Strengthening Social Accountability to Improve Reproductive Health and Family Planning Services:

Lessons from West Africa

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Acronyms

Amplify-FP	Amplify Family Planning
CAC	Community Action Cycle
CTAR	Comité d'Appui Technique au Réseau Intégré d'Apprentissage
FP	Family planning
HSS	Health systems strengthening
MCMT	Multisectoral Community Mobilization Team
PDQ	Partnership Defined Quality
RH	Reproductive health
RISE II	Resilience in the Sahel Enhanced II
SBC	Social and behavior change
WABA	West Africa Breakthrough ACTION
WASH	Water, sanitation, and hygiene
WHO	World Health Organization
USAID	United States Agency for International Development

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I. Introduction

Social accountability is an approach that encourages ordinary citizens and/or civil society organizations to hold elected leaders and government entities answerable to their commitments. In the health sector, social accountability approaches seek to improve health service quality, delivery, and outcomes by applying a wide range of approaches, tools, and methods; including information about user rights, entitlements to client exit interviews, and participatory budget exercises.[1] The Ottawa Charter of 1986[2] and the Alma-Ata Declaration of 1978[3] link social accountability and health systems strengthening (HSS) in the call to action for community participation and primary health care support. With global democratization trends, decentralization, and the increase in civil society organizations, opportunities for community participation for social accountability are increasing. However, community roles and responsibilities in the health sector need re-examination, and social and behavior change (SBC) approaches can strengthen social accountability efforts for improved health outcomes. Similarly, programs can also apply social accountability approaches to achieve SBC outcomes, and these are increasingly present in the SBC practitioners' narrative.

In West Africa, Breakthrough ACTION implements community initiatives to increase the use of reproductive health (RH) and family planning (FP) services under two regional buy-ins: West Africa Breakthrough ACTION (WABA) and Resilience in the Sahel Enhanced (RISE II). These community efforts build interest and confidence at the population level while increasing accountability within the health and municipal governance systems to impact service delivery positively.

- WABA aims to increase demand for FP/RH services and improve the practice of priority behaviors, such as intergenerational and couples' communication in the following countries: Burkina Faso, Côte d'Ivoire, Niger, and Togo. This project collaborates closely with USAID's Amplify Family Planning (Amplify-FP) project.
- RISE II provides technical assistance to USAID implementing partners in Burkina Faso and Niger to use SBC approaches and engage communities for collective action employing a problem-solving lens. The RISE II project seeks to improve health outcomes at the primary healthcare level in four areas: nutrition; maternal, newborn, child, and adolescent health; family planning; and water, sanitation, and hygiene (WASH).

This brief presents the WABA and RISE II project experiences in addressing social accountability while implementing community engagement efforts in the context of SBC for health.

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[1] Malena, C., Forster, R., & Singh, J. (2004). Social accountability: An introduction to the concept and emerging practice. *Social Development Paper 76*. World Bank.
[2] WHO, Health and Welfare Canada, & the Canadian Public Health Association. (1987, May). *Ottawa charter for health promotion.* 1st International Conference on Health Promotion. https://www.who.int/publications/i/item/WH-1987
[3] WHO & UNICEF. (1978, September). *Declaration of Alma-Ata.* The International Conference on Primary Health Care. https://cdn.who.int/media/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2

II. What is Social Accountability?

Social accountability relies on civic engagement and includes a wide range of social accountability approaches and tools. Data suggests well-designed and well-implemented social accountability interventions can improve health service quality and outcomes effectively.

The World Health Organization (WHO) HSS building blocks framework[4] shows how social accountability addresses leadership and governance and demonstrates different places on the health systems spectrum where social accountability can positively influence health outcomes.

Social accountability tools and approaches encompass a broad range of interventions, with diverse designs and democratic principles that allow citizens to have a voice regarding decisions that impact their lives—including how public services are designed, delivered, and maintained. Civic engagement increases transparency, fosters greater civic voice and participation in public service delivery, and supports social accountability tools and approaches, including patient charters, exit interviews, user committees, community scorecards, Partnership Defined Quality (PDQ), and talk-back radio (**Annex 1** provides a table of accountability tools). Both WABA and RISE II projects used a combination of patient charters, community dialogues and the community action cycle (CAC) (these are similar to PDQ), data for decision making, and community feedback.

In Breakthrough ACTION programming, social accountability takes place at multiple levels and with different stakeholders, all of whom have a vested interest in the outcomes. Therefore, a functional health system, adequately supported by municipal services, is necessary for improving the health and lives of its citizens. These two projects worked primarily on the second and third levels of accountability.

1. **The first level of accountability occurs within the health system**, where the regional, district, and national actors hold one another accountable for meeting their responsibilities. These actors maintain accountability through supervision, monitoring, and regular meetings.
2. **The second level of accountability occurs between health facility providers and the communities** they serve. Community members have shared their thoughts about health service quality through selected health committees, quality improvement teams, and individually as private citizens. Community groups can use participatory tools (e.g., scorecards, a problem tree) to analyze their health situation to implement and monitor collective actions. In addition, citizens must learn to advocate with leaders in the health and municipal systems to collaborate and agree upon commitments and obligations. Private citizens can use exit surveys, suggestion boxes, or community radio to hold health workers accountable for services.
3. **The third layer of accountability occurs when community members hold their health committees accountable for planned activities**. The health committees or community action

[4] WHO. (2007). *Everybody's business—Strengthening health systems to improve health outcomes: WHO's framework for action*. https://apps.who.int/iris/handle/10665/43918

groups communicate with the broader community to share and validate plans and report on implemented activities and results. This feedback loop enables the wider community to respond and share opinions on the collective action process. Community fora can be scheduled quarterly or semi-annually for that purpose as well.

Elected political appointees, technical officials, private citizens, and civil society organizations all also carry out accountability. For example, community groups often need to advocate by lobbying with municipalities, local and national parliamentarians, and governments to improve health facility infrastructure and provide the necessary equipment, medical supplies, and staffing.

Figure 1 illustrates the conditions and community engagement process outcomes necessary for promoting the second and third layers of social accountability used by Breakthrough ACTION's WABA and RISE II programs. While power relations and rights are important elements of social accountability, the project did not focus on these aspects concerning community engagement efforts.

This brief describes how Breakthrough ACTION developed an environment that fosters social accountability between health service providers and communities. Community engagement interventions enabled citizens to engage with health providers (in person or through meetings) to discuss improvements regarding the demand and use of health services. These experiences show that community engagement processes create positive changes in service quality, including improved conditions for health workers, increased health worker performance, positive interactions with health system users, and improved health facilities—all of which ultimately increased demand for health services.

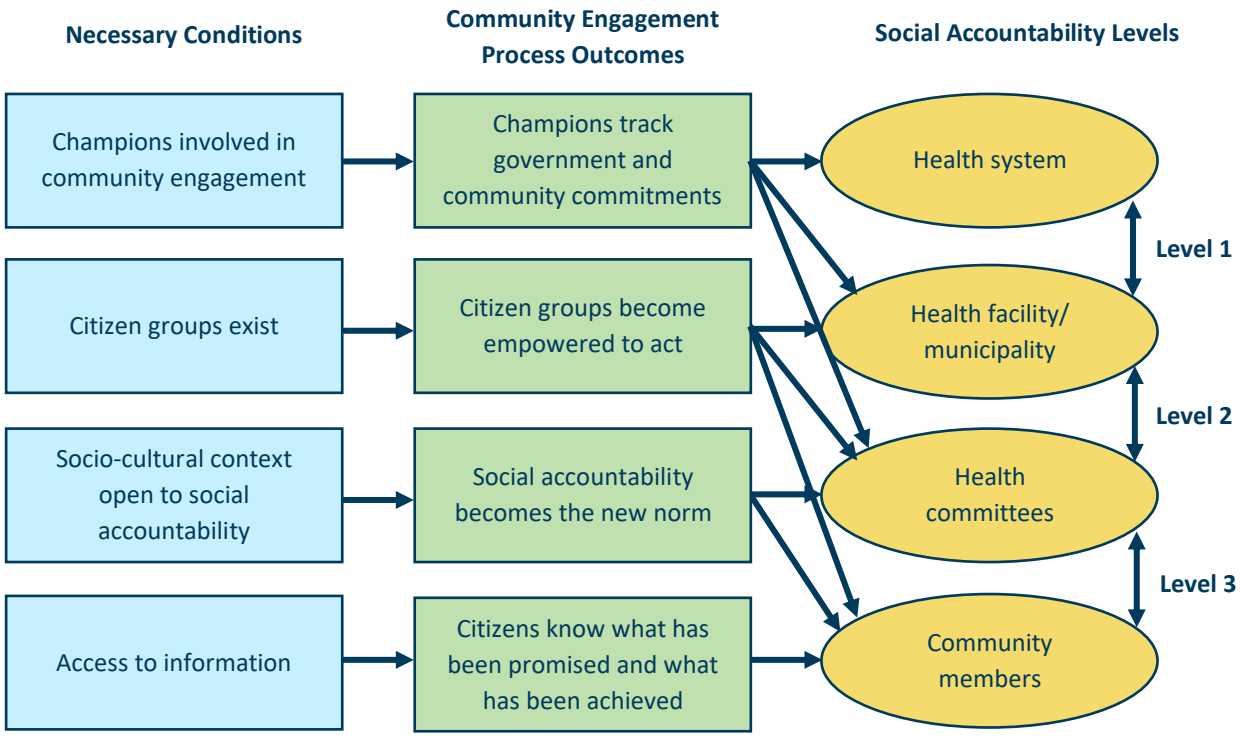

Figure 1. Social Accountability Pathways

III. Interventions and Context of Implementation

WABA and RISE II implemented similar community engagement approaches in Burkina Faso, Côte d'Ivoire, Niger, and Togo. RISE II applied the traditional CAC approach that included a community entry phase: "Organize the Community for Action." Meanwhile, WABA started at the explore problem phase with integrated community dialogues and health center walkthroughs. Both approaches focused on problem-solving through collective action, which created an opportunity to incorporate social accountability within communities and between health service providers and community members. These approaches increased demand for improved health services as described above in the second and third layers of social accountability.

RISE II supported four USAID Resilience Food Security Activities and two health service delivery partners to implement the CAC process in selected health facilities to address FP/RH; maternal, neonatal, and child health; nutrition; and WASH. **Figure 2** illustrates the iterative community engagement process that connects health service providers, communities, and sometimes municipal and health systems leaders, to explore health challenges, set priorities, and develop plans and actions together. This community engagement process aims to assure high-quality health services that promote healthy behaviors within households and at the community level.

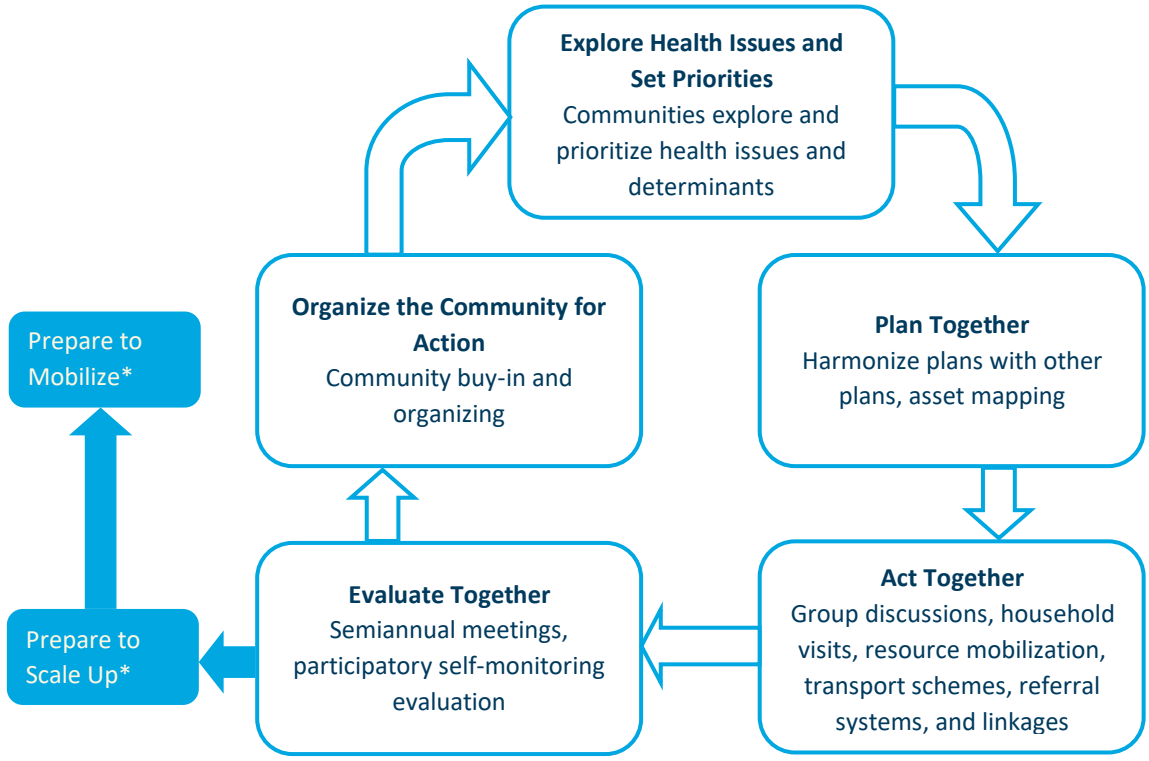

Figure 2. Community Action Cycle

Using the same framework, WABA started at the "explore problems" phase with community dialogues and health facility walkthroughs that moved to the "plan together" phase by developing joint action plans. These inclusive and transparent community engagement processes provided community members including women, marginalized members, men, youth, and religious leaders, with a voice on how to improve health services to meet their needs. When leaders such as the secretary general of the commune, or the mayors, participated in community engagement activities, they recognized their roles and responsibilities and tried to address them. As a result, select health centers made necessary repairs or organized clean-up days, and two districts included FP in their budgets. One district assigned a female health worker to the health center so that women could deliver their babies with a female health professional. Another district provided Aquatabs to prevent diarrhea during the rainy season for families who work in the fields.

Although showing great achievements, such as advocacy for local municipalities to invest more in primary health care as per their roles defined in "decentralization" policy, these Breakthrough ACTION projects did not focus on improving competencies in advocating for more powerful structures such as the health system. The project recognizes this shortcoming of these community engagement processes in realizing robust social accountability.

WABA Community Dialogues, Site Walkthroughs, and Action Plans

WABA, in collaboration with the Amplify-FP project, worked with Ministries of Health to support 135 health facilities in conducting community engagement activities. The WABA teams initially worked with district health officials to identify key regional, district, and municipal government stakeholders responsible for overseeing FP/RH services and community-based activities. These stakeholders formed a core district multisectoral committee called *Comité d'Appui Technique au Réseau Intégré d'Apprentissage* (Technical Committee Supporting Integrated Learning Networks [CTAR]) that managed the community engagement and FP service quality improvement process. During the district entry phase, WABA project staff met these leaders to review and analyze FP/RH indicators and discuss gaps and problems. The district-based health team and the CTAR identified key performance and behavioral issues around FP/RH, such as low numbers of antenatal care visits, low adoption of family planning methods, and poor use of FP services. In collaboration with the district health officials, the project chose the health centers with the weakest statistics for this community engagement activity. WABA staff trained the CTAR and other district health officials to define priority topics and plan community dialogues using tools developed for this purpose.

The CTAR organized and facilitated community dialogues with health service providers and local citizens to identify both health provider and patient barriers to the uptake of services. These groups included health facility management committees and key women's groups. Approximately 100 community stakeholders per health facility catchment area, including community and religious leaders, representatives from village development committees, women's associations, youth groups, and other prominent community-based groups, and the primary health center staff participated in each

community dialogue. CTAR organized community dialogues in the project's 19 health districts across the four WABA countries. As the Langabou health facility manager at the Blitta Health District in Togo noted, "*In the three years that I have been assigned to this health post, I have not had the opportunity to discuss health issues directly with the community until today*."

Recurring obstacles that surfaced during these community dialogues included poor provider attitudes about clients, lack of men's involvement in facilitating women's access to FP/RH services, fear of FP method side effects, perceptions of costs as barriers, and absence of providers from services. Providers also shared their challenges, including little or no pay for services, crumbling infrastructure, lack of FP methods to offer, and no job stability.

After the community dialogues, a subset of stakeholders (about 30) participated in a health facility walkthrough to help them understand the conditions health workers face at their workplace. This allowed health workers to explain how the center operates, how they are resourced, and other challenges they face as providers. These site walkthroughs dispelled rumors about how services are offered, illustrated that district health and municipal officials make decisions rather than health facility staff, and provided an intimate space to speak openly and honestly. During one site walkthrough in Burkina Faso, a community association leader remarked, "*Health workers target only women for FP, while you know that women cannot decide without their husbands. Change your communication methods, or the problem will always be there*."

Once the teams completed the community dialogue and site walkthrough, the CTAR and a subset of community stakeholders (e.g., health committee members, religious leaders, youth and women's group representatives), reviewed the challenges identified and jointly drafted a community action plan to tackle the identified issues using local solutions, such as, mobilizing financial resources to pay for the cost of reorganizing facilities or engaging traditional, religious, and community leaders to publicly support couple communication and male engagement in FP/RH. With a plan in place, the CTAR and community engagement teams returned to the community periodically to track progress: examining what had been accomplished and what still needed to be done. At the end of the process, they discussed the actions required in a new action plan to achieve the desired outcomes. As a result, across the four WABA countries, communities developed, implemented, and updated 84 facility-based community action plans addressing the barriers to FP/RH service uptake. The action plans included activities at all levels (district, municipal, health center, community), such as reorganizing the space for client privacy and welcoming clients, raising funds to buy equipment, and conducting targeted household and group discussions. The CTAR after that had regular check-ins with a committee in charge of implementing the plan. This established a follow-up mechanism, created an opportunity

> *"What is good about the 'site walkthrough' is that the population itself detects the problems related to the health facility and the participants find solutions and implement them. So long story short, I would say that in this health facility, after the site walkthrough, our structure had issues [...], now you can see that our windows are well furnished with grills and mosquito nets. These are donations from the community."*
>
> — Health provider, Anyron health center (Togo)

and a culture for the implementation committee, and enabled the health service providers and the CTAR to hold each other accountable for accomplishing designated action plan activities and quality improvement. Instilling this culture of taking stock of what has been implemented, reporting back, and sharing feedback between service providers and community health committees has improved accountability among stakeholders in the health catchment areas.

RISE II Community Action Cycle

The RISE II project worked with four Resilience Food Security Activities and two health service delivery projects in Burkina Faso and Niger to introduce the CAC under the auspices of the multisectoral community mobilization team (MCMT) that involved regional, district, and municipal stakeholders from health, water, agriculture, and community outreach services. This group is equivalent to the CTAR in the WABA approach. Niger and Burkina Faso held over 100 community entry meetings attended by 14,000 people (over half of which are women) from 80 communities. As a key outcome of the community entry process, village representatives verbally expressed and affirmed their commitment to the process during an official ceremony. These commitments constituted a memorandum of understanding that each village put in place with the health facility in their respective areas, establishing the first opportunity for social accountability. The MCMT conducted three-day community workshops with community groups and champions to identify and prioritize problems. Stakeholders in Niger identified low antenatal care attendance in the first trimester of the pregnancy, low health facility delivery, and low utilization of family planning methods as key FP/RH priorities. In Burkina Faso, stakeholders identified low uptake of family planning methods as the key priority.

Pregnant women from Téké, Lihidda, and Guida Rouwa in Niger board the ambulance canoe purchased by the health committee to attend antenatal care at Elkolta integrated health center in Maradi. Photo credit: Souley Ibrahim, Breakthrough ACTION

The MCMT helped stakeholders in Niger develop health center community action plans, while in Burkina Faso, each village developed an action plan which they shared with the broader community and district officials for input and validation. Involving district stakeholders and the community in validating these action plans made the health system's and health committee's commitments visible. Through the CAC process, these communities developed plans and commitments to hold these parties accountable to their promises. The CAC process enabled the health management committee to express their expectations to district stakeholders and hold district authorities accountable for fulfilling their responsibilities, which included supporting health promotion through collective community action.

The open and cooperative atmosphere created during the community engagement process enabled women, youth, and other marginalized individuals to speak up and express their opinions. As noted, this was sometimes the first time that health workers heard from the community or that clients understood

the challenges health workers face in navigating the health system. The health committee mobilized resources and documented actions to implement the action plan. The MCMT provided coaching and supervision to guide the health committee and community in fulfilling these actions. This regular engagement created a feedback loop for community stakeholders, health service providers, and the health committee to discuss progress, performance, and ways to improve. This a sense of teamwork and cohesiveness in the community because members could see positive changes and recognize that they were responsible for them. When the action plans reached completion, the district-based MCMT invited the community and the health facility stakeholders to reflect on their achievements. The use of participatory tools (i.e., scorecards and quick key informant interviews with local actors), enabled community members and health officials to compare achievements against key indicators. They documented lessons learned and recommendations and used them to develop a new community action plan. This phase also allowed community members to hold their representatives accountable for completing their responsibilities, such as ensuring the availability of medical supplies and access to water and electricity. The MCMT in coordination with community members amplified findings through community radio and other community media, allowing more distant members to participate in collective community action for improving health outcomes.

IV. Achievements and Results

The Breakthrough ACTION community engagement activities in West Africa through RISE II and WABA achieved exciting social accountability results among health committees and service providers and with district health management teams. Both projects contributed to improving the relationships between health service providers, community leaders, and community members in all four countries to drive collective community action and increased accountability toward one another regarding improved uptake of FP/RH services. Working together to solve identified problems helped different groups understand and appreciate each other's perspectives and contributions to solving the problem. For example, one community member from Droum village in Niger participated in a site walkthrough during which he discovered the workload of a health worker. After the walkthrough, he hugged him, saying, "*I understand your attitude now. Please forgive me for everything I thought and said about you. I will be your advocate before other community members and the local authorities henceforth* […]."

The mayor of the same village added, "*This approach needs to be institutionalized because it allows decisions to be made with the community and gives them the right to ask [local leaders] for accountability. Because of that, as local leaders, we are forced to keep our word by implementing what we committed to do.*"

When the municipal and technical service officials got involved in community engagement activities, they were reminded of their responsibility to provide adequate services, such as paying health workers salaries or ensuring functional utilities. These officials felt further excited and encouraged to see communities contributing to resolving identified problems, which prompted them to support these communities because they believed their investment in the community would be valued.

Donation from the municipality Wacha in Niger to its health facilities after advocacy from the health committees. Photo credit: Amadou Habou, Mayor, Wacha commune

Finally, contributions came mainly from the communities mobilizing resources themselves. One community in Niger made and stored bricks that could be used to construct observation of child labor and delivery rooms. Another instituted fines for couples who did not go to the health facility for birth delivery. They used these resources to equip the health center better. Others requested resources from members who were living in the city or from the diaspora. The unifying element in these communities was that the actions were important to them, so they sought and found the resources. And as a result, the health centers started reporting increased demand for and use of services.

Across the four countries, communities contributed ideas, raised funds and in-kind donations to address the low uptake of FP/RH services, as illustrated in the examples below:

- **Togo**: Communities raised over $20,000 to renovate health facility buildings and repair and purchase equipment (e.g., lamps, examination beds, water infrastructure) and medical supplies (e.g., oxygen cylinders, wheelchairs).
- **Burkina Faso**: Communities raised over $50,000 to reorganize health centers to improve clients' privacy and experience, purchase equipment (e.g., hospital beds, delivery tables, mattresses, timetables, blood pressure monitors, chairs, benches, lamps for night shift, intrauterine device insertion materials), and to cover community health workers transportation and lunch allowances for outreach services.
- **Niger**: Communities mobilized in-kind and financial resources valued at almost $100,000 to construct private labor and delivery rooms and improve electricity and water supply at the health centers. They built houses for staff to be onsite. Some health committees advocated with the local municipalities to purchase health facility equipment, and others implemented transportation schemes (ambulances and boats) to support travel to various FP/RH health facilities.
- **Côte d'Ivoire**: Communities raised over $60,000 to build perimeter walls, supply electricity, and repaint and rebuild sections of dilapidated health centers.

Though the projects did not explicitly design interventions at the community level to demonstrate the effect of social accountability on health outcomes, creating conditions for communities to take tangible collective action and resolve barriers to service use did generate demand for FP services. For example, WABA implemented a referral coupon activity in sentinel sites, where data over the past three years suggests this intervention contributed to the uptake of FP services.

V. Lessons Learned

Social accountability approaches use civic engagement and community participation to empower responsible citizens and organizations to improve service delivery that, in turn, improves health outcomes. Further, building a shared understanding of effective community engagement interventions and standards may enhance social accountability as part of SBC and health system programming. The following are key insights learned through these projects.

Government sector staff with demonstrated facilitation skills encourage social accountability.

Skilled facilitators that mobilize community members strengthen those members' capacity to act collectively on FP/RH related issues and link community members to different levels of government and health systems. This helps assure accountability by identifying responsible parties and encouraging community members to advocate for those services guaranteed by the health system and municipal leaders. Projects can work with health system staff to strengthen facilitation skills so these staff can promote and oversee social accountability mechanisms and apply relevant social accountability tools (e.g., community scorecards, Partnership Defined Quality tools, citizens charters). Implementing pre- or in-service training packages to improve facilitation skills is worth the effort. Beyond staff capacity strengthening, social accountability needs to be institutionalized. Governments must develop social accountability policies and implementation guidelines that outline various structures, regular community engagement, and required reporting. For example, a standard operating system detailing community engagement guidance for social accountability and a social accountability performance rewarding mechanism area are tools that can be considered.

Multisectoral participation ensures multi-level engagement and outcomes.

Typically, the health system lacks trained staff with competencies in community development and community capacity strengthening for collective action. Thus, developing effective community engagement activities requires field staff and extension workers from other sectors to facilitate and coordinate these efforts. Breakthrough ACTION found that when these stakeholders got involved in problems identified by the community, they took the information back to the different technical services to receive responses. Therefore, if a health center needs water or improved toilets, having a Ministry of Water or a municipal representative involved in the community engagement process will help deliver results. While involving staff from other line ministries adds challenges that demand strategic and structured joint planning, coordination, and political will, the team's multisectoral nature reinforced the community's confidence in the process. The benefits of broadening participation to other sectors increased the quality of the process and allowed for economies of scale.

Linking social accountability and community engagement initiatives to the municipality and local council mandates can accelerate positive change.

The responsibility for primary health care in African countries has primarily devolved to locally elected leaders and municipalities according to decentralization guidelines. The CAC approach purposefully involved elected municipal officials and government technical services because when mayors participated, they understood how critical their contributions were to a properly functioning health system. It also enabled the community to advocate with the municipality for health facilities, staffing, equipment, and other resources the municipality is responsible for supplying. Further, when the municipal officials saw the energy and commitment stemming from the community to tackle issues they had identified as problems, these officials gained greater confidence that their investments would be valued and protected.

Training community members to strengthen their skills and communication skills gives them greater confidence to demand social accountability from themselves and their leaders.

When communities understand that they can solve problems themselves, they gain the confidence to make changes in their community. They also better understand the responsibilities of the municipality and the health system. When community engagement processes include an advocacy component to hold elected officials accountable, the community is better equipped to demand accountability from the local leaders in collaboration with and in support of the health providers.

Measuring social accountability can be difficult but is not impossible.

The project measured community engagement but did not have specific systems to measure social accountability. As noted by others, "*Monitoring progress in social accountability is difficult because accountability initiatives are often abstract and complex, consisting of dynamic interactions between social actors*." WABA and RISE II demonstrated that engaging stakeholders at different levels of the system can spur leaders to improve services that in turn, improve health outcomes. Still, these projects did not formally measure or study this phenomenon.

Improving advocacy capacity as part of the community engagement initiatives may assist communities and health center personnel in improving accountability with local leaders and technical officials.

While the projects focused on really engaging the communities in understanding, prioritizing, and solving problems that affect their use of health services, they did not focus on strengthening the advocacy skills of communities to push for systemic changes at the municipal or technical services level. This is a shortcoming that Breakthrough ACTION recognizes and plans to address in Niger under the next phase of the work.

Investing in public sector structures secures a position for community engagement within the government system, but it may not be the most effective way to ensure sustained social accountability.

While the project involved public sector structures in the community engagement process to help ensure that such activities became an intrinsic part of government systems, these power structures may not be best suited for ensuring social accountability within their system. The project purposefully did not provide resources to communities because the approach aims to demonstrate to communities that they can solve their problems without relying on outside resources. Government entities have mandates to engage with communities, but often, they cannot do so effectively. Therefore, a public-private partnership approach involving civil society organizations to serve as a conduit between communities and government systems as they seek social accountability might be helpful.

VI. Conclusion

The Breakthrough ACTION RISE II and WABA programs in francophone West Africa implemented community engagement interventions to improve the uptake of FP/RH services. In the context of these two programs, social accountability became a way to draw attention to stakeholders' (communities, programs, and governments) unfulfilled commitments or deficiencies, and increase the likelihood of delivering what is promised. Results from both projects show promising improvements in the relationships among health service providers, municipal leaders, and citizens that can lead to tangible collective community action to improve health service delivery, ultimately improving demand for and uptake of health services. Communities, municipalities, and health actors secured funds to improve health facilities, purchase equipment and medical supplies, and remunerate health workers for outreach activities. These experiences demonstrate promising approaches for improving relationships between health service providers and communities, bolstering collective community action, enhancing transparency and accountability, and delivering quality services through the cooperation of all health actors and communities. The outcome of the Breakthrough ACTION experience in West Africa in applying a social accountability approach for the uptake of FP/RH services is consistent with other experiences elsewhere. These outcomes demonstrate that social accountability can lead to improvements in health services and supplies, higher quality care, an increase in public funding, positive changes in government policies, and health system resiliency. **Annex 3** contains a list of bibliographic resources.

SBC and health system programs are still developing social accountability approaches, and promising interventions are emerging. Three broad categories to advance the field include (1) a shared understanding of viable social accountability approaches, (2) implementation standards, and (3) coherent ways to measure social accountability. How the sector monitors progress, recognizes gaps and opportunities for improvement, ensures inclusiveness, and measures success deserves focus and investment to move the field forward. As community engagement and social accountability advance, practitioners in SBC, HSS, and community health spaces must discuss and identify elements of promising social accountability and systems interventions. Strengthening the capacity of government sector staff to implement social accountability interventions requires a sustained strategy to build community engagement skills in sectors that often lack development approaches and political will with a long-term vision that harnessing community resources will lead to improved health outcomes.

Social accountability flourishes when communities and health workers trust each other and learn to identify and resolve problems together. Thus, when implemented with attention to accuracy and effectiveness, community engagement processes that emphasize social accountability can spur collective action. Moreover, such processes can improve a perceived self-efficacy to improve health status in collaboration with health sector stakeholders.

Annex 1: Social Accountability Tools

Annex 2: Social Accountability: Function, Tools, and Application

FUNCTION	TOOLS	APPLICATION
Increase transparency	• Patient charters (applied under WABA) • Budget literacy campaigns • Public policy announcements/ hearings	• Democracy and governance • Advocacy • Service delivery/quality improvement • HSS (financing and government) • Data for decision making • Community action planning
Strengthen voice and participation	• Facility exit interviews • User committees • PDQ (a version applied under WABA) • CAC (applied under RISE II)	
Strengthen monitoring and accountability	• Social audits • Public expenditure tracking survey • Community score cards (a modified version applied under RISE II in combination with the CAC) • Community feedback processes (applied in the context of the CAC under RISE II)	

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