform for registering grievances exist?**

Score: 3/3

Score	Criteria
3	There is a platform for grievances that includes a process for tracking responses, and a time limit mechanism through which a response must be received within a certain amount of time and there is consequence to non-compliance of duty bearers.
2	There exists a platform for grievances that includes a process for tracking responses, and a time limit mechanism through which a response must be received within a certain amount of time.
1	There exists a platform for grievances that includes a process for tracking responses.
0	There is no platform for registering grievances and tracking responses.
0	N/I = No information
0	N/A = Not applicable

Justification: The process is institutionalized through links between community level governance and the national public health system. At the community level the processes are not uniform, but active—different communities use different approaches, primarily 1) Community Score Card, 2) Citizens Voice in Action; 4) the Citizen Charter; and 4) *Bwalo*. The national health system has incorporated or linked these approaches through SA structures, institutionalized across the national system through the QM Policy and Strategy. Moreover, the sub-national level is expected to respond to complaints that are communicated through these community

SA systems and immediately address the grievance or refer it to the next administrative level.[68] Although this process is not seamless and functional in every community and every district in Malawi, it has successfully been initiated and expanded, and it continues to scale.[69]

7. **Is there a national policy that protects rights holders, stating that anyone who submits a grievance will not suffer retribution?**

Score: 2/3

Score	Criteria
3	All MoH Staff is required to be trained or oriented on the rights and protections of right-holders to file grievances without retribution.
2	All public facilities and offices are required to publicly display the policy of that protects the rights holders to submit grievances without retribution.
1	There is a national policy that protects rights holders who file a grievance.
0	There is no national policy protecting rights holders who file a grievance.
0	N/I = No information
0	N/A = Not applicable

Justification: There is a national policy that protects rights holders to file a grievance without reprisal or retribution. The National Community Health Policy states that citizens have the right to file or lodge grievances in order to hold the system accountable at all levels.[70] At the same time, the MoH Citizen's Charter grants the right of citizens to make complaints, and the Ombudsman Act expounds tasks the Ombudsman with investigating alleged instances or matters of abuse of power, oppressive conduct, or unfair treatment.[71] Furthermore, MoH staff are required to be trained on rights and protections of rights holders, and there is a dedicated Office of Ombudsman—a paid position—who has the responsibility to address rights holder complaints.[72]

There is no requirement that public offices or facilities must publicly display or disseminate information on this policy or the rights it endows to rights holders; though, the Ombudsman Platform does use public fora, social media, district level provider workshops, and public service messaging on radio and television to make the public aware of the social accountability system and the access available to all rights holders.[73] These communications also re-emphasize the importance of this role among public health staff and providers.

The score is calculated at 2/3 because even though the community members were aware of their rights to registering complaints on poor services, there is no known requirement that ensures that public offices disseminate or publicly post information on these rights. It should be noted that KII and FGD respondents felt that stronger advocacy around the importance of collaboration between government and community may be needed to achieve greater awareness and sensitivity among duty bearers as to the extent of their mandate and responsibility to hear the voices of rights holders, find ways to respond to grievances, and find ways to collaborate toward highest quality services.

3.2 Functionality

Development Maturity Score of Functionality = 8/9 (89%)

The Functionality domain looks at whether or not processes are enabled within the structures. Specifically, it assesses the following: 1) there should be a budget line item assigned to the SA program or system, to support its function; 2) if there are improvements to be made, which are identified through the SA program/system, there should be some process for monitoring, documenting, and evaluating progress towards those improvements; and 3) if there are structures for community participation and grievance submission, there should be a means through which they are accessible to rights holders at national, sub-national, and community levels.

In a review of the functionality of the Quality Management Policy for the Health Sector, which is linked with the QM Strategy and the Malawi Health Sector Strategic Plan II (HSSPII, 2017-2022),[74] both the policy and the strategy align, and prescribe a health system focal person at each level to oversee SA activities. As evidenced through the Ombudsman reports, monitoring and evaluation structures exist at each level and are being used consistently at sub-national and community levels to facilitate the chain of command for quality programming and achievement of objectives The QM Strategy and the HSSPII policy describe clear guidelines on how policies will be carried out with a general budget line assigned to SA.

The Assessment Score for Functionality was, based on three questions:

1. **Does an M&E process exist (i.e., a process for data collection of and reporting on a set of standard national indicators)?**

Score: 3/3

Score	Criteria
3	The M&E process incorporates indicators from all administrative levels; AND reports on the combined results are regularly shared at all levels.
2	The M&E Process includes input from at least two administrative levels but results are not regularly shared.
1	There is an M&E process at national level but does not include input from other administrative levels.
0	There is no M&E Process
0	N/I = No information
0	N/A = Not applicable

Justification: The national M&E plan includes formal M&E structures for social accountability at national and sub-national level. At community level, conflicts and resolutions around quality of service delivery are monitored through a variety of M&E processes, including Community Score Card, Citizen Charter and CVA. These are interchangeable processes selected by the villages themselves based on their familiarity with the approaches and the support available from external organizations to implement them. Accountability meetings are held monthly at facilities between the CHAS and HCACs and the Ombudsmen, as per the Ombudsman responsibilities, where reports are produced listing the complaints of the village representatives and the concerns of the providers. These reports are fed to the District Health Officer and are answered and addressed, with responses sent back to the community. There is a liaison officer within the five QM quality management satellites across the country; and staff is tasked with monitoring data to ensure implementation and documentation of quality oversight.[75] Ombudsmen reports are produced annually and document the sectors, including health, and report publicly on complaints registered and fulfilled. The reports are published online, accessible to those who have access to internet. Those without computer literacy or internet connection have access to facility responses but not to the annual reports that monitor the utilization and fulfillment of the accountability system.

2. **Is the national social accountability program or system budgeted?**

Justification: SA program budget line items exist at national, sub-national and community levels. It should be noted that the program is budgeted and budgetary allocations

Score: 3/3

Score	Criteria
3	There are SA program budget line items at national, sub-national, and community levels.
2	There are SA program line items in the budgets of national and sub-national administrative levels.
1	There are SA program budget line items at national level only.
0	There is no / are no line items in the national budget for the SA program/system.
0	N/I = No information
0	N/A = Not applicable

may be sufficient, but some key informants reported that disbursements are often lower than the approved budget; and thus, donor funding is required to fill the gap. A recommendation for sustainability, as part of a monitoring and evaluation function, should be an annual budget and an adequate disbursement assessment for the SA system at each level.

3. Is the redress system accessible to all rights holders?

Score: 2/3

Score	Criteria
3	The redress system is used at all three levels (national, sub-national, or community).
2	The redress system is used only at two levels (national, sub-national, or community).
1	The redress system is used only at one level (national, sub-national, or community.
0	The redress system is not used.
0	N/I = No information
0	N/A = Not applicable

Justification: The redress system is accessible at all three levels (national, sub-national, and community) through various formats and opportunities to discuss complaints or report gaps. Evidence of this was reported by the PACHI Trust Malawi[77] regarding a Bwalo forum hosted by the Dowa district. The purpose of the Bwalo was to address RMNCAH service challenges, as well as health promotion. Representatives from all parts of the population participated, from the Ministry of Health (providers and district managers), CSOs, both adult and adolescent community members, and youth groups.

Respondents also reported that SA structures at both sub-national and community levels are accessible and functional, with resources dedicated to collaboration between government and non-state actors. As described previously, village and facility level mechanisms include score cards, village health committees address items that can be solved, such as cleanliness or safety of the health facility, or positive behavior applauded, such as perceived good quality of health services provided. More sensitive complaints about health provider behavior, including disrespectful communication or absenteeism, are sometimes brought to the district level so as to be able to report the gaps without directly confronting the target of those gaps.[78]

Both rights holders and duty bearers reported that community members find SA structures accessible. Rights holders and duty bearers described regular meetings at facilities using score cards and feedback reports where rights holders could make their concerns known and expect immediate responses from facility managers or district managers—or to expect that grievances requiring health system or health service changes or resource allocation shifts would be referred to regional levels for review and response. Some respondents did note the long waits for some responses to be addressed.

> *"The SA mechanisms brought in different ways for us to give feedback that we use, such as the suggestion box and the phone lines for citizens to engage (with government focal point) directly by phone."*
>
> ***— Community member, FGD participant***

> *"We like the community score cards. The only problem is that it takes too long to receive the feedback. It should be provided within the waiting period; and sometimes action is taken without issues being discussed."*
>
> ***— Community member, FGD participant***

Focus group discussions revealed that community members feel confident accessing community health SA processes, and are comfortable communicating with the health system Ombudsperson. However, there are flaws in some of the community level SA processes, which risks breaking trust and losing participation. Therefore, the score is only 2/3 for this question under functionality. Key respondents from national level government and donor organizations reported gaps in coordination in addressing grievances brought from sub-national management teams and civil society organizations to national level. They described a national level platform for coordination that had been established with the support of UNICEF and USAID as part of a maternal and child health program and had been used effectively to convene government and civil society representatives to discuss and solve RMNCAH grievances together at national level that had been referred from Community Score Cards and CVA and that reflected common challenges requiring national level attention. However, upon the conclusion of project support, the platform was no longer functional, and the practice of coordination for social accountability action was inconsistent. Key informants recounted that social accountability efforts were still more functional at sub-national levels and community levels, with less consistent coordinated function at national level due to lack of political will and need for leadership in good governance. One respondent explained that at the highest central Ministry level, where politics of influence were prioritized over SA, politicians were less interested in being held accountable.

> *"Most politicians do not support the SA as they feel it compromises their agenda, as most of them are involved in corrupt practices and abuse of power."*
>
> ***— UN employee***

3.3 Effectiveness

Development Maturity Score for Effectiveness = 2/6 (33%)

"Effectiveness" refers to the extent to which SA system is positioned to achieve SA objectives. For example, the level to which duty bearers respond to rights holders' needs and complaints should be reflected in their performance reviews. Rights holders must be held accountable and have incentive to be responsive and steer the accountability of the system. In addition, the SA system's performance should be monitored with reports on the average response time to grievances, number of grievances that were solved, and changes or

improvements that were made as a response to grievances or service delivery improvements that were accomplished.

In Malawi, the M&E plan within the QM Strategy does define health system and service delivery performance indicators, and the QM policy requires regular project and performance evaluations. Standards for provider performance are also included in the QM Strategy, but they are defined broadly without specific criteria addressing the duty bearer's obligations to the rights holders. The MoH does have a public website through which health service improvement indicators are published and accessible. However, researchers found no documentation or evidence that evaluations of those indicators are carried out, or a process established for review. Even during the years when UNICEF and USAID had supported a platform for collaboration between MoH (duty bearers) and stakeholders (rights holders), (e.g., the National Task Force on Social Accountability,[79] which is no longer functioning), there were no documentation or reports evaluating SA data or performance indicators. They were made available through the M&E Directorate as part of the QM Strategy.

Quantitative scores for effectiveness are:

1. **Do performance criteria for staff include the fulfillment of SA responsibilities that respond to rights holder needs?**

Score: 0/3

Score	Criteria
3	Performance reviews at national, sub-national, and community levels include criteria to measure staff's responses to rights holders' needs.
2	Performance reviews at national and sub-national levels include criteria to measure staff's responses to rights holders' needs.
1	Performance reviews at national level only include criteria to measure staff's responses to rights holders' needs.
0	There is no staff performance criteria tied to implementation of SA program/system (responding to rights holders).
0	N/I = No information
0	N/A = Not applicable

Justification: Provider performance is kept in check by community members through local SA processes, such as the Community Scorecard. Sanctions have been primarily delivered in relation to criminal misconduct, such as theft, drug use, or rape. Respondents did report that in cases where continued patterns of poor performance are identified and issues are raised through the SA approaches, the offending provider is often transferred to a remote low-resourced area as a punitive measure. However, institutional guidelines for sanctions or escalating response to poor performance were not found. Recommendations for standardized guidelines and consistently delivered sanctions in response to sub-standard performance or consistent complaints.

> *"They will transfer such a person to a remote area with more hardships like no proper road network, no electricity. This acts as a punitive measure that is expected to change bad behavior."*
>
> *— Civil Society Stakeholder*

2. **Are M&E findings on the performance of the SA system (i.e., the duty-bearers' responsiveness to rights-holder complaints) shared back with the community (i.e.: on public platforms such as the MoH website; or through other public communication mechanisms)?**

Score: 2/3

Score	Criteria
3	M&E results, redress cases, and/or progress reports are provided on an MoH or CSO website.
2	There is a public platform but it is not accessible through a website or other broadly accessible mechanism.
1	There is no public platform.
0	N/I = No information
0	N/A = Not applicable
0	N/A = Not applicable

Justification: There is a public platform at the community level through the various mechanisms (community scorecard, Citizen Voice and Action, etc.) in which rights holders receive feedback and updates on progress in response to grievances. Information is shared with the community verbally and reported up to district, subnational, and national level through reports. Service indicators are published publicly,

but there was no evidence of specific SA program/system evaluation at national level or public dissemination of results of the program overall performance (i.e., consistency in addressing grievances; response time; or resulting systems improvements).

In KII's, stakeholder interviews confirmed high rates of satisfaction and success with several SA initiatives, including Community Score Cards, suggestion boxes, communication with the Ombudsman, Town Hall meetings/*Bwalo*, dialogue sessions, Service Charters, and CVA. All respondents at national, district and local level acknowledged existence of mechanisms to enable rights holders to hold health providers and other officials (duty bearers) to account, and to receive redress of grievances and feedback on improvements.

Rights holder respondents, through FGDs, indicated general satisfaction with the SA program and agreed that it effectively provided an opportunity for their voices to be heard. Recognizing the strengths and progress that has been made, rights holders also raised critical issues where improvements are needed.

In one example, the rights holders explained how they themselves had disseminated reports on the success of the social accountability system and reflected:

> *"Now I am happy because I know where I can report any grievances and bad experiences I have when I go to seek services"*
>
> ***— Respondent in community FGD***

Community members and civil society organizations reported on both system and service complaints being resolved or consequences being observed.

> *"I know of a case where a nurse was transferred to another facility after our community reported to the district managers about her rudeness"*
>
> ***— Community Leader***

Several shared their satisfaction but noted that the response time was lengthy.

> *"Some of these issues were addressed at community level, while other resource issues were escalated to district or national levels. The time period to resolve the issue was satisfactory with the community, especially where complaints were to do with change of attitude by providers. Issues to do with resources took a long time."*
>
> ***— Respondent from CSO FGD***

> *"Members of parliament and other elected officials and duty bearers are held accountable and reduced corruption, promoting equity on resource distribution, promotion of ownership and sustainability of development projects. We appreciate that SA is a process, you need time and a political will to start seeing results."*
>
> ***— Respondent from CSO FGD***

Gaps were also noted. As mentioned previously, there was sentiment among both duty bearers and rights holders that the SA system needs to be more strongly supported by higher level government members. Although feedback is provided by zonal, district, and regional duty bearers, the real engagement at national level, and even higher level sub-national levels is seen to be lacking. Resourcing and political will is seen as driven by the donors and international NGOs.

Further, community members expressed that there needs to be greater empowerment and capacity of the community members and their CSOs to engage in, and influence planning and policies.

> *"CSOs need to be more involved in collective decision-making processes, and there needs to be greater participatory planning, implementation, and monitoring of the SA program. The system needs to be stronger at going up the ladder; it is easier to do this on local level providers, this has to be cascaded up to zonal and regional level."*
>
> ***— Respondent from CSO FGD***

3.4 Sustainability

Development Maturity Score for Sustainability = 13/21 (62%)

The Sustainability domain explores factors that position the SA system in health to continue autonomously through its being institutionalized by laws and regulations and supported by funding. This measurement requires that the structure not only exist, but that some type of legal or regulatory framework must be in place to enforce common standards. This 'Sustainability" domain also goes a step further than the 'Functionality" domain with regard to financial autonomy. For example, it requires that there be not only budgets for programmatic support, but that there be budget line items to support staff assigned to drive the national SA structures. Monitoring and evaluation must be not only functional,

through a structure for and process of data collection and evaluation, but also sustainable with a data management system that is integrated across all levels, with capacity for consistent dissemination of information and transparency of results.

Although the SA policies and QM Strategy detail guidelines and processes to enable functionality, there is not a regulatory framework to enforce redress or define and uphold standards, such as response time. The QM Policy and the National Community Health Strategy define funding for the focal person and QM directorate staff at each level. Budget for strategy implementation carries through 2022 and is funded with international support; however, although international support is expected to continue, there is no evidence of increased capacity of the GoM to sustain budgetary support of SA system activities autonomously. Even so, the GoM continues to prioritize the same focus defined in the Malawi Growth Development Strategy of 2017-2022[80] (education, energy, agriculture, health and tourism) and remains committed to advancing toward the SDGs. It is expected that the GoM will continue to incorporate funding for the SA systems; recommendations from this assessment will support resources and plans that strengthen national level SA processes that support a platform for duty bearers and rights holders to cooperate towards redress of health concerns at national level. There are current efforts toward budget accountability, positioning greater awareness and advocating capacity building through the Health Budget Transparency and Accountability initiative, implemented by USAID's Evidence for Action (E4A) as part of the MamaYe project.[81]

The following seven questions were asked in instrument for quantitative scoring:

1. **Are the M&E processes for the SA program or system institutionalized (or mainstreamed /normalized within the institutions)?**

Justification: At national level and sub- national level, data is integrated from the health sector through the QM Directorate. Although the systems functions, and monitoring is carried out at some levels, use of electronic—means (databases, emails, websites) is not consistent, across levels and cannot be monitored in real time.[82]

Score: 1/3

Score	Criteria
3	The M&E of the national SA program/system is integrated into the broader health M&E processes.
2	Electronic information systems are used to manage M&E of SA program/system across all levels so data can be monitored in real time.
1	Actors at national and subnational levels meet regularly to review M&E reports to inform national SA program/system improvements.
0	Only national actors meet regularly to review reports to inform SA program system improvements.
0	N/I = No information
0	N/A = Not applicable

2. **Is there a mechanism for the rights holders to approve of and/or participate in the development of the social accountability strategic plan objectives**

Score: 3/3

Score	Criteria
3	There is a mechanism through which representatives from rights holders groups approve of and/or participate at community level operationalization of the national social accountability strategic plan objectives.
2	There is a mechanism through which representatives from rights holders groups approve of and/or participate in the sub-national level operationalization of the national social accountability strategic plan objectives.
1	The development of and approval of the strategic plan in some way includes rights holders groups and/or interest groups at national level (such as committees, advocacy groups, and technical experts).
0	Only centralized government structure (such as cabinet, parliament, or Ministry leadership at national level) participates and /or approves.
0	N/I = No information
0	N/A = Not applicable

Justification: Through the widespread Bwalo process, rights holders can participate in planning and operationalization of national SA plans at all levels. This has been demonstrated in USAID projects in the recent past.[83]

3. **Does the budget fund at least one person to be responsible for managing the SA process?**

Score: 1/3

Score	Criteria
3	There are SA program/system line items that budgets specifically for at least one full-time person at each of three administrative levels: (national level, sub-national level, and community level)
2	There are SA program/system line items that budgets specifically for at least one full-time person at both national level and at least one sub-national level
1	There are SA program/system line items that budgets specifically for at least one full-time person at national level only
0	There is no/are no line items in the national budget for the SA program/system
0	N/I = No information
0	N/A = Not applicable

Justification: A staff person at the national level of the QM Directorate oversees the 5 regional offices, and focal persons are located at each district and facility level. Ultimate responsibility and funding often falls onto international NGOs to convene meetings and drive results at national, sub-national and still at many community levels.

4. **Do budget line items support the SA program or system activities and materials in three health administrative levels (national level, sub-national level, and community level)?**

Justification: There are budget lines to support the SA program/ system activities and materials in three health administrative levels (national level, sub-national level, and community level). Because of adoption of Community Score Card as a national practice, there is a budget for its implementation. In some cases, it is managed locally without NGOs and this autonomy is expanding.[84] There was common agreement among government level respondents that SA activities were specifically budgeted.

Score: 1/3

Score	Criteria
3	There are budget line items to support the SA program/system activities and materials in three health administrative levels (national level, sub-national level, and community level)
2	There are budget line items to support the SA program/system activities or materials in the national health budget and in the budget of least one sub-national administrative level
1	The development of and approval of the strategic plan in some way includes rights holders groups and/or interest groups at national level (such as committees, advocacy groups, and technical experts,)
0	Only centralized government structure (such as cabinet, parliament, or Ministry leadership at national level) participates and/or approves.
0	N/I = No information
0	N/A = Not applicable

5. **Is the responsibility for M&E of the SA program/ system assigned to an MoH staff member and included in his/her job description?**

Score: 2/3

Score	Criteria
3	An MoH staff at three levels (national, sub-national, and local) are tasked with the responsibility of the M&E for the SA program/ system as specified on his or her job description.
2	An MoH staff both at the national and subnational levels are tasked with the responsibility of the M&E for the SA program/ system as specified on his or her job description.
1	An MoH staff person(s) is responsible for M&E of the SA as part of his/her job description at national level only.
0	There is no/are no person on staff at the MoH who has the responsibility for M&E of the SA as part of his/her job description.
0	N/I = No information
0	N/A = Not applicable

Justification: There is a salaried staff responsible for M&E at the QM Directorate who is designated for M&E at the national level and linked to sub-national level through the five regional QM offices. The Office of Ombudsman has representatives at the tertiary and district referral hospitals and a focal point at district level dedicated to review citizen complaints at the community level (through the health facility); each referring complaints to the next administrative level as required. The Deputy Director of the M&E division at the QM Directorate (central level) is responsible for monitoring this policy, and documenting success guided by a detailed Monitoring and Evaluation Plan.[86] Job descriptions define the responsibilities of Deputy Director of M&E and related MoH staff at each level, including the ombudsmen. The score in this section is a 2 of 3 instead of 3 because the facility level staff that serve the Ombudsman function, tasked with linking to the district level Ombudsman and coordinating social accountability activities, is not dedicated to only that role, and respondents suggested the two responsibilities (facility staff and SA ombudsman) create a conflict of interest and may compromise both the intent of the SA structure and the trust of the rights holders in that structure.

6. **Are annual trainings held for participating staff (MoH) and stakeholders (MoH, NGO, and/or CSO) on the principles and practices of the SA program/system?**

Score: 3/3

Score	Criteria
3	Trainings are held for staff and stakeholders at all three levels (national, sub-national, and community).
2	Trainings are held for national and sub-national staff and stakeholders only.
1	There are trainings held for national level staff and stakeholders (at national level only).
0	There are no regularly scheduled trainings held.
0	N/I = No information
0	N/A = Not applicable

Justification: Funding for staff training on job responsibilities regarding SA is expected and budgeted.[86] KII and FGD respondents reported that they had received training. It should be noted, as stated earlier, that despite regular trainings, there is evidence of capacity gaps and need for further capacity development. In addition, as training is still facilitated by international NGOs, the capacity to train and supervise needs to be strengthened within the MoH. Therefore, the score is not 100%.

7. **Do job descriptions of all duty bearer staff at all levels include a statement or description of their responsibility to rights holders?**

Score: 3/3

Score	Criteria
3	There exist - at national, sub-national, and community level—job descriptions describing responsibilities of MoH staff to rights holders.
2	There exist—at national and sub-national level—job descriptions describing responsibilities of MoH staff to rights holders.
1	There exist—at national level only—job descriptions describing responsibilities of MoH staff to rights holders.
0	There are no job descriptions that mention the staff's responsibility to rights holders.
0	N/I = No information
0	N/A = Not applicable

Justification: National level staff at the QM Directorate have responsibilities defined to supervise QM staff in the implementation of QM tasks and responsibilities at regional level and district levels. SA responsibilities are included in MoH staff job descriptions, as per the National Community Health Policy and QM Policy. There is a salaried Ombudsman at national and also at the subnational level, with specific SA related responsibilities designated through job description.[87]

The QM Directorate is tasked with training along with numerous M & E responsibilities, but there is no detail about how often staff will be regularly trained in their SA responsibilities and no documentation to ensure that training. Neither is there an outlined budget specifically for social accountability related training activities, or materials which would indicate some sustainability of capacity and skills.

Community stakeholders participate in the SA process by serving on a Community Health Advisory Committee (CHAC) or Village Development Committee (VDC). There is no documentation regarding how community stakeholders collaborate with the district management teams and

commissioners to review objectives against the performance. Nor is there reporting on any review and comparison of grievances and responses by rights holders and duty bearers as part of a standard and institutionalized M&E process to improve the service delivery planning and implementation.

KIIs and FGDs with central level stakeholders shared frustration with the SA processes and especially the lack of attention toward private sector initiatives.

> *"There is a need (for duty bearers) to work better with communities and enhance their involvement in health policy and program design and implementation. This is easier said than done, especially because data collected from community engagement initiatives is sometimes done for formality sake. For example, much has been documented on promoting private and public sector participation in the design, implementation, and monitoring of health development policies and programs, but we have not seen any response around that for years now; and community members keep on raising this issue"*
>
> ***— National level MoH representative***

Respondents also noted the need for a regulatory framework requiring performance standards to ensure the government follows through in their commitments and their duty to protect the members of society.

> *"There is a need to advocate for a stronger legal environment to protect critical civil society and whistle-blowers, and for national government to building strong, self-regulating social accountability policies and systems"*
>
> ***— Civil Society stakeholder***

Respondents also pointed out a need for a more rapid and effective transfer of responsibility to Malawi leadership at the sub-national and community levels. They explained that CSO leadership in the social accountability process needed to be strengthened. One government member pointed out that to enable the social accountability program to function autonomously, CSOs needed to take more action and lean less on the support of NGOs. Despite the expansion of the MoH roles in SA program at every level, the local civil society needs take a bigger role in driving the process to ensure a true public-private partnership and rights holder collaboration, influence, and ownership.

> *"We have seen that donors allocate significant shares of resources to encouraging civil society to partner with NGOs to facilitate holding government accountable but not much is done by CSOs"*
>
> ***— Representative of National government***

Policies, processes, and practices are in place and budgeted, which positions Malawi to continue its SA system. However, heavy reliance on international funding obstructs development maturity in the Sustainability domain; and capacity gaps will need to be addressed.

3.5 Transformation

Assessment Score for Transformation = 7/15 (50%)

The Transformation domain discusses potential markers of lasting change in Malawi's health system and health outcomes as a result of SA policies. It goes beyond sustainability, which stems from institutionalizing practices and providing resources to sustain them and extends to incorporate shifts in attitudes of rights holders and duty bearers and the self-reliance of SA within health governance systems. The transformation domain also looks at whether the program is self-reliant, to which questions were asked about capacity and will. The transformation domain also looks at the results of the national social accountability system, asking if services and health outcomes have improved.

It should be noted that even though Malawi's effectiveness scores are low, transformation scores are higher. This discrepancy reflects the need for more attention by the GoM on addressing the gaps in functionality and effectiveness through oversight mechanisms, civil society and professional society reprimand functions, public employee performance links to responsiveness and SA redress duties, and improved documentation of health system and service improvements related to the SA system. Despite the weaknesses of the SA system itself, government will and rights holder engagement have shifted perceptions and transformed expectations in that duty bearers at every level recognize the government's obligation to be responsive to and collaborative with rights holders. At the same time, rights holders are active in voicing grievances and participating in public discourse with health system representatives, or duty bearers, to address challenges and improve the quality of service delivery. The establishment of a sustainable SA structure that has been expanded, and further developed over recent years suggests a commitment to engaging rights holders in collaboration for

improved health services. It also suggests a commitment to responsiveness to needs and concerns of beneficiaries of the system, linking community governance systems with health system mechanisms in a coordinated, collaborative social accountability process.

The commitment of some community members and civil society rights holders to continue the score card process and the participation in social accountability systems at facility and district level, also suggest a transformation that has already occurred and the positioning of democratic principles that have taken hold. However, perceived limited commitment at the higher national level, despite institutionalized committees and staff positions responsible for social accountability in health, stem from corrupt political influences and financial self-reliance. Inputs from USAID, and other government and international development agencies are helping to build capacity, but progress is slow; however, community level capacity and demand for improved government accountability continues to grow, as demonstrated by a variety of SA methods being implemented by communities.

In addition, while the USAID Journey to Self-Reliance (J2SR) measurements were being applied, Malawi's J2SR roadmap for 2021 is reflected in these findings, indicating low marks in the area of Commitment and higher marks in the area of Capacity, both leaving room for improvement.[88] However, longstanding obstacles to transformational change in Malawi's health system continue to be slowed by its severe economic challenges. Those obstacles include a severe shortage of health personnel, weak supply chain management, poor information systems and infrastructure. These key components of the country's public health system are still supported largely by external donors.[89]

There were five questions in this section of the instrument:

1. **Is the SA program self-sustaining (demonstrating self-reliance both through national commitment and national capacity)? Please note that this question addresses both technical and financial sustainability.**

Justification: Despite gaps identified by KIIs and FGDs, the GoM has invested resources in SA at all levels through its QM Directorate and national Community Health Policy, with a monitoring function defined through the QM Directorate, demonstrating country commitment.[90] Capacity is increasing, and commitment is evident at subnational and community levels as communities who have learned the score card process and continue to engage in SA activities, even after project and donor support has ended. Malawi's establishment of an ombudsman assignment at every health facility, despite its limitations, also demonstrates continued commitment and investment in capacity to supporting SA processes. Even so, commitment levels are mixed, and the country as a whole struggles with the economic stability to sustain the QM and community health strategies that define its national SA system. There are also evidence that continued SA activities have created expectations among rights holders that they will be included in decision making and are expected to voice grievances or dissatisfaction. One respondent even suggested that mechanisms for social accountability in health have shifted common practice from reserved restraint to active participation in change.

Score: 0/3

Score	Criteria
3	A public sector body or organization has official responsibility for ensuring that improvements to processes are maintained.
2	An external body reviews the quality and consistency of data collection and analysis.
1	Domestic funds/resources/structures (rather than donor funds) are used to maintain and sustain the SA Program.
0	The program still runs on help from external donors and implementers.
0	N/I = No information
0	N/A = Not applicable

> *"Usually Malawians are a quiet culture, and providers seen to be kings, Malawians do not like speaking against local leaders or providers, poor health seeking behaviors, issues are somehow accepted as norms—Maternal deaths, early marriages, etc. However, this began to change as citizens became empowered."*
>
> *— Civil Society Stakeholder*

2. **Have Provider performance indicators improved?**

Justification: Client satisfaction with provider performance indicates that providers are improving their behavior. However, it is difficult to know whether this improvement is due to the SA process without clear M&E documentation.

Score: 1/3

Score	Criteria
3	Provider performance indicators or reports from rights holders mark improvements and/or the decrease of grievances against providers that can be directly related to the SA process.
2	Provider performance indicators or reports from rights holders have improved and grievances against providers (outside of staff performance) have decreased.
1	Provider performance indicators or reports from rights holders have overall improved.
0	Provider performance indicators or reports from rights holders have not improved.
0	N/I = No information
0	N/A = Not applicable

There were no performance reviews available; neither is there public documentation of the number of grievances against provider performance.

3. Have health service indicators improved?

Score: 1/3

Score	Criteria
3	Service indicator improvements and/or the decrease of grievances against facilities can be directly related to the SA process.
2	DHIS2 service indicators have improved and response times to grievances against health facilities (outside of staff performance) have decreased.
1	DHIS2 Service indicators have overall improved but not attributable to SA.
0	DHIS2 service indicators have not improved.
0	N/I = No information
0	N/A = Not applicable

Justification: Malawi reduced its maternal mortality by 53 percent between 1990 and 2013. The percentage of women 15-49 who had 4 or more antenatal visits with a provider went up from 46% to 51% in only five years, from 2010 to 2015; and births assisted by a skilled provider were sustained at 95% during the same time period. Continuing on an upward trend, institutional deliveries increased from 73% in 2010 to 91% in 2015.[91] Between 2010 and 2019, the infant mortality ratio decreased from 66 to 42 per 1,000 LB. During the same time period, Under-5 mortality ratios decreased from 112 to 63 deaths per 1,000 LB. Contraceptive prevalence rate, modern methods (mCPR) among all women increased from 38.1% in 2012 to 48.3% in 2019; and percentage of women (married /in-union) whose demand was satisfied by modern methods increased from 65.9% to 78.4%.[92] Community members are now more aware of their rights and are more often demanding improved service delivery. However, improvements in health indicators cannot be attributed directly to the SA process. Neither have response times for grievances by health providers been documented.

4. Have rights holders' satisfaction with the health system improved?

Score: 3/3

Score	Criteria
3	Rights holders report that they are pleased with the social accountability (grievance and redress) mechanism.
2	Rights holders satisfaction has improved.
1	Rights holders satisfaction has not improved.
0	Rights-holders do not now their rights.
0	N/I = No information
0	N/A = Not applicable

Justification: Rights holders stated in interviews that they are pleased with the redress system, and CSO's reported having seen system and service improvements due to the SA system.

5. Have population level RMNCH health outcomes improved?

Justification: Although service indicators continue to improve, those improvements cannot be directly attributable to accountability. However, multiple individual examples of local level responsiveness to community complaints were reported by rights holders and representative CSOs to have resulted in strengthened service quality. Malawi has benefited from remarkable MNCH improvements, but greater investments are needed to see if SA can be attributed to national MNCH improvements and sustainable system improvements that can continue to advance them.

Score: 2/3

Score	Criteria
3	Evidence shows that the SA program/system has contributed to the improvements in population health outcomes.
2	Population RMNCH indicators have overall improved (meaning that more RMNCH indicators of the DHIS2, or national health information reporting system, have improved than not).
1	MNC deaths have decreased.
0	No improvements in population health.
0	N/I = No information
0	N/A = Not applicable

Respondents from both the KIIs and FGDs, discussed different strategies to ensure greater and broader community involvement in transformational strategies. The most successful community level pilots include Community Scorecard (CARE), National Budget Consultation, Analysis and Advocacy, and the pilot of health budgeting transparency initiative (E4A-Mamaye). It should be noted that because of the success of the Community Scorecard in Malawi, it is the only SA approach that is explicitly mentioned in both the National Community Health Strategy. This indicates public confidence in the method and directs scale up of the approach across the country.

Respondents from another community reported that the SA system is not consistent. There are still obstacles, as identified previously, when complaints reach higher levels of government. Respondents pointed to this gap when complaint redress would require resources or health systems improvements, requiring higher level attention.

> *"There is a need to institute a proper mechanism to facilitate feedback on every issue or complaint raised by the community, otherwise there have been some cases where issues are never responded to. When we get no response, it's discouraging to give any feedback on service performance. Then we will see no value."*
>
> ***— Respondent from community FGD***

4. DISCUSSION

Key informants and FGD participants who had been part of donor projects, as rights holders, implementing partners, or duty bearers, provided insights into the enabling environment that facilitated or obstructed the development and expansion of Malawi's SA system in health.

4.1 Facilitating Factors

The initiation of multiple community level SA community projects

Donor-funded projects introduced the concept of rights holder agency and voice through social accountability pilots. Organizations such as CARE Malawi introduced training and tools, such as the Community Score Card, to empower community members.[93] These tools and the accompanying capacity building, reinforced by practice and participation across multiple communities, influenced a cultural shift from passive acceptance to active engagement in health system performance improvements to uphold the rights and meet the needs of rights holders.

Operational Approach for community SA processes

Several respondents emphasized the importance of having a clear strategy that guides implementation of SA processes that fulfil policies for national SA systems in health. The Community Health Strategy and the QM Strategic Plan mandate participation of rights holders in the health system decision-making and define processes through which duty bearers solicit feedback from rights holders, act on that feedback, and communicate progress and results.

> *"The National Community Health Strategy is a key reference document for community engagement in the health sector. Its guidelines have helped promote feedback loops between clients and providers. This is important to address the gap on information accessibility between these two parties and to reinforce to citizens the rights they are entitled to".*
>
> ***— Civil Society Stakeholder***

4.2 Obstacles

Interview respondents also shared perceptions of obstacles that hinder SA system development and performance. Key obstacles were lack of motivation of MoH staff to comply with the guidelines of the QM Policy and Strategic Plan, duty bearer capacity for implementation and guidance of SA practices, and gaps in communication and information management.

Capacity

District managers shared the challenges faced in consistently carrying out the SA practices. Duty bearers participating in SA processes felt inadequately prepared to monitor providers. They struggled with the nuanced difference between providing oversight and accountability on one hand and passing judgement or punishment on the other. They felt their role to respond to and act on complaints of rights holders sometimes put them in difficult positions to demand higher performance levels from low-resourced, over-worked providers. Some said that community members also needed better training as participants in the quality improvement process so that their grievances and suggestions could be more constructive.

> *"Monitoring of the policy regulation is more complicated, since placing sanctions on public officials (using public funds) is not as simple as following up on issues with facility staff."*
>
> ***— Member of Facility Provider Management Team***

> *"Social accountability should not be seen as a witch hunt"*
>
> ***— Member of District Management Team***

> *"Guidelines must also acknowledge that strengthening capacity for social accountability needs to happen both among citizens and government officials, government entities and mechanisms also need investment so that they can effectively engage with and respond to citizens."*
>
> ***— Representative from the Ministry of Local Government***

As part of capacity building, several respondents representing both duty bearers in the district management team and rights holders in the community groups noted that local civil society organizations should take a greater role in leading SA activities. Strengthened civil society is necessary for sustainability.

Incentives

Participation in *Bwalos* or committee meetings takes time away from other duties. Although some MoH staff are designated as part of the SA system, with a scope of work defined specifically for that role, others are expected to participate in SA system functions in addition to other duties. There is lack of buy-in as to the importance of this participation and limited commitment. Further, due to initial programs' being run through donor projects, which continue in many areas, MoH staff have come to expect per diems, free lunches and other benefits to participate; and they resist if these entitlements are not provided tools and methodologies, combined with training and technical assistance, enabled this shift whereby rights holders now have greater expectations of being heard at the decision-makers table. At the same time, international donors supported national structures to facilitate the expansion and maturity of the SA program. For example, USAID and UNICEF guided the establishment of a National Task Force on Social Accountability, which supported international NGOs to implement social accountability initiatives. It brought NGOs, government, and Civil society representatives together to establish responsive social accountability practices at the national or central level. For these reasons, Malawi scores high in the **Structure domain (95%)** and **Functionality domain (89%)** domains, having set up the structures and guidelines to enable the national SA system to be function effectively.

The **Sustainability domain (62%)**, although garnering a lower score, reflects Malawi's potential to sustain its national SA structures and functions. Buy-in and participation of local civil society organizations, such as through district civil society networks and district youth networks, have been successful in convening rights holders, disseminating information, and providing peer to peer support and collaboration among rights holders and community and district level duty bearers. At the same time, however, *gaps in capacity of the local CSOs and competing political agendas at national level* create risks to the sustainability of the expansion and maturity of SA system in health.

Heavy reliance of Malawi on donor funding and continued technical assistance discourage ownership and incentive and thwart Malawi's potential for sustaining the program. Donors must design a realistic exit strategy that diminishes Malawi's financial dependence. Part of that process will be to incorporate collaborative initiatives for economic development as part of the development package, coupled with requirements for the GoM to *strengthen its economic independence*. Further, as part of that exit strategy, sustainable capacities among public and civil society organizations should be included so that GoM, CSOs, and broader citizenry to steer the SA system autonomously. In addition, *leadership and steering capacity need to be further developed* to strengthen Malawi's good governance and to overcome corruption, commit to the social and economic development of the country, and guide the necessary improvements to advance prosperity. As part of that exit strategy, the transition needs to spotlight the benefits, both short term and long term, of social accountability programming that is supported by funds, staffing, guidelines, training, and monitoring and reporting. Without incentives and clear benefits to both government and citizenry, the nascent SA system will not grow and continue.

Finally, researchers noted that although the Citizen's Score Card was the most common SA mechanism used by rights holders at community level, there remain flexibility and innovation across communities to allows rights holders to carry out their own form of engagement and structure for grievance registration and feedback. This flexibility has reinforced rights holder ownership of the SA process. As the SA system continues to mature, it may be useful to standardize these processes, particularly as M&E practices are instituted and consistency is required.

Assessment Instrument Improvement: Two questions will be asked to explore self-reliance.

- A question will be added that asks how much of the funding of the SA system is donor driven
- A KII / FGD question will ask of CSOs and Government representatives to scale their comfort level or confidence with implementing SA activities.

The **Effectiveness domain** is a weakness for Malawi's SA system, with a score of (33%). This score is not due to the perception of the rights holders or the duty bearers in their experience as participants in the program, but rather gaps in operationalizing the functions available to the program, meaning that the structures and functions have been established, but for many of those structures and functions,

there are no reports to demonstrate that they are being used regularly. Documentation is the biggest weakness. Despite an M&E framework, guidelines, and staffing for documentation, monitoring, and evaluating, there is little documentation of common complaints, resolutions, and challenges to inform medium- and long-term system improvements or policy changes at the national level. Likewise, documentation of performance reviews of staff, facilities, or district management teams that tracks their contributions to the SA program, grievance repeats, and responsiveness to the grievances .is lacking. *Regulatory and legal enforcement is needed.* Although there are consequences for criminal behavior and common punitive action that may result from consistent poor performance, there are no standardized consequences or consistent oversight institutionalized to ensure standards are consistently upheld as part of the SA. In addition, institutionalizing standards through job descriptions and performance standards will further contribute to effectiveness, as well as sustainability and consistency across the system. Job descriptions of providers, district managers and MoH employees should incorporate specific performance expectations for SA activities of all duty bearers, and performance reviews should incorporate incentives for compliance. Policies and strategies need to be taken to the next level of annual work plans and HRH packages that reflect the SA specifically.

A standardized process for reprimand, for example through professional societies, is recommended as there is resistance to carry out consequences when government representatives, facilities or providers are not responsive to rights holder requests. Stronger referral and feedback practices should be established between the subnational and national levels, with more rapid response times between the subnational and community level to lead to greater transparency and fluidity in the SA processes and the KM management. Further a *time limit for feedback and response needs to be nationally enforced* so that the feedback loop is reliable and consistent. Peer pressure at the community level has shown to be effective, but an institutional process is needed.

Assessment Instrument Improvement: A additional question is needed asking if guidelines are provided at each level to lead social accountability processes.

Assessment Instrument Improvement: Two questions will be added to address social inclusion.

- One will inquire if processes are in place to overcome inequities in access to SA activities and mechanisms.
- A second question will be added to inquire participation in the SA system is documented and if participation is disaggregated by sex and age.

The **Transformation domain (47%)** shows a mixed result in that community involvement of rights holders is certainly robust, and participation of duty bearers is strong and well-established. However, a *lack of M&E processes and attribution of RMNCAH indicators to the SA activities* renders a weak score for Transformation, despite the rights holders' positive feedback. Researchers Monga and Shanklin[94] recommended "that more research focused on linking local social accountability activities to specific national health advocacy strategies could be impactful in linking citizen participation to systematic national health system strengthening. Greater enforcement, documentation, and clear guidelines and training for monitoring the effectiveness of the SA program is necessary, including measurements that will demonstrate attribution of improved service and health indicators, particularly with regard to RMNCAH, to the SA system.

It is hoped that Malawi's Digital Health Strategy (2019-2022) will enable the implementation of the Monitoring, Evaluation and Health Information Systems (M&E/HIS) Strategy, which was initiated in 2017, to standardize tools and progress indicators across the health system and include the tracking and analysis of the SA system in health.

An additional element that may advance transformation is *social media*. The assessment instrument did not explore social media or related communication vehicles as means of facilitating rights holder engagement in and influence toward health system and health service accountability. It is expected that as access to technologies and bandwidth expands, rights holders will have access to a broader public platform through which to voice grievances, influence change, and receive information and feedback from duty bearers.

Assessment Instrument Improvement: It is recommended that the assessment instrument integrate an assessment of social media utilization in SA as part of its transformation and sustainability domains.

Assessment Instrument Improvement:

- Quantifying the qualitative responses so that they are calculated into the scoring will further strengthen the score and preclude subjective weighting.
- Qualitative questions will be reshaped to additionally solicit suggestions or recommendations for action from each level of both duty bearer and rights holder responses.

5. CONCLUSION

In closing, an analysis of the assessment instrument shows that it has been valuable in synthesizing information and highlighting areas where greatest opportunity for improvement lie. Qualitative data reinforced findings and have informed additional questions that will be included in the updated instrument.

A key aim of this research was to test the assessment instrument. The first-time application of this instrument demonstrated the limitations of the scoring component for each domain. Often data captured through the KIIs and FGDs provided color and context that reinforced the quantitative findings. Other times, however, the qualitative data provided nuanced exceptions, caveats or conditions that should have shifted the quantitative score higher or lower. This gap in the monitoring instrument did limit the ability of the quantitative scoring to accurately prioritize areas for improvement and increase opportunities to identify low hanging fruit or partnerships for improving the SA system or for strengthening the health system. This understanding will inform the improved assessment instrument so that it will remain useful and provide more specific insight.

We discovered that in both Rwanda and Malawi, the social accountability system is actually not a named program but a collection of policies and strategies with the intent of establishing accountability across the national health system and ensure that all rights holders have the opportunity to participate in decision making, contribute feedback, and lodge complaints.

This assessment instrument is intended to provide a high-level snapshot. Therefore, managing the length of the scoring component, the scoring component for each domain was limited to only 2 to 5 questions. Researchers tested these questions during the development of the assessment instrument to ensure that they utilized indicators and scoring criteria that would be most effective, while at the same time ensuring that the process did not become too cumbersome or lengthy. It will be useful to adapt the assessment instrument to incorporate a limited number of additional questions to reveal some nuanced insights, so that it captures common themes that were revealed in the interviews.

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APPENDIX 2

ASSESSING THE NATIONAL SOCIAL ACCOUNTABILITY SYSTEM IN HEALTH

RWANDA

This report was produced for review by the United States Agency for International Development. It was prepared by the HEARD project and was authored by Allison Annette Foster (WI-HER), Cassien Havugimana (co-investigator for Rwanda), Adriane Martin Hilber (USAID HEARD/CUNY). Early contributions on the design and testing of the tool were received from Beth Outterson (Consultant), Kristen Mallory (Children International), Ligia Paina (JHU), and Eric Sarriott (GAVI).

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APPENDIX 2 CONTENTS

List of Tables

ACRONYMS

ANC	Antenatal Care
ASRHR	Adolescent Sexual and Reproductive Health and Rights
CEDAW	Convention on the Eradication of all forms of Discrimination Against Women
CHW	Community Health Worker
CBHI	Community Based Health Insurance
CSC	Community Score Card
CSO	Civil Society Organization
DH	District Hospital
DHU	District Health Unit
EMR	Electronic Medical Record
GDP	Gross Domestic Product
GoR	Government of Rwanda
HRH	Human Resources for Health
IHMIS	Integrated Health Management Information System
IRB	Institutional Review Board
JADF	Joint Action Development Forum
HSS	Health Systems Strengthening
MDG	Millennium Development Goal
MLG	Ministry of Local Government
MoH	Ministry of Health
MSC	Mutuelle de Sante Communautaire
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
RGB	Rwanda Biomedical Center
RGB	Rwanda Governance Board
RMNCH	Reproductive, Maternal, Newborn and Child Health
RNEC	Republic of Rwanda National Ethics Committee
SA	Social Accountability
SDG	Sustainable Development Goal
TWG	Technical Working Group
U5MR	Under 5 Mortality Rate
UHC	Universal Healthcare
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Increasingly, communities, activists, and ordinary citizen rights holders are holding duty-bearers to account for their commitments to improve and or deliver reproductive, maternal, newborn, child and adolescent health (RMNCAH). Over the past two decades, rights holders have organized themselves to demand respect for their right to health care services, particularly maternity services using social accountability approaches. And increasingly, government duty bearers are heeding their call by putting place accountability mechanisms at community, facility, and system levels. In some countries and contexts, these mechanisms have become established and even institutionalized within the health system.

In 2020, Martin Hilber et al. developed an 'Accountability Development and Measurement Framework' and tool for global health initiatives (https://pubmed.ncbi.nlm.nih.gov/32494815/) to help practitioners assess how local and national accountability mechanisms or systems are developed, implemented and institutionalized over time. The framework provides a roadmap on how accountability can be integrated into programs and policies, including the stakeholders who should be involved, the data that needs to underpin the social accountability system, and the review and feedback loop (consequences for inaction), that create accountability in the health system. The framework indicates how accountability mechanisms, once embedded and institutionalized can be transformative within the health system creating answerability to rights holders for the quality of the services or policies implemented.

The final step and sustainability of the process lies in the institutionalization of the accountability system. There is little documentary evidence of how social accountability becomes institutionalized, and the robustness of that institutionalization to deliver transformative change and greater accountability within health systems. To better understand the process of institutionalization in countries, an adaption of the tool was developed and piloted in 2 countries—Rwanda and Malawi.

In each country, social accountability mechanisms were institutionalized using a variety of different formats, platforms and tools. Rather than a singular Social Accountability Program, both Rwanda and Malawi, have defined and refined these social accountability mechanisms into a **system of SA in health**. This study pilots the use of the adapted social accountability assessment instrument, to assess the development maturity of a country's SA program or system in health. It also attempts to evaluate the SA system's performance according to the experiences of those who use it. This paper describes the application of the tool to the Rwandan accountability system at community level related to government responsiveness to the delivery of social goods for the population including health service delivery. Use of the adapted tool can facilitate governments and partners to recognize strengths and gaps in national accountability systems and make informed decisions on investments for improvement.

Methods

Researchers conducted a rapid desk review of available literature, including national and sub-national plans, strategies, demographic health data, job descriptions and other program documents; development project reports; and peer reviewed literature to inform the scoring component of the assessment. The scoring component ranges from zero to three and measures the level of development maturity (with zero representing the lowest score, and three the highest) of a national social accountability mechanism or system—in this case the Rwanda's national system for SA in health. The scoring assessed five domains: structure, functionality, effectiveness, sustainability, and transformation. Key informant interviews (KIIs) and focus group discussions (FGDs) with both duty bearers (those in public positions responsible to provide quality health services), and rights holders (those who hold rights to access quality health services provided by the state) were conducted. KIIs and FGDs provide qualitative information on the relative functionality of the SA systems informed the scoring by providing user experience with the SA system, and perceptions of its performance.

The assessment instrument will provide a benchmark for improvement of Rwanda's national SA mechanisms to strengthen the responsiveness of the health system and the

quality of RMNCH and other primary care services. Further, it can provide a comparison from which other countries may develop, assess and improve their national programs or systems for SA in health.

Findings

Rwanda's total development maturity score was 52 out of a total possible score of 72, or 71%. This result suggests while Rwanda is on its way to good governance in the health system with service delivery that is accountable to its constituency, more work is needed to demonstrate a fully functional accountability system is in place in the health sector. We note however, that while the 52/72 (71% of the total response rate) is not particularly strong, some questions in the instrument were not answered as there was no data available, thus lowering the overall score. The rating might be higher were the information available, a point noted for the revision of the scoring of the instrument.

Several 'promising practices' emerged, primarily from traditional Rwandan community accountability practices, such as national dialogues (*Umushyikirano*). These community mechanisms, which also occur in other countries, may be adapted within similar structures or processes to create greater accountability within their own national social accountability programs/systems. Building on the common tradition of community members' convening to air complaints and explore solutions, the government of Rwanda incorporated the *Umushyikirano* into health system governance processes so as to institutionalize social accountability practices.

Rwanda's Social Accountability policies have successfully linked government decentralization with efforts of the health sector.[1] National policies and programs have leveraged and harmonized existing traditional practices common at local level with national strategies to improve quality and accessibility and broaden citizen participation in planning oversight. Sustainability rates high in the assessment, as staff positions have been institutionalized at national, sub-national and local level, with funding and training to manage the SA processes and activities; and monitor activities that are in place.

Learning from this pilot study investigating the SA systems in Rwanda found the need for greater specificity and information sharing with rights holders will strengthen the health system. Specifically, the SA systems can be utilized more directly to respond to rights holder needs and complaints, and broaden citizen participation by: 1) more clearly defining (internally amongst duty bearers) the role of the SA program or system and its link to improving RMNCH and other public health services; 2) better informing rights holders or system users on the purpose of the program or system; and 3) strengthening the monitoring and evaluation (M&E) of the SA program/system so as to better link the functioning and effectiveness of that national SA program/system to service improvements.

Applying this instrument, authors initially aimed to study a single program and came to recognize through the Rwanda experience, as well as that of Malawi where the instrument was also tested, that a commitment to social accountability in health requires a system of complimentary policies, strategies and implementation mechanisms. This system reflects the country's purpose to improve its health governance and strengthen the health system and its services, to be not only responsive but collaborative, adaptive, and accountable. There must be a policy that decentralizes health management so that the responsibility for service delivery is closer to the point of service, and to the people or rights holders to which it is accountable. Secondly, a community health policy is necessary so that the responsibility to rights holders is defined at the lowest administrative level, establishing clear lines of accountability between duty bearers and the community itself. Quality assurance policies establish standards and oversight that drive accountable practices that improve accessibility and quality of services needed to improve health and save lives. This instrument helped to illuminate strengths and gaps in Rwanda's ongoing commitment to be accountable in reducing maternal mortality and improving child health; and results will inform and steer efforts and resources to areas where improvements are most needed.

1. INTRODUCTION

Social Accountability (SA) is defined as the broad range of policies, actions or mechanisms, which citizens, civil society, and media can use to directly or indirectly hold officials to account to fulfill their obligations as duty bearers to their citizens and rights holders.[2] SA activities or formalized systems can be initiated and supported by the state, citizens, or both. Functional accountability systems provide a platform through which citizens may submit grievances, demands, recommendations, and inputs, thereby ensuring community participation of rights holders in claiming those rights to accessible quality care.[3] Social accountability is an important element to achieving universal health coverage goals and to progressing toward Sustainable Development Goal (SDG) #3: "Ensure healthy lives and promote well-being for all at all ages." SA systems allow rights holders to hold duty bearers accountable for meeting their commitments and upholding their responsibilities as public servants to the populations.[4] SA incorporates monitoring and reporting processes through which citizens: a) understand the obligations of the system; b) have a way to report where and when the system is failing to meet those obligations; and c) include a response process or feedback loop through which the duty bearers must recognize claims and report back to the rights holders on their performance.[5] In this way, SA engages citizens in the process of strengthening the system and making them more responsive to clients' needs. Right holders have the opportunity to define what, and how services should be provided. SA is therefore intended to promote equity, accessibility, and quality of health services for all.[6, 7, 8, 9]

Guidance and support from the World Bank and other development agencies have led to a growing consensus that social accountability, as "an approach toward accountability that relies on civic engagement,"[10] is a cornerstone for good governance and essential for responsive health service delivery. Some countries, including Columbia, Malawi, Pakistan, and Rwanda, have established national programs or systems for social accountability. These programs/systems have developed either from the ground up, scaled from SA interventions introduced at community level as pilot projects, or have been initiated from the top down, wherein governments, motivated by global targets such as the Millennium Development Goals (MDGs) or Sustainable Development Goals (SDGs) and supported by global partners, build a national SA system as part of advancing good governance practice and better health systems.

In Rwanda, the national SA mechanisms to improve health services were initiated at the national or central government level and were borne out of decisive post-war reconciliation and transformation efforts to establish good governance. The post war environment facilitated the creation of a more accountable health system. Efforts were further advanced through the global MDG and SDG campaigns that emphasized devolution in the health system and greater engagement of community members, or rights holders, in health system planning and service delivery improvement decisions.

As more and more countries embark on the establishment of national SA programs or systems or scale up community programs that support citizens to claim their rights and entitlements at the national level, their experiences can inform other national and sub-national efforts to institutionalize and sustain SA processes as part of their health systems. Currently however there has not been a framework nor common metrics to assess whether a SA program or SA system is accomplishing its intent. As countries advance in self-reliance in their health systems and continue to sustain progress and improvements in social development, it will be important that they have frameworks and tools for assessing their progress and guiding development efforts. Further, a common measurement will allow countries to compare their progress and to continually share learning on progress towards making heath systems more responsive to their citizens.

Measuring progress on institutionalizing social accountability: a framework and tool.

In 2020, Martin Hilber et al. developed an Accountability Development and Measurement Framework and Tool for global health[11] to help practitioners assess how local and national accountability mechanisms are developed, implemented, and institutionalized over time to become a national SA program or system in health. The framework provides a roadmap on how accountability can be integrated

into programs and policies, including the stakeholders who should be involved, the data that needs to underpin SA, and the review and feedback loop (consequences for inaction), that create accountability in the health system. The framework indicates how accountability mechanisms, once embedded, and institutionalized can be transformative within the health system, creating answerability to rights holders for the quality of the services or policies implemented.

To better understand the process of institutionalization in countries, an adaption of the framework was developed and piloted in two countries, Rwanda and Malawi. The adapted instrument used in this research aims to assess the status of the national accountability program or systems, looking at the development maturity level and the perceived performance of SA in health. Like that framework, this assessment instrument focuses on **five domains: structure, functionality, sustainability, effectiveness, and transformation**.

The United States Agency for International Development (USAID) supported the testing of this adapted instrument in two countries, Rwanda and Malawi, with the intent of updating and strengthening the original framework and its application for better understanding what it takes to create truly accountable health systems. In addition, results of this assessment offer a baseline for Rwanda and Malawi from which they can further strengthen, and measure progress of their SA system. Further, learnings gained from applying this instrument in Rwanda and Malawi will inform improvements in the assessment instrument that will then be made available to support governments in their effort to better monitor and improve their national SA systems in health.

Assessing institutionalization of social accountability systems

The assessment process begins with an initial rapid desk review, which provides a synthesis of available documentation describing the national health system, the policies that advance social accountability in health and the implementation of the SA system across the five domains. A Likert scoring process, using zero to three, looked at the level of development maturity (zero being the lowest and three being the highest) that the country's social accountability system has attained across the five domains. The scoring mechanism of the assessment instrument allows governments to establish a baseline from which to measure progress and compare strengths and weaknesses of their SA systems with those of other countries. Additional qualitative data collected from key informant interviews (KIIs) and focus group discussions (FGDs) further informed the scores in each domain and shed light on the system's strengths and weaknesses from the perspective of those that participate in the SA system, and use reproductive, maternal, newborn, child and adolescent health (RMNCAH) services. Information gained from both the desk review and the interviews highlight contextual and environmental factors that may facilitate or hinder the SA system's expansion. Further description of the scoring is provided in the Methodology section.

2. RWANDA COUNTRY CONTEXT

Rwanda is one of the most densely populated countries in Africa, with a total population of 10,515,973 million in 2012,[12] but projected to increase to at least 12,658,536 million in 2021[13] with an annual population growth rate of 2.6%. The literacy rate in Rwanda for people aged > 15 years is 73%,[14] with GDP growth rate of 8.9% in 2017/2018.[15] Rwanda has a Corruption Perception Index score of 53 per 100[16] and Gini coefficient of 0.429 with 16.0% of the population below the poverty line (<1.90 PPP USD).[17]

After the 1994 Genocide, the Rwandan government leveraged the reconciliation period to reframe its national policies according to WHO guidelines and standards. As part of that effort, Rwanda decentralized its health system to be more responsive, inclusive, and oriented toward the experience of the end-user. It also established policies and processes at the national level to achieve greater transparency and accountability across the health system whereby duty bearers are held responsible in their obligation to provide accessible, quality health services to their citizens, or rights holders.

2.1 Rwanda's Health Improvements

Rwanda's efforts in strengthening its health system has contributed to a steady increase in access to, and utilization of health services.[18] By 2015, Rwanda had achieved Millennium Development Goal (MDG) 4, and had reduced its Under 5 Mortality Rate (U5MR) by more than two thirds (from 152 deaths per 1,000 live births in 1990 to 50 in 2014/15).[19] The maternal mortality ratio for Rwanda decreased remarkably from 750 deaths per 100,000 live births (LBs) in 2005 to 203 deaths per 100,000 LBs in 2019.[20] Yet despite these gains, considerable disparities in health outcomes persist across the country. [See **Table 1** for demographic health indicators.]

The Government of Rwanda (GoR) is committed to reducing gaps, particularly in maternal, neonatal, child and adolescent health.[21, 22, 23]

The GoR attributes its improved health indicators to its strengthened health systems, and to its national policies and processes to ensure accountability of duty bearers to rights holders for the delivery of quality services. The Rwandan Ministry of Health reports that it is putting in place processes

Table 1: Demographic and Health Indicators in Rwanda

Infant mortality	33 per 1,000 live births[24]
Under five mortality	45 deaths per 1,000 live births[25]
Stunting rate (H/A)	33.1% (% severe)[26]
Low birth weight rate (%)	13.3% (% <2,500 g)[27]
Maternal mortality (15 to 60)	203 deaths per 100,000 live births[28]
HIV prevalence (adults)	3.0% among people aged 15-64 years[29]
Total Fertility rate	4.1 per woman[30]
Life expectancy	69.06 at birth[31]
% of children immunized for measles by 12 months	98%[32]
% of infants exclusively breastfed for first 6 months	80.9%[33]
% of births attended by skilled attendant	88% (2019 -2020)[34]
% of population with social health insurance coverage	78.7[35]
% of population with private health insurance coverage	0.9%[36]
Doctors per 1,000	1/ 8,294 (2019)[37]
Nurses per 1,000 people	1/1,420 (2019)[38]
Midwives per 1,000 people	1/2,889 (2019)[39]
Teenage pregnancy	5.2%[40]
Married women using family planning	64% (58% using modern methods and 6% using traditional methods)[41]
Contraceptive prevalence for women (15-19)	53%[42]
Unmet need for family planning	13.6%[43]
Antenatal care from skilled provider	97.7%[44]
Postnatal care	9.7%[45]

to ensure that services are responsive to population needs and consistently accessible at all levels, from urban cities and national hospitals to community facilities and village households. To this end, the GoR credits its integrated, performance-driven interventions at each level as critical for driving national social accountability throughout the health system.[46, 47]

Rwanda's national SA system in health, was included in the 2017 'National Strategy for Transformation' (NST, 2017-2024),[48] the 2018 'Governance and Decentralization Sector Strategic Plan 2018/19 – 2023/24'[49] and later codified as part of the specific health policies described below. The health policy framework aims to enable the rights holders to express their needs with providers, systems managers, and decision makers so that the rights and responsibilities of both duty bearers and rights holders are appreciated and ensured. This process includes a mechanism for rights holders to file grievances without fear of retribution, and to receive fair and respectful feedback from health system representatives.

2.2 Health System in Rwanda

Rwanda's complex health system combines public and private services in a decentralized regulatory framework that is steered by the MoH with contributions and collaboration from civil society, faith-based organizations, and other partners. The GoR aims to achieve the three critical elements of an effective health system, as defined by the World Health Organization (WHO) *World Health Report 2000*: 1) health services are delivered at the individual and general population levels; 2) there is an enabling environment for delivering health services; and 3) there are cross-cutting activities aimed to influence other sectors to contribute to health services even when their primary purpose is not health.[50]

After the Genocide of 1994, Rwandan citizens were committed to integrate good governance processes and practices in the rebuilding of the health system, and to focus on access, quality, and accountability.[51] This was achieved by 1) strengthening financial capabilities through coordinating aid, private sector investments, and civil society advocacy; 2) linking financing to performance; 3) strengthening community-based health insurance systems; and 4) solidifying collaboration and commitment across sectors.[52] These processes are designed to control use and guard against misuse of public resources in health sector. In addition, a consistent and regular public reporting schedule was established.

Rwanda's decentralized government system follows a pyramidal structure of central, intermediary (sub-national) and peripheral (community) levels, with four provinces, Kigali city, and 30 districts. Each province, including Kigali city, is divided into districts, which are then divided into sectors, cells and finally into villages. Medical services are decentralized across all three levels: 1) the central level with the Rwanda Biomedical Center (RBC) and referral teaching hospitals and provincial hospitals; 2) the intermediary or sub-national level, made up of an administrative district office (District Health Unit or DHU) in each of 30 districts, a district hospital (DH), health centers, and health posts; and 3) the peripheral or community level where a network of CHWs link the health centers to the community. Rwanda's health system (as of 2019) includes 8 national referral hospitals, 4 provincial hospitals, 36 district hospitals, 509 health centers, 13 prison clinics, 885 health posts, 123 private dispensaries, 149 private clinics and polyclinics, and 8 private hospitals.[53] The central or national level is responsible for the formulation of health policies, strategic planning, high-level technical supervision, monitoring and evaluation, and coordination of resources at the national level.[54] Under the four provinces, or sub-national level, the districts are responsible for community level health planning and budgeting, including human resources staffing, salaries, and the supervision and oversight of service quality.

3. RWANDA'S NATIONAL SYSTEM FOR SOCIAL ACCOUNTABILITY IN HEALTH

3.1 Policy Framework

Aligned toward an accountable health system, Rwanda's governance framework for the health system includes the Health Sector Policy,[55] the Health Financing Sustainability Policy[56] and Health Sector Strategic Plan 2018 – 2024[57] aligned with its Second Economic Development and Poverty Reduction Strategy II,[58] which has health finance accessibility as the main priority. These policies and strategies have facilitated the country to achieve improved health outcomes through increasing number of doctors and nurses in rural areas and increasing number of people using medical insurance[59,60] The percentage of the government budget for health has progressively increased from 8.2% in 2005 to 11.5% in 2010/11 to 17.0% and 15.8% in 2016/17.[61] Total health Expenditure per capita has also increased over time to 35,071 Rwandan Francs (37 USD); and with support from international development partners, Rwanda has increased both total budget expenditure and domestic funding.

Rwanda has also strengthened its community health system over the last 15 years. Building on initial introduction of community health workers (CHWs) in 1995, Rwanda expanded its community health program and broadened the role of CHWs through its 2008 Community Health Policy, which focused community health efforts on Reproductive, Maternal, Newborn, and Child Health (RMNCH).[62] The subsequent National Community Health Policy of 2015 highlighted the role of the community health system in reinforcing the decentralization of the health system to achieve local ownership and the participation of community members in the planning, monitoring and evaluating services.[63]

In 2017, Rwanda launched its National Strategy for Transformation (NST, 2017-2024), through which the government indicated its obligation to ensure accountability in all government institutions, including the health sector.[64] In priority area #5 of the NST, Rwanda aims to strengthen the capacity, service delivery, and accountability of public institutions; and in area #6 Rwanda commits to increase citizen's participation, engagement, and partnership in development. These commitments were particularly important with regard to RMNCH services, where a strengthened system, and access to and quality of services were priorities to further lower the maternal mortality rates and improve the health of babies and children.

The NTS aligned with Rwanda's "National Vision 2050,"[65] and set the stage for subsequent national strategies to improve RMNCH services so they will be responsive to rights holders and accountable to their rights to accessible, quality RMNCH and primary care services. The MNCH National Strategy 2018-2024, the Integrated RMNCAH Policy 2018, the National Family Planning and the Adolescent Sexual and Reproductive Health Strategic Plan (FP/SRH Strategic Plan, 2018-2024) all contained components for accountability of RMNCH and primary services to be accountable to commitments of the National Vision 2050 and to articles 21 and 45 of the Constitution.[66] The Rwandan Constitution, article 21, states that all Rwandans have the right to good health. In its article 45, it goes on to say that the state has the duty to mobilize the population for activities aimed at good health and to assist them in the realization of those activities. To further engage citizen participation, the GoR initiated the Volunteerism Policy in 2012 aimed at providing guidance on the management, rights, responsibilities, and roles of every sector in the success of the government strategies.

The GoR also integrated its commitment to an accountable government by establishing a plan for monitoring and evaluation, as well as enforcement, across the decentralized levels of government. In 2018, the GoR initiated Governance and Decentralization Sector Strategic Plan 2018/19 –2023/24, which indicated that to ensure citizen participation, empowerment, and inclusiveness, the public institutions would evaluate the percentage of citizens' satisfaction in their participation in the planning and budgeting process. The governance and decentralization strategic plan indicated a process for monitoring and evaluating the level of transparency and accountability in the public sector by monitoring the percentage of the population that perceived

the district administration as transparent, accountable, and citizen-oriented and the level of the decision-making as inclusive.[67]

Rwanda's decentralized health system provides an environment to facilitate a stronger partnership between the health system and the population, or the rights holders. Decentralization not only brings health services closer to the point of care to be more responsive to rights holders' needs, but also allows community members more access to engage in health planning and decision-making. The Governance and Decentralization Sector Strategic Plan highlighted key elements that will promote social accountability at the community level to ensure that rights holders are fully involved in government planning.

3.2 Platforms for Public Discourse

At the community level, Rwanda has a long tradition of community engagement, oversight, and problem solving through traditional structures called homegrown initiatives (HGIs).[68] The national strategies for establishing social accountability in health have incorporated these into the broader processes for facilitating responsive health and social services. At national level, to promote inclusion, participation, and responsiveness of good governance, the GOR has made information regarding the performance of the health system and its services available to its citizens through broader public platforms and dashboards, such as the MoH website where M&E updates are published. It should be noted that although internet accessibility and usage has increased dramatically over the last 15 years, internet penetration stands at 31.4% (as of January 2021),[69] social media usage stands at only 6.1%, and only 22% of Rwandans use the internet as of 2019.[70] Therefore, only a proportion of the citizenry have easy access to these reports.

Through public dialogue platforms, as well as other national platforms and the more traditional forms of community level public discourse through HGIs, communication between rights holders and duty bearers takes place both directly, in such venues as town hall meetings, and indirectly through phone-in discussions and commentaries or through dedicated phone lines and MoH online discussion platforms. These different accountability platforms provide space for rights holders to hold duty bearers accountable for implementing the policies to which they have committed. For example, through regularly scheduled *Umanganda* meetings (defined in **Table 2** below), generally scheduled monthly, citizens come together with facility providers as well as district managers to register complaints and concerns, to provide input on solutions, and receive reports on improvements that have been made in response to previous complaints registered.

3.3 HGIs sustain citizen-led practices

Given their positive impact assessment and successful implementation,[71,72] HGIs have increased recognition of citizen-led accountability mechanisms in the country, including for example, the *Abunzi* program (Community Courts led by a mediation committee of elders and wise persons), which promotes justice via conflict resolution and mediation at the community level.[73] Rwanda considers HGIs as essential tools to promote good governance efforts across different areas of health and social services. As part of its national social accountability process, it has formalized these previously informal mechanisms, to be an institutional part of the health system. The process now extends beyond just the village community under the auspices of the village elders or elected leaders, to include collective meetings scheduled as part of the formal health system governance process in which district and provincial health managers also participate. As part of its decentralized system, each district may shape the accountability structure and meeting schedules, depending on the customary HGI that was in place previously, leveraging existing practices to strengthen the formal SA in health practices. In **Table 2** are descriptions of several key HGIs currently functioning in Rwanda as part of the national SA system.

The HGI's listed represent the primary platforms that are predominantly used across the country. One of the strengths of the Rwanda SA system in health is that the government leverages local processes and incorporates them into the formal health system as part of the institutionalized SA activities. A weakness remains in that as these platforms vary in structure and are not all consistently documented and tracked in a central database to be easily accessible and categorized. This gap is one of the challenges to measuring and monitoring the functionality of the SA system in health and is reflected in the scoring.

Table 2: HGIs in Rwanda[74,75]

Elements of the HGI	Connection to the community
Umuganda: ► Mandatory citizen community services, ► Meeting platform ► Organized last Saturday of each month ► Occur in every community national wide	► Routinely brings community members together, many of whom would not otherwise interact or discuss issues in any depth; people get to know neighbors, participate in community beautification/infrastructure projects, discuss/ resolve problems affecting immediate environment for conflict resolutions; inspires sense of shared purpose, reinforces community connections and integration ► Mechanism for GoR to communicate directly with citizens; dissemination forum for GoR and community messaging. One of the most effective mediums of communication in Rwanda for disseminating messaging at community level (e.g., Umuganda seen as vital to national family planning efforts, access to community health services).
Umushyikirano or national dialogue: ► Annual, mandatory, public meeting for all members of government, ► Discussions on socio-economic development ► Open forum for citizens to engage with leaders and critique policies and processes ► The social media discussion platform is open and continuous; monitored by the government as a feedback loop to answer citizen's concerns.	► One of the most transparent mechanisms in the GoR to promote accountability, especially through the use of social media to ensure grievances are heard, with national feedback on implementation. Hailed as a valuable problem identification mechanism that forms consensus between national and local authorities. It is further strengthened by its being rooted in Rwanda's zero corruption policies. It acts as a forum to air grievances that would otherwise remain unsaid especially regarding rural issues.
Imihigo or performance-based contract system: ► Formal contracts between the central government and local government authorities, ► Agencies responsible for reaching self-defined targets, ► Mechanisms for creating more effective public agencies and promoting citizen's participation in health planning.	► Citizens are invited to contribute to planning discussions and to defining local performance targets as part of the contract design and indicator definition. ► One of the key homegrown mechanisms for public accountability that introduces results-based management culture into government services and engages citizens in establishing the measurement framework.
Joint Action Development Forum (JADF): ► This is a key forum for all actors within the district for participatory governance ► Operates mainly at the district and sector level but coordinated at the national level under the Rwanda Governance Board (RGB). ► All district development partners, public and private entities, civil society organizations, religious institutions, and other actors are required to participate.	► JADF staff oversee the coordination and harmonization key stakeholders within a district toward improved service delivery. ► JADF staff monitor provision of quality services according to what has been agreed upon and promised to rights holders as part of their rights to quality care. ► JADF staff in each district work with local community leaders and facility staff managers to promote active participation and dialogue between rights holders and duty bearers by sharing information and gathering feedback. ► JADF Forum recruits community member participation in health planning discussions—primarily through village leaders and CSOs—and ensures that voices have opportunity to contribute to development and service delivery strategies.

continued

Table 2: HGIs in Rwanda continued

Elements of the HGI	Connection to the community
Abunzi or community courts: Justice at the village level provided through conflict resolution and mediation via committees of elders and wise persons. It is accessible to everyone in the community	► Initiatives instrumented to ensure easy access to free of charge justice by bringing disputing parties to resolve conflict without having to go through the formal court process.
Monitoring processes and reports related to social accountability: These tools include Governance Scorecard, Rwanda Reconciliation Barometer, Rwanda Civil Society Barometer, Media Barometer, and citizen report card. (See **Annex 1**)	► Reports publish assessments across multiple sectors that highlight the performance improvements and gaps in Rwanda's governance. ► The reports from each body or mechanism are published on the Rwanda Governance Board website, which is supported by the UNDP. (https://www.rgb.rw/publications?tx_filelist_) ► These good governance tools inform and guide strategies.

4. METHODOLOGY

4.1 Assessment Design

Rwanda was selected as one of the two countries to participate in the research according to three criteria:

1. The country has a national policy to establish a social accountability program/system in health;
2. The national social accountability program/system has been active for at least 18 months; and
3. Published reports exist and are available on the social accountability program/system.

As mentioned previously, the tool has been adapted from a broader accountability assessment tool and framework (See Introduction). It specifically reviews the strength and sustainability of the national social accountability system across five domains: **structure, functionality, sustainability, effectiveness, and transformation**. For each domain, a series of questions are explored and assessed based on a criterion for each (See Assessment Instrument in Appendix I). Based on the scores, an aggregated quantitative score indicates the development maturity of the SA system at national level. Disaggregated scoring of each domain provides insight into opportunities for exploration and improvement.

An initial rapid desk review provided a synthesis of available documentation describing the national health system, policies related to SA, and implementation structures for social accountability across the five domains. The desk review provided data for scoring in each domain. Additional qualitative data collected through focus group discussions (FGDs) and key informant interviews (KIIs) enriched information from the desk research and filled gaps in the quantitative scoring, where data was unavailable through the rapid desk review. More importantly, qualitative data from interviews shed light on the system's strengths and weaknesses from the perspective of the providers (duty bearers) and the users (rights holders) of primary care and RMNCH services.

4.2 Methodological Process

The concept for this assessment was submitted to USAID and received final approval in September of 2020. The assessment design and implementation were conducted from October 2020 through May 2021. After funding was awarded, **preparation** and **inception** were carried out between October to November 2020.

A study protocol was submitted to the Republic of Rwanda National Ethics Committee (RNEC) in October 2020, and a presentation of the project was presented by the national co-investigator Cassien Havugiman. A contingent ethical approval was received in January 2021, with Ref. No. 026/RNEC/2021; and requested revisions were completed and submitted in February 2021.

Data collection, carried out between February and April 2021, included a rapid desk review and field assessment, including KIIs and FGDs at national, sub-national, and community level. The rapid desk review collected relevant data from: 1) available published peer-review journal articles of the last 10 years from international and local researchers; 2) open-source data provided by the World Bank and other global agencies and government policies, strategic plans, laws, budgets where available, and other relevant government documents or reports; and 3) reports and studies from civil society organizations, donors, and implementing agencies.

Field assessment interviews began in March 2021 and continued through May 2021, with some delays due to COVID 19 government office closures and meeting postponements. Respondents included decision makers and managers (duty bearers) and beneficiaries (rights holders), and interviews were carried out at national, subnational and community levels of the health system. KIIs and FGDs were carried out either face-to-face or virtually. Field interview guides were used as prompt in a flexible fashion for the qualitative questions to be contextualized with local language and custom. This facilitated interviewees to raise additional or complementary issues, while remaining structured and controlled for consistency.

Before conducting KIIs and FGDs, information letters, and oral or written consent forms were obtained from all the participants. Consent form contents were explained verbally, including the purpose of the study, its funding, and the use of the data. All study participants were informed that their

participation was voluntary, that no remuneration would be provided, and that all responses were confidential and anonymous. FGD participants were directed to respect the confidentiality of other group participants and to refrain from sharing participant names or responses outside of the group. Data collectors explained that KII and FGD participants had the freedom to decline participation, decline to respond to any specific question, or withdraw from the interview at any point during the KII or FGD. They were also invited to interrupt at any time to ask questions or request clarification. All the KIIs and FGDs were audio-recorded in the participants' preferred language, which was either English or Kinyarwanda, and transcribed and translated.

4.3 Sampling

The sampling was purposive. The assessment team identified: a) key government informants from national, sub-national, and community (or district) levels government with knowledge of Rwanda's health system and the existing platforms of SA; b) global and bi-lateral agencies working in health and social accountability; c) project implementers identified by USAID or CSO stakeholders; d) CSOs working with community youth and women who use primary health and RMNCH services; and d) community members who were identified per their availability, based on support from CSOs working with youth and women in the targeted districts. The Kicukiro and Nuarugenge districts of Kigali city, the Nyaruguru district from the Southern Province, and the Rusizi of the Western Province. These were selected to provide a broad sampling of rural and urban locations, varied populations, and locations where there was information readily available on the social accountability activities. USAID Rwanda provided guidance and support in identifying CSOs working in community health and in identifying relevant project implementers who might have useful insights on SA mechanisms in the target districts.

Some of the contacted key informants did not respond to requests to participate in the study or repeatedly postponed the dates of the interview until it was not possible to schedule the interview due to the timeline of the study. The small size of the study and the limitations for face-to-face meetings due to COVID 19 created challenges in reaching a wide range of government representatives and community groups. For more information on limitations, see section 4.5 below. A total of 30 respondents participated, 16 community members participating in FGDs and 14 participants in KIIs. [See **Table 3**: KII and FGD Participants]

4.4 Data Analysis and scoring

Data Analysis and scoring was conducted in May 2021. Each domain consists of questions, and a score criteria for assessing the factor. Scoring of the assessment was informed primarily from the findings of the desk review and confirmed through the responses provided in the FGDs and KIIs.

Interviews were audio-recorded, transcribed verbatim, and translated. Each transcription was given an ID number that was used for analytical purposes. Field notes taken during interviews facilitated the analysis. The National co-investigator and a data collection assistant conducted a data analysis workshop to validate the translation of the responses and agree upon the steps of analysis of key words and phrases using a codebook. The data analysis involved line-by-line coding of the data to recognize the patterns and links between the concepts highlighted by the participants. After the development of the preliminary set of codes, the team conducted multiple rounds of coding until there was consensus on the identification of codes and the subsequent definition of each code as related to the five domains. These codes provided the basis for data analysis. Researchers used Dedoose qualitative software for the qualitative analysis.

Specifically, qualitative data from the KIIs and FGDs provided context for the scoring, providing a snapshot of the SA system's functionality, effectiveness, sustainability and transformative properties. Questions were also asked to determine rights holders' experience regarding the quality of primary health care services they received and service responsiveness to their needs and concerns, focusing on RMNCH services. A development maturity score was then produced for each of the five domains, and a total score informed scoring of the development maturity level of the SA system.

Scores were assessed for each of the five domains, ranking conformity to the question. Overall, a **score of zero** denotes that structures do not exist, that there is no evidence available, or that the answer is unknown. A **score of one** is used when minimal data or evidence that the structure/processes exist (e.g., a program/system exists on paper but there is no evidence of it as operational). A **two score signifies** that structures or processes partially conform (e.g., a program/system is in place but is not fully functional). A **score of three** reflects that the structure or processes fully conform to the purpose at all levels (e.g., program/system is in place and is functional as a social accountability system at national,

Table 3: KII and FGD Participants

Type of Stakeholder	Target Group	KII	FGD	Sample size	Total Respondents	Level and Reason for Sampling
Public Institutions: National Level Government	Ministry of Health representatives	2		2	2	Two respondents selected due to their working in maternal and child health
Public Institutions: Sub-National Level Government	District Level Management Team: Director of Health	1		4	4	Purposive sampling from those responsible for overseeing the quality of health care services in the above-mentioned 4 targeted sample districts.
Development Partners	USAID Rwand		1	3	3	FGD with 3 people working for USAID (working in health systems, community health, and governance)
	UNICEF Rwanda	1		1	1	UNICEF Organizational representative working in SA in health
	World Bank	1		1	1	World Bank organizational partner working in health financing
Stakeholders: Civil Society Organizations	Rwanda Civil Society Platform (RCSP)	1		1	1	CSO umbrella organization facilitates citizen's participation in development decisions and facilitates cross-learning and support among local CSOs that support sustainable development. Funded by Rwandan government entities, local CSOs, and international agencies and country bi-lateral agreements.
	Rwanda Network of People Living with HIV (RRP+)	1		1	1	Supports people living with HIV/AIDS
	Never Again Rwanda (NAR)	1		1	1	Supports and promotes youth and university students in leadership and peace building. Funded by USAID.
	Health Development Initiative (HDI)	1		1	1	Promotes inclusive development and equal access to health services. Funded by multiple international agencies, local foundations, the GoR, and bi-lateral country support, including from USAID.
	ACHIEVE Project Rwanda	1		1	1	USAID/Rwanda's ACHIEVE project task order supports two local CSO's in advancing adolescent girls and young women, youth living with HIV/AIDS, and orphans and vulnerable children and families. Funded by USAID, with support to CSOs funded by local foundations, the GoR, and international agencies.
	Centre for Rule of Law Rwanda (CERULAR)	1		1	1	Promotes social justice and accountability. Supported by RGB, and multiple local CSOs.
Rights Holders: Youth/girls association	Afriyan Rwanda	1		1	1	CSO that tracks progress on regional and international commitments on sexual reproductive health rights and advocates policies to improve health of youth people and girls.
Rights Holders: Community Members	Members of the community committee or action group linked to primary health care facility in Districts of Kigali		2	8	16	Two separate focus group discussions: one with youth and one with women.
TOTAL		**12**	**3**	**16**	**34**	

Table 4: Assessment Tool domains and definitional criteria for scoring

Domain	Questions	Definition
Structure	1. Is there a national SA program or system in Rwanda? If so, how long have policies in existence with information easily accessible to citizens? 2. Are there policies and legal constructs in place to establish the institutionalized social accountability program or system? 3. Do the subnational and community levels of government include a social accountability process in their strategic plans? 4. Are there social accountability bodies or structures (committees or social action groups) at each administrative level identified in question #3 to ensure participation of rights holders and continuing communication and inclusion between duty bearers and rights holders? 5. Are there processes for interaction between the social accountability bodies or structures (committees or social action groups) at each of the relevant administrative levels listed above? (Note: By interaction, it is meant two-way sharing of information or feedback loops) 6. Does an accountability platform for registering grievances exist? 7. Is there a national policy that protects rights holders, stating that anyone who submits a grievance will not suffer retribution?	'Structures' refers to national policies that codify a social accountability intention so it can be institutionalized and systems that define how that policy will be applied. For this assessment only countries that had some sort of SA policy or policies in place for at least two years were eligible. Also included in 'Structures' are strategic plans (or strategies) with processes that translate intent into an implementing framework whereby policies may be operationalized. Fourth, an essential structure for an accountability program or system are feedback loops
Functionality	1. Does an M&E process exist (i.e. - a process for data collection of and reporting on a set of standard national indicators)? 2. Is the national social accountability program or system budgeted? 3. Is the redress system accessible to all rights holders?	The Functionality of the national SA system in health refers to what extent the existing social accountability platforms are functioning to ensure active participation of citizen and other key stakeholders to improve health systems in Rwanda. To ensure the functionality of the government social accountability structures, the functionality score assesses if: 1) there are monitoring and evaluation processes in place; 2) budgets exist to support the SA systems in the country; and 3) the system is accessible to all rights holders.
Effectiveness	1. Do performance criteria for staff include the fulfillment of SA responsibilities that respond to rights holder needs? 2. Are M&E findings on the performance of the SA system (i.e., the duty-bearers' responsiveness to rights-holder complaints) shared back with the community (i.e.: on public platforms such as the MoH website; or through other public communication mechanisms)?	By the term "Effectiveness" we refer to the extent to which the SA system is positioned to achieve SA objectives. For example, the level to which duty bearers respond to rights holders' needs and complaints should be reflected in their performance reviews. Rights holders must be held accountable and have incentive to be responsive and steer the accountability of the system. In addition, the SA system's performance should be monitored with reports on the average response time to grievances, number of grievances that were solved, and changes or improvements that were made as a response to grievances or service delivery improvements that were accomplished.

Table 4: Assessment Tool domains and definitional criteria for scoring continued

Domain	Questions	Definition
Sustainability	1. Are the M&E processes for the SA program / system institutionalized (or mainstreamed /normalized within the institutions)? 2. Is there a mechanism for the rights holders to approve of and/or participate in the development of the social accountability strategic plan objectives? 3. Does the budget fund at least one person to be responsible for managing the SA process? 4. Do budget line items support the SA program/ system activities and materials in three health administrative levels (national level, sub-national level, and community level)? 5. Is the responsibility for M&E of the SA program/ system assigned to an MoH staff member and included in his/ her job description? 6. Are annual trainings held for participating staff (MoH) and stakeholders (MoH, NGO, and/or CSO) on the principles and practices of the SA program/ system? 7. Do job descriptions of all duty bearer staff at all levels include a statement or description of their responsibility to rights holders?	The Sustainability domain explores factors that position the SA program/system in health to continue autonomously through its being institutionalized by laws and regulations and supported by funding. This measurement requires that the structure not only exist, but that some type of legal or regulatory framework must be in place to enforce common standards. This 'Sustainability" domain also goes a step further than the 'Functionality" domain with regard to financial autonomy. For example, it requires that there be not only budgets for programmatic support, but that there be budget line items to support staff assigned to drive the national SA structures. Monitoring and evaluation must be not only functional, through a structure for and process of data collection and evaluation, but also sustainable with a data management system that is integrated across all levels, with capacity for consistent dissemination of information and transparency of results.
Transformation	1. Is the SA program / system self-sustaining (demonstrating self-reliance through both national commitment and national capacity)? (This question addresses both technical and financial sustainability.) 2. Have Provider performance indicators improved? 3. Have health service indicators improved? 4. Have rights holders' satisfaction with the health system improved? 5. Have population level RMNCH health outcomes improved?	The Transformation domain discusses potential markers of lasting change in Rwanda's health system and health outcomes as a result of SA programs and policies. It goes beyond sustainability, which stems from institutionalizing practices and providing resources to sustain them and extends to incorporate shifts in attitudes of rights holders and duty bearers and the self-reliance of SA within health governance systems. The transformation domain also looks at whether the program or system is self-reliant, to which questions were asked about capacity and will. The transformation domain also looks at the results of the national accountability program/ system, asking if services and health outcomes have improved.

sub-national, and community levels). With each increasing score, there is evidence, through the desk review or through interviews, that these structures exist at each level of the three health system administrative levels defined for this analysis: national (or central), sub-national (province), and community (district and below). Determination of the score is drawn from documentation and key stakeholder opinion when there is no documentation. Additional input from stakeholders added insights and guided further exploration for understanding barriers, but rarely were reflected in the scoring unless it clearly addresses the criteria. Bias has been mitigated through triangulation of the responses received when possible.

Reporting provided an overview of the two country findings and the strengths and recommended improvement of the assessment instrument, as well as the individual findings from each of the two country investigations.

4.5 Limitations

COVID 19

Due to COVID-19 pandemic, the approach of data collection and the logistical plan were revised whenever there were changes to COVID 19 lockdowns restrictions, including restrictions on movement, permissions to convene, and limits to size of group meetings. COVID-19 led to a number of delays. Initially, there was a delay in the review and approval process with Rwanda's Institutional Review Board (IRB) ethical approval. This delay added eight weeks to the approval process. The country co-investigator fell ill during the data collection period, which also resulted in additional postponements. Delays in themselves do not skew results. However, stopping and starting in data collection interrupts flow of thought and can disrupt the consistency of interviews.

COVID-19 restrictions required that CSO partners in the field convene small groups of beneficiaries for FGDs rather than allowing the co-investigator to travel to pre-determined locations as planned.

COVID-19 restrictions also limited some access to documents located at the Ministry of Health at national, sub-national, and district level that would have allowed analysis of provider performance evaluations, job descriptions, local budget details, and local strategy documents, particularly as they related to specific RMNCH services. It also limited the sample pool of respondents as mentioned above in Sampling section.

Funding

The limited funding available allowed for a very small sample size, and additional pools of respondents might have allowed further investigation into the environmental enablers that promoted or inhibited roll-out of the SA system across the country as well as broader beneficiary interviews to capture a wider rights holder experience on the performance of the system as it influences the RMNCH services specifically.

Broadened scope

In addition to the COVID-19 delays and funding constraints, there were requests from USAID/Rwanda that additional interviews be pursued with representatives from other USAID-supported projects which proved to be useful but extended data collection.

Limited Sample Representation

Due to both the COVID-19 restrictions affecting access to community members and the limited funding to pursue broader reach of sampling, researchers were limited in convening focus groups specifically to discuss RMNCH services. Researchers particularly note the gap in the limited access to pregnant women and mothers of under five children. Due to time and travel limitations, specific respondent groups representing marginalized populations, for example persons with disabilities (PWDs), were not sought to include in the sampling. Including PWDs, as well as ethnic, cultural, or religious minorities will be helpful in guiding countries to recruit greater participation in the health system among marginalized communities.

While the purpose of the assessment was to capture a snapshot of the SA system that benefits from larger sample pool, it does not require it. Nonetheless, it is expected that there was some bias due to: 1) limitations of our sample size and respondent availability; and 2) common origins of the pool of respondents from which we selected. Both or either of these factors may skew results in a positive direction.

5. FINDINGS

5.1 Structure

The development maturity score for the Structure domain of the National Program/System for Social Accountability for Health is 18/21 (86%).

The purpose of the Structure domain is to identify if structures have been established on which a national SA program or system may function. 'Structures' refers to national policies that codify a social accountability intention so it can be institutionalized and programs that define how that policy will be applied. For this assessment, only countries that had some sort of SA policy or policies in place for at least two years were eligible. Also included in 'Structures' are strategic plans (or strategies) with processes that translate intent into an implementing framework whereby policies may be operationalized. Fourth, an essential structure for an accountability program/system are feedback loops; the 'Structure' domain asks if vehicles (platforms, practices, or processes) for communication between rights holders and duty bearers. Fifth, Structures must be bodies, such as a division or agency within the government and civils society groups that are linked across the three levels of government (national or central; sub-national, which in Rwanda include provinces and districts; and community, which are structures below the district level, such as sectors, cells, and villages. For a national accountability program/system to be considered 'in place', bodies that implement the system must be established at each of the three levels and must have a process and platform for collaborating and coordinating. Finally, the 'Structure' looks at whether a platform has been established through which community members can register grievances.

Below the scores are defined with justification.

1. **Is there a national SA program or system in place in Rwanda? If so, how long have policies in existence with information easily accessible to citizens?**

Score: 3/3

Score	Criteria
3	Yes, a policy has been in existence for at least five years with information accessible through a public platform, such as an MoH website.
2	Yes, a policy has been in existence for five or more years with no publicly accessible information (website; published and disseminated reports, etc.).
1	Yes, a policy intended to institutionalize a social accountability process at national level has been in existence between 2 to five years.
0	Yes, a policy intended to institutionalize a social accountability process at national level has been in existence for less than two years.
0	N/I = No information
0	N/A = Not applicable

Justification: A written national policy exists, and the national health strategy includes steps for operationalizing it. In fact, several policies and plans enabling and promoting social accountability have shaped the structure of Rwanda's national system for SA in health. Between 2015 and 2020, the GoR has put in place a SA system for health through multiple policies and strategies that mutually complement and reinforce a comprehensive effort toward achieving a health system that is responsive and accountable to the constituents it serves. Those policies and strategies include the Governance and Decentralization Sector Strategic Plan 2018/19 – 2023/24, MNCH National Strategic Plan 2018 – 2024, the National Community Health Policy (2015), the Human Resources for Health Policy, Health Sector Policy 2016, the Fourth Health Sector Strategic Plan, and the Health Financing Strategic Plan 2019 -2024. These policies align with Rwanda's Vision 2050, which emphasizes local ownership, self-reliance, and accountability.

Further, written guidelines specifically direct the implementation of a redress mechanism in the health system, whereby complaints are addressed and solved. Having Information freely available to the public online and through regularly held meetings allows individual citizens to access information as to the progress of service improvements; and citizens may directly communicate with the national and

subnational government representatives, including the filing of complaints and the receipt of responses from the cell level to the central level, via phone, online dialogues, and in-person public forums.

2. Are there policy and legal constructs in place to establish the institutionalized social accountability program or system?

Score: 2/3

Choices for the Respondent:

a. A written national social accountability policy exists.
b. The national health strategy includes steps for operationalizing the social accountability policy
c. Written guidelines or legal constructs to support implementation exist
d. Guidelines specifically direct the implementation of the redress mechanism

Score	Criteria
3	3 = Yes to all four (a,b,c,d)
2	2 = Yes to a, b, and c
1	1 = Yes to a and b
0	0 = Yes to a
0	N/I = No information
0	N/A = Not applicable

Justification: There are national policies, and national-, district- and community-legal constructs, including community courts that enable citizens to present their legal complaints publicly, and receive a hearing, through which duty bearers must respond and offer a remedy. To further strengthen accountability of duty bearers to rights holders, the government of Rwanda established in 2012 a Law No. 49/2012, which instituted medical professional liability insurance including the medical service user's rights and responsibilities of the service providers. The law also defines compensation benefits for healthcare users who, due to failure of the health system to provide necessary services, become incapable due to provided services.[76] While the law is a good step towards increased accountability by the health system, the law has not yet been made known throughout the communities; and rights holders may lack knowledge of their legal rights. This lack of dissemination of the law renders it insufficient as a legal protection. In addition, this law may lead to unintended negative consequences, creating obstructions to access when providers hesitate to provide care when they may be liable if the results are not positive.[77]

One respondent commented on this deficiency:

> *"We need to educate healthcare service users on their rights and the law on medical liability and the insurance law that talks about rights of patients and health service users but also obligations of service providers as duty bearers."*
>
> *– CSO Representative*

Despite these policies institutionalizing social accountability, with legal constructs to support it, the score for this question is a 2 because of the limitations mentioned above.

3. Do the subnational and community levels of government include a social accountability process in their strategic plans?

Score: 3/3

Score	Criteria
3	Some District (or woreda, parish, or similar) and/ or community strategic plans incorporate social accountability processes.
2	The social accountability program/ system processes are part of the national and sub-national plans (provincial, regional, county, or other sub-national administrative level)
1	The social accountability program/system processes are part of the national strategy but not included in the sub-national plan (provincial, regional, county or similar) strategies
0	The social accountability program/system is not yet incorporated at national level.
0	N/I = No information
0	N/A = Not applicable

Justification: Processes for implementing social accountability are included in strategic plans. First, the process of planning in itself incorporates mechanisms for rights holder participation. Technical working groups are active as key mechanisms to engage and include the public in the planning process at sub-national level. For example, the JADF (Joint Action Development Forum) is a multi-stakeholder platform that convenes public sector representatives, private

sector actors and civil society groups to discuss health and social services development initiative proposals and provide input on decisions for implementation or improvement. Also at subnational level, Rwanda has a program of *Imihigo*, through which local authorities are obligated to reach targets specified in public performance contracts (*Imihigo*) led by district mayors. The program includes a standardized process through which village members are included in the oversight and feedback on whether and how well the contract's obligations are met. The village, Rwanda's smallest political-administrative entity, has its own process for priority setting, including the collective identification of problems, priorities, and solutions, which are incorporated into the strategies for embedding social accountability processes into the community health system strategies. Village leaders (chiefs) are volunteers elected by village residents and come together as a Cell Council (The cell is next higher community administrative level) to bring the voices of their villagers to address and evaluate technical and key political issues. These issues, including health service complaints, are expressed and addressed to duty bearers at the *Imihigo* meetings.

4. **Are there social accountability bodies or structures (committees or social action groups) at each administrative level identified in question #3 to ensure participation of rights holders and continuing communication and inclusion between duty bearers and rights holders?**

Justification: There are bodies or structures for communication and interaction at each administrative level. The *Umushyikirano* is a structure that enables formal communication between community, sub-national, and national level. It is considered one of the most transparent forms of communication where rural citizens can make their concerns known to national government. It is an annual open meeting where citizens may voice their concerns, in person, or through social media and other means. Qualitative evidence from interviews cautions that there are challenges in this mechanism to the extent to which the dialogue is powered by the national government at its own schedule, rather than being scheduled by citizens or at citizen's request. Most of the communication is at the local level with dialogue and between local and sub-national level. Who participates however in such meetings is unclear (though this was not specifically explored in the question).

When asked if communication and interaction structures exist between rights holders and duty bearers, one respondent answered:

Score: 3/3

Three administrative levels considered are:

— national
— sub-national (provincial, state, municipal)
— community (all levels from district / parish or below)

Score	Criteria
3	There are communication and interaction structures at three or more different levels that ensure continuing communication feedback loops between duty bearers and rights holders.
2	There are communication and interaction structures that ensure continuing communication feedback loops between duty bearers and rights holders at two different levels (national and sub-national, sub-national and community, or community and national).
1	There are communication and interaction structures at only one level (national or sub-national or community) that ensures communication feedback loops between rights holders and duty-bearers.
0	There are no interaction or communication bodies/structures at any administrative level that would allow for feedback loops between duty bearers and rights holders.
0	N/I = No information
0	N/A = Not applicable

"I now chair one of the JADF forums. As chair, part of my mandate is to ensure that I interest all the stakeholders to participate, coordinate and link them with the district and we set priorities together. We monitor the implementation of the district priorities and ensure that they are being implemented based on the agreed upon agenda. We work with other stakeholders to ensure that citizens are respected, and their voices, we follow up to see if the feedback from citizens is being integrated into the follow up of actions following the implementation of their priorities, so yes, we participate in a number of them."

– CSO Representative

5. **Are there processes for interaction between the social accountability bodies or structures (committees or social action groups) at each of the relevant administrative levels listed above? (Note: By interaction, it is meant two-way sharing of information or feedback loops)**

Score: 3/3

Score	Criteria
3	There are processes for interaction (two-way sharing of information; feedback loops) across the SA structures at all three administrative levels (national, sub-national, and community).
2	There are structures or processes for interaction between the sub-national and the community level, but they don't reach the national level.
1	There are structures or processes for interaction between national sub-national levels and one other level but not the third level.
0	There are no structures that allow interaction between the national level and other levels.
0	N/I = No information
0	N/A = Not applicable

Justification: Administrative councils at community (at cell and sector levels), sub-national, and national levels bring community rights holders representatives across levels together to express complaints, assessments or concerns to public representatives. These councils also serve as a platform for feedback loops through which responses and information is disseminated from duty bearers to stakeholders. Representatives from these councils participate in the *Umushyikirano*, or national dialogues, which engage citizens at community, sub-national (district) and national level in two-way communication for resolving complaints and planning improvements. Along with these HGIs, Rwanda has also implemented modern technologies to facilitate communication. For example, the RapidSMS program allows community health workers to communicate directly with the Ministry of Health, with the primary goal being to improve MNCH service delivery to be more responsive, so as to increase uptake of maternal and newborn health services. It should be noted however, that one study found that this process did not demonstrate to increase uptake of maternal and newborn health services in Rwanda.[78]

When asked about the existence of processes for interaction between the social accountability bodies or structures (committees or social action groups) at each of the relevant administrative levels, one KII respondent answered:

> *"I think Rwanda has a number of spaces and policies that provide for social accountability. When you look at national level, we have spaces like Umushyikirano (national dialogue), Umwiherero (national retreat), etc. which enables the national dialogue, where different representatives of citizens are engaged, and they participate."*
>
> *– CSO Representative*

6. **Does an accountability platform for registering grievances exist?**

Score: 3/3

Score	Criteria
3	There is a platform for grievances that includes a process for tracking responses, and a time limit mechanism through which a response must be received within a certain amount of time and there is consequence to non-compliance of duty bearers.
2	There exists a platform for grievances that includes a process for tracking responses, and a time limit mechanism through which a response must be received within a certain amount of time.
1	There exists a platform for grievances that includes a process for tracking responses.
0	There are no platform for registering grievances and tracking responses.
0	N/I = No information
0	N/A = Not applicable

Justification: There are several formal platforms for registering grievances. Across the country, radio discussions are held regularly and are open to the public to call in and register grievances and confront duty-bearers directly. Second, the MoH website allows rights holders to file grievances online. Within many communities across the country there are institutionalized practices using Community Score Cards (CSC), through which communities and providers convene and evaluate the performance of the services and plan solutions to gaps.

While there are platforms for relating grievances, follow up or action based on the grievance was less clear. This point is taken up in question #7 below.

Respondents noted that multiple structures have been established to promote SA in Rwanda and ensure citizen participation at all levels of the government from central level to the community level.

> *"What I can say is that there are many mechanisms that enhance social accountability. There is Imihigo, the Joint Action Development Forums where development partners and other stakeholders meet with leaders at district level; and there are also administrative councils at the sector level, cell level and district level."*
>
> *– Development Partner*

> *"There is also the National dialogue, and they put a line, where they tweet, or write in using WhatsApp, and broadcast on radio too. The President usually heads that radio dialogue and the citizen speaks directly to the President."*
>
> *– Civil Society Organization*

7. **Is there a national policy that shelter the rights holders, specifically stating that no one who submits a grievance will suffer retribution?**

Score: 3/3

Score	Criteria
3	All MoH Staff is required to be trained or oriented on the rights and protections of right-holders to file grievances without retribution.
2	All public facilities and offices are required to publicly display the policy of that protects the rights holders to submit grievances without retribution
1	There is a national policy that protects rights holders who file a grievance.
0	There are no national policy protecting rights holders who file a grievance.
0	N/I = No information
0	N/A = Not applicable

Justification: This score is low because even though community members report active participation in registering grievances, in open town hall meetings, in small facility score-card meetings, and on social media accounts, there is still no law that specifically protects rights holders from retribution. Rwanda has put in place a law that provides access to information, including freedom of press, expression, and access to information in its article 38 of the constitution. However, if the grievances lodged against the health system—or against other government services—are found to be capricious, then the rights holder could face prosecution. There are no clear guidelines for what grievances are, or are not 'capricious'; thus, the determination is completely subjective and made by duty bearers—thus adding risk of retribution in itself),

The organic law N° 61/2008 of 10/09/2008 on the leadership code of conduct, modified and complemented by Organic Law n° 11/2013/0L of 11/09/2013 in article 34, also protect informers and witness in the courts but does not indicate the protection of other people that submit a grievance or other claims or of whistleblowers, even if this might be interpreted as a protection of any informers and witnesses.

Therefore, the score is 1 out of 3.

Figure 1 shows the various platforms made available to rights holders to engage in debate, lodge a complaint, or contribute to planning at the various levels.

5.2 Functionality

The Functionality of the national SA system in health refers to what extent the existing social accountability platforms are functioning to ensure active participation of citizen and other key stakeholders to improve health systems in Rwanda. To ensure the functionality of the government social accountability structures, the functionality score assesses if: 1) there are monitoring and evaluation processes in place; 2) budgets exist to support the SA mechanisms in the country; and 3) the SA system is accessible to all rights holders.

The development maturity score for the Functionality domain of the National Program for Social Accountability for Health is 6/9 (67%).

Based on three questions from the scoring element of the assessment instrument, the individual results are the following:

Figure 1. Three Levels of various mechanisms for citizen participation in the health system

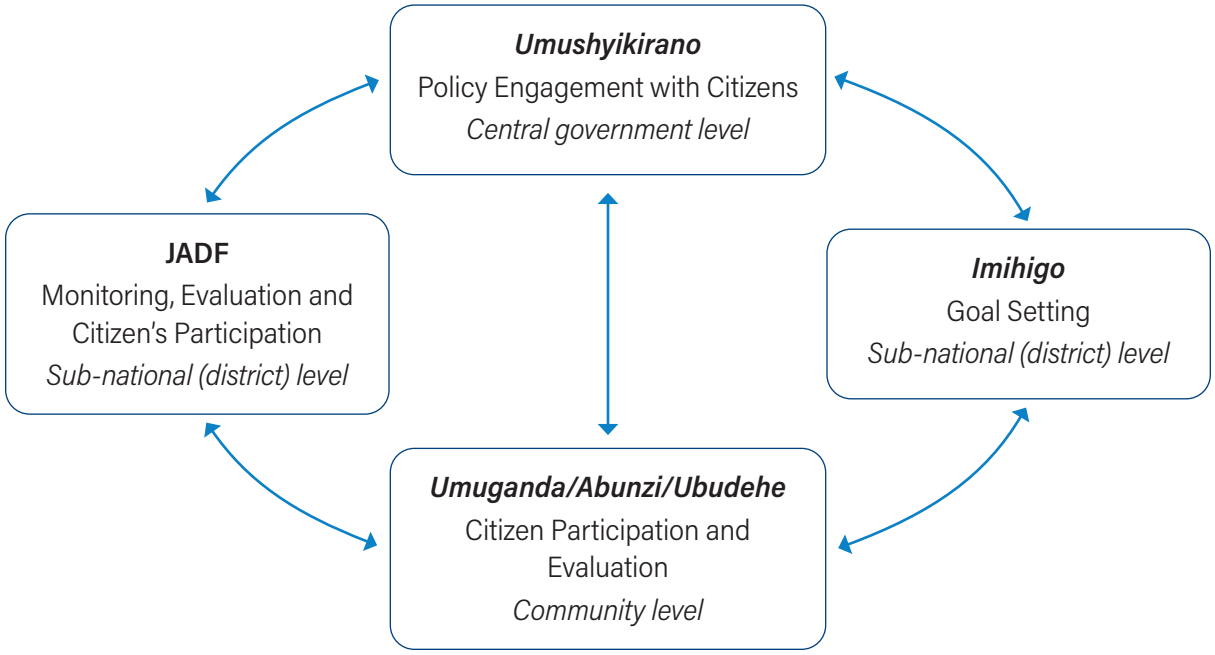

Table 5. Analysis of 'Structure' Domain

Question	Score	Justification
1. Is there a national SA program/system in Rwanda? If so, how long have policies in existence with information easily accessible to citizens?	3/3	A written national policy exists, and the national health strategy includes steps for operationalizing it. In fact, several policies enabling and promoting social accountability have shaped the structure of Rwanda's national system for SA in health. Further, written guidelines specifically direct the implementation of the redress mechanism, whereby complaints are addressed and solved.
2. Are there policies and legal constructs in place to establish the institutionalized social accountability program or system?	2/3	There are national policies, and there are and national-, district- and community-level legal constructs, including community courts, that enable citizens to make their legal complaints. However, the legal constructs are deficient.
3. Do the subnational levels of government include a social accountability process in their strategic plans?	3/3	Yes, processes for implementing social accountability are included in strategic plans at national, sub-national, and community levels. In additional the process for establishing health strategies has institutionalized processes for engaging public participation.
4. Are there communication and interaction structures at national, subnational, and community levels that ensure continuing communication feedback loops between duty bearers and rights holders?	3/3	Yes. The *Umushyikirano* is a structure that enables formal communication between community, sub-national, and national level. It is considered one of the most transparent forms of communication where rural citizens can make their concerns known to national government.

Table 5. Analysis of 'Structure' domain.

Question	Score	Justification
5. Are there processes for interaction between the social accountability bodies or structures (committees or social action groups) at each of the relevant administrative levels listed above? (Note: For this assessment, 'interaction' is defined as a two-way sharing of information or feedback loops)	3/3	Administrative councils at community (at cell and sector levels), sub-national (district) and national (central) levels bring community rights holders representatives together to express complaints, assessments or concerns to public representatives and to receive reports on how complaints have been or are being addressed.
6. Does an accountability platform for registering grievances exist?	3/3	There are several platforms through which community members may file grievances, both for those who have internet access and those who do not. The MoH website, radio discussions with duty bearers, and community score cards are examples of institutionalized processes at all levels that allow rights holders to register grievances.
7. Are there protections within the national policy that shelter the rights holders, specifically stating that no one who submits a grievance will suffer retribution?	1/3	Despite evidence of active participation of community members in registering grievances, in open town hall meetings, there is no law that specifically protects the rights holders from retribution if they lodge health system grievances.

4. Does an M&E process exist (i.e., a process for data collection of and reporting on a set of standard national indicators)?

Score: 3/3

Score	Criteria
3	The M&E process incorporates indicators from all administrative levels; AND reports on the combined results are regularly shared at all levels.
2	The M&E Process includes input from at least two administrative levels, but results are not regularly shared.
1	There is an M&E process at national level but does not include input from other administrative levels.
0	There is no M&E Process.
0	N/I = No information
0	N/A = Not applicable

Justification: Monitoring and Evaluation is conducted and reported at all three administrative levels. Data managers operating at almost all health facilities in Rwanda carry out data management from the health centers to the sub-national and central level and then report publicly through the HIMS.[79, 80] Public availability of HMIS data, even across most facilities, is important in accountability. More importantly, metrics and processes for monitoring the SA system itself is critical to the functionality of the national SA system. Rwanda does have metrics and annual reporting practice through the Rwanda Governance Score Card.[81] The score card is one of the accountability reports published by the Rwanda Governance Board, an independent commission that is supported by a partnership between the Rwanda Government and the United Nations Development Programme (UNDP). The score card monitors and reports on several domains directly related to the government's performance in social accountability, including 'Quality of Service Delivery,' 'Participation and Inclusiveness,' and 'Fighting Corruption, Transparency, and Accountability.' This monitoring process is not exclusive to but is inclusive of indicators that address Rwanda's social accountability in health, such as '% of citizen satisfaction with service delivery in Health sector,' 'local administration accountable to the citizens,' and 'advocacy on citizens' complaints.'

5. **Is the national social accountability program or system budgeted?**

Score: 1/3

Score	Criteria
3	There are SA program/ system budget line items at national, sub-national, and community levels.
2	There are SA program/ system line items in the budgets of national and sub-national administrative levels
1	There are SA program/ system budget line items at national level only.
0	There is no / are no line items in the national budget for the SA program/ system.
0	N/I = No information
0	N/A = Not applicable

Justification: There are budgets mentioned by respondents in the FGDs and KIIs, but specific budgets themselves were not retrieved within National Strategic Plan documents. In general, all the existing SA mechanisms are included in the national budget, but most are at the national level only. (Note, SA program elements may be budgeted at sub-national and community levels, but budgets were not able to be accessed or retrieved.)

6. **Is the redress system accessible to all rights holders?**

Score: 2/3

Score	Criteria
3	The redress system is used at all three levels (national, sub-national, or community).
2	The redress system is used only at two levels (national, sub-national, or community).
1	The redress system is used only at one level (national, sub-national, or community.
0	The redress system is not used.
0	N/I = No information
0	N/A = Not applicable

Justification: There are processes at all three administrative levels for citizens to access the redress system, but rights holders report gaps. Most citizens have access to the redress system through the *Umushyikirano* (National Dialogue). In addition, sub-national and community level processes provide accessibility through online outlets, media outlets such as radio programs, and community in-person SA meetings, such as score card processes. These redress processes, including the community level SA meetings, all link individual complaints with the national SA redress system and allow for participation even in low-resourced and rural facility catchment areas. Despite the reach of accessibility to provide feedback and to receive response at all three administrative levels, FGD respondents did report gaps. For example, some rights holders do not have the opportunity to voice their input into reports or policy designs due the timing parameters of reporting and submission. In addition, sometimes the methods for contributing to feedback on services are not used by the rights holders. Therefore, despite availability and potential for access, this score was decreased by one based on respondent contributions during FGDs.

One KII respondent saw the SA system as widely accessible.

> *"...Different systems that are in place, those are things that the government has done to ensure access ..... we can see how we are progressing in terms of how many deliveries are happening in hospitals, etc"*
>
> ***– Development Partner***

When asked if the SA process was accessible to all citizens, one respondent pointed out inclusion gaps:

> *".... when it comes to effective contribution by all these actors, there are still gaps. One of the areas is, how do we ensure that citizens' voices are strengthened, citizens are empowered to be able to confidently raise their issues, to track if the issues that are raised are being addressed, so there is a lot of work that needs to be looked into."*
>
> ***– CSO Representative***

A rights holder also pointed out gaps in the accessibility of ways to submit grievances:

> *".... suggestions boxes and phone numbers! However, for suggestions boxes when you look at them, they are just there. People do Not use them! One day I actually checked to see and found that there is nothing inside them; even the pad lock has got rust! You find that people do not use the suggestion boxes, I don't know why! Even for the phone numbers, a person might get bad services but won't remember to call the numbers."*
>
> ***– FGDs with young people***

Table 6: Analysis of 'Functionality' Domain

Question	Score	Justification
1. Does an M&E process exist (i.e., a process for data collection of and reporting on a set of standard national indicators)?	3/3	Monitoring and Evaluation of RMNCH indicators is conducted and reported at all three administrative level—even in 80% of facilities. However, despite consistent HMIS reporting, there are no metrics or processes by which to monitor and publicly report on the performance of the SA system
2. Is the national social accountability program/ system budgeted?	1/3	There are budgets mentioned in the FGDs and KIIs, but specific budgets themselves were not retrieved within National Strategic Plan documents. Further budgets for the SA activities were only defined for national level SA activities and were not found for sub-national or national level. (Note, that budgets were not able to be collected at sub-national or community levels)
3. Is the redress system accessible to all rights holders?	2/3	There are processes at all three administrative levels for citizens to access the redress system, but rights holders report gaps.

5.3 Effectiveness

"Effectiveness" refers to the extent to which SA system is positioned to achieve SA objectives. For example, the level to which duty bearers respond to rights holders' needs and complaints should be reflected in their performance reviews. In addition, the SA program's performance should be monitored with reports on the average response time to grievances, number of grievances that were solved, and changes or improvements that were made as a response to grievances or service delivery improvements that were accomplished.

The development maturity score for the Effectiveness domain of Rwanda's national program/system for Social Accountability for Health is 3/6 (50%).

Key questions asked within the scoring element of the assessment instrument:

1. **Do performance criteria for staff include the fulfillment of SA responsibilities that respond to rights holder needs?**

Score: N/I (0/3)

Score	Criteria
3	Performance reviews at national, sub-national, and community levels include criteria to measure staff's responses to rights holders' needs.
2	Performance reviews at national and sub-national levels include criteria to measure staff's responses to rights holders' needs.
1	Performance reviews at national level only include criteria to measure staff's responses to rights holder's needs.
0	There are no staff performance criteria tied to implementation of SA program/ system (responding to rights holders).
0	N/I = No information
0	N/A = Not applicable

Justification: No performance reviews were accessible to evidence staff fulfillment of SA complaints. As a result, evidence of individual accountability of the staff and managers to be responsive and accountable to rights holders in carrying out their services was not available. However, the continued and consistent implementation of social accountability activities, the feedback provided to rights-holders regarding their grievances, and the assessment reports of the RGB demonstrate that staff are being held accountable at every level. In addition, the combined feedback loops provided through the HGIs at sub-national and community level provide a system of checks and balances for promoting systems accountability and transparency at all three levels.

When asked about the performance expectations of staff and managers, one district manager responded:

> *"... I went to the health center for a consultation; I wanted to get more information and details, there are patients' rights to information and to understand the treatment that is being provided! So, I asked the provider, but instead of her responding and providing the information; she responded in a rude way.... and it made me feel like what the provider will do after that will not help me anyway, so immediately left the room without medications or anything. I saw the number of the health center representative and immediately called him and explained what happened and even mentioned that even if that provider can give me medications, I won't be able to take them due to the way she treated me! So, the representative took me back in the consultation room and we sat the three of us (with the provider); and the representative mentioned to her that it is my right to ask information about my condition and she has the responsibility to provide explanations in a friendly way without being rude! I left the room very happy and took the medications and they helped!"*
>
> *– FGD with young people*

2. **Are M&E findings on the performance of the SA program/system (i.e., the duty-bearers' responsiveness to rights-holder complaints) shared back with the community (i.e., on public platforms such as the MoH website; or through other public communication mechanisms)?**

Score: 3/3

Score	Criteria
3	Reports and reviews are shown on websites with explanatory graphs and visuals.
2	M&E results, redress cases, and/or progress reports are provided on an MoH or CSO website.
1	There is a public platform, but it is not accessible through a website or other broadly accessible mechanism.
0	There is no public platform.
0	N/I = No information
0	N/A = Not applicable

Justification: M&E findings on the performance of the SA system is widely available. For those with internet connection, national scorecard reports are available online through the RGB, and the results of those reports are made available through media outlets. For those who do not have internet access, town hall meeting reports, facility score card reports, and performance contract reports at sub-national and community level are accessible through radio reports and regularly scheduled face-to-face meetings.

When asked if they received feedback on the performance of the health system in responding to grievances, a rights holder responded:

> *"... during establishment of the District's performance contracts "Imihigo" which is one way where citizens can participate, and then comes those established systems such as open days which is an exhibition in every district where all the key stakeholders including the district gather, also including Hospitals, as well as those other organs that work around community services to present to the people what they are doing in the district. It is one way of being open about accountability so that everyone can show achievements to the community...."*
>
> *– District Health Director*

5.4 Sustainability

The Sustainability domain explores factors that position the SA system in health to continue autonomously through its being institutionalized by laws and regulations and supported by funding. This measurement requires that the structure not only exist, but that some type of legal or regulatory framework must be in place to enforce common standards. This 'Sustainability" domain also goes a step further than the 'Functionality" domain with regard to financial autonomy. For example, it requires that there be not only budgets for programmatic support, but that there be budget line items to support staff assigned to drive the national SA structures. Monitoring and evaluation must be not only functional, through a structure for and process of data collection and evaluation, but also sustainable with a data management system that is integrated across all levels, with capacity for consistent dissemination of information and transparency of results.

Table 7: Analysis of 'Effectiveness' Domain

Question	Score	Justification
1. Are performance reviews were conducted at national, sub-national, and community levels include criteria to measure staff's responses to rights holder's needs?	N/I 0/3	No performance reviews were accessible to provide evidence for a response.
2. Are M&E findings on the performance of the SA program/ system (i.e., the duty-bearers' responsiveness to rights-holder complaints) shared back with the community (i.e.: on public platforms such as the MoH website; or through other public communication mechanisms)?	3/3	M&E findings on the performance of the SA system is widely available.

Rwanda has institutionalized mechanisms at each level of government (local, sub-national, and national) that have combined the traditional local accountability processes with the formal systems processes and have linked both within the larger government commitment to accountability across all sectors and includes health accountability indicators among its standard national reports on governance and accountability.

The development maturity score for the Sustainability domain of the National Program/System for Social Accountability for Health is 15/21 (71%).

Key questions asked within the scoring element of the assessment instrument:

2. **Are the M&E processes for the SA program/system institutionalized (or mainstreamed/normalized) within the institutions?**

Justification: The M&E processes are institutionalized and regularly reported through a number of reporting mechanisms that address all levels. The primary platform through which the reports are made public is the Rwanda Governance Board (RGB), which is a commission that tracks and reports on Rwanda's governance and accountability practices not only in health but across all sectors. In addition to the national level reporting, there are M&E processes institutionalized through contracts made between provider teams and user groups. There are inter-level reporting mechanisms, with district level oversight of contracts made between district and sub-national authorities and with national government. In turn those contracts translate into performance agreements between facility heads (as relates to health) and district authorities. Performance agreements engage local community leaders and CSOs in aligning performance service delivery standards with community needs and designing indicators for monitoring activities that will enhance at all levels. Monitoring and reporting are standardized and institutionalized from facilities, as well as CSO's and related agencies, to sub-national (district) authorities and from sub-national authorities to as above-indicated, Rwanda also has established reporting mechanisms in the Health Management Information System (HMIS) from local level to the central level.[82, 83]

Score: 3/3

Score	Criteria
3	The M&E of the national SA program/ system is integrated into the broader health M&E processes.
2	Electronic information systems are used to manage M&E of SA program/ system across all levels so data can be monitored in real time.
1	Actors at national and subnational levels meet regularly to review M&E reports to inform national program improvements
0	Only national actors meet regularly to review reports to inform SA program / system improvements.
0	N/I = No information
0	N/A = Not applicable

3. **Is there a mechanism for the rights holders to approve of and/or participate in the development of the social accountability strategic plan objectives?**

Score: 3/3

Score	Criteria
3	There is a mechanism through which representatives from rights holders groups approve of and/or participate at community level operationalization of the national social accountability strategic plan objectives.
2	There is a mechanism through which representatives from rights holders groups approve of and/or participate in the sub-national level operationalization of the national social accountability strategic plan objectives.
1	The development of and approval of the strategic plan in some way includes rights holders groups and/or interest groups at national level (such as committees, advocacy groups, technical experts).
0	Only centralized government structures (such as cabinet, parliament, or Ministry leadership at national level) participate and/or approve.
0	N/I = No information
0	N/A = Not applicable

Justification: There are numerous examples of opportunities for rights holders to provide feedback and recommendations on service gaps, which are highlighted in the 'Structures domain.' However, it is important that citizens actually participate in the planning. In Rwanda, there are several platforms institutionalized for citizen participation in planning, a primary one being *Imihigo* (noted in the table on HGIs and discussed above), and the level of citizen participation in planning through the *Imighigo* is monitored and reported on as evidence of good governance through the RGB Governance Score Card. Rights holders' participation in the planning process is necessary for sustainability to lead to local ownership of health system activities, greater cooperation and trust between rights holders and duty bearers, and an expectation seeded that all voices must be reflected in decision-making.

When a CSO representative was asked if rights holders are included in planning discussions and or approval of strategies for accountable health strategies, one respondent answered:

> *"...We have been working on involving young people (meaningful involvement) to ensure that the programs are successful. It is giving good outcome on what has been done recently (past few years) so also that gives a good projection when you see like a few things that has been done. If we keep improving on highly engaging the target population then we can achieve on having sustainable solutions for different issues that the population is facing."*
>
> *– SRHR Youth Organizations Representative*

Another CSO representative pointed out barriers to rights holders inclusion in the planning process, such as the respondent's experience with deadlines or time limitations.

> *"..... Sometimes the planning which is very improvised it doesn't allow adequate feedback from the citizens. Say for example you have to submit a proposal with a deadline, and people come to consult, but decisions have been made. .... I do not think that we have done enough to ensure that the end users are aware of this. We have policies that are produced but they only remain with a few, but it is the responsibility of the government as well to ensure that these are disseminated."*
>
> *– CSO Representative*

4. **Does the budget fund at least one person to be responsible for managing the SA process?**

Justification: The Joint Action Development Forum (JADF) as described in **Table 3** has an established full-time staff at the central level located in the Rwanda Governance Board (RGB) and a funded full-time staff in charge of JADF at each district office to monitor and report on accountability.[84] Their responsibilities are to oversee the coordination and harmonization of all the key stakeholders within a district toward improved service delivery and to monitor that all the stakeholders are providing quality services according to what has been agreed upon and promised to rights holders as part of their rights to quality care. JADF staff in each district work with local community leaders and facility staff managers to promote active participation and dialogue between citizens.

Score: 3/3

Score	Criteria
3	There are SA program/system line items that budgets specifically for at least one full-time person at each of three administrative levels: (national level, sub-national level, and community level).
2	There are SA program/system line items that budgets specifically for at least one full-time person at both national level and at least one sub-national level
1	There are SA program/system line items that budgets specifically for at least one full-time person at national level only.
0	There is no/are no line items in the national budget for the SA program/system.
0	N/I = No information
0	N/A = Not applicable

5. Do budget line items support the SA program/ system activities and materials in three health administrative levels (national level, sub-national level, and community level)?

Score: 3/3

Score	Criteria
3	There are budget line items to support the SA program/system activities and materials in three health administrative levels (national level, sub-national level, and community level).
2	There are budget line items to support the SA program/system activities or materials in the national health budget and in the budget of least one sub-national administrative level.
1	The development of and approval of the strategic plan in some way includes rights holders groups and/or interest groups at national level (such as committees, advocacy groups, and technical experts).
0	Only centralized government structure (such as cabinet, parliament, or Ministry leadership at national level) participates and/or approves.
0	N/I = No information
0	N/A = Not applicable

Justification: The health budget does fund activities and/ or materials required to implement the national SA program. Technical working group meetings and other subnational and community meetings, such as town hall meetings and community score card meetings are funded by the MoH. Global entities, such as the World Bank and WHO, as well as bi-lateral partners, including the United States and Germany, collaborate with the GoR and provide additional support to civil society organizations that also facilitate the process and support funding of the activities, particularly at local level, coming in the form of both technical assistance and development investments. Even so, health budgets do provide resources to support SA activities.

6. Is the responsibility for M&E of the SA program/ system assigned to an MoH staff member and included in his/her job description?

Score: 3/3

Score	Criteria
3	An MoH staff at three levels (national, sub-national, and local) are tasked with the responsibility of the M&E for the SA program/ system as specified on his or her job description.
2	An MoH staff both at the national and subnational levels are tasked with the responsibility of the M&E for the SA program/ system as specified on his or her job description.
1	An MoH staff person(s) is responsible for M&E of the SA as part of his/her job descirption.at national level only.
0	There is no/are no person on staff at the MoH who has the responsibility for M&E of the SA as part of his/her job description.
0	N/I = No information
0	N/A = Not applicable

Justification: There are health management requirements for M&E functions that MoH staff must follow per job description requirements and management guidelines at each administrative level to monitor and report on the national social accountability system. The MoH in Rwanda requires all health institutions from the health center at community level to the central level to routinely provide data management updates, validation and verification. The routine data conducted retrospectively is submitted to the

centralized HMIS by all the health institutions in the country. Therefore, the MoH provides data managers to all the health centers, including health centers from remote areas, and even supports reporting from CHWs.[85, 86, 87, 88]

7. **Are annual trainings held for participating staff (MoH) and stakeholders (MoH, NGO, and/or CSO) on the principles and practices of the SA program/system?**

Score: 0 (N/I)

Score	Criteria
3	Trainings are held for staff and stakeholders at all three levels (national, sub-national, and community).
2	Trainings are held for national and sub-national staff and stakeholders only.
1	There are trainings held for national level staff and stakeholders (at national level only.
0	There are no regularly scheduled trainings held.
0	N/I = No information
0	N/A = Not applicable

Justification: There is no evidence within the MoH of an institutional structure for initial trainings or scheduled refresher trainings of MoH staff or providers on social accountability principles or practices. The most significant MoH training initiative in recent years was the Rwanda Human Resources for Health Program (HRH Program, 2012-2019),[89] led by the Government of Rwanda and funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund). This program built capacity of clinical education and strengthened the curricula for clinical professionals and health managers. The management curricula of the HRH Program did not include capacity building for engaging beneficiaries in planning or implementing social accountability processes. The HRH program focused on clinical training, but there was a missed opportunity in incorporating SA understanding and practice guidelines within the clinical education. There is no evidence of any in-service training for health sector managers.

When a development partner was asked if annual trainings are held for participating staff and stakeholders on the principal and practices of the SA system, the respondent answered:

> *"... we always strive to make sure that there are local capacities in government agencies implementing our programs so by doing this we ensure that there are needed capacities to conduct monitoring and evaluation."*
>
> *– Development Partner*

This answer speaks to development partners' role in training MoH staff in social accountability but does not provide evidence that the MoH has institutionalized or formalized training to strengthen capacity for staff or leadership on implementing SA activities.

8. **Do job descriptions of all duty bearer staff at all levels include a statement or description of their responsibility to rights holders?**

Score: 0/3

Score	Criteria
3	There exist—at national, sub-national, and community level—job descriptions describing responsibilities of MoH staff to rights holders.
2	There exist—at national and sub-national level—job descriptions describing responsibilities of MoH staff to rights holders.
1	There exist—at national level only—job descriptions describing responsibilities of MoH staff to rights holders.
0	There are no job descriptions that mention the staff's responsibility to rights holders.
0	N/I = No information
0	N/A = Not applicable

Justification: Even though access to job descriptions was limited, online job descriptions for national and subnational MoH management positions or provider positions consistently lacked mention of social accountability responsibilities or responsibilities related to engaging beneficiaries or responding to rights-holders' or beneficiaries' concerns or grievances.

When asked if MoH staff are accountable to rights holders as part of their responsibilities, one CSO representative responded:

"We have the performance contracts – Imihigo – that are done by different institutions but also done by the districts, where again the performance includes the participation from different stakeholders. However, they end up becoming district commitments. We have other non-formal spaces that happen where you have leaders going to meet citizens like community meetings in a form of Umuganda"

– CSO Representative

Table 8: Analysis of 'Sustainability' Domain

Question	Score	Justification
1. Are the M&E processes for the SA program/ system institutionalized (or mainstreamed/ normalized) within the institutions?	3/3	The M&E processes are institutionalized and regularly reported through a number of reporting mechanisms that address all levels.
2. Is there a mechanism for the rights holders to approve of and/or participate in the development of the social accountability strategic plan objectives?	3/3	There are several platforms institutionalized for citizen participation in planning, a primary one being *Imihigo* (noted in the table on HGIs and discussed above). Even the level of citizen participation in planning through the *Imighigo* is monitored and reported on as evidence of good governance through the RGB Governance Score Card.
3. Does the budget fund at least one person to be responsible for managing the SA process?	3/3	The Joint Action Development Forum (JADF) as described in the Table 3 has an established full-time staff at the central level located in the Rwanda Governance Board (RGB) and a funded full-time staff in charge of JADF at each district office to monitor and report on accountability.
4. Does the health budget fund activities and/ or materials required to implement SA programs (such as regular meetings, travel, communication national level, sub-national level, and community level)?	3/3	The health budget does fund activities and/or materials required to implement the national SA program.
5. Is the responsibility for M&E of the SA program/system assigned to an MoH staff member and included in his/her job description?	3/3	There are health management requirements that MoH staff must follow per job description requirements and management guidelines at each administrative level to carry out the M&E responsibilities of the national social accountability system.
6. Are annual trainings held for participating staff and stakeholders on the principal and practices of the SA program/system?	0/3	No evidence was found of any institutionalized pre-service or in-service training on either principles or practices of social accountability for providers or managers.
7. Do job descriptions of all duty bearer staff at all levels include a statement or description of their responsibility to rights holders?	0/3	Even though access to job descriptions was limited, online job descriptions for national and sub-national MoH management positions consistently lacked mention of social accountability responsibilities, or responsibilities related to engaging beneficiaries or responding to rights-holders' or beneficiaries' concerns or grievances.

5.5 Transformation

The Transformation domain discusses potential markers of lasting change in Rwanda's health system and health outcomes that emerges when SA programs and policies are sustained overtime and have become part of the health system fabric and ways of working. It goes beyond sustainability, which stems from institutionalizing practices and providing resources to sustain them and extends to incorporate shifts in attitudes of rights holders and duty bearers and the self-reliance of SA within health governance systems. The transformation domain also looks at whether the program is self-reliant, to which questions were asked about capacity and will. The transformation domain also looks at the results of the national accountability program, asking if services and health outcomes have improved.

The level of development maturity in the domain of Transformation is 9/15 (60%)

In this domain, five questions explored changes having been observed or noted in the performance of health providers, the responsiveness in the health system, and the improved health outcomes.

1. **Is the SA program/system self-sustaining (demonstrating self-reliance through both national commitment and national capacity)? (This question addresses both technical and financial sustainability.)**

Score: 3/3

Score	Criteria
3	A public sector body or organization has official responsibility for ensuring that improvements to processes are maintained.
2	An external body reviews the quality and consistency of data collection and analysis.
1	Domestic funds/resources/structures (rather than donor funds) are used to maintain and sustain the SA Program/ System.
0	The program/ system still runs on help from external donors and implementers.
0	N/I = No information
0	N/A = Not applicable

Justification: Both commitment and capacity in steering social accountability suggest that the GoR program is self-sustaining. At the national level, recent health policies, specifically those associated with RMNCH, and the *Umushykyirano* incorporate requirements of the government to allow rights holders to state their grievances and receive response from the national government. These policies represent commitment. The continued fulfillment of the practice, the perception that this process is in fact transparent, and the multiple avenues for rights holders and CSOs to participate represents capacity of the national government to fulfill its commitment. Budgeted staff and program resources to oversee and implement social accountability activities at all three levels further confirms the commitment and capacity of the GoR to sustain the national social accountability system. The scoring (3/3) recognizes the fulfillment of the criteria for this question; however, it must be noted that significant technical and financial investment and collaboration is provided through international partners. It is unclear how the removal of this support will impact GoR's capacity and will to sustain this program.

2. **Have provider performance indicators improved?**

Score: N/I (0/3)

Score	Criteria
3	Provider performance indicators or reports from rights holders mark improvements and/or the decrease of grievances against providers that can be directly related to the SA process.
2	Provider performance indicators or reports from rights holders have improved and grievances against providers (outside of staff performance) have decreased.
1	Provider performance indicators or reports from rights holders have overall improved.
0	Provider performance indicators or reports from rights holders have not improved.
0	N/I = No information
0	N/A = Not applicable

Justification: There is no information available regarding provider performance improvement. The only Service Delivery Report available through the RGB publications site was the 2021 report on the delivery of health services for PWDs. This report establishes a base line but does not reference improvement; and no other broader health performance reports were available. In addition, there are no performance

reviews available or evidence of an institutionalized provider performance review process at any of the three health administrative levels.

3. Have health service indicators improved?

Score: 2/3

Score	Criteria
3	Service indicator improvements and/or the decrease of grievances against facilities can be directly related to the SA process.
2	DHIS2 (or HMIS) service indicators have improved and response times to grievances against health facilities (outside of staff performance) have decreased.
1	DHIS2 (or HMIS) Service indicators have overall improved but not attributable to SA.
0	DHIS2 (or HMIS) service indicators have not improved.
0	N/I = No information
0	N/A = Not applicable

Justification: DHIS indicators on key service markers related to RMNCH have improved over the last five years.[90] Among married and sexually active unmarried women ages 15-the use of modern contraceptive methods increased from 48% to 58%, with total demand for contraception increasing from 72% to 78%, and demand satisfied with modern methods increasing from 66% to 75%. Percent of children aged 12-23 who received all basic vaccinations increased from 93% to 96%. Pregnant women who attended all four ANC visits showed a very slight increase from 45% to 47%, and the percentage of live births delivered in health facilities also slightly increased from 91% to 93%.

The improvement of outcomes would warrant a 3/3 however, as these improvements cannot directly relate to the SA in health process a score of 2/3 has been given. Correlations can be suggested due to the increase in client satisfaction, the participation of rights holders in health planning, and the improvements in service delivery and health outcome indicators.

4. Have rights holders' satisfaction with the health system improved?

Score: 2/3

Score	Criteria
3	Rights holders report that they are pleased with the social accountability (grievance and redress) system.
2	Rights holders satisfaction has improved.
1	Rights holders' satisfaction has not improved.
0	Rights-holders' do not now their rights.
0	N/I = No information
0	N/A = Not applicable

Justification: Rights holders' satisfaction has improved. The Rwandan Governance Scorecard shows an increase of rights' holders satisfaction with health services rising from 70.4% in 2016 to 80.4% in 2020. However, again, as the improvements in satisfaction cannot be directly attributed to Rwanda's national SA system, the score is a 2. When directly asked about participation in or responsiveness of the health system, the respondents are satisfied, as per the example seen in the 'Effectiveness' section.

5. Have population level RMNCH health outcomes improved?

Score: 2/3

Score	Criteria
3	Evidence shows that the SA program / system has contributed to the improvements in population health outcomes.
2	Population RMNCH indicators have overall improved (meaning that more RMNCH indicators of the DHIS2 (or HMIS), or national health information reporting system, have improved than not).
1	MNC deaths have decreased.
0	No improvements in population health.
0	N/I = No information
0	N/A = Not applicable

Justification: Population level RMNCH outcomes have overall improved from the DHS reports of 2014/15[91] and 2019/2020.[92] Under-5 mortality rates per 1,000 live births decreased from 50 during 2014/15 to 45 during 2019/20, although infant mortality rates remained stagnant at 33 deaths per 1,000 live births. The maternal mortality ratio for Rwanda for the period 2014/15 to 2019/20 is 203 deaths per 100,000 live births decreasing from 210 for the previous five-year period. Teen pregnancy rates decreased as well. The 2014/2015 DHS indicators showed seven percent of young women between age 15 and age 19 had already begun childbearing (6 percent were already mothers and 2 percent are pregnant for the first time). The 2019/2020 report showed five percent of women age 15-19 had begun childbearing. There are no measurements that isolate SA activities to attribute population level RMNCH outcomes with social accountability activities other than recounting of service improvements made in response to community level grievances. We note that best practices support community engagement and accountability as factors in health improvements, increased health behaviours, and improved system performance;[93] yet a qualitative study conducted in Rwanda, also indicated that the improvement of RMNCH indicators is due to multiple efforts, not any specific program, targeted to improve RMMCH services and outcomes.[94] As the scores are not attributable and are difficult to even correlate due to the multiple interventions to improve the RMNCH indicators, the score is 2/3 instead of 3/3.

Evidence of transformation is clear per these criteria. Despite need for improvement in various aspects across the domains, the social accountability processes are continuing, information is monitored, and both the accountability indicators and health indicators have improved. These gains suggest positive influences for Rwanda's national social accountability in health. Concrete measurement of contribution of the SA system however should be improved to provide quantifiable evidence of the effects of specific health system improvements that came about due to the SA process.

Table 9: Analysis of 'Transformation' Domain

Question	Score	Justification
1. Is the SA program / system self-sustaining (demonstrating self-reliance through both national commitment and national capacity)? (This question addresses both technical and financial sustainability.)	3/3	Both commitment and capacity in steering social accountability suggest that the GoR program is self-sustaining.
2. Have Provider performance indicators improved?	0/3 (N/I)	No information was available to demonstrate improved provider performance.
3. Have health service indicators improved?	2/3	Health service indicators have improved but cannot be directly attributed to the national health social accountability system.
4. Have rights holders' satisfaction with the health system improved?	2/3	Rights holders satisfaction has improved, yet again cannot be directly attributable to Rwanda's SA system.
5. Have population level RMNCH health outcomes improved?	2/3	As above, RMNCH outcomes continue to improve. The SA system is one of many programs that have been implemented toward improving health outcomes.

6. DISCUSSION

Rwanda's national 'program' for social accountability in health is actually a combination of mutually reinforcing policies, strategies and activities that constitute a 'system.' This national SA system aligns with Rwanda's commitment to greater accountability, which is reflected in its Vision 2050 and rests on complimentary policies for a decentralized government, a community health system, the institutionalization of community practices, and laws that establish the SA structure and enable sustainability. The GoR has integrated SA across its health system policies, and particularly in policies relevant to reproductive health and maternal, newborn and child health, that promote citizen voices. Policies are translated into structures and practices at all three levels of the decentralized government system, with institutionalized processes through which citizens can claim their rights and hold officials accountable to uphold those rights and keep their health service commitments. This instrument highlights where those structures and practices need to be strengthened and reinforced. Further, the expansion and sustainability of Rwanda's national SA system in health is rooted in Rwanda's history and culture where there is an expectation that individuals will live up to their commitments and one's duty bearers at all levels will be accountable to the rights holders they serve.[95]

Key stakeholders interviewed expressed the expectation of rights holders that duty bearers must respond knowledgably and be responsive, even at the central Ministry level:

> *"... Our leadership has done a great thing, remember we have different platforms, Umushyikirano, national dialogue, national retreat, those are things when you attend as Minister or somebody of high level, you have to be ready to respond to a question from Rusizi far from where you are ..... You know, you have to be ready to respond to those requested questions from person, for example they can ask any question you know about community-based medical insurance or Mutuelle de Sante, those are the things they ask and as Minister you have to respond."*
>
> ***– Development Partner***

It is important to note that despite the policies, structures, and public avenues for rights holders to hold duty bearers accountable, there are limits to the grievances that civil society groups can make due to their capacities related to both skill and funding, and due to the control that the government has over the CSOs. In 2015 a national assessment on the performance and development of CSOs indicated that 61.7% of civil society agreed that there is citizen participation and CSO inclusiveness in Rwanda. However, the same respondents also indicated that CSOs in Rwanda lack the capacity to engage in adequate policy analysis, advocacy, and influence on the government due to need for training and also to the high level of control and regulations that the GoR steers.[96] There needs to be greater separation between CSOs and government influence through fewer licensing constraints and regulatory requirements. The study that was conducted by CSOs themselves indicated that there is a need to conduct further evaluation of the level of citizen's voices and citizen's engagement in Rwanda to understand where improvements will be useful.[97]

As noted earlier in the document, stakeholders' comments aligned with the above statement, highlighting the need for capacity building among civil society organizations to implement existing SA mechanisms:

> *"... to improve social accountability in the health sector, one of the areas I have mentioned that still needs a lot of capacity building, is the capacity to track and monitor resource allocation, prioritization, and usage of the existing mechanisms. Therefore, you need to have organizations that have the capacity to do budget monitoring".*
>
> ***– CSO Representative***

> *"For the civil society, we need to have civil society hire competent skilled staff to be able to champion social accountability. To be able to do policy monitoring, you need skilled human resources".*
>
> ***– CSO Representative***

7. RECOMMENDATIONS

This assessment will be useful in providing a common means through which governments may assess their national SA programs or systems. Results will shed light on both strengths and weaknesses of the processes in place and will direct efforts for improvement to specific domains and areas within those domains, as well as to specific rights holders' perception of the health system's responsiveness to their complaints or concerns.

Rwanda's national social accountability system is rooted in traditional systems that operate at all levels and are based on the belief that dialogue is necessary and that rights holders' and duty bearers' voices need to be heard to resolve conflicts. The structure of the SA mechanisms are well established, including good governance policies promoting transparency and accountability and MoH policies that integrate accountability processes within RMNCH service delivery strategies. Communities included in this assessment organize and engage in the SA process, and the M&E mechanism operates at all levels and publish updated aggregated results on the MoH website. These solid structures and functions of the SA mechanisms lead to a strong score in effectiveness, with civil society playing an essential role in piloting and instituting best practices.

A decentralized administrative structure brings decision-making closer to the point of service and provides an enabling environment for social accountability to develop. There is a real opportunity for civil society to be strengthened to harness and address community members' perceived needs. There are also some emerging trends like digital tools for monitoring data and social media platforms that could be leveraged to broadly share rights holders' concerns and empower them to know how to make their voices heard when their rights are not being met.

With the strengths of Rwanda's national SA system in health, there are areas that need to be improved. Several recommendations may respond to gaps identified through assessment findings.

7.1 Structure

Legal Protections for rights holders. Expand the legal protections of whistleblowers to include legal protection of citizens or organizations that register grievances against public services. Freedom to participate without fear of negative consequences is central to the principles of social accountability. Second, the oOR should address barriers to Rwanda's 2012 Law No. 49/2012, which instituted medical professional liability insurance including the medical service user's rights and responsibilities of the service providers. Information about this law, and how to pursue legal action needs to be more widely disseminated; and unintended consequences affecting clinician hesitancy to provide care need to be addressed.

7.2 Functionality

Budget Transparency. Evidence of budget inclusion for social accountability activities at each level are evident from sub-national guidelines, decentralized processes, and national budget reports. However, access to budget sub-national and local health budgets and information regarding dispersal of funds was not easily accessible to researchers. COVID-19 created barriers to data collectors' accessing administrative offices but addressing access challenges to public budget and other administrative information will improve the maturity score.

Accessibility of Redress System. Improvements are needed in ensuring access to the redress system. The MoH can institutionalize a process through which scheduled surveys are distributed to discover where rights holders are finding barriers or challenges to register their grievances. For example, if a suggestion box at a facility and is not functional, the MoH has an obligation be aware of this barrier and to address it. If the timing of town hall meetings or facility score card discussions create barriers to community members, then a survey would allow rights holders to make that barrier known, and the MoH would have an obligation to address that barrier. Documentation of the results of these surveys and reports of the redress action taken and date accomplished should be made public within the challenged community,

as well as included among national reports and online data. Enhancing these processes will also enhance understanding of the functionality of the national SA system.

- ***Improvement to the assessment instrument:*** Three questions will be added to the assessment instrument to strengthen the scoring results.
  - Are there avenues through which rights holders can make duty bearers aware of deficits in the redress system?
  - Do independent or private entities or news outlets provide oversight or advocacy to make known the deficits in the redress system?
  - Do gender-sensitive policies or strategies address challenges for women or historically marginalized groups to create equitable access to redress systems?

7.3 Effectiveness

Incorporate social accountability practices in performance review criteria. There was no evidence of an institutionalized process for performance reviews among managers or providers. Access to administrative information was limited due to COVID-19 restrictions, but there were no references to performance reviews in the literature or in the interview responses, other than the performance contracts that refer to entities rather than individuals. For social accountability processes to be effective, managers and staff alike need to comply to an expectation that they perform their roles and fulfill responsibilities to rights holders. Further, staff performance reviews are in themselves a form of accountability, so important to institutionalize within the health system.

- ***Improvement to the assessment instrument:*** To strengthen the results, FGDs with providers and managers across a sampling of facilities and districts will be required. In those FGDs, three questions will be asked and scored.
  - Does your job description include responsibilities directly or indirectly related to accountability to rights holders? Please explain.
  - Do you have regular performance reviews? Please elaborate.
  - If you have regular performance reviews, are there criteria for performance in your accountability to rights holders? Please explain.

Developing Capacity of CSOs. (Relates to Question 6 under the Sustainability domain, but does not link to a specific domain question, and fits most appropriately under 'Effectiveness'). There is some consideration, as expressed through interviews, that CSO's can improve their capacity in M&E and in advocacy. Training in these areas, with clear guidelines is needed.

- ***Improvement to the assessment instrument:*** The scoring reflected the need for improvement in training, but to specifically address the important aspect of civil society's role in social accountability, three questions will be added in the 'Sustainability' domain:
  - Do CSOs have the capacity to monitor, report on, and/or advocate for social accountability?
  - Do CSOs have the capacity to facilitate social accountability activities without technical or financial assistance from donors?
  - To what extent are CSO's free from government regulations so that they can advocate on behalf of rights holders or provide oversight to report on weaknesses, failures, or discrepancies in the SA mechanisms.

7.4 Sustainability

Institutionalize annual trainings of all health providers and managers on social accountability principles. As part of in-service trainings required for health providers and health managers, training curricula components that address the importance of social accountability, knowledge of the practices and processes through which social accountability policies are implemented, skills in facilitating town hall meetings or discussions of performance contracts or facility score cards, behavior competencies in respectful and timely responses to grievances, roles in strengthening access to and use of social accountability mechanisms, and processes and tools for monitoring and reporting on social accountability indicators. Some of these elements are currently embedded in training guidelines. For example, the community health policy provides guidelines on the training of CHWs to facilitate community participation in health planning discussions and in monitoring and oversight. However, trainings across all management and provider cadres and at each administrative level is necessary for adequate implementation of the social accountability practices. Incorporating SA competencies in pre-service clinical education will also further advance the sustainability and transformative influences in the SA domains.

Social Accountability Responsibilities included in Job Descriptions. (Question 7) Job descriptions of staff responsible for social accountability roles were not available, somewhat due to lack of access to administrative offices during COVID-19 restrictions. However, management level job descriptions accessible online did not include specific job responsibilities for responsiveness to rights holders needs or concerns. To sustain social accountability as a national program or system, job descriptions are an important instrument for institutionalizing duty bearers responsibility to uphold the system's accountability commitments.

7.5 Transformation

Separate political self-reliance and financial self-reliance in assessing transformation of the SA mechanisms.

- ***Improvement in the assessment instrument****:* the first question in the Transformation domain combines two questions into one; rather there needs to be two questions with appropriate scoring criteria sub-questions.
  - First: Is the Is the SA system financially self-sustaining (demonstrating self-reliance through both national commitment and national capacity)?
  - Second: Is the SA system politically self-sustaining (demonstrating self-reliance through both national commitment and national capacity)? (This question addresses both technical and financial sustainability.)

Publish national level reports on provider performance. Provider performance reports were not available under the Service Delivery Reports on the RGB publications website. To reinforce the performance contracts made between national and sub-national administrative levels and between sub-national government and facilities/service organizations, provider performance reports, aggregated as well as disaggregated by sub-national level, will be useful in transforming norms and behaviors of duty bearers. Making those reports available both through the website and through more locally accessible distribution channels, such as announcements at facility level meetings and report summaries on radio programs and town hall meetings, will also reinforce trust in the social accountability mechanisms that voices are being heard. It will also be important to institutionalize processes for rights holder input to specifically go to these reports.

- ***Improvement to the assessment instrument****:* A question should be added to the Transformation domain that captures the important information that rights holders are part of the process of assessing provider performance.
  - Is there a nationally institutionalized process through which rights holders give assessment input to a provider performance report?
- ***Improvement to the assessment instrument*** *(2):* A question should be added to the FGD guide for rights holders and providers:
  - Are there nationally institutionalized processes through which rights holders give assessment input to a provider performance report? Please explain.
  - Do rights holders contribute to these performance assessment opportunities? Please explain.

More direct tracking and reporting of services and health outcomes related to RMNCH. Given the GoR's prioritized improvements in RMNCH services and commitment to decreasing maternal and newborn mortality as well as preventable under-five deaths, M&E processes need to track RMNCH service performance and improvements as they relate to SA. These improvements would better allow GoR to provide oversight at all levels to be sure that those services specifically are responsive to grievances and that the rights holders experience that their rights are being protected and their RMNCH needs are being met.

- ***Improvement to the assessment instrument****:* COVID-19 restrictions limited the capacity to convene groups for FGDs during this implementation, and we were confined to two groups that were convened by a CSO partner. The learning from this experience confirms that additional FGD interviews are needed with a broader sample size across representative districts. In addition, to ensure that the instrument fully captures the experience of those using RMNCH services, particularly women and adolescent girls, FGD sampling instructions will require that for each target community, one FGD will be held with adolescents (as was done in this application), one be held with adolescent girls alone, and one be held with pregnant women. (These three groups will be required, as well as one mixed group of adult men and women from the community and one FGD of CSO partners.) When a geographical area is characterized by marginalized population groups, such as religious, racial or cultural sub-populations, there will need to at least one FGD held with representatives from this population. Questions to the required FGD groups will include seven questions that will also be included in the score under the Effectiveness domain:

- Do you use RMNCH services in the public health system? Please explain.
- If so, are you satisfied with the RMNCH services that are provided in the public health facilities you use? Please elaborate.
- Do you give input or feedback about your experience or about complaints you may have about your services?
- If yes, to above, what complaints or feedback have you made?

- How did you make those complaints?
- Were those complaints addressed? Please explain.
  - Do you know if others give feedback about the services they use at the health facility? If yes, please describe.

Additional Cross-Cutting Recommendations

Citizen Access to Health Information. Increased access of citizens to their medical history through digital services or even through access to paper documents, will strengthen transparency and further open avenues for citizen participation. If citizens are able to view their own medical records, they will gain better understanding and tracking of their own health status and be able to prioritize their concerns, pose informed questions, receive responses, and document discrepancies.

Greater independence for CSO's. Interview responses revealed that the government control and regulatory compliance requirements may make it easy for the government to pressure CSO's to limit complaints or advocacy efforts. Though CSOs are supported by a combination of government, international donor, and private foundation support, it will be important that as international support transfers to local self-reliance, then there is oversight from local private entities. Linkages with private sector may strengthen both the capacity and the independence of CSO's and provide the public pressure to mitigate government controls. Private journalism, media, and advocacy organizations will also contribute to greater sustainability of the national SA system, and to long term cultural transformation which stems from ongoing public scrutiny of duty bearers' implementation of government commitments.

- ***Improvement to the Assessment Instrument*** *(1):* The insight gained from interview responses have informed an improvement to the instrument, which will include specific questions addressing objectivity and independence of SA implementation and inquiring about the existence of oversight protections against bias or corruption. These questions will be added to the 'Transformation' domain section.
  - Are independent oversight bodies engaged in reporting on grievances of rights holders?
  - Are there protections against bias, government influence, or corruption that might create barriers to open dialogue and reporting in the SA processes?
- ***Improvement to the Assessment Instrument*** *(2):* FGDs with rights holders and KIIs with CSOs and Development Partners will include three specific question on oversight protections that will be included in scoring for Transformation:
  - Are CSO's independent from government influence in their ability to facilitate and/or advocate SA processes? Please explain.
  - Does media play a role in exposing bias or government influence in SA processes? Please describe?
  - Do you feel that the SA program in health is free from government censoring? Please explain.

8. CONCLUSION

Rwanda has set an exceptional example of attempting to put in place a national social accountability system. It has maintained and incorporated existing practices and mechanisms for community participation and cooperation towards claiming agency and ownership into the health system as part of a national framework and procedures. Rwanda has also demonstrated commitment to sustaining and improving SA in health programs through budgeted initiatives, staffing, oversight mechanisms, transparency in reporting, and open discussion opportunities at all levels. Improvements in capacity of CSOs and community groups to monitor results, consistent and accessible reports and better tracking of RMNCH improvements that are related to SA will improve function, sustainability and transformation. With a baseline score now established in Rwanda, the GoR can examine scores and respondent inputs to design informed strategies for strengthening the national SA system in health.

The implementation of the assessment instrument demonstrated that the scores were effective in highlighting strengths and weaknesses in the national SA system, and that the additional inputs gained from the KIIs and FGDs informed recommendations for improvement. The application of the instrument also highlighted where the tool can be improved through additional questions to capture information that was missed in the initial application and specific guidelines for interview groups to capture the most relevant voices. In the improvements, interview responses will be quantified to incorporate in the scoring so that they will be reflected in a standardized and more objective process through the scoring analysis. With the improvements identified through this testing phase, the tool will be a useful for governments in assessing their own programs, and for external bodies, either local civil society organizations or international development organizations to assess the level of maturity of a country's SA system and then compare one country to another and across regions how countries are progressing and what best practices are being used to advance that progress.

It will be important to better define what is meant by a Social Accountability 'program' or 'system.' Here we have used the word 'system' to recognize that Rwanda's social accountability in health activities are not part of a specific SA in health program but are part of a nationally led effort to incorporate SA across the health system. An additional recommendation that may benefit countries who embark on such a national effort is that they label that effort as a SA in health program to clarify and emphasize that the programs and processes that have been institutionalized within the health system do in fact combine and harmonize under a specific commitment to ensure social accountability in health.

As a final thought, it should be noted that when the government is actually driving the SA system itself, it is difficult to gauge if it can allow rights holders to truly hold the duty bearers accountable. For example, organizations working in advocacy and/or human rights may face challenges to having their activities included in the district plan or budgets, and without having activities in the health plan, there may be barriers for an organization to renew its registration. This type of vulnerability exemplifies the risk that is inherent with any government-led SA accountability mechanism tasked with holding the government itself accountable. Even so, with policies and legal frameworks in place, and the determination of both duty bearers and rights holders to sustain the post-conflict transformation, the SA system in health may very well create a positive influence toward ongoing responsiveness and inclusive health system with sustainable practices toward improvement.

ANNEX 1.

Illustrative list of Reports published by the Rwanda Governance Board

Below are several report descriptions related to Social Accountability that are published by the Rwanda Governance Board (RGB). The reports are available on the RGB website, which is supported by the UNDP (https://www.rgb.rw/publications?tx_filelist_)

The Rwanda Reconciliation Barometer (RRB) report is produced every five years by a non-partisan commission at the central government level and disseminated internationally to report on various indicators of Rwanda's recovery from the genocide and ongoing sustainability of peace and reconciliation. The most recent report is from 2020:

https://www.nurc.gov.rw/fileadmin/Documents/RWANDA_RECONCILIATION_BAROMETER.pdf

The Civil Society Barometer report assesses the status , capacity, and the role of civil society in development process of Rwanda. The assessment is carried out every five years and the report updated. It also serves as a source of data for Rwanda Governance Scorecard (RGS). It is currently being updated, and the latest available report is from 2015.

https://www.rgb.rw/fileadmin/user_upload/RGB/Publications/RWANDA_CIVIL_SOCIETY_BAROMETER/Rwanda_Civil_Society_Barometer_2015.pdf

The Rwanda Media Barometer report is published every two years and assesses the transparency and self reliance of good governance and the oversight of independent media. The most recent. Available report is from 2018:

https://www.rgb.rw/fileadmin/user_upload/RGB/Publications/RWANDA_MEDIA_BAROMETER-RMB/RWANDA_MEDIA_BAROMETER_2018.pdf

The Service Delivery Report uses surveys to assess rights holders' experiences across various sector government services and to make gaps and grievances about service delivery available to the public. The GoR then uses these reports to inform intervention strategies and improvement plans. Recent reports on health service delivery are not accessible online; however, a 2021 report on service delivery for PWDs can be found.

https://www.rgb.rw/fileadmin/user_upload/RGB/Publications/SERVICE_DELIVERY_REPORTS/SERVICE_DELIVERY_ASSESSMENT_TO_PEOPLE_WITH_DISABILITIES.pdf

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APPENDIX 3

NATIONAL SOCIAL ACCOUNTABILITY SYSTEM IN HEALTH ASSESSMENT TOOL (NSASHAT)

This report was produced for review by the United States Agency for International Development. It was prepared by the HEARD project and was authored by Allison Annette Foster (WI-HER), Thumbiko Wachizma Msiska (co-investigator for Malawi), Adriane Martin Hilber (USAID HEARD/CUNY), Adriane Martin Hilber (USAID HEARD/CUNY). Early contributions on the design and testing of the tool were received from Beth Outterson (Consultant), Kristen Mallory (Children International), Ligia Paina (JHU), and Eric Sarriott (GAVI).

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APPENDIX 3 CONTENTS

Concept and Background on the National System for Social Accountability in Health Assessment Tool

This instrument was designed to help countries assess and monitor their own national and/or sub-national social accountability (SA) programs and synthesize data to inform ongoing improvements in the transparency and responsiveness of their health systems. As part of their Journey to Self-Reliance, countries will be able to adapt and apply this instrument, through their own M&E office or through support from a local NGO or technical assistance partner. This will enable countries to demonstrate their capacity and commitment to reach the SDGs and advance toward UHC through strengthening democratic societies with equitable access to quality public services, namely health. This initiative began in response to findings from a systematic review carried out by Ligia Paina, et al.[1] Paina et al. found that there is a dearth of information on national systems or programs that support SA. Some countries, including Columbia, Pakistan, Malawi, Afghanistan, Rwanda, and others, have either scaled community level pilot SA interventions, or have developed a national program as part of advancing good governance practices. However, little is known about the strengths and weaknesses of these programs. These country experiences can contribute to other national and sub-national efforts to institutionalize and sustain SA practices and processes as part of their health systems.

Authors adapted a framework developed by developed by Novametrics and Options Group as part of the Mamaye Projecy.[2] Building on the framework developed by Martin-Hilber, et al., and informed by the measurement recommendations of Paina, et al., authors will test this instrument, which collects both qualitative and quantitative data, in the hopes that it will prove helpful as countries assess, improve, and strengthen their SA systems.

Malawi and Rwanda were selected to participate in the research according to three criteria:

- The country has a national policy to establish a social accountability program or system in health;
- The national social accountability program has been active for at least 18 months;
- Published reports exist and are available on the social accountability program/ system;

Using the assessment instrument, researchers will collect and analyze the quantitative and qualitative data defined in the instrument, resulting in a score that characterizes the social accountability program. Using the instrument's framework, researchers will identify strengths and highlighting opportunities for improvement.

Summary of Methodology Related to Using this Instrument

An initial rapid desk review will be conducted for each country, Malawi and Rwanda, to understand the current status of their national SA programs/systems in health.

For the rapid desk reviews, researchers will gather and synthesize in a summary report information from descriptive reports, policy documents, evaluations, and country strategy and budget documents

Information from these sources will be used to summarize the current knowledge of the structure of the SA program/ system, as well as the resources dedicated and processes practiced to support the program's implementation or effectiveness.

Analysts will use the rapid desk reviews to complete the initial quantitative data component. Data to complete the **Qualitative Score Component** will be gathered through

[1] Ligia Paina, Julie Saracino, Jessica Bishai, and Eric Sarriot. Monitoring and Evaluation of Evolving Social Accountability Efforts in Health: A Literature Synthesis. Core Group (2019). Available online: https://coregroup.org/wp-content/uploads/2019/05/ME-of-Evolving-SA-Efforts-in-Health-2019-Final.pdf

[2] Adriane Martin-Hilber, Patricia Doherty, Andrea Nove, Rachel Cullen, Tunde Segun, Sara Bandali. The Development of a New Accountability Framework and Tool for Global Health Initiatives. Options (2019)"

key informant interviews (KIIs) and focus group discussions (FGDs).

For FGDs with community level rights holders, questions will be posed from the **Preliminary FGD Questions** section to capture overall familiarity with the SA program/system and satisfaction with both the SA system and the health services.

Note that key informants may be able to fill gaps in information from the desk reviews to complete Quantitative questions in the Quantitative Score Component.

Using the instrument and applying the information from these sources, researchers will explore the national SA program/system both retrospectively and prospectively to understand if the SA program/system fulfills its purpose to 1) include community members in decision-making and monitoring of the services that they receive from their health systems; and 2) receive grievances and provide timely responses with service improvements.

Prospectively the data collected will aim to explore:

1. Rights holders perceptions of the national, sub-national, or community levels program, regarding whether the SA program/system is or is not functional, effective, sustainable and transformative
2. Duty bearers of the national, sub-national and community administrative levels of the public health system perceptions as to whether the national SA program/system is or is not functional, effective, sustainable, and transformative

Retrospectively the data collected will aim to explore:

3. Environmental or health system management factors that facilitate or hinder the program's capacity to be functional, effective, sustainable and transformative

The data will be analyzed, and results will be documented and reported in a paper that recommends structures, practices, or processes that may contribute to the advancement of sustainable and effective national SA programs.

The paper will also highlight lessons learned in applying the instrument with recommendations that may improve it. The paper will be presented by the authors at various public venues.[3]

[3] Note that authors presented the initial framework at the World Bank's 2019 GPSA conference in Washington, DC as part of an interactive session, led by WI-HER, and with USAID and Options at the 2021 Health Systems Research Global Forum

Guidance to Data Collector

PURPOSE: The purpose of this tool is to provide a framework for governments to assess their national health system's Social Accountability program to demonstrate its structure, functionality, and effectiveness. A quantitative scale allows governments to establish a baseline from which to progress and compare their programs with those of other countries. A qualitative assessment framework also sheds light on the program's strengths and gaps in inclusiveness and responsiveness This qualitative portion aims to capture environmental factors that may facilitate or hinder the programs improvement.

The **Title Page** and the **Concept and Background** provide background information on the development and purpose of this research, who the authors are, what organization is funding the assessment, and what organization is leading the administration of the assessment. A brief **Summary of the Methodology** is provided in greater explanation in the IRB application.

The **Administrative Information** should be completed by the data collector once he or she initiates the data collection process. The consent process is described in the **Consent Information** section. The consent forms will be provided to the data collector along with this tool.

For each interview or focus group, we recommend you use a new file/document and save as that interview or focus group number. Thus you will use a separate document for each key informant interview and a separate document for each focus group.

There are several components to this instrument. The **Quantitative Score Component** that can be completed through information publicly available in policy documents, evaluations, assessments. For questions that cannot be completed through these means, key actors may be able to provide missing information. There is a column that asks to clarify the source of the information—please note the source from the desk review resource list as well as KIIs that may confirm or add to the information. **Key informants will only be asked the quantitative questions that were unable to be answered through documents of the desk review.**

The Qualitative Component will be completed through key informant interviews and focus group discussions. This component will explore the experience of rights holders regarding the responsiveness and inclusiveness of the program. When key informants respond to these questions,

data will reveal if duty bearers are aware of the strengths and weaknesses of the program. It will also provide background information to understand the development and management of the program to reveal some understanding of what common environmental or management influences may lead to a more effective or less effective program. The Focus Group Discussions (FGDs) will examine the experience of the rights holders in using the SA program/system and will show whether or not and to what extent the program is responsive to the needs of the rights holders. This portion will highlight where there are gaps between the rights holders' and the duty bearers' perceptions of the SA system's effectiveness and where improvements are needed. Note that for FGDs, there are five additional questions listed in the **Preliminary FGD Questions** that should be asked in the focus group ***before*** going onto the **Qualitative Component** section.

In the **Qualitative Component** section, the data collector lists the names and occupations of the **Interviewees** and lists the names and occupations or roles of the FGD participants. Names and information are kept to inform the reporting of total number of participants and to find common answers across gender, profession, or service level. This information is only to help data collector keep track of interviews and to help analysts to understand the data. This information will not be shared beyond the researchers

The **Glossary of Terms** provides the data collector with additional information that may be useful or informative or may help her or him respond to questions posed by the participants.

Administrative Information

Please complete these five questions below for general information

Name of country _____

Name of assessor populating the tools _____

Position and organization of the assessor _____

Date of completion of instrument _____

Name or type of social accountability mechanism assessed: _____

Consent Information

Prior to all interviews, key informants, as well as members of all focus groups , will be read their consent form and asked to sign and date the document.

If the participant is unable to read, the data collector will read the form to him or her, and will ask the participant to sign the acknowledgement that the consent form has been read and has been understood.

The data collector will also sign and date the form. If the participant is unable to sign the document, he or she may place an X on the signature line.

One copy of the consent form will be retained by the data collector, and one will be left with the interview / focus group discussion participant.

The consent forms are attached in a separate document and labeled **"Appendix A"**.

All completed forms and recordings retained by the data collector will be submitted to Allison Annette Foster electronically and will be shared only with the researchers listed on the consent form.

Data collectors will be trained by the research team and overseen by the facilitators in Rwanda and Malawi. Facilitators are trained researchers with ethics certification.

Interviews will not be held with children or patients. There are no questions or topic discussions that should put any participant at risk. And no clinical studies or procedures are included in this assessment

Names and information are recorded under Tab 8, to facilitate the data collector's processes. That tab will be accessed only by the researchers and will not be included in any reports or any sharing of raw data.

Quantitative Score Component

#	Question	Answer Key	Score	"N/I" (No Information)	"N/A"	Comments / Questions	*Cite sources from the desk review where you obtained this information (You may also have received this information from a KII respondent, so please indicate that respondent by number from the Qualitative Component).*
A Structure for a National Social Accountability Program / System Exists							
1	Has the country established a policy to institutionalize social accountability at the national level?	3 = Yes, a policy has been in existence for at least five years with information accessible through a public platform, such as an MoH website. 2 = Yes, a policy has been in existence for five or more years with no publicly accessible information (website; published and disseminated reports, etc.). 1 = Yes, a policy intended to institutionalize a social accountability process at national level has been in existence between 2 to five years. 0 = Yes, a program or system intended to institutionalize a social accountability process at national level has been in existence for less than two years. N/I = No information (Column E) N/A = Not applicable (Column F)					
If the answer to #1 is not yes, the country is not eligible							
2	Are there policies and legal constructs in place to operationalize the institutionalized social accountability program or system? a. A written national policy exists. b. The national health strategy includes steps for operationalizing the social accountability policy c. Written guidelines or regulatory constructs to support implementation exist d. Guidelines specifically direct the implementation of the redress mechanism	3 = Yes to all four (a,b,c,d) 2 = Yes to a, b, and c 1 = Yes to a and b 0 = Yes to a N/I = No information (Column E) N/A = Not applicable (Column F)					

continued

Quantitative Score Component continued

#	Question	Answer Key	Score	"N/I"	"N/A"	Comments / Questions	*Sources from the desk review where you obtained this information*
3	Do the subnational levels of government include a social accountability process in their strategic plans?	3 = Some District (or woreda, parish, or similar) and/or community strategic plans incorporate social accountability processes. 2 = The social accountability program/ system processes are part of the national and sub-national plans (provincial, regional, county, or other sub-national administrative level). 1 = The social accountability program/ system processes are part of the national strategy but not included in the sub-national plan (provincial, regional, county or similar) strategies. 0 = The social accountability program/ system is not yet incorporated at national level. N/I = No information (Column E) N/A = Not applicable (Column F)					
4	Are there social accountability bodies or structures (committees or social action groups) at each administrative level identified in question #3 to ensure participation of rights holders and continuing communication and inclusion between duty bearers and rights holders? Three administrative levels considered are: ▪ national ▪ sub-national (provincial, state, municipal) ▪ community (all levels from district parish or below)	3 = There are communication and interaction structures at three or more different levels that ensure continuing communication feedback loops between duty bearers and rights holders. 2 = There are communication and interaction structures that ensure continuing communication feed back loops between duty bearers and rights holders at two different levels. (national and sub-national, sub-national and community, or community and national). 1 = There are communication and interaction structures at only one level (national or sub-national or community) that ensures communication feedback loops between rights holders and duty-bearers. 0 = There are no interaction or communication bodies/structures at any administrative level that would allow for feedback loops between duty bearers and rights holders. N/I = No information (Column E) N/A = Not applicable (Column F)				If you indicated that mechanisms exist at one or more levels, at which levels do they exist?	

continued

Quantitative Score Component continued

#	Question	Answer Key	Score	"N/I"	"N/A"	Comments / Questions	*Sources from the desk review where you obtained this information*
5	Are there processes for interaction between the social accountability bodies or structures (committees or social action groups) at each of the relevant administrative levels listed above? (Note: By interaction, we mean two way sharing of information or feedback loops)	3 = There are processes for interaction (two-way sharing of information; feedback loops) across the SA structures at all three administrative levels (national, sub-national, and community). 2 = There are structures or processes for interaction between the sub-national and the community level, but they don't reach the national level. 1 = There are structures or processes for interaction between national sub-national levels and one other level but not the third level. 0 = There are no structures that allow interaction between the national level and other levels. N/I = No information (Column E) N/A = Not applicable (Column F)					
6	Does an accountability platform for registering grievances exist?	3 = There is a platform for grievances that includes a process for tracking responses, and a time limit mechanism through which a response must be received within a certain amount of time and there is consequence to non compliance of duty bearers. 2 = There exists a platform for grievances that includes a process for tracking responses, and a time limit mechanism through which a response must be received within a certain amount of time. 1 = There exists a platform for grievances that includes a process for tracking responses. 0 = There are no platform for registering grievances and tracking responses. N/I = No information (Column E) N/A = Not applicable (Column F)				If you said yes, an accountability platform exists – can you describe the platform: • Is it online? • Are grievances public (all can see when a grievance is made and/or responded to)	

continued

Quantitative Score Component continued

#	Question	Answer Key	Score	"N/I"	"N/A"	Comments / Questions	*Sources from the desk review where you obtained this information*
7	Is there a national policy that protects rights holders, stating that anyone who submits a grievance will not suffer retribution?	3 = All MoH Staff is required to be trained or oriented on the rights and protections of right-holders to file grievances without retribution. 2 = All public facilities and offices are required to publicly display the policy of that protects the rights holders to submit grievances without retribution. 1 = There is a national policy that protects rights holders who file a grievance. 0 = There are no national policy protecting rights holders who file a grievance. N/I = No information (Column E) N/A = Not applicable (Column F)					
National Social Accountability Program/ System is Functional							
1	Does an M&E process exist (i.e., a process for data collection of and reporting on a set of standard national indicators)? Administrative levels include national, sub-national, and community	3 = The M&E process incorporates indicators from all administrative levels AND reports of the combined results are regularly shared at all levels. 2 = The M&E Process includes input from at least two administrative levels but results are not regularly shared. 1 = There is an M&E process at national level but does not include input from other administrative levels. 0 = There is no M&E Process. N/I = No information (Column E) N/A = Not applicable (Column F)				If you answered 'not applicable (N/A)', please explain your answer.	
2	Is the national social accountability program/system budgeted?	3 = There are SA program/system line items at national, sub-national and community levels. 2 = There are SA program/system line items in the budgets of national and sub-national administrative levels. 1 = There are SA program/system line items at national level only. 0 = There is no/are no line items in the national budget for the SA program/ system. N/I = No information (Column E) N/A = Not applicable (Column F)"					

continued

Quantitative Score Component continued

#	Question	Answer Key	Score	"N/I"	"N/A"	Comments / Questions	*Sources from the desk review where you obtained this information*
3	Is the redress system accessible to all rights holders? *Note: We realize that the term "all levels" does not represent all rights holders (leaving out language differences, etc.) – however – if all levels use a redress system, then the breadth of access suggests that the SA system is spreading and will eventually reach all rights holders.*	3 = The redress system is used at all three levels (national, sub-national, or community). 2 = The redress system is used only at two levels (national, sub-national, or community). 1 = The redress system is used only at one level (national, sub-national, or community. 0 = The redress system is not used. N/I = No information (Column E) N/A = Not applicable (Column F)					
National Social Accountability Program / System is Sustainable							
11	Are the M&E processes for the SA program/ system institutionalized (or mainstreamed/ normalized within the institutions)?	3 = The M&E of the national SA program/system is integrated into the broader health M&E processes. 2 = Electronic information systems are used to manage M&E of SA program/ system across all levels so data can be monitored in real time. 1 = Actors at national and subnational levels meet regularly to review M&E reports to inform national SA program/ system improvements. 0 = Only national actors meet regularly to review reports to inform SA program/ system improvements. N/I = No information (Column E) N/A = Not applicable (Column F)					

continued

Quantitative Score Component continued

#	Question	Answer Key	Score	"N/I"	"N/A"	Comments / Questions	*Sources from the desk review where you obtained this information*
12	Is there a mechanism for the rights holders to approve of and/ or participate in the development of the social accountability strategic plan objectives?	3 = There is a mechanism through which representatives from rights holders groups approve of and/ or participate at community level operationalization of the national social accountability strategic plan objectives. 2 = There is a mechanism through which representatives from rights holders groups approve of and/or participate in the sub-national level operationalization of the national social accountability strategic plan objectives. 1 = The development of and approval of the strategic plan in some way includes rights holders groups and/or interest groups at national level (such as committees, advocacy groups, technical experts) 0 = Only centralized government structure (such as cabinet, parliament, or Ministry leadership at national level) participates and /or approves. N/I = No information (Column E) N/A = Not applicable (Column F)					
13	Does the budget fund at least one person to be responsible for managing the SA process?	3 = There are SA program/system line items that budget specifically for at least one full-time person at each of three administrative levels: (national level, sub-national level, and community level). 2 = There are SA program/ system line items that budget specifically for at least one full-time person at both national level and at least one sub-national level. 1 = There are SA program/system line items that budget specifically for at least one full-time person at national level only. 0 = There is no/are no line items in the national budget for the SA program system. N/I = No information (Column E) N/A = Not applicable (Column F)					

continued

Quantitative Score Component continued

#	Question	Answer Key	Score	"N/I"	"N/A"	Comments / Questions	*Sources from the desk review where you obtained this information*
14	Does the health budget fund activities and / or materials required to implement the SA program system (such as regular meetings, travel, communications)?	3 = There are budget line items to support the SA program/ system activities and materials in three health administrative levels (national level, sub-national level, and community level). 2 = There are budget line items to support the SA program/system activities or materials in the national health budget and in the budget of least one sub-national administrative level. 1 = There are SA program line items in the national health budget for SA program activities or materials. 0 = There is no/are no line items in the national budget for the SA program/ system. N/I = No information (Column E) N/A = Not applicable (Column F)					
15	Is the responsibility for M&E of the SA program/ system assigned to an MoH staff member and included in his/her job description?	3 = An MoH staff both at three levels (national, sub-national, and local) are tasked with the responsibility of the M&E for the SA program/system as specified on his or her job description. 2 = An MoH staff both at the national and subnational levels are tasked with the responsibility of the M&E for the SA program as specified on his or her job description. 1 = An MOH staff person(s) is responsible for M&E of the SA as part of his/her job description at national level only. 0 = There is no/are no person on staff at the MoH who has the responsibility for M&E of the SA as part of his/her job description. N/I = No information (Column E) N/A = Not applicable (Column F)					

continued

Quantitative Score Component continued

#	Question	Answer Key	Score	"N/I"	"N/A"	Comments / Questions	*Sources from the desk review where you obtained this information*
16	Are annual trainings held for participating staff (MoH and/or NGO) and stakeholders (MOH and/or CSO) on the principles and practices of the SA program/system?	3 = Trainings are held for staff and stakeholders at all three levels (national, sub-national, and community). 2 = Trainings are held for national and sub-national staff and stakeholders only. 1 = There are trainings held for national level staff and stakeholders (at national level only). 0 = There are no regularly scheduled trainings held. N/I = No information (Column E) N/A = Not applicable (Column F)					
17	Do job descriptions of all duty bearer staff include a statement or description of their responsibility to rights holders? *Please note that in this situation there can include scenarios where there are job descriptions at a lower level (community facility for example—but not at national level); and this may be difficult to track—more than most of the others. Despite that, the respondent needs only to answer the question at hand*	3 = There exist – at national, sub-national, and community level – job descriptions describing responsibilities of MoH staff to rights holders. 2 = There exist – at national and sub-national level – job descriptions describing responsibilities of MoH staff to rights holders. 1 = There exist – at national level only – job descriptions describing responsibilities of MoH staff to rights holders. 0 = There are no job descriptions that mention the staff's responsibility to rights holders. N/I = No information (Column E) N/A = Not applicable (Column F)					
National Social Accountability Program / System is Effective							
18	Does performance criteria for staff include the fulfillment of SA responsibilities that respond to rights holder needs? *For follow-up question, please ask if there are consequences for duty bearers who do not implement the parts of the action plan that are their responsibility (e.g. public shaming, disciplinary procedures, litigation).*	3 = Performance reviews at national, sub-national, and community levels include criteria to measure staff's responses to rights holders needs. 2 = Performance reviews at national and sub-national levels include criteria to measure staff's responses to rights holders needs. 1 = Performance reviews at national level only include criteria to measure staff's responses to rights holders needs. 0 = There is no staff performance criteria tied to implementation of SA program (responding to rights holders). N/I = No information (Column E) N/A = Not applicable (Column F)					

continued

Quantitative Score Component continued

#	Question	Answer Key	Score	"N/I"	"N/A"	Comments / Questions	*Sources from the desk review where you obtained this information*
19	Are results from monitoring and evaluation shared with rights holders?	3 = Reports and reviews are shown on websites with explanatory graphs and visuals. 2 = M&E results, redress cases, and/or progress reports are provided on an MoH or CSO website. 1 = There is a public platform, but it is not accessible through a website or other broadly accessible mechanism. 0 = There is no public platform. N/I = No information (Column E) N/A = Not applicable (Column F)					
National Social Accountability Program/System is Transformative							
20	Country Ownership: Is the SA program/system self sustaining (demonstrating self reliance both through national commitment and national capacity)? *Please note that this question addresses both technical and financial sustainability.*	3 = A public sector body or organization has official responsibility for ensuring that improvements to processes are maintained. 2 =An external body reviews the quality and consistency of data collection and analysis. 1 = Domestic funds/resources/structures (rather than donor funds) are used to maintain and sustain the SA Program / System. 0 = The program still runs on help from external donors and implementers. N/I = No information (Column E) N/A = Not applicable (Column F)					
21	Duty-Bearer (MoH staff and provider) Capacity and Performance: Has the performance of duty bearers improved?	3 = Provider performance indicators or reports from rights holders mark improvements and/or the decrease of grievances against providers that an be directly related to the SA process. 2 = Provider performance indicators or reports from rights holders have improved and grievances against providers (outside of staff performance) have decreased. 1 = Provider performance indicators or reports from rights holders have overall improved. 0 = Provider performance indicators or reports from rights holders have not improved N/I = No information (Column E) N/A = Not applicable (Column F)					

continued

Quantitative Score Component continued

#	Question	Answer Key	Score	"N/I"	"N/A"	Comments / Questions	*Sources from the desk review where you obtained this information*
22	Health system Improvement: Have health service indicators improved?	3 = Service indicator improvements and/or the decrease of grievances against facilities an be directly related to the SA process 2 = DHIS2 (or HMIS) service indicators have improved and response times to grievances against health facilities (outside of staff performance) have decreased. 1 = DHIS2 (or HMIS) Service indicators have overall improved but not attributable to SA. 0 = DHIS2 (or HMIS) service indicators have not improved. N/I = No information (Column E) N/A = Not applicable (Column F)					
23	Have rights holders' satisfaction with the health system improved?	3 =Rights holders report that they are pleased with the social accountability (grievance and redress) program/ system. 2 = Rights holders' satisfaction has improved. 1 = Rights holders' satisfaction has not improved. 0 = Rights-holders do not know their rights. N/I = No information (Column E) N/A = Not applicable (Column F)					
24	Have population level RMNCH health outcomes improved?	3 = Evidence shows that the SA program / system has contributed to the improvements in population RMNCH health outcomes 2 = Population RMNCH indicators have overall improved (meaning that more RMNCH indicators of the DHIS2, or national health information reporting system, have improved than not). 1 = MNC deaths have decreased. 0 = No improvements in population health. N/I = No information (Column E) N/A = Not applicable (Column F)					

Preliminary Focus Group Discussion Questions

These questions are asked of the FGDs before continuing with qualitative questions in the next section.	FGD 1 (#M/#F)	FGD 2 (#M / #F)	FGD 3 (#M/ #F)
1. Have any of you heard about a mechanism where you can launch a grievance if you don't get the services you need at the health center?			
2. Do you know what to do if you are unhappy with the services you receive at the health center? If so, please explain.			
3. Have any of you ever tried participating in the process, meaning submitting a grievance against a health provider or health services? If so, what was the outcome?			
4. What are your suggestions to improve the system so you can make sure you have access to it? (make a complaint, etc.)			

Qualitative Component: Questions on the Effectiveness and Transformation of the Current Social Accountability Program

#	Questions on the effectiveness and transformation of the Current Social Accountability Program. *After asking each question, continue to the right for instructions on how to respond before going to the next question.*	Y (yes) / N (no) / Don't know (DK)	If answer is 'NO', please skip to question #20. If answer is 'YES', please continue to the next question. If the answer is "I DON'T KNOW", please respond to the question in column E and F, and then continue.	If 'I don't know', please ask the respondent to recommend relevant literature or refer a contact for an interview	Additional resource or contact recommended	*In the next columns (H-L), please check one of the boxes to match the respondent number (Respondent names and corresponding numbers are listed 'Interviewees' tab*							
						Key Informant #1	Key Informant #2	Key Informant #3	Key Informant #4	Key Informant #5	etc.	FGD #1 (#M / #F)	FGD #2 (#M / #F)	etc.
RETROSPECTIVE: Questions on the initiation and development of the national Social Accountability Program														
Retrospective - Community level Pilot Project														
1	Was the national social accountability program developed from a pilot project?		Please describe the initiation and the pilot to the best of your ability, and then continue to the next question	If you don't know, or if you are not sure, what do you know about the how this national social accountability program came about? And can you guide us to another contact or source (see next column to the right)?										
2	Was the pilot funded by external partners/ resources?		Which partner(s)											
3	How many communities or sites were involved in the pilot? (Answer in column D)													
4	What tools and/or guidelines were used during implementation of the pilot. For example, were national or local guidelines, scorecard tools, verbal autopsies, or other social accountability development tools used? (List tools and/or guidelines in column D)		List tools or guidelines here and refer to the "Glossary of SA Tools" Tab for reference											
5	Did you play a role in the pilot project?		If the answer was 'YES', please describe that role, and then continue to the next question											
6	From the local communities and the included households, who was involved in the initial intervention of the pilot project? (Answer in Column D, and circle all that apply; Indicate 'male', 'female', or circle both, if more than one person)		Village Leader (M /F) Opinion leader/influencer (M /F) Community Group Leader (M /F) Mothers' Group (M/F) Father's Group (M/F) Health Center Group (M /F) Community Health Worker (M /F) Others (specify) _____(M / F)											

continued

Qualitative Component continued

#	Questions on the effectiveness and transformation of the Current Social Accountability Program. *After asking each question, continue to the right for instructions on how to respond before going to the next question.*	Y (yes) / N (no) / Don't know (DK)	If answer is 'NO', please skip to question #20. If answer is 'YES', please continue to the next question. If the answer is "I DON'T KNOW", please respond to the question in column E and F, and then continue.	If 'I don't know', please ask the respondent to recommend relevant literature or refer a contact for an interview	Additional resource or contact recommended	*In the next columns (H-L), please check one of the boxes to match the respondent number (Respondent names and corresponding numbers are listed 'Interviewees' tab*								
						Key Informant #1	Key Informant #2	Key Informant #3	Key Informant #4	Key Informant #5	etc.	FGD #1 (#M / #F)	FGD #2 (#M / #F)	etc.
8	Were members of the health system involved in the pilot project? If 'yes' in Column C, please circle – in Column 'D' – all that apply regarding who was involved.		Health facility staff: nurse (M / F) Health facility staff: physician (M / F) Health facility staff: pharmacist (M / F) Member(s) of district management team (M / F) Member(s) of the provincial management team (M/F) Representative(s) from the national MoH (M/F) Project Implementers (external partners helping to facilitate the project (M/F) Funders (external partners providing financial support) (M/F) Educators (from university or training institution) (M/F) Other _____ (M / F) (Specify)									
10	Were other groups or representatives from other sectors involved in the pilot social accountability project? If yes, in column "C", please circle those representative groups (all that apply) in column "D")		Opinion leader/influencer (M /F) Financial Sector (M / F) Academic Sector (M / F) Labor Sector (M / F) Policy and/or Regulation (M / F) Advocacy or Interest Groups (M / F) Journalists (M / F) International organizations (M / F) Private Businesses (M / F) Others (specify) _____(M / F)									
12	Was there a specific health service gap, weakness , or complaint that the social accountably pilot was supposed to address? (If there was more than one, please choose one that is most illustrative)		What was that health service gap / weakness / complaint?									

continued

Qualitative Component continued

#	Questions on the effectiveness and transformation of the Current Social Accountability Program. *After asking each question, continue to the right for instructions on how to respond before going to the next question.*	Y (yes) / N (no) / Don't know (DK)	If answer is 'NO', please skip to question #20. If answer is 'YES', please continue to the next question. If the answer is "I DON'T KNOW", please respond to the question in column E and F, and then continue.	If 'I don't know', please ask the respondent to recommend relevant literature or refer a contact for an interview	Additional resource or contact recommended	*In the next columns (H-L), please check one of the boxes to match the respondent number (Respondent names and corresponding numbers are listed 'Interviewees' tab*								
						Key Informant #1	Key Informant #2	Key Informant #3	Key Informant #4	Key Informant #5	etc.	FGD #1 (#M / #F)	FGD #2 (#M / #F)	etc.
Retrospective - Scale from Community Level Pilot to National Program														
13	Can you describe how the pilot project then scaled to become a national program?		If you answered, 'YES', please describe here the process by which the pilot program evolved into a national program.	Who might we talk with to get more information? *(please answer to the right)*										
14	Who do you consider were the champions who were essential to the process?			Are there others you would recommend that we speak to get more information?										
15	How do you think the political context hindered or advanced the scale ?			Are there others you would recommend that we speak to get more information?										
16	How do you believe the cultural environment hindered or advanced the scale of the program? Please describe			Are there others you would recommend that we speak to get more information?										
17	How did implementing partners / donors advance or hinder the successful scale of the social accountability mechanism / process from initial pilot to national program?			Are there others you would recommend that we speak to get more information?										
18	What obstacles hindered the development of the SA program? And how did the community overcome the obstacles?			Are there others you would recommend that we speak to get more information?										
19	What recommendations do you have for other champions who are working to institutionalize and scale their pilot programs for SA?			Are there others you would recommend that we speak to get more information?										
PROSPECTIVE: Questions on the effectiveness and transformation of the current national SA Program														
20	Can you name a recent gap or weakness in or complaint about the health service delivery that was solved through the national Social Accountability program/ mechanism?		If yes, please explain and answer the subsequent six questions below	If the answer was 'NO' or "I don't know', can you recommend someone else that we talk to? (please list the information in column F)										

continued

Qualitative Component continued

#	Questions on the effectiveness and transformation of the Current Social Accountability Program. *After asking each question, continue to the right for instructions on how to respond before going to the next question.*	Y (yes) / N (no) / Don't know (DK)	If answer is 'NO', please skip to question #20. If answer is 'YES', please continue to the next question. If the answer is "I DON'T KNOW", please respond to the question in column E and F, and then continue.	If 'I don't know', please ask the respondent to recommend relevant literature or refer a contact for an interview	Additional resource or contact recommended	*In the next columns (H-L), please check one of the boxes to match the respondent number (Respondent names and corresponding numbers are listed 'Interviewees' tab*								
						Key Informant #1	Key Informant #2	Key Informant #3	Key Informant #4	Key Informant #5	etc.	FGD #1 (#M / #F)	FGD #2 (#M / #F)	etc.
22	Did the solution initiate at the community level?			Can you recommend someone else that we talk to get more information? (please list the information in column F)										
23	How was the information shared from community to decision makers?			Can you recommend someone else that we talk to get more information? (please list the information in column F)										
	Was the time it took to resolve satisfactory to the community?			Can you recommend someone else that we talk to get more information? (please list the information in column F)										
25	How was it resolved - in other words, what happened?			Can you recommend someone else that we talk to get more information? (please list the information in column F)										
26	Once the problem was answered, did the community itself agree that the problem had been addressed (and/or mitigated) adequately ?		Please explain your answer	Can you recommend someone else that we talk to get more information? (please list the information in column F)										
27	Do you think this national social accountability program is successful?		Please explain your answer											
28	What suggestions do you have to improve it?													

Interviewees

Key Informant or FGD #	Individuals Interviewed	M/F	Key Informant or FGD	Current Position	Organization/ Administrative Level	Position Role at Time Initiative Began	Organization/ Administrative Level	Notes
1								
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Interviewees continued

Key Informant or FGD #	Individuals Interviewed	M/F	Key Informant or FGD	Current Position	Organization/ Administrative Level	Position Role at time initiative began	Organization/ Administrative Level	Notes
20								
21								
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Glossary

For additional terms, assessment teams may refer to : How To Note: How, When and Why to Use Demand-side Governance Approached in Projects, Social Development Department, World Bank, 2011.
www.worldbank.org/content/dam/Worldbank/Event/MNA/yemen_cso/english/Yemen_CSO_conf_glossary_SA_ENG.pdf

Accountability — When an individual or body, and the performance of tasks or functions by that individual or body, are subject to another's oversight, direction or request that they provide information or justification for their actions.

Accountability Mechanism — A structure, process, or program that is designed to help ensure that those with responsibility for making improvements are held to account for progress (or lack of it) responding to rights holders' needs.

Administrative Levels — For this framework we consider three administrative levels in our assessment of how far and how well the national program reaches from central government level to other levels of government. When assessing the structures developed and used by the Social Accountability program, the questions ask about 1) **national level (central)**; 2) **sub-national**, which should take into account state, provincial, county, or other sub-national level that is between the national and the final administrative body above community villages; and 3) **community level**, which is to include the district, or woreda (such as used in Ethiopia) or other administrative body that oversees the community levels below - including the providers, community groups, and facilities serving their catchment areas.

Advisory Body or Committee — Consultative group that includes a limited number of relevant stakeholders (e.g. citizens, members from academia, private sector, civil society) that provides public input on the project/program during the design and implementation stages of the project.

Beneficiary/Participant/Client — An individual or organisation that benefits from or uses the goods or services being provided by a duty-bearer.

Budget Literacy Campaigns — Efforts—usually by civil society, academics, or research institutes—to build citizen and civil society capacity to understand budgets in order to hold governments accountable for budget commitments and to influence budget priorities.

Champion — An individual or organisation with social, political or financial power / influence and who uses that power/influence to help ensure that the mechanism is properly implemented. (Also an influencer)

Citizen Charter — A document that informs citizens about the service entitlements they have as users of a public service, the standards they can expect for a service (timeframe and quality), remedies available for non-adherence to standards, and the procedures, costs and charges of a service. The charters entitle users to an explanation (and in some cases compensation) if the standards are not met.

Citizen Report Card (CRC) — Assessment of public services by the users (citizens) through client feedback surveys. It goes beyond data collection to being an instrument for exacting public accountability through extensive media coverage and civil society advocacy that accompanies the process.

Citizen's Budget — A simplified, nontechnical summary/presentation of a local or national budget that is designed to reach and be understood by citizens. There are usually two types of CBs: a simplified version of the Executive's Budget Proposal and a simplified version of the Enacted Budget after the legislature has considered the budget and voted on it.

Citizen Surveys — Assessment of government performance and service delivery based on citizens' experience. Depending on the objective, the surveys can collect data on a variety of topics ranging from perceptions of jurisdictional services and elected officials, to desires for new capital projects and services.

Citizen Service Centers — Provide citizens with access to a variety of national, state, and municipal and/ or private sector services in a single location. The CC informs citizens about the service entitlements they have as users of a public service, the standards they can expect for a service (timeframe and quality), remedies available for non-adherence to standards, and the procedures, costs and charges of a service.

Committees or Social Action Groups or Bodies — These are representative bodies that speak for the communities they serve in contributing to decisions, voicing grievances, monitoring responses, and providing a watchdog or oversight function. They also contribute to both communication directions for feedback loops to pass on community concerns to government bodies (which are part of the social accountability structure) and disseminate responses and reports received from the government back to the community

Community — Social accountability team used this category to include all service levels, organizations, and population groups who are located or sub-categorized below district (for example, may be a woreda, a zone, a catchment area, a village, etc.)

Community Score Card — A community-based monitoring tool that assesses services, projects, and government performance by analyzing qualitative data obtained through focus group discussions with the community. It usually includes interface meetings between service providers and users to formulate an action plan to address any identified problems and shortcomings.

Duty Bearer — An individual or organization with legal responsibility, as assigned by position or profession, for providing goods/services to a population (to the rights holders) to which the rights holders are entitled to receive through social compact and/or legal and regulatory framework. Within an accountability mechanism, the duty-bearer is the organization or individual who is being held to account. Note that a duty-bearer may also be a rights-holder, e.g. a health worker bears the duty to provide health care, and also holds the right to expect their employer to provide an enabling work environment. Likewise, rights holders, at the mature stages of the SA program may also be duty bearers. For example, community members both hold rights to expect their government representatives to be accountable, and are responsible to carry out their duties of engagement, commitment, and participation in the health system.

Focus Group Discussion — Composed of a small number of stakeholders to discuss and consult in an informal setting project impact and concerns. They are designed to gauge the response to the project's proposed actions and to gain a detailed understanding of stakeholders' perspectives, values and concerns.

Financial Accountability — Ensuring compliance with commitments, laws, rules and regulations regarding the control and management of public financial resources. Examples may include budget tracking schemes and performance-based payment schemes.

Grievance Redress Mechanism — A formal complaints-handling mechanism by which queries or clarifications about the project are responded to, problems with implementation are resolved, and complaints and grievances are addressed efficiently and effectively.

Influencer — A person or institution that has the social, political or financial power or standing to change public opinion and/or influence policy and practice. (Also a champion)

Integrity Pact — An accountability tool that allows participants and public officials to agree on rules to be applied to a specific procurement. It includes an "honesty pledge" by which involved parties promise not to offer or demand bribes. Bidders agree not to collude in order to obtain the contract; and if they do obtain the contract, they must avoid abusive practices while executing it.

Performance Accountability — Demonstrating and accounting for performance in the light of agreed-upon performance targets, with a focus on services, outputs and results. Examples include maternal death surveillance and response (MDSR) systems, accreditation systems, and annual performance review systems.

Opinion Leader — Opinion leader – see 'influencer'

Political and Democratic Accountability — Use of social, political and legal pressure and judicial processes to pressure, punish or shame institutions or persons responsible—such as elected officials, managers, ministers or Ministries—to keep commitments, to abide by law, to demonstrate legal and responsible stewardship of resources, and to respond to complaints, requests, and needs of rights holders. Accountability focuses on governance, citizen participation, equity, transparency and openness, responsiveness, and trust. Examples include social accountability campaigns, documented and accessible commitment tracking and assessments, and human rights monitoring and legal action.

National Level — In this project, refers to central government level.

Public Hearings — Formal community-level meetings where local officials and citizens have the opportunity to exchange information and opinions on community affairs. Public hearings are often one element during consultations or in a social audit initiative.

Recourse or Redress Mechanism — A means of holding duty bearers to commitments and responsibilities that includes punitive or disciplinary action when a duty bearer (individual or institution that is responsible for any action) fails to meet the expectations or criteria established in the social accountability or improvement process. Examples include transgressions of codes of conduct that are met with professional disciplinary action such as suspension from duties, financial penalties, loss of accreditation.

Remedial action — Action taken in response to the monitor and review phases of an accountability mechanism.

Review — The process of drawing conclusions from monitoring data about the strengths and weaknesses of the duty-bearer, and formulating an action plan to address the weaknesses.

Rights holder — A person or group with the right to expect the duty-bearer to be held to account for the proper performance of their duties. For example, all individuals have the right to health and therefore the right to expect the health service (the duty bearer) to provide the health care they need, all health workers have the right to a safe workplace and therefore the right to expect their employer (the duty-bearer) to provide this.

Social Accountability — A type of political and democratic accountability that engages citizens (rights holders) in accountability processes. Examples include tracking of government commitments in MNH, social audits and complaint mechanisms, petitions, campaigns and protests, and quality of services assessments (scorecards) with community participation.

Social Accounting or Social Audit — Monitoring process through which organizational or project information is collected, analyzed and shared publicly in a participatory fashion. Community members conduct investigative work at the end of which findings are shared and discussed publicly.

Social Action Groups or Committees or Bodies — These are representative bodies that speak for the communities they serve in contributing to decisions, voicing grievances, monitoring responses, and providing a watchdog or oversight function. They also contribute to both communication directions for feedback loops to pass on community concerns to government bodies (which are part of the social accountability structure) and disseminate responses and reports received from the government back to the community

Sub National — Refers in this project to the level of government below national level (may be province, state, department; district; county parish, municipal)

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