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ENGAGING CIVIL SOCIETY IN HEALTH FINANCE AND GOVERNANCE: A GUIDE FOR PRACTITIONERS

J. Kanthor, B. Seligman, T. Dereje, L. Tarantino

September 2014

The Health Finance and Governance Project

USAID's Health Finance and Governance (HFG) project will help to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team will work with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. As a result, this five-year, $209 million global project will increase the use of both primary and priority health services, including HIV and AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG will support countries as they navigate the economic transitions needed to achieve universal health care.

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September 2014

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Acronyms

CBO	Community-based organization
COGES	Comité de Gestion (Management Committees)
CHW	Community Health Worker
CSO	Civil Society Organization
DC	District Commissioners
EPCMD	Ending Preventable Child and Maternal Death
FBO	Faith Based Organization
HFG	Health Finance and Governance Project
HIV and AIDS	Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome
MP	Members of Parliament
MSLS	Ministry of Health and the Fight Against HIV
NGO	Non-governmental organization
PETS	Public Expenditure Tracking Survey
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Governments and international donor organizations increasingly acknowledge the role of civil society organizations (CSOs) in strengthening health systems. By facilitating dialogue between government and citizens on issues of health sector priorities, performance, and accountability, CSOs can help to improve health service delivery and contribute to evidence-based policy. Often, however, CSOs lack the skills and tools needed to engage other stakeholders in issues of health finance and governance. This guide provides practical advice on the range of tools available to CSOs in the health sector, with a specific focus on social accountability tools to help gain access to information, mobilize collective action and advocacy, and support sanctions. The guide also describes how effective civil society engagement, including efforts using social accountability tools, has resulted in important reforms to improve health service delivery performance and inform evidence-based policy. Designing programs that include the use of mechanisms and tools to engage both civil society and government counterparts that are guided by an understanding of the country context, and that recognize and mitigate potential risks are significant factors in productive civil society engagement. Intended for both governments and donors, this guide details several specific and tested practices to promote effective use of these tools.

Introduction

The objective of this guide is to provide governments and donors practical advice on engaging civil society in health finance and governance in order to meet health sector objectives and to improve health outcomes. This guide describes the potential and limitations of civil society engagement entry points and presents an array of tools that may be used to do so. Several existing publications summarize methods and approaches for involving communities, citizens, and civil society organizations (CSOs) in the delivery of government services, including health services (O'Meally 2013, Ringold et al. 2011). Other publications offer assessments of the impact specific tools have on the quality of health services. This guide focuses specifically on the health sector and offers practitioners a range of tools from which to choose based on the environment they work in and the objectives they seek to achieve. It emphasizes approaches that foster collaboration between public health officials and civil society that can improve access to and the quality of health services, ultimately contributing to improved health outcomes. This guide also seeks to provide practical mechanisms for how civil society engagement may be achieved, at the national, subnational, and community levels.

Governments and international donor organizations increasingly acknowledge the role of CSOs in strengthening health systems. USAID's Global Health Strategic Framework (USAID 2012) recognizes the importance of civil society in a strong health system and emphasizes the need for strong links between health service providers and the communities they serve, as well as the need for robust accountability. Likewise, the World Health Organization (WHO), recognizing the key role nongovernmental organizations (NGOs) have as important CSO actors in the health sector, is currently developing a civil society engagement policy that includes promoting member state engagement with CSOs to encourage informed policy making. Similarly, the Global Fund to Fight HIV and AIDS, Malaria and Tuberculosis placed a premium on embedding civil society from both developed and developing countries in its structures and processes. This is accomplished through civil society representation on bodies that coordinate the submission of countries' proposals, a dedicated engagement team in the Geneva secretariat and the creation of a governance structure that includes a wide variety of constituencies. Governments are increasingly recognizing the role civil society can play in developing health policy as well as in implementing governance functions such as licensing, certification, standards of practice, and reporting and monitoring.

In Section 1 of this guide, we describe the objectives and limitations of civil society engagement. In Section 2, we outline the opportunities for working with civil society on issues specifically related to health finance and governance. These opportunities emphasize the importance of supporting productive and durable partnerships between government and civil society. The benefits of such engagement for health access and quality are also summarized. In Section 3, we present brief descriptions of key tools for engaging civil society in health finance and governance, with an emphasis on "social accountability tools." In Section 4, we examine the various entry points for civil society engagement in the health system and discuss how these entry points have been used to contribute to improved health outcomes. In Section 5, we present a series of best practices for achieving impact in civil society programs, distilled from impact evaluations and lessons learned from work in the field, and we describe their relevance to efforts to engage civil society in the areas of health finance and governance.

This guide includes an Annex, which provides a detailed description of each of the tools, a summary of step by step implementation, resources required to implement the tools, and examples of how these tools have been used in developing contexts.

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Section 1: Objectives and Limitations of Civil Society Engagement

Citizen voice and civic expression are essential to building and sustaining democratic societies. Civil society organizations provide channels for citizen voice and can help citizens hold government accountable.

(USAID 2013)

Civil society is broadly understood as the diverse group of NGOs and not-for-profit organizations that have a presence in public life and express the interests and values of their members or others, based on ethical, cultural, political, scientific, religious, or philanthropic considerations. CSOs refer to organizations such as community groups, NGOs, labor unions, indigenous groups, charitable organizations, faith-based organizations (FBO), professional associations, political parties, and foundations.

Objectives of Civil Society Engagement

The importance of civil society engagement in sectors such as health is associated with several key functions that CSOs can play. First, to be responsive to its citizens, governments must provide information and solicit public feedback on the formulation and implementation of policies and programs. By serving as a channel for relaying information and the views of their constituents, CSOs can play an important intermediary role in the dialogue between government and citizens. The exchange between governments and CSOs, especially those representing divergent constituencies, can result in better informed health policies and programs and can increase civil society influence in expressing preference for health services.

Second, CSOs may possess specialized expertise that can help to inform policy making and facilitate successful health reform implementation.

This expertise may include the following:

- Technical knowledge and detailed understanding of specific disease and/or policy issues
- Access to and knowledge of the opinions or experience of geographic or demographic groups who may be affected by health care policy decisions, such as women, those affected by HIV and AIDS, or those using rural health facilities
- The skills necessary to analyze or assess a range of policy options, which are most often found in health policy think tanks or academic research institutions.

These skills are valuable both to those responsible for formulating and implementing policy (government bureaucrats, service delivery agents) and to those responsible for reviewing policy proposals and monitoring the performance of government policy implementation (oversight agencies, elected leaders).

Finally, given CSOs' range of interests and constituents, they can provide an outside voice to policy debates and assessment of government policy implementation. The presence of external actors in evaluating government performance, the quality of service delivery, or the advocating for such evaluations, is important to promote accountability and hold public health officials responsible for achieving results. Without external checks, few incentives exist for a detailed assessment of whether government policies are succeeding, both in general and for particular target beneficiaries. CSOs can also serve as external sources of information about service delivery quality to expand the range of options for citizens.

Examining civil society's contribution to health governance, while understanding important limitations (see Text Box 1), offers practical options for how targeted civil society engagement efforts can promote improved health outcomes. The following presents three key lessons for engaging civil society in health finance and governance.

Limitations to Civil Society Engagement

There are significant limitations to engaging civil society to promote accountability.

Civil society diversity: Civil society is an extremely broad term that can obscure the heterogeneity of CSOs, even those advocating for similar issues. Factors such as size of an organization, its mission, who the organization represents, and its funding sources contribute to the diversity within civil society. This diversity reflects the advantages of engaging CSOs—the ability to access different viewpoints and interests—as well as the challenges, indicating that there is no one model to use for creating CSOs and engaging them.

Elite capture: Organizations can, and often do, represent the voices of elites, at the expense of key beneficiaries for the health sector such as women, the poor, disabled, and those living with HIV and AIDS.

Lack of accountability: CSOs can mirror the issues of corruption that exist in great society.

CSO competition: Because of the complex range of civil society interests and agendas, there can be great competition among CSOs. This may manifest as competition for resources, attention, and credit for successes as organizations seek to influence policymakers, expand membership, and/or build their profiles.

Challenges to sustainability: The most successful examples of civil society achieving greater participation and influence of policy and service delivery is a result of CSOs leveraging ongoing social mobilization movements. Time- and budget-limited donor or host government interventions are more likely to result in short-term participation rather than long-term civil society engagement.

Requirement for willing and able government partners: The ability for CSOs to influence the quality of health care and its policies depends on the presence of willing partners among political or government leadership. However, it is only when these partners have the skills necessary to effectively engage with CSOs that these political or bureaucratic partners can be effective.

Lesson 1: Efforts to promote civil society engagement in the health sector can spur greater access to policy advocacy. This access can be particularly effective in achieving short-term, issue-specific gains. Where policy issues are directly related to the missions of participating CSOs, externally supported advocacy efforts are more likely to result in sustained reforms.

Lesson 2: Initiatives to promote civil society engagement in the health sector can successfully introduce new competencies or tools to a CSO's skill set. These competencies may help CSOs generate information for monitoring health facility performance and engaging in dialogue with health policymakers and those responsible for service delivery. How CSOs use the new skills and for how long will reflect the underlying interests, incentives, and resources of the organizations.

Lesson 3: The greatest opportunities for strengthening health sector accountability and performance come from efforts that combine civil society engagement with capacity building for the health policymakers and health services delivery agents who will implement improvements. Likewise, efforts by civil society to improve accountability are likely to be more effective when they collaborate with formal oversight institutions such as parliamentary standing committees, supreme audit institutions, anti-corruption agencies, and regulatory agencies.

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Section 2: Opportunities and Objectives for Civil Society to Engage in Health Finance and Governance

People, as part of the civil society, form the core of health systems. They use health services, contribute finances, are caregivers, and have a role in developing health policies and in shaping health systems. In all these respects, there is growing pressure for public accountability and increased response to inputs from civil society. The manner in which the state responds to these changes, and the extent to which civil society actors are recognized and included in health policies and programs, are some of the critical factors determining the course of public health today.

(WHO, 2001)

In this section, we present opportunities for civil society engagement to contribute to improved health service delivery and discuss the limitations of civil society engagement given the above discussion.

Who Are Health CSOs?

CSOs, including FBOs, play an important role in providing health services in underserved areas and to populations that are otherwise hard to reach. CSOs also spearhead information campaigns to promote healthy behaviors and to introduce new protocols and medical products and treatments. Non-service provider CSOs in the sector include professional associations and unions for doctors, nurses, and other medical professionals that represent the interests of their members and participate in policy advocacy. In the area of policy advocacy, they are joined by a growing number of health advocacy groups, which are often focused on a single health issue (e.g., expanding access to HIV and AIDS treatment, safe motherhood).

Box 2 summarizes common civil society organizations in the health sector.

2 Civil Society and the Health Sector

Within the health sector, and specifically regarding issues of health finance and governance, prominent civil society actors include the following:

- Think tanks and research institutions conducting public health research
- Community groups organized to monitor local health facilities or performance-based incentive programs
- Membership associations, for example, national and local organizations of persons living with disabilities or HIV and AIDS
- Coalitions of NGOs or individual NGOs addressing specific health issues
- Professional associations of health professionals

How civil Society Can Contribute to Strengthening Health Systems

As discussed in Section 1, CSOs have a key role in contributing to improved quality of health services by holding governments and policymakers accountable and by shaping the services that contribute to their well-being. Increased citizen voice on health issues can inform providers about consumer needs and preferences. More responsive health services are more likely to align with consumer requirements (health worker behavior, service quality, facility condition). Involvement of citizens and CSOs can promote informed decision making by consumers and, as a result, greater competition among providers. Likewise, greater scrutiny of health performance can create mechanisms to hold providers responsible for the quality and accessibility of services (Berlan and Shiffman 2011).

Box 3 summarizes reasons why health CSOs may not be active in health finance and governance issues.

3 Where Are Health CSOs Involved in Health Finance and Governance?

The involvement of civil society in health financing and governance, which is generally different than civil society engagement on specific disease or health issues, is less systematic than it is in service delivery. The lack of broad CSO engagement in reviews of health budget requests, allocations and expenditures, or in the promotion of accountability, transparency, and performance of health services and informed and inclusive health policy is due to a number of key factors, including the following:

- Those organizations with the strongest association within the health sector—service delivery-oriented NGOs—often depend upon the government for permission, licenses, and access to the populations they serve. As a result, they may be reluctant to undertake activities that might be perceived as confrontational and potentially threatening to their relationship with government officials.
- Engagement on issues of health finance and governance requires a set of analytic and advocacy skills and tools that many CSOs, including service delivery-oriented organizations, lack.
- In many country contexts, the relationship between government and civil society is fraught with mutual suspicion and distrust. This complicates finding opportunities for collaboration and dialogue between CSOs and public health officials on issues of finance and governance.
- Funding, from governments, donors, and international NGOs, is available primarily for health service delivery, the purchase of drugs, and other activities that directly contribute to health outcomes. Far less funding is targeted to activities that do not directly improve health outcomes or that are not linked to a specific outcome, such as those in health finance and governance

The role citizens play in holding government accountable is referred to as social accountability. Social accountability is achieved through three key mechanisms: information, collective action, and sanctions (Devarajan et al. 2011). These three mechanisms are discussed in detail below, with special reference to its application in the health sector and recognition of the limitations of what can be achieved through externally driven support to civil society.

Information: Access to health sector information is a necessary precondition for CSO engagement in health policy or monitoring health service delivery or expenditures. At the national level, CSOs with access to public health expenditure data are more likely to ask questions about whether budget allocations for specific disease programs reflect public needs and the efficiency and accountability of public expenditures (see Box 4). At the facility level, the ability of community groups to gather data on the performance of health service delivery in their local clinic, such as drug stock outs or health professional attendance, allows for informed decision making and advocacy for improvements.

4 Using Budget Information to Monitor Health Resources in Kenya

The Institute of Policy Analysis and Research (IPAR), an NGO in Kenya, was commissioned to research causes of the recent decline in the quality and availability of publicly provided health services in the country. Despite the recent increase in public spending on health care, no corresponding increase in health outcomes has occurred (International Budget Partnership 2009). . Significant increases in Kenya's health budget, from 16 billion Kenyan schillings (Ksh) in 2003-2004 to 27 billion Ksh in 2006-2007 (representing7.92 percent of total government expenditures and 2 percent of gross domestic product for that year), have coincided with decreases in a number of health indicators, such as infant mortality and life expectancy. Between 50 and 54 percent of health expenditures between 2002 and 2007 went to public health care workers' salaries, which are significantly lower than those of private sector health workers, especially for doctors and pharmacists.

A budget analysis indicating that a significant portion of health expenditures was being allocated to salaries, coupled with the 2005-2020 National Health Sector Strategic Plan suggestion that personnel management needed to be more efficient, led IPAR to conduct a study of public health care facilities in the Machakos district to determine the extent and causes of health care provider absenteeism. IPAR hypothesized that absenteeism was a problem contributing to a leakage of public funds. Upon visiting 40 health facilities unannounced, researchers found an average absenteeism rate of 25 percent. According to IPAR's estimate, employee absenteeism costs the district of Machakos 6,659,832 Ksh (approx. US$107,000) per month 1. Estimates show that, over the course of a year, the accumulated cost of more than $1 million would be enough to build a fully equipped mid-level health care facility.

Compared to developed countries, civil society in the developing world plays a relatively small role in shaping health policy. Poor access to information, for example, where to find data on public spending for health may partly explain why CSOs do not have a larger role (Glassman and Buse 2008). As for the information that is available, many CSOs do not possess the skills required to access and analyze data on health expenditures or facility performance. Organizations that do have the necessary capacities, such as think tanks or academic research departments, may not have an interest in using their skills for advocacy.

Collective Action: A single complaint from a patient who was forced to make an informal payment is unlikely to draw the attention of facility managers or district health officials. Mobilizing the many clients who have paid informal payments across several facilities, however, can make a powerful statement, and encourage others to speak up. This collective action can gain the attention of policymakers and health sector managers. Collective action can also serve to aggregate disparate individual views, or experience from individual facilities, into a more focused common agenda for CSO advocacy.

Recent research on the success of collective action in the global health arena has focused on global health initiatives (Shiffman 2009). Examples of national collective action in health, for example, by women's health advocates (Dixon Mueller 1993) and around access to AIDS treatment (Grebe 2009) are also available.

Shiffman (2009) proposes a framework to explain why some health issues attract attention and others do not, which may have relevance more broadly to understanding the conditions likely to predict successful collective action. The factors that explain why a health issue attracts policy attention cluster into four categories: (1) the strength of the actors involved in an issue, (2) the ideas they use to understand and position the issue, (3) the nature of the political contexts in which these actors operate, and (4) the inherent characteristics of the issue itself. Box 5 below presents an example of collective action taken to improve the quality of services provided by district (upazila) health facilities in Bangladesh.

It is important to be realistic about whether external support to civil society can spur collective action. Successful collective action is typically the result of several overlapping factors at various levels and not directly linked to any one civil society initiative (Booth 2012). It is also easier to promote short-term action at the community level than regionally or nationally.

Sanctions: While CSOs do not have the power to formally sanction public health officials, they can use social accountability tools to identify problems and raise public awareness. With credible evidence and effective publicity, civil society can exert pressure on public officials to take action. The strategic use of media to expose issues can be one of the most effective sanctions available to CSOs (see example in Box 6). Oversight institutions such as anti-corruption agencies, parliamentary standing committees on health, regulatory bodies, and audit agencies are also effective partners in promoting formal sanctions. These institutions often lack the research capacity and on-the-ground knowledge that CSOs can provide.

5 Community Mobilization for Improved Health Performance in Bangladesh

Through the USAID/Bangladesh-funded Promoting Accountability, Governance, Transparency, and Integrity (PROGATI) project, CSOs received support to conduct community scorecards on local public services. In Ramnathpur, a village in the Rangpur Division, a local organization called Debi Chowdhurani Palli Unnayan Kendra (DCPUK) organized the community to use scorecards to assess the local health and family welfare center. DCPUK is a long-established Bangladeshi NGO committed to improving the condition of the most disadvantaged. By virtue of its longstanding presence in the division, DCPUK brought significant social and political capital to the scorecard exercise. The scorecard process, which included identifying performance indicators with the community and conducting meetings with facility management and focus groups within the community, identified the absenteeism of medical professionals and the lack of access to medicines that should be available for free as key performance issues. At a public hearing to present the scorecard findings in the presence of district health officials, over 300 community members stated publicly that they saw medicines that should be available for free in the public clinic being sold in the local market. As a result of the scorecard process, the clinic medical staff began to retain medicine wrappers so that future monitoring efforts could determine what was being distributed, and, district-level health officials also noted a reduction in absenteeism. The broad engagement of community members, district health and government authorities, as well as health care providers, helped clearly define the issues – which were not of a technical nature – in terms all could understand.

There are, however, significant constraints on the CSOs' ability to effectively impose sanctions. Media in countries with restrictive media laws or with politically aligned media houses may not be interested in raising controversial issues. Enforcement of sanctions is limited in many developing country health contexts due in part to inadequate financial and human resources regulatory and oversight bodies (Savedoff 2011) CSOs working at the local level may have greater potential for sanctions because health workers at local facilities are members of their communities.

The few rigorous impact assessments that have been conducted (Björkman and Svensson 2009) indicate that where civil society and communities are engaged in social accountability work, service health delivery has improved. This is due to the lack of broad civil society accountability efforts and the fact that efforts to improve the accountability and performance take place in complicated environments with numerous contributing influential institutional, political, and resource factors. As Gaventa and McGee (2013) note, "Transparency and accountability initiatives unfold with complex, non-linear, contextually specific social and political processes and it is these complex contexts and processes that they seek to change."

6 CSOs Use Public Attention to Secure Sanctions in Thailand

Rural Doctor Solidarity, a watchdog group of doctors who work in remote rural hospitals in Thailand, first raised allegations of medicine and medical supply corruption in 1998 (Suwanmala 2010). The group alleged that the purchasing prices of medicines and medical supplies in 34 provinces were so unusually high that some corruption must exist in the purchasing process. Rakkiat Suksthana, the public health deputy minister at the time, was suspected of involvement. The media brought the scandal to public attention in a short time. The parliament, police, and then the National Counter Corruption Commission (NCCC) investigated.

The police alleged that Rakkiat had ordered or induced his subordinates to purchase medicines and medical supplies from two colluding firms. A sum of 33,400,000 baht appeared in the bank accounts of his wife. In August 1998, just before leaving the post, Rakkiat obtained a cashier's check for 5 million baht from the managing director of a colluding firm. Chirayu Charatsathien, his secretary—who was also convicted and imprisoned—testified that the check was payment for the minister's lifting of the ceiling price and purchasing from the colluding firms.

Figure 1 below illustrates the theory of change where civil society engagement contributes to improving health outcomes by spurring improvements in service delivery and more informed policy making. It is critical to note that the several external factors are essential to how civil society can influence health policy and service delivery. These external factors include:

- Government partners that are willing to participate and responsive to civil society initiatives;
- CSOs and government officials that possess the appropriate range of skills to implement social accountability efforts and implement solutions;
- An organic demand from civil society for accountability and transparency reforms; and
- Existing social movements that may be tapped for public pressure.

Figure 1: Theory of Change

Section 3: Tools for Engaging Civil Society in Health Finance and Governance

This guide provides details on the following eight tools CSOs can use to engage in health finance and governance:

1. Community scorecards
2. Entry point mapping
3. Social audits
4. Citizen charters
5. Public Expenditure Tracking Surveys (PETS)
6. Report cards
7. Health facility exit surveys
8. Private sector engagement.

Many of these tools, including citizen charters, community scorecards, report cards, social audits, and PETS, have been applied extensively, often in the health sector. Others, such as entry point mapping and private sector engagement, have relatively narrow application, but offer important additions to how CSOs may engage in health finance and governance.

These specific tools were selected to reflect the diversity of CSOs involved in the health sector as well as governance and finance issues in which civil society engagement can have an impact.

The following is a summary of each tool – a detailed description of each can be found in Annex A.

7 What Type of Civil Society Organizations Can Use these Tools?

Implementing these tools, and using the data that result from their use, requires that CSOs possess capacities in the following areas:

1. Monitoring and evaluation skills such as research techniques, sampling, and data quality
2. Ability to develop and implement targeted advocacy and communication strategies
3. Ability to promote productive dialogue with the public sector

Those organizations that do not possess these requisite skills may find it difficult to successfully implement these tools.

For each, we provide an example of how the tool might be used to engage civil society organizations on priority issues such as ending preventable child and maternal death (EPCMD), ending HIV and AIDS, and eradicating malaria.

Community Scorecards: The community scorecard is an evidence-based tool CSOs can use to assess performance of local public health services. The scorecard process emphasizes dialogue between beneficiaries and service providers and local authorities to identify solutions and improvements. Through the community scorecard process, CSOs gather community perceptions about the quality of health service delivery and evaluate indicators of health service performance. Following these assessments, the groups then facilitate public dialogue between beneficiaries and service providers to present and discuss findings and develop joint action plans. In isolation, a community scorecard presents an opportunity for civil society groups to document and address specific areas of weakness, including corruption, mismanagement, absenteeism, and poor performance, at an individual public health facility. Implemented on a broader scale, a series of community scorecards allows for civil society groups to compare results across several health facilities and aggregate common challenges to engage policymakers at the national level.

8 Community Scorecards to Support EPCMD

Community scorecards can be used to monitor the presence of community health workers (CHW) and the quality of services they provide. At the community level, the data can be used to identify and address management and performance issues such as absenteeism, access to services and informal payments. Aggregated data across several communities can be used to monitor and improve CHW programs and training.

Entry Point Mapping: Entry point mapping provides a methodology for systemic review of the health system and identification of mechanisms, forums, and public platforms where CSOs can participate in the health sector decision making. CSOs often know the stakeholders they want to influence to development of national and local health policies, provide feedback to health service delivery quality, and conduct oversight on the effectiveness and efficiency of health spending. Often, however, CSOs are not aware of the institutionalized forums through which civil society can engage with policymakers and facility managers. Entry point mapping helps CSOs and public health institutions determine their options for institutionalizing engagement between civil society and public health officials.

9 Entry Point Mapping to Address HIV and AIDS

CSOs at both the grassroots and national level can use entry point mapping to strategically identify the most appropriate and effective platforms for advocating for raising service delivery performance to relevant officials and calling for greater domestic resource mobilization for HIV and AIDS programs.

Social Audits: The social audit is a participatory process that allows community members to monitor the implementation of a government health program and measure the program's impact against intended results. The social audit process includes a review of the many factors relating to program impact, including compliance to procedures, quality of services, and accountability and transparency measures such as the frequency of government monitoring and existence of dispute resolution mechanisms. This tool can also generate recommendations on policy changes to improve the program implementation.

10 Social Audit to Improve Malaria Programming

A social audit of a national malaria control program can engage civil society and communities in systematically identifying gaps in program performance, foster dialogue with health officials on necessary improvements, and promote local- and national-level accountability.

Citizen Charters: The citizen charter, developed between civil society and public health officials, aims to improve the quality of services by publishing standards that users can expect for each service they receive from the government. A citizen charter is a document or publication that informs citizens about the entitlements they have as users of public health services, the standards they can expect for a service, remedies available for when service provider do not adhere to standards, and the procedures, costs, and charges of a service. The charter informs users to a formal mechanism they can use when standards are not met, and the joint effort from civil society and public health officials fosters the conditions for sustainable engagement on service quality and accountability.

11 Citizen Charters for Improve Family Planning Services

Citizen charters can be used to document and build community understanding of the services, costs and eligibility requirements at family planning centers. With participation from center staff, charters can improve cooperation with communities and increase transparency of service delivery standards

Public Expenditure Tracking Surveys: PETS are a set of tools developed in 1996 to uncover points of leakage in the expenditure chain for particular programs or line items. While PETS has become an umbrella term for budget tracking more widely, PETS led by CSOs involve the comparisons of budget and financial records from different sources for the purposes of promoting external accountability. Civil society-led PETS have two goals. The first is to identify inconsistencies in records regarding the allocation and disbursement of funds by one office or facility and the corresponding receipt of funds by a different office or facility. The second is to use the PETS findings to advocate for, and monitor improved accountability and more effective management.[1]

12 PETS to Improve Efficiency of HIV and AIDS Services

Civil society led PETS can be used to track how resources allocated to critical services for HIV and AIDS care and treatment reach the facility level and identify potential leakages. Through the PETS process, CSOs can advocate for efficiency improvements and greater accountability.

Report Cards: Report cards are a citizen-driven exercise to collect data on the performance of a health facility and its personnel. Report card activities can be organized by civil society as a method for systematically gathering information for advocacy and accountability efforts, or to disseminate information to the public about high- and low-performing facilities. Report cards may also be organized by government, leveraging CSO's grassroots presence to collect data on performance of targeted facilities or across several facilities. This standard questionnaire is used to collect basic feedback from health service users on issues such as wait times, service costs, drug availability, quality of service, and personnel attitude. The scorecard may focus on general facility performance, but may also target specific services such as prenatal and antenatal

1 Adapted from: Courtney Tolmie. October 2012. Where Are Our Budgets? Public Expenditure Tracking Surveys as Tools for Engaging with Civil Society. Bethesda, MD: Health Finance and Governance project, Abt Associates Inc.

services, HIV, malaria, and reproductive health. The results of multiple scorecards for the same facility are aggregated to provide a picture of overall facility performance and also to be assessed against results from other facilities. Report cards can be conducted once or repeatedly in order to understand changes over time.

13 Report Cards to Track Effectiveness of Malaria Drugs

Report cards focused on tracking the type of anti-malarial drugs available and community level health facilities can provide CSOs with evidence of the prevalence of counterfeit or substandard drugs. The results can be used for more effective advocacy and targeted public information campaigns.

Health Facility Exit Surveys: Health facility exit surveys are a method to measure the prevalence and scale of informal payments made by patients at specific health facilities. At the completion of their visit, patients are asked questions about the services they received and the associated costs. The surveys can offer important insight into the informal payments patients are required to pay and potential barriers to health services. The survey results can be used at the facility level to inform dialogue between the community and facility managers on corruption issues. When compared across facilities, the exit surveys can help to identify systemic management issues and those patients and services most vulnerable to informal payments.

14 Health Facility Exit Surveys for Improved HIV and AIDS Services

Health facility exit surveys focused on HIV and AIDS programming can be used to assess the prevalence of patients being subject to informal payments and potential barriers to access of HIV services.

Private Sector Engagement: Private sector engagement is a term that describes a spectrum of engagement between the public health sector and either the private (non-health) corporate sector or the private health sector; these are also known as public-private partnerships. For the purposes of this guide, the partnerships discussed are between the public and private health sectors only, and are referred to as "private sector engagement." These partnerships vary in complexity. They can be as simple as a public and private health sector forum, wherein leaders of the private health sector interact and exchange information, express preferences, tackle barriers, and define opportunities for enhanced cooperation between the sectors and discuss priorities for the country's health sector. On the more advanced end of the spectrum, the partnerships entail formal and transparent private sector access to government funding for delivering goods and services, and/or private sector engagement in health sector oversight and regulation (such as self-regulating medical associations.) The private health sector can be leveraged to improve data quality for decision making, increase technical knowledge for regulation and oversight, and mobilize a more complete response to health priorities.

Deciding What Tool Is Best

There are several factors that might influence the decision to use one tool over another.

- **Geography:** Some tools lend themselves to community based efforts, while others are more regional and national in scope.
- **Objective:** There are some tools more appropriate for fostering community level dialogue. Others are more appropriate for data collection and analysis.
- **Timing:** The time required to conduct the tools ranges from one month to over one year.
- **Local Capacity:** All the tools require a level of advocacy capacity. Some tools require more specialized analytic and monitoring and evaluation skills, while others use simpler methodologies and require community dialogue skills.

Table 1 presents the tools across these four factors.

Table 1: Factors for Deciding Between Civil Society Tools

Factor	Appropriate Tools
Geography	
Regional/ National	Social Audit
	Entry Point Mapping
	Community Scorecards (if designed intentionally)
	Report Cards (if designed intentionally)
	Citizen Charters
	PETS
	Public and Private Health Sector Engagement Mechanism
Local/Facility	Community Scorecards
	Report Cards
	PETS
	Citizen Charters
Objective	
Data Collection	Report Cards
	PETS
Community Dialogue	Social Audit
	Community Scorecards
	Citizen Charters
	Entry Point Mapping
	Public and Private Health Sector Engagement Mechanism
Timing	
Short Term	Report Cards (one month)
	Community Scorecards (six weeks)
	Entry Point Mapping (two months)
	Citizen Charters (two months)
Long Term	Social Audit (four months)
	PETS (three months)
	Public and Private Health Sector Engagement Mechanism (minimum of six months)
Local Capacity	
Low	Community Scorecards
	Report Cards
	Entry Point Mapping
	Citizen Charters
High/ Specialized	Social Audit
	PETS
	Public and Private Health Sector Engagement Mechanism

Talk Family Planning
wit ya partner
Waka go do
Family Planning

Section 4: Entry Points for Civil Society in the Health System

This section examines the various entry points for civil society engagement in health systems and includes examples of how these entry points have been used to contribute to improved health service availability and quality. Table 1 is organized by health systems building blocks[1] and, for each of these blocks, identifies the kinds of issues civil society engagement might effectively address, the tools or approaches for doing so, and offers an example of where this has been done and with what results. The evidence of the effectiveness of the approach can come from impact evaluations (e.g., results of a randomized control trial) or be project-based. In some cases, the evidence is presented as a policy reform outcome. For example, under the medical supplies and equipment building block, a citizen petition was used to expedite approval of experimental AIDS drugs by the FDA in the early 1990s, and where approval was granted based on laboratory results rather than long-term evidence of patient survival (Kolata 1990). Not every example, however, has been evaluated.

Table 2 shows the breadth of ways in which civil society engagement has been used to address common challenges to improving the availability and quality of health services. The examples are selected from a broad range of settings; occasionally an example from the United States is included when it is thought to be adaptable to selected developing world settings.

[1] See The World Health Organization. 2007. Everybody's business: Strengthening health systems to improve health outcomes. WHO's Framework of Action.

Table 2: Civil Society Strategies for Meaningful Engagement in Health Systems Strengthening

Health System Building Block	Issues	Civil Society Entry Points	Evidence
Leadership and Governance	Limited formal structures or processes (such as health boards) for community to participate and have their voices heard. This contributes to poor transparency regarding decisions (e.g., hiring decisions, fee schedules, hours, organization of services) made by local health authorities.	Mandated CSO representation on local health boards along with clear requirements on minimum board operating requirements formalizes opportunities for meaningful citizen engagement in local oversight bodies. Sanctions exist to enforce requirements, including timely sharing of board minutes.	Ramiro (2001) published an evaluation on the effects of health boards on health system effectiveness using data from the Philippines. Local government units (LGUs) with functioning health boards have greater potential for meaningfully engaging communities; they also had higher rates of consultation and higher per capita expenditure on health than those where there was less participation.
	Informed consent and voluntariness in provision of services not respected	Inclusion of health and reproductive rights as areas for oversight by human rights organizations.	The *Defensoria del Pueblo* functioned as a trusted human rights ombudsman responsible for receiving and investigating allegations of reproductive rights abuses, specifically forced sterilization, in Peru (Pegram 2010). An independent institution with broad authorities, it enjoyed strong support from both civil society and government. The Defensoria monitored reports of forced sterilization from 1997–2006.

Table 2: Civil Society Strategies for Meaningful Engagement in Health Systems Strengthening *(Cont.)*

Health System Building Block	Issues	Civil Society Entry Points	Evidence
Financing	Citizens lack information about the use of government funds to implement government policy and commitments to health issues.	Resource tracking using National Health Accounts (NHA) and other monitoring tools can provide information on actual expenditures, including for sub-categories such as HIV and AIDS and reproductive health. Engaging CSOs in research tracking efforts can equip them with the data they need to advocate effectively to increase funding for neglected health priorities.	CSOs had difficulty engaging the Kenyan government in national debates, due in part to the paucity of data available to them. The 2002 assessment of the HIV and AIDS subaccount reported that the government spent most of its HIV and AIDS money on prevention and did not contribute to antiretroviral therapy (ART). The Kenya Treatment Access Movement used findings from the HIV and AIDS subaccounts to lobby the government for an ART budget line item and to gain a more prominent role in policy discussions.
	Budget documents are inaccessible to ordinary citizens, who therefore cannot easily understand whether budget allocations are honoring the government's policy commitments.	A Citizen's Alternative Budget reflects budget allocation priorities, including for health and education. It creates space for CSOs to participate in the pre- and post-budget hearings and to advise on health budget priorities.	In Kenya a policy research organization works with CSOs and political parties to formulate a national budget reflecting the priorities of diverse citizens. Many of the policy alternatives presented in the Citizen's Alternative Budget have been forwarded to the Kenyan Treasury for incorporation into the country's national budget.

Table 2: Civil Society Strategies for Meaningful Engagement in Health Systems Strengthening *(Cont.)*

Health System Building Block	Issues	Civil Society Entry Points	Evidence
Service Delivery	Providers lack incentives to improve the quality of services	Citizen Report Cards, facilitated by trained CBOs, followed by community-led action plan development to address identify service delivery issues. Focus was on district-level public sector dispensaries providing primary health care services.	In a randomized controlled trial RCT evaluation (see Bjorkman and Svensson 2009) community monitoring of a public sector primary health care service delivery led to improved quality and quantity of health care service delivery, service utilization, and selected outcome measures, including weight-for-age-z-scores.
	Asymmetries in information between providers and clients mean clients are in poor position to evaluate quality of provider care	Educating catchment populations about their right to access government services and about mechanisms through which to register grievances.	An RCT in Uttar Pradesh, India found that communities that received such information had increases in the number of clients treated during nurse visits to the communities, higher frequency of village council meetings, and households of all castes reporting improved quality of services (Pandey 2007)
Human Resources	Provider absenteeism is a major obstacle to public sector health service delivery, especially in rural areas. The centralized hiring, promotion, and deployment of public health workers in most countries reaches beyond the authority of local boards or community oversight bodies, thereby limiting the effectiveness of local accountability structures (Lewis 2006).	Community Monitoring Cards along with Participatory Absenteeism Tracking, including through the use of video and information and communication technology ICT, followed by interviews to screen out legitimate reasons for absence have been used by Results for Development and local partners in Rajasthan to reduce provider absenteeism. The effectiveness of community monitoring seems to be greatly enhanced when accompanied by the use of financial incentives.	A randomized study classroom monitoring combined with financial incentives of locally hired teachers (rather than teachers hired by the central government) found substantial reductions in absenteeism, to 21 percent compared to 44 percent at baseline and 42 percent in the comparison area (Duflo et al. 2012). Teacher attendance varied by time stamped photograph. Teachers were given a bonus for being present a certain number of days, and were fined for missing work. The government of Rajasthan created a similar system for government nurses, who were monitored using time and date stamps, and it included a severe fine for chronic absence. In the first few months of the program, absenteeism among nurses dropped by about 50 percent; once sanctions were lightened, absenteeism rose to the level of the control group, suggesting community monitoring must be paired with sanctions to have an enduring impact.

Table 2: Civil Society Strategies for Meaningful Engagement in Health Systems Strengthening *(Cont.)*

Health System Building Block	Issues	Civil Society Entry Points	Evidence
Information	Performance monitoring data may be fabricated and not represent actual delivery and quality of services unless it is independently verified.	CSOs can contribute meaningfully to the independent verification of facility-based performance data while offering the additional benefits of local knowledge which enables them to contextualize results in a way an external verifier might not be able to. Contracting CSOs to monitor performance data links them to the routine functioning of the health system and thereby ensures the sustainability of community engagement.	Burundi's national PBI program uses community based organizations CBOs to verify results reported by health facilities and conduct the patient satisfaction surveys. A facility's score on the community survey determines 40 percent of its quality bonus. The CBOs are selected by local and provincial committees. Contracts with CBOs are signed for one year, and may be renewed if CBO performance is deemed acceptable. The CSOs are paid a fee per survey completed.
Medical Products, Vaccines, Technology	Stock out of drugs and medical supplies	Citizen feedback, e.g. through scorecard process	Under the USAID-funded PROGATI program in Bangladesh, 100 districts (upazilas) used community scorecards leading to improvements in drug availability. Nearly 30 upazilas developed citizen charters publicizing the standard and availability of service and their prices for public display
	Long drug approval process prevents people from accessing potentially lifesaving drugs	Citizen petition allows for citizens to request accelerated process for approving drugs that address urgent needs (e.g., HIV)	Physicians and AIDS activists signed a citizen petition demanding that the FDA ask drug companies testing two experimental AIDS drugs to send in their data for review and apply for marketing approval and that the FDA expedite review of the data and use laboratory results as evidence that the drugs are working rather than requiring long-term evidence of patient survival (Kolata 1990). The two drugs were approved quickly, by FDA standards.

CLOVER A1c
ANANTA
MEDICARE
Powder-FREE

Section 5: Good Practices for Achieving Impact With Civil Society Engagement

Social accountability tools have long been applied to the health sector. Although relatively few rigorous impact assessments exist for social accountability efforts, several evaluations document how the design of programs using social accountability tools have influenced the ability to achieve results. In the following section, we distill several of the critical factors affecting successful application of these tools in various development contexts. These findings and lessons learned are intended to help those designing social accountability programs determine appropriate tools and use them to achieve greater and more sustained results.

Using Political Economy Analysis to Diagnose Health Challenges

A study of power and influence in the Uganda pharmaceutical supply chain (Camargo 2012) identified limitations on district-level health facility staff advancement due to the government's decentralization policy as a key reason for stock-outs and pilferage. Likewise, a political analysis study of the distribution of health professionals in Nepal (Harris et al. 2013) identified patronage networks and fear of violent reprisals from service beneficiaries if their relatives die during treatment as contributors to the lack of health professionals in rural areas.

I. Understand the Context

Prior to designing and implementing a program using social accountability tools, conducting an assessment of the underlying political, institutional, and geographical contexts is key. Such an assessment will help to identify areas (both geographic and technical) where engagement of civil society may be useful, at what level, and what tools might have the greatest impact. In addition, the assessment may pinpoint where fundamental vested interests prevent success in improving quality service delivery at the local level. The following serve as key elements to consider when assessing the political economy of the health sector:

- **Roles and Responsibilities:** Who are the key stakeholders in health? Who are the principal actors responsible for initiating policy reforms? What is the balance between central and local authorities? How do these dynamics differ across health issues (e.g., HIV and AIDS versus health financing)?
- **Ownership Structure and Financing[1]:** How are the primary sectors of the health system – public, private (both commercial for-profit and NGO/FBO) – organized? Which agencies and organizations are in charge of the following functions of the health system: implementation, insurance, governance, financing, information and statistics, management, and regulation?

[1] The questions suggested here are adapted from Section 1.2 of the Health Systems Strengthening 20/20 Project's, Health Systems Assessment Approach: A How-To Manual, 2012.

- **Power Relations:** To what extent is power vested in the hands of specific individuals or groups? How do different interest groups outside government (e.g., private for-profit providers, NGOs and FBOs, professional associations, private insurers) seek to influence policy?
- **Historical Legacies:** What is the past history of the sector, including previous reform initiatives, regarding privatization of public health care delivery?
- **Corruption and Rent Seeking:** In which areas is corruption most problematic? This includes areas such as contracting and procurement, petty theft, unaccounted for public funds, absenteeism/ghost positions, informal payments, and selling accreditation or positions.
- **Service Delivery:** Which groups benefit most from subsidies for health? Are particular social, regional, or ethnic groups included or excluded?
- **Ideologies and Values:** What are the dominant ideologies and values that shape views around the health sector? Are there political or policy commitments to a right to health for all? What is the role of the commercial private sector in health service delivery?

It is also important to note that the impact of civil society engagement is also a function of broader governance and health system dynamics. In environments where government is responsive to citizen concerns and focused on accountability, civil society engagement may reap benefits. As Brinkerhoff and Bossert (2013) note, however, "In countries with authoritarian governments, political leaders and health officials may not see themselves as agents acting on behalf of citizen-principals." Likewise, broader governance and health system reform can impact how effective civil society engagement can be. Activities that engage communities in health decision making where decentralization is also taking place can "present the most promise for improving provider accountability" (Berlan and Shiffman 2011).

II. Forge Constructive Partnerships with Government

The successful implementation of tools presented in this guide requires forging a constructive partnership between civil society organizations and public health officials at the national and local level. In a review of 282 studies of community empowerment strategies for health (Rassekh and Segaren 2009), those that included a partnership between communities and policymakers had the highest odds of success. Although tools could be applied independently of government participation, a strong partnership with government is beneficial for three key reasons:

- **Access to Information:** Many of the tools, including community scorecards, citizen charters, social audit, and PETS, require detailed information about the design of public health programs and access to public health facilities and officials. A social audit of a malaria control program will require soliciting information from local governments, community members, and local hospitals or clinics. Without government buy-in, CSOs may struggle to get consistent access to the data necessary to complete the audit.
- Promoting Sustainability: The tools described in this guide can help CSOs to diagnose accountability issues in the health system and identify solutions. Many of these solutions depend upon management and system improvements within the facilities and ministry operations. A strong partnership with government in using these tools is a key component of identifying and implementing sustainable solutions. If community scorecards of local health clinics identify informal payments and stock outages as significant problems, the facility managers and higher level ministry officials will play a significant role in identifying realistic solutions to improve the supply chain and increase oversight.

- **Fostering Accountability:** As noted in Section 3, CSOs alone cannot impose sanctions through social accountability efforts. Partnerships with formal oversight institutions such as parliamentary standing committees on health, anti-corruption agencies, regulatory bodies, and audit agencies offer CSOs the link to formal mechanisms for redress and corrective action.

III. Recognize and Mitigate the Risks

Engaging civil society organizations and communities in social accountability work involves risks to the individuals and organizations involved. Employing tools that identify mismanagement, lack of accountability, and corruption of public health officials can expose participants to backlash. Organizations that depend upon government funding or permissions to provide services can be resistant to engaging in social accountability efforts. Individuals who rely on the care of local health service providers are vulnerable when speaking out at public hearings.

The following are strategies for mitigating risks to organizations and individuals participating in implementation of these tools:

- **Promote Productive, Non-confrontational Dialogue:** Involving government officials in the design and implementation of social accountability efforts mitigates against suspicion and vulnerabilities public health officials and facility level staff may have towards use of these tools. Promoting dialogue between health officials and communities throughout the tool implementation process is important.
- **Institutionalize Improvements:** Working to institutionalize the commitments health officials have made is critical to reducing the risks to participants. For example, if a social audit identifies mismanagement of an antiretroviral distribution program, health officials may use the public hearings to commit to improvements. Without mechanisms to ensure that these commitments are followed through, however, participants in the social audit can be left vulnerable. Obtaining donor or government commitment to follow through with the necessary capacity building of communities (on how to continue to monitor the program) and health officials (on how to improve systems and oversight) may be required to implement change.
- **Facilitate Partnerships:** An important method for reducing risks to any one organization is to implement social accountability tools through partnerships and coalitions. Some organizations may be strong at data collection and analysis, while others have experience with advocacy and monitoring government programs. Including this range of skills will allow for credible evidence and strong advocacy follow-through. Though these partnerships may not continue beyond the specific intervention, their combined skills will help to ensure the tools are implemented, communities are engaged, and the results are used for advocacy.

IV. Build Civil Society Engagement into Existing Health Finance and Governance Efforts

Integrating civil society engagement efforts into ongoing health finance and governance activities can help build more public awareness of government policy decisions and accountability for public expenditures on health.

- **Government-led Resource Tracking Exercises:** Government-led resource tracking exercises (as opposed to civil society-led PETS discussed earlier) generally involve tracing funds throughout the health sector to determine the where the funds originate and how funds are linked to their intended outcomes. Engaging civil society in resource tracking exercises can help promote both the regular use of tools to assess the effectiveness and efficiency of health funding and to advocate for the management and accountability improvements identified through resource tracking. Civil

society engagement early in a resource tracking exercise, during the planning and scoping stage for example, can help with framing better key questions that reflect the needs of a broader set of stakeholders. CSOs can also be a critical source of information during the data collection stage and potentially facilitate the overall collection and verification of information. CSOs can provide an important external voice as policy makers draft recommendations for prioritizing future health expenditures, and once final policy recommendations are final, civil society can advocate for and monitor their implementation.

Table 3 summarizes examples of key resource tracking methodologies currently under use and presents questions they help answer.

- **Performance-Based Incentives (PBI)[2]:** In PBI programs that offer performance incentives to health care providers, collecting and verifying data about provider performance – both the quantity and quality of services they deliver – is a routine activity that can be *performed* by communities and *used by* citizens to monitor or grade provider performance.

  Engaging CBOs to monitor and verify provider performance may strengthen the implementation of PBI schemes. Communities are often better informed about the status of service delivery than external monitors are, and they may have means of punishing providers that are not available to outsiders (e.g., social sanctions). Community monitors may also be able to stimulate increased effort by providing non-financial rewards for good performance, such as recognition at community gatherings (Björkman and Svensson 2009).

  In addition, the data generated by PBI programs can be used to inform and target social accountability initiatives, particularly those using tools such as community scorecards, report cards, and citizen charters. Performance data from facilities within a predefined geographic area can be shared with CSOs, along with area averages and targets. For example, if the PBI program offers incentives to facilities for increasing the number or quality of facility deliveries, data on each facility's performance in relation to this indicator would be shared with the CBO, along with national averages, and possibly facility targets and data on the performance of facilities in neighboring areas. This would enable the CSOs to target those facilities that are performing poorly, or performing below the area average, for a community scorecard or citizen charter initiative.

  Leveraging PBI programs in this regard has several benefits: first, where CBOs are already engaged in verification, they are primed to take this role further by using their knowledge and capacity to facilitate dialogue in their communities. Furthermore, the fact that verification and collection of data on health services is a routine activity in PBI programs overcomes the challenge observed in community engagement programs that once the intervention ends, the data collection activity upon which it depends is often not sustained (Croke 2012).

- **Promoting Accountability to International Commitments:** Civil society organizations can play an influential role in monitoring their country's progress towards international commitments and mobilizing local constituencies for advocacy. For example, at the 2012 Family Planning 2020 Summit in London, over 20 countries made commitments to achieving clear family planning targets and budgetary expenditures. CSOs can use tools such as PETS, community scorecards, and report cards to track expenditures and service quality performance of family planning services, thereby supporting robust domestic accountability. Domestic efforts could, in turn, augment international efforts to promote accountability towards meeting commitments. Likewise, as CSOs seek to engage with government on family planning issues, entry point mapping can be used to identify the mechanisms and platforms for advocacy.

[2] Adapted from: Lindsay Morgan. December 2013. Where Are Our Budgets? Public Expenditure Tracking Surveys as Tools for Engaging with Civil Society. Bethesda, MD: Health Finance and Governance project, Abt Associates Inc.

Table 3: CSO Roles in Government-led Resource Tracking

Methodology	Key Features	Questions Methodology Helps Answer	Potential Role for CSO Engagement
National Health Accounts (NHA)	• Used to determine a nation's health expenditure patterns • Describes the magnitude and flow of funds through a health system; uses expenditure as a basis • Looks at overall health expenditures, including public, private, and donor contributions. • Provides standard set of tables that organizes information in an easy-to-understand manner	• Who finances health care? • How much do they spend? • Where do their health funds go? • How are the resources pooled and managed? • Who benefits from this health expenditure pattern?	**Participation in Design:** Resource tracking exercises provide a forum for engaging civil society stakeholders in dialogue about the design, scope, or intended use of results. This is particularly true for N/SHA activities that require data collection from health NGOs.
Public Expenditure Review	• Analyzes public sector spending against policy, efficiency, effectiveness, equity, and sustainability parameters • Focused on spending in social sectors; not limited to health • Provides policy and finance management information	• How are budgetary allocations and public expenditures, as well as services, distributed among the population? • How efficient/effective is the use of public spending to achieve the desired health outcomes?	**Use of Results for Advocacy** CSOs can use the findings to inform advocacy campaigns on issues of budget allocations and expenditures for health priorities. The findings of PETS may also inform campaigns on the accountability and effectiveness of public expenditures in health.
Public Expenditure Tracking Survey	• Tracks the flow of resources through the various layers of government bureaucracy • Has diagnostic purpose – to identify bottlenecks and leakages	• What is the magnitude of these impediments? • Where are the key impediments of public resource flows to the service providers?	**Complementary Use of Social Accountability Tools** Scorecards, report cards, and social audits can be used to monitor expenditures and government performance in policy implementation. CSO-led PETS can focus on analyzing expenditures at local level facilities.
National AIDS Spending Assessment (NASA)	• Tracks annual flow of funds used to finance response to HIV and AIDS • Designed to track both budget and spending • Goes deeper into tracking the non-health resource flows related to HIV and AIDS	• Who finances HIV and AIDS? • How much do they spend? • Where do their HIV and AIDS funds go? • Who benefits from this HIV and AIDS expenditure pattern?	**Complementary Use of Social Accountability Tools** Scorecards, report cards, and social audits can be used to monitor expenditures and government performance in policy implementation. CSO-led PETS can focus on analyzing expenditures at local level facilities

Conclusion

CSOs can play important roles in contributing to more efficient, responsive, and accountable health systems. Through civil society engagement, and mechanisms to channel and aggregate the voice of citizen consumers of health services, health care providers and health policymakers have evidence for policy making and new incentives for improving service quality.

There are many tools at the disposal of program managers who wish to design activities focused on engaging civil society in health finance and governance. These include social accountability tools that engage communities at the national, subnational, and local levels through improved access to information, communal action, and sanctions. They also include tools that create platforms for dialogue and planning between government and the private sector.

Program managers should take into consideration a number of lessons learned when designing activities to engage civil society in health finance and governance. Experience demonstrates that activities that take into account the operating environments where civil society organizations are working work and that have taken efforts to promote strong and productive dialogue with government officials are most likely to be successful. In addition, to promote sustainability, program managers need to engage a broad spectrum of CSOs to ensure key population are represented. Such coalitions should include organizations that have the appropriate skills, not only to complete the tools (research, monitoring and evaluation), but to disseminate the findings, advocate for change, and draw on strong links to local communities.

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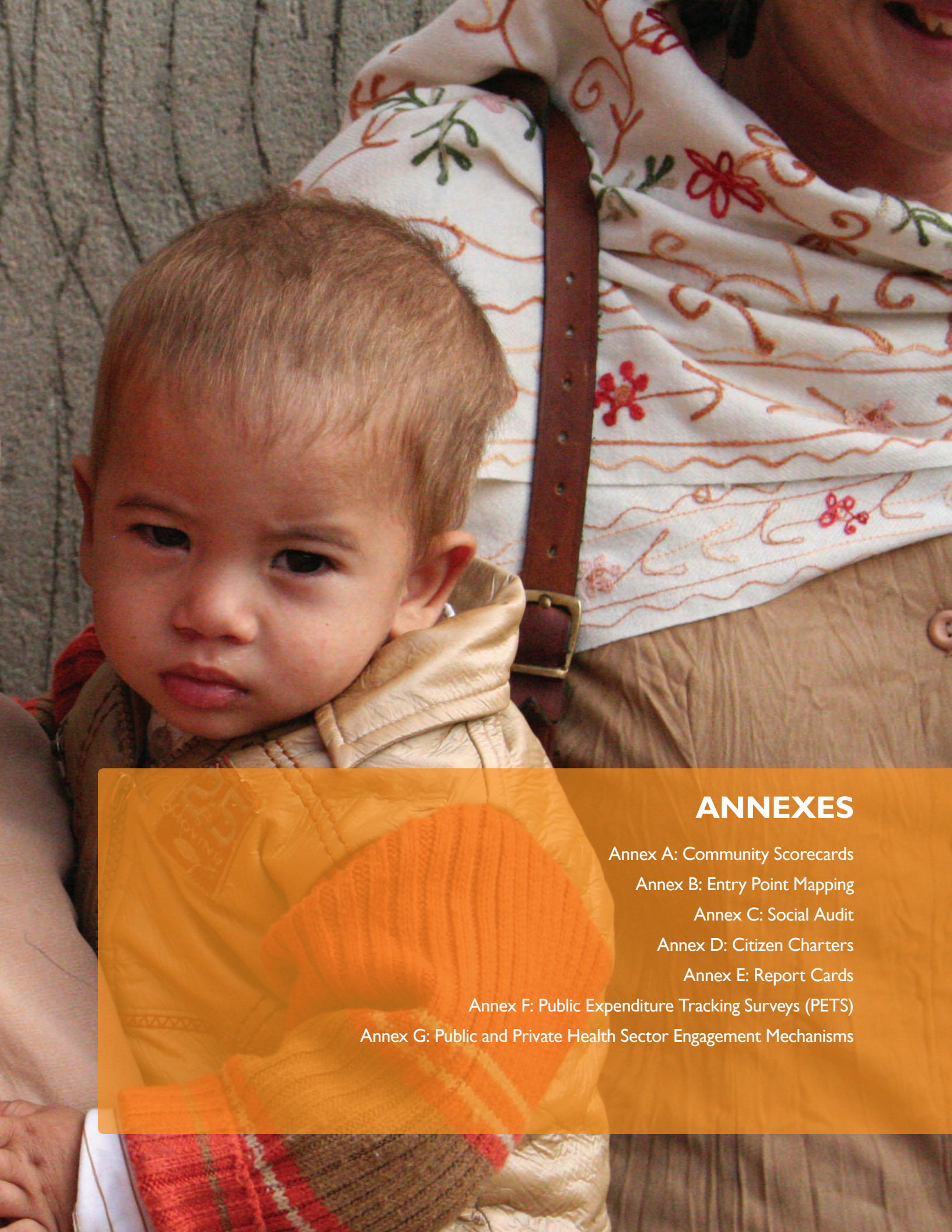

ANNEXES

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Annex A: Community Scorecards

The community scorecard is an evidence-based tool that civil society organizations (CSOs) can use to assess performance of local public health services and facilitate dialogue between beneficiaries on the one hand and service providers and local authorities on the other to identify solutions and improvements to any concerns or problems. Through the community scorecard process, CSOs gather community perceptions of health quality and evaluate indicators of health service performance. Following these assessments, the CSOs facilitate public dialogue between beneficiaries and service providers to present and discuss findings and develop joint action plans. Individual community scorecards present an opportunity for CSOs to document and address specific areas of weakness, including corruption, mismanagement, absenteeism and poor performance at an individual public health facility. Implemented on a broader scale, a series of community scorecards allows CSOs to compare results across multiple health facilities and aggregate common challenges to engage policy makers at the national level.

Tool Overview

Why is the tool necessary?

Sustainable improvements to health service delivery at the facility level require dialogue between beneficiaries, health service providers and local officials. A common constraint to such dialogue is the lack of evidence and structured feedback on health facility performance; service providers can easily dismiss individual or nonspecific complaints. Community scorecards offer a mechanism for beneficiaries to employ a standard process and established indicators to assess health service quality, document results of user perceptions, and use those findings to become involved in defining improvements and solutions. CSOs can use community scorecards as a way to gauge community perceptions of health services quality and to manage and facilitate structured dialogue between service providers and health service beneficiaries.

What does the tool achieve and what can the user expect for results?

CSOs using community scorecards can expect improved dialogue between service providers and beneficiaries about the quality and performance of services offered at local health facilities. The emphasis on a standard and transparent process with clear indicators results in a level of evidence that enables civil society organizations to attract the attention of service providers and local officials. Public dialogue between community members, service providers and local officials provides a platform for identifying improvements and solutions, as well as new accountability for following through on commitments.

The scorecard process may highlight a range of issues at the health facility level, including: doctor absenteeism, staff conduct, drug access, facility condition, unauthorized user fees and bribery, and lack of transparency on available services and required fees. Scorecards can be used for more targeted health initiatives such as assessing indoor residual spraying programs or antiretroviral drug distribution.

At the community level, the scorecard process spurs dialogue between communities and service providers about the improved provision of health services.

This dialogue both addresses key service gaps and establishes a platform for more institutionalized civil society accountability mechanisms. Aggregating the results of numerous scorecards can offer civil society a base of evidence on systemic issues facing health service delivery and form the base of broader policy advocacy.

Who is the tool for?

Community scorecards are most appropriate for CSOs that wish to facilitate community engagement and dialogue with health service providers and local officials. These CSOs may be health oriented – including those providing direct services, advocating for user groups, or managing health programming. CSOs implementing community scorecards do not have to be involved in the health sector, however. Groups that have gender- or youth-based mandates, that focus on transparency and accountability, or that represent disabled or minority groups may also have an interest in implementing community scorecards. CSOs with the following skills and attributes are best suited to implement community scorecards:

- Community mobilization
- Gender and youth awareness
- Training and mentoring
- Data collection and analysis
- Advocacy and policy dialogue

Where has the tool been used?

Community scorecards focusing on the health sector have been widely implemented, including in the following countries: Bangladesh, Gambia, Kenya, Malawi, Mozambique, Philippines, South Africa, Tanzania, Thailand, Uganda, and Ukraine.

What are the time and resource requirements to use the tool successfully?

The entire community scorecard process takes approximately six weeks to complete.

Initiating a scorecard program requires a lead CSO that has the skills to train and mentor local-level community committees to conduct scorecards. An individual scorecard process requires resources to facilitate local meetings and conduct a public hearing. Support for report writing and documentation may also be necessary.

Example

As part of the Transparency and Accountability Program (TAP) implemented by the Results for Development Institute (R4D), Citizen Report Cards were used in Bushenyi, Uganda, with the assumption that they would increase provide accountability to the client and bolster ways to incentivize providers to provide quality care and services. The Citizen Report Cards collected information on users' perception of accessibility, availability, and quality of services at select health facilities. The survey used was designed specifically to measure the level of client satisfaction with the health services in those regions. The information collected supported the development of recommendations for both providers and clients on how to use and leverage the information that was presented. These reports were used at local community meetings and helped CSOs work with community members to monitor health care providers and services. A randomized field test one year after completing the Citizen Report Cards found positive results due to increased effort by providers to serve their communities. The assessment noted a 16% increase in service utilization in the communities, higher infant weight, and a decrease in under-5 mortality. Additionally, the communities that used the report cards were notably more involved in monitoring service provision following the intervention. By providing a mechanism for active dissemination and accountability, the communities were able to provide feedback that had a measureable positive impact on the services of the health facilities.[1]

[1] Martina Bjorkman and Jakob Svensson, "Power to the People: Evidence from a Randomized Field Experiment on Community-Based Monitoring in Uganda," The Quarterly Journal of Economics (2009) 124 (2): 735-769.

Transparency and Accountability Program, Results for Development Institute, "Client Satisfaction with Health Services in Uganda: A citizens' report card on selected Public Health Facilities in Bushenyi and Lira districts," December 2012, http://unhco.or.ug/wp-content/uploads/downloads/2013/05/CRC_UNHCO_HEPS_TAP_Final_Report_2012.pdf .

Step by Step Guide to Use the Tool

1. Identify service area and form community committee

Select target area. Select the specific area(s) and villages, or clusters of villages, to be included. Facilitators from the lead CSO may also wish to select areas based on assessment of representation of target groups, such as women, ethnic minorities and/or disease prevalence.

Form a coordinating committee. The facilitators help to form a coordinating committee of 15 to 20 people to help facilitate the implementation of the scorecard. They may include traditional leaders, civic leaders, service workers, community volunteers, NGO staff, or other partners.

2. Raise awareness

Build public awareness. Conduct a broad community awareness-raising campaign to inform the community about the scorecard process, and ensure that community members are aware of their rights to quality services and their role in monitoring public services.

Establish partnership with government. As appropriate in the particular area, visit senior public service officials to explain the purpose and scope of the activity and seek their cooperation. This is a good way to start building a positive relationship – and get valuable information about how health services are intended to be delivered.

3. Research

Investigate expected inputs. The coordinating committee members must find out what the expected inputs are for the selected health facility and locality. Inputs include factors such as drug availability, staff presence, and transparency of fees.

Identify indicators. Select the key inputs to be tracked and list them as measureable indicators, such as medicines available, and number and/or qualifications of staff. Select 4-5 inputs that facilitators believe are important to the community and possible to gather information about.

4. Generate scorecard

Convene community gathering. Organize a large community gathering to generate the community scorecard. Divide into focus groups, each of which is led by members of the coordinating committee. Each focus group brainstorms performance indicators that they will then score through a group discussion consensus process. Examples of indicators are the attitude of staff (politeness, punctuality, etc.), quality of services (adequate infrastructure and equipment, staff qualifications, etc.), maintenance of facilities, and access to services. Once the scorecard is created, the focus group then discusses how to score the selected indicators.

Generate recommendations. Focus group members should identify recommendations they would make to improve health services. The main recommendations should be recorded by the facilitators.

5. Report and public hearing

Aggregate scorecard information and produce report. The coordinating committee now combines all of the information from the input investigation and the community perceptions scorecard to create one "Community Scorecard Report."

Facilitate a public hearing. A public meeting, including representatives of the community who participated in focus groups and service providers from the health facility, should be held to review and discuss the findings of the community scorecard. The hearing will likely identify areas of improvement for facility management as well as issues where joint community and facility advocacy are needed (e.g., availability of drugs from a central facility). The hearing should generate specific recommendations for next steps in continued community monitoring of commitments to improve health service delivery.

6. Continued dialogue

The facilitators and coordinating committee should then implement the recommended actions for continued monitoring and advocacy.

Key Considerations

- **Time.** If this is the first time communities are involved in monitoring of public services, there will need to be an initial investment in time discussing the scorecard process, the community's role, and citizen responsibilities.
- **Inclusiveness.** To be most effective, the coordinating committee should include representatives of key service beneficiaries, including women, the disabled, and youth. While it is easy to simply work with local elites, many of them may not use public health facilities.
- **Government buy-in.** Engaging senior government officials early on in the community scorecard process is a critical step. Conducting orientation sessions and one-on-one consultations can be methods for ensuring these officials will support the process, and more importantly be attentive to its findings.
- **Strategy.** Clearly planning how to use the scorecard findings is key to designing an effective community scorecard program. If the intention is to focus on impact in individual communities, the process can evolve organically; if the intention is to focus on aggregating findings across several communities, the process needs to be more structured, with standard indicators and report formats.

Resources

Community Score Card Process – A Short Note on the General Methodology for Implementation. http://siteresources.worldbank.org/INTPCENG/1143333-1116505690049/20509286/comscorecardsnote.pdf

The Community Scorecard in Tanzania. http://familyplanning.care2share.wikispaces.net/file/view/Community+Score+Card+case+study.pdf

Operational Manual for Community-Based Performance Monitoring. http://siteresources.worldbank.org/INTPCENG/1143333-1116505690049/20509292/CSCmanual.pdf

Annex B: Entry Point Mapping

Entry point mapping is a methodology for systemic review of the health system and identification of mechanisms, forums, and public platforms by which civil society organizations (CSOs) can participate in the health sector. CSOs can play important roles in helping to articulate their members' priorities during the development of national and local health policies, providing feedback to health facilities on service delivery quality, and conducting oversight on the effectiveness and efficiency of health spending. Often, however, there are few institutionalized forums through which civil society organizations can engage with policymakers and facility managers. In some cases, this is because CSOs are not aware of the forums and platforms through which they can participate. In other situations, such platforms do not exist or, while mandated by law, are dormant or underutilized. Entry point mapping helps CSOs and public health institutions determine their options for institutionalizing engagement between civil society and public health officials.

Tool Overview

Why is the tool necessary?

The participation of CSOs in health policy formation, oversight of facility quality, and monitoring how public health funds are spent promotes the inclusion of the perspectives of diverse interest groups. Such participation offers public officials access to feedback from a range of user groups, helping them align policy and services to the needs of the public, and prevents the implementation of policy and delivery of services in a vacuum.

While many donor-funded initiatives create ad hoc opportunities for exchanges between civil society and public health officials (through community scorecards, public hearings, etc.), sustained participation requires institutionalized forums and venues for dialogue. The entry point mapping methodology allows CSOs and governments to identify where such forums exist; where they exist but are not utilized for government dialogue with CSOs; and where new venues may be necessary. These venues might include facility-level governing committees, local government health committees, and national-level policy forums.

Identifying the existing and potential venues is a key first step. Once these are identified, the entry point mapping tool offers CSOs strategies for utilizing the forums for dialogue. For existing venues, understanding how to understand and influence the agenda is a key skill. For potential venues, where the rules or bylaws do not preclude civil society participation but where civil society participation is not yet a practice, other skills are necessary. Understanding how to negotiate with conveners and advocate for more public participation is required.

What does the tool achieve and what can the user expect for results?

Those using entry point mapping can expect a systematic picture of the existing and potential venues for civil society dialogue with public health officials. This will help to inform where civil society organizations can engage in sustained dialogue with public health officials on issues of health service quality, accountability, and allocation of resources, or where new venues need to be established.

Who is the tool for?

The entry point mapping tool is for CSOs seeking to identify an institutionalized mechanism for engagement with public health officials. Groups working on broader health activities – oversight initiatives including those associated with use of community scorecards, public expenditure tracking surveys (PETS), and report cards, and national health policy reform advocacy – may have greatest use for the entry point mapping tool.

Public health officials seeking to increase sustained public participation at the national, subnational, or facility level may find entry point mapping useful for identifying opportunities and obstacles to engaging civil society organizations.

Where the tool has been used?

Entry point mapping has been used in Bangladesh to improve facility level engagement with civil society groups. In over 30 districts, use of the tool resulted in new or more active mechanisms to allow civil society dialogue with public health officials. It has also been tested in Cote d'Ivoire.

What are the time and resource requirements to use the tool successfully?

The entire entry point mapping process takes approximately two months to complete.

Initiating an entry point mapping program requires a lead CSO with the skills to review local legal documents and facilitate dialogue between grassroots organizations and local health officials in each community.

Example

Entry point mapping was used successfully by CSOs in 30 Bangladesh districts in several states. The CSOs networked among their members and government officials known by their members to obtain circulars that direct district-level elected and health ministry officials in the establishment and convening of various task forces and advisory councils that govern policy implementation and service delivery in the districts' health facilities. This process began with a lead CSO mapping health care entry points in their home district, and then sharing their mapping results with CSOs in other districts. This provided immediate leads for the other CSOs in their search for entry point requirements in their districts and generated a number of circulars requiring entry points for civil society engagement.

All of the CSOs then requested initial meetings in their districts with the respective district commissioners (DCs) and the health directors to bring the circulars to their attention and request information on how the circular instructions are carried out. Most DCs were not aware of the circulars and expressed appreciation to the CSOs for bringing them to their attention. In at least five cases, the DCs called for immediately constituting and convening the task forces called for in the circulars. In some cases, the circulars presented by the CSOs were outdated, and the DCs helped to located current versions. In other cases, the DCs realized only after seeing the circulars presented by the CSOs that they called for the DC and/or Members of Parliament (MPs) to convene, or participate in, more monthly and quarterly meetings of various task forces and committees than was reasonably possible. This prompted the DCs to request CSO assistance in prioritizing and streamlining the task forces and committees – which were potential entry point forums – called for in the circulars so that health issues could be deliberated more efficiently.

The Bangladeshi CSOs expected government resistance to their attempting to enforce requirements for entry point forums. They were successful in winning government collaboration in opening existing entry points, however, for four main reasons:

1. ***CSO preparation.*** In all collaborative advocacy efforts, CSOs must be well prepared to engage government, and the Bangladeshi CSOs adhered to this principle. Before their initial meetings with the DCs, the CSOs strategized over possible courses that the DCs might take in their meetings and prepared diplomatic, yet feasible, responses that would keep the meetings moving toward their objectives of opening the entry points. Some CSOs role-played potential positions that the DCs might take in the meetings and effective responses. The CSOs also defined their individual roles for the meetings so that they knew who should take the lead for each topic the DC might raise. For example, they knew who would speak if the DC hesitated at making certain necessary commitments or agreements. In one meeting, the DC attempted to challenge the CSOs with an untenable request and, per their preparations, the most knowledgeable CSO member on that topic responded with firm but tactful diplomacy that dissuaded the DC from pursuing the request. This helped to keep the meeting on track and in the direction of the CSOs' desired outcomes.
2. ***CSO knowledge sharing.*** CSOs from various districts compared experiences from their individual entry point meetings. As a result, in one entry point meeting, a District Director expressed reservation about moving forward on opening a specific entry point without authority from her Ministry. The CSOs, however, were able to assuage her concerns by citing CSO experiences with entry point meetings in other districts, and how the District Directors of the same Ministry had already opened the entry points called for in the same circular.
3. ***Action Planning.*** After initially presenting the entry point circulars to DCs, the CSOs developed time-bound action plans with the DCs to implement the steps needed to open the required entry points. This included commitments by both government and CSOs to ensure results on opening entry points.
4. ***Elevated stature for the CSOs.*** The mere act of CSOs' informing themselves on legal entry points, and asserting the need to open the entry points, gained government officials' respect for the CSOs. The collaboration offered by CSOs enhanced their standing even more. The officials saw the CSOs as valuable aids in a number of ways. Like many government officials, the DCs and the directors of the district administration and health facilities faced heavy management burdens and they welcomed CSO support in carrying out their responsibilities. For example, in one district, a social sector director cited the value of CSOs helping her office increase public awareness over the social programs they were attempting to launch. This collaboration early on helped CSOs win the trust of government officials as they worked to open additional entry points.

Step by Step Guide to Use the Tool

1. **Information collection.** Much of the information about legally mandated meetings and responsible committees accessible to CSOs can be found in government call circulars, bylaws, and committee terms of reference. An initial step is to collect this information.
2. **Entry point analysis.** A thorough review of the collected documentation will determine the full range of entry points, where public participation is possible (either clearly mandated or not explicitly prohibited), and what institutions do not yet have entry points.
3. **Dialogue with public health officials.** Civil society and public health officials conduct a series of structured meetings to review the results of the mapping exercise and develop a work plan for expanding targeted civil society participation.

4. **Implementation of the work plan.** CSOs coordinate among themselves to regularly participate in meetings with public health officials and provide input. These initial meetings are critical to institutionalizing these new mechanisms for dialogue.

Key Considerations

- **Demand driven.** The utility of the entry point tool is a function of demand. Where the tool is applied to a targeted issue, program, or facility, the chance of success is greater.
- **Working with government.** Entry point mapping is a joint government and civil society exercise and requires active participation from both entities. Gaining access to government documentation such as call circulars, bylaws and committee terms of references can be difficult with government cooperation. Likewise, governments will want to work with CSOs to target entry points associated with high interest topics.
- **Link to Right to Information (RTI) initiatives.** Identifying those public health officials or organizations involved in access to government information can be an effective strategy. If a country has a Right to Information Law, designated information officers can be useful allies.

Resources

Paraskeva, Connie and Kanthor, Jeremy. June 2014. "Entry Point Mapping: A Tool to Promote Civil Society Engagement on Health Finance and Governance," Bethesda, MD. Health Finance and Governance Project, Abt Associates Inc. www.hfgproject.org/tools-civil-society-health-governance/

Annex C: Social Audit

Public health agencies are given mandates and associated funding, but their performance is often not properly assessed and civil society organizations lack the means to hold them accountable for performance. A social audit is a mechanism that can create the enabling conditions for public accountability on health program delivery. Social audit is a participatory process that allows community members to monitor the implementation of a government health program and measure the program's impact against intended results. This process includes a review of the factors affecting program impact, including procedures, quality, utility, and accountability and transparency measures involved. Social audits also lead to recommendations on policy changes to improve program implementation.

Tool Overview

Why is the tool necessary?

Assessing the performance of public health programs is a challenge even for government institutions to which data and documentation are accessible. CSOs may have access to anecdotal information about health programming, or localized results from social accountability efforts. However, determining whether public health programs are delivering as intended on a broader scale, without access to data and documentation, is extremely difficult. Even more difficult is holding officials accountable when health programs fail to deliver. The social audit serves as a mechanism for civil society organizations to achieve two objectives – systematically assessing health program performance, and engaging citizens in the oversight of health program delivery.

What does the tool achieve and what can the user expect for results?

Social audits provide detailed information about the performance of health programming, including systemic areas of poor performance, and help create a platform for engagement of citizens in health program oversight and policy development. The social audit is most effective when conducted by an organization with a thorough understanding of health program design using an audit instrument to assess how day-to-day practice complies with stated objectives and guidelines. As a result, the most successful social audits are typically conducted by CSOs working in partnership with a health institution. Social audits provide CSOs with details on where subsequent monitoring and oversight is necessary, as well as valuable insight for public institutions seeking to refine policies and guidelines for implementing health programs.

The social audit should be focused on a specific health program to assess its programming and/or service delivery, such as the following issues: inclusion of eligible participants in social safety net programs, availability of health professionals, drug quality and access, unauthorized user fees and bribery, achievement against targets in family planning, immunization and nutrition programs, and compliance with data recording requirements.

At the community level, social audit results are presented in a public hearing to promote dialogue between communities and service providers about improvements in health services. This dialogue addresses key service gaps and establishes a platform for the institutionalization of civil society accountability

mechanisms. The aggregated results can offer civil society a base of evidence on systemic issues affecting health service program performance and form the basis for broader policy advocacy as government revises program guidelines and overall policy. The collaboration between government and civil society in implementing social audits can help establish a sustainable platform for dialogue and cooperation.

Who is the tool for?

Successful social audits require a partnership between civil society and government and can be led by either CSOs or government institutions. The role of the CSO, whether acting as the lead or as a partner to government, is to organize and train local organizations to conduct data collection, analyze findings, and facilitate local meetings to publicize the findings. As a result, the CSO should be health-oriented and have a strong network of local partners with the capacity to be responsible for data collection and follow-up. CSOs with the following skills and attributes are best suited to implement social audits:

- Community mobilization
- Monitoring and evaluation
- Training and mentoring
- Data collection and analysis
- Advocacy and policy dialogue

Where has the tool been used?

Social audits focused on health have been used in India.

What are the time and resource requirements to use the tool successfully?

The entire social audit process takes approximately four months to complete.

Initiating a social audit program requires the skills to design the audit and sample methodology, conduct the training of local organizations, analyze the data, facilitate the local presentations of the findings, and engage partners for national level advocacy.

Example

Social audit tools have been used in the Baltic region as part of health reform efforts in the countries of the former USSR to gather information on corruption and unofficial payments in the health sector. A study conducted in Estonia, Latvia, and Lithuania measured perceptions of corruption and the link between perception, attitude, and experience in order to provide actionable steps to mitigate corruption and unofficial payments in the health sector. The study helped researchers to highlight gaps in the understanding of both providers and clients regarding what constitutes corruption. This information will be useful for local government officials, providers, community organizations, and clients as design educational campaigns and policies to stem unofficial payments.

In Pakistan, as part of a devolution of responsibility for public services to local governments in 2001, social audits were used to conduct a baseline study on local government services, including health services. This turned into an annual exercise to track the continued devolution of public services, which continues to monitor improvements in services, assess people's perceptions, and inform local level policy.

Step by Step Guide to Use the Tool

1. **Define the scope of the social audit.** Select the scope of the social audit, including the specific public health program to be assessed and the geographic boundaries where the audit will take place. Identify the civil society and government officials that lie within the area. Develop sampling methodology.
2. **Research.** Complete research on the public health program to be assessed, including methods for implementation, offices and individuals involved, criteria for participation, government performance goals and targets, previous government audits and studies.
3. **Social audit protocol.** Develop the audit protocol for collecting information from providers, receivers, and other stakeholders regarding the specific public health program.

4. **Train CSOs, citizen representatives and government organizations.** CSOs and their members will be responsible for completing the audit based on the final social audit tool. A training of trainers methodology can be particularly useful for completing social audits. Lead trainers are identified from local CSOs in the areas where the audit will take place. These lead instructors conduct training at the local level. Engaging government officials in the training events is important for engaging them in the process and gaining access to information.
5. **Collecting and analyzing information.** Supervise the data collection exercise and prepare local and national findings.
6. **Presenting information in an easy-to-understand format.** Presenting social audit findings at the local level is an effective method for engaging citizens in continued oversight of health programs and seeking further feedback. A public hearing provides the opportunity for dialogue between citizens and public health officials.
7. **Follow up on recommendations gathered from public presentations.** Public presentations of the social audit will generate recommendations on how to improve public health program implementation. Document these recommendations for discussion with policy makers as they revise program design and implementation.

Key Considerations

- **Government partnership.** Bringing a government partner on board during the design process serves two purposes. First, it achieves buy-in to the overall objectives and survey methodology. After the completion of the audit, this buy-in will increase the investment to find solutions to the problems revealed by the audit while providing a critical buffer against other interests, including other government entities, that may contest the findings. Second, it will facilitate access to information, data sources, and to the public officials while completing the audit.
- **Anticipate resistance.** The results of the social audit may reveal mismanagement of health resources, non-compliance with program criteria, or corruption. Resistance to the findings from other government entities, local officials, or vested interests should be expected. The strength of the partnership with government is critical to demonstrating the neutrality of the process and the validity of the findings.
- **Local partner capacity.** Identifying an appropriate lead CSO is an important element of designing a successful social audit. A key consideration is the monitoring and evaluation capacity of the organization. Designing and completing a social audit requires a complex understanding of sampling methodologies, data analysis, and quality control. In addition, the organization must have established linkages with networks of local CSOs that can provide and train data collectors in their regions.
- **Linking local reaction to national policy reform.** Presenting the localized findings of the social audit at the community level is an important mechanism to create accountability. The more people aware of the social audit findings and the recommendations for improving the health program implementation, the more pressure there will be to make improvements. This local mobilization can help drive necessary policy reform at the national level.

Resources

Social Audit – A People's Manual. http://www.lpcb.org/index.php/component/docman/doc_view/11151-2007-india-social-audit-a-peoples-manual?Itemid= (Accessed May 2, 2014)

Social Audit Manual: A guide to support "beneficiaries" to become "right holders." http://www.ippfsar.org/NR/rdonlyres/4791BB55-49FD-4FA7-BB00-56E416A60922/3111/socialauditmanual.pdf (Accessed May 2, 2014)

Social Audit: A Toolkit – A Guide for Performance Improvement and Outcome Measurement. http://unpan1.un.org/intradoc/groups/public/documents/cgg/unpan023752.pdf (Accessed May 2, 2014)

Annex D: Citizen Charters

A citizen's charter is a document or publication that informs citizens about their rights as users of public health services, the standards they can expect for a service, the remedies available for non-adherence to standards, and the procedures, costs, and charges of each service. The citizen's charter, developed with civil society and public health official participation, aims to improve the quality of services by publishing standards that users can expect for each service they receive from the government. The charters provide users access to a formal mechanism to address concerns when standards are not met. The joint development of citizen charters builds sustainable accountability mechanisms. If citizens are well informed about their rights as clients of public services and about existing complaint mechanisms to voice grievances, they can exert pressure on health service providers to improve performance.

Tool Overview

Why is the tool necessary?

Institutionalizing any ad hoc improvements to accountability, transparency, and improved performance at health facilities resulting from community monitoring efforts can be very challenging. While health officials may make commitments in the follow-up after community scorecards, social audits, and report cards, civil society groups may lack powers to hold these officials accountable. Likewise, CSOs may not be able to sustain the interest and commitment of communities after the completion of social accountability efforts. By documenting and publicizing the rights and responsibilities of public health officials and the communities they serve, citizen charters can leverage public health officials' recognition of performance improvements with new community knowledge of their rights. Once codified, the charter can serve as an accountability mechanism for longer-term community monitoring.

The development of a citizen charter involves representatives from both user groups and facility managers. This differs from service charters that are typically developed by government without community involvement.

What does the tool achieve and what can the user expect for results?

Communities and CSOs using citizen charters can expect three key outputs: 1) structured dialogue between health facility officials and communities; 2) a document detailing key aspects of facility operations; and 3) a mechanism for long-term accountability of local health services. These outputs are detailed below.

Citizen charters are developed through a series of meetings between users and managers of the health facility about their rights and responsibilities in obtaining and delivering health services. In areas where community scorecards have already been completed, the results of these efforts – such as the areas of poor performance and the commitments for improvement from facility officials – may serve as the basis for discussions. In areas that have not completed community scorecards, discussions may include additional feedback from the community through focus groups and structured discussion around key facility performance indicators. These discussions result in a more detailed understanding of community health needs and expectations, as well as the limitations on facility managers.

This dialogue between health facility users and managers is then translated into a public document detailing issues of interest to the community such as facility hours of operation, available services, costs, number of medical professionals on staff, and drug availability. To increase effectiveness, charters often include a formal complaint mechanism the community can use to report performance issues. Citizen charters are often published for public circulation and posted as sign outside the clinic.

Finally, the citizen charter serves as a long-term accountability mechanism for health service delivery. At the completion of the charter, officials and community members develop a plan for follow-up. This plan ensures that the charter remains up-to-date and that both users and managers are involved in dialogue about performance.

Who is the tool for?

Citizen charters are most appropriate for CSOs seeking to facilitate community engagement and dialogue with health service providers and local officials. CSOs developing citizen charters may be health-oriented – including those providing direct services, advocating for user groups, or managing health programming. Civil society groups with the following skills and attributes are best suited to implement community scorecards:

- Community mobilization
- Gender and youth awareness
- Training and mentoring
- Advocacy and policy dialogue

Where has the tool been used?

Citizen charters focused on health have been used in the following countries: Australia, Bangladesh, Canada, India, Malaysia, Nepal, Kenya, and the United Kingdom.

What are the time and resource requirements to use the tool effectively?

The entire citizen charter process takes approximately two months to complete.

Initiating a citizen charter requires a lead CSO that has the skills to train and mentor local community committees and government officials on how to draft charters. An individual charter process requires resources to facilitate local meetings and print the final charter and signage. Support for writing and documentation may also be necessary.

Example

In Bangladesh, the Ministry of Health and Family Welfare (MOH&FW) has introduced Citizen Charter at of all its health care facilities. As a part this initiative, important information for patients related to health services will be displayed in health facilities ranging from tertiary level hospitals to primary health care centers. The clearly visible information promotes citizens' rights to information and further encourages claiming rights to services. When a patient arrives at any point of service (e.g. medical college hospital) he/she can see clearly displayed information about topics such as types of emergency care available, service provisions of this particular facility, the nature of outpatient and inpatient care, the availability of drugs, and the number of service providers at any point. Further, the displayed information informs patients about their entitlements to get services and commodities with privacy and confidentiality.

As part of Citizen Charter, facility managers must show increased care towards women and infants through measures such as supplying safe drinking water, and providing breast feeding corners and clean lavatories; none of this was available in the recent past. A list of available drugs are also displayed in each ward in inpatients department of hospitals, along with information about user fees or cost of services. An additional component of this initiative is that all government facilities now have information corners in order to help patients get proper services. Patients are also given methods for registering complaints if sanctioned services are not available or any disagreement arises.[1]

[1] http://healthmarketinnovations.org/blog/citizen-charter-health-care-services

Step by Step Guide to Use the Tool

1. **Facilitate committee development.** An initial step of the citizen charter process is the establishment of a committee that will represent the community. In some cases, such a committee may already exist. For example, if the community has already engaged in social accountability activities such as a community scorecard, a committee may already be in place. Civil society representatives on a health facility governing board may also form the core of such a committee. Typically, committees include traditional leaders, civic leaders, service workers, community volunteers, NGO staff or other existing partners, and should emphasize those actually using the health facility.
2. **Build rapport.** The development of a citizen charter requires collaboration between the community and health service providers. Establishing the foundation for this collaboration requires building relationships through a series of meetings and discussions. In communities where community scorecards or other social accountability tools have been implemented, it is likely this rapport will already be established. In communities where community scorecards have not been developed, the initial meetings on the citizen charter will serve two purposes: they will build familiarity and joint ownership of the process, and they will generate information on strengths and weaknesses in the performance and management of the facility.
3. **Conduct meetings.** Citizen charters are developed through a series of three to five structured meetings between the community committee and facility staff. The lead CSO facilitates these meetings, leading the participants through key steps of developing a framework, identifying information that must be included in the charter, developing a complaint mechanism and identifying and agreeing upon standards.
4. **Finalize draft.** After the completion of the meetings, the group develops a draft of the citizen charter based on a standard template. The draft is reviewed and agreed upon by both community and facility participants before being finalized. In some environments, the charter may require higher-level government approval. The final charter is circulated among the community and displayed in local language outside the facility.
5. **Monitoring work plan.** Once the charter is complete, the community group develops a work plan for follow-up monitoring of the facility performance. Including the facility staff in this process promotes transparency and continued collaboration. Such openness can also build awareness of community expectations and prevent tension over monitoring visits.
6. **Periodic review.** The citizen charter must remain up-to-date to promote accountability and serve as a mechanism for community monitoring of facility performance. For example, prices may change or the portfolio of services may expand. A review by the community committee and facility staff every six months will help to ensure the information in the charter remains accurate.

Key Considerations

- **A true partnership.** For citizen charters to be effective in providing clear standards for health facility performance, the process must represent a true partnership between the community and facility staff. Fostering such a partnership takes time and effort, and the lead CSO must assess the starting point in each community before holding discussions.
- **Working within a broader framework.** If other donors have started working on citizen charters, they may be working within a framework established with or by the government. Positioning any new program within this framework can help expedite obtaining the buy-in and willingness to participate of health officials.

- **Importance of dissemination.** A citizen charter should reflect the priorities of the community. Determining the best methods for dissemination for each community is key to ensuring the information gets into the hands of citizens.

Resources

Citizen's Charters – A Handbook. http://goicharters.nic.in/cchandbook.htm (Accessed May 2, 2014)

Citizen Charters: Enhancing Service Delivery through Accountability. http://siteresources.worldbank.org/EXTSOCIALDEVELOPMENT/Resources/ 244362-1193949504055/ 4348035-1298566783395/7755386-1301510956007/CC-Final.pdfView shared post (Accessed May 2, 2014)

Annex E: Report Cards

Report cards are a citizen-driven exercise to collect data on the performance of a health facility and its personnel. A report card is a standard questionnaire used to collect basic feedback from health service users on issues such as wait times, service costs, drug availability, quality of service, and personnel attitude. The report card may focus on general facility performance, but may also target specific services such as antenatal services, HIV, malaria, and reproductive health. Report card activities can be organized by civil society as a method for systematically gathering information for advocacy and accountability efforts, or to disseminate to the public information about high- and low-performing facilities. They may also be organized by government, leveraging the grassroots presence of CSOs to collect data on performance of targeted facilities or across several facilities. Report cards can be conducted once or repeatedly to understand changes over time, with the results of multiple report cards for the same facility aggregated to provide a picture of overall facility performance and compare results from other facilities. Increasingly, report cards are being integrated with mobile applications to expand reach and facilitate data entry.

Tool Overview

Why is the tool necessary?

Report cards offer a standard and easy-to-apply methodology for collecting rapid feedback from health service clients covering data on both facility performance and client perceptions. For CSOs, aggregating the first-hand experience of those using health services can be a powerful tool for evidence-based advocacy or an accountability initiative. It may also serve as a service to the public by identifying high- and low-performing facilities. For government, report cards provide a method for leveraging CSOs' proximity to end users to gain valuable information on the quality of health service delivery and the perceptions of clients.

What does the tool achieve and what can the user expect for results?

Organizations investing in report cards can expect to generate data on the performance of health facilities or specific health services against client perceptions. Report card data can be used as evidence in a civil society–led advocacy or health accountability initiative. Report cards may also be used as a mechanism for government to monitor its own health facilities.

Although reports cards are similar to community scorecards, there are two important differences between the tools. First, report cards are simpler to conduct and can be completed in a short time, while community scorecards are more labor-intensive and take longer to complete. Second, report cards are primarily a data collection exercise that may contribute to broader advocacy or monitoring initiatives. Community scorecards, on the other hand, seek both to generate

data and to foster dialogue between communities and health service providers on resolving performance and management issues.

Who is the tool for?

Report cards are most appropriate for CSOs that wish to collect data on health service quality. These organizations may be health-oriented – including those conducting research, providing direct services, advocating for user groups, or managing health programming. CSOs with the following skills and attributes are best suited to implement community scorecards:

- Community mobilization
- Data collection and research
- Advocacy and policy dialogue

Where the tool has been used?

Report cards focused on health issues have been used in: Rwanda, Tanzania, and Uganda.

What are the time and resource requirements to use the tool successfully?

The entire report card process takes approximately one month to complete.

Initiating a report card program requires a lead CSO that has the skills to design and conduct a survey of local citizens and to collect and analyze results. It is beneficial for the organization to have a broad network with grassroots members in the target area. Depending upon the objectives of the report card program, a coalition of groups may participate to ensure the results are applied to advocacy or oversight activities. This is particularly true if the lead organization is a research institution or think tank.

Example

In response to perceived weakness in health care delivery at the primary level, Uganda initiated a pilot report card project aimed at enhancing community involvement and monitoring. The project was designed by Stockholm University and the World Bank, and implemented in cooperation with Ugandan practitioners and 18 community-based organizations. Information collected through the exercise was compiled into report cards that compared user satisfaction and health outcomes with neighboring areas using easy-to-understand graphic tools. The report cards provided the basis for an informed dialogue with community members and between community members and health workers.

To determine the impact of report card follow-up activities on service delivery performance, the project randomly assigned 25 sites to the treatment group and 25 to the control group (e.g., facilities that would continue using their existing feedback mechanisms). Local NGOs organized focus groups with residents and health service providers in the treatment communities to discuss the report card results. No such discussion took place in the control communities. In communities where meetings were held, absenteeism by providers decreased and quality of service (measured by wait time, quality of care, and cleanliness of facilities) improved.

The report card pilot led to demonstrated improvements in a number of outcomes—both in the quantity and quality of health service delivery. It prompted the development of stronger processes (e.g., instituting suggestion boxes, numbered waiting cards, and duty rosters); improved treatment practices and staff behavior (measured by reductions in waiting times for patients and staff absenteeism as well as increases in information-sharing and immunization coverage); and better usage of services, leading to improved health outcomes (reflected in a decrease in the under-five mortality rate in communities where meetings were held).[1]

1 Sanjay Agarwal, David Post, and Varsha Venugopal, "How To Notes: Citizen Report Cards: Monitoring Citizen Perspectives to Improve Service Delivery," World Bank's Social Development Department (SDV), p. 11

Step by Step Guide to Use the Tool

1. **Define objectives.** A key step in designing a report card program is to start by defining what the data will be used for. This definition will shape implementation, including the target geography and services, the sample size, and whether the report card is a snapshot of the current situation or conducted repeatedly over time. Equally important is consideration of the type of organizations that need to be involved in the report card activity to ensure the data is used as intended. If, for example, the data is intended to inform an advocacy effort, a lead organization that is research-oriented may need to team with a broader coalition of partners to ensure broad dissemination and use of the data for advocacy. If the objective of the report card effort is to influence government policy, engaging key government stakeholders at various levels early in the design to determine what type of data is most effective and relevant to their decision-making processes is critical. Likewise, if the information is to be used for broad advocacy, working with media outlets to understand how they can use the data will be helpful.
2. **Target initiative.** Report cards can generate data on general facility performance, specific management issues or the quality of a specific subset of health services. They can provide a snapshot of service performance or can be organized to regularly assess performance over time. It is important to target the focus, geography and duration of the report card program based on the overall objectives.
3. **Design report card methodology.** Report cards collect data using a standard questionnaire. Designing the questionnaire and an appropriate methodology for collecting responses is necessary for the quality and effectiveness of the data. The methodology should take into consideration targeting key client groups such as women, minorities, and youth. Mobile phones (including SMS, IVR, smartphone apps and webforms) are an increasingly useful tool for data collection and can be used for either self-reporting, which can increase scalability and willingness to report honestly, and surveying through enumerators, that ensures representative sampling. Data collection through mobile phones can have other benefits as well including real-time review and analysis of incoming data, collection of multimedia files such as photographs, and geo-tagged survey that support geospatial analysis of performance indicators. While the up-front cost of mobile data collection can seem high, the savings in data input and printed paper often events out over the life of a report card.
4. **Collect data.** The lead civil society partner collects data using a standard format and approved methodology by hiring local staff or through partnership with local organizations.
5. **Aggregate data.** Once data collection is complete, information is aggregated to present the findings. An early understanding of the type and format of information that is most effective to government, legislative, and media stakeholders will define how the information is presented.

Key Considerations

- **Data quality.** The quality of data is particularly important when using data for advocacy aimed at government officials. Implementing a data collection protocol with sufficient mechanisms to ensure data quality can enhance the credibility of the findings.
- **Engaging facility staff.** Report cards can be conducted without civil society groups engaging or interacting with the target facilities or services. Nevertheless, to increase the likelihood that the report card findings will lead to improved services, it is important to build opportunities for discussion among civil society and facility personnel about the results into a report card program.

Resources

Citizen Report Card Surveys - A Note on the Concept and Methodology. http://siteresources.worldbank.org/INTPCENG/1143380-1116506267488/20511066/reportcardnote.pdf (Accessed May 2, 2014)

Improving Local Governance and Service Delivery: Citizen Report Card Learning Tool Kit. http://www.citizenreportcard.com/crc/pdf/manual.pdf (Accessed May 2, 2014)

Annex F: Public Expenditure Tracking Surveys

Public Expenditure Tracking Surveys (PETS)[1] are a set of tools developed in 1996 to uncover points of leakage in the expenditure chain for particular programs or line items. While PETS has become an umbrella term for budget tracking more widely, traditional PETS involves the triangulation of budget and financial records from different sources on the expenditure map. The goal of PETS is to identify inconsistencies in records regarding the allocation and disbursement of funds by one office or facility and the corresponding receipt of funds by a different office or facility. Although PETS was not designed to be implemented by CSOs, an increasing number of independent organizations at the country level have worked to adapt this tool to use in their own work.

Tool Overview

Why is the tool necessary?

PETS have two primary purposes. First, they seek to promote overall improved financial and administrative management within the public sector by tracking how public funds are spent. Through a detailed tracking of resources from their source to the office or facility where they are spent, PETS help to identify potential leakage, corruption, delays, mismanagement or misallocation, and inefficiencies. Second, because quality service delivery is dependent upon a reliable and timely flow of resources, PETS can identify faults and potential solutions to sector specific issues.

A clear picture of what funds are making it from national ministries to local health facilities can help pinpoint how to improve service delivery.

For CSOs, PETS offers a recognized methodology for collecting and analyzing data on financial flows and efficiency. Effective advocacy for improvements in efficiency and management of public resources requires an in-depth understanding of how health systems are funded and how systems are used to manage these finances. The results of a PETS offers CSOs with the evidence required to have a credible voice in discussing health finance concerns and possible solutions.

What does the tool achieve and what can the user expect for results?

PETS begin with a mapping of funding flows from the national ministry to local service providers and use surveys to track what and when resources arrive from a sample of facilities. The output of PETS is an analysis of the financial inputs and outputs and identification of potential leakages, delays, and inefficiencies in a health facility or broader health system. This analysis can be used by CSOs to advocate for management improvements to accountability departments within health ministries (such as internal audit, inspector generals, ombudsmen) or external institutions such the media, parliamentary standing committees, anti-corruption bodies or supreme audit institutions. In addition, successful PETS rely on access to data that requires collaboration with public health officials. Such constructive engagement can also allow CSOs to offer suggestions for the management improvements necessary to correct and address issues.

[1] Courtney Tolmie. October 2013. *Where Are Our Budgets? Public Expenditure Tracking Surveys as Tools for Engaging with Civil Society*. Bethesda, MD: Health Finance and Governance project, Abt Associates Inc.

Often, PETS highlight the lack of information or documentation on how, when, or where funds were spent. This lack of accountability can raise many unanswerable questions. The fact that these questions cannot be answered, however, can prove an effective advocacy tool to shine a spotlight on weak management systems and internal controls.

Who is the tool for?

PETS is a complex tool that requires a sophisticated skill set of research and data analysis skills, knowledge of public administration systems, and access to public expenditure information. They have typically been conducted by think tank or research organizations with these skills. While these organizations can conduct the survey and analysis, they often lack the skills or partnerships to conduct advocacy using the results. As a result, they frequently work with CSOs to conduct advocacy and follow up to monitor how the PETS findings are being implemented.

Where has the tool been used?

Since the mid-1990s, more than 50 PETS/QSDS have been conducted in about three dozen countries, covering more than 70 sectors. A large majority of these surveys have been conducted in Africa, which currently accounts for 66 percent of the total number of studies.[2]

What are the time and resource requirements?

PETS is a resource intensive tool that requires at least three months of time to complete and sophisticated research and data analysis skills.

[2] World Bank. PETS/QSDS Portal. http://pets.prognoz.com/prod/Guidelines.aspx (accessed 31 July 2013)

Example

Making medicines more efficient in Uganda. The Coalition for Health Promotion and Social Development (HEPS) began an expenditure tracking survey in 2010 to identify points of inefficiency in the supply and disbursement of medical supplies in Uganda. While the lack of financial records made the process of conducting a PETS extremely difficult, HEPS did identify several ways in which health facilities and district health offices could improve their record-keeping, as well as better communications regarding stock-outs and supply needs for essential medicines. Rather than highlighting the leakages in the system (something that proved to be impossible given the current state of records in Ugandan health facilities), HEPS did work with local officials and service providers to systemize medical supply tracking to improve their efficiency as well as set the stage for more successful resource tracking in the future.[3]

Step by Step Guide to Use the Tool

1. **Defining the objective.** Before beginning the process of data collection, the organization conducting PETS should identify the specific program and resources to investigate. Further, while PETS is traditionally known as a tool for tracking leakages of funds, the tool can be used to identify additional problems such as delays in resources reaching service provision points. PETS should begin with a clear definition of what the study leaders would like to achieve.
2. **Mapping resource flows.** Because PETS follow funding and resources from the point of budget allocation to the service user, it is critical to first understand how resources move from the top to the bottom. Mapping how funding should move through the system can be one of the most challenging parts of PETS, but it is essential to complete before collecting data.

[3] Results for Development Institute's Transparency and Accountability Program (TAP), http://tap.resultsfordevelopment.org . (Accessed May 2, 2014)

3. **Collecting and analyzing data.** After mapping the flow of resources, PETS implementers should design instruments for collecting financial information at each point at which money changes hands. Instruments may include surveys or interview guides and templates for disaggregated financial records. Very good templates are available for PETS surveys, but implementers should review and adapt them to the setting. In particular, instruments for each point should identify (1) resources that they expect to receive from the point above them on the chain, (2) how much they actually received, and (3) how much was transferred to the point below them on the chain. After all data is collected, PETS implementers should compare different accounts of funding from points on the chain for any discrepancies (such as one level reporting transferring one amount of funding to another level that reports receiving something different).
4. **Identifying the issues.** After analyzing the data, the PETS implementer should pinpoint discrepancies and attempt to use their data (from the surveys or from supporting qualitative work) to identify the reasons for the discrepancies.
5. **Recommending solutions.** While not all PETS end with recommendations, a scan of PETS cases suggests that those that adapt their findings into concrete recommendations are most likely to see changes based on their findings.
6. **Dissemination/advocacy.** The extent and form of dissemination and advocacy vary greatly depending on those implementing the PETS. Our interviews showed that all implementers do at least some basic form of dissemination of results to the government. More innovative advocacy generally happens either when a CSO is leading the PETS or when the findings are disseminated by the implementers to civil society, who then organize advocacy around the findings.

Key Considerations

- **Ensuring participation of government and service providers in the process.** Evidence suggests that the most successful PETS involve stakeholders along the expenditure chain during the design, implementation, and dissemination phase. However, even CSOs that seek to ensure collaboration reported that expenditure tracking is still generally viewed as an "audit" by government officials; this is particularly true of PETS led by CSOs, which in most countries have historically been viewed as adversarial to government. Further, frontline service providers may be unwilling to provide financial information or be interviewed, as they do not see the usefulness of the PETS exercise to their work.
- **Data availability can be poor or nonexistent.** A traditional PETS tracks financial data from the national level down to the facility level. However, CSOs may face more opposition in accessing data than researchers from international organizations, particularly at the national and sub-national levels. At the facility level, there may simply be a lack of financial reports (an issue that can also be seen as an opportunity, as discussed below).
- **Difficulty in identifying the true expenditure map, especially in the health sector.** While we often describe expenditure as a linear process, one CSO interviewed in Latin America described health sector spending in her country as a web. She described the difficulty in identifying the different agencies responsible for (sometimes overlapping) decisions regarding budgeting, transferring funds, and procuring supplies. As a result, expenditures can be extremely tedious to track and it can be challenging to identify where the actual breakdown occurs when there are spending problems. While this is a challenge for all implementers of PETS (civil society and international organization alike), international organizations frequently have access to documents and high-level individuals who can help distinguish the resource flow mappings more easily than civil society.

- **Getting people interested in budgets.** Beyond design and implementation problems, CSOs reported facing an uphill battle in getting citizens, communities, media, and even local officials interested in issues that they may see as mundane or too complex. One CSO in India reported that many organizations they spoke with about their expenditure tracking results were only interested in outcome monitoring (i.e., disease incidence and mortality rates) and could not be engaged around budget issues.

Resources

World Bank. PETS/QSDS Portal. http://pets.prognoz.com/prod/Guidelines.aspx (accessed 31 July 2013)

Amin, Samia, Jishnu Das, and Markus Goldstein, eds. Are you being served? *New tools for measuring service delivery.* The World Bank: Washington DC, 2008.

Gauthier, Bernard. "PETS-QSDS in sub-Saharan Africa: A stocktaking study." The World Bank: Washington DC, 2006.

Koziol, Margaret and Courtney Tolmie. *Using Public Expenditure Tracking Surveys to Monitor Projects and Small-Scale Programs: A Guidebook*. The World Bank: Washington DC, 2010.

Oyugi, Lineth, Andrew Riechi and Evelyn Anupi. *Public Expenditure Tracking of Secondary Education Bursary Fund in Nairobi Province, Kenya*. IPAR: Kenya, 2008.

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Reinikka, Ritva and Jakob Svensson. *Explaining Leakage of Public Funds* (Policy Research Working Paper Series No. 2709). The World Bank: Washington DC, 2001.

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Annex G: Public and Private Health Sector Engagement Mechanisms

Public and private sector partnerships comprise a spectrum of engagement between the public health sector and either the private (non-health) corporate sector or the private health sector. For the purposes of this guide, we are discussing partnerships between the public and private health sectors only[1]. These can range from a public and private health sector forum to more formal arrangements, such as a contracting mechanism or a policy advisory body with both sectors. A public and private health sector forum allows leaders from both sectors to interact and exchange information, express preferences, tackle barriers, define opportunities for enhanced cooperation between the sectors and discuss priorities for the country's health overall sector. More advanced partnerships may provide formal and transparent private sector access to government funding for delivering goods and services and private sector engagement in health sector oversight and regulation (such as self-regulating medical associations). The private health sector can be leveraged to improve data quality for decision-making, provide technical knowledge for regulation and oversight, and mobilize a more complete response to health priorities. This guide will focus on a set of tools that engage the private sector in health governance, including public and private health sector fora, policy groups, and association-based oversight vehicles.

[1] The private health sector is a large and diverse community comprising both for-profit and not-for-profit entities that lie outside the public health sector. The private sector covers a wide range of health sector entities, including individual private practitioners, clinics, hospitals, and laboratories and diagnostic facilities; nongovernmental organizations (NGOs); faith-based organizations; shop keepers and traditional healers; pharmacies; and pharmaceutical wholesalers, distributors, and manufacturers. (Source: www.shopsproject.org accessed on December 3, 2013)

Tool Overview

Why is the tool necessary?

In many countries, the health sector includes a private sector that operates independently of the government sector, with inadequate information flows between them, and uneven regulation that impacts quality as well as the ability of the private sector to more fully participate in meeting the health needs of the population—thereby taking some burden off the public sector. The private health sector has been proven to be an important source of health services for all segments of the population. The expertise, interests, and influence of private health sector providers can help governments form appropriate policy, garner support for reform, monitor the health sector, and implement programs. Yet in many countries few if any formal mechanisms exist that allow for organized participation in health governance.

What does the tool achieve and what can the user expect for results?

Public and private health sector fora, policy groups, and association-based oversight vehicles offer formal mechanisms to engage the private sector in order to improve regulation, enhance information sharing, and enable technical contributions to policy and health sector oversight.

- Public and private health sector fora (stakeholder committees, groups, etc.) provide a forum for the private sector to learn about developments in the public sector (such as policy changes) and the health sector more broadly (such as clinical and health status updates.) They provide the government with a vehicle for reaching the private sector to convey important updates, receive feedback, and learn about the experiences and needs of the private sector. These fora can help to improve relations between the sectors, facilitate formal and informal information exchange and cooperation, and achieve important buy-in among key stakeholders for policy changes.
- Public and private health sector policy groups can be in the form of technical working groups organized by the Ministry of Health or other health institution around a specific health need or disease (such as an HIV and AIDS); cross-institutional, national-level groups addressing a broad range of health sector issues; and sub-national groups formed to inform and oversee reform implementation at the sub-national level. These more formal groups have the authority and mandate to provide technical inputs to health policy impacting the private and public sectors. In some cases these groups facilitate information dissemination among stakeholders as well as policy implementation. Policy groups that include the private sector can more effectively meet the needs of the private sector, leverage private sector resources, and achieve early buy-in for health policy.
- Association-based oversight vehicles allow the government to leverage the technical expertise of professional groups (either exclusively private sector representatives or a mix of public and private.) One example is a medical association responsible for licensing members and overseeing the quality of their services.

Who is the tool for?

These tools may be used by any or all of the following groups:

- Governments at all levels wishing to leverage the private sector as described above, and to improve communication with the private sector;
- Private health sector representatives seeking a greater voice in the governance of the sector, including policy, regulation, communication, and increasing business opportunities; and
- Donors and other international actors that wish to have a vehicle for communicating and working with the public and private health sectors on important initiatives impacting both.

Where has the tool been used?

Committees that include public and private sector (including for-profit and not-for-profit health care providers, and professional associations) to discuss health reform, recommend policy actions, facilitate communication among the sectors, and/or monitor health sector activity, are operational in a number of countries, including, Albania, Antigua and Barbuda, Kenya, and Tanzania. In Ghana, Uganda and Zambia, Public-Private Partnership (PPP) Units in the Ministries of Health have organized roundtables and consensus workshops on an ad hoc basis to engage private sector providers.[2]

[2] Barbara O'Hanlon and Angela Stene, "African Public-Private Partnerships in Health: What Are They and What Do They Do?" PSP-One Project (September 2009), Abt Associates Inc., Bethesda, MD.

What are the time and resource requirements to use the tool successfully?

The process of establishing a public and private health sector forum, policy group, or association-based oversight vehicle can take several months up to several years (particularly in the case of a policy group), depending on the starting point in the individual country. Factors impacting the time needed include the following:

- Current status of communication and collaboration between the public and private health sectors;
- Level of organization within the private sector, such as NGOs and associations of private providers;
- Level of interest and commitment on behalf of the public and private sectors to participate in joint initiatives; and
- Government's private sector interaction capacity – for example, is there a PPP unit in the Ministry of Health tasked with working with the private sector, or are there individuals with the skills and experience to work effectively with the private sector?

If little is known about the private sector at the outset, resources may be needed to conduct a Private Health Sector Assessment and/or a private sector mapping exercise to determine the size, composition and capacity of the sector. [3]

Overall, the process requires resources to establish the key stakeholders and their interests, identify the objectives of the group, establish consensus on its purpose and operations, and facilitate initial meetings. Often a neutral third party can be useful to broker some early agreements. Technical assistance for developing terms of reference for the group and supporting documentation may also be necessary.

[3] For more information see: http://www.shopsproject.org/about/highlights/getting-a-complete-picture-of-the-private-health-sector (accessed December 12, 2013).

Example

Public Private Partnership – Health Kenya (PPP-Health Kenya) brings together the state and non-state actors in health to foster ongoing dialogue on key and emerging policy issues linked to PPPs in health. The group was established in early 2010 with support from both the Ministry of Medical Services (MOMS) and the Ministry of Public Health and Sanitation (MOPHS), the two ministries overseeing the health system in Kenya. Members include representatives of MOMS, MOPHS, the Health NGOs Network (HENNET), Kenya Episcopal Conference, Christian Health Association of Kenya, The Health Sector Board of KEPSA (an apex organization representing 60 Business Membership Organizations and more than 180 corporate organizations), and the Supreme Council of Kenya Muslims (SUPKEM.) PPP-Health Kenya benefits from some donor support in the form of research, technical assistance, and funding for organizing some meetings.

Step by Step Guide to Use the Tool

1. Identify the opportunities, challenges, and key stakeholders

Assess the opportunities and challenges of engaging the private sector in health sector governance. This early assessment would ideally take into consideration the size and composition of the private sector, its current relationship with the government sector, and both sectors' objectives and needs. This can be achieved by conducting either a comprehensive private sector assessment or a smaller study including a policy review and extensive interviews with public and private sector representatives.

Identify key stakeholders. Key stakeholders include Ministry of Health and other government representatives, professional associations with private sector members, and NGO groups.

2. Engage stakeholders

Either a third party such as a donor or technical assistance provider, or a champion from the government or private sector, can engage stakeholders by drawing attention to the potential benefits to both of greater private sector engagement. Ideally, this step would generate at least one champion from each of the public and the private sectors. A champion is a key success factor in the establishment and ongoing functionality of the new mechanism.

3. Develop a common vision and prioritize the objectives of the group

By analyzing the results of the assessment, learning about the experiences of other countries, and simply meeting together to discuss objectives and needs, the public and private health sector key stakeholders should together establish a vision for the future of the mechanism. Early priorities in establishing the group must be agreed upon. Stakeholders should identify the early priority issues (ideally with the broadest potential impact) to be tackled. This serves to motivate participation. Short and long term objectives should also be agreed upon.

4. Agree on a terms of reference, including the form the group will take

The terms of reference of the group will define its objectives, membership, organizational structure, operational considerations, and activities. They may also address the form that the group would like to take, such as a parastatal organization, an informal advisory group, or a forum for communication. Alternatively, the group could decide to determine its ultimate form after the group being established, when the feasibility of the various forms could be clearer.

5. Continue dialogue, starting with one or two issues

The group should begin by tackling one or two key policy or regulation issues, so as to focus efforts and hopefully achieve an early success. As the group moves forward with dialogue, members may choose to create smaller working groups that may be long-standing or temporary, to address certain subtopics, such as health information or facility regulation for example.

Key Considerations

The process described above could take several months, or several years. Stakeholders need time to build consensus. A purely pragmatic issue is that participation in such a group is likely to be in addition to government representatives' regular duties, and private sector representatives' time can be even more difficult to obtain.

Successful public and private health sector engagement mechanisms have the following characteristics:

- Clearly specified, realistic and shared goals.
- Clearly delineated and agreed roles and responsibilities.
- Distinct benefits for all parties.
- The perception of transparency.
- Active maintenance of the partnership.
- Equality of participation. To be most effective, the entire process of identifying the need for a group, its priorities, membership, and functions should be conducted in inclusive fora with government, non-profit and for profit private health care providers participating. Membership in the group should include leaders from both sectors.
- Meeting agreed obligations.[4]

[4] K. Buse and G. Walt, "Global public-private partnerships: Part II – What are the health issues for global governance?" Bulletin of the World Health Organization 2000 78 (5), p. 704

- Government buy-in. Engaging senior government officials early on and identifying a champion who understands the potential benefits of engaging the private sector are essential for long-term success. This government support will be essential when the group begins to consider policy and make recommendations.
- Public and private sector champions. A few influential leaders can drive the process forward, attain consensus, and help garner the resources needed for an effective partnership.

Resources

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