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WORLD BANK GROUP

GPSA NOTE 17

HOW SOCIAL ACCOUNTABILITY STRENGTHENS CROSS-SECTOR INITIATIVES TO DELIVER QUALITY HEALTH SERVICES?

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Citizens have a role to play in supporting health care quality and access as well as equality in the delivery of health services. This note is an overview of lessons from evidence about how social accountability processes can strengthen cross–sector programs to deliver health services. Social accountability is a process that enables the inclusive participation and collective action of citizens and civil society organizations in public policy making and implementation so that state and service providers are responsive to citizens' needs and held accountable.

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Three principal, not mutually exclusive, approaches are found for social accountability to add value to health sector reforms: producing information, campaigning for accountability, and undertaking programmatic problem solving. The latter is called collaborative social accountability. It is a process that engages citizens, civil society groups, and public sector institutions in joint, iterative problem solving to improve service delivery, sector governance, and accountability. This note underscores the added value of collaborative social accountability processes. This includes improving the quality of design of operations, mitigating risks associated with implementation, strengthening health systems and governance, and aligning stakeholders.

In so doing, collaborative social accountability can contribute toward strengthening health and cross-sector programmatic gains. Rules of thumb guidance for future opportunities would include connecting health reforms and civil society led interventions throughout the life cycle of project operations and investing in social and political capital for the sector. This note concludes with insights about the roles that international development partners can play to support locally-led processes for improving the quality and delivery of health services.

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Health Delivery as a Team Effort

Health care access and quality is unequal around the world, limiting people's ability to receive the services they need to live fulfilling lives. Twenty-first century health initiatives to address access, quality, and equality are clear: the health sector on its own will not overcome these challenges. These initiatives include the Universal Health Coverage coalition, the Global Financing Facility, and the World Bank's Human Capital Project, among others. Health policy making and programming is becoming a team effort in which the whole government has a role to play. These are cross-sector initiatives — neither health nor any single sector can deliver outcomes on its own.

While government should lead on delivering access to the quality health services that all people need without hardship, other actors have a role to play as well, including citizens, health users and patients, local communities, and health care workers. According to the World Bank (2018):

▸ Citizens should be empowered and informed to actively engage in health care decisions and in designing new models of care to meet the needs of their local communities.

▸ Health care workers should see patients as partners and commit themselves to providing and using data to demonstrate the effectiveness and safety of health care.

▸ Health systems should focus on competent care and user experience to ensure confidence in the system.

If health should be a whole of society effort, social accountability processes can help make that vision a reality. Social accountability is a process that enables the inclusive participation and collective action of citizens and civil society organizations in public policy making and implementation so that state and service providers are responsive to citizens' needs and held accountable. Social accountability is about citizen action

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and state action, supported by three enabling levers that should work in tandem. They are civic mobilization, interface spaces between citizens and the state, and information (Grandvoinnet, Aslam, and Raha 2015), even if in its discourse and practice discussions about these three "ingredients" have advanced through parallel pathways.

In practice, social accountability takes place or develops as a process within dynamic sociopolitical contexts. It entails the combined use of public spaces and forums, mechanisms, and tools to gather citizen feedback and encourage participation. This process includes formal (mandated by laws and regulations) and informal (set up by citizen groups) ways for engaging people and communities in meaningful and inclusive participation and deliberation aimed at public problem solving. Social accountability efforts put emphasis on a broad range of results — including transparency, accountability, improved governance, better service delivery, citizen empowerment, and rights claiming.

This note presents a framework and guideposts to support public sector and international development partner teams working in cross-sector initiatives for health to operationalize social accountability processes. It synthesizes and draws on a growing body of evidence and learning about the value add and limits of social accountability in health.

The note then deepens the discussion of collaborative social accountability. It is distinct because it engages citizens, civil society groups (CSOs and other types of organized citizen groups) and public sector institutions (public, semi-public, or third-party service providers contracted by the state) in processes aimed at joint, iterative problem solving. These processes invest in creating new or strengthening existing collaborative spaces whereby CSOs and public sector institutions with decision-making power and public management authority at different levels across the institutional and service delivery chain convene to analyze a problem, identify citizen participation mechanisms to help solve it, and agree on joint actions to co-produce solutions and appropriate responses.

It argues that collaborative social accountability processes add value to cross-sector health interventions by improving the quality of policy and program design by articu-

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lating insights from stakeholders across the system (Guerzovich and Schommer 2016). These processes introduce mechanisms to mitigate the risks that political and social dynamics will undermine the implementation of carefully designed, technically sound, sensible policies (World Bank 2017). Collaborative social accountability can strengthen health systems and governance (Ball and Westhorp 2018) as well as align stakeholders across the system. In so doing, collaborative social accountability can contribute toward more effective programmatic results.

The note offers some rules of thumb to design more effective and sustainable social accountability processes. It concludes by specifying ways in which international development partners can support locally-driven, collaborative social accountability processes for health systems. These insights are particularly timely because the Universal Health Coverage agenda provides a potential environment in which to ensure that collaborative social accountability processes at the country level are adapted and scaled up (Burgess et al. 2019).

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What Is the Value of Social Accountability for Health?

The *World Development Report 2004: Making Services Work for Poor People* changed the conversation about the delivery of public services, proposing accountability as a key feature of health systems (World Bank 2003). It argued that traditional technical fixes recommended by sector experts to address the immediate causes of faulty delivery will not suffice to improve the quality of service delivery to the poor. When doctors are not delivering quality health care, better equipment is often not enough to solve the problem. Drug stockouts and incentives to stay in marginalized communities will not suffice to improve quality. These solutions will not work unless the incentives in the health delivery system are realigned. For instance, increasing doctors' salaries will not have the desired effect if doctors receive salaries when they are absent from clinics or they earn more in private practice.

In the years since 2004, the report's insights spurred experimentation in the health sector. Practitioners looked at a range of actions through which they expected to contribute to health delivery in concrete contexts and at scale. These included, among others, efforts to produce information to hold providers to account, interventions to raise awareness about patients' rights, and ways to monitor health budgets and their allocation. Fifteen years later, the field cannot be reduced to a single paradigm (Guerzovich 2019a). No single set of assumptions about how change happens captures the complex dynamics in which social accountability processes operate. No single set of assumptions can prescribe how actors supporting change from different vantage points in the system can better contribute toward change.

This section introduces three distinct approaches to social accountability for health and discusses them in detail.[2] Key characteristics of these ideal types are summarized in table 1. To be sure, reality is more complex and specific interventions may combine

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2   The note does not attempt to do a systematic review of the literature in the field. Multiple reviews of evidence and practice are building blocks for the analysis. It proposes a framework to revisit and update the findings from those reviews.

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elements across columns in the table. The note presents each approach in its own terms, rather than trying to fit them into a single map.[3] This task is important moving forward as the note contends that practitioners can benefit from engaging the potential and limits of each approach in concrete circumstances as well as possible synergies, rather than pretending that one of them may be universally applicable.

Table 1. Three Approaches for Social Accountability at Scale

	Scaling Monitoring for Health Outcomes through Information and Replication	Scaling Monitoring for Accountability through Civil Society Campaigns	Scaling Coproduced Monitoring through Health Programs, Policies, and Delivery Chains
Key Problem	People lack information about the quality of providers and cannot hold them to account.	Power structures and political dynamics preempt people's ability to hold the state and providers to account.	Processes to foster meaningful engagement of people, governments, and providers in health policy making (especially implementation) and service delivery are lacking.
Value Add and Function of Social Accountability	Produce information through structured participation and use it to induce behavior and other types of changes at the point of service delivery.	Combine macro and micro demands and present them to public sector institutions through civil society intermediaries and networks to create and sustain pressure for changes in the system.	Improve the quality of design, implementation, and assessment of specific sectoral programs and policies. Mitigate political and implementation risks entailed in particular delivery chains and policy processes.

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3   Thanks Alan Hudson for challenging us on this point.

	Scaling Monitoring for Health Outcomes through Information and Replication	Scaling Monitoring for Accountability through Civil Society Campaigns	Scaling Coproduced Monitoring through Health Programs, Policies, and Delivery Chains
Main Site for Problem Solving	Service delivery frontline.	Accountability system, including institutions and agencies with oversight responsibilities at high–level areas — within and outside the sector, such as sector legislative committees — responsible for policy making.	Intermediate governance and managerial levels in the sectoral chain of service provision, in coordination with frontline and high–level decision–making areas.
The Pathway for Problem Solving at Scale	First, pilot feedback gathering and community and users' monitoring tools tailored to improving access to health information and use of health services in select sites. Second, use rigorous evidence to inform replication across a larger number of sites.	Social movements and civil society organizations organize campaigns (such as awareness raising and people mobilization) to build and deploy countervailing power to influence the decisions that affect the access and quality of health delivery across the system.	Collaborative social accountability processes enable politically informed experimentation in targeted entry points of the health and country systems, first. These processes are a purposeful investment in paving the way for ongoing adaptation for improved policy making and delivery beyond the original target.

To visualize the three alternative approaches, which can be combined, consider the three parts of Figure 1. Social accountability is a complex process – full of tangible and in–tangible components that we mix and match. This means that the field and researchers keep coming up with different types of maps to represent the work. Figure 1 includes three of these maps, considering that the maps are never the same as the territory.[4]

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4   We thank Eric Sarriot for his suggestions.

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The first approach to social accountability concentrated on stand–alone civil society interventions working on the frontline as a way to generate results in select sites in the short term. Those sites could be multiplied but did not change the system (Figure 1a illustrates the short route to accountability).

The second strand of social accountability interventions puts emphasis on the pressure exerted, at once, from reformists which may include champions in the public sector and civil society networks, especially international nongovernmental organizations, etc., and from the bottom by grassroots movements, local organizations, etc. Think of the teeth of two cogs coming together and triggering a result via pressure, or the slices of bread in a "sandwich" leaving little room for the filling in the middle (Fox 2014) (see Figure 1b).

These two strands of debate have dominated discussions about what social account–ability is, how it should be researched and evaluated, and what we are learning about its results. Individually and collectively, they fail to capture practice's evolution: we have a blind spot about what the work is for many practitioners (Guerzovich 2020; Jacobstein 2020). Figure 1c illustrates the blind spot and contrast by introducing a third cog and changing the directions of dynamics. It illustrates the governance and managerial lev–els in the sectoral chain of service provision that is overlooked by the other approach–es. Emphasis is not on individual reformists or general accountability institutions in the top cog, nor on the function of civil society as a watchdog in the bottom cog. The spotlight is on how civil society efforts fit with public sector reforms as well as deliv–ery systems to generate trust and solve problems together. The direction of the arrows indicates that the third approach expects insights from work in the frontline to interact with the "middle" cog representing, for example, the spaces where actors in the sys–tem have mandates to interpret ambiguous protocols and procedures as well as adapt standards and policies to local realities. The frontline insights flow through the middle, to channel insights into the policy arena. Insights would flow through policy and pro–grammatic processes oriented toward service delivery adjustments and changes.

Figure 1. Comparison of the Three Approaches for Social Accountability
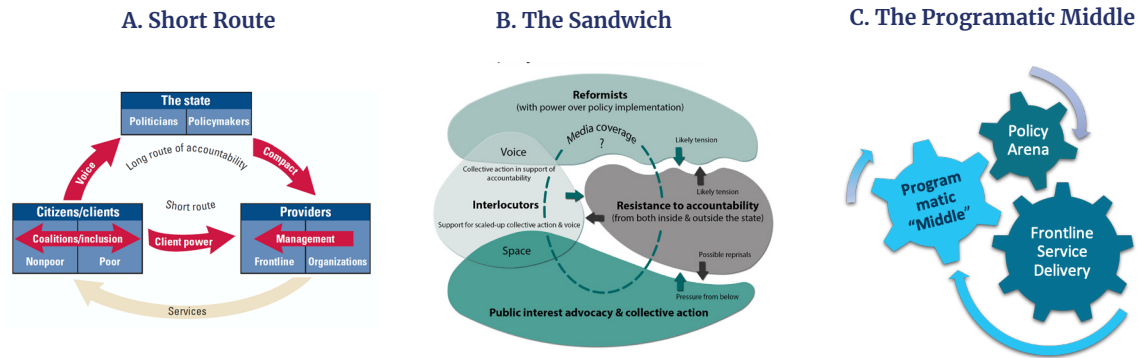
Sources: World Bank (2003), Fox (2014), KOMPAK (2018), Levy and Walton (2013).[5]

MONITORING TO IMPROVE OUTCOMES: INFORMATION AND REPLICATION

Much early social accountability work for health focused on closing the information gap that prevents citizens from holding providers to account at the frontline. The typical theory of change was that health service delivery and its outcomes could be improved by empowering community members to demand high-quality services, monitor service providers, and hold them accountable for poor performance (Fox 2007; Ringold et al. 2011; Molyneux et al. 2012; Khemani 2007; Mansuri and Rao 2013). It often overlooked the role of contextual variations in terms of the country system and the sectoral problem or failed to provide systematic insights about how country and sector contexts mattered (Kosack and Fung 2014; O'Meally 2013; Grandvoinnet, Aslam, and Rao 2015; Wild and Foresti 2013).

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5   Thanks to Sue Cant and Elvi Tambunan who contributed to this visual.

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In a well-known randomized field experiment, Björkman and Svensson (2009) tested the effects of mobilizing communities to use information to create citizen report cards and apply bottom-up pressure to health providers in 50 rural communities in Uganda. They found that the intervention improved infants' weight, lowered the number of under-five children deaths, and increased utilization of outpatient services and of antenatal care and family planning, among other positive results. A range of positive procedures improved as well (e.g., immunization of children, waiting time, examination procedures, and absenteeism). "These large treatment effects on health care delivery and health outcomes remain more than four years after the initial intervention" (Björkman, de Walke, and Svensson 2017).[6]

According to Donato and Garcia Mosqueira (2018), the relative simplicity of information-based interventions makes the results attractive to policy makers with scarce resources (although see, Arkedis et al. 2019). The related assumption for policy makers was that if information, as other simple, short-term interventions (e.g., vaccination, provision of iron supplements and condoms), had proved efficacious and cost effective, they should be delivered to millions across contexts (Banerjee and He 2008). The challenge was primarily logistical: rolling out a new product line across an existing series of outlets.[7] Many social accountability practitioners thought that the way to persuade health colleagues to join the team was to show they could match or outperform simple sectoral interventions.

Ten years later Raffler, Posner, and Parkerson (2019) tried to set up an information-based intervention by replicating the Björkman and Svensson (2009) study at scale through a program called "Accountability Can Transform Health." They tested a large randomized intervention with 14,000 people in 376 villages in 16 districts across 4 regions of Uganda. However, the simple intervention did not lead users to

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6   Donato and Garcia Mosqueira (2018) conducted research to reproduce the original results using the same data and published methodology from Björkman and Svensson (2009). They found that the intervention modified health care provider behaviors and utilization. The results surrounding the program's impact on health outcomes appear less robust.

7   Barder (2014) remarked this common model is the wrong one: "Scaling up in development is more like building a series of separate businesses from scratch, each in a different market."

apply pressure on underperforming health providers. Community monitoring and bottom-up pressure was very difficult to mobilize. The program marginally improved the quality of treatment patients received and increased patient satisfaction 20 months after it began. It did not affect how often people sought health care (utilization) or improve health outcomes, such as child mortality rates, at least in the short term. This study's results suggest that factors that are often put in a black box – from changes in the health baseline, to the quality of facilitation and implementation, to a range of other variables – matter for the potential of social accountability to be realized.[8]

Arkedis et al. (2019) published the results of another large-scale, randomized controlled intervention perched on the potential of information. "The result of the randomized controlled trial component of the evaluation was null — meaning that, on average, the program did not measurably improve the targeted health outcomes." Qualitative data, nonetheless, pointed to localized, fragmented results. These may include communities coming together for a variety of purposes that on their own did not produce different health outcomes, such as improving access to health infrastructure for service delivery or the provision of supplies in certain contexts (Whitt 2019a,b; Rasaiah 2019). This reinforced the viewpoint that it is challenging to grow the number of people effectively engaged, so that efforts to achieve lasting change in health outcomes may be sustained (Joshi 2013; Fox 2014; ePact 2016; Lodenstein et al. 2016; Waddington et al. 2019).

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8   The synthesis made by Tsai et al. (2019) selects evidence on the impact of government transparency on non-electoral accountability, identifying three main causal mechanisms, which help to organize and categorize different types of accountability-enhancing information interventions: (1) increasing knowledge of how to monitor and sanction, (2) increasing motivation to do so, and (3) lowering monitoring costs. They find the evidence base about the power of monitoring for sanctions is thin and disproportionately concentrated in particular regions, countries, and sector. The comprehensive framework does not explore social accountability programs that seek to solve problems prior to imposing sanctions. More generally, research and evaluation surveyed black boxes causal mechanisms.

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MONITORING TO IMPROVE OUTCOMES:
ACCOUNTABILITY AND CIVIL SOCIETY CAMPAIGNS

Many social accountability practitioners learned from the past and experimented with new forms of action (Carothers 2016). Many interventions designed in the 2010s have an information component, but they are not simple interventions only focused on providing information and improving the user–provider relationship. The doctor may receive information from patients about ways to improve delivery but data for providers will not suffice to improve the quality or equality of delivery because power dynamics (e.g. asymmetries of power between health staff and patients, or between unions and health upper management, or clientelism) will get in the way (World Bank 2017).

Unlike the early social accountability interventions focusing on micro interventions that did not address systemic problems, latter work focuses action in complex systems. For example, one approach focuses action on building and deploying "countervailing power" to influence the decisions that affect the access and quality of health delivery in different arenas. For proponents of this approach, the provision of accountability, or the failure to provide it, is a collective one, beyond the health sector. The focus of action is addressing and shifting power relations that underpin accountability within the broader accountability system — that is, "the actors, processes and contextual factors, and the relationships between these elements that constitute and influence government accountability" (Halloran 2015).[9]

The assumption is that monitoring public officials and providers and denouncing them whenever they deviate from the prescribed or desired behavior will force the state to

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[9]   This section highlights the "more power for bigger change" approach to ecosystems, as the area where a specific community of research-action has moved forward. Other related approaches, in the transparency and accountability field, include : 1) Follow the money – coordinate interventions that focus on different parts of the revenue chain; 2) Do no harm – coordinate interventions that amplify the voices of different constituencies; 3) Collaborate across governance levels – ensure collaboration between international and local level actors; 4) Capitalize on the power of three – coordinate across transparency, participation and accountability interventions (Guerzovich and Mills 2014).

deliver its obligations to fulfill the right to health and provide health services.[10] This route is grounded in the work of social movements and other collective actors that not only apply social accountability tactics at the grassroots, but also advocate and campaign in other levels of government (AMHI 2011; Gaventa and Barrett 2010; Beyerle 2014; Fox 2014; Beyerle et al. 2017). For example, the International Budget Partnership created its new SPARK program (Strengthening Public Accountability for Results and Knowledge) to turn its focus on public budgets into service delivery wins. The program engages with citizen-led organizations and movements as well as media, auditors, courts, and other actors or mechanisms that can add "teeth" to the "voice" expressed by citizen collective action (Halloran 2019).

Relatively, the framing gives importance to the potential of pressure, adversarial relationships, discomfort, and, at times, fear that a state-society coalition exerts over anti-accountability forces in the state and society through a "sandwich strategy" to trigger results (Fox 2014, 2019). The pressure from the grassroots can be supported by pressure from the top. Different specifications of this approach prioritize different actors on the top. In some cases, these are champions in the national public sector, such as in oversight agencies that complement "voice" with "teeth," while in others, the emphasis is on international actors exerting pressure from outside. The common theme is the mechanism through which action works, i.e., the top and bottom of the sandwich coming together as an underspecified mechanism. The mechanism is indeterminate because it fails to specify important aspects of the processes through which change is expected to happen.

However, evidence to back up these assumptions is limited. Using qualitative analysis, Joshi (2017) researched whether social accountability and legal empowerment for health accountability was delivered in Guatemala, India, Macedonia, and Uganda. Similarly, Hernández et al. (2019) conducted a comparative study of 29 municipalities in Guatemala and also examined the potential and limits of using legal actions against right vio-

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10   "Public accountability failures are not accidental—they occur due to embedded power structures and political dynamics that are systemically anti-accountability" (Joshi 2013, 2017; Joshi and Houtzager 2012; Gaventa and McGee 2013; Freedman and Schaaf 2013; Hernández et al. 2017; Hernández et al. 2019; Halloran 2015).

lations, coupled with the use of social accountability tools. Both studies found improvements in users' awareness and confidence, among other positive immediate outcomes.

Other studies also identify localized and individual wins that can help sustain momentum. The absence of transformative results is "reasonable" because struggles are expected to take time. Yet, it is unclear whether campaign-based social accountability focused on sanctions, on its own, is a viable route to achieve policy changes or other transformative results in the delivery of health through the broad country-level accountability system. Evidence suggests that the contribution of stand-alone, primarily civil society led, social accountability is limited, fragmented, and localized:

▸ First, while intra-civil society networks seem to be necessary, broader alliances may be needed to address systemic roots of poor health delivery. Reformers in this tradition may be making unrealistic assumptions about civil society's strength and capacities to create a critical mass for change (Brinkerhoff and Bossert 2014). Entrepreneurs within the state can be critical to tap into opportunities and effectively advance civil society's goals to build participatory institutions in health (Falleti 2009; Mayka 2019).

▸ Second, civil society practitioners of social accountability fail or struggle to adapt their strategies to effectively engage the specific government actors with the authority and know-how to resolve a problem (Guerzovich and Rosenzweig 2014; Guerzovich and Poli 2014b; Joshi 2017). Research provides few guideposts about how to design smart strategies and operationalize them in complex contexts that require multiple, interconnected actions in contexts of limited civil society resources.

▸ Third, research shows that participatory institutions that have deepening democracy as their primary objective struggle with institution building more than reforms that tap into opportunities opened by major reforms driven by sectoral needs (Mayka 2019). The latter are a window of opportunity for institutionalizing citizen engagement for secondary, instrumental reasons. Yet, under certain conditions, it might be possible to support both goals.

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COLLABORATION TO IMPROVE OUTCOMES:
PROBLEM SOLVING AND PROGRAMMATIC ENGAGEMENT

A third strand of action is emerging at the intersection of theory and practice: collaborative social accountability (Box 1). Lessons from experience suggest that development outcomes might be improved where collaborative social accountability creates synergies between civil society–led and government efforts (ePact 2016; Lodenstein et al. 2016; World Bank 2018; Waddington et al. 2019).

Box 1. Collaborative Social Accountability: What Is It, and What Is It Not?

Social accountability is collaborative when civil society and other types of actors adopt nonconfrontational strategies to join interests and resources (knowledge, ideas, power and authority, capacities, and institutional and financial assets) toward addressing common problems and delivering results, as opposed to confrontational strategies based on developing civil society's countervailing power (Kosack and Fung 2014; Guerzovich and Poli 2014b; Guerzovich and Schommer 2016). Forthcoming research from the Transparency for Development Project finds that when communities are left to choose their social actions they often opt for collaborative action and problem solving rather than confrontation. In other words, communities paying attention to the context in which change is expected to occur often choose to use their voice to solve problems before resorting to biting with their own or others' teeth. O'Sullivan (2019) contends that civil society can best be part of a country's journey to self-reliance by having an active role in a society's governance, not just by advocating for changes in government law or policy. However, many funding agencies often undermine those efforts by "directing (civil society organizations) to be 'advocates and watchdogs' rather than solution brokers." *(Cont.)*

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Box 1. Collaborative Social Accountability: What Is It, and What Is It Not?

Collaboration and joint problem solving are consensus oriented (Levy 2014). However, they do not entail harmonization of interests and values or the elimination of disagreements. Collaboration does not mean that stakeholders' power is equal or that conflict has been eliminated.

Collaboration here is understood as a pragmatic rather than a dogmatic approach. It calls for political savvy in doing – a detailed appreciation of, and flexibility and adaptability to respond to fluid and contested local contexts.[11] This means that political analysis may require revisiting regularly who are partners, coalitions, alliances that are fit for purpose at a given political juncture. It also requires revisiting whether collaboration itself is the way to go to support, broker, facilitate and aid "the emergence and practices of reform leaderships, organizations, networks and coalitions" (DLP 2018: 24-25) that can use social accountability to contribute to health systems and outcomes.

In this sense, collaborative social accountability is also inconsistent with collusion, cooptation or other forms of automatic alignment of stakeholders. It requires organized civil society groups that can think politically, assess the context critically and preserve their independence while playing intermediary (facilitation and negotiation) roles in relation to government counterparts. At minimum, actors collaborating can agree to disagree, at maximum, they can turn to confrontational strategies. Concrete decisions about when civil society consider they should exit require thinking and working politically in context and, thus, beyond the scope of this work. The point here is that all collaboration cannot, by default be equated, with collusion or cooptation and, in so doing, be normatively dismissed. On the contrary, this is a strategy that calls for paying attention to the empirical boundary conditions, risks, and trade-offs of collaborating, confronting, or pursuing a strategy in the middle. *(Cont.)*

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11   On thinking and working politically associated with social accountability, see Guerzovich and Poli (2014c), and more generally, Hudson and Leftwich (2014), ABT Associates (2017), DLP (2018), and Laws and Marquette (2018).

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> **Box 1. Collaborative Social Accountability: What Is It, and What Is It Not?** *(Cont.)*
>
> Collaboration is politically pragmatic insofar as it starts from the evidenced-based assumption that no single actor can produce equal, quality, accessible health and health systems on its own. Its value add lies in actors' ability to tap into a diversity of resources, mandates,[12] and opportunities by setting a process that brings different stakeholders to problem solve together even when they agree to disagree on specific matters.
>
> Collaborative social accountability, as other forms of collective action, is challenging. Stakeholders often fail to coordinate, commit, and cooperate with others toward long-term goals. A possible function of international development partners is to ensure the rules of engagement foster collaboration and preempt cooptation and collusion (World Bank 2017).

Collaborative social accountability is a blind spot between two ideal types. It is a principled, albeit pragmatic and opportunistic, approach that works politically and technically in the space in between the two routes described previously.[13] That space is comprised of the governance and managerial levels in the sectoral chain of service provision in which citizen participation can contribute to results.

These spaces have been black boxed by the social accountability and governance literatures (Pritchett 2019). According to Levy and Walton (2013) and Levy (2014), these in-between spaces are major domains of political, stakeholder, and organizational behavior. These are sources both of within-country and across-country variation in the quality of public service provision and also provide the locus where many opportunities for achieving gains in performance are to be found. Too many times, sound international and national policies, programs and standards are not implemented due to decisions (or lack of thereof) by actors downstream in the health system. Many social accountabili-

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12   We thank Jeff Thindwa for highlighting the often forgotten significant role of diverse mandates, among other factors.

13   The road in the middle may have other shapes and value add. However, its systematization is in its infancy.

ty processes, including those studied by Björkman and Svensson (2009), contribute to providing meaning to ambiguous operational procedures and protocols, or even stretching them, affecting the access, quality and equality of delivery even when the system cannot be overhauled.[14] Exploiting the interactions between social accountability and these spaces is particularly relevant as health delivery is decentralized and mandates for implementation are, at least partly, decentralized. KOMPAK (2018) provides a related rationale to focus on these spaces, underscoring that the middle is critical because it includes the functionality, reliability, and integrity of financial management and flows that turn national policies into quality frontline service delivery or not.

This section discusses three distinct characteristics of this third approach in greater detail. First, it does not assume the unconditional value addition of social accountability for service delivery. Second, it is programmatic in nature (it works through the middle cog of Figure 1). Third, the emerging hypothesis is that a problem-driven approach that levers public sector efforts can be scaled up through a programmatic route.

On the first characteristic, transparency and accountability are neither the only nor main routes in which social accountability can add value to solving problems that undermine access, quality, and equality of health delivery.[15] Collaborative social accountability is problem-driven and oriented toward solutions and responses. It can perform different functions to support problem resolution and improvements in sector programs, policies, and across service delivery chains — from maternal health to HIV/AIDS treatment. Social accountability's contribution is conditional, rather than absolute. Whether collaborative social accountability's functions contribute toward programmatic additions or not will depend on their fit with the needs and context of sectoral policies and interventions. Fit is a technical and a political assessment in context.

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14   Tom Aston provided useful attention and comments to reinforce this point.

15   Thanks to Brian Levy for underscoring this point as well as Tom Aston, Sue Cant, Rebecca Haines, and Paula Schommer, who are working with GPSA on a research proposal on the project "Scaling Social Accountability for Health: Leveraging Public Policies and Programs."

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Second, this approach is programmatic. Falleti and Cunial (2018) define programmatic participation for policy making as institutionally organized and state-sanctioned collective or collaborative behavior that influences or attempts to influence the management or distribution of public goods or social services. Participatory processes help set communal priorities, plan health policies, design programs (consultation and planning), and execute (at least in part) policies and programs, often with the financial or technical backing of the state bureaucracy (management and delivery). Systematic feedback coupled with other critical elements of collaborative social accountability is conducive to policy action as well as to the action of watchdogs or advocates and enforcers of accountability (monitoring). That is, programmatic social accountability can happen across the whole policy and program cycle.

Third, this approach is experimental and adaptive in nature. That means that it starts with localized, small investments intended as a way to understand what and how social accountability may contribute toward cross-sectoral efforts for improved health delivery. Localized wins can be used to gradually pave the way for taking collaborative social accountability processes, including but not limited to the careful deployment of strategies and tactics,[16] from one point of the system to other arenas of policy making and delivery.[17]

Scale-up is not about going bigger by wholesale replication of interim steps, nor about transforming the system at once. Any lesson about an intervention would more likely emerge from a discreet process within the delivery chain, and needing to be further adapted and developed before it can be applied in the broader system (Barder 2014). Scale-up of collaborative social accountability processes can look like an expansion of the social accountability process through public policies and programs (e.g., participatory mechanisms enacted by laws and regulations and usually implemented through decentralized service delivery and local governance structures) at the geographic and

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16   Thanks Alan Hudson for ensuring we do not appear to overreact against the important careful deployment of tools as a component of processes.

17   Adler, Sage, and Woolcock (2009) identify this characteristic of "good struggles" that focus on principles and processes as a more promising pathway to scale than alternatives that focus on form. They find that these characteristics make other participatory efforts, namely community driven development, promising (Guggenheim 2006). On purposive action to support ongoing engagement, see Levy (2014) and Florez et al. (2018).

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sector levels (e.g., from small to large numbers of service delivery points), or at a national scale (e.g., all health centers required to organize budget meetings).

A key mechanism to nudge scale-up is purposively linking the actors making decisions (citizens and elites in the state or outside as well as international development partners), by linking lessons from time-bound experimentation into institutional and programmatic processes of decision making, as those illustrated in the next pages (Poli and Guerzovich 2016). Unlike interpretations of the second approach, this one does not propose that coordination of citizen action (oversight and advocacy) across local, subnational, national and transnational levels is the pathway to sustainable institutional change (Fox 2016). Linkages are established when and where it is opportunistic given the way power is exercised in practice, paying attention to decentralization in practice, and considering limited resources, including those required to enable collective action (Guerzovich and Poli 2014b; Falisse, Mafuta and Mulongo 2019). Thinking and working politically, therefore, is inherent to this approach to scale.

Sustainability of these processes is an understudied area. This third approach, unlike the previous two, is also consistent with findings from the U.S. Agency for International Development (USAID 2018) about the sources of sustainability of governance projects in Indonesia (see Box 2).

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Box 2. Underlying Factors Contributing to Signs of Sustainability (or Not)

Factors that appear to support sustainability are:

▸ Commitment of local government and nongovernment leaders – particularly middle and upper management – to pursuing project outcomes, often evidenced through development of strategic plans, sufficient allocation of resources, or replication of adopted practices in other units, institutions, or districts.

▸ Alignment with priorities of national or local policy and regulatory frameworks.

▸ Stakeholder participation in project planning and implementation, including routine coordination and feedback mechanisms.

▸ Counterpart funding support, including cost-sharing, cost contributions, and other forms of in-kind or direct support.

▸ Project management by implementing partners, including field staff relationships with counterparts, use of local expertise and organizations, and close proximity to partners.

Factors that appeared to inhibit sustainability:

▸ Implementation environments with highly politically influenced counterparts or stakeholders, resulting in less certainty of support or counterproductive motivations among those partners. *(Cont.)*

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Box 2. Underlying Factors Contributing to Signs of Sustainability (or Not) *(Cont.)*

▸ Absence of dedicated project strategies to transfer capacity and practices to local stakeholders, in particular lack of strategies to address the shifting authorities and high staff turnover of local government counterparts.

▸ Limited involvement of project partners in planning or executing project interventions, leading to less certainty or willingness to carry on useful – but complex or expensive – approaches post-project.

▸ Strong dependence on the donor agency and project team for execution, management, capacity, technologies, or funding.

▸ Lack of capacity, support, or initiative from mid-level bureaucrats. Internalization and incorporation of ideas or practices require support from these middle managers. A related factor is lack of authority or political support for such mid-level officials who are innovators but do not control agency resources. The frequent rotation of civil servants out of target districts and agencies can multiply the impact of this inhibiting factor.

By proposing cross-sectoral and whole of government approaches to health, trends in 21st century health delivery are opening concrete windows of opportunity for institutionalizing, scaling, and sustaining social accountability for health (Burgess et al. 2019)..Social accountability no longer needs to make the case that it is better placed than technical health policies to deliver health impacts (Guerzovich and Gattoni 2019). Rather, it needs to be able to contribute to the complex technical and political task of delivering health — from upstream in the system to the last mile in people's homes.

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Unpacking the Contribution to Health Services Delivery

What are the specific mechanisms through which collaborative social accountability adds value at scale to programs and policies? The analysis of tacit knowledge and evaluations from the portfolio of the GPSA suggests the contribution of collaborative social accountability to health delivery programs and policies can be generally categorized in four ways: (i) improving the quality of design; (ii) mitigating political and implementation risks; (iii) strengthening health systems and governance; and (iv) aligning stakeholders for action.

These changes open the door to integrate social accountability as part of the package of interventions and processes that may contribute toward improved health outcomes — transforming whole of government efforts into whole of society ones. Relatedly, they may provide a more productive way to maximize the contribution of civil society's actions. A review of evaluations by Waddington et al. (2019) found that "in the absence of complementary interventions to address bottlenecks around service provider supply chains and service use, citizen engagement interventions alone may not improve key wellbeing outcomes for target communities."

IMPROVING THE QUALITY OF DESIGN

By better targeting government actions to address the needs of citizens, improvements can be made in the quality of a program's or policy's design. Collaborative social accountability processes engage communities and other stakeholders, including government, to jointly define priority needs taking into account opportunities and constraints. Often, stakeholders are concerned by health sector financing constraints, but allocation of resources is rarely optimal. Through these processes, different actors can provide insights to identify and agree on options to better allocate resources in ways that fit the context.

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For example, SEND Ghana, a nonprofit organization, implemented a multistakeholder project — supported through a 4-year, $650,000 GPSA grant. Its objective was improving access and quality of health and education budget allocations, execution, and service delivery through iterative social accountability processes at central, regional, and district levels. Together with several partner CSOs and government counterparts, SEND led a participatory "Citizens' Budget" process to improve alignment between available resources, stakeholders' needs, and the priorities of decision makers.[18] The collaborative engagement framework encompassed coordinated central and subnational feedback gathering, consolidation, and channeling processes. At the national level, the Project Steering Committee helped focus the social accountability process around specific public budget and service delivery issues, and to ensure interministerial coordination as well as responsiveness from district-level authorities (i.e., District Assemblies).

The process included periodic massive efforts to gather and collate citizens' feedback in 4 out of the country's 10 provinces — covering 30 of the country's poorest districts. It was accomplished through an existing "participatory monitoring and evaluation network" (PME), a grassroots network comprised of public sector and civil society stakeholders. PME network representatives engaged with District Assemblies as well as District Citizens Monitoring Committees (DCMCs), which are public sector and civil society bodies.

Since then, SEND has fostered an enabling environment for constructive engagement between government and civil society. It established formal agreements with relevant authorities at central, regional, and district levels and strengthened the capacity of SEND-Ghana's PME network of local civil society groups to coordinate and implement social accountability tools and processes in municipalities, schools, and health clinics. For example, SEND led a process to create a "citizen's alternative budget" and presented the results to the Ministry of Health and Finance as well as Ghana Health Service as inputs into the 2019 budget. After the 2019 budget proposal was laid before Ghana's parliament, preliminary analyses were conducted to ascertain the adequacy of allocations to the health sector as well as to track the uptake of the Citizens' Budget proposal.

18   Key operational lessons are included in Agyemang (2018) and Mills (2020), the project's final evaluation.

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Multiple engagement actions were carried out and citizens priorities considered in the budget. This included government commitments to increase resource allocation to primary health care and lower-level facilities, particularly the Community Health Planning Services (CHPS) program. Of the total health budget, 63 percent was spent on primary health and the construction of 250 out of 1,600 proposed CHPS Compounds across the 10 regions in 2016. Financial allocation for the administration and management of health facilities as well as the National Health Insurance Scheme was increased (GH₵2.7 billion) as compared to compensation (GH₵1.7 billion) for health staff. At the core of this work is linking national discussions within the public financial management ecosystem and health system actors through a process in which different actors can bring in their questions, priorities, and understandings to find a better way forward in designing policies and programs, especially in light of budgetary restrictions.

MITIGATING POLITICAL AND IMPLEMENTATION RISKS

By creating and strengthening mechanisms for ongoing joint problem solving, risks can be mitigated that would otherwise compromise the execution of policies and programs. Technically sound policies for improving the delivery of health often do not work in practice. For example, many health interventions assume that Village Health Committees will contribute toward delivering quality health. Yet, these institutions may be established in law but not work in practice, partly because citizens and other stakeholders do not engage as expected. Many times top-down policies, programs rules and standards leave significant room for adaptation and interpretation (Mahoney and Thelen 2010). They provide mandates and/or implicitly call for actors closer to the frontline to fill in gaps and reduce ambiguity. Sometimes these actors could "stretch" those rules, protocols and procedures to put them to work.[19] When these actors fail to do so, they sustain ineffective implementation with the grain of the system. These implementation pitfalls and bottlenecks create obstacles for the proper functioning of programs and policies, and ultimately, undermine effective delivery (World Bank 2017).

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19   Thanks to Tom Aston for highlighting this point.

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Collaborative social accountability can provide a mechanism to monitor and mitigate these implementation and political risks by, for example, raising patients' awareness of health delivery standards, nudging improvements in protocols and procedures to implement and adapt procedures and protocols, monitoring provider absenteeism, supporting community health workers in going the last mile from the formal system to homes, as well as feeding back information about how the delivery chain works in practice. In different contexts, different bottlenecks may have greater salience than others. Collaborative social accountability can and should be adapted to these contexts, but can also help monitor the risks that local adaptations of health policies may produce in generating inequalities across the system.[20]

In 2015, Cordaid, a large international nongovernmental organization (NGO), received a $800,000 grant from the GPSA to deepen its work with Comités de Développement Sanitaire (Health Development Committees), a health users–elected body in charge of health delivery monitoring in public and publicly–funded health facilities in the Democratic Republic of Congo's South Kivu and Kongo Central provinces.[21] Health facilities in the country have some degree of management autonomy, which has been growing through decentralization, insecurity, and performance–based financing. For instance, under performance–based financing, health facilities are rewarded for their performance on a quarterly basis, after which facility management has a relatively high degree of autonomy in deciding how to use these additional revenues. The level of patient satisfaction is one of three elements, besides the quantity and the quality of health services provided, which determine the level of the quarterly.[22]

The Health Area Development Committees (CODESAs) constitute, in theory and by law, an interface of direct contact between the service provider and the population. However, the mechanism had failed to function in practice for a long time. Cordaid's

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20   Thanks to Ali Subandoro for explaining this point.

21   The case discussion draws on the evaluation of the Cordaid project (Falisse, Mafuta and Mulongo 2019). For more information on the project, see *https://www.thegpsa.org/project/improving-health-service-delivery-drc.*

22   We thank Marteen Oranje for the clarification.

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initiative sought to realign stakeholders' incentives by introducing adjustments to the CODESA model, which included innovations, such as micro-grants for self-selected small community projects, and new terms of interaction between CODESAs and health clinics' management. Additionally, problem solving at the service point was linked to problem solving at the provincial level, as needed. By simultaneously incentivizing the population, local service providers and provincial government actors, the Cordaid approach aimed to encourage all actors to engage in joint problem solving.

The project's final evaluation found that the collaborative social accountability processes went beyond traditional social accountability results (information and accountability): "It is more of a broader change of the community's capacity for collective action." New joint practices enabled stakeholders to reimagine what their roles, relationships and potential could be in a broader range of issues than those targeted by the project. These dynamics, in turn, contributed to changes in health facility co-management, in planning, monitoring, and evaluating CODESA activities, while strengthening participation and cohesion.

In this case, the social accountability process enabled a virtuous cycle to begin unfolding thanks to the collaborative concerted action between provincial health authorities, local health actors, and the community as well as key international actors (e.g., German Agency for Technical Cooperation, International Rescue Committee, United Nations Children's Fund, and USAID), which report they are starting to use approaches derived from the GPSA and CODESA experience — often after having witnessed it in the field. A multistakeholder coalition fostered participation and consolidated a "homegrown" process to solve local problems locally and changed how the CODESA works, especially in South Kivu.[23] That is, the CODESA process became a catalyst by facilitating other external projects, generating new local community projects, and being an example for other community-level projects.

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23   Different contextual circumstances meant that results in Kongo Central were not as auspicious. There CODESA is simply a tool to extract information from the population and transmit it to the upper level. Then, after that information has been analyzed at the upper level (chief nurse, Health Zones), CODESA is told what to do.

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Actors from Indonesia to Ghana to the DRC learned to embrace collaboration – it was not a decision by default. This practical insight should be a call for social accountability researchers to grapple with how actors' come to understand when and where collaboration can be effective in the health sector. That is, how targeted interactions around specific social accountability processes may inform new ideas (ideologies, discourses and beliefs, values, social norms and even day-to-day perceptions and preferences, etc.), that enable new forms of behavior within the system. The interaction between ideational political economy, social accountability processes and their aims, are overlooked transactional approaches of the first pathway as well as in the second pathway.[24]

The potential for collaborative social accountability processes as providing a concrete mechanism by which multiple actors can co-construct ideas about health service delivery and shape together the political salience and norms surrounding specific services, seems particularly worthy of exploration, even if beyond the scope of this note. These dynamics could have important implications for linking improved health care access, quality and equality to broader issues such as the construction of state legitimacy, addressing systemic breakdowns in institutions, markets and social cohesion, such as in the case of the CODESA.[25] In this note, the point is that these potential functions of social accountability processes towards broader change within the health system and the broader systems within which it operates are a blind spot that may broaden the gap between theory and practice.

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24   Thanks Tom Aston for encouraging further discussion on this line of enquiry, which merits much more exploration than it has had to-date.

25   On the relevance of this approach to service delivery for state legitimacy, see McCullough and Papoulidis (2020) and Papoulidis (2020).

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STRENGTHENING HEALTH SYSTEMS AND GOVERNANCE

By enabling multistakeholder collective action and reducing asymmetries of power over time, health systems and governance can be strengthened.[26] A corollary of collaborative social accountability processes that mobilize collective action for service delivery is that they can, in turn, strengthen health systems and governance. This process is often coupled with another one — diminishing the asymmetries of power between citizens and providers as well as within the delivery chain. This is a finding of the final evaluation of the Maternal, Newborn, Infant, and Child Health Services (MNCHN) project (Ball and Westhorp 2018).

The project's overall aim was to improve health services and specifically to achieve "improved quantity and quality of midwives and District Health Office's services for MNCHN" in 60 villages in three districts (Kupang, Sikka, and Timor Tengah Utara) in Indonesia's East Nusa Tenggara province between 2014 and 2018. GPSA provided a flexible funding envelope of $950,000 to Wahana Visi (an Indonesian civil society organization) and its partners. World Vision Australia provided additional support.

The project's final evaluation identified behavioral changes or trends that have "great significance" for improving child and maternal health. These include increases in institutionalized births, children's immunization, and use of village maternal and child health center's services to provide health checks for pregnant women, infants, and children. An increase was also seen in supplementary feeding programs, which provide a healthy meal and teach parents how to cook healthy food for their children using local foods.

The final evaluation also mapped detailed operational insights about how the project contributed to changes in concrete stakeholders' behaviors. In mapping individual inputs and results, Figure 2 illustrates the significance of aligning actors' priorities,

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26   While social accountability sometimes works within existing power structures in the short term, the evaluation of Indonesia discussed here made the first effort to systematically track whether and how this approach is consistent with reducing asymmetries of power over time. Thanks Alan Hudson for pointing to the apparent contradiction in the argument.

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resources, and interests across the system to ensure improved service delivery chains for the access and delivery of quality services at the local level.

Two additional mechanisms help link experimentation in Indonesia to the discussion of collaborative social accountability processes that open roads for programmatic scale-up:

▸ **First, the process strengthened the health system.** Health delivery in Indonesia is composed of multiple chains and levels responsible for different types of services (promotion, prevention, cure, and rehabilitation). These components need to come together to contribute to better health outcomes for MNCHN. No single actor or chain can deliver results. In this context, it is especially important to ensure that all actors that matter are part of the health system. According to the evaluation, the project expanded the boundaries of the system to include citizens and local governments that were previously excluded.

The project also contributed to strengthening the health system's components as well as relationships and flows of information among them. By creating and sustaining collaborative spaces for joint action, social accountability processes helped build multiple kinds of capacities for multiple stakeholders, not limited to technical skills. Health delivery chains must improve in times of scarce resources — the capacity to jointly prioritize resource allocation is particularly important. The ability to work with others also stands out as better health outcomes are contingent on working with many layers of the system. Reports of changes from hostile confrontations, ineffective complaints, and passivity toward respectful advocacy and cooperative actions are another promising example of increased capacity for collaboration. Actors re-learned how to think of others in the system. The process enabled cooperation and coordination between health services and local governments, supported by real commitment to making changes. These kinds of processes enabled "increasing the resources available, by bringing resources from multiple sectors to bear on priority issues, and enabled resources to flow through the system, to the points at which they were needed" (Ball and Westhorp 2018).

▸ **Second, the project influenced behavior by changing power relationships.** It organized collective opinion that is harder to dismiss than individual opinions, increased the legitimacy of claims on the system, and empowered women and other users. Some participants explained that they have moved from a position of "participating and being told what to do," to "participating and disagreeing, or suggesting what is to be done," and making some decisions.

The process also brought in different types and levels of decision makers and forms of authority to address different issues. Moreover, the role of the leading CSO was critical to connect the dots. "World Vision itself brings multiple types of power and 'authorizing' to the table, including its independence; access to higher levels of government; access to media; and the fact that it is a donor organization" (Ball and Westhorp 2018).

Figure 2. How Power Relationships Change
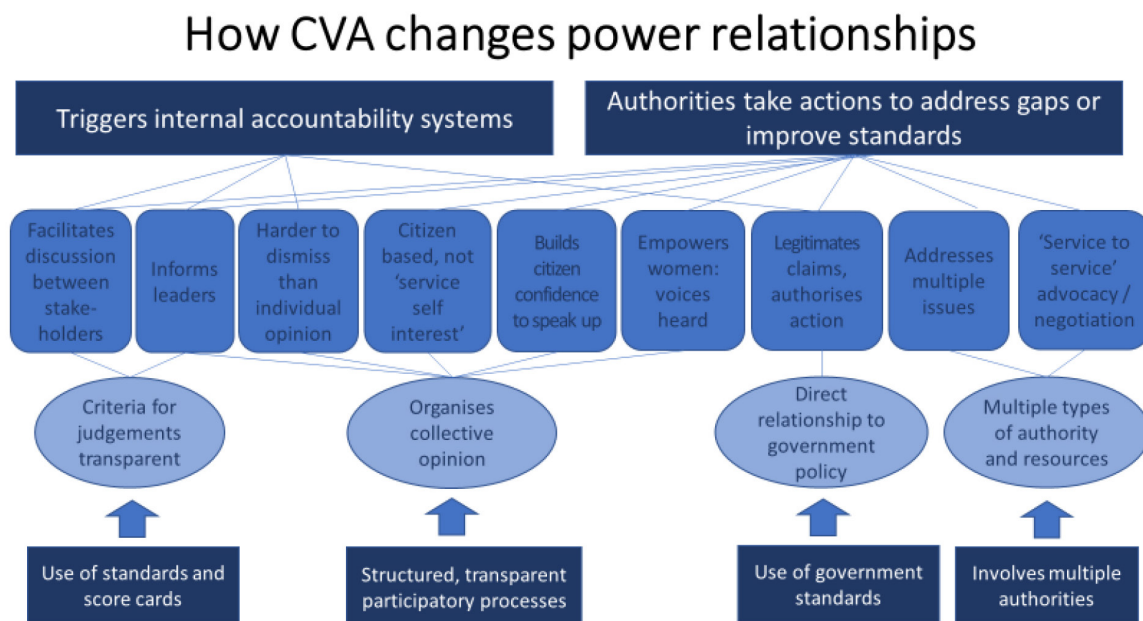
Source: Reprinted from Ball and Westhorp (2018).
Note: Citizen voice and action, or CVA, refers to a social accountability approach developed and employed by Wahana Visi, a local independent chapter of World Vision International. It is one way in which collaborative approaches can be operationalized.

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ALIGNING STAKEHOLDERS FOR ACTION

The strategic, political process to build political will to make change happen is a collective process (DLP 2018). Motivated and strategic change-makers, in state and society, have to overcome barriers to cooperation. They have to build coalitions with others that can pull the weight of advancing, implementing, and critically improving the effectiveness of reforms, despite technical and political obstacles for change.

One insight from collaborative social accountability processes, is that different actors can be supported to discover or learn their roles and how they align in the arena of collective action for health "by doing". Collaborative social accountability processes enable actors to learn by doing how they can work with others toward reshaping the governance system (Guerzovich, Mukorombindo, and Eyakuze 2017; Guerzovich, Poli, and Fokkelman 2018). These processes contest and de-legitimize ideas of what are the roles that different actors have vis-à-vis the system, where citizens, providers, and public officials do not problem solve together and legitimize an alternative set of options that can be legitimate and sustainable. As other collaborative governance processes, social accountability can enable actors to gain a renewed sense of agency, constructing new visions and narratives about how the health system can function and what roles different actors can play in bringing about those outcomes (Levy et al. 2018). These attitudinal, ideational, and behavioral changes are part of the qualitative discussions of the three cases mentioned previously. In Peru, an initiative from CARE, ForoSalud, the Ombudsman's Office, and local women's organizations identified a way in which social monitors can play a concrete function in the system. They act as antennae for rights abuses, providing timely and detailed information around the quality of provision in health establishments.[27] Unlike what might be assumed by proponents of social accountability as a vehicle to sanction, the effort's function was not to reinforce the "blame game." Quite the contrary, through social accountability

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27   For more on this case, see CARE (2015). The systematization of data about the case prepared by Rosana Vargas V. as well as Tom Aston's insights also supported the analysis.

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processes stakeholders built trust, dialogue, and spaces for negotiation and joint action (e.g. co-definition of intervention areas, embeddedness of CARE staff in the government, cross-technical assistance, formal accreditation of citizen monitors by the Ombudsman, and periodic joint revisions of the information). They learned to work with providers to address gaps in the implementation of norms and accountability mechanisms. These dynamics challenged the status quo.[28]

Partnership facilitated a close collaboration and complementarity among actors, taking into account each one's mandates and competences. It paved the way towards further aligning actors as well as institutionalization of these new processes.[29] This kind of approach to aligning actors is critical because, as CARE (2015: 2) learned, "building demand for accountability through citizen monitoring also raises users' expectations for better quality provision, and these raised expectations may not be matched by improvements in the quality of services unless the incentives are right for service providers. Too much focus on the demand side can be counter-productive". The same dynamic and new joint understanding of collaborative social accountability seems to have diminished barriers for the institutionalization of these processes in other contexts (Guerzovich 2016).

Different actors can be supported to discover or learn their roles and how they align in the arena of collective action for health "by doing." Collaborative social accountability processes enable actors to learn by doing how they can work with others toward reshaping the governance system (Guerzovich, Mukorombindo, and Eyakuze 2017; Guerzovich, Poli, and Fokkelman 2018). As other collaborative governance processes, social accountability can enable actors to gain a renewed sense of agency, constructing new visions and narratives about how the health system can function and what roles different actors can play in bringing about those outcomes (Levy et al. 2018).

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28   This function also prompted Brazil's General Comptroller of the Union to step up its efforts to work with and strengthen civil society capacities for the co-production of social accountability (Guerzovich and Schommer 2016; Schommer et al. 2015).

29   In January 2011, the National Policy Guidelines for the Promotion of Citizen Health Monitoring were promulgated, and Article 9 of the Regulations of the Law for Universal Health Insurance (Law 29344) highlights that the Ministry of Health is responsible for establishing spaces and mechanisms for citizen participation in the framework of Integral Health Insurance.

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Schrank (2018) provides another example by tracing the process through which the Dominican Republic went from purchasing medicines and other medical supplies in relatively small batches by several different agencies — a source of graft and inefficiency — to a centralized and simplified system.[30] Now, a single procurement agency buys in bulk through competitive tenders and receives high marks for transparency and efficiency. Unified procurement also increased the bargaining power of the government of the Dominican Republic, generating significant cost savings in the health sector.

Schrank contends the multistakeholder Participatory Anti-Corruption Initiative (Iniciativa Participativa Anti-Corrupción, or IPAC) served as a "force multiplier," of sorts, by allowing political entrepreneurs in civil society and the public sector to coordinate their efforts on behalf of procurement reforms that had previously been delayed or derailed. IPAC benefited from the tacit support of the government, the active support of the World Bank, and the participation of NGOs. This multistakeholder initiative was designed to combat corruption in the Dominican Republic by fostering structured deliberation, learning, and monitoring by key stakeholders in sectors, including health. All these processes challenge the idea that health or procurement experts have to go alone in delivering quality health by introducing a cross-sector dynamic that engages society as well.

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30   Professor Andrew Schrank presented to social accountability forums in New Delhi in 2018 on the cost effectiveness of these interventions based on his study on health care reforms in the Dominican Republic.

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Rules of Thumb to Operationalize Processes for Health

This note maps three alternative approaches to use social accountability for health with the aim of filling a gap in the literature on social accountability practice in the "missing middle" (Guerzovich 2019b). These approaches are ideal types based on the literature and tacit knowledge. Concrete realities in actual contexts may call for iterating or combining elements across approaches, especially over long periods of time (Poli, Guerzovich, and Fokkelman 2020). However, understanding each approach in its own terms is a necessary first step to do so smartly. A second step, beyond the scope of this note, is to better understand the potential and limits of each approach in concrete circumstances as well as possible synergies, rather than pretending that one of them may be universally applicable.

With this caveat in mind, the note concludes with some "rules of thumb" for those considering that collaborative social accountability may be a good bet for their specific circumstances.

Do not think of social accountability interventions as stand-alone (or "add-ons") but in relationship to the sectoral context. "Context matters" has become a ubiquitous statement in social accountability. It often is operationalized in terms of national level variables. Less frequently, sectoral divergences are considered. Evidence emerging across all three strands of work suggests that civil society led interventions can do much more to harness sectoral contexts and entry points (Guerzovich and Poli 2014b).

Consider social accountability as an iterative process for bringing health users and groups into specific problem-solving spaces across the management and service delivery chain, rather than for tackling the whole system at once. This requires experimenting with existing and new mechanisms and adjusting them overtime.

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Formulate comprehensive, but feasible and, where relevant,[31] opportunistic, social accountability strategies. Rather than using isolated tools and activities or trying to muster resources to do it all at once, prioritize actions taking into account opportunities and constraints. There is a tendency to think of social accountability in terms of tools, such as community scorecards or citizen report cards. These are feedback gathering mechanisms, and in the case of community scorecards, evidence shows that they can play an important role in nurturing collaborative spaces at the point of service. When they are considered in isolation, however, they are difficult to link to sustainable changes in the system. Iterate priorities and strategy, as things evolve. In short, think and work technically and politically.

Connect sectoral reforms and civil society's value added (capacities, resources, and interests) by design and through the lifecycle of reforms. Consider tapping into the delivery and implementation entry point in the policy cycle rather than assume that civil society action should be focused on the design stage (consultation) or the assessment stage (monitoring) as fragmented interventions disconnected from the core reform processes.

If you are thinking about strengthening and leveraging partnerships, coalitions, or alliances, find common ground with partners that bolster your efforts (even if sometimes you need to agree to disagree on specifics). From professional associations to health users' groups and patients, reforms require engaging various types of civil society groups. Cultivate intersectoral, multigroup partnerships with complementary roles and functions. Programs are more effective when they aim to strengthen cooperation and coordination by engaging smartly the segments of the local population, together with citizens' groups, academic institutions, and multiple bodies and levels of government, including service providers, local authorities, and policy makers. At the same time, the benefits of the diversity of partners need to be weighed against the transaction costs of coordinating different stakeholders into a joint position all the time.

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31   This does not mean that social accountability is or should be opportunistic at all times.

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Nurturing people's mobilization. Interventions that work through organized local civil society and engage leaders from existing networks and groups seem to be more effective than those that rely on unorganized citizens (Ball and Westhorp 2018; Falisse, Mafuta and Mulongo 2019). The mobilization of social networks is not automatic — but requires careful investments in skilled facilitation, relationship building, and the proactive engagement of informal, traditional community, and other leaders to create common knowledge across members of social networks, among others. For example, Mohanan, Thirumurthy, and Rajan (2018) found that skilled facilitation adds value for the provision of health through social accountability— having larger effects than provision of information alone.

Investing in social capital. Engagement over time can become a "stock" of social capital that benefits interventions. Tendler and Freedheim (1994), among others, have shown that social capital (trust, knowledge, and information sharing, and participation in voluntary organizations) contributes to improved health governance and service delivery (Waddington et al. 2019). It can also mitigate the risk of doing harm through attempts at inducing participation (Kosack et al. 2018). The knowledge and relationships that come from repeat engagement may also help external partners be more sensitive to context, including conflict. Although a proactive focus on conflict sensitivity may be granted, including working with those we do not agree on everything.[32]

Consider Extending time horizons. The focus on networks and relationship building may require extending the time horizons for monitoring and evaluating investments in social accountability processes. Costs in short-term interventions may become investments in "stocks" of networks, social capital, know-how, and other nonmaterial resources. They are stepping stones that can take additional efforts forward. This does not necessarily mean increasing interventions over a long period of time. In the cases of the initiatives in the Democratic Republic of Congo, Ghana, and Indonesia, new interventions were built on the results and lessons of the past, while adapting them to emerging opportunities and challenges.

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32   Thanks to Eric Sarriot for pushing us to think about this point.

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Adapt interventions to shifts in country systems and delivery chains. Much social accountability practice and research is designed with the same health targets, as interventions designed 5 or 10 years ago. However, health baselines and targets have changed around the world. The significant variation in health results begs the question: Would health sector specialists prioritize and implement the same intervention considering ongoing changes in demographics, epidemiologic patterns, as well as changes in health care trends and reform efforts? There are reasons to suspect that sector specialists should or would adapt to make the most of scarce resources and focus on emergent issues, rather than replicate an intervention that no longer matches the main concerns at hand. Moreover, evidence in the health sector (and beyond) suggests that interventions piloted by implementing agencies may not produce the same effects if implemented by civil society groups, external researchers, or governments.[33] Adaptation may be in order, given variations in context and process.

Invest in processes that target the development of collaborative capacities among public sector actors and providers: Collaborative social accountability requires different stakeholders, including those in the public sector, to learn to work with others and adapt to make the most of the process. Processes and learning by doing can nurture those capacities, but targeted efforts can facilitate the process.

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33   A study in education found a stark contrast in success of an intervention implemented by a civil society organization compared with the government as the result of "implementation constraints and political economy forces put in motion as the program went to scale" (Bold et al. 2013).

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The Role of International Development Actors

The note concludes by discussing the functions that international actors can play to support locally-driven collaborative social accountability processes for health. The focus is on those international development partners who expect to lever social accountability as a means toward improved public health delivery. These are organizations and groups that are comfortable with investing their scarce financial and nonfinancial resources pragmatically — seeking principled second bests that can be improved over time rather than ideals. The following roles are mutually linked:

▸ **Convene dissimilar local players and provide them with conditions to find their own solutions.** Formal (invited) participation seems necessary to facilitate improved service delivery at scale through social accountability, and targeted measures can significantly improve participation of marginalized groups (ePact 2016). External actors can play an important function as honest brokers to issue these invitations to civil society (Green 2017). They can also play an important role in deciding whom to invite from among the public, private sector, and development partners to support meaningful and actionable engagement. The idea is to bring into the room the critical mass of actors who have a standing and a stake in the problem, so they are in a position to face opposition and preempt capture (Levy 2014).

▸ **Facilitate cooperation.** Free-rider and other moral hazard problems can limit cooperation among participants to achieve joint benefits. Asymmetries of power, different capacities to work with others, and conflicts can also undermine actors' abilities to engage meaningfully in these processes. External actors can step in to ensure the rules of engagement and accountability mechanisms are perceived as fair and legitimate (Levy 2014; Ostrom 1997); broker relationships (Green 2017); support capacity building;[34] level the playing field; translate insights across

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34   A study in Nigeria found that, to function optimally, community health committees require mentoring and support, among other factors (Abimbola et al. 2016). More generally on relevant forms of capacity building, see Guerzovich, Mukorombindo, and Eyakuze (2017) and Poli and Guerzovich (2020).

different stakeholders; and help negotiate conflicts among actors whose interests, resources, and power may be fundamentally misaligned. The latter is likely in a collaborative social accountability process to the extent that empowering marginalized groups challenges the status quo or decisions that have distributional implications (Adler, Sage, and Woolcock 2009).

▸ **Inform priorities to better allocate scarce resources.** Development partners can share and exchange information with who may be interested, or those who are already involved in resolving a problem or may have failed in solving it (Guerzovich and Poli 2014b). Their understanding can help identify whether and where there are windows of opportunity in the health system to meaningfully engage civil society in solving a concrete problem. Conversely, they can give civil society groups valuable insights to understand when and how their assessment can fit into ongoing discussions and pipelines of programs and policies. The latter point is critical to ensure that citizens' demands meet capable states and willing governments to meet those demands.

▸ **Encourage learning from others' experiences and from failure.** Many social accountability practitioners are not used to working with others or accepting failure as a productive input for course correction (Guerzovich and Poli 2014a). International development partners can provide safe spaces, incentives and resources, and build relationships with stakeholders to further ways of learning for adaptive action. The role of international actors is not to crowd out learning by imposing known technical or normative solutions, specifying the form that social accountability processes should take (or specific tools and other externally sourced recipes), or what outcomes may look like (Adler, Sage, and Woolcock 2009).[35]

▸ **Learning for course correction applies to funders' strategies as well.** There is more that international actors could do "to encourage CSO–led innovation, and

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35   Also see Barder (2014). For additional operational guidance, see Ross (2015) and Guerzovich and Poli (2016).

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to recognize and promote the uptake of innovation successes" while advancing localization (ICAI 2019). However, international actors, as clear from the discussion above, are political agents that provide more than funding and technical assistance (Laws and Marquette 2018). The very role of international actors as "outsiders" inside should be the focus of learning, reflection and course-correction.

▸ **Provide additional deliberate financial support to facilitate collective action.** Social accountability processes are not free, but the structure of costs is distinct from most health interventions (Vissapragada and Joswiak 2017). No heavy investments in goods or infrastructure can be measured "per unit." Much of the "labor" is volunteer-based. However, ongoing community and public sector buy-in is a resource-intensive task. Transaction costs of coordination and collaboration, in politically complex environments, can be high. Investment in long-term "stocks," such as relationships, may be necessary. Organized networks can increase the ability to mobilize citizens.[36] Some functions might be contingent on the availability of financial and nonfinancial resources and, as important, how they are deployed.

▸ **Lend different forms of legitimacy and power to local actors.** Local and external actors, with strong incentives to have collaborative social accountability processes succeed, can buffer processes and results from actors who seek to preserve the status quo (Levy 2014). They can bring in their skills and assets to mobilize actors for good performance. Their networks and connections can not only help them connect with norms of fairness, legitimacy, and justice (Levy 2014; Adler, Sage, and Woolcock 2009), but also provide credibility and communicate knowledge to strengthen political incentives to build state capacities (Khemani 2019).

▸ **Be sensitive to existing power dynamics within the community and civil society.** Initiatives that give locally appointed councils, forums, and facilitators decision-making authority without taking local power dynamics into account risk elite

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36   Uttar Pradesh.

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capture and social exclusion — which can disempower the very populations being targeted. The emphasis on patients as a core concerned group may overlook other parts of the community that have no access to services. However, efforts to include marginalized segments of the population risk exacerbating social tensions and undermining programmatic legitimacy. These risks reinforce both the need for a variety of integrated approaches and engagement with stakeholders, such as higher-level officials, subnational CSOs, and media organizations, that can provide counterweights to local or national elites. Engaging multiple stakeholders can reduce the risk that program implementers and other external actors will override the community's interests.

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