

Fostering Joint Accountability Within Health Systems

Training Curriculum, Guidance for a Participatory
Assessment of Accountability Linkages, and Action
Steps for Advocates



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This publication was prepared by Andrea Vazzano, Alyson Lipsky, Sue Richiede, and Anne Jorgensen of the Health Policy Plus project.

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Contents

Acknowledgments	iv
Abbreviations	v
Introduction	1
Purpose of this Curriculum and Participatory Assessment Guidance	1
Policy Context: Why Accountability Matters in Family Planning	1
Overview	3
Design and Framework.....	3
Curriculum Structure.....	3
Providing Feedback to HP+	5
Module 1: Understanding the Basics of Accountability	8
Session 1.1 Accountability Fundamentals	9
Session 1.2 Case Studies in Accountability	29
Module 2: Understanding and Mapping Accountability Relationships	41
Session 2.1 Prioritizing Accountability Issues	43
Session 2.2 Mapping Accountability.....	47
Module 3: Examining Accountability Relationships to Identify Gaps and Opportunities	52
Session 3.1 Selecting Critical Accountability Relationships.....	55
Session 3.2 Preparing for Qualitative Data Collection	57
Session 3.3 Preparing for Qualitative Data Analysis	80
Session 3.4 Action Planning for Participatory Assessments and Follow-up.....	95
Appendices	100
A. Template of a Sample 3-Day Workshop Agenda.....	101
B. Templates/Instructions for Preparing Workshop Tools.....	102
C. Further Reading	110

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Abbreviations

COGES	Community Health Management Committee
DCMCs	District Citizen Monitoring Committees
FP2020	Family Planning 2020
GSFP	Ghana School Feeding Program
HP+	Health Policy Plus
MP	Member of Parliament
NGO	Nongovernmental organization
SEND	Social Enterprise Development Foundation
USAID	U.S. Agency for International Development

Introduction

Purpose of this Curriculum and Participatory Assessment Guidance

The material presented here is a roadmap that advocates, program implementers, and decisionmakers can use to increase knowledge of accountability within health systems, gain skills to better understand existing accountability linkages, and seek consensus-driven recommendations for action. The Health Policy Plus (HP+) project—a five-year project funded by the U.S. Agency for International Development (USAID) to advance equitable and sustainable health programming in HIV, maternal and child health, and family planning—developed and piloted these materials through an activity on advocacy and accountability for Family Planning 2020 (FP2020) commitments. Although this curriculum was developed for family planning stakeholders, the authors encourage advocates and implementers in other health fields to apply a similar process to strengthen accountability for other pressing issues.

Policy Context: Why Accountability Matters in Family Planning

Current global development frameworks and agendas—from the Global Financing Facility to the Sustainable Development Goals—emphasize family planning programs as an investment with benefits across sectors, ultimately advancing a country’s growth and development. Since the 2012 London Summit on Family Planning—where 69 of the world’s poorest countries signed commitments to provide an additional 120 million women and girls with high-quality, voluntary family planning services—governments have set country-specific goals to improve family planning programming by 2020.

Ensuring that countries achieve these FP2020 commitments—and decisionmakers deliver on promises in the face of competing demands for resources—requires multilevel advocacy and monitoring. In short, it requires **increased accountability** for family planning goals and commitments. Accountability is a key area of focus for global health donors and global initiatives, yet there is limited practical guidance on how public health practitioners, civil society, and government stakeholders can jointly and effectively promote governance and accountability within health systems. Civil society has successfully used social accountability tools, such as budget tracking and community score cards, to gather evidence of dysfunction for presentation to decisionmakers.¹ However, for many, a robust concept of joint

“Commitment makers must follow through with implementation and hold themselves accountable for results.”



¹ McGinn, E. and A. Lipsky. 2015. *Social Accountability: A Primer for Civil Society Organizations Working in Family Planning and Reproductive Health*. Washington, DC: Palladium, Health Policy Project.

Boydell, V. and J. Keesbury. 2014. *Social Accountability: What Are the Lessons for Improving Family Planning and Reproductive Health Programs?* Washington, DC: Population Council, the Evidence Project.

accountability within health systems remains ill-defined; rather, accountability is more often associated with the sensational topics of rooting out financial corruption or political scandal.

Accountability need not connote sensational and negative concepts; it is simply a dynamic component of good governance. Accountability is critical for a health system to reach established goals and ensure the well-being of the population. HP+ designed these materials and a process to help demystify the concepts of governance and accountability among public health stakeholders; move accountability out of a negative frame and demonstrate how it comprises a complex and interwoven series of relationships and responsibilities; and provide a clear means to identify, understand, and improve gaps in accountability for health commitments.

In its midpoint report on progress, the FP2020 reference group chairs posed the following challenge, not just to countries or institutions with formal commitments, but to anyone invested in ensuring quality family planning programming:

*What can we do to build better accountability mechanisms into our work, from tracking investments to assessing the impact of specific programs? How can we strengthen donor and government accountability for resource allocation, commodity security, and rights-based programming? On an individual level, what can each of us do in our institutional capacities to deliver on our commitments?*²

This document offers a curriculum and tools to do just that: to foster recognition that accountability works at multiple levels in the health system; operationalize the different ways stakeholders are accountable to one another; and provide a framework for promoting joint accountability in family planning programs, promises, and everyday work.

² FP2020 Secretariat. 2016. "Momentum at the Midpoint: Progress Report." Available at: <http://progress.familyplanning2020.org/>.

Overview

Design and Framework

In 2016, HP+ staff developed these materials as part of a capacity-strengthening initiative to promote women's leadership and accountability for FP2020 goals. They were piloted throughout a series of 4-day workshops in Kenya, Malawi, and Uganda for multisectoral groups of women working in family planning, most of whom were alumnae of past women's leadership and advocacy programs. After each workshop, HP+ provided country teams with small grants to conduct a participatory assessment of accountability linkages for a selected issue and present findings to larger groups of family planning stakeholders to promote action. The overriding message from participants was the uniqueness of the process and how it changed their perspectives and those of others on how to address accountability, and how empowering it was to do so. More about the issues, findings, and outcomes of the three country pilots is available in a brief posted at www.healthpolicyplus.com/pubs.cfm?get=2083.

In November 2017, HP+ gathered representatives of the Malawi, Kenya, and Uganda networks to reflect on the collaborative component of the activity, lessons learned, and personal and professional impacts, and to offer suggestions for future applications. This version of the curriculum incorporates adaptations and lessons learned from the pilot initiative.

The curriculum and participatory assessment tools draw heavily on Derick Brinkerhoff's (2004) posited framework on accountability linkages within health systems.³ This framework recognizes the various actors involved in health programming—each with their own accountability roles and interests—and describes how the relative strength of all accountability relationships may affect the capacity of the health system to perform. By identifying, mapping, and examining key accountability relationships around a priority issue, participants gain an understanding of how accountability works—or not—and can offer ideas to larger groups of stakeholders and advocates on interventions to shore up gaps in accountability. This effort was the first known field application of the framework. Based on participant feedback and burgeoning outcomes, it has thus far proved to be a useful framework for on-the-ground application for those stakeholders interested in improving accountability as a health systems-strengthening intervention.

This is a positive approach that brings together sometimes disparate groups within the health system to work toward a common goal. Although this pilot series engaged networks of women leaders, the principle of working with like-minded individuals to advance a shared agenda can work with a variety of actors in different sectors. Many participants lauded the positive nature of the approach. Hon. Patricia Lasoi of Kenya noted, "Looking at accountability this way was empowering—I never thought about it [accountability] like this. Now I know what everyone is supposed to do."

Curriculum Structure

The curriculum comprises three modules, each of which addresses a key learning objective. The first module (3.5 hours) provides participants with a basic understanding of accountability

³ Brinkerhoff, D. 2004. "Accountability and Health Systems: Towards Conceptual Clarity and Policy Relevance." *Health Policy and Planning* 19(6): 371–379.

terminology, key concepts, and relevant interventions. The second module (3.5 hours) builds skills to identify and map accountability actors and relationships throughout the health system for a priority issue that affects progress toward meeting commitments. The third module (7-9 hours) provides the opportunity to practice new skills and apply additional resources and implementation tools to further examine these relationships through a participatory assessment and present findings to broader groups of stakeholders.

The modules are sequential and build on content introduced in previous modules. However, they are also easily adapted and applied to different contexts. For example, should the assessment, validation, and dissemination components of Module 3 not be feasible, HP+ has found that Modules 1 and 2 can be incorporated in whole or part to deepen understanding of accountability linkages for informing advocacy planning efforts as well as program and policy design. The accountability mapping process is another way of understanding target audiences and identifying potential pressure points for advocacy or policy or program interventions, particularly as they relate to ensuring that government commitments are carried out.

HP+ teams have adapted and integrated various components of the curriculum into field programs in Guatemala, Nigeria, and Pakistan (without incorporating the participatory assessment and follow-up activities). These applications have varied in scope and focused on technical areas ranging from operationalizing youth components of a Costed Implementation Plan for FP2020 to education and nutrition advocacy to understanding health financing decision pathways to help strategize for advocacy opportunities. For example, in Pakistan's Sindh province, family planning advocates found that mapping accountability relationships among a web of family planning providers offered important insights as they strategized how to best support, advocate for, and monitor implementation of Sindh's Costed Implementation Plan commitments to expand family planning outreach and services to youth ([view video on achievements made in Pakistan](#)). These experiences have demonstrated the value and adaptability of the training sessions in other contexts.



Women leaders in Pakistan mapped accountability linkages during a participatory workshop.

An illustrative 3-day agenda for completing all three modules is provided in Appendix A.

The foundation of the curriculum is some form of government commitment—in this case, the respective country commitments to FP2020. When using the curriculum outside of the family planning sector, facilitators can tailor the curriculum text and tools included here to the specific issue and organize the workshop around a national or subnational commitment to an issue that falls within the context of their program. On the first day of the workshop, the facilitation team should include a session that provides background on the issue and the commitment—when and where the commitment was made, by whom, and its details—along with updates on progress and participants’ engagement in meeting the commitment. The illustrative agenda includes 1.5 hours on the first morning for setting the context.

Providing Feedback to HP+

We would welcome your feedback on this curriculum as you use it. We want to hear facilitator feedback on what worked, what did not work, or how you adapted or integrated any part of it into different contexts. We would especially appreciate your sharing with us any representative participant feedback about the most important things learned, how skills were applied, or any gaps, so we can adapt and update the curriculum in new contexts moving forward.

To provide feedback, please contact: policyinfo@thepalladiumgroup.com

Module	Name	Objective
1	Understanding the Basics of Accountability	To strengthen basic knowledge around accountability and governance within health systems, specifically regarding family planning and health programming.
2	Understanding and Mapping Accountability Relationships	To develop skills for identifying and visually mapping accountability actors and relationships throughout the health system for an issue of interest. The participatory exercise produces an <i>accountability map</i> that may inform advocacy efforts or program intervention designs.
3	Examining Accountability Relationships to Identify Gaps and Opportunities	To practice applying new knowledge and skills in conducting a participatory assessment of existing priority accountability linkages based on an analysis of the mapping exercise.

Module 1: Understanding the Basics of Accountability

Session	Name	Learning Objectives	Estimated Time
1.1	Accountability Fundamentals	<ul style="list-style-type: none"> Understand basic accountability concepts and definitions, including three types of accountability within health systems Describe accountability roles and relationships between key stakeholder groups in the health system 	2 hours
1.2	Case Studies in Accountability	<ul style="list-style-type: none"> Identify concepts in real-life examples of accountability gaps and interventions Articulate links between accountability, advocacy, and improved outcomes 	1.5 hours

Module 2: Understanding and Mapping Accountability Relationships

Session	Name	Learning Objectives	Estimated Time
2.1	Prioritizing Accountability Issues	<ul style="list-style-type: none"> Identify key issues affecting family planning or health programming in a given context Prioritize one issue to explore through accountability mapping 	1 hour 15 minutes
2.2	Mapping Accountability	<ul style="list-style-type: none"> Identify health system actors involved in ensuring accountability for the selected issue Classify and define financial, programmatic, and political accountability relationships between actors 	2.5 hours

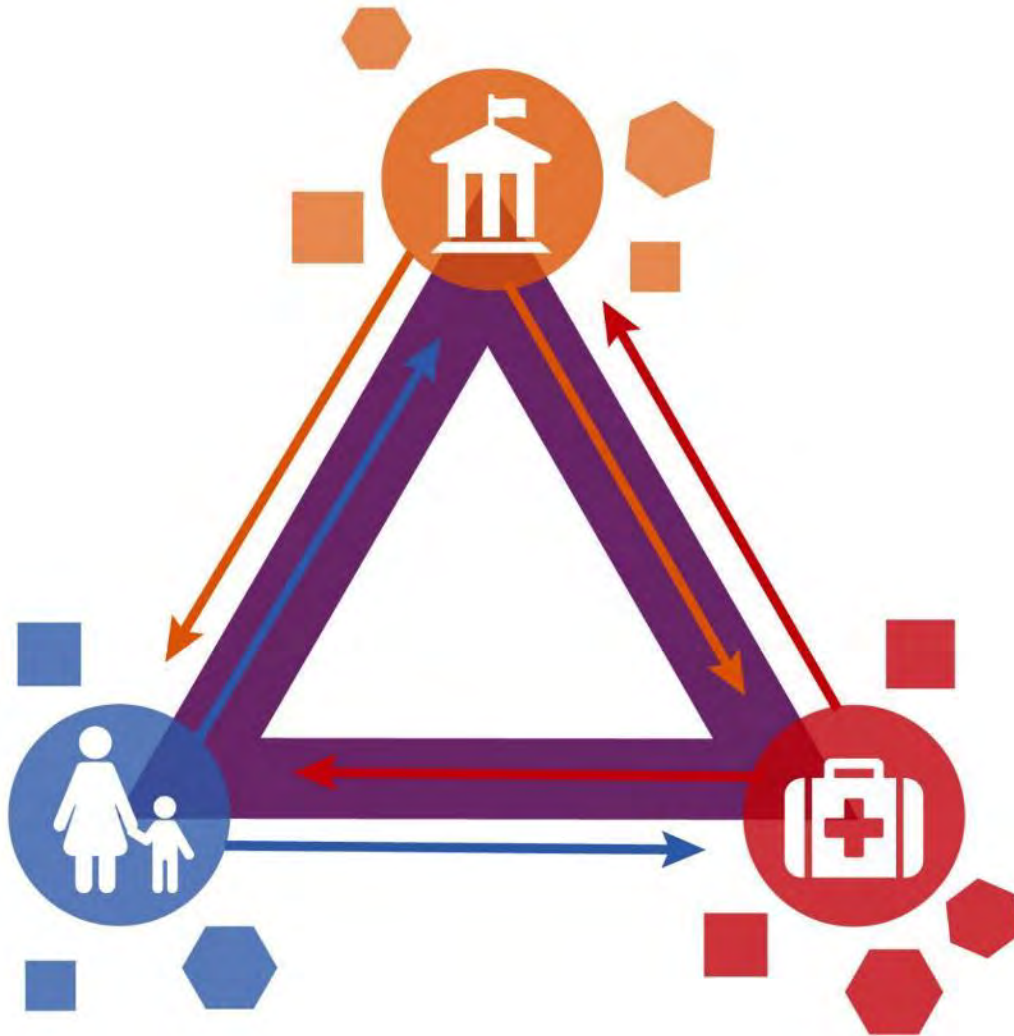
Module 3: Examining Accountability Relationships to Identify Gaps and Opportunities

Session	Name	Learning Objectives	Estimated Time
3.1	Selecting Critical Accountability Relationships	<ul style="list-style-type: none"> Identify critical relationships with the most influence on the family planning issue 	1 hour
3.2	Preparing for Qualitative Data Collection	<ul style="list-style-type: none"> Understand basic concepts of qualitative assessments Describe the principles of effective interviewing Review and tailor a structured template to guide interviews for assessing accountability linkages between two key actors Draw lessons learned from practicing semi-structured interviews 	3.5 hours
3.3	Preparing for Qualitative Data Analysis	<ul style="list-style-type: none"> Understand basic concepts of qualitative analysis Practice coding and identifying themes from sample interview transcripts Draw lessons learned from practicum 	2 hours
3.4	Action Planning for Participatory Assessments	<ul style="list-style-type: none"> Articulate assessment goals and outputs Establish a timeline, budget, and roles and responsibilities 	1–2 hours

Appendices

Session	Name	Learning Objectives	Estimated Time
A	Template of a Sample 3-Day Workshop Agenda	<ul style="list-style-type: none"> Sample template 	
B	Templates/ Instructions for Preparing Workshop Tools	<ul style="list-style-type: none"> Instructions, templates, and questions for the terminology-matching exercise in Session 1.1, Accountability Fundamentals Instructions for preparing Health Governance Triangle components for building out the triangle in Session 1.1, Accountability Fundamentals 	
C	Further Reading	<ul style="list-style-type: none"> Suggested resources for additional learning about accountability and qualitative assessments 	

Module 1: Understanding the Basics of Accountability



Sessions

1.1 Accountability Fundamentals

1.2 Case Studies in Accountability

Module 1 Overview

Module 1 introduces participants to basic concepts in accountability and health governance, particularly as they relate to family planning and health systems. This module includes facilitator guides and participant handouts for two workshop sessions.

The first session, *1.1, Accountability Fundamentals*, draws on Brinkerhoff's (2004) framework of accountability within health systems as well as Brinkerhoff and Bossert's (2008) model of health governance. Facilitators are strongly encouraged to read both papers, cited below, as part of the preparation process. If time and resources allow, it would be ideal to engage a co-facilitator with deep experience in governance and accountability in a given context.

The session begins with an activity in which participants find partners by matching puzzle pieces with key accountability terms and definitions, and then discussing questions about how the terms apply in their specific context. Facilitators then lead interactive presentations on key definitions and concepts, including the two tenets of accountability—answerability and enforceability—as well as three types of accountability within the health system: programmatic accountability, financial accountability, and political/democratic accountability. The session closes with participants brainstorming a list of health system actors related to family planning and sorting them according to the roles, relationships, and dynamics between key groups within the health system.

In the second session, *1.2, Case Studies in Accountability*, participants get a chance to ground their new knowledge in real-world examples of accountability gaps and interventions. Working in small groups, participants examine one of five case examples of interventions that seek to address an existing gap in accountability. Each group identifies the type of accountability the example addresses (programmatic, financial, or political/democratic) and discusses whether the intervention was successful in improving accountability. Each group presents its case study and conclusions, giving participants a chance to learn from all 5 examples.

Suggested Reading:

Brinkerhoff, D. 2004. "Accountability and Health Systems: Towards Conceptual Clarity and Policy Relevance." *Health Policy and Planning* 19(6): 371–379.

Brinkerhoff, D. and T. Bossert. 2008. "Health Governance: Concepts, Experience, and Programming Options." *Health Systems 20/20*, Washington, DC: USAID.

Session 1.1 Accountability Fundamentals

Learning Objectives:	<ul style="list-style-type: none"> • Understand basic accountability concepts and definitions, including three types of accountability within health systems • Describe accountability roles and relationships between key stakeholder groups in the health system
Overall Time:	2 hours
PowerPoint and Handouts:	<ul style="list-style-type: none"> • PowerPoint: “Accountability Fundamentals” • Handout: <i>Accountability and Health Governance: Key Concepts and Definitions</i> • Handout: <i>The Health Governance Triangle</i> • Handout: <i>What Is Accountability?</i>
Materials Requiring Preparation:	<p>(See Appendix B for templates and instructions)</p> <ul style="list-style-type: none"> • Puzzle pieces for terminology-matching game and discussion questions • Labels and arrows for Health Governance Triangle activity • A piece of plain fabric or several flipcharts taped together (5 feet x 5 feet) and securely taped to the wall
Other Materials:	<ul style="list-style-type: none"> • Sticky Post-It notes of various colors • Markers/pens • Masking tape
Considerations for Preparation and Adaptations:	<ul style="list-style-type: none"> • Plan for at least 1–2 hours to prepare the materials above. • PPT: Accountability Fundamentals <ul style="list-style-type: none"> ○ Slides 5 and 6 provide participants with an example of how answerability and enforceability might work within a health system, specifically in relation to FP2020. Adapt for other topic areas. ○ Slide 12 offers talking points for accountability within the context of a decentralized health system (i.e., when responsibilities are shifted from the national level to lower levels of government). If this scenario is not relevant for the audience, skip this slide.

- **Start** the session by reviewing the learning objectives.

Activity: Accountability Definitions

Time: 20 minutes

Facilitator's Note: *Be sure that each person has only one puzzle piece and each term/concept distributed has a matching definition. If there is an odd number of participants, one of the facilitators can participate in the activity. Select the most important concepts for the activity if there are fewer than 30 participants (co-facilitators or other team members can join in to round out the numbers).*

- **Explain** that the session starts with a terminology-matching game to familiarize participants with some key accountability terms and concepts.
- **Review** the rules:
 - Each person receives one puzzle piece. It will have either a term/concept or a definition written on it. On the back of each definition piece is a discussion question or questions.
 - Participants should move around the room to find the puzzle pieces matching theirs. Those with terms/concepts should look for the matching definitions; those with definitions should look for the corresponding terms/concepts.
 - Once everyone has found a match, participants will sit in pairs and review the definition to ensure comprehension, and then discuss the question on the back of the definition puzzle piece. They should take time to discuss the questions in detail.
- **Explain** that participants may be asked to report to the group on their understanding of their concept and discussion questions.
 - Participants have 10 minutes to find a match and discuss the questions on the back of the matched set. **Ask** if people have any questions.
- **Distribute** the puzzle pieces—one per participant.
- Allow 10 minutes for participants to find their matching piece, review the definition, and discuss the questions.
- **Call time** after 10 minutes.
- **Ask** whether a few pairs would like to share some highlights of their conversations with the larger group.
- **Explain** that all the definitions will be reviewed throughout the course of the next hour.
- **Ask** everyone to go back to their seats, remembering both their partners and discussion points.

Presentation: Accountability Fundamentals, Part 1

Time: 30 minutes

Facilitator’s Note: Over the next 30 minutes, present Slides 1–6 from the PowerPoint “Accountability Fundamentals.” Each slide contains terms/concepts from the terminology-matching game. Throughout the presentation, call on the pairs to share various definitions and highlights from their discussions. Remember: Each pair has been exposed to only one term/concept and definition, so it is important to invite all pairs to share throughout the presentation. At the end of the session, distribute the handout containing all terms and definitions.

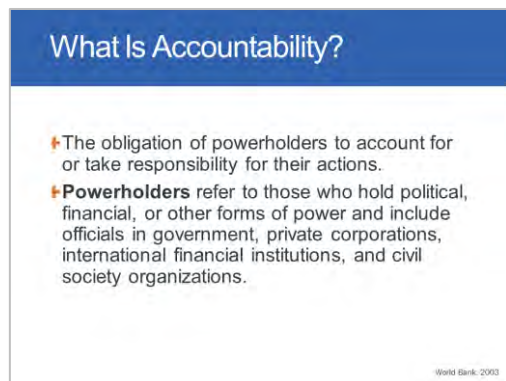
➤ **Open the PowerPoint “Accountability Fundamentals”**

- **Begin** by asking the group for suggestions about what words, concepts, or actions come to mind when they hear the term “accountability.” Encourage people to call out anything that comes to mind. As they do so, record some key words on a flipchart.
 - Common answers include tracking, money, finances, budgeting, corruption, monitoring, civil society, etc.
- **Facilitate a brief discussion** about the responses.
 - How are the words/concepts similar or different?
 - What about negative or positive connotations?
- **Point out** to the group that although many people, groups, and global frameworks talk a great deal about accountability, the term itself can be hard to define.
- **Explain** that in this session, we will explore how accountability works within a health system.



➤ **Click to Slide 2**

- **Ask** the pair that had the term **accountability** to read the definition aloud slowly and share any interesting points or insights from their discussion.
- **Spend** a few minutes discussing the concept of “powerholders” to ensure the group’s understanding. Guiding questions include the following:
 - Who are some key powerholders in this health system?
 - Are powerholders always in government?
 - What are some examples of relationships in which the powerholder is not a government agency? (Answers could be some of the following: in a private provider-client relationship; when decentralization is not accompanied by devolution of power for fund allocation; when an external donor mandates use of funds.)



- Note: This pair's questions were "How do ordinary citizens know what powerholders are accountable for in family planning?" "Who is responsible for holding them accountable?"

➤ **Click to Slide 3**

- **Explain** that in attempting to understand accountability within a health system, it can be helpful to ask the question: *Accountability for what?* In essence: What is someone or some entity accountable for managing or delivering?



- **Ask** the pair that had **financial accountability** to read the definition aloud and briefly recap their discussion.
 - Explain that often people think about financing, budget flows, money, or corruption when then hear the term "accountability," but there are other aspects in the health system for which someone can be accountable.
 - Allow for discussion/questions.
 - Note: This pair's questions were "Are there examples of actions being taken around financial accountability in the health sector?" "Other sectors?" "What are they?"
- **Next** ask the pair that had **programmatic accountability** to read the definition aloud and briefly recap their discussion.
- Note that by "providers," we do not mean only healthcare providers. "Providers" refers to all actors responsible for helping government achieve program goals and objectives.
- Allow for discussion/questions.
- Note: This pair's question was "What are some examples of programmatic accountability in the health sector, whether between/among government agencies or between civil society and government?"
- **Finally**, ask the pair that had **political/democratic accountability** to read the definition aloud and briefly recap their discussion.
- Again, stimulate discussion. What sort of political promises have been made regarding family planning (or other health areas)? How are these promises being monitored?
- Note: This pair's questions were "What are some examples of political/democratic accountability that you can share, particularly in the social sector?" "Are there examples in the health sector?" "Do these work?"

➤ **Click to Slide 4**

Facilitator’s Note: Spend some time on this slide and the discussion that results—these concepts are the most important for participants to grasp. It can be helpful to provide concrete examples that are familiar to participants to ground these concepts in their everyday experiences. At a loss? Ask participants whether they can think of an example of answerability and enforceability in their work.

- **Explain** that two concepts lie at the heart of accountability. These are **answerability** and **enforceability**. To have proper accountability, both must exist.
- **Ask** the participants who had **answerability** as their concept to read the definition aloud and briefly recap their discussion.
 - Stress that answerability is essential for accountability.
- **Further** explain that when we say the “obligation to answer questions,” it encompasses two levels of questioning:
 - The **first level** is simply to provide information. It is a one-way transmission from the accountable actor(s) to the overseeing actor(s). An accountable actor may, for example, release a report.
 - The **second level** moves beyond information and includes explanations or reasons for decisions. This is not just about making a report available but, for example, being available and answering questions about the details in the report.
 - Note: This pair’s question was “How do powerholders answer questions or explain or justify decisions to stakeholders around health issues?”
- **Ask** the pair that had **enforceability** to read the definition and briefly recap their discussion.
 - Explain that legal and regulatory frameworks, as well as professional norms and standards, are at the core of enforcing accountability (e.g., in healthcare, professional associations can provide certification to those actors meeting certain professional standards). Answerability without sanctions is weak accountability.
 - Note: This pair’s questions were “How are certain actions that promote health norms, standards, etc. encouraged or rewarded?” “How are certain actions that hinder these norms, standards, etc. discouraged?”
- **Reinforce** the symbiotic relationship of these two concepts: you cannot enforce the rules if no one is answerable for them, and answerability without enforcement does not get you very far.

Answerability & Enforceability

- **Answerability:** Having the obligation to answer questions regarding decisions and/or actions.
- **Enforceability:** Availability and application of repercussions for illegal or inappropriate actions and behaviors uncovered through answerability, or incentives to reward or encourage desired behavior.

➤ **Click to Slide 5**

Facilitator’s Note: Please note that the structure shown in Slides 5 and 6 is simplified to allow participants to focus on accountability concepts; it does not reflect reality in most cases. First, this structure assumes a clear commitment from which to start. In many cases, there are commitments (perhaps in an overarching policy document), but they can be ambiguous. Second, commitments are often made within the context of activities that have been ongoing for years or decades—this history will also have an impact on the accountability system in question.

Example:
How Accountability Can Work in a Health System

FIRST	Commit	Powerholders make commitment.
SECOND	Inform	Powerholders inform stakeholders about commitments made.
THIRD	Monitor	Powerholders and stakeholders track and monitor progress toward commitment.
FOURTH	Dialogue	Powerholders and stakeholders dialogue about results from tracking and monitoring.
FIFTH	Motivate	Powerholders and stakeholders use repercussions and/or incentives to spur action.

- **Explain** that accountability can manifest itself in various ways, but this slide shows a scenario of how accountability for a commitment, such as to the FP2020 goals, might work in a health system.
- **Specifically**, it breaks down the concepts of answerability and enforceability into 5 different actions: (1) Commit, (2) Inform, (3) Monitor, (4) Dialogue, and (5) Motivate.
- First, powerholders make a commitment. They then inform relevant stakeholders about the commitments made. Next, both stakeholders and powerholders track and monitor progress toward the commitment. Both then engage in dialogue about monitoring results. Finally, powerholders use sanctions (repercussions) and/or incentives to motivate and spur action.

➤ **Click to Slide 6**

Facilitator’s Note: This slide requires thoughtful tailoring before the workshop begins. The example here comes from an HP+ workshop on Accountability within the context of Malawi’s FP2020 commitments. When editing the slide, attempt to use an example directly related to the health issue or focus of the workshop. Also, consider using the word “repercussions” because the technical term “sanctions” may be too inflammatory in certain contexts.

Example:
Accountability for FP2020 Commitments in Malawi

FIRST	Commit	Malawi Minister of Health made family planning commitments at the 2012 London Summit.
SECOND	Inform	Commitments communicated and operationalized through Family Planning Costed Implementation Plan.
THIRD	Monitor	Commitments monitored for progress by Track20 and FP2020 Working Group.
FOURTH	Dialogue	FP2020 Working Group held dialogue about findings from monitoring/tracking.
FIFTH	Motivate	Track20 and FP2020 Secretariat published findings from all countries.

- **Explain** to participants that these steps may become clearer when applied to a familiar example. Review *[insert your example below]*.
- **First**, the Malawi Minister of Health made FP2020 commitments at the 2012 London Summit.
 - *Probe:* To whom did he make those commitments?
- **Then** the commitments were communicated and operationalized through a Family Planning Costed Implementation Plan.
 - *Probe:* How were the commitments and operational plan communicated, and to whom? What sorts of communication channels were used? Did you hear about them?
- **Next**, various entities tracked progress on FP2020 commitments through tools such as Track20 and the country’s FP2020 Working Group.

- *Probe*: Could other methods or initiatives be used? What about civil society groups? These two examples illustrate tracking progress to program targets, but what about financial or budget tracking?
- **Ideally**, there would have been dialogue about FP2020 progress, either formal or casual.
 - *Probe*: Does this sort of dialogue happen? Why or why not? Who might be involved in this dialogue? What do you think this dialogue should look like? (e.g., formal meetings or ongoing collaboration)
- **Finally**, incentives or sanctions emerge based on evidence from the tracking and dialogue. The evidence allows us to ask “What is going well? What is not going well?” Repercussions and/or incentives can reward good progress or seek to correct bad progress.

➤ **Click to Slide 7**

- **Pause** for questions and check for understanding.
- **After the** questions, **tell** participants it is time to stretch their legs in the upcoming participatory activity.



Activity: Building a Health Governance Triangle

Time: 30 minutes

Facilitator's Note: *The goal of this activity is to introduce the health governance triangle to participants by guiding them in creating their own version of the triangle using the prepared pieces. The activity requires a wall or other flat surface. Throughout the exercise, provide supportive facilitation so that the triangle seems to appear organically—but follow the participants' lead as much as possible. Through your leadership, the group will catch on eagerly.*

- **Explain** that in the next activity, participants will do a deeper dive into accountability for family planning. To do so, they will first brainstorm all the actors and stakeholders that contribute to family planning (policy, programming, funding, etc.) in their country (or county, state, etc., depending on context). Give them guidance such as the following:
 - *Be creative!* Not just who is already part of the family planning world, but who could or should be. This participation can be at national, state, or community levels.
 - *Be specific!* You can write down “Ministry of Health,” but also think about the specific units within the ministry that might be relevant (e.g., Division of Reproductive Health, Office of Family Health, etc.).
 - *Think broadly!* What other sectors are important for family planning, both within and outside the government? (e.g., Ministry of Youth and Education, civil society organizations targeting women or youth, HIV testing and treatment centers, etc.).
- **Give** the following instructions as you or a co-facilitator hand out Post-It notes and markers to each table:
 - Working individually or with others at your table, write the name of one stakeholder/entity/actor per Post-It note.
 - Write clearly with a marker (not a pen).
 - Allow 5 minutes to brainstorm as many names as possible.
- **Tell** participants to begin.
 - Allow a few minutes for brainstorming and discussion with colleagues. Walk around to the tables to offer helpful prompts, if needed.
 - Give participants a 1-minute warning.
- **When** everyone has finished, ask participants to place their notes anywhere on the wall/screen.
- Invite the participants to **gather** at the wall and start scanning the Post-It notes, reading aloud some of the stakeholders you find important, interesting, or that have been written down by multiple participants.



Participants brainstorm family planning stakeholders at national and county levels.

- **As** you scan the Post-Its, begin removing or grouping actors and stakeholders that have been named more than once.
- **Next**, suggest to participants that they begin to organize the stakeholders into categories.
- **Guide** the activity so that three categories emerge in accordance with the health governance triangle—at the top point, place the **government** stakeholders/actors; at the bottom left, place **clients/citizens**; and at the bottom right, place various **providers**.
- **Once** the basic structure is set up, ask participants to help you with this task.
- **If** you see stakeholders placed in the wrong area or with roles that are harder to define (e.g., donors, insurance providers), take this opportunity to probe:
 - Should these stakeholders be moved to another group? Why or why not?
 - What should we do with stakeholders that fall outside the three main groups? (In some cases, participants may say that those should go in the middle of the triangle. In other cases, they may suggest placing them off to the side.)
- When all of the Post-It notes have been sorted and grouped, ask participants to take their seats and return to the PowerPoint to present the remaining slides.



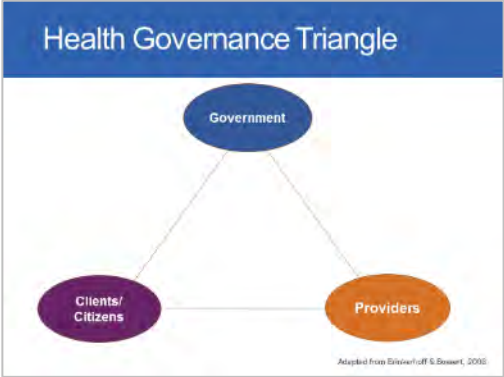
Participants work with a facilitator to remove duplicates and begin organizing actors into groups while other participants call out various actors.

Facilitator's Note: *As an alternative to showing the remaining slides, facilitate the discussion while standing around the triangle posted on the wall. If you choose to do it this way, you could still project Slides 8 and 9 but ask participants to remain standing.*

Presentation: Accountability Fundamentals, Part 2

Time: 30 minutes

➤ **Click to Slide 8**

- **Refer** to the image on Slide 8 with the heading “Health Governance Triangle.”
 - Acknowledge that this slide may look familiar to everyone—this is what we just created! This is known as the health governance triangle.
 - As you discuss the triangle, you or a co-facilitator should place the pre-made cards labelled “government,” “clients/citizens,” and “providers” in the correct position on the wall, near the clusters of Post-It notes.
- 
- The diagram, titled "Health Governance Triangle", shows three interconnected stakeholders in a triangular arrangement. At the top is a blue oval labeled "Government". At the bottom left is a purple oval labeled "Clients/ Citizens". At the bottom right is an orange oval labeled "Providers". Lines connect each pair of stakeholders, forming the sides of a triangle. A small note at the bottom right of the diagram reads "Adapted from Glavin/Hoff & Stewart, 2005".
- **Ask** the participants who had the **health system governance puzzle pieces** (from the terminology-matching activity) to read their definition and briefly recap their discussion.
 - Note: This pair’s question was “How do you think governance of (family planning) affects achievement of (family planning) commitments?”
 - **Explain** that the health governance triangle is a useful framework for thinking about relationships between groups of stakeholders within the health system. It’s particularly helpful to frame it this way:
 - To achieve health sector objectives, what does each stakeholder group **provide** to the other groups?
 - **Ask** participants for some ideas about the following:
 - What does government provide to clients/citizens? To providers?
 - What do clients/citizens provide to providers? To the government?
 - Ideally, what do providers give to clients/citizens? To the government?
 - **During** this discussion, place the blank pre-made arrows (two per side) on the growing triangle.
 - **Ask the** group to come to a consensus on what should be written to summarize what each group provides to the others (six relationships in total).
 - As **participants** identify what each group provides to the others, affix the appropriate cards next to each arrow.
 - **Once** all arrows are labeled, facilitate the conversation described in the next slide.



Facilitator’s Note: See the photo above for an example of a finished health governance triangle from a workshop in Kenya. Note the various placements of actors falling outside of the three stakeholder groups, e.g., donors, media, etc.

➤ **Click to Slide 9**

- **Refer** to the image on Slide 9—now with labels on the arrows.
- **Reiterate** to the group:
 - The health governance triangle describes the interactions between three categories of actors in the health system: **government**, **providers**, and **clients/citizens**.
 - The words describing the arrows are the general concepts that each stakeholder ideally provides to the others in a well-functioning health system. This triangle helps us think about the roles and responsibilities one group of stakeholders has relative to another group.



- **Ask** the group to look at the arrows on the PowerPoint slide and compare them to their own answers. Are there any that are different?
 - As they talk through the differences, add the pre-made arrow labels to the triangle the group has made on the wall.
- **Note** that whereas the arrows appear similar in size, we know there are imbalances in the power and influence of each actor/interaction. **Ask** how the arrows might be sized to reflect the current reality in their own context.

Facilitator’s Note: The arrows contain two words that have not yet been defined—**responsiveness** and **client power**. When these relationships/concepts are introduced, ask the pairs that had those cards to define and share their thoughts on these concepts.

The question on responsiveness was “How do politicians, policymakers, and public officials react to citizens’ expressed needs around (family planning)?”

The question on client power was “How do providers offer opportunities for clients to provide feedback on (family planning) services?”

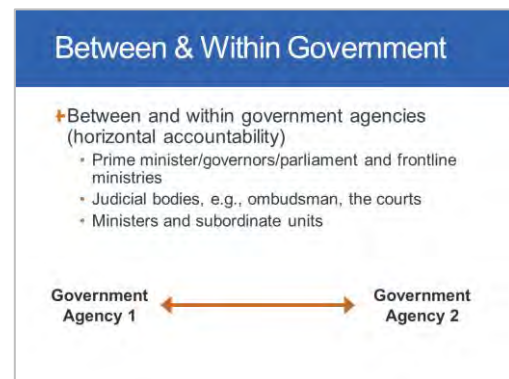
➤ **Click to Slide 10**

- **Explain** that, similar to how the health governance triangle shows roles/responsibilities as relationships, *accountability mechanisms* can be thought of in relational terms as well.
- **Tell** participants that accountability between and within government agencies is often called horizontal accountability.
- **Ask** the pair that had the **horizontal accountability** puzzle piece to read the definition and briefly recap their discussion.
- Note: This pair’s questions were “Which government units lead the way in achieving the (remaining FP2020 commitments)?” and “Which government units provide oversight of those units that are leading the way?”
 - If the pair does not have an example of a horizontal accountability mechanism, ask the others and also ask for more effective and less effective examples.



➤ **Click to Slide 11**

- **Ask** the pairs that had the **vertical accountability** and **social accountability** puzzle pieces to read the definitions and and briefly recap their discussion.
- Explain that vertical accountability is external to government and that social accountability is a vertical accountability mechanism. Civil society uses social accountability tools to hold decisionmakers to account.
- Note: The pair’s questions on vertical accountability were “What are some examples of vertical accountability for (family planning)?” “Are there examples from other sectors?” “What are they?”
- Note: The pair’s questions on social accountability were “Are there examples of social accountability for (family planning) that have led to some positive changes?” “Are there examples from other sectors?” “What are they?”
 - If the pairs are unable to share examples of vertical and social accountability mechanisms, ask the others, or, if needed, provide an example from the local context.



- **Note** that social accountability includes both **claimed spaces** and **invited spaces**. Ask participants with those puzzle pieces to read those definitions.
- Note: The pair’s questions on claimed space were “What are some examples of claimed spaces for (family planning)?” “For health?” “If none, what are the barriers?”
- Note: The pair’s questions on invited space were “What are some examples of invited spaces for (family planning)?” “For health?”
- **Probe** their answers with additional questions such as the following:
 - Who has used social accountability mechanisms? What were the challenges, successes, and outcomes?

➤ **Click to Slide 12**

***Facilitator’s Note:** Most countries have some level of decentralization within their health systems. The degree of decentralization, both on paper and in practice, is different in each country.*

- **Explain** that accountability relationships and mechanisms become even more complex and significant in the context of decentralization.
 - Decentralization often shifts responsibilities from the national level to lower levels of government.
 - National administrative and political reform processes may not consult the family planning sector; nevertheless, such reforms can **result in gaps** in decision making, implementing policies and programs, securing and expending funding, etc.
 - Decentralization can result in more complex accountability relationships within and between subnational and national governments. For a period of time during which guidance is being ironed out, local stakeholders may be unaware of new procedures and reporting lines, and for what they are accountable.
 - Who has the authority for *what* in a decentralized context?
 - Does new decision-making authority come with fiscal authority?
- **If appropriate**, ask participants to identify any financing, decision-making, or implementation gaps they have noted in their decentralized (ing) health system.

Accountability & Decentralization

- ✦ Decentralization (devolution) can fundamentally change governance roles and relationships between national and subnational governments
- ✦ Family planning sector may not be consulted in planning, resulting in gaps in processes
- ✦ Can make for more complex accountability relationships
 - Who has the authority for *what* in a decentralized context?
 - Sometimes decision-making authority doesn't come with fiscal authority

Williamson et al., 2014

➤ **Click to Slide 13**

- **In closing**, tell participants that in an ideal world, all stakeholders would work together toward a common goal, and the accountability mechanisms would all hum like a fine-tuned motor.
- **Explain** that **joint accountability** is a good step toward that ideal, in which various groups or teams, possibly representing different sectors, embark on a shared process of holding each other to account and strengthening the linkages among them.

Everyone Together

- ✦ Joint accountability
 - Task forces/partnerships/formal mechanisms
 - Representatives of different sectors (e.g., civil society, government, private sector, donors)
 - Embark on shared process
 - Hold each other to account
 - Strengthen linkages among them
 - Build consensus
 - Act on solutions

- **This** effort can be difficult, but the lessons learned and the connections forged during this training can provide a strong foundation for a participatory and joint process of strengthening accountability linkages to address gaps in progress toward achieving family planning goals.

➤ **Click to Slide 14**

- **Check** for understanding. Are there any lingering questions or concerns?
- **Distribute** the following handouts:
 - *Accountability and Health Governance: Key Concepts and Governance Definitions*
 - *What Is Accountability?*
 - *The Health Governance Triangle*
- **Transition:** Having had a chance to learn more about accountability and related concepts in a health systems context, the next session provides an opportunity to explore some actual field examples of identifying and addressing accountability gaps.

Resources

1. Brinkerhoff, D. and T. Bossert. 2008. "Health Governance: Concepts, Experience, and Programming Options." Bethesda, MD: Abt Associates, HealthSystems2020.
2. World Bank. 2003. *Social Accountability: A Concept Note Based on Emerging Practice*. Draft for discussion. Washington, DC: World Bank.
3. Williamson, R. T., S. Duval, A. A. Goldsmith, K. Hardee, and R. Mbuya-Brown. 2014. *The Effects of Decentralization on Family Planning: A Framework for Analysis*. Washington, DC: Futures Group, Health Policy Project.
4. Agarwal, S., R. Heltberg, and M. Diachok. 2009. "Scaling-Up Social Accountability in World Bank Operations." Washington, DC: World Bank.
5. McGinn, E. & Lipsky, A. 2015. *Social accountability: A primer for civil society organizations working in family planning and reproductive health*. Washington, DC: Futures Group, Health Policy Project.

HANDOUT:

Accountability and Health Governance: Key Concepts and Definitions

Accountability: The obligation of powerholders to account for or take responsibility for their actions. The term “powerholders” refers to those who hold political, financial, or other forms of power; they include officials in government, private corporations, international financial institutions, and civil society organizations.⁴

Answerability: Having the obligation to answer questions regarding decisions and/or actions. Powerholders are also obligated to explain and justify why certain things were done. Answerability is one of the two components of accountability.

Enforceability: The availability and application of sanctions/repercussions for illegal or inappropriate actions and behaviors, or incentives to reward or encourage desired action. Enforceability is the second component of accountability.⁵

Financial Accountability: Concerns tracking and reporting on allocation, disbursement, and utilization of financial resources, using the tools of auditing, budgeting, and accounting. It seeks to ensure that health service providers and others are using resources for agreed-upon and appropriate purposes, and to reduce corrupt practices.⁶

Programmatic Accountability: Demonstrating and accounting for performance with respect to agreed-upon program milestones. At the health system level, the focus is on the services, outputs, and results of public agencies and programs, not on individual service encounters between patients and providers.⁷

Political/Democratic Accountability: Ensuring that government delivers on electoral promises, fulfills the public trust, aggregates and represents citizens’ interests, and responds to ongoing and emerging societal needs and concerns. This type of accountability occurs when politicians press the health ministry and other health-related agencies to pursue objectives and employ resources so that providers respond to what citizens want/need/have a right to regarding healthcare.⁸

⁴ Malena, C., R. Forster, S. Janmejy. 2004. *Social Accountability: An Introduction to the Concept and Emerging Practice*. Washington, DC: The World Bank.

⁵ Brinkerhoff, D. 2001. *Taking Account of Accountability: A Conceptual Overview and Strategic Options*. Washington, DC: USAID, Center for Democracy and Governance, Implementing Policy Change Project, Phase 2.

⁶ Brinkerhoff, D. 2006. “Accountability and Good Governance: Concepts and Issues.” Pp. 269–288 in *International Development Governance*, edited by Huque, A.S. and H. Zafarullah. Boca Raton, FL: Taylor & Francis.

⁷ Ibid.

⁸ Ibid.

Health System Governance: Developing and implementing effective rules, institutions, and relationships for policies, programs, and activities related to fulfilling public health functions and achieving health sector objectives.⁹

Responsiveness: Occurs when politicians, policymakers, and public officials react to citizens' expressed needs.

Client Power: Occurs when clients/citizens convey their needs and demands for services—and their level of satisfaction—directly to providers.

Horizontal Accountability: Occurs when government units ensure that other units within the same government fulfill their commitments through institutional mechanisms of oversight. These mechanisms can include internal audits and parliamentary hearings.¹⁰

Vertical Accountability: Occurs when forces external to government, such as citizens, advocacy groups, and the media, work to ensure that government units meet their obligations. Mechanisms for this type of accountability include elections, mass protests, publication of shadow reports, and investigative news reports.¹¹

Social Accountability: Occurs when citizens are engaged in holding the state to account. It includes a broad range of actions and mechanisms that citizens, communities, civil society organizations, and the independent media can use to hold government accountable.¹²

Claimed Space: Occurs when citizens initiate accountability mechanisms or approaches on their own, without government involvement.¹³

Invited Space: Occurs when governments invite active and meaningful involvement of citizens or civil society organizations in horizontal accountability mechanisms. These mechanisms may include participatory planning and budgeting, citizen testimony in public hearings or oversight committees, or community representation on health committees.¹⁴

Joint Accountability: Occurs when government and civil society actors work together for policy making; program/service delivery planning and implementation; and monitoring and oversight of public policies, programs, and services.¹⁵

⁹ Brinkerhoff, D., and T. Bossert. 2008. *Health Governance: Concepts, Experience, and Programming Options*. Washington, DC: USAID, Health Systems 20/20.

¹⁰ McGinn, E., and A. Lipsky. 2015. *Social Accountability: A Primer for Civil Society Organizations Working in Family Planning and Reproductive Health*. Washington, DC: Health Policy Project.

¹¹ Ibid.

¹² Ibid.

¹³ Staphenurst, R., and M. O'Brien. N.D. "Accountability in Governance." Washington, DC: The World Bank Group.

¹⁴ McGinn, E., and A. Lipsky. 2015. *Social Accountability: A Primer for Civil Society Organizations Working in Family Planning and Reproductive Health*. Washington, DC: Health Policy Project.

¹⁵ Brinkerhoff, D.W., J. Hertz, and A. Wetterberg. 2016. "Introduction: Governance, Social Accountability, and Sectoral Service Delivery." Pp. 1–8 in *Governance and Service Delivery: Practical Applications of Social Accountability Across Sectors*, edited by Wetterberg, A., D.W. Brinkerhoff, and J.C. Hertz. Washington, DC: RTI Press.

HANDOUT

What Is Accountability?

Accountability can be defined as *the obligation of powerholders to account for or take responsibility for their actions*. The term “powerholders” refers to those who hold political, financial, or other forms of power; they include officials in government, private corporations, international financial institutions, and civil society.¹⁶

Accountability Within the Health System



Financial Accountability

Involves tracking and reporting on allocation, disbursement, and utilization of financial resources. Budgeting, auditing, and accounting systems help to ensure that health service providers and others use resources for agreed-upon and appropriate purposes, and to reduce corrupt practices.



Programmatic Accountability

Calls for health system actors to demonstrate and account for performance with respect to agreed-upon program milestones. At the health system level, the focus is on the services, outputs, and results of public agencies and programs, not on individual service encounters between patients and providers.



Political/Democratic Accountability

Seeks to ensure that government delivers on electoral promises, fulfills the public trust, and represents citizens' interests. It occurs when politicians press the health ministry and other health-related agencies to pursue objectives and employ resources so that providers respond to what citizens want/need/have a right to regarding healthcare.

How Does Accountability Work?

For proper accountability, a health system must have mechanisms to ensure answerability and enforceability for powerholders and their commitments to the public. These two concepts—answerability and enforceability—lie at the heart of accountability.

- **Answerability** refers to having the obligation to answer questions regarding decisions and/or actions. Powerholders are also obligated to explain and justify why certain things were done.
- **Enforceability** refers to the availability and application of sanctions/repercussions for illegal or inappropriate actions and behaviors, or incentives to reward or encourage desired action.

¹⁶ **Information in this handout adapted from:** World Bank. 2003. *Social Accountability: A Concept Note Based on Emerging Practice*. Draft for discussion. Washington, DC: World Bank.

Brinkerhoff, D., and T. Bossert. 2008. *Health Governance: Concepts, Experience, and Programming Options*. Bethesda, MD: Abt Associates, Health Systems 2020.

Accountability in a Health System

How do these concepts work in practice? There are many ways answerability and enforceability can work together to ensure accountability within a health system. The following scenario illustrates one such way these concepts could play out in a given health system:

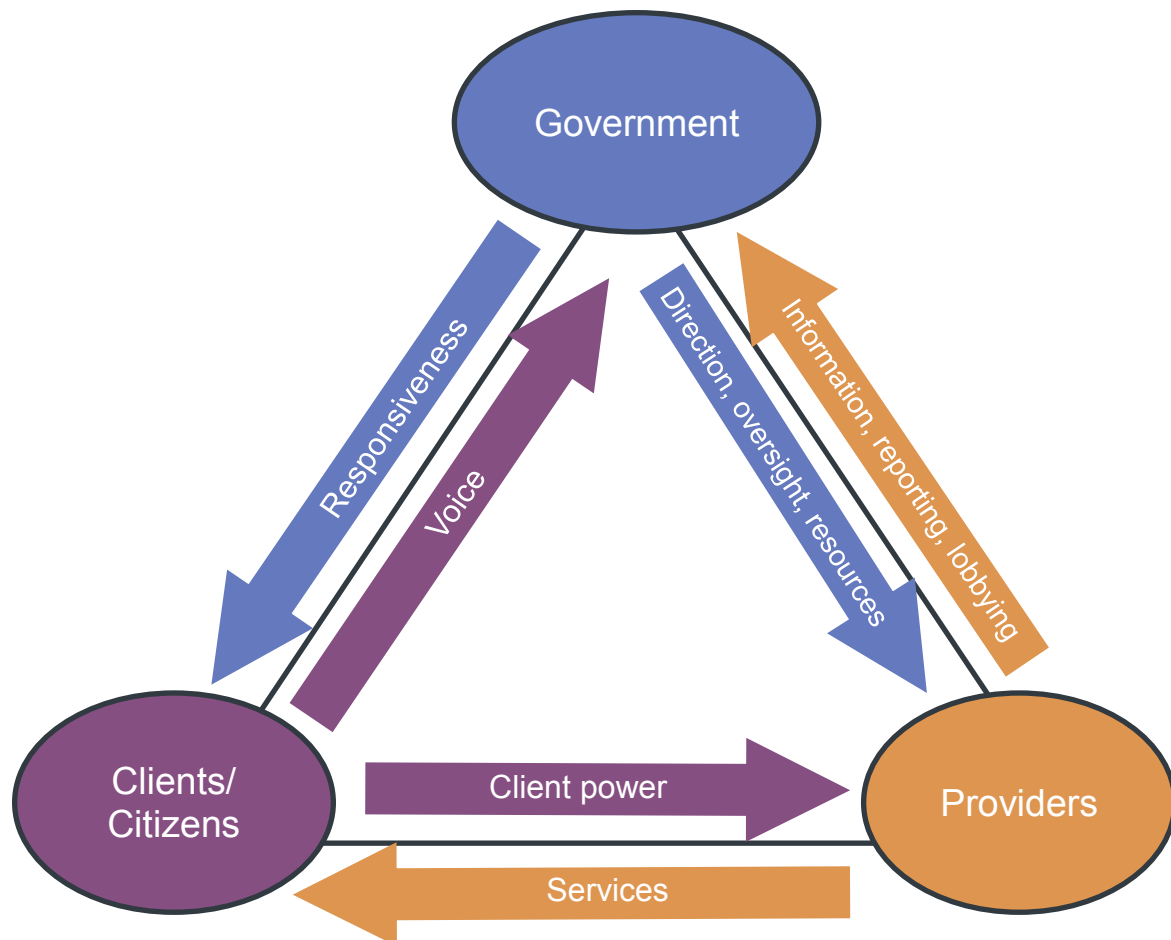
1	Commit	Powerholders make a commitment
2	Inform	Powerholders inform stakeholders about commitments made
3	Monitor	Powerholders and stakeholders track and monitor progress toward commitment
4	Dialogue	Powerholders and stakeholders dialogue about results from tracking/monitoring
5	Motivate	Powerholders and stakeholders use repercussions and/or incentives to spur action

1. In 2020, powerholders in Country X make a **commitment** to roll out a new family planning program for youth.
2. Because the powerholders are **answerable** for this commitment, they **inform** relevant stakeholders about this program. Relevant stakeholders might include civil society organizations or implementing partners, as well as those working within Country X's government. Communication to stakeholders might be done through an announcement, press release, or official guidance. Within the government, it might also be done by initiating chains of communication and command.
3. Knowing there are legal **repercussions** should the program not come to fruition, the powerholders develop a system to track and **monitor** the program roll-out. To ensure the powerholders deliver on their promise, civil society organizations and implementing partners may develop their own methods of tracking and monitoring the program.
4. Through their monitoring, stakeholders may find that although funds for the program have been disbursed, there is little evidence of program roll-out. They request and are granted a **dialogue** with the relevant powerholders to discuss their concerns.
5. At the meeting, the stakeholders present their findings and demand answers. The powerholders explain the reason for the delays, conveying information not previously available to the stakeholders. With election season approaching in Country X, the powerholders are **motivated** to keep the stakeholders happy. The two groups agree to form a multisectoral task force to ensure program implementation.

HANDOUT**The Health Governance Triangle**

The **health governance triangle** describes the interactions between three categories of actors in the health system: **government**, **providers**, and **clients/citizens**. Arrows indicate the roles and responsibilities of one group in relation to the others. The arrows appear similar in size, but imbalances exist in the power and influence of each actor/interaction.

To understand the triangle, it is helpful to ask: What does one group *provide* the other?



Government: Offers direction, oversight, and resources to **providers**; Responds to needs and demands from **clients/citizens**

Providers: Deliver services to **clients/citizens**; Provide information, reporting, and lobbying to **government**

Clients/Citizens: Voice needs and demands to **government**; Exercise power in choosing **providers** and communicating demands or levels of satisfaction

Session 1.2 Case Studies in Accountability

Learning Objectives:	<ul style="list-style-type: none"> • Identify concepts in real-life examples of accountability gaps and interventions • Articulate links between accountability, advocacy, and improved outcomes
Overall Time:	1.5 hours
PowerPoint and Handouts:	<ul style="list-style-type: none"> • Handout: <i>Case Studies #1–5</i> • Handout: <i>Case Studies: Instructions</i> • Handout: <i>Case Studies: Suggested Answers and Discussion Points</i>
Other Materials:	<ul style="list-style-type: none"> • Flipchart paper (at least 5 pieces for group work) • Markers/pens • Masking tape
Considerations for Preparation and Adaptation:	<ul style="list-style-type: none"> • Set aside 30 minutes to an hour to read through the 5 case studies and accompanying questions. Before looking at the suggested answers, jot down your own responses to the questions. This quick exercise can shed light on any areas that might require more clarity and will prepare you for questions from participants.

- **Start** the session by reviewing the learning objectives.

Activity: Group Work

Time: 40 minutes

- **Explain** that this session will give participants the opportunity to examine real-life examples of how accountability has been used to improve outcomes in health and other areas.
- **Describe** the activity:
 - Participants will break into 5 groups. Each group will receive a case study and a list of 5 discussion questions.
 - Participants should read the case study to themselves and review the accompanying questions.
 - Next, the small groups will discuss the case study using the 5 questions and reach consensus on their responses. (Note that the questions are the same for all 5 case studies.)
 - Each group should write their responses on a flipchart and choose a member to present and discuss their case to the larger group.
 - Presentations and discussions should last 5–7 minutes.
- **Divide** participants into 5 groups. Assign a space in the room for each group.

Facilitator's Note: *Group size should be no larger than 6 participants. If the core group is large, assign the same case study to multiple groups. Duplicate groups may collaborate on presentations but should stay in small groups for the initial discussion and recording to promote greater participation.*

- **Distribute** the case studies, questions, flipchart paper, and markers.
- **Each** group member should get its own copy of the case study.
- Allow 30 minutes to complete this exercise.
- **Remind** them of the time at the 10- and 5-minute points.
- **After** 30 minutes, call time.

Activity: Report-out

Time: 50 minutes

- **Explain** that each group will present its case study and answers. Before reporting out, allow time for everyone to read the other groups' case studies.
- Distribute the case studies. Give participants 10 minutes to read the other cases and consider the responses.

Facilitator's Note: *Depending on the workshop agenda and participant profile, facilitators may choose to assign the case studies as a reading assignment for the previous night. If participants do not have the chance to read all of the cases before the group presentations, it will reduce their comprehension.*

- **After** 10 minutes, ask the presenter from the group with Case Study #1 to begin the presentations.
 - **Remind everyone that each** presentation and discussion should last 5–7 minutes, and the group is “accountable” for that time limit. As facilitator, prepare in advance some fun “sanctions” and “incentives” for keeping to the time limits.
 - **Throughout** the discussions, allow the participants to lead. However, refer to the handout *Case Studies: Suggested Answers and Discussion Points*, to ensure that key points for each case study are captured or reiterated as part of the session closing.
- **Once** all groups have presented, **ask** if there are any overarching comments.
- Facilitate a large group discussion, drawing on the following questions:
 - Is anybody familiar with these kinds of interventions? How or when did you come across them? In what context were they used? What were the outcomes?



Women in Uganda analyze an accountability case study.

- Are there any commonalities across the case studies? (For example, many of them provided opportunities for civil society to get involved in partnership with government.)
- Are there any differences across the case studies? (For example, are there differences in the level at which they were operating, what they were able to achieve, etc.?)
- If you were to try to implement any of these interventions, what are some challenges to anticipate?
- **Distribute** copies of the handout *Case Studies: Suggested Answers and Discussion Points*, to all participants.
- **Summarize** that these case studies demonstrate how enhancing accountability is not the only response to ensure better outcomes. Rather, it can contribute to better outcomes and is one necessary component for building and sustaining strong and well-functioning health systems.
- **Transition to the next module**, which focuses on mapping accountability linkages for an important issue affecting achievement of FP2020 commitments.

HANDOUT: Case Studies 1–5

Case Study 1: Health Program Tackles Underage Marriage in East Java

Adapted from USAID/Indonesia Local Governance Service Improvement (Kinerja) Program. 2014. USAID Success Story. Available at: <http://www.kinerja.or.id/pdf/9edb59d1-624f-4304-8599-e4a08ac10aa3.pdf>.

As Indonesia continues struggling to reduce the rates of maternal and infant mortality and entrenched gender inequality, a new health program in Bondowoso District, East Java, is helping to combat these trends by addressing the issue of underage marriage.

Cultural influences are very strong in many parts of Bondowoso; women are encouraged to get married and start families at an early age to avoid social stigma. In extreme cases, girls as young as 12 or 13 are married off, leaving them particularly vulnerable during pregnancy and childbirth because their bodies are still developing.

With support from USAID’s Kinerja program—which sought to improve the governance of public health delivery—and its local partner, the Women’s Health Foundation (*Yayasan Kesehatan Perempuan*), the Bondowoso District administration launched a reproductive health program in 2011 for junior and senior high school students. The program included several measures, ranging from reproductive health education during student orientation for teenagers in schools to training of peer educators and adolescent reproductive health ambassadors, and awareness-raising during sermons. The program achieved early success. Between 2011 and 2013, the number of underage marriages in Bondowoso District fell from 50.9 percent to 43.3 percent.

This achievement was due in large part to the program’s cross-sectoral approach and the enthusiastic participation of a wide range of stakeholders at all levels of the community. These stakeholders included a civil society-based multistakeholder forum, which included participants from local nongovernmental organizations (NGOs), religious leaders; government agencies, school teachers in the Community of Teachers Who Care about Reproductive Health (*Paguyuban Guru Peduli Kespro*), teenage ambassadors, and women community leaders. Both teenage ambassadors and the women community leaders conducted outreach at local levels between multistakeholder forum meetings. The forum met regularly to raise citizens’ awareness of their rights, build formal commitments among stakeholders, and formulate action plans based on complaint-handling surveys.¹⁷

One member of the multistakeholder forum expressed his surprise at how open community members were to discussing the issues surrounding reproductive health and underage marriage. “This is something that community leaders rarely talk about, let alone broader society,” he said.

As of 2014, 26 out of 327 secondary schools in Bondowoso had joined the program, leaving tremendous scope for replication to other schools in villages across the district. Within two years of the program’s implementation, 279 peer educators had been trained—up from 24 when the program first began. These peer educators were an important resource for the district in supporting the program’s replication.

According to the head of the District Family Planning and Women’s Empowerment Body (*Badan Pemberdayaan Perempuan dan Keluarga Berencana*), plans were already in place to add another 10 junior and 15 senior high schools to the program in 2015, as well as 10 Islamic boarding schools. “Underage marriage needs to be avoided in an effort to reduce maternal and infant mortality. The reproductive health program is intended to allow women to prepare for childbirth, both physically and mentally, so that they remain healthy and give birth to healthy babies. For those reasons, the program must be continued in a sustainable way,” he said.

¹⁷ Hertz, J. 2016. “Social Accountability in Cross-Sectoral Service Delivery: The Kinerja Public Service Delivery Program in Indonesia.” Pp. 81–100 in *Governance and Service Delivery: Practical Applications of Social Accountability Across Sectors*, edited by Anna Wetterberg, Derick W. Brinkerhoff, and Jana C. Hertz. Research Triangle Park, NC: RTI Press.

Case Study 2: Transparency in Fees for Services and Products

Adapted from Faisons Ensemble Project. 2011. *Good Governance, Better Health*. Conakry: Faisons Ensemble.

Mr. Ibrahima Diarra knows he and other Dinguiraye, Guinea, community health center clients should be prepared to pay 1,400 Guinea Francs (GNF), or approximately 30 cents, no more and no less, for treatment with antibiotics. Mr. Diarra also knows that although access to such information is common in many communities around the world, it is uncommon in Guinea. He and his fellow good governance champions in Dinguiraye worked for more than a year to ensure that health service fees are posted for all who enter the center to see, and for center workers to observe.

In Guinea, how the fee charged by a local health center to a health center client is calculated often presents a mystery. Standard fees are set by the central government and include an assumption that the central pharmacy will provide supplies, including drugs, to the health center. Supplies do not flow smoothly through the system, however, forcing local health centers either to buy from sources with more volatile price schedules or do without.

At the end of the chain is the citizen who needs healthcare. Center workers frequently set fees at the moment of treatment and consider an assortment of factors that may include personal gain.

Mr. Diarra and his fellow good governance champions, who were involved in the USAID/Guinea-supported Faisons Ensemble project, decided to take the mystery out of health center service fees in their community. Mr. Diarra was well suited to the task. He is a retired senior civil servant with experience as an elected local council member and the president of the Community Health Management Committee (COGES) of the Dinguiraye urban commune. Like those in many Guinean communities, the Dinguiraye COGES is committed to improving health center services and management. Both public and civic representatives sit on the COGES board.

Since its birth as a community-based organization in 2002, the Dinguiraye COGES had struggled to produce results. In 2007, the Dinguiraye urban commune was among 113 local governments selected as good governance champions by the Faisons Ensemble project. The selection brought Dinguiraye public and civic organizations, including the COGES, training and customized technical assistance to support good governance and improved services in health, education, and agriculture.

Along with members of the elected council, public service providers, and other community-based organizations, COGES members learned about their rights and responsibilities, including those related to transparent management of public resources and services as defined in the Guinean local government law (Code des Collectivités Locale). They learned how to conduct open meetings; how to plan and budget effectively; and how government and civil society can work together to mobilize and manage resources that support common priorities, including improved health services. The COGES members also learned financial management techniques; the treasurer now takes part in the center's bank transactions. Members can now ensure that health product prices are posted and charged consistently.

In 2011, a Faisons Ensemble project inspection of champion local governments supported by USAID revealed that Dinguiraye is one of 58 community health centers that publicly display service fees. This practice has resulted in an end to the practice of overcharging patients for drugs.

Case Study 3: Parliamentarians Push for Increased Investment in Family Planning in Ghana

Adapted and excerpted from: Ardayfio, Rosemary. "Parliamentarians Push for Increased Investment in Family Planning." *Daily Graphic*, Ghana. August 5, 2013.

In 2012, a Ghanaian delegation of parliamentarians committed to the Ghana Action Plan to help guide the country's progress toward achieving international commitments for reproductive health. In the Action Plan, delegates committed to working "towards mainstreaming reproductive health, including family planning, maternal health and child health activities," and building the capacity of relevant parliamentary committees and caucuses.

As part of the parliamentarians' efforts to be accountable for those commitments, in August 2013, members of the Parliamentary Committees on Health, Gender and Children, the Caucus on Population and Development, the National Population Council (NPC), and the Africa Regional Office of Partners in Population and Development held a meeting in Accra to discuss the progress made by the Ghana Action Plan.

In a presentation on the Action Plan's progress, Dr. Richard Anane, the Member of Parliament (MP) for Nhyiaeso, said the MPs had served as advocates among their own colleagues by advocating for increasing budgetary allocation for reproductive health, including family planning, making statements, public speeches, and pronouncements on the floor and outside of the Chamber of the House. "We have also supported the allocation and disbursement of funds for reproductive health, including family planning, and further collaborated with Ipas for greater liberalization of the abortion laws in Ghana." Further, according to Dr. Anane, as a result of these advocacy efforts, free maternal care and care for children are now available under the revised National Health Insurance Authority (NHIA) Act.

Dr. Anane stated that the MPs were working to get the government to allocate 0.5 percent of the health budget to family planning by 2014 and further explore the possibility of the government taking over funding for family planning. The MPs also called for other government stakeholders—the Ministry of Health, the Coalition of Health, and other NGOs—to develop an estimate of how much it will cost for Ghana to achieve its commitments.

In a presentation at the meeting, Professor Stephen Kwankye, Executive Director of the National Population Council (NPC), emphasized that the government needs to invest in family planning because "no country has come out of poverty without making family planning a national priority." He pointed out that family planning promotion in Ghana faced many challenges, including inadequate commitment and funding from the central government, not making the issue a priority in the national development agenda, and misconceptions about the side effects of family planning.

He urged the MPs to serve as ambassadors of family planning in their constituencies to increase uptake and suggested they learn more about integrating population variables into development planning to enable them to appreciate the relationship between family planning and economic development.

In her remarks, Minister of Social and Allied Agencies Mrs. Comfort Doyoe Cudjoe Ghansah congratulated the parliamentarians on their commitment to tracking the implementation of global and regional commitments on health, and demanding accountability from the government.

Case Study 4: Tracking Implementation of the Ghana School Feeding Program

Adapted from “International Budget Partnership.” 2015. Available at: <https://www.internationalbudget.org/wp-content/uploads/LP-case-study-SEND-one-page-summary.pdf>.

In March 2007, Ghana introduced a National Social Protection Strategy, which included the Ghana School Feeding Program (GSFP). The GSFP aimed to provide children in public primary schools and kindergartens in the poorest areas with one hot, nutritious meal per day, using locally grown foodstuffs.

The Social Enterprise Development Foundation (SEND-Ghana) used its participatory monitoring and evaluation framework to monitor the GSFP. It did so by working with ordinary citizens, who were organized into district citizen monitoring committees (DCMCs).

The first step SEND and its partners took was to sign a memorandum of understanding with the GSFP National Secretariat. The memorandum gave SEND and the DCMCs the task of independent monitoring of the GSFP at the schools in 50 target districts. SEND insisted on having a memorandum of understanding because it encouraged the official GSFP district structures to work with SEND and its network. The memorandum also helped to solve the problem of access to information. SEND signed memorandums with the main civil society organizations in the target areas, district assemblies, and DCMCs.

SEND's next steps followed the four phases of its participatory monitoring and evaluation framework. In the first phase, SEND and its partners educated their staff, DCMC members, and local staff members of government institutions on the school feeding policy.

For the second phase—participatory research—SEND trained the DCMCs on using the framework and tools for data collection and then analysis. District-based teams visited the beneficiary schools to see how GSFP was working. They also interviewed all relevant local government agencies. Their monitoring revealed a large number of weaknesses in how the GSFP was being implemented. One important weakness was a lack of understanding among all of the different actors about how the GSFP was meant to work. After analyzing the data, the DCMC members validated the data with the executive committees of the district assemblies. This step was important because the district assemblies receive the program funding for their districts.

The third phase—policy advocacy—involved presenting the findings of the participatory research to the schools, traditional authorities, and other leaders at the community level, and subsequently at higher levels. At the local-level presentations, district and regional government officials described the challenges they faced. Their comments strengthened SEND's case. For the national level, the two national reports SEND produced were especially important.

After the release of SEND's first report, the government changed the leadership of the GSFP and established a review committee to investigate the problems uncovered by SEND's monitoring. The government also co-hosted a National Policy Dialogue on the GSFP with SEND.

In the fourth phase, SEND and its partners followed up to track whether the agreements reached in policy dialogues at the district, regional, and national levels were being implemented.

Overall, SEND's biggest contribution was at the district and regional levels. GSFP implementing structures that had previously been inactive started to meet regularly and perform proper monitoring. Their monitoring resulted in real changes, such as use of a water tanker to bring clean water to schools and a decision to purchase 80 percent of the food for GSFP from local farmers. More districts also began allocating budgets for GSFP instead of relying only on the national government.

Case Study 5: Information Is Power: Experimental Evidence of the Long-run Impact of Community-based Monitoring

Adapted from Nyqvist, M.B., D. de Walque, and J. Svensson. 2014. "Information Is Power: Experimental Evidence on the Long-run Impact of Community-based Monitoring." Impact Evaluation series Policy Research Working Paper no. WPS 7015. Washington, DC: World Bank Group.

Three researchers set out to determine whether health service end user participation can improve health outcomes in Uganda. To do so, they designed two interventions that were implemented through a randomized control trial across 75 rural communities in Uganda from 2004–2008. The interventions included (1) a participation intervention and (2) a participation and information intervention. Both interventions were implemented at the facility/community level.

The participation intervention involved holding three different types of meetings—one with community members, one with the health facility, and one with both. The objectives of each meeting were "to encourage community members and health facility staff to develop a shared view on how to improve service delivery and monitor health provision in the community." The community and health facility meetings included focus group discussions, community score cards, and role plays, during which they identified and prioritized key problems and issues at the health facility level. In the meeting with both the community and health facility, representatives from each group presented and discussed their suggestions and, through facilitation, agreed on priority issues to be addressed. The participants then developed an action plan that outlined "the community's and providers' joint agreement on what needs to be done to improve healthcare delivery, how, when, and by whom... After the meetings, the communities themselves had the responsibility to monitor the implementation of the issues outlined in the joint action plan."

The participation and information intervention mirrored the process described above and also "provided the participants with quantitative data on the performance of the health provider," which had been collected from previous facility and household surveys. Each facility had a report card that was used to compare its performance against other facilities.

The researchers looked at impacts on births and pregnancies because of their link to the quantity and quality of family planning and health education. They also looked at child mortality because of its links to the quality and quantity of a number of services that should be available at the facility level. Finally, they looked at the height and weight of children because of their use as a summary measure of health and nutrition since conception, and current nutrition and illness status.

The researchers found that the participation intervention did not result in improvements in health outcomes or healthcare usage. However, the participation and information intervention was associated with a reduction of 14 percent in the number of pregnancies and births, a reduction of 18.4 percentage points in under age-2 mortality, and a reduction of 13.7 percentage points in infant mortality. There were also improvements in children's weight, height, and healthcare utilization.

The researchers concluded that participation alone is not enough to improve health outcomes; information is a critical piece of the puzzle.

HANDOUT

Case Studies: Instructions

In your small group, do the following:

1. Each person should read the assigned case study.
2. As a group, discuss the case study and answer the following 5 questions:
 - a. What kind of accountability does this example address—programmatic, political/democratic, and/or financial?
 - b. What actors were involved?
 - c. What was the intervention?
 - d. Did the intervention improve accountability? Why or why not?
 - e. How did the intervention improve service delivery, quality, or another sector objective?
3. After discussing, write your group's responses to each question on a flipchart. Be sure to write legibly so that others can easily read your responses!
4. Identify someone in the group to be the presenter. In 5–7 minutes, the presenter should:
 - Summarize the case study to the large group
 - Present your group's responses to the 5 questions
 - Present any key points or interesting observations that emerged from your discussion
 - Respond to questions from the larger group

You are accountable to your colleagues to stay within the 5- to 7-minute timeframe for presentation and discussion of your case study!

HANDOUT

Case Studies: Suggested Answers and Discussion Points

Case Study 1: Health Program Tackles Underage Marriage in East Java

What kind of accountability does this example address? Programmatic, political/democratic, and/or financial?

- Programmatic. There was a lack of engagement with key community members, including youth, women role models, and teachers.

What actors were involved?

- Local NGOs, religious leaders, government agencies, school teachers, teenage ambassadors, women, project staff, and others. This case study provides an example of creating an invited space.

What was the intervention?

- Multistakeholder forum—it is an example of an invited space because government was involved.

Did the intervention improve accountability? Why or why not?

- The multistakeholder forum provided an opportunity for members of the community, who previously had no venue, to discuss sensitive topics, such as underage marriage. It gave these community members a voice on this particular issue, which they lacked previously.

How did the intervention have an impact on service delivery, quality, or another sector objective?

- The number of underage marriages in Bondowoso District fell from 50.9 percent to 43.3 percent.

Case Study 2: Transparency in Fees for Services and Products

What kind of accountability does this example address? Programmatic, political/democratic, and/or financial?

- Financial and programmatic accountability. Patients did not know what they were supposed to be paying for medications and services. Facility staff were taking advantage of this by demanding higher payments.

What actors were involved?

- Community health center clients, health facility staff, community health management committee.

What was the intervention?

- Posting of set fees at each health facility.

Did the intervention improve accountability? Why or why not?

- Yes. It made the fees clear to both health center staff and clients.

How did the intervention improve service delivery, quality, or another sector objective?

- It resulted in the reduction of out-of-pocket payments made by clients, which are often a barrier to health-seeking behavior if they are too high.

Case Study 3: Parliamentarians Push for Increased Investment in Family Planning

What kind of accountability does this example address? Programmatic, political/democratic, and/or financial?

- Political. This example is that of a political body (Parliament) using its political authority to hold the country accountable to its international commitments.

What actors were involved?

- Members of the Parliamentary Committees on Health, Gender and Children, the Caucus on Population and Development, the National Population Council, and the Africa Regional Office of Partners in Population and Development.

What was the intervention?

- Parliamentary alliances and meetings.

Did the intervention improve accountability? Why or why not?

- Yes. The parliamentarians were successful in developing action plans and advocating for budgetary allocations to hold the government accountable for its commitments.

How did the intervention improve service delivery, quality, or another sector objective?

- It improved allocation and disbursement of funds for reproductive health; however, based on the handout's contents, it is not entirely clear by how much the allocation increased.

Case Study 4: Tracking Implementation of the Ghana School Feeding Program

What kind of accountability does this example address? Programmatic, political/democratic, and/or financial?

- Financial and programmatic accountability. Ghana introduced a strategy that included a school feeding program. There was a need to track its implementation to ensure programmatic outcomes and appropriate use of resources.

What actors were involved?

- Civil society (SEND-Ghana and the DCMCs) and the Ghana School Feeding Program National Secretariat.

What was the intervention?

- A participatory monitoring and evaluation framework that had four phases: (1) education of staff by SEND and its partners, (2) participatory research, (3) policy advocacy, (4) follow-up on whether the agreements reached as a result of the policy advocacy were actually being implemented.

Did the intervention improve accountability? Why or why not?

- Yes. It improved communication between civil society and the government, increased transparency on implementation of the strategy, and provided a clear avenue for civil society to contribute to government efforts to monitor the program.

How did the intervention improve service delivery, quality, or another sector objective?

- It resulted in the Ghana School Feeding Program implementing structures meeting regularly and performing proper monitoring. The monitoring resulted in such changes as using a water tanker to bring clean water to schools and a decision to purchase most of the food for the program from local farmers; also, more districts began allocating funds for the program rather than just relying on funds from the national government.

Case Study 5: Information Is Power: Experimental Evidence of the Long-run Impact of Community-based Monitoring

What kind of accountability does this example address? Programmatic, political/democratic, and/or financial?

- Programmatic. This is another case in which there was a lack of engagement with community members—specifically, the users of health services in 75 rural Ugandan communities.

What actors were involved?

- Health service users and health facility staff.
- This case study is an example of creating an invited space.

What was the intervention?

- There were two: (1) a participation intervention, which included a series of meetings between community members and health facility staff; and (2) a participation and information intervention that held the same types of meeting, but also included the development and distribution of a report card that made key facility indicators public.

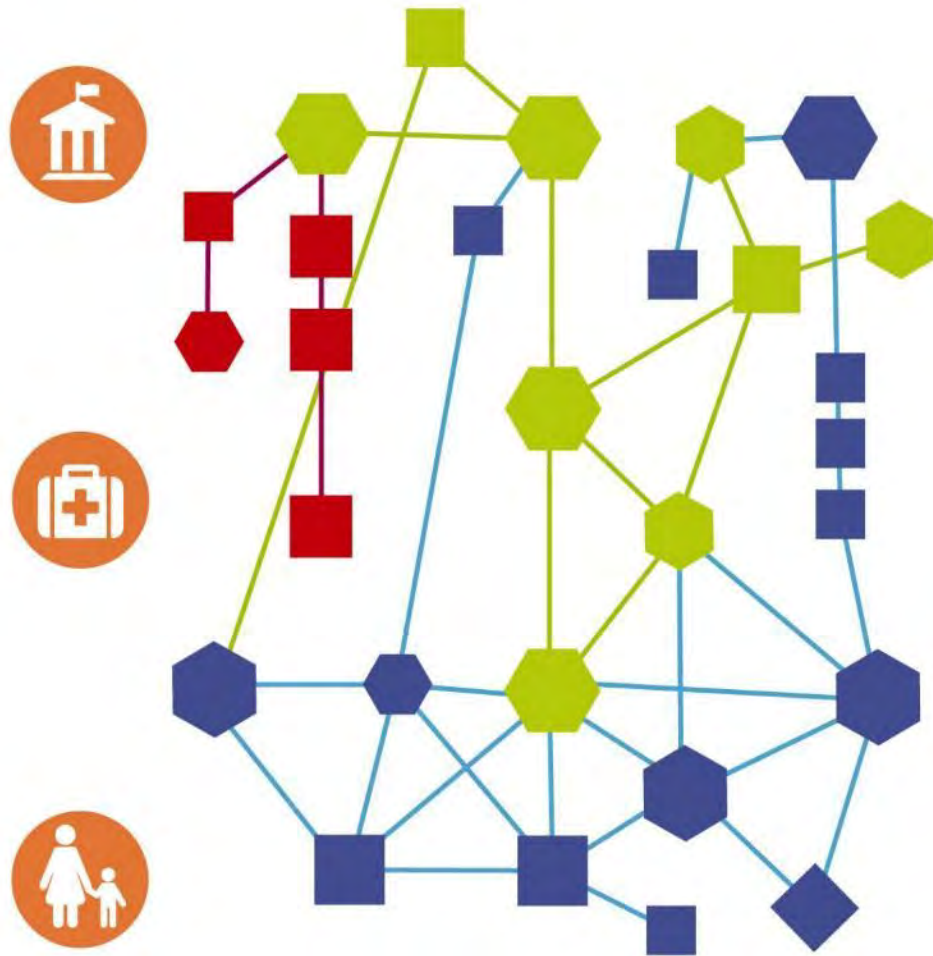
Did the intervention improve accountability? Why or why not?

- Yes. Both interventions improved participation, but only the participation and information intervention really improved knowledge about performance (or transparency).

How did the intervention improve service delivery, quality, or another sector objective?

- The participation intervention did not have any impacts on health outcomes. The participation and information intervention was associated with a reduction in pregnancies and births, a reduction in under age-2 and infant mortality, and an increase in healthcare utilization.

Module 2: Understanding and Mapping Accountability Relationships



Sessions

2.1 Prioritizing Accountability Issues

2.2 Mapping Accountability

Module 2 Overview

This module outlines a participatory process for visually mapping accountability relationships for a specific issue. In Session 2.1, *Prioritizing Accountability Issues*, participants brainstorm pressing family planning or other health issues in their country/state/district. They then use a set of suggested criteria to systematically select one issue to explore via accountability mapping. As a facilitator, you are free to use any method of prioritization, not just the process described in Session 2.1. However, it is critical to home in on a specific issue. As described in Brinkerhoff (2004) and Module 1, due to the complex nature of the health system, accountability actors and relationships can vary depending on the question at hand. Therefore, the more specific the issue, the more granular the accountability map. Examples of issues explored in past mapping exercises include the following:

- Accountability for quality family planning data capture and reporting
- Accountability for ensuring the presence of family planning line items in county health budgets (in the context of a decentralized health system)
- Accountability for ensuring that national standards for youth-friendly health service standards are implemented in health facilities

Note: If advocates have already selected an issue, skip Session 1.1 and start with Session 1.2.

In Session 2.2, *Mapping Accountability*, participants identify health system actors involved in ensuring accountability for the issue and describe relationships between actors using the three types of accountability discussed in Module 1 (financial, programmatic, political/democratic). This curriculum describes two alternatives for the mapping.

In the first alternative, participants brainstorm, organize, and describe relationships around financial accountability only, and then repeat the same process for **programmatic** and **political/democratic** accountability. The second alternative requires the use of a matrix and keen group facilitation skills because all three types of relationships are mapped through an evolving conversation. The mapping process is flexible and iterative, and different facilitators may have different approaches to organizing this activity.

If there is no plan to move forward with Module 3 and prepare for a participatory assessment of the key accountability relationships, this module completes the general accountability linkages skills-building portion of the curriculum. At the end of Session 2.2, facilitators will need to transition to the next steps per the respective program. If no specific program interventions are planned as a follow-up, before closing, facilitators should gather feedback on the learning that has occurred and explore how participants may apply it to various contexts in their own work.

Suggested Reading:

Brinkerhoff, D. 2004. "Accountability and Health Systems: Towards Conceptual Clarity and Policy Relevance." *Health Policy and Planning* 19(6): 371–379.

Session 2.1 Prioritizing Accountability Issues

Learning Objectives:	<ul style="list-style-type: none"> Identify key issues affecting family planning or health programming in a given context Prioritize one issue to explore through accountability mapping
Overall Time:	<ul style="list-style-type: none"> 1 hour and 15 minutes
PowerPoint and Handouts:	<ul style="list-style-type: none"> Handout: <i>Checklist for Choosing an Issue of Interest</i>
Other Materials:	<ul style="list-style-type: none"> Wall Grid: 4 x 5 matrix, with three selection criteria columns and the top three potential issues as rows Flipchart Markers/pens Small colored sticker dots or Post-It notes
Before you Begin:	<ul style="list-style-type: none"> Decide which of the two mapping alternatives to use for reaching consensus on the issue to focus future efforts on. Prepare the handout or, if you choose the second alternative, the wall grid. Print out one handout per participant; if using the matrix, put it on a board.

- **Start** the session by reviewing the learning objectives.

Activity: Brainstorming Issues

Time: 30 minutes

- **Introduce** the module by telling participants they will soon explore how to improve accountability within the health system through an exercise called accountability mapping. However, to create a map of accountability, we must identify a goal, problem, or issue of focus. In other words, we need to specify: **accountability for what?**
- **Turn** to a clean sheet of paper at the flipchart. Ask participants to brainstorm a list of family planning commitments at the national/state/county or other levels, or goals that they feel require attention in terms of accountability. What are some of the issues or barriers to reaching commitments?
 - If you have kept a “parking lot” of questions or issues that came up during the workshop, allow participants to pull issues from here.
- **Once** you have a healthy list of issues, read each one out loud. Facilitate the discussion until you have a core list of issues/problems that the group agrees on. Guiding questions might include the following:
 - *What barriers exist to achieving family planning goals and/or achieving commitments?*
 - *Are there other issues or problems not listed here?*
 - *Are there repetitions or similar issues on this list that can be consolidated?*
- **Explain** to participants that there are many ways to prioritize issues. For the purposes of this workshop, the group will agree on the top three issues and rank them against specific criteria to select one accountability issue.

- **Ask** the group to look at the list and then facilitate a discussion to help participants reach consensus on the top three issues. If a consensus cannot be reached, ask them to vote for their top choice and use the three issues that garnered the most votes.

Activity: Prioritizing Issues

Time: 45 minutes

- **Distribute** the handout *Checklist for Choosing an Issue of Interest*. As you do, read the criteria aloud (or ask for a participant to do so).
- **Generate** discussion around the criteria (noted below) to ensure understanding.
 - **Importance:** *How important is it to solve this issue?*
 - **Feasibility:** *How feasible is it (politically/financially/socially) for this group to address this issue?*
 - **Relevance:** *How relevant is this issue to the participants and the context?*
 - **Opportunity:** *Does this issue present opportunities to leverage current work or connections of participants?*
 - **Urgency:** *How urgent is it to solve this issue?*
 - **Reach:** *Is this an issue that affects stakeholders at all levels of the health system?*
- **Explain** that we will use these criteria to prioritize among the top 3 issues from the list they have generated.
 - For each criterion (noted in the columns) participants should work in groups to rank the issues from 1 to 3, with 1 indicating the lowest score/level for the criterion and 3 indicating the highest score.
 - **When** they are finished, they should total their scores for each issue (i.e., total for each row) and identify the issue with the highest score.
- **Break** up the larger group into smaller ones, with no more than 6 participants per group. Tell them that they will have 30 minutes to discuss and rank the issues.
- **Before** beginning, ask each group to choose a recorder and a reporter. At the end of 30 minutes, each group's reporter should be ready to present on the following points:
 - The top-ranked issue
 - Key moments in the discussion that weighed into selecting the issue
 - The key criteria that made it their top-ranked issue
 - Their assessment as to whether the scoring reflects their actual preferences—ascertain whether they really want to work on this issue
- **Begin** the activity. Give participants 10-, 5-, and 1-minute warnings.
- **After** 30 minutes, ask the reporter for each group to present on the points cited above.
- **After** all groups have presented, ask for their reflections on the process.
- **Facilitate** a discussion to reach consensus on **one issue**. (If consensus does not work, ask participants to vote.)

Facilitator’s Note: Consider the following process as an alternative for the prioritization activity, particularly if the group is smaller or if you have a sense of the issue the group will want to focus on. Based on the pilot workshops, this method is equally effective for reaching consensus on a priority issue. (Time for alternate prioritization process: 30 minutes)

- After the plenary group has agreed on the top 3 priority issues, **place** the prepared grid on the wall as shown below:

	Importance	Urgency	Feasibility	Reach	Total
List issue X here					
List issue Y here					
List issue Z here					

- **Give** each participant 3 sticker dots or Post-It notes.
- **Explain** that each participant will vote by placing one dot or Post-It in each column—that is, they should address these questions: Which issue is most important to solve? Which issue is most urgent to address? Which issue is most feasible for this group to influence in the current context?
- **Ask** participants to think for few minutes and, when ready, place their votes.
- **Tally** the number of “votes” for each issue and add to the grid.
- **Ask** the group if this method has resulted in an issue that actually matches their interest and if everyone can support it.

If so, it will be the issue selected. If not, **facilitate** a process of reaching consensus by asking participants to advocate to their colleagues for their favored issue.

- **Transition** to the accountability mapping exercise—and it’s a good time for an energizer!



Team prioritizes the issue for accountability linkages mapping.

HANDOUT**Checklist for Choosing an Issue of Interest**

Write the three issues your group has identified in the boxes on the left so that each issue has its own row. The selection criteria are listed in the columns. For each criterion, rank the issues from 1 to 3, with 1 indicating the lowest/least and 3 indicating highest/most. You can use a number only once for each criterion!

	Importance	Urgency	Feasibility	Relevance	Opportunity	Reach	TOTAL
	<i>How important is it to solve this issue?</i>	<i>How urgent is it to solve this issue?</i>	<i>How feasible is it (politically/ financially/socially) for this group to address this issue?</i>	<i>How relevant is this issue to the workshop aims and participants?</i>	<i>Does this issue present opportunities to leverage current connections or create new ones?</i>	<i>Is this an issue that affects stakeholders at all levels of the health system?</i>	
	1 = Least/not important 2 = Middle 3 = Most/very important	1 = Least/not urgent 2 = Middle 3 = Most/very urgent	1 = Least/not feasible 2 = Middle 3 = Most/very feasible	1 = Least/not relevant 2 = Middle 3 = Most/very relevant	1 = Least/no opportunities 2 = Middle 3 = Most/many opportunities	1 = Least/lowest reach 2 = Middle 3 = Most/ highest reach	
Issue 1							
Issue 2							
Issue 3							

Session 2.2

Mapping Accountability

Learning Objectives:	<ul style="list-style-type: none"> Identify health system actors involved in ensuring accountability for the selected issue Classify and define financial, programmatic, and political accountability relationships between actors
Overall Time:	2.5 hours
PowerPoint and Handouts:	None
Other Materials:	<ul style="list-style-type: none"> Flipchart Post-It notes of different colors Yarn (3 different colors) pre-cut in small (6 inches), medium (2 feet), and long (4 feet) pieces. Cut at least 5 of each size in each color Markers/pens A 5 x 5 foot piece of plain fabric or flipchart paper firmly applied to wall with masking tape
Before you Begin:	Discuss with the team in advance to confirm which of the methods presented here to facilitate the mapping exercise will work best for the group and the context. Weigh the pros and cons based on the background of the group, the time available, the level of participation, and expertise among the facilitators.

- **Start** the session by reviewing the learning objectives.

Activity: Brainstorming and Mapping Accountability Actors

Time: 1 hour and 30 minutes

- **Explain** that in the next session, participants will build on the work done earlier when brainstorming key family planning actors for the health governance triangle. Instead of sorting the actors into groups, participants are going to map out specific accountability relationships and mechanisms in place for their selected issue—that is, who is answerable to whom for what, and who can sanction or provide incentives to whom for what.
- **Describe** the brainstorming and mapping process:
 - First, the group is going to identify the actors involved in financial accountability for the priority issue and talk through the existing accountability links between them.
 - Next, participants will do the same thing for actors with programmatic accountability links to the issue.
 - Finally, participants will repeat the exercise for political accountability actors.
 - When all actors are on the board, we will continue to think through the entire system in greater depth. For example:
 - *Who are the powerholders?*

- *What does each actor provide the others?*
- Point out that the links between actors can involve more than one accountability relationship (e.g., a relationship can be both programmatic and financial).
- Also stress that this process is iterative and is meant to generate discussion. Actors can be removed/added as the discussion continues.
- **Before** beginning, ask participants to recall the definitions of financial, programmatic, and political accountability.
 - Ask someone to define/describe financial accountability. When finished, write the definition on a flipchart page.
 - Do the same for programmatic and political accountability.
 - When finished, make sure all three definitions are displayed in a place where they are visible to participants.
- **Distribute** one color of Post-It notes and ask participants to brainstorm all of the actors involved in **financial accountability** for their priority issue.
- **Ask** participants to think deeply about the selected issue and be sure to capture the names of at least **3 actors** who are absolutely critical for resource management of the issue. They should range from highest to lowest levels of fiscal responsibility within the system. **Ask** them to write one name or position per Post-It note.
 - Allow 10 minutes to brainstorm and write names on Post-Its.
 - After 10 minutes, ask volunteers to collect the notes and put them on the fabric or large flipchart in loose groupings of their choosing (e.g., national, state, local levels; or government providers, citizens, etc.—whichever categories they choose).
 - Read the names on the Post-Its aloud and talk through the actors on the board. Who is each actor financially accountable to, and why?

Facilitator's Note: *If participants name actors who are more programmatic than financial, you can remove those names and come back to them in the next round. Remind participants that we are focusing on financial accountability first.*

- As participants are talking, use one color of yarn to start laying out the financial accountability links between actors. (Alternatively, you can ask for two volunteers to map the linkages as you facilitate the discussion and help reach consensus among the group.)
- Make a legend on the fabric or large flipchart so participants remember what each color of yarn refers to.



Starting the mapping process.

- **Next, follow the same process for programmatic accountability linkages.**

- Pass out a second color of Post-It notes and ask participants to brainstorm all of the actors involved with programmatic accountability for the issue.
- Allow 5–10 minutes to brainstorm and write names on the Post-Its.
- After 10 minutes, ask volunteers to collect the notes and put them up on the fabric or large flipchart in loose groupings.
- Read the names on the Post-Its aloud and talk through the actors on the board, using the following guiding questions:
 - *Who is each actor programmatically accountable to, and why?*
 - *Are there any relationships between actors that are both programmatic and financial?*
- As you talk through the relationships, use a different color of yarn to indicate the programmatic accountability linkages between actors.
- Add this color of yarn to the legend.



Participants debate the linkages from national- to county-level actors.

Facilitator's Note: *As you work through the process, if the group is well informed and there are facilitators among them, ask for volunteers to continue the process so you can step aside to observe and offer clarifications as needed.*

- **Next, move to political/democratic accountability linkages.**

- Pass out a third color of Post-Its and ask participants to brainstorm all of the actors involved with political/democratic accountability for the issue.
- Allow 5–10 minutes to brainstorm and write names on Post-Its.
- After 10 minutes, ask volunteers to collect the notes and put them up on the board in loose groupings.
- Read the names on the Post-Its aloud and talk through the actors on the board, using the following guiding questions:
 - *Who are the new actors politically/democratically accountable to, and why?*
 - *Are there any accountability relationships that overlap (e.g., financial and political accountability)?*
- As you talk through the relationships, use a third color of yarn to indicate the political/democratic accountability linkages.
- Again, add this color of yarn to the legend.

Activity: Discussion about Accountability Relationships

Time: 1 hour

- **Facilitate** a large group discussion about the accountability linkages, using the following guiding questions:
 - *Are there any glaring omissions? Any actors that perhaps should not be there?*
 - *Are there offices/committees/subcommittees that have been inadvertently omitted? (Try to get as specific as possible.)*
 - *Do any patterns emerge (e.g., not many political accountability linkages, but a lot of programmatic and financial ones)?*
 - *Who are the existing powerholders? Who could be a powerholder but isn't?*
 - *Who have the powerholders made commitments to?*
 - *Are there specific relationships in which participants feel that answerability and enforceability are weak? Where? Why?*
 - *Taking a step back, what have we learned from this process?*
 - *Why did we do it? What were your "Ah-ha" moments?*
 - *How can you use this exercise in your work? Would you find it interesting to repeat this with other colleagues or stakeholders?*
- **Wrap up** the mapping activity and **congratulate** the team on their map. This is also an excellent moment for a team photo with their map. Have fun!



Women leaders from Kenya with their accountability map.

Identify a participant or colleague who can create a digital version of the map in Excel, PowerPoint, or other software so that it can be used in follow-up meetings or other opportunities to discuss accountability. If the group will do the participatory assessment, interviewers will use a printed version of the map to show the interviewees as part of their discussion.

At this point, for groups that will continue with a participatory assessment, close the accountability “training” sessions and transition to Module 3, *Examining Accountability Relationships to Identify Gaps and Opportunities*.

For those who will not continue with the participatory assessment, close the accountability “training” sessions and transition to the next step in the respective context.

In either case, the points to consider are as follows:

- **Mapping the relationships among and between actors in the health system by different types of accountability responsibilities can be used to advance an advocacy issue.** The map and discussion can make clear additional avenues for applying pressure on stakeholders around an issue. The process may elucidate target audiences that hold sway with decisionmakers but don’t emerge from a more traditional power mapping of support and influence, which advocates often do when creating an advocacy strategy.
- **Accountability relationships can be used to ensure policy implementation.** The process may highlight certain gaps in reporting structures or the lack of a transparent accountability mechanism that will require advocacy to bring to the attention of decisionmakers. Advocates may also realize they need to catalyze new forums for dissemination and discussion of policy promises. They may recognize the need to advocate to government to strengthen the capacity among stakeholders to better play their part in developing a well-functioning system for implementing and monitoring policy.

Module 3: Examining Accountability Relationships to Identify Gaps and Opportunities



Sessions

- 3.1 Selecting Critical Accountability Relationships
- 3.2 Preparing for Qualitative Data Collection
- 3.3 Preparing for Qualitative Data Analysis
- 3.4 Action Planning for Participatory Assessments and Follow-up

Module 3 Overview

The first two modules cover a process and materials to strengthen understanding around accountability and explore accountability relationships for a specified issue of interest. This module contains workshop sessions and accompanying materials to prepare workshop participants to conduct semi-structured interviews with actors to better understand the strength of critical accountability linkages uncovered through the accountability mapping exercise in Session 2.2. This includes facilitator guides for workshop sessions to prepare participants for conducting qualitative assessments, as well as templates for interview guides and action planning.

This module does NOT constitute a comprehensive training on how to conduct qualitative interviews. It presents basic information that will give all participants a sense of what the assessment and analysis will entail. Unless participants come to the workshop with experience in conducting qualitative assessments, they will likely need ongoing support throughout all stages of the assessment and analysis.

If doing the assessment after the workshop, be sure to follow the sponsoring organization's human research requirements as well as those of the target country, which may include submitting the assessment methodology to an institutional review board. Every organization and country has different review times and documentation requirements. Address this question as early as possible to avoid potential delays in implementation.

In Session 3.1, *Selecting Critical Accountability Relationships*, participants collectively identify and prioritize accountability relationships they want to explore further through the assessment that follows the workshop. This session presents several criteria to help with the selection process, including the budget available for the activity.

In Session 3.2, *Preparing for Qualitative Data Collection*, participants begin preparing for the accountability assessment. Facilitators will introduce the basic components of qualitative assessments. Participants will then use one of the identified accountability relationships to validate and tailor the interview guide. After tailoring the individual sections in the guide, each group will present/practice what they learned in the section to the group via a role play of the interview. The group will then discuss and further validate the interview guide.

In Session 3.3, *Preparing for Qualitative Data Analysis*, participants learn and practice some basics of analyzing information gathered from semi-structured interviews.

Finally, in Session 3.4, *Action Planning for Participatory Assessments and Follow-up*, participants determine how they want to carry out the assessment, subsequent analysis, presentation of findings to stakeholders, and who will be involved. The focus should be on who has the time, interest, availability, and relevant experience to support different stages of the assessment and analysis. The session also encourages thinking about where there are gaps in capacity so that participants can identify where they will need support to complete the activity.

Of the three modules, Session 3.4 is most heavily reliant on the context and the project/program's objectives. HP+ designed and has used the process and materials presented here based on its activity objectives; they are suited for participants with some experience in qualitative research or assessment. The qualitative assessment components of this module are not comprehensive enough to prepare people who are new to qualitative methods to conduct the assessment and analysis without support. The purpose of the qualitative methods

components is to orient the participants to the process and build ownership of it. In the HP+ activity, after the workshops, the project supported the participants in completing the assessments using local expertise and technical assistance.

Also, the interview guide presented here is meant to serve as a template for users to adapt to specific contexts. Note that after they completed the interviews, those who actually conducted them said that even though they revised the template significantly after the workshop, they would have shortened and simplified the language even further.

Suggested Reading:

Bovens, M. 2007. "Analysing and Assessing Accountability: A Conceptual Framework." *European Law Journal* 13: 447–468.

Save the Children. "Session 6: Methods of Data Collection and Analysis. Monitoring, Evaluation, Accountability and Learning (MEAL) introductory course." Available at Open University: <http://www.open.edu/openlearnworks/course/view.php?id=1641>.

Taylor, C., and G.R. Gibbs. 2010. "What Is Qualitative Data Analysis (QDA)?" Online QDA website. Available at: http://onlineqda.hud.ac.uk/Intro_QDA/what_is_qda.php.

Session 3.1 Selecting Critical Accountability Relationships

Learning Objectives:	<ul style="list-style-type: none"> Identify critical relationships with the most influence on the family planning issue
Overall Time:	1 hour
PowerPoint and Handouts:	None
Other Materials:	<ul style="list-style-type: none"> Accountability map created in previous session Flipchart Masking tape Colored markers
Before you Begin:	The facilitation team, and a local governance specialist if available, should review the accountability linkages map carefully and identify any gaps or feedback to share with the group. In addition, based on its own knowledge of the context, the team should identify which accountability relationships are crucial and why so they can help participants if needed. Finally, the team should review the map and potential interviewees in view of the technical and financial support they can provide so the participants consider that support as part of their decision making.

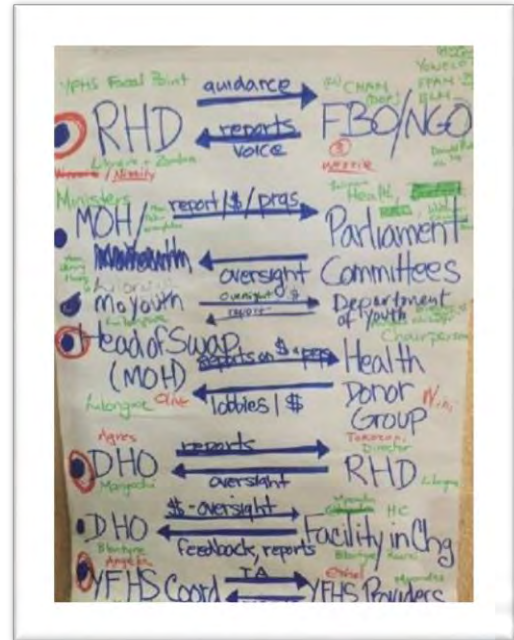
- **Start** the session by reviewing the learning objectives.

Activity: Identifying and Prioritizing Accountability Relationships

Time: 1 hour

- **Explain** that now that they have a working accountability map for the selected issue, participants are going to prioritize and select the most critical relationships between stakeholders—key pairs of stakeholders—to explore through a qualitative assessment.
- **Refer** to the accountability map. Point out some of the key relationships the participants identified in the previous session, reviewing who is accountable to whom and for what. Also keep in mind the available funding to conduct and complete the analysis. Such funding will have an impact on how many interviews the participants can conduct, where the interviews can take place, and so on.
- **Explain** that participants will decide how to prioritize and select the pairs /relationships for the assessment. Suggested criteria can include the following:
 - Clarity of accountability role
 - Likelihood of being able to schedule interviews with key actors
 - Ability to travel to location where actors are based, if necessary
 - Ability to get honest interviews
 - Importance in accountability for family planning

- High level of curiosity about the accountability relationship between two actors
- Anticipated feasibility of potentially working with actors on improving accountability for family planning
- Once criteria are established, **facilitate** a discussion around how many pairs/relationships can be explored, and which of the pairs the participants will include in their assessment following the workshop.
- On the flipchart, **write** the names of the offices/individuals in each pair/relationship selected by participants.



Prioritizing key relationships for interviews.

Session 3.2 Preparing for Qualitative Data Collection

Learning Objectives:	<ul style="list-style-type: none"> • Understand the basic concepts of qualitative assessments • Describe the principles of effective interviewing • Review and tailor a structured template to guide interviews for assessing accountability linkages between two actors • Draw lessons learned from practicing semi-structured interviews
Overall Time:	3.5 hours
PowerPoint and Handouts:	<ul style="list-style-type: none"> • Handout: <i>Template: Semi-Structured Interview Guide</i> • Handout: <i>A Sample Semi-Structured Interview Guide</i> (completed by past workshop participants) • Handout: <i>Characteristics of Effective Qualitative Interviewers</i>
Before you Begin:	<ul style="list-style-type: none"> • Well before the workshop, confirm potential institutional review board requirements. Be prepared to discuss these requirements during this session. • At least one day before delivering this session, preload flash drives with illustrative draft interview guide or send to participants via email • Laptops—The day before, ask participants to bring their laptops with them • Load YouTube video “The Research Interview.” Available at: https://www.youtube.com/watch?v=9t-hYjAKww . • Prepare flipchart with 2 headings: “Qualitative” and “Quantitative”

- **Start** the session by reviewing the learning objectives.

Facilitated Presentation: The Qualitative Approach

15 minutes

- **Explain** that, having identified the accountability pairs/relationships they believe are crucial to addressing the priority issue, the participants will begin preparing to conduct a qualitative assessment of these relationships. By examining key relationships with an accountability lens, the assessment aims to provide insight into various gaps, opportunities, and suggestions for improving accountability.
- **Say** that we will start by reviewing the two main approaches to research.
- **Ask** whether anyone knows what these two approaches are (hint: qualitative and quantitative research).
- **Uncover** the prepared flipchart and ask participants to share differences between the two approaches.
- **Write** their responses in the appropriate column, using the table below as a guide:

- If participants run out of ideas, ask questions to draw out the most important information below. For example:
 - What are some reasons you might use one method over the other? How would your study goals differ?
 - What are some examples of the types of data collected for each method?
 - What are some benefits or limitations of each method?

	Qualitative Research	Quantitative Research
Type of knowledge	Subjective	Objective
Aim	Exploratory and observational	Generalizable and testing
Characteristics	Flexible Contextual portrayal Dynamic, continuous view of change	Fixed and controlled Independent and dependent variables Pre- and post-measurement of change
Sampling	Purposeful	Random
Data collection	Semi-structured or unstructured	Structured
Nature of data	Narratives, quotations, descriptions	Numbers, statistics
Analysis	Thematic	Statistical

*Source: Save the Children. "Session 6: Methods of Data Collection and Analysis. Monitoring, Evaluation, Accountability and Learning (MEAL) Introductory Course." Available at Open University: <http://www.open.edu/openlearnworks/course/view.php?id=1641>.

- **Summarize** the major benefits of each approach.
- **Ask** participants which approach might be most appropriate for exploring the nature of the accountability relationships and for identifying gaps, opportunities, and suggestions (qualitative). Why?
- **Ask** participants how to collect this kind of information. If participants are reluctant to answer, prompts can include interviews, surveys, questionnaires, and observations. Explain that there is a particular type of tool called a "semi-structured interview guide."
- **Ask** if anyone can describe what is meant by a semi-structured interview guide. Some questions to help guide this discussion might include the following:
 - *How does a semi-structured interview guide differ from a survey or questionnaire?*
 - *How does it differ from a structured interview guide?*
 - *Has anyone had experience in conducting semi-structured interviews? If so, what was your experience?*
- **Transition** to the next activity: review and begin tailoring an interview guide for the assessment.

Activity: Tailoring a Semi-Structured Interview Guide to the Context and IssueTime: 1 hour 45 minutes

- **Introduce** this activity by sharing the context for human subject research and what this type of information gathering requires. This discussion depends on what the sponsors/facilitators discovered before the workshop. Be sure to discuss what an institutional review board is, the purpose of institutional review board approval, and what is required (if anything) for this particular data collection process and content.
- **Explain** the different steps we will take to tailor the guides to the priority accountability pairs/relationships selected earlier.
 - We will review the interview guide template together for clarity.
 - Everyone will read the interview guide individually, noting any major changes to questions.
 - We will work in small teams to review and suggest changes to the questions.
 - As a large group, we will reach consensus on the changes and create a new version of the template.
 - We will work in groups to draft guides tailored for one priority pair.
 - Finally, participants will self-select one of the priority accountability pairs and tailor the templates further for that specific relationship.
- **Explain** that we will conclude the workshop with action planning to carry out the assessment, analyze findings, and share the results with stakeholders. Tailoring the template for each pair of interviewees is one of the first tasks.
- **Distribute** a copy of the handout *Template: Semi-Structured Interview Guide* to each participant.

Facilitator's Note: *If there is not enough time available to tailor the guides during the workshop, an alternative is to use the handout A Sample Semi-Structured Interview Guide (completed by past workshop participants) to practice the interviews as outlined in the next activity.*

- **Lead** a detailed review of the guide.
- **Explain** the background portion and the process for gaining support for the interviews. If possible, suggest that someone from the team speak with interviewees beforehand to sensitize them to the purpose of the interviews.
- **Highlight** the main sections:
 - Background information
 - Information sharing and dialogue
 - Sanctions and incentives
 - Conclusion
- **Explain** that the guide is designed to assess the components of answerability and enforceability within a given accountability relationship.
 - **Point out** that the “information sharing and dialogue” and “sanctions and incentives” categories refer back to the two components of accountability discussed in Module 1—answerability and enforceability. Specifically, questions about information sharing

- and dialogue aim to assess answerability within the relationship. Questions around consequences and incentives aim to assess enforceability within the relationship.
- **Note** that the introduction section ensures that the person being interviewed understands what the interview will cover.
 - **Note** that the conclusion section allows the interviewee an opportunity to share any additional thoughts or information.
 - **Ask** whether there are any questions about the template's main sections.
 - **Ask** participants to take 10 minutes to read through the questions themselves. Before they begin reading, ask them to mark any questions as follows:
 - Those that are particularly important
 - Those that need to be clarified
 - Those that seem repetitive or unnecessary
 - Those that can/should be combined
 - Those that are missing and must be added
 - After everyone has finished, divide the larger group into smaller ones to discuss and reach consensus on the suggested changes.
 - **Ask** groups to be ready to share their initial discussion and consensus with other groups in 20 minutes.
 - **Bring** the participants back together to review each category of questions and agree on the suggested changes to them. As facilitator, keep the focus on the main types of changes desired (e.g., keep, clarify, delete, combine, or add), and help the group avoid wordsmithing each question.
 - During this discussion, a co-facilitator can **adapt** the questions, which now become the group's own template.
 - **Break** for 10 minutes while a facilitator quickly cleans up the soft copy of the template and emails it to participants.
 - **Explain** that the next step is to go through the process of tailoring the template for one pair of interviews, so that after the workshop we will know how to do this for each of the selected pairs.
 - **Ask** the group to select a priority pair/relationship from its list.
 - **Divide** the group into two groups and ask someone to type the changes they will make on a laptop.
 - **Explain** that one group will adapt/adjust the guide for one of the interviewees in the stakeholder pair. Half of the small group will tailor the questions in the first half of the template; the other half of the group will tailor the questions in the second half.



Groups work on tailoring the interview guide template.

- **Explain** that the second small group will adapt/adjust the guide for the other interviewee in the stakeholder pair. Again, half of the group will work on questions in the first half of the template and the other half of the group will tailor the questions in the second half of the template.
- **Ask** participants to check their email and open up the new template.
- Allow 20 minutes for the groups to tailor their respective sections for their assigned interviewee. Each group should designate one person who will be responsible for capturing all edits in a single soft copy.
- After 20 minutes, **ask** participants in each group to take an additional 10 minutes to review the suggested changes to the guide and reach consensus on what the final guide should look like. Again, each group should designate one person who will be responsible for capturing all edits in a single soft copy.
- **Bring** everyone back together and ask each group to report on how they tailored the questions for their respective interviewees.
- **Identify** any additional revisions to be made, based on the large group discussion.
- **Wrap** up the session by explaining that toward the end of the workshop, the participants will organize themselves into 3 teams and create action plans to (1) finalize the interview tools and plan for and conduct the interviews/assessment, (2) plan for and complete the analysis of the interview results, and (3) plan for a stakeholder meeting to validate and disseminate the assessment findings.
- **Thank** everyone and transition to the next activity on practicing interviewing skills.
- **Warning!** A co-facilitator should quickly gather and consolidate the revisions for the two interview guides and print copies of the tailored guides (they won't be perfect!) for participants to use in the latter half of the next activity.

Activity: Practice Conducting Semi-Structured Interviews

Time: 1 hour 30 minutes

- **Explain** that now that participants have had a chance to start tailoring the interview guides, they will practice the interviews through role plays.
- **Ask** who has had experience in conducting qualitative interviews or key informant interviews?
 - If so, what was your experience? Probe for lessons learned, highlights, and so on.
- **Turn** to the flipchart and ask participants to brainstorm: What are characteristics of a good interview or good interviewer? Record responses on the flipchart.
- **Distribute** handout *Characteristics of Effective Qualitative Interviewers*. Read through the keywords and see how they compare with the words on the flipchart.
- **Explain** that you are going to show a video that describes these characteristics in greater detail. Start the video at the following link from the beginning: <https://www.youtube.com/watch?v=9t-hYjAKww>.
- **Stop** the video just before the narrator introduces the first interview (timestamp 3:45). Ask participants to take notes on how the interview can be improved.
- **Play** the video of Interview 1.
- **Stop** the video after Interview 1 (time 8:06). Divide larger group into groups of six or fewer. Explain that over the next 10 minutes, they should compare notes and compile a list of recommendations for the interviewer.
 - **Give** 5- and 1-minute warnings to wrap up.
- **After 10 minutes**, ask each group to report out one by one. As they do, either you or a co-facilitator should write a master list of improvements on the flipchart. Ask the groups to share only new or different suggestions to avoid repetition.
- **Explain** that they are now going to hear from the narrator of the video on the points he felt could be improved. Ask participants to compare his list to theirs.
- **Play** the video through 7:45, then press pause.
- **Compare** to the participants' list.
 - Any differences?
 - Any additions?
- **Now** explain to the group that together you are going to practice interviewing the priority pair of interviewees using the guides the group has updated.
- **Ask** participants to work in pairs (ideally with someone they do not know well) and give each pair the tailored interview guides for the prior pair of stakeholders.
 - Ask the pairs to spend 10 minutes practicing the interview questions in Section 3—questions on **Background and Information Sharing** (questions 1 -5). For this first round, one of the pair will be the interviewer and the other will be the interviewee.
 - **Illustrate** the roles using one of the pairs.
 - **Ask** everyone to be as realistic as possible in their roles.

- **Start** the practice. Call time in 10 minutes.
- **Ask** them to switch interviewer and interviewee roles. This time, practicing Section 3—questions on **Feedback and Dialogue** (questions 6-9).
 - **Start** the practice. Call time in 10 minutes.
 - **Ask** for any observations or reactions to practicing.
- **Ask** if anyone took notes while they practiced their interview. Explain that we will now add that element.
- **Choose**/invite one pair to do a role play for the rest of the group, practicing Section 3—questions on **Sanctions and Incentives** (questions 10-16).
- **Turn** to the group and let them know that they will have different responsibilities.
 - One half of the room will observe for good interviewing techniques.
 - The other half of the room will take notes on the responses. They should try to be as accurate as possible when recording the responses and capture as much information as possible.



Pairs practice interviewing skills.

Facilitator's Note: *A co-facilitator should covertly record the role play and take typed notes. As the group debriefs, the co-facilitator should move to a separate room and try to produce transcript-ready notes for at least a portion of the interview. These notes will be used during the qualitative session to demonstrate the value of recording and transcribing vs. handwritten notes.*

- **Ensure** that the roles are clear.
- **Start** the role play. Call time in 10 minutes.
- **Thank** the pair and ask them to rejoin the group as themselves.
- **Debrief** first on the interviewing skills
 - **Ask the interviewer/interviewee** for their impressions. Was anything more difficult than expected? Was anything easier than expected? What do they think they did well? What could they do better?
 - Next, **ask the participants in the half of the room that was observing:** What do they think went well? What do they feel could be done better?
- Now **debrief those in the other half of the room.** Ask participants how difficult it was to capture the responses.
 - **Explain** that we will use the notes they took in the next session, so please keep them.
- **Wrap up** the session by summarizing interviewing tips and tricks.
- **Ask** the participants who have had experience in conducting interviews to share any additional suggestions. Key points to draw out include the following:

- Sensitize your interviewees to the purpose of the interview. Make sure they understand what you will be asking about, and why.
- Schedule an hour for each interview.
- Assume that some interviewees will not be able to spare a full hour. In advance of the interview, identify which questions are most important to ask. Be prepared to think on your feet!
- Allow for travel time (and traffic jams) to get to appointments. Also, prepare to wait for some interviewees, even if you have made an appointment.
- Make sure to have accurate phone, email, and physical addresses for each appointment.
- Clarify roles and responsibilities of the interviewers—nominate a lead interviewer and a lead note-taker. Switch roles in later interviews to build experience and confidence.
- Allow time after your interviews to discuss them and document highlights.
- Have a method to record the interview. Make sure to get the interviewee's consent to record. If possible, get that consent when you first make the appointment so if the person does not want to be recorded, you can plan to do the interview only when you have a designated note-taker available to go with you.
- **Thank** everyone and transition to the **Qualitative Analysis** session: Now that the group has thought through the data to be collected, the participants will consider how best to analyze the responses.

HANDOUT

Template: Semi-Structured Interview Guide

Section 1: Suggested Instructions for Interviewer

Introduction

This questionnaire was designed to guide semi-structured interviews exploring accountability relationships for the following priority issue:

Interview Goals

The semi-structured interviews have the following goals:

- To identify gaps and opportunities for strengthening the above issue
- To learn about a specific *health system actor* and that actor's role in ensuring accountability for the priority issue
- To learn about the *accountability relationship* between this actor and the actor's counterpart for the priority issue. Specifically, you will explore:
 - The type and quality of information sharing, communication, and dialogue between actors
 - The sanctions (penalty or negative actions) and incentives facing the actor
 - Any challenges or capacity gaps that act as barriers in fulfilling relationship roles
 - Any opportunities or suggestions to address these challenges

Interview Preparation

Before conducting each interview, please undertake the following preparation:

1. First, review the interview guide and the accountability map for the priority issue from the workshop. Remind yourself how the interviewee is situated within the health system, the organizations/actors with whom the interviewee is linked, and the specific accountability relationship you are exploring.
 - Indicate the *health system actor* you will interview:

 - Indicate the *accountability relationship* you will explore:

2. Second, draw upon your experience, networks, and outside research to prepare for the interview. Ensure that you have a firm understanding of the following:

- The interviewee's role and responsibilities related to ensuring the priority issue (describe below):

The role of the second actor in the accountability relationship in ensuring the priority issue (describe below):

3. **Third**, thinking about the accountability relationship and the respective roles you've outlined above, tailor the interview guide for the health system actor you are about to interview. To do this, you must determine whether the actor should or could do the following:

- **Apply** sanctions/incentives to the other actor
- **Respond to** sanctions/incentives applied by the other actor
- **Both apply and respond** to sanctions/incentives in this relationship

Section 2: Suggested Interviewee Consent

Introduction

Good morning/afternoon. Thank you for speaking with me/us. My name is [name] and I am here on behalf of [group/organization]. We are conducting an assessment to gain a better understanding of how to improve [priority issue].

More specifically, we are interested in how stakeholders in the health system work together to ensure accountability for [priority issue]. We would like you to think of the health system as a whole, in which various actors (people/institutions/organizations) work together to plan, implement, and monitor programming for [priority issue].

We are interested in better understanding the relationships between different actors. We are not interested in who is or isn't fulfilling duties or roles, and we are not conducting a performance audit. The objective is to gain an understanding of the following:

- What is working well in terms of information sharing and dialogue on progress toward a goal or commitment
- What could be improved in these areas
- What types of sanctions and incentives are in place to ensure this progress
- Whether these mechanisms are effective or could be improved

For this interview, I would like to focus on your [actor] relationship with [corresponding actor] with regard to ensuring [priority issue].

Consent

This interview should take about 45–60 minutes. This is not a formal research study—it is an assessment. However, before we begin, we would like to assure you that we will safeguard the identities of everyone we speak with. This will be done by [explain safeguards, e.g., if we reference your statements in any documentation, the source will be cited as a general descriptor such as: *respondent*; *healthcare provider*; or *national leader*]. If you do not wish to answer a question, you are welcome to skip it.

We would also like to record the interview so we can ensure we do not miss any valuable points. Any recordings will be safeguarded by [explain safeguards, e.g., recordings will be kept on a password-protected computer]. If you do not wish to be recorded, we will document our conversation through written notes.

If you have any concerns about the interview process or about your statements being kept in strict confidence, please contact [name and contact info].

I now ask for your consent so that we can start the interview.

Verbal consent provided to participate. Check: Yes No: **If No, do not continue**

Are you willing to be recorded for data analysis purposes only? Check: Yes No

For the records, indicate the following:

Interview ID: _____

Date of interview: _____

Time started: _____

Time ended: _____

Name of Interviewer(s): _____

Name of note-taker (if applicable): _____

Name of transcriber (if applicable): _____

Section 3: Assessment Questions

Background information

1. To start, can you please confirm your title and position here at [actor's organization]?
2. In a few words, how would you summarize the way [actor/actor's organization and corresponding actor/organization] work together in regard to [priority issue]? (**Probe:** *roles in the relationship; who provides what to whom*)

Information sharing and dialogue

In any relationship in a health system, information is passed from one actor to another actor. I'd like to learn more about how information on progress toward [priority issue] is shared, reported, and discussed between [actor/actor's organization] and [corresponding actor/organization].

3. From your response about how your organizations work together, it sounds as though the following is true:
 - Summarize who **provides** information to whom [type, frequency, format]
 - Summarize who **receives** information from whom [type, frequency, format]

Ask: Is there anything you would like to add or clarify about how your organizations share information, either formally or informally?
4. Has providing this information been helpful to [actor/actor's organization] in working toward [priority issue]? (**Probe:** *If yes, please provide an example and/or details on how information has been used.*)
5. Has receiving this information been helpful to [your organization] in working toward [priority issue]? (**Probe:** *If yes, details on how information has been used.*)
6. Are there any opportunities for feedback and/or dialogue between your [actor/actor's organization] and [corresponding actor/organization] regarding shared information? (**Probe:** *type, frequency, format; e.g., working meetings, forums, informal discussions*)
7. If yes, can you give an example of a time when feedback or dialogue on the information shared between [actor/ actor's organization] and [corresponding actor/organization] helped you in your work toward [priority issue]? (**Probe:** *details on mechanism; how was it helpful?*)

8. Does [your organization] face challenges when sharing information or engaging in feedback and/or dialogue with [Organization B]? (**Probe:** *If so, what are they? Do they affect information sharing, feedback, and/or dialogue? Can you please provide an example? Probe on the following topics:*)
- Time, cost, capacity (i.e., technical staff, equipment)
 - Organizational relationships/connections
 - Other organizations/stakeholders or aspects of the health system
9. Thinking of those challenges, how do you think information sharing and dialogue with [corresponding actor/organization] on progress toward [priority issue] could be improved? (**Probe:** *improvements by [your organization], improvements by [Organization B], improvements by other organizations/stakeholders, improvements to health system*)

Sanctions and Incentives

Now we would like to discuss the incentives or sanctions that exist to ensure that everyone works together to achieve [priority issue].

10. First, let's talk about incentives. Does [corresponding actor/ organization] provide incentives for [actor/actor's organization] to ensure progress toward achieving [priority issue]? (**Probe:** *If yes, how so? Can you give an example? How have you responded to these incentives in the past?*)
11. Does [actor/actor's organization] provide incentives for [corresponding actor/ organization] to ensure progress toward achieving [priority issue]? (**Probe: if yes, how so? Can you give an example? How have they responded to these incentives in the past? Probe: If no, why do you think so?**)
12. What happens when this progress doesn't occur? Does [corresponding actor/ organization] sanction [actor/actor's organization] in the case of a lack of performance regarding [priority issue]? (**Probe: If yes, how so? Can you give an example? How have you responded to this sanction in the past? Probe: If no, why do you think so?**)
13. Does [actor/actor's organization] sanction [corresponding actor/organization] in the case of a lack of performance regarding [priority issue? (**Probe: If yes, how so? Can you give an example? How have they responded to this sanction in the past? Probe: If no, why do you think so?**)

14. Does [actor/actor's organization] face challenges when responding to sanctions regarding [priority issue]? (**Probe: If yes, what kinds of challenges? Wait for respondent to answer and then ask for specific details. If not discussed, probe on the following topics:**)
- Time, cost, capacity (i.e., technical staff, equipment)
 - Organizational relationships/connections
 - Other organizations/stakeholders or aspects of the health system
- (Probe: If no, can you provide an example of when you/your organization responded positively to sanctions?)**
15. Does [actor/actor's organization] face challenges when responding to incentives regarding [priority issue]? (**Probe: If yes, what kinds of challenges? Wait for respondent to answer and then ask for specific details. If not discussed, probe on the following topics:**)
- a. Time, cost, capacity (i.e., technical staff, equipment)
 - b. Organizational relationships/connections
 - c. Other organizations/stakeholders or aspects of the health system
- (Probe: If no, can you provide an example of when your organization responded positively to incentives?)**
16. How do you think these challenges could be improved? (**Probe: improvements by [actor/actor's organization], improvements by [corresponding actor/organization], improvements by other organizations/stakeholders, improvements to health system)**

Conclusion

17. Do you think improving information sharing, feedback, dialogue, incentives, and sanctions, which we have discussed today, could help [country/state/district] to better achieve [priority issue]? Why or why not?
18. Are there any other concerns or suggestions you would like to offer?
19. Here is a draft map we have created that depicts the key stakeholders and linkages relating to accountability for achieving [priority issue]. (*Explain what the different arrows depict.*)
- a. Do you agree with how your organization is situated on this map?
 - b. Are there other organizations that you would add to this accountability map, particularly those with whom you work?

20. Would you and [actor/actor's organization] be willing to work with us and other stakeholders to strengthen joint accountability for meeting [priority issue]?

Section 4: Interviewer Notes

After the interview is complete (or after a day of multiple interviews), review the notes/recordings and write out a summary of key points. You should also document any impressions, observations, or unique circumstances that may be important for data analysis.

It is important to do this review while the interview is fresh in your mind. The more time passes, the more difficult it may be to recall important parts of the interview that didn't make it into your notes.

Finally, type up any handwritten notes or transcribe the recording if you made one. Pass along the transcript and your summary to the analysis team.

HANDOUT

A Sample Semi-Structured Interview Guide

Section 1: Instructions for Interviewer

Introduction

This questionnaire was designed to guide semi-structured interviews exploring accountability linkages between country-level actors for family planning in [Country]. It is meant to be used by women who have taken part in the Women's Leadership and Accountability for FP2020 Commitments workshop and have received training on how to use this questionnaire. *Note: NO beneficiaries may be interviewed as part of this assessment!*

Interview Goals

- Identify gaps and opportunities for strengthening family planning accountability in [Country].
- To learn about a specific *accountability actor* and their role in ensuring accountability for a priority family planning goal
- To learn about the *accountability relationship* between this actor and their counterpart, specifically:
 - The type and quality of information sharing, communication, and dialogue between actors
 - The sanctions, or penalty or negative actions, and incentives facing the actor
 - Any challenges or capacity gaps that act as barriers in fulfilling relationship roles
 - Any opportunities or suggestions to address these challenges

Interview Preparation

Before conducting each interview, please undertake the following preparation:

- First, review the interview guide and the accountability map for *data capture and reporting for family planning data* from the workshop. Remind yourself how the interviewee is situated within the health system, the organizations/actors with whom the interview is linked, and the specific accountability relationship you are exploring.
 - Indicate the *accountability actor* you will interview: health facility 3 (HF 3) in-charge
 - Indicate the *accountability relationship* you will explore: HF 3 & HF 4
- Second, drawing upon your experience, networks, and outside research, ensure that you have a firm understanding of the following:
 - HF 3's role in achieving improved *data capture and reporting for family planning data*
 - HF 4 in-charge's role in achieving improved *data capture and reporting for family planning data*

- **Third**, think about the actor you are about to interview, and determine whether it's appropriate to ask about how they apply sanctions and/or offer incentives, or appropriate to ask them about how to respond to sanctions/incentives.

Section 2: Interviewee Consent

Introduction

Good morning/afternoon. Thank you for speaking with me/us. My name is [name]. I am a member of a women's leadership network for family planning in [country] conducting an assessment to gain a better understanding of how [country] can best achieve the country's family planning goals or commitments.

More specifically, we are interested in how various family planning stakeholders work together to ensure that we succeed in achieving the commitments made at the London Summit in 2012, commonly referred to as the FP2020 commitments.

We would like you to think of the health system as a whole, where different organizations and institutions are connected to each other by partnering and working together during dissemination, implementation, and reporting.

We are interested in exploring the partnerships between actors in the health system in [country]. We are not interested in who is or isn't fulfilling duties or roles, and we are not conducting a performance audit. Our objective is to gain an understanding of:

- What is working well in terms of information sharing and dialogue on progress towards a goal or commitment
- What could be improved in these areas
- What types of sanctions and incentives are in place to ensure this progress
- Whether these mechanisms are effective or if/how they could be improved

For this interview, I would like to focus on your relationship with HF 4 in-charge with regard to ensuring *improved data capture and reporting for family planning data*.

Consent

This is not a formal research study. However, before we begin, I want to assure you that we will safeguard the identities of everyone we speak with. If we use any of your statements in any documentation, we will cite the source of the statement with a general descriptor such as: *respondent; healthcare provider; or national leader*. Your responses will be anonymous, so please speak freely.

If you do not wish to answer any question, you're welcome to skip it. If you have any concerns about the interview process or about your statements being kept in strict confidence, please contact (**Name and contact information**).

We will be recording the interview because we want to take the shortest time possible and we do not want to miss any of your valuable points.

This interview should take about 45–60 minutes.

I am kindly asking for your consent so that we can start the interview.

Verbal consent provided to participate Check: Yes No If "No," do not continue

Are you willing to be recorded for data analysis purposes only? Check: Yes No

Unique ID number of respondent: _____ (copy number on interview form)

Date of interview: _____

Time started: _____ Time ended: _____

Interviewer: _____

Note-taker/analyst: _____

Section 3: Assessment Questions

3.1 Background information

1. To start, can you please confirm your title and position here at [the health facility]?
2. In a few words, how would you summarize the way you (HF 3 in-charge) and HF 4 in-charge work together to ensure *data capture and reporting for family planning data*? (**Probe:** *roles in the relationship; who provides what to whom*)

3.2 Information sharing and dialogue

In any relationship in a health system, information is passed from one actor to the other actor. I'd like to learn more about how information on *data capture and reporting for family planning data* is shared, reported, and discussed between you (HF 3 in-charge) and the HF 4 in-charge.

3. From your response about how you work with the HF 4 in-charge, it sounds as though:
 - Summarize who **provides** information to whom [type, frequency, format]
 - Summarize who **receives** information from whom [type, frequency, format]

Ask: Is there anything you would like to add or clarify about how your organizations share information, either formally or informally?
4. Has providing this information been helpful to you (HF 3 in-charge) in working towards improved *data capture and reporting for family planning data*? (**Probe:** *If yes, please provide an example and/or details on how information was used.*)
5. Has receiving this information been helpful to HF 4 in-charge in working towards improved *data capture and reporting for family planning data*? (**Probe:** *If yes, details on how information was used.*)
6. Are there any opportunities for feedback and/or dialogue between you (HF 3 in-charge) and the HF 4 in-charge regarding information that is shared? (**Probe:** *type, frequency, format. For example: working meetings, forums, informal discussions*)
7. If yes, can you give an example of a time when feedback or dialogue on the information shared between you (HF 3 in-charge) and HF 4 in-charge helped you in your work towards improved *data capture and reporting for family planning data*? (**Probe:** *details on mechanism, how was it helpful?*)

8. Do you (HF 3 in-charge) face any challenges when sharing information or engaging in feedback and/or dialogue with HF 4 in-charge? (**Probe:** *If so, what are they? Do they affect information sharing, feedback, and/or dialogue? Can you please provide an example? Probe on the following topics:*)
 - Time, cost, capacity (i.e., technical staff, equipment)
 - Organizational relationships/connections
 - Other organizations/stakeholders or aspects of the health system

9. Thinking of those challenges, how do you think information sharing and dialogue with HF 4 in-charge on *data capture and reporting for family planning data* could be improved? (**Probe:** *improvements by you (HF 3 in-charge), improvements by HF 4 in-charge, improvements by other organizations/stakeholders, improvements to health system*)

Section 3.3 Sanctions and Incentives

Now I would like to discuss the incentives or sanctions that exist to ensure everyone works together to achieve improved *data capture and reporting for family planning data*.

10. First let's talk about incentives. Do you (HF 3 in-charge) provide incentives for HF 4 in-charge to ensure progress towards achieving improved *data capture and reporting for family planning data*? (**Probe: If yes:** *how so? Can you give an example? How have you responded to this in past? Probe: If no:* *why do you think this is?*)

11. What happens when there is no progress on performance? Do you (HF 3 in-charge) sanction HF 4 in-charge in the case of lack of performance with *data capture and reporting for family planning data*? (**Probe: If yes:** *how so? Can you give an example? How have you responded to this in past? Probe: If no:* *why do you think this is?*)

12. Do you (HF 3 in-charge) question and follow up with the HF 4 in-charge in case of lack of performance with *data capture and reporting for family planning data*? (**Probe: If yes:** *how so? Can you give an example? How have they responded to this in past? Probe: If no:* *why do you think this is?*)

13. Do you (HF 3 in-charge) face challenges when responding to sanctions regarding *data capture and reporting for family planning data*? (**Probe: If yes:** *what kinds of challenges? Wait for respondent to answer and then ask for specific details. If not discussed, probe on the following topics:*)
 - Time, cost, capacity (i.e., technical staff, equipment)
 - Organizational relationships/connections
 - Other organizations/stakeholders or aspects of the health system

Probe: If no: can you provide an example of when your organization successfully responded to sanctions?)

14. Do you (HF 3 in-charge) face challenges when given/ provided with incentives regarding *data capture and reporting for family planning data*? (**Probe: If yes:** what kinds of challenges? Wait for respondent to answer, and then ask for specific details. If not discussed, **probe** on the following topics):

- a. Time, cost, capacity (i.e., technical staff, equipment)
- b. Organizational relationships/connections
- c. Other organizations/stakeholders or aspects of the health system

Probe: If no: can you provide an example of when your organization successfully responded to incentives?)

15. How do you think these challenges could be addressed? (**Probe:** improvements by HF 3 in-charge, improvements by HF 4 in-charge, improvements by other organizations/stakeholders, improvements to health system)

Section 3.4 Conclusion

16. Do you think improving information sharing, feedback, dialogue, incentives, and sanctions, which we have discussed today, could help the country to better achieve improved *data capture and reporting for family planning data*? Why or why not?

17. Are there any other concerns or suggestions that you would like to offer?

18. Here is a draft map (*share the picture*) we created depicting the key stakeholders and linkages relating to accountability for *data capture and reporting for family planning data*. (*Explain what the different arrows depict.*)

- a. Do you agree with how you are situated in this map?

- b. Are there other organizations that you would add to this accountability map, particularly those with whom you work?

19. Would you be willing to work with us and other stakeholders to strengthen joint accountability for family planning?

HANDOUT

Characteristics of Effective Qualitative Interviewers

Knowledgeable

- Knows the interview questions and the subject matter
- Takes time to practice in advance

Provides Structure

- Uses a clear conversational structure, including an opening to explain the purpose and a conclusion to round out the conversation (e.g., *Is there anything you would like to add?*)

Clear

- Asks simple and short questions
- Does not read directly from the interview guide
- Does not use shorthand or jargon

Gentle

- Tolerates pauses to allow the interviewee time to think
- Does not interrupt

Sensitive

- Listens attentively
- Empathizes with the interviewee

Open

- Remains flexible in the way s/he asks the questions
- Responds to any issues raised by the interviewee
- Senses and allows time for issues important to the interviewee

In charge

- Controls the interview, uses probing and prompts to get the information, and is prepared to clarify inconsistencies or ambiguities in the interviewee's answers

Remembers

- Recalls what the interviewee has said already
- Relates the current topic back to points made previously
- Avoids asking questions already answered (requires knowledge of interview guide!)

Interprets

- Clarifies the meaning of what the interviewee has said by summarizing a response

Balanced

- Should not talk too much, which can make the interviewee take on a passive role
- Should not talk too little, which can make the interviewee feel s/he is not being heard

Ethically sensitive

- Remains sensitive to the ethical elements of the interview by ensuring the interviewee knows how responses will be reported/attributed

Session 3.3 Preparing for Qualitative Data Analysis

Learning Objectives:	<ul style="list-style-type: none"> • Understand basic concepts of qualitative analysis • Practice coding and identifying themes from sample interview transcripts • Draw lessons learned from practicum
Overall Time:	2 hours
PowerPoint and Handouts:	<ul style="list-style-type: none"> • PowerPoint: "Qualitative Data Analysis: Identifying Key Themes from Transcripts" • Handouts: <i>Coding Exercises A and B</i> • Handout: <i>Checklist: Before, During, and After Conducting a Qualitative Interview</i> • Handout: <i>Suggested List of Pre-Determined Themes for the Accountability Linkages Interviews</i>
Other Materials:	<ul style="list-style-type: none"> • Flipchart • Projector
Before you Begin:	<ul style="list-style-type: none"> • This session is meant to provide a basic overview of qualitative data analysis for the purposes of this assessment. There are many resources that provide a more in-depth exploration of this topic, some of which are listed below and in Appendix C. • Review the PowerPoint slides and Facilitator's Guide. Determine whether you need to amend the content to fit your audience level and time constraints. The session is based on two open-source resources that offer a wealth of additional material: (1) The online resource, <i>How and What to Code</i> by Taylor and Gibbs (http://onlineqda.hud.ac.uk/Intro_QDA/how_what_to_code.php); and (2) Save the Children's <i>Methods of Data Collection and Analysis</i> from its online Monitoring, Evaluation, Accountability and Learning (MEAL) introductory course (http://www.open.edu/openlearnworks/course/view.php?id=1641). • In the previous session, a co-facilitator should have recorded the role-play exercise and transcribed at least part of the recording verbatim in a Word document. Be sure to load that document onto the computer being used to show the slides.

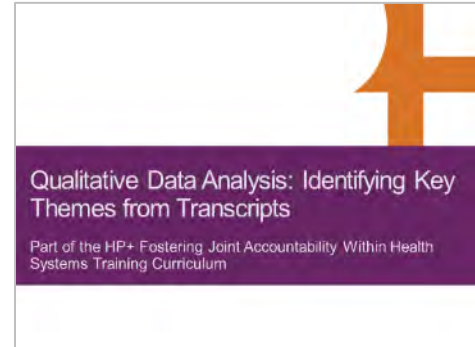
- **Start** the session by reviewing the learning objectives.

Facilitated Presentation: Introduction to Qualitative Analysis

Time: 20 minutes

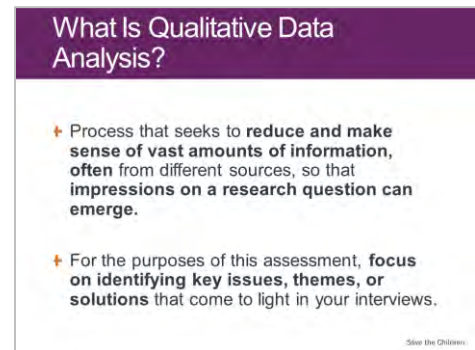
➤ Open to Slide 1

- **Recall** that in the last session, participants learned basic principles of qualitative research and had a chance to practice interview skills using the semi-structured interview guides.
- **Explain** that now we will talk about what comes next: after all interviews are completed and transcribed, there will be a large amount of qualitative data to review and analyze. How do we make sense of this information?
- **Begin** by asking whether anyone has experience in doing qualitative analysis. If so:
 - *What was the project and how did you approach the analysis?*
 - *What were some experiences or lessons learned?*



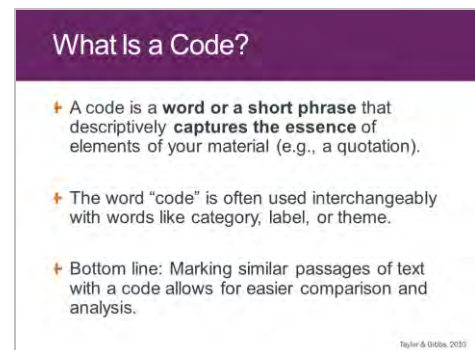
➤ Click to Slide 2

- **Read** the definition of qualitative data analysis.
- **Explain** that your aim as an analyst is to condense all of the collected information into key themes and topics that respond to the assessment question(s).
- **Note** that there are various approaches to qualitative data analysis. For the purposes of this assessment, we will focus on identifying key themes, issues, or solutions that come to light during the interviews.



➤ Click to Slide 3

- **Tell** participants that the first step in qualitative data analysis is to code the data.
- **Ask:** What is a code? Take a couple of responses.
- **Read** the definition of a code:
 - *Coding* is the process of breaking data down into smaller components and labeling or categorizing those components.
 - It is a word or a short phrase that descriptively captures the essence or key elements of your data (e.g., a quotation).
 - Once these smaller components are categorized (coded) you can more easily examine regularities, variations, and singularities.



- **Explain** that a code can be as specific as a word or as broad as a concept or topic— basically anything that will help mark and organize text in a way that makes sense. When we mark similar passages of text with a code, they can be retrieved easily at a later stage for further comparison and analysis.

➤ **Click to Slide 4**

- **Explain** that in general, there are two main approaches to coding.
 - The first approach is to begin with a pre-defined set of codes or themes. These are codes that you decide on before analyzing any data and are typically based on categories or themes in the over-arching assessment questions and/or the specific interview questions.
 - The second approach is to allow to codes to emerge from the data set as you read it.
 - Codes can emerge from the data because you put aside your preconceived notions, presuppositions, and previous knowledge of the subject area, and concentrate instead on finding new themes in your data.
 - Many people call this approach “grounded coding” because the codes are grounded in the data.
- **Note** that people most often combine the two approaches. That is, they start with a pre-defined set of codes and add any new codes or themes that become apparent during the review of the data.

How Do I Code Qualitative Data?

- ✦ Pre-defined codes guided by a research question or framework
- ✦ Let the codes emerge from your data
- ✦ Both!

Activity: Coding Practice

Time: 1 hour (30 minutes for each exercise)

➤ **Click to Slide 5**

- **Explain** that participants are going to do an exercise to practice these two approaches to coding text.
- **Distribute** the handout *Coding Exercise A: Assigning Pre-defined Codes to a Passage of Text* and *Coding Exercise B: Determining Codes from a Passage of Text* to each participant.
- **Ask** participants to read the short pieces of text and then complete the corresponding exercises. Exercise A is an example of coding with pre-defined codes. Example B includes a passage to use for the “grounded coding” method.
- **After** 10 minutes, ask for a volunteer to read and report on Exercise A, using the handout *Answer Sheet: Coding Exercise A: Assigning Pre-defined Codes to a Passage of Text*, Explore the following:
 - Did you find this process difficult?
 - Could there be different answers?

Exercise: Coding Practice

✦ Try it!

- What would be a good way of “validating” these answers? [Key point: two people review the same text, compare answers, and come to a consensus.]
- **Do** the same for Exercise B. Use the handout *Answer Sheet: Coding Exercise B: Determining Codes from a Passage of Text*. Explore the following:
 - Was this approach harder or easier than the first one? Why or why not?
 - What types of things did you look for when determining with codes? How did you “descriptively capture the essence” of the sentence?
- **Return** to the slides.

Activity: Coding Qualitative Interviews on Accountability Linkages

Time: 40 minutes

➤ Click to Slide 6

- **Remind** participants that these were just short exercises to illustrate what it means to analyze passages of text. In actuality, the text from their interviews will be much longer. Ideally, they will have verbatim transcripts of the interviews to use for the coding exercise.
- **Explain** that this slide shows the basic flow of data for this assessment:



- First, data are collected via interviews and recorded on a phone, tape, or mp3 player. If recording is not possible, try to arrange to have someone join the interview as a dedicated note-taker. Notes taken on computer are often more accurate than those taken by hand.
- Next, the recording is transcribed, meaning that someone listens to the recording and types out exactly what is said. This process can be very time-consuming, but it also provides the opportunity to really understand the data. In fact, the transcription process can begin the analysis process, such as identifying new codes or themes based on responses.
- When transcriptions of the interviews are complete, the team can begin coding and categorizing passages based on either the pre-defined or new codes. Ideally, coding is done by multiple people to validate the analysis.

However, if this approach is not feasible, one person can code all transcripts and the team members can serve as reviewers (e.g., read the transcripts, review the codes, and agree/disagree with findings). Alternatively, the team could pay a stipend to a student familiar with the coding process to assist.
- Finally, team members should meet to discuss the codes/themes and interpretations.

Facilitator’s Note: *You will come back to the importance of recording at the end of the session.*

➤ **Click to Slide 7**

- **Tell** participants that it can be difficult to understand how a transcript is coded without seeing something more concrete.
- **This** slide shows an example of a transcript that has been coded by hand. Ask participants to describe what they see. What is the coder doing?
 - Note how the coder uses brackets to the right of the transcribed text to indicate that the code/label/descriptor is assigned to a larger piece of text.
 - Also point out that the coder has highlighted words that reflect a common theme. It could be that “challenges” is a theme, and the coder has noticed that “not doing job,” “inaccurate data,” etc., are types of challenges.
- **Tell** participants that for the purpose of this assessment, keep things simple! Start by looking through transcripts using a pre-determined list of codes based on the interview guide.
- **Distribute** the handout *Suggested List of Pre-Determined Themes for the Accountability Linkages Interviews*. Read the codes aloud (or have a participant do so) and demonstrate how they map back to the interview guide.

Identifying Codes/Themes from Interview Transcripts

- ✦ Mark up transcripts to identify key words, etc.
- ✦ Keep it simple! Use the questions/topics from your interview guide as a set of pre-defined codes.

➤ **Click to Slide 8**

- Here are some examples of **what to look for** in codes that emerge from the transcripts:
 - **Repetitions:** Topics that reoccur
 - **Metaphors and analogies:** People often represent their thoughts, behaviors, and experiences through analogies and metaphors
 - **Transitions:** Naturally occurring shifts in content may be markers of themes

Identifying Codes/Themes

In addition to your pre-defined codes, keep an eye out for patterns and words such as:

- ✦ Repetitions
 - Topics that occur and reoccur
- ✦ Metaphors and analogies
 - People often represent their thoughts, behaviors, and experiences with analogies and metaphors
- ✦ Transitions
 - Naturally occurring shifts in content may be markers of themes

Taylor & Gibbs, 2010

➤ **Click to Slide 9 to continue**

- **Similarities and differences:** How is this interview different from the preceding text?
- **Certain words or phrases:** Words or phrases like “because,” “since,” “as a result of,” and “so” often indicate causal relationships; words and phrases such as “if/”then,” “rather than,” and “instead of” may signify what should/could happen.
- **Missing data:** What *is not* being discussed?

Identifying Codes/Themes

- ✦ Similarities and differences
 - How is this interview different from the preceding text?
- ✦ Certain words and phrases
 - Words and phrases such as “because,” “since,” and “as a result,” which often indicate causal relationships
 - Words and phrases such as “if/”then,” “rather than,” and “instead of” may signify what should/could happen
- ✦ Missing data
 - Anything striking about what *wasn't* discussed?

Taylor & Gibbs, 2010

➤ **Click to Slide 10**

- **Explain** that in addition to marking the transcript to show coding, researchers keep a separate list of the codes, including pre-defined and new codes. Ideally, you would write a short definition for each code, so that someone else would be able to understand it.
 - When you find a passage you think can be coded using an existing code, check that it is on your list. If so, check the definition to be sure the passage fits with that code.
 - If you can't find an appropriate code, you can create a new one and add it to your list. When you do so, be sure to go back to the transcripts you already have reviewed because there may be passages in the previous transcripts that fit this new code.
- **Note** that you may need to organize your list of codes if it becomes too long. In some cases, you may be able to collapse similar codes. In other cases, you might create a hierarchy with sub-codes.
- **Ask** participants to look at the list of codes from Coding Exercise A.
 - Are there codes that could be combined? Any that could be organized into a hierarchy?
 - Which ones? Why? Do others agree?
- **Finally**, reiterate that in an ideal world, more than one person would code the transcripts to validate the analysis, but this is not always the case. Thus, after reviewing a few transcripts, it is a good idea to meet with colleagues to reach consensus on a final list of codes/themes.

Data Management

- ✦ Keep a master list of codes/themes.
- ✦ If you find that a new code/theme emerges, return to older transcripts; there may be passages that fit this new code.
- ✦ After coding at least a few transcripts, review codes with colleagues to determine a final list of codes.

➤ **Click to Slide 11**

- **Explain** that once the coding is complete, you can begin to organize the interview notes according to the codes. This process can be done in a variety of ways. For example, you can do the following:
- Create a Microsoft Word document for each code/theme. Copy and paste passages from transcripts marked with that code. Be sure to note the interview from which the passage came so you can cite it later.
 - An Excel table can be used for the same purpose.
 - Cut out coded phrases and sort them on the floor or a table.
- **Once** the data are reduced to their essence and organized by code/theme, you can look for comparisons across and interrelationships between codes to identify key findings.
- **To end**, distribute the handout *Checklist: Before, During, and After Conducting a Qualitative Interview*.
- **Lead** a quick review of the points on the handout.
- **Thank** participants and transition to the next session.

Identifying Findings

- ✦ Group notes and transcript passages according to codes/themes
 - Word document
 - Excel sheet
 - Print and spread out on table/floor/flipchart
- ✦ Extrapolate key findings
 - What do you see when you view everything together?
 - Look for contrasts and comparisons. Do some people agree or disagree on certain topics?

HANDOUT**Coding Exercise A: Assigning Pre-defined Codes to a Passage of Text***Instructions:*

1. Read the passage of text from an interview with an assistant district health officer on how they work with the biostatistician.
2. Look at the pre-determined list of codes.
3. In the table below, decide which code best summarizes what is being discussed in each line of the text. You may use a code more than once.
4. Select the corresponding box to indicate which code you are assigning to that line.
5. Once you have selected codes for all passages in the table, discuss with your group.

List of Codes:

1. Role/responsibility in ensuring implementation of (*selected issue*—e.g., family planning data capture and use)
2. Information sharing
3. Dialogue
4. Sanctions or repercussions
5. Incentives

Sentence	Number of Corresponding Code				
	1	2	3	4	5
I ensure that family planning data are entered in the HMIS; I also assess gaps and performance and share with the district health team. I receive MCH and family planning data monthly from all the service providers and health facilities and forward it to the biostatistician.					
Yes [providing information], has helped him because it beefs up the data that are already gathered by the biostatistician from other public and private facilities.					
Of course, yes, [information provided by the biostatistician] gives me an insight of the kind of data that have been captured in the HMIS.					
Yes, feedback is given by the biostatistician in the quarterly performance review meetings.					
No, there is no challenge faced at all [when sharing information or engaging in feedback and/or dialogue with biostatistician].					
Hard-working people are generally recognized at the district once in a while.					
No sanctions, but he is always reminded to enter data in the DHIS on time.					

Adapted from Taylor, C. and G.R. Gibbs. 2010. "How and What to Code." Online QDA. Available at: http://onlineqda.hud.ac.uk/Intro_QDA/how_what_to_code.php.

Excerpt from Interview

Interviewer (I): In a few words, how would you summarize the way the assistant district health officer (ADHO) and the biostatistician work together to achieve improved data capture and reporting for family planning data?

Key informant (KI): I ensure that family planning data are entered in the HMIS; I also assess gaps and performance, and share with the DHT. I receive MCH and family planning data monthly from all the service providers and health facilities, and forward data to the biostatistician.

I: Has providing this information been helpful to [biostatistician] in working towards [*data capture and reporting for family planning data*]?

KI: Yes, it has helped him because it beefs up the data that are already gathered by the biostatistician from other public and private facilities.

I: Has receiving this information been helpful to you (the ADHO) in working towards improved [*data capture and reporting for family planning data*]?

KI: Of course, yes, it gives me an insight of the kind of data that have been captured in the HMIS.

I: Are there any opportunities for feedback and/or dialogue between you and the biostatistician regarding information that is shared?

KI: Yes, feedback is given by the biostatistician in the quarterly performance review meetings.

I: Do you face any challenges when sharing information or engaging in feedback and/or dialogue with biostatistician?

KI: No, there is no challenge faced at all.

I: Do you provide incentives for the biostatistician to ensure progress toward achieving improved [*data capture and reporting for family planning data*]?

KI: Hard-working people are generally recognized at the district once in a while.

I: What happens when there is no progress on performance? Do you sanction the biostatistician in the case of lack of performance with [*data capture and reporting for family planning data*]?

KI: No sanctions, but he is always reminded to enter data in the DHIS on time.

HANDOUT

Coding Exercise B: Determining Codes from a Passage of Text

Instructions:

1. Read the passage of text from an interview with a representative from a village health team on their relationship with a health facility.
2. In the table, assign a code (e.g., word or phrase) that summarizes the main idea for each line of text.
3. When you have finished, discuss with your group.

Excerpt from Interview:

Interviewer (I): Are there any opportunities for feedback and/or dialogue between you, the village health team (VHT), and the health facility in-charge regarding information that is shared?

Key Informant (KI): No feedback from the facility in charge, because I submit data to the family planning focal person, but feedback is received from the family planning focal person during quarterly review meetings.

I: Do you face any challenges when sharing information or engaging in feedback and/or dialogue with the health facility in-charge?

KI: As I said earlier, after submitting my data to the family planning focal person, that's it.

I: Does the health facility provide incentives for you as a VHT to ensure progress toward achieving improved *data capture and reporting for family planning data*?

KI: A few incentives are given once in a while by partners (transport to and from meetings).

I: What happens when there is no progress on performance? Does the health facility in-charge sanction you in the case of lack of performance with [*data capture and reporting for family planning data*]?

KI: There are no sanctions given.

I: Do you think improving information sharing, feedback, dialogue, incentives, and sanctions, which we have discussed today, could help achieve improved *data capture and reporting for family planning data*? Why or why not?

KI: Of course, feedback meetings would be an opportunity to share challenges that need to be addressed.

Sentence	Code
No feedback from the facility in charge...	
...because I submit data to the family planning focal person...	
...but feedback is received from family planning focal person during quarterly review meetings.	
As I said earlier, after submitting my data to the family planning focal person, that's it.	
A few incentives are given once in a while by partners (transport to and from meetings).	
There are no sanctions given.	
Of course, feedback meetings would be an opportunity to share challenges that need to be addressed.	

HANDOUT**ANSWER SHEET: Coding Exercise A: Assigning Pre-defined Codes to a Passage of Text***List of Codes:*

1. Role/responsibility in ensuring implementation of (SELECTED ISSUE)
2. Information sharing
3. Dialogue
4. Sanctions or repercussions
5. Incentives

Sentence	Number of Corresponding Code				
	1	2	3	4	5
I ensure that family planning data are entered in the HMIS; I also assess gaps and performance, and share with the DHT. I receive MCH and family planning data monthly from all the service providers and health facilities, and forward it to the biostatistician.	X				
Yes [providing information] has helped him because it beefs up the data already gathered by the biostatistician from other public and private facilities.		X			
Of course, yes, [information provided by the biostatistician] gives me an insight of the kind of data that have been captured in the HMIS.		X			
Yes, feedback is given by the biostatistician in the quarterly performance review meetings.			X		
No, there is no challenge faced at all [when sharing information or engaging in feedback and/or dialogue with biostatistician].		X	X		
Hard-working people are generally recognized at the district once in a while.					X
No sanctions, but he is always reminded to enter data in the DHIS on time.				X	

Participants may choose to code the text differently from the answer key; this does not mean that they are wrong, as they may have a very good reason for selecting those codes. Often the same text can be coded in two or more different ways.

HANDOUT**ANSWER SHEET: Coding Exercise B: Determining Codes from a Passage of Text**

Sentence	Code
No feedback from the facility in charge...	Dialogue
...because I submit data to the family planning focal person...	Data flow
...but, feedback is received from family planning focal person during quarterly review meetings.	Dialogue
As I said earlier, after submitting my data to the family planning focal person, that's it.	Dialogue
A few incentives are given once in a while by partners (transport to and from meetings).	Incentives; Partners
There are no sanctions given.	Sanctions
Of course, feedback meetings would be an opportunity to share challenges that need to be addressed.	Opportunity

Participants may have chosen to use different codes from the ones mentioned above; this does not mean they are wrong, as they may have a very good reason for selecting that code. Often the same text can be coded in two or more different ways. This is why it is important to validate coding with others.

HANDOUT

Suggested List of Pre-Defined Themes for the Accountability Linkages Interviews

Corresponds to Semi-Structured Interview Guide Template

Role/responsibility in ensuring implementation of (SELECTED ISSUE)

- Interviewee’s role in ensuring implementation
- Perception of role of other actor in the relationship in ensuring implementation
- Perception of role of others in ensuring implementation

Information sharing (within relationship)

- Definition of “information”
- What works well
- What are the challenges
- Suggestions for improvement

Information sharing (outside of relationship)

- Definition of “information”
- What works well
- What are the challenges
- Suggestions for improvement

Dialogue (within relationship)

- What works well
- What are the challenges
- Suggestions for improvement

Dialogue (outside of relationship)

- What works well
- What are the challenges
- Suggestions for improvement

Sanctions or repercussions (within relationship)

- What works well
- What are the challenges
- Suggestions for improvement

Sanctions or repercussions (outside of relationship)

- What works well
- What are the challenges
- Suggestions for improvement

Incentives (within relationship)

- What works well
- What are the challenges
- Suggestions for improvement

Incentives (outside of relationship)

- What works well
- What are the challenges
- Suggestions for improvement

Other/general

- What works well
- What are the challenges
- Suggestions for improvement

HANDOUT

Checklist: Before, During, and After Conducting a Qualitative Interview

Before the Interview

- When scheduling the interview, briefly explain its purpose and set a firm time to meet the interviewee in person.
- Confirm your appointment with the interviewee one day before (and in some cases, again the day of).
- Spend time reviewing the interview guide and ensure that it is tailored to the stakeholder you are interviewing.
- Review the accountability map you made at the workshop and remind yourself of how the interviewee is situated within the system, which groups the interviewee is linked with, and which specific accountability relationship you will be exploring.
- Review the interview guide to make sure you understand each question. If the interviewee doesn't understand a question, how will you explain it?
- Familiarize yourself with the flow of the entire guide. Your interviews will be smoother if you are not constantly referring back to the guide and if you do not ask questions that have already been answered.
- Ensure that you will have backup notes, either by arranging to record the interview or by making sure someone is coming with you exclusively to take notes. If you are planning to record the interview, make sure your equipment is working.
- Practice, practice, practice! Find a friend, record yourself interviewing him/her, and ask for feedback.

During the Interview

- Be warm and friendly from the beginning. You want to make the interviewee feel comfortable.
- Express your thanks for the interviewee taking time to meet with you.
- Read the consent script or let the interviewee read it. Ask if s/he has any questions.
- Be sure to tick the “yes” boxes to signify that you explained about consent. Then tick the boxes to indicate whether the participant consented to being interviewed and recorded (if applicable).
- Pay attention to what the interviewee is saying. This point may seem basic but try not to get too caught up in taking notes or your conversation will stall. That is why it is important to record the interview or have a note-taker with you.
- Don't be afraid to ask follow-up questions. For example, “Can you explain that response? Why do you say that? What happened? How did this happen?” These questions are especially relevant if the interviewee brings up a personal experience or talks about challenges.

- Be mindful of the interviewee's time. While answering a question, if an interviewee gives an answer to an upcoming question, try not to repeat that question later. (This is why it is important to be familiar with the interview guide!)
- When the interview is over, let the interviewee know you are available for any questions and will follow up with the key findings once the interviews are conducted and the data are analyzed.

After the Interview

- Send a written thank you for participating in the assessment (email is fine).
- The day of the interview, review your notes (and if necessary, the recording) and write out a summary of key points. This is important to do while the interview is fresh in your mind. The more time passes, the more difficult it might be to recall important parts of the interview that were not captured in your notes.
- Type up any handwritten notes or transcribe the recording if you have one.
- Pass along the transcript to the analysis team.
- Begin qualitative analysis. The basic steps for analyzing qualitative data are as follows:
 1. Develop categories or themes. In this case, you can begin with the themes in the questionnaire: information sharing, dialogue, and repercussions/incentives.
 2. Begin reading through the transcripts (without coding) and make notes of any other codes/themes that emerge. Identify subcategories. In this case, start with the subcategories in the questionnaire: challenges, opportunities to improve, other important actors. Again, feel free to add anything that you feel captures some of the data that the questionnaire codes don't.
 3. Once you have established the large list of codes, share your analysis with your colleagues. Did you all identify the same themes and subcategories? With your colleagues, go back through the data to group any related topics and look for interrelationships to identify the final list of codes.
 4. Organize the data belonging to each category (this can be done in Microsoft Word or Excel, or in whichever way is helpful to you) and look for overarching themes or key findings you want to present to the stakeholder meeting. Pay special attention to contrasts and comparisons. For example, does one actor in a relationship think that information sharing is vibrant, whereas the other actor thinks there is room for growth in how information is shared? Do actors agree on certain things—for example, that improving dialogue would be helpful?

Session 3.4 Action Planning for Participatory Assessments and Follow-up

Learning Objectives:	<ul style="list-style-type: none"> • Articulate assessment goals and outputs • Establish a timeline, budget, and roles and responsibilities
Overall Time:	1–2 hours
PowerPoint and Handouts:	<ul style="list-style-type: none"> • Handout: <i>Action Planning for Accountability Assessment and Follow-up</i> template (may be provided digitally)
Other Materials:	<ul style="list-style-type: none"> • Flipchart • Markers

- **Start** the session by reviewing the learning objectives.
- **Explain** that this session will help participants organize their joint efforts following the workshop and will help them complete the assessment and present findings to a broader group of stakeholders for action.
- **Agree with the group** on how many groups should be formed for key tasks.

Facilitator’s Note: *As noted earlier, this will depend on factors such as the level of additional financial and technical support that can be offered to the group, particularly for the time-intensive tasks, such as transcriptions and data analysis. Other factors to consider are the ease with which the groups can communicate and meet for planning, the number and reach of the interviews, the level of experience of the group, etc. For instance, the HP+ activity groups initially divided into three teams: “interviews,” “analysis,” and “stakeholder dissemination”; in practice, however, they functioned as two: an assessment team and a stakeholder dissemination team.*

- **Ask** for volunteers to be the focal points for the respective groups.
- **Ask** others to select the working group they would like to join—both for the action planning today and to complete tasks in the action plan later.
- **Check** for reasonable distribution across experience levels, sectors represented, geographic locations, and types and levels of access to stakeholders.
- **Write** the name of the focal point/team lead and member names on respective flipcharts for each group. **Explain** information about any grant funds or cost reimbursements that are available to support the assessment and follow-up activities, and any parameters that would affect the timeline.

Facilitator’s Note: *HP+ provided a small grant (less than \$10,000) to one NGO on behalf of the larger group to cover direct costs for conducting the interviews (e.g., travel, refreshments, digital tape recorders); facilitating members’ work together on the analysis (e.g., travel for team meetings, a data validation meeting); covering costs of the stakeholder meeting (e.g., venue, refreshments, travel, etc.); and implementing one follow-up action based on recommendations from the stakeholder meeting. In addition, HP+ directly engaged a local consultant to do the transcriptions and the draft analysis and provided local and long-distance technical assistance throughout the process.*

- Before breaking into small groups, **agree on** a timeframe for reaching the main milestones.
- **Help** the participants to be as realistic as possible, considering their ongoing work responsibilities, holidays, and any external deadlines required by grants or the sponsoring organization.



Getting ready for action planning.

- The following is a potential post-workshop timeline:
 - 1 month: Finalize interview guides
 - 2 to 4 months: Complete interviews, notes, transcriptions
 - 4 to 5 months: Complete draft analysis of key findings
 - 6 months: Data validation meeting with respondents
 - 7 months: Conduct stakeholder dissemination meeting
 - 8 to 10 months: Complete follow-up action and reporting
- **Explain** the small group task, which is to spend 30 minutes creating an action plan that includes the following:
 - The sub-activities to complete their respective milestone(s)
 - The person responsible for each task
 - The direct costs that need to be covered for each activity
 - An indicator for the milestone(s)
- **Share** a template for creating the action plan. A sample is included as the handout *Action Planning for Accountability Assessment and Follow-up*.
- **Call time** and **ask** the small groups to share their action plans in consecutive order.
- **Ask** whether participants have feedback or questions after each group presents.
- When all groups have shared, **facilitate a discussion** to ensure that the various timelines work together, the workload is shared, all roles and responsibilities are clear, and any budget issues are raised.

Facilitator's Note: *In implementing this activity after the workshop, HP+ provided technical assistance to the participants as they finalized the interview guides and conducted interviews. As noted, HP+ engaged local consultants to conduct the analysis in partnership with the participants. The consultant worked with the groups to prepare for the data validation meetings, which were held among the participants and, in some cases, the key informants. The data validation meetings were used to verify findings and brainstorm recommendations. After the data validation meetings, the participants convened broader stakeholder sessions to present the validated findings and come to a consensus around recommendations.*

- **Thank** the participants for their active participation and enthusiasm.
- **Wish** them good luck as they embark on the next stage of improving understanding and raising awareness of accountability for their selected issue.
- **Clarify** that you will be following up in the coming days to help make sure everything progresses smoothly and that you look forward to continuing to work with them.

Additional resources:

Family Health International. 2005. "Qualitative Research Methods: A Data Collector's Field Guide." Washington, DC: FHI 360.

HANDOUT

Action Planning for Accountability Assessment and Follow-up

Issue Description			
Milestone(s) for the Group			
Group Members			
Group Lead			
Group Resources	Skills	Tools	Funds
Context and Assumptions			

List Tasks Required to Achieve Milestone(s)	Start By	Due By	Person(s) Responsible	Status		
				G	Y	R
1.						
2.						
3.						
4						
5.						
Notes						

Legend:

G = moving well and on target

Y = moving slowly and might cause delays

R = not moving and causing delays

Appendices



A. Template of a Sample 3-Day Workshop Agenda

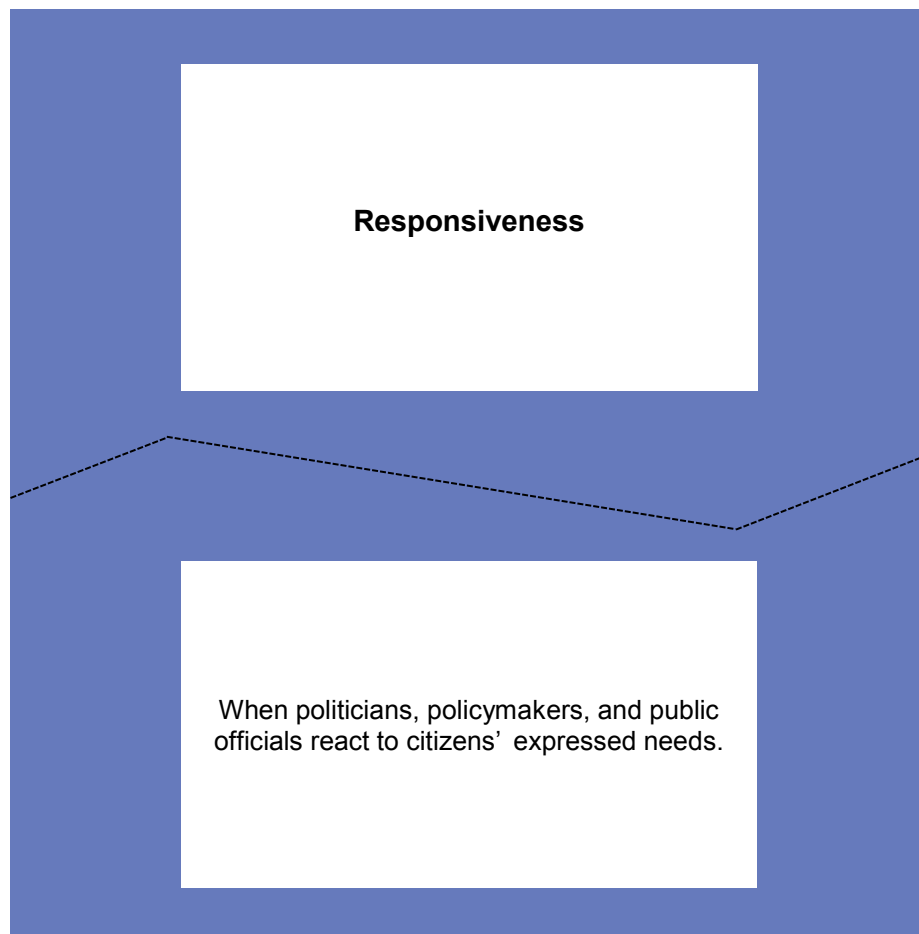
(For instances in which plans include the participatory assessment after the workshop)

DAY 1	DAY 2	DAY 3
<p>Welcome and Opening (1 hour)</p> <p>Overview of Activity/Contextualization (1.5 hours)</p> <p>Accountability Fundamentals (1 hour)</p>	<p>Opening and Recap (15 minutes)</p> <p>Prioritizing Accountability Issues (1.25 hours)</p> <p>Mapping Accountability (2.5 hours)</p>	<p>Opening and Recap (15 minutes)</p> <p>Preparing for Qualitative Data Collection (cont.) (1.5 hours)</p> <p>Preparing for Qualitative Data Analysis (2 hours)</p>
LUNCH	LUNCH	LUNCH
<p>Accountability Fundamentals (1 hour)</p> <p>Case Studies: Accountability Gaps and Interventions (1.5 hour)</p> <p>Daily Evaluation and Closing</p>	<p>Selecting Critical Accountability Relationships (1 hour)</p> <p>Preparing for Qualitative Data Collection (2 hours)</p> <p>Daily Evaluation and Closing</p>	<p>Action Planning for Participatory Assessment (1–2 hours)</p> <p>Final Evaluation and Closing</p>

B. Templates/Instructions for Preparing Workshop Tools

Instructions for Making the Puzzle Pieces for the Terminology-Matching Activity for Session 1.1

1. Print the templates for terms and definitions for the terminology-matching activity (on the following pages) on white card stock.
2. Cut along the dotted lines so there are 60 cards in total.
3. Glue or tape both matching pieces to a piece of colored paper so there is at least a 2” border around the cards.
4. Cut each sheet of colored paper in a different puzzle design (diagonal, zigzag, etc.) to separate the term from the definition. Note: This part will help participants find their match. See example below.
5. Next, print the questions for the terms on card stock.
6. Cut along the dotted lines so there are 30 cards in total.
7. Glue or tape the question cards to the back of the cards that have the definitions.



<p style="text-align: center;">ACCOUNTABILITY</p>	<p style="text-align: center;">ANSWERABILITY</p>
<p>The obligation of powerholders to account for or take responsibility for their actions. “Powerholders” refer to those who hold political, financial, or other forms of power, and include officials in government, private corporations, international financial institutions, and civil society organizations.</p>	<p>Having the obligation to answer questions regarding decisions and/or actions. Powerholders are also obligated to explain and justify why certain things were done. Answerability is one of the two components of accountability.</p>
<p style="text-align: center;">FINANCIAL ACCOUNTABILITY</p>	<p style="text-align: center;">ENFORCEABILITY</p>
<p>Concerns tracking and reporting on allocation, disbursement, and utilization of financial resources, using the tools of auditing, budgeting, and accounting. Seeks to ensure that health service providers and others are using resources for agreed-upon and appropriate purposes, and to reduce corrupt practices.</p>	<p>Availability and application of sanctions/repercussions for illegal or inappropriate actions, and behaviors or incentives to reward or encourage desired action. Enforceability is the second component of accountability.</p>

<p>PROGRAMMATIC ACCOUNTABILITY</p>	<p>POLITICAL/DEMOCRATIC ACCOUNTABILITY</p>
<p>Demonstrating and accounting for performance with respect to agreed-upon program milestones. At the health system level, the focus is on the services, outputs, and results of public agencies and programs, not on individual service encounters between patients and providers.</p>	<p>Ensuring that government delivers on electoral promises, fulfills the public trust, aggregates and represents citizens' interests, and responds to ongoing and emerging societal needs and concerns. It occurs when politicians press the health ministry and other health-related agencies to pursue objectives and employ resources so that providers respond to what citizens want/need/have a right to regarding healthcare.</p>
<p>HEALTH SYSTEM GOVERNANCE</p>	<p>RESPONSIVENESS</p>
<p>Developing and implementing effective rules, institutions, and relationships for policies, programs, and activities related to fulfilling public health functions and achieving health sector objectives.</p>	<p>When politicians, policymakers, and public officials react to citizens' expressed needs.</p>

<p style="text-align: center;">CLIENT POWER</p>	<p style="text-align: center;">HORIZONTAL ACCOUNTABILITY</p>
<p>When clients/citizens convey their needs and demands for services—and their level of satisfaction—directly to providers.</p>	<p>Occurs when government units ensure other units within the same government fulfill their commitments through institutional mechanisms of oversight. This can include internal audits and parliamentary hearings.</p>
<p style="text-align: center;">VERTICAL ACCOUNTABILITY</p>	<p style="text-align: center;">SOCIAL ACCOUNTABILITY</p>
<p>Occurs when forces external to government, such as citizens, advocacy groups, and the media, work to ensure that government units meet their obligations. Mechanisms for this type of accountability include elections, mass protests, publication of shadow reports, and investigative news reports.</p>	<p>Occurs when citizens are engaged in holding the state to account. It includes a broad range of actions and mechanisms that citizens, communities, civil society organizations, and the independent media can use to hold government accountable.</p>

<p style="text-align: center;">CLAIMED SPACE</p>	<p style="text-align: center;">INVITED SPACE</p>
<p>Occurs when citizens initiate accountability mechanisms or approaches on their own, without government involvement.</p>	<p>Occurs when governments invite active and meaningful involvement of citizens/civil society organizations in horizontal accountability mechanisms. These may include participatory planning and budgeting, citizen testimony in public hearings/oversight committees, or community representation on health committees.</p>
<p style="text-align: center;">JOINT ACCOUNTABILITY</p>	
<p>Occurs when government and civil society actors work together for policy making; program/service delivery planning and implementation; and monitoring and oversight of public policies, programs, and services.</p>	

Questions to be Printed for Terminology-Matching Game

<p>Health System Governance</p> <p>How do you think governance of (family planning) affects achievement of (family planning) commitments?</p>	<p>Accountability</p> <p>How do ordinary citizens know what powerholders are accountable for in (family planning)? Who is responsible for holding the powerholders accountable?</p>
<p>Social Accountability</p> <p>Are there examples of social accountability for (family planning) that have led to some positive change? Are there examples from other sectors? What are they?</p>	<p>Horizontal Accountability</p> <p>Which government units lead the way in achieving the (remaining FP2020 family planning) commitments? Which government units provide oversight of those units that are leading the way?</p>
<p>Vertical Accountability</p> <p>Are there examples of vertical accountability for (family planning)? In other sectors? What are they? What happened?</p>	<p>Financial Accountability</p> <p>Are there examples of actions being taken around financial accountability in the health sector? In other sectors? What are they?</p>
<p>Programmatic Accountability</p> <p>What are some examples of programmatic accountability in the health sector that you can share, whether among government units or between civil society and government?</p>	<p>Political/Democratic Accountability</p> <p>What are some examples of political/democratic accountability that you can share, particularly in the social sector? Are there any examples in the health sector? Do these work?</p>

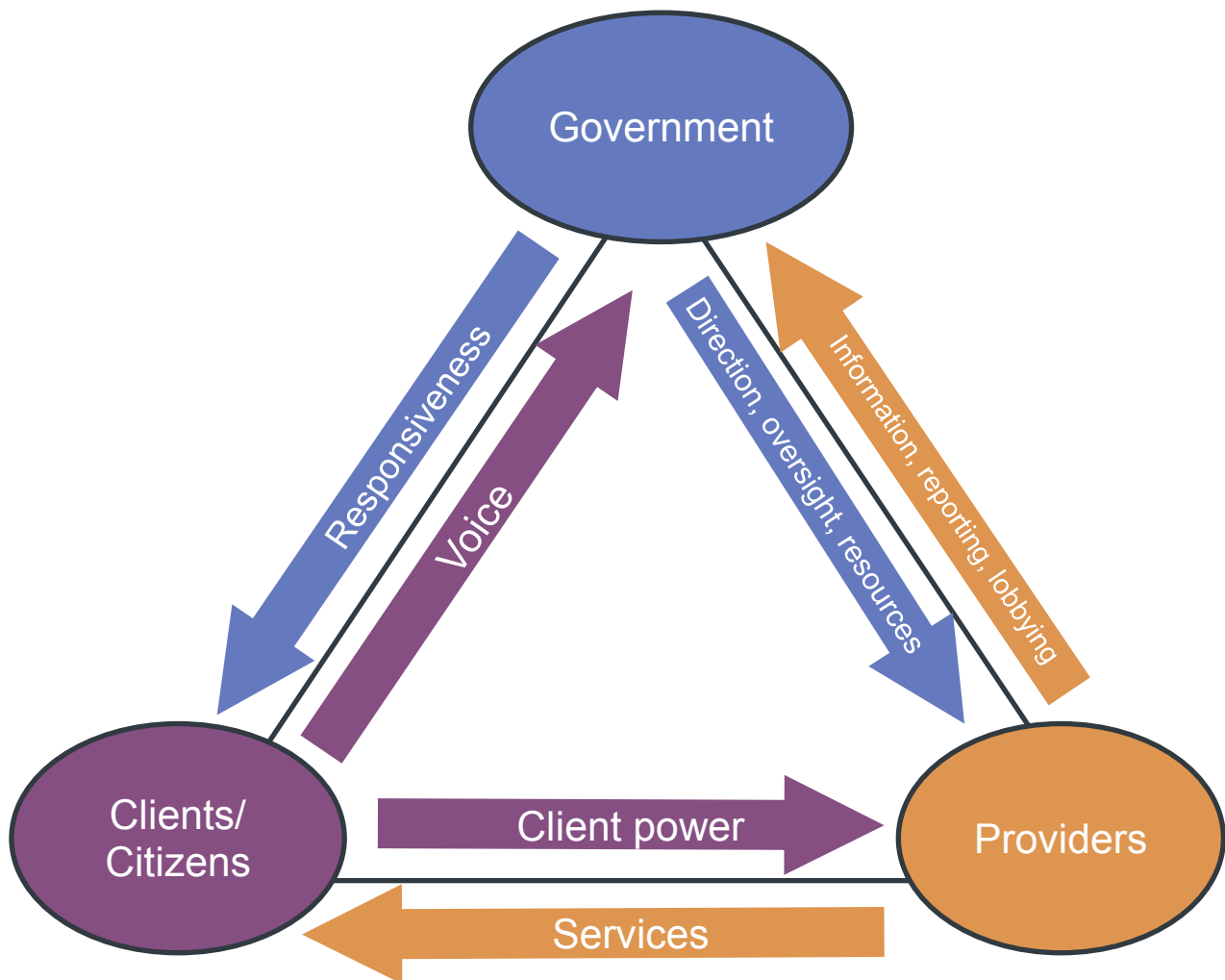
<p>Answerability</p> <p>How do powerholders answer questions or explain or justify decisions to stakeholders around health issues?</p>	<p>Enforceability</p> <p>How are certain actions that promote health norms, standards, etc. encouraged or rewarded? How are certain actions that hinder these norms, standards, etc. discouraged?</p>
<p>Responsiveness</p> <p>How do politicians, policymakers, and public officials react to citizens' expressed needs around (family planning)?</p>	<p>Client Power</p> <p>How do providers offer opportunities for clients to provide feedback on (family planning) services?</p>
<p>Claimed Space</p> <p>What are some examples of claimed spaces for (family planning)? For health? If none, what are the barriers?</p>	<p>Invited Space</p> <p>What are some examples of invited spaces for (family planning)? For health?</p>

Instructions for Making the Health Governance Triangle for Session 1.1

Refer to the diagram below as you read the instructions:

1. Use 3 different colors of paper to prepare the pieces of the health governance triangle.
2. Cut out 3 circles or squares. Write “government,” “providers,” and “clients/citizens” on the circles/squares.
3. Cut out 6 arrows, 2 per color, using the same three colors of paper.
4. Cut out 6 squares, 2 in each color, large enough to write the words shown below on the arrows.
5. Write the text shown below on the arrows and the squares. Be sure the color of the square matches its corresponding arrow.

Note: The squares are used instead of writing the text directly on the arrows so that during the activity, the facilitator can build the triangle along with the participants.



C. Further Reading

Accountability

Bovens, M. 2007. “Analysing and Assessing Accountability: A Conceptual Framework”. *European Law Journal* 13: 447–468.

It has been argued that the EU suffers from serious accountability deficits. But how can we establish the existence of accountability deficits? This article tries to come to grips with the appealing but elusive concept of accountability by asking three types of questions. First a conceptual one: What exactly is meant by accountability? In this article, the concept of accountability is used in a rather narrow sense: a relationship between an actor and a forum, in which the actor has an obligation to explain and justify his or her conduct, the forum can pose questions and pass judgement, and the actor may face consequences. The second question is analytical: What types of accountability are involved? A series of dimensions of accountability are discerned that can be used to describe the various accountability relations and arrangements that can be found in the different domains of European governance. The third question is evaluative: How should we assess these accountability arrangements? The article provides three evaluative perspectives: a democratic, a constitutional, and a learning perspective. Each of these perspectives may produce different types of accountability deficits. **This paper informed the template interview guide in Module 3.**

Boydell, Victoria, and Jill Keesbury. 2014. “Social Accountability: What Are the Lessons for Improving Family Planning and Reproductive Health Programs? A Review of the Literature.” Working Paper. Washington, DC: Population Council, Evidence Project.

The concept of accountability is increasingly important in the family planning/reproductive health field. Although much recent discussion has focused on developing global or national-level mechanisms for accountability, less emphasis has been placed on understanding the relevance of “social accountability” approaches for ensuring access to and the quality of family planning services. Social accountability refers to the efforts of citizens and civil society to scrutinize and hold duty bearers (politicians, government officials, and service providers) to account for providing promised services—actions most often at the subnational or community level. In the family planning field, this concept builds on a rich history of community involvement and civil society participation. This paper draws on the debates and emerging lessons of the social accountability field to better understand its potential for improving family planning programs. It synthesizes the literature across a variety of sectors, including the health sector, and on broad review papers as well as individual studies related to family planning programs.

Brinkerhoff, D. 2004. “Accountability and Health Systems: Towards Conceptual Clarity and Policy Relevance.” *Health Policy and Planning* 19(6): 371–379.

Improved accountability is often called for as an element in improving health system performance. At first glance, the notion of better accountability seems straightforward, but it contains a high degree of complexity. If accountability is to be more than an empty buzzword, conceptual and analytical clarity is required. This article elaborates a definition of accountability in terms of answerability and sanctions, and distinguishes three types of accountability: financial, performance, and political/democratic. An analytic

framework for mapping accountability is proposed that identifies linkages among health sector actors and assesses capacity to demand and supply information and exercise oversight and sanctions. The article describes three accountability purposes: reducing abuse, ensuring compliance with procedures and standards, and improving performance/learning. Using an accountability lens can (1) help to generate a system-wide perspective on health sector reform, (2) identify connections among individual improvement interventions, and (3) reveal gaps requiring policy attention. These results can enhance system performance, improve service delivery, and contribute to sound policy making. **This paper informed content in all modules in this document.**

Brinkerhoff, D., and T. Bossert. 2008. "Health Governance: Concepts, Experience, and Programming Options." *Health Systems* 20/20, Washington, DC: USAID.

Country health officials and donors have increasingly realized that resources allocated to health will not achieve their intended results without attention to governance. Particularly as global programs inject large amounts of funding targeting specific diseases, weaknesses in health system governance threaten to undermine the effective utilization of the funds. Corruption is perhaps the most dramatic governance-related threat, but in addition, poor accountability and transparency, weak incentives for responsiveness and performance, and limited engagement of citizens in health affairs contribute to low levels of system effectiveness. This paper provides an overview of health governance concepts to inform the development of intervention options for health programming. Specifically, aims include (1) clarifying the meaning of health governance (2) identifying health governance issues and challenges, (3) developing a model for health governance that highlights its practical dimensions, (4) reviewing selected experience with interventions to improve health governance, and (5) proposing options for health governance programming that can strengthen health systems and ultimately lead to increased use of priority services. **This paper informed content in Module 1 of this document.**

George, A. 2003. "Using Accountability to Improve Reproductive Health Care." *Reproductive Health Matters* 11(21) 161–170.

Accountability is best understood as a referee of the dynamics in two-way relationships, often between unequal partners. The literature on accountability distinguishes between political, fiscal, administrative, legal, and constitutional accountability. This paper focuses on accountability mechanisms in healthcare and how they mediate between service providers and communities, and between different kinds of health personnel at the primary healthcare level. It refers to case studies of participatory processes for improving sexual and reproductive health service delivery. Information, dialogue, and negotiation are important elements that enable accountability mechanisms to address problems by supporting change and engagement between participants. To succeed, however, efforts toward better accountability that broaden the participation of users must take into account the social contexts and the policy and service delivery systems in which they are applied, address power relations, and improve the representation of marginalized groups within communities and service delivery systems.

Health Policy Project. 2014. *Capacity Development Resource Guide: Accountability Systems*. Washington, DC: Futures Group, Health Policy Project.

Part of a series of Capacity Development Resource Guides produced by the Health Policy Project, this guide describes specific skills, knowledge, and capabilities that

individuals, organizations, and systems should possess in accountability systems in order to effectively influence health policy and programming. It also includes performance indicators that could be adapted and used in assessment settings. Finally, it offers illustrative activities and useful resources for designing and delivering technical assistance in accountability systems.

Qualitative Assessment

Aronson, J. 1995. "A Pragmatic View of Thematic Analysis." *The Qualitative Report* 2(1) 1–3.

Ethnographic interviews have become a commonly used qualitative methodology for collecting data (Aronson, 1992). Once the information is gathered, researchers are faced with the decision on how to analyze the data. There are many ways to analyze informants' talk about their experiences (Mahrer, 1988; Spradley, 1979; Taylor and Bogdan, 1984), and thematic analysis is one such way. Although thematic analysis has been described (Benner, 1985; Leininger, 1985; Taylor and Board, 1984), there is insufficient literature outlining the pragmatic process of thematic analysis. This article attempts to outline the procedure for performing a thematic analysis.

Family Health International. 2005. "Qualitative Research Methods: A Data Collector's Field Guide." Washington, DC: FHI 360.

This field guide is based on an approach to doing team-based, collaborative, qualitative research that has repeatedly proven successful in research projects sponsored by Family Health International (FHI) throughout the developing world. With its straightforward delivery of information on the main qualitative methods being used in public health research today, the guide speaks to the need for simple yet effective instruction on how to do systematic and ethically sound qualitative research. The aim of the guide is thus practical. In bypassing extensive discussion on the theoretical underpinnings of qualitative research, it distinguishes itself as a how-to guide to be used in the field.

Guest, G., and K.M. MacQueen. 2008. *Handbook for Team-based Qualitative Research*. Lanham, MD: AltMira Press.

This collection provides a practical and comprehensive introduction to team-based qualitative research. The authors are social scientists and health researchers with extensive experience in this rapidly expanding field. Qualitative research has become increasingly interdisciplinary and team oriented. The transition away from the lone-researcher approach to collaborative and inter-institutional research creates new challenges for designing and implementing qualitative research. The authors use examples from both American and international studies to show how working in teams affects research design, project management, data analysis, and the presentation of research findings. The book offers numerous approaches and methods for making team research more efficient and enhancing the quality of research findings throughout all stages of the research process. Topics covered include project design and preparation, logistics, research ethics, political dimensions of collaborative research, data collection, transcription and data management, codebook development, data reduction and analysis, monitoring and quality control, and dissemination of results.

Ryan, G.W., and H.R. Bernard. 2003. "Techniques to Identify Themes." *Field Methods* 15(1): 85–109.

Theme identification is one of the most fundamental tasks in qualitative research. It also is one of the most mysterious. Explicit descriptions of theme discovery are rarely found in articles and reports; when they are, they are often relegated to appendices or footnotes. Techniques are shared among small groups of social scientists, but sharing is impeded by disciplinary or epistemological boundaries. The techniques described here are drawn from across epistemological and disciplinary boundaries. They include both observational and manipulative techniques, and range from quick word counts to laborious, in-depth, line-by-line scrutiny. Techniques are compared on six dimensions: (1) appropriateness for data types, (2) required labor, (3) required expertise, (4) stage of analysis, (5) number and types of themes to be generated, and (6) issues of reliability and validity.

Save the Children. "Session 6: Methods of Data Collection and Analysis. Monitoring, Evaluation, Accountability and Learning (MEAL) Introductory Course." Available at Open University: <http://www.open.edu/openlearnworks/course/view.php?id=1641>.

This open-use, self-guided course was developed by Save the Children in collaboration with Open University. The full course comprises 18 modules and can be accessed at the link above. In "Session 6: Methods of Data Collection and Analysis," the authors discuss the process of identifying research questions, selecting appropriate methodologies, and understanding the difference between quantitative and qualitative data. It offers an overview of common methods and data analysis techniques for both quantitative and qualitative research and discusses the interpretation of findings. Though the session is broad in scope, it contains links to useful resources on the main concepts covered. **This course informed content in Module 3 of this document.**

For more information, contact:

Health Policy Plus
Palladium
1331 Pennsylvania Ave NW, Suite 600
Washington, DC 20004
Tel: (202) 775-9680
Fax: (202) 775-9694
Email: policyinfo@thepalladiumgroup.com
www.healthpolicyplus.com

