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Helpdesk Report: Voice and accountability in the health sector

Date: 31 May 2013

Query: Write a report to identify: 1) Useful sources on assessment of voice and accountability (V&A); 2) Examples of V&A in the Bangladesh health sector; and 3) Different models of V&A.

Contents

1. Assessment of voice and accountability in the health sector
2. Assessment of specific voice and accountability initiatives in health sector
3. Voice and accountability in the Bangladesh health sector
4. Models of voice and accountability
5. Additional information

1. Assessment of voice and accountability in the health sector

A systematic review of the literature for evidence on health facility committees in low- and middle-income countries
McCoy D, Hall J, Ridge M. 2012. Health Policy and Planning 27:449–466
http://heapol.oxfordjournals.org/content/early/2011/12/08/heapol.czr077.short?rss=1

Community participation in health (CPH) has been advocated as a health improving strategy for many decades. However, CPH comes in many different forms, one of which is the use of health facility committees (HFCs) on which there is community representation. This paper presents the findings of a systematic literature review of: (a) the evidence of HFCs' effectiveness, and (b) the factors that influence the performance and effectiveness of HFCs. Four electronic databases and the websites of eight key organisations were searched. Out of 341 potentially relevant publications, only four provided reasonable evidence of the effectiveness of HFCs. A further 37 papers were selected and used to draw out data on the factors that influence the functioning of HFCs.

A conceptual model was developed to describe the key factors. It consists of, firstly, the features of the HFC, community and facility, and their interactions; secondly, process factors relating to the way HFCs are established and supported; and finally, a set of contextual factors. The review found some evidence that HFCs can be effective in terms of improving the quality and coverage of health care, as well as impacting on health outcomes. However, the external validity of these studies is inevitably limited. Given the different potential roles/functions of HFCs and the complex and multiple set of factors influencing their functioning, there is no 'one size fits all' approach to CPH via HFCs, nor to the evaluation of HFCs. However, there are plenty of experiences and lessons in the literature which decision makers and managers can use to optimise HFCs.

Community accountability at peripheral health facilities: a review of the empirical literature and development of a conceptual framework
Molyneux, S., Atela, M., Angwenyi, V, Goodman, C., 2012. Health Policy Planning, 27 (7)
http://heapol.oxfordjournals.org/content/27/7/541.full.pdf+html

Public accountability has re-emerged as a top priority for health systems all over the world, and particularly in developing countries where governments have often failed to provide adequate public sector services for their citizens. One approach to strengthening public accountability is through direct involvement of clients, users or the general public in health delivery, here termed 'community accountability'. The potential benefits of community accountability, both as an end in itself and as a means of improving health services, have led to significant resources being invested by governments and non-governmental organisations. Data are now needed on the implementation and impact of these initiatives on the ground. A search of PubMed using a systematic approach, supplemented by a hand search of key websites, identified 21 papers from low- or middle-income countries describing at least one measure to enhance community accountability that was linked with peripheral facilities. Mechanisms covered included committees and groups ($n=19$), public report cards ($n=1$) and patients' rights charters ($n=1$). In this paper the authors summarise the data presented in these papers, including impact, and factors influencing impact, and conclude by commenting on the methods used, and the issues they raise. Key influences on the impact of the community engagement activities are:

- How committee and group members are selected and their motivation for involvement;
- The relationship between groups or committees, health workers and health managers;
- Provision of adequate resources and support by local and national governments.

The authors highlight that the international interest in community accountability mechanisms linked to peripheral facilities has not been matched by empirical data, and present a conceptual framework and a set of ideas that might contribute to future studies.

The income elasticity of health care spending in developing and developed countries
Marwa Farag, M., Nanda Kumar A.K., Wallack, S., Hodgkin, D., Gaumer, & G.,Erbil, C. 2012, Int J Health Care Finance Econ, 12:145–162
http://link.springer.com/article/10.1007/s10754-012-9108-z#page-1

To date, international analyses on the strength of the relationship between country level per capita income and per capita health expenditures have predominantly used developed countries' data. This study expands this work using a panel data set for 173 countries for the 1995–2006 period. The authors find that health care has an income elasticity that qualifies it as a necessity good, which is consistent with results of the most recent studies. Health care spending is least responsive to changes in income in low-income countries and most responsive to in middle-income countries with high-income countries falling in the middle. Finally, it was found that 'Voice and Accountability' as an indicator of good governance seems to play a role in mobilising more funds for health

"Voice and Accountability" had a significant impact on mobilising more funds for health in South America but the variable was not significant in other continents (albeit positive). The role of "Voice and Accountability" has not been explored much in the literature in the context of health care. However, it has been found that voice and accountability can strengthen sustainability of conditional transfer programs in Latin American Countries through improved oversight over programme implementation as well as the use of funds. Latin American countries as a group seem to have experienced considerable improvements in this area compared to other countries over the time period of the study. This finding is intriguing and

prompts further investigation into the role that "Voice and Accountability" can play in mobilising more funds for health in South America using more in depth data from this region.

Challenges to fair decision-making processes in the context of health care services: a qualitative assessment from Tanzania.
Shayo, E.H, Norheim, O.F., Mboera, L.E.G., Byskov, J., Maluka, S., Kamuzora, P., Blystad., A. 2012, International Journal for Equity in Health, 11: 30
http://www.biomedcentral.com/content/pdf/1475-9276-11-30.pdf

Fair processes in decision making need the involvement of stakeholders who can discuss issues and reach an agreement based on reasons that are justifiable and appropriate in meeting people's needs. In Tanzania, the policy of decentralisation and health sector reform place an emphasis on community participation in making decisions in health care. However, aspects that can influence an individual's opportunity to be listened to and to contribute to discussion have been researched to a very limited extent in low-income settings. The objective of this study was to explore challenges to fair decision-making processes in health care services with a special focus on the potential influence of gender, wealth, ethnicity and education. We draw on the principle of fairness as outlined in the deliberative democratic theory.

The study was carried out in the Mbarali District of Tanzania. A qualitative study design was used. In-depth interviews and focus group discussion were conducted among members of the district health team, local government officials, health care providers and community members. Informal discussion on the topics was also of substantial value.

The study findings indicate a substantial influence of gender, wealth, ethnicity and education on health care decision-making processes. Men, wealthy individuals, members of strong ethnic groups and highly educated individuals had greater influence. Opinions varied among the study informants as to whether such differences should be considered fair. The differences in levels of influence emerged most clearly at the community level, and were largely perceived as legitimate.

Existing challenges related to individuals' influence of decision making processes in health care need to be addressed if greater participation is desired. There is a need for increased advocacy and a strengthening of responsive practices with an emphasis on the right of all individuals to participate in decision-making processes. This simultaneously implies an emphasis on assuring the distribution of information, training and education so that individuals can participate fully in informed decision making

Strengthening Voice and Accountability in the Health Sector
DFID. 2008. PATHS Technical Brief.
http://www.healthpartners-int.co.uk/our_expertise/documents/Voiceandaccountability.pdf

Voice and accountability really matter if health services are to be improved. Knowing how, when and where to intervene to strengthen citizen voice and accountability within the health sector is challenging in contexts where health systems are very weak and many issues require urgent attention. Partnerships for Transforming Health Systems Programme (PATHS) is funded by DFID and was implemented in Nigeria in 2002. This Technical Brief looks at how seven different systems strengthening and service delivery improvement initiatives helped strengthen citizen participation and voice, and enhanced accountability in the PATHS states over the period 2003 to 2008. The authors found that involving members of the community in the governance of health facilities through facility health committees proved an effective way to progress a V&A agenda. However, to ensure that these committees functioned effectively, considerable capacity building support, in the form of formal training and on-going mentoring

support, was required. The quality of community participation in Facility Health Committees (FHCs) was low in the PATHS states that relied on a one-off training, whereas in Kaduna, where the support was more broad-ranging and extensive, early results pointed to some interesting V&A outcomes.

Initiatives that provided formal mechanisms through which citizen voices could reach health providers and policy makers appeared to offer the most potential from a voice and accountability perspective. In the PATHS states these initiatives not only placed an obligation on different parts of government to listen to the voice of the people, but also introduced incentives to respond. In contrast, initiatives that relied on citizens trying to influence policy-makers via informal routes (e.g. safe motherhood demand-side initiative and facility health committees) could not guarantee that citizens would get an audience with a policy-maker, while getting a response appeared to depend on a policy-maker's personal initiative or whim. Such initiatives are likely to fail in the absence of parallel efforts to strengthen public accountability at local government level. This highlights the importance of timing work on V&A so that it links in with other initiatives that aim to strengthen performance management and public accountability at local government level.

Civil society organisations, such as Non-Government Organisations (NGOs) and Community-Based Organisations (CBOs), have a potentially important role to play in creating space for voice and catalysing changes in accountability between providers, policy-makers and communities. This requires further exploration as new V&A initiatives are designed and implemented.

Community-directed interventions for priority health problems in Africa: results of a multicountry study
The CDI Study Group, 2010, Bulletin of the World Health Organization (88)
http://www.who.int/bulletin/volumes/88/7/09-069203/en/index.html

A Community-Directed Intervention (CDI) is one that is undertaken at the community level under the direction of the community itself. Initially, local health services and their partners introduce the range of possible interventions in a participatory manner and explain the community-directed approach and how it can ensure community ownership from the outset. Subsequently the community takes charge of the process, usually through a series of community meetings where the roles and responsibilities of the community in the CDI process are discussed and the community decides how, when and where the intervention will be implemented and by whom; how implementation will be monitored, and what support (financial or otherwise), if any, will be provided to implementers. The community then collectively selects the implementers. Health workers train and monitor the latter, but the community directs the intervention process.

This study was designed to evaluate the effectiveness, cost and process of progressively adding four established health interventions of different complexity to the CDI process already used for the delivery of ivermectin. Quantitative survey methods were used to evaluate effectiveness and cost, and qualitative methods were used to evaluate processes.

Effectiveness: In both years of the study the coverage for vitamin A supplementation, insecticide-treated nets and home management of malaria was significantly higher when delivered through the CDI process. The increased coverage was particularly striking for the antimalaria interventions. While very low in the comparison districts, it nearly doubled when delivered through CDI.

Costs: At the district level, cost analysis suggests that delivering health care interventions through the CDI process is relatively cost-efficient. There was little difference in the relative allocation of costs between CDI trial sites and comparison districts. In both cases staff

salaries comprised the major cost (51.2% versus 48.6%, respectively). Maintenance, training and social mobilisation each accounted for 10–17% of costs in both groups of districts. The cost of transport comprised less than 3% in the CDI districts and about 8% in the comparison districts.

At the first-line health facility level, the CDI strategy did not result in significant cost savings. While costs were slightly lower in the CDI districts (median: US$ 1,025) than in the comparison districts (median: US$ 1,170), the difference was not statistically significant. In this case as well staff salaries were the costliest component.

Critical process factors: Implementing the CDI strategy involved five major processes at different levels of the health system. The authors evaluated stakeholder processes, health system dynamics, engaging and empowering communities, engaging community implementers, and the effect on broader systems. The authors found that stakeholder identification and consultation at all levels of the health system was critically important for the success of the CDI strategy, and that the degree of consensus increased over time as the CDI process matured. The participatory consultation and sensitisation process and the improved availability of intervention materials led to an increased commitment of the health system to the CDI process at all levels in all seven sites.

Integrated delivery of different interventions through the CDI strategy proved feasible and cost-effective where adequate supplies of drugs and other intervention materials were made available. Communities, health workers, policy-makers and other stakeholders were quite supportive and their buy-in to the CDI approach increased significantly over time. Since intervention coverage also increased as more interventions were gradually included in CDI delivery, the results of the study are promising in terms of the sustainability of the CDI approach.

Assessing the impact of Health Centre Committees on health system performance and health resource allocation
Loewenson R, Rusike I, Zulu M (2004) EQUINET Discussion Paper 18. Harare, Zimbabwe
http://www.equinetafrica.org/bibl/docs/DIS18%20res.pdf

In this study in Zimbabwe, four wards serviced by clinics with a Health Centre Committee were compared with four wards with clinics without a Health Centre Committee. Clinics with Health Centre Committees (HCCs) had, on average, more staff and there was some evidence of higher budget allocations from the Ministry of Health and Child Welfare than those without HCCs. They also had more Expanded Programme on Immunisation campaigns than those without HCCs. Drug availability at the clinics with HCCs was better than those without HCCs, although drug availability was generally poor. It could be argued that improved health performance and staffing in these areas is associated with an improved capacity to draw and use health resources. If this is the case then there is a virtuous cycle for those clinics with HCCs and a vicious cycle for those without.

The study indicated also that areas with HCCs performed better on Primary Health Care (PHC) statistics (environmental health technician (EHT) visits, oral rehydration salts (ORS) use) than those without, and that there is improved contact with the community in areas with HCCs. Community health indicators (health knowledge, health practices, knowledge and use of health services) were higher in areas with HCCs than in those without. Communities in areas with HCCs had a better knowledge of the organisation of their health services from the indicators assessed, making services more transparent to them. There was also evidence of improved links between communities and health workers in these areas.

HCCs have not had direct influence over core health budgets and have little influence in how their clinics are managed and run. The improved resources to clinics in areas with HCCs

indicates some indirect association between HCCs and primary care resources. This may be exerted through support for clinic security, for staff needs, for clinic facilities and outreach and other services.

2. Assessment of specific voice and accountability initiatives in health sector

Community participation and voice mechanisms under performance-based financing schemes in Burundi
Falisse J, Meessen B, Ndayishimiye J, Bossuyt M. 2012. Tropical Medicine and International Health 17(5) pp 674-682
http://onlinelibrary.wiley.com/doi/10.1111/j.1365-3156.2012.02973.x/full

This paper analyses the roles of two community accountability mechanisms in a Performance-Based Financing (PBF) scheme. It evaluates 100 health committees and 79 Community-Based Organisations (CBOs) in six Burundi provinces (2009-2010) and a framework based on the literature on community participation in health and New Institutional Economics.

CBOs are existing local organisations, set up for other purposes (e.g. cooperatives, charities, etc.) They were selected through a bidding process by peer organisations or by a panel of experts. They are offered quarterly contracts by the Purchasing Agency to 'authenticate' with randomly selected users the declarations of the Health Centres on patients and care. The data collected through CBOs' verification regard (i) the existence of the users, (ii) the existence of the treatment these users received, (iii) their perception of the price, (iv) their perception of the quality of the services, and (v) their possible comments. This information is reported directly to the Purchasing Agency that pays CBOs between US$1 and US$2 per validated questionnaire.

PBF schemes also use pre-existing health committees (Comité de Santé, COSA). COSA members are representatives elected by the population living in the catchment area of a Health Centre. COSA's role is defined as participating in (i) technical comanagement of the Health Facilities (mostly planning and evaluation), (ii) administrative co-management (including controlling the finances), (iii) promotion in the population, and (iv) other (unspecified) activities. COSA's members are invited, along with the Health Centre's medical staff, to design the Health Centre quarterly development plan. This plan includes a decision on the allocation of the funds received through the PBF scheme.

This paper discusses how these two community participation mechanisms function in practice through the results of a recent survey. The authors conclude that the health committees appear to be rather ineffective, focusing on supporting the medical staff and not on representing the population. CBOs do convey information about the concerns of the population to the health authorities; yet, they represent only a few users and lack the ability to force changes. PBF does not automatically imply more 'voice' from the population, but introduces an interesting complement to health committees with CBOs. However, important efforts remain necessary to make both mechanisms work. More experiments and analysis are needed to develop truly efficient 'downward' mechanisms of accountability at the Health Centre level.

Health facility committees and facility management - exploring the nature and depth of their roles in Coast Province, Kenya
Goodman, C., Opwora, A., Kabare, M., & Molyneux, S. (2011) BMC Health Services Research 11:229
http://www.biomedcentral.com/1472-6963/11/229

This paper explores the nature and depth of the roles of Health Facility Committees (HFCs) in two rural districts of the Coast Province in Kenya through interviews with health workers, committee members, patients and district managers, and evaluates how they have contributed to community accountability. Structured interviews were conducted with the health worker in charge and with patients in 30 health centres and dispensaries. In-depth interviews with health workers and HFC members included a participatory exercise to stimulate discussion of the nature and depth of their roles in facility management.

While the HFC members described their work in the facility as largely voluntary, Direct Facility Financing (DFF) allowances were seen as partially compensating members for the time spent on health-related activities, thus increasing commitment to facility management and improving general committee functioning. However, allowances were still viewed as insufficient in many cases, with several HFC members recommending that they be increased, or introduced where they were currently not provided.

The authors reported that the HFCs were generally functioning well and played an important role in facility operations. The breadth and depth of engagement had reportedly increased after the introduction of direct funding of health facilities which allowed HFCs to manage their own budgets. Although relations with facility staff were generally good, some mistrust was expressed between HFC members and health workers, and between HFC members and the broader community, partially reflecting a lack of clarity in HFC roles. Moreover, over half of exit interviewees were not aware of the HFC's existence. Women and less well-educated respondents were particularly unlikely to know about the HFC.

The authors concluded that there is potential for HFCs to play an active and important role in health facility management, particularly where they have control over some facility level resources. However, to optimise their contribution, efforts are needed to improve their training, clarify their roles, and improve engagement with the wider community.

Power to the People: Evidence from a Randomized Field Experiment of a Community-Based Monitoring Project in Uganda
Björkman, M. & Svensson, J., 2007, Quarterly Journal of Economics
http://www.cid.harvard.edu/neudc07/docs/neudc07_s2_p11_bjorkman.pdf

Strengthening the relationship of accountability between health service providers and citizens is by many people viewed as critical for improving access to and quality of healthcare. How this is to be achieved, and whether it works, however, remain open questions. To examine whether beneficiary control works, the authors designed and conducted a randomised field experiment in 50 "communities" from nine districts in Uganda. In the experiment, or intervention, communities were provided with baseline information on the status of service delivery, both in absolute terms and relative to other providers and the government standard for health service delivery. As a way to mitigate local collective action problems, community members were also encouraged to develop a plan that identified the most important problems in health service provision and ways to monitor the provider.

The intervention resulted in 1.7 percentage points fewer child deaths in the treatment communities during the first project year. To the extent that this number is representative of the total treatment population, this would imply that approximately 550 under-5 deaths were averted as a result of the intervention. A back-of-the-envelope calculation then suggests that the intervention, only judged on the cost per death averted, must be considered to be fairly cost-effective.

As communities began to more extensively monitor the provider, both the quality and quantity of health service provision improved. The findings on staff behaviour suggest that the

improvements in quality and quantity of health service delivery resulted from an increased effort by the staff to serve the community. Overall, the results suggest that community monitoring can play an important role in improving service delivery when traditional top-down supervision is ineffective.

Community participation in population-based non-insulin dependent diabetes mellitus control program: A paradigm
Abanobi, O. 2012. International NGO Journal 7(1), pp 1-8
http://www.academicjournals.org/INGOJ/contents/2012cont/May.htm

A paradigm for community participation in population-based non-insulin-dependent diabetes mellitus (NIDDM) control program being used in rural south-eastern Nigeria is presented. The paradigm features the use of area primary health care district health committees as Community-based Diabetes Control Implementation Committees (CDCICs). It also calls for the deployment of village health workers/volunteers as Community-based Diabetes Control Workers (CDCWs) with responsibility for suspect case search, community mobilisation, blood-sugar monitoring and referral, and health education. The model integrates population-based NIDDM into area primary health care system. It also aligns control activities with traditional authority hierarchies and political processes of rural communities. Experience from the implementation of the paradigm in five communities in South-eastern Nigeria is presented. Implications for achieving long-term sustenance, relating diabetes control to prevailing socio-cultural norms and practices as well as for demystification of diabetes control are discussed.

Health care access of the very poor in Kenya. Workshop Paper 11. Meeting the health related needs of the very poor, DFID Workshop 14-15 February. Kenya: Aga Khan Health Service.
Sohani, S. 2005. DFID workshop paper.
http://www.eldis.org/fulltext/verypoor/11_agakhan.pdf

This paper describes a before-and-after intervention study in two districts of the Coast province of Kenya. The intervention consisted of organising local communities to form representative Dispensary Health Committees (DHCs) that would allow people to govern the health and development activities at the dispensary level. The DHCs were given authority to manage revenue generated from user fees, to establish fee levels and to shape the local policy for user fee exemptions and waivers. Other functions included identifying and supporting village health workers; facilitating outreach health care and health education; and helping to improve the supply of essential drugs.

The intervention was found to have had a number of positive impacts. Health care utilisation and revenue generation increased in all clinics. The original model at six sites in Kwale implemented in 1998-2000 showed a significant increase in utilisation of the preventive and promotive services and in the revenue collection at various sites. At the same time, cost barriers for the poorest were reduced through the more effective implementation of fee exemptions and deferrals.

The study concluded that a pro-poor health system can be developed if the true representatives of the poorest are enabled to participate in health care delivery and good governance and proper systems are established, and that semi-literate community members can be trained to collect, aggregate and use health and financial information for decision making and taking corrective action against the misuse and appropriation of scarce resources.

Examining the links between accountability, trust and performance in health service delivery in Tanzania. Consortium for Research on Equitable Health Systems (CREHS). Ifakara Health Institute, Tanzania.
Macha. J., Mushi, H., Borghi, J. 2011. CREHS.
http://www.crehs.lshtm.ac.uk/tan_accountability12jul.pdf

Health Facility Governing Committees (HFGC) are run within health facilities of all levels of the health system in Tanzania. The aim of this study was to examine the pre-conditions for the effective functioning of the committees, both in terms of representing community voice and in improving health worker performance and resource mobilisation in relation to the Community Health Fund (CHF), a voluntary health insurance scheme over which the committees have some responsibility. This report examines case studies of a "well performing committee" and a "less performing committee" in Ulanga District.

Both committees had some impact on health worker performance in terms of health worker availability and opening hours. The impact of the committees on resource mobilisation was examined in terms of how money was spent by the committees. In Kivukoni, the committee approached the district about drug shortages but no response was received. In Sofi Majiji, the committee approached the district about drug shortages and was encouraged to use CHF money to purchase more drugs. Efforts to mobilise communities to join the CHF were mostly undertaken by health care providers in both sites although this is officially a role of the HFGCs. In Sofi Majiji, the committee also mobilised labour from the community for construction of the health facility and provider houses. They managed to levy funds from an NGO to support construction activities. In both sites, the committees managed to use user fee funds to finance small expenses at the facility, with Sofi Majiji also managing to use CHF money to buy drugs. Generally, however, the committees were limited in their availability to decide how to spend user fee and CHF revenue.

One constraint against effective action of the HFGC identified in this study is the absence of meeting and transport allowances. Committee members can be unwilling to give up their time in the absence of allowances to attend meetings or activities.

A summary of this study is available at:
http://resyst.lshtm.ac.uk/sites/resyst.lshtm.ac.uk/files/docs/reseources/Health%20Facility%20Committees_Are%20they%20working.pdf

A Rough Guide to Community Engagement in Performance-Based Incentive Programs: With Lessons from Burundi, Indonesia, and Mexico. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc.
Morgan, L. 2012. USAID.
http://www.healthsystems2020.org/files/92722_file_CE_Guide_5_editor_MA_FINAL_mm.pdf

The role of Community-Based Organisations (CBOs) in verifying health centres' performance in Burundi is described in this paper. Verifying results for every health facility in a country (even one as small as Burundi) implies significant costs; engaging CBOs to carry out this function is likely to be significantly cheaper than other independent auditing agencies – not only because their professional fee expectations are lower, but also because the programme does not incur the same magnitude of transportation costs, since the CBOs are physically closer to households.

In Mexico, the *Oportunidades* conditional cash transfer (CCT) programme provides cash stipends to mothers in poor households, conditional on them ensuring that each family member attends a health check-up once a year, that their children attend school, and that the mothers attend a monthly class on health topics. Volunteer programme beneficiaries, known as *vocales* are engaged as local arms of programme administration, providing participants

with programme information and conducting workshops on self-help topics. In terms of oversight, *vocales* see their role predominantly as one that ensures beneficiary compliance with the programme, and less one of oversight of any other entity (for example, health providers). Engaging the *vocales*, to administer the programme at the local level, effectively cuts the cost of implementation. The lowest level of programme staff in *Oportunidades* are the *Responsable de Atención* (RA), who are responsible for overseeing large numbers of beneficiaries: in one locality called Queretaro, for example, there are 25 RAs who each coordinate an average of 3,600 households. By contrast, the almost 250,000 registered *vocales* in the *Oportunidades* programme represent on average 25 beneficiary families each. Replacing them with paid staff would increase the cost of administering *Oportunidades* considerably.

But this apparent cost savings is not as straightforward at it might appear at first glance. In Burundi, for example, the Performance-based Incentive (PBI) unit in the Ministry of Health decided in 2011, to reduce the frequency of verification – from once per quarter to twice per year – while maintaining the household sample size (80 households per facility), thus effectively reducing the sample. Part of the reason for doing so was to give CBOs sufficient time to conduct the surveys, and the provincial authorities sufficient time to analyse the results, but the decision was also driven by the substantial financial and administrative costs of conducting quarterly verification. Verifying results is at the heart of any PBI scheme: paying for reported results gives providers an incentive to over-report, thus it is essential to verify and counter verify what is reported.

Regarding the role of the *vocales*, their importance creates enormous potential for the abuse of power, yet their supervision is extremely limited. This is partly due to cost. Additionally, v*ocales* sometimes ask participants for volunteer contributions, or to give them a portion of their cash transfer, to reduce the cost of materials, food, and travel they undertake as part of their duties. This may point to a programme design issue: programmes cannot expect volunteers to incur expenses to conduct the functions they are responsible for.

The bottom line is that even if engaging communities saves money in terms of the direct costs of hiring them, there are nonetheless other costs related to the function and role the community is playing that must be considered if the function is to be robust. In the Mexican example, these costs may include budget for more and better training for *vocales*, including training on how to report "up" to the programme; for visits by higher level authorities to check on the programme; in advertising channels among beneficiaries where they can report abuse by *vocales*; and even by paying *vocales* modest salaries for their work.

In regards to the CBOs role in verification, these costs certainly include the cost of conducting verification at a frequency that will ensure the programme is paying only for real, verified results; and the cost of counter-verifying what the CBOs report. For example, in Senegal, CBOs make quarterly visits to households to, as in Burundi, verify results reported by health facilities; but the subsequent quarter, an external auditing agency also counter-verifies a small sample of households – i.e. goes back to the household to ensure the CBO was in fact making the visit and recording information accurately.

The female community health volunteer programme in Nepal: Decision makers' perceptions of volunteerism, payment and other incentives
Claire Glenton, C., Scheel., I.B., Pradhan, S., Lewin, S., Hodgins, S., Shrestha, V. 2010.
Social Science and Medicine. 70 (12): 1920-1927
http://www.sciencedirect.com/science/article/pii/S027795361000198X

The Female Community Health Volunteer (FCHV) Programme in Nepal has existed since the late 1980s and includes almost 50,000 volunteers. Although volunteer programmes are widely thought to be characterised by high attrition levels, the FCHV Programme loses fewer

than 5% of its volunteers annually. The degree to which decision makers understand community health worker motivations and match these with appropriate incentives is likely to influence programme sustainability.

The purpose of this study was to explore the views of stakeholders who have participated in the design and implementation of the FCHVs regarding Volunteer motivation and appropriate incentives, and to compare these views with the views and expectations of Volunteers. Semi-structured interviews were carried out in 2009 with 19 purposively selected non-Volunteer stakeholders, including policy makers and programme managers. Results were compared with data from previous studies of Female Community Health Volunteers and from interviews with four Volunteers and two Volunteer activists. Stakeholders saw Volunteers as motivated primarily by social respect, religious and moral duty. The freedom to deliver services at their leisure was seen as central to the volunteer concept. While stakeholders also saw the need for extrinsic incentives such as micro-credit, regular wages were regarded not only as financially unfeasible, but as a potential threat to the Volunteers' social respect, and thereby to their motivation. These views were reflected in interviews with and previous studies of Female Community Health Volunteers, and appear to be influenced by a tradition of volunteering as moral behaviour, a lack of respect for paid government workers, and the programme's community embeddedness.

This study suggests that it may not be useful to promote a *generic* range of incentives, such as wages, to improve community health worker programme sustainability. Instead, programmes should ensure that the context-specific expectations of community health workers, programme managers, and policy makers are in alignment if low attrition and high performance are to be achieved.

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3. Voice and accountability in the Bangladesh health sector

Voice and Accountability: The Role of Maternal, Neonatal and Child Health Committee
Rashid, S., Leppard, M., Nasreen, H.E., Akther, M. & Rahman, A. 2011. BRAC working paper no. 26
http://research.brac.net/workingpapers/red_wp26_new.pdf

This study aims to explore how the maternal, neonatal and child health (MNCH) committee encouraged community participation and how its communication activities empowered the community people to ensure the healthcare needs of the poor and disadvantaged people. A range of qualitative method was used in the study. In-depth interview, focus-group discussion, informal discussion, observation and document review were used as data collection method. This study conducted in two sub-districts of Nilphamari and Mymensingh districts of Bangladesh during February-April 2010. Thematic content analysis technique was followed.

Findings reveal that the committee members took necessary steps to solve the maternal complication by referral, follow-up of referred cases, and providing financial support to the extreme poor if needed, and the committee helped increase the availability of healthcare service providers and improve the nature of services accessible to the community people. However, the capacity of the committees to raise the voice of poor people was fairly limited due to lack of adequate orientation of the committee members and also for lack of publicity about their roles. Besides, the committee could not run properly due to disagreement between power and literacy among the committee members.

The MNCH committee has potential as it allowed the people's voice and could, thus, serve as a pathway through which ordinary people could hold local health authorities and local service providers to account. The findings informed the further development of an enabling

environment in which the voices of MNCH committee members and community people would be stronger.

Harnessing Technology to Strengthen Accountability
Allen, J. et al. 2012. The National Bureau of Asian Research.
http://www.pacifichealthsummit.org/downloads/2012_Summit/Accountability.pdf

Case Study example: Bangladesh, SMS and teleconferencing

With 800 public hospitals, ensuring patient satisfaction in one of the world's most densely populated countries is a challenge, but a team at the Ministry of Health in Bangladesh has designed a text messaging program that gives patients a voice. "We placed sign boards in all our hospitals that describe how to send complaints or suggestions for improving healthcare services via SMS," said Abul Kalam Azad, Director of Management Information Systems for the Ministry of Health and Family Welfare.

The messages, which total around 1,000 received per day, aggregate in a web portal monitored by Ministry of Health staff. The complaints, said Azad, range from absent hospital employees and poor patient-doctor/nurse interaction, to out-of-stock medicines and unsanitary restroom conditions. A dedicated team follows up with a phone call to the SMS senders to better assess the situation, and then contacts local authorities who can facilitate immediate solutions.

A separate monitoring component of the program is also alleviating the once common problem of absent doctors. The remote, difficult-to-monitor environments of rural Bangladesh created conditions in which doctors could frequently miss work without detection. "Doctors were taking a salary every month, but not [actually] working there," explained Azad. The government responded by setting up a monitoring system that vets physician attendence at 100 of Bangladesh's 800 public hospitals each day. At random, hospitals are asked to join a Skype videoconference call in which doctors must stand in front of the camera to demonstrate their physical presence. Unexcused absences are reported to the Ministry, which then takes action. Azad noted that these measures have improved the office attendance of doctors by 80-90 percent. "The patients are now seeing more doctors, and have more time with each of them. They have much higher levels of satisfaction with the service they are receiving."

Citizen Participation in the Health Sector in Rural Bangladesh: Perceptions and Reality
Mahmud, S. 2004. IDS Bulletin, 35.2.
http://r4d.dfid.gov.uk/PDF/Outputs/CentreOnCitizenship/1052734415-mahmud.2004-citizen.pdf

This article explores people's perceptions about participation for claiming the right to health in rural Bangladesh, and the reality of experiences of participation in newly opened spaces for participation within the state healthcare delivery system, known as "community groups" (CGs). This article presents preliminary findings from research into the CGs that sought to explore the enabling and disabling factors for citizen participation in these intermediary spaces for citizen participation in governance.

So far, the effectiveness of the CGs in operating community clinics for service delivery to the most disadvantaged groups of the population has been limited, and their ability to function as a space for citizen participation and a means for developing capabilities to participate has been negligible. The CGs have not been able to address the constraints of poverty, dependence on powerful groups, social inequality and invisibility, low self-esteem and lack of interpersonal skills and absence of political clout, all of which prevent citizens from engaging

with state institutions in decision-making processes affecting their lives. If anything, these structural constraints have been reproduced and reinforced within the CG, undermining participation within. Hence, citizen capabilities to participate in governance and accountability of state institutions have not been developed. Neither have the CGs been able to foster a sense of community since perceptions of rich–poor differences in capabilities and citizen responsibility remain very strong.

When interviewees in the case study villages were asked what resources they believed helped in acquiring the capabilities for citizen participation, the two most strongly identified were formal schooling and mobilisation of the poor. People feel that knowledge gained formally through schooling, rather than through less visible non-formal means, allows one to contribute to improving society and influencing public action. Being "educated in school" is believed to impart status (respect) and social value (especially for girls by their in-laws) and increase visibility. Education is believed to enhance interpersonal skills and reduce exposure to exploitation. Unity and solidarity is highly valued, especially by poor people, since it is believed to generate strength and power to confront both the lack of accountability of state institutions as well as deal with the dependence of the poor on the patronage and support of more powerful groups. Being part of a group also reduces the possibility of being identified or singled out and minimises individual costs of participation. It is felt, even by the non-poor, that if poor people are united they can articulate their demands more forcefully.

Evidence suggests that schooling to a certain threshold level can be an important resource to develop capabilities for participation and that group membership can provide a fallback against different kinds of class- and gender-based oppression, creating a social and political space for organising collective action and enhancing individual agency in taking positive actions that improve well-being. In rural Bangladesh, the key educational factor is access to secondary schooling, which for the poor is severely constrained as a result of direct and indirect costs and the associated pressures to drop out for marriage or to enter the labour market. Access to institutions that promote organisation and mobilisation is relatively greater, and for the poor and women group membership appears to be a promising resource for developing participation capabilities.

What this analysis has shown is that even if structural factors are addressed, fundamental questions of power, hierarchy and exclusion will continue to condition the potential for the emergence of a process of empowerment as both driver and consequence of citizen participation. Investing in education and group solidarity as sources of empowerment are neither easy nor short term solutions. But implementing initiatives for community involvement in health such as the CGs, without adequate attention to these questions, carries the risk of simply reinforcing existing power hierarchies and generating further frustrated expectations among the poor and marginalised.

Incorporation of Community's Voice into Health and Population Sector Programme of Bangladesh for its Transparency and Accountability
Uddin, J., Ashraf, A., Sirajuddin, A.K.M., Alam, M., Tuñón, C. 2001, ICDDR, B Working Paper 148
http://www.icddrb.org/what-we-do/publications/doc_download/1002-incorporation-of-communityas-voice-into-health-and-population-sector-programme-of-bangladesh-for-its-transparency-and-accountability-wp148-2001

The study assessed the implementation processes of Stakeholder Committees, and affects of the committees, especially participation of Essential Services Package (ESP) users in incorporation of community's voice into Health and Population Sector Programme (HPSP) to establish transparency and accountability in the programme.

Members of the Stakeholder Committees themselves developed the terms of reference (TOR). Each committee prepared its own workplan. About two-thirds of them had correct

knowledge on the purpose of forming the committees and their TOR. The male members than the female members were more knowledgeable about the TOR. Seventy percent of the members were aware of the major issues of TOR. All the members considered the TOR appropriate.

Over 90% of the planned meetings of committees were held with 90% attendance. Ninety-two percent of the committee members reported that they had an equal scope to get themselves involved in activities of the committees, and the opinions of members were respected. The local health problems dominated the discussions of meetings, and the members made efforts to solve the problems identified. They indicated the usefulness of committees in raising awareness among the rural people about sources of health services and effects of adolescent marriage, assisting in organisation of the National Immunisation Days (NIDs), and removing unauthorised structures from the compound of health centres.

The committees regularly monitored the activities of local health centres, resulting in regular attendance and a longer period of stay of service providers, elimination of the practice of charging money illegally from clients, and serving poor patients with respect.

Most health service users in FGDs reported that there were improvements in cleanliness, waiting arrangement, waiting time, and service-providing hours at the health centres after the formation of committees.

About 60% of both male and female members were aware of the HPSP, and half of them could explain the NID. The female members were knowledgeable about the EPI sites as a place for vaccination of children aged less than 5 years and tetanus toxoid (TT) for pregnant women and Satellite Clinics (SCs) as a place for serving pregnant mothers.

The knowledge about Union Health and Family Welfare Centres (UH&FWCs) was almost equal between the male and the female members. Similarly, the knowledge about Thana Health Complexes (THCs) was higher among the male members compared to the female members. The female members had low knowledge about Community Clinics (CCs) compared to the male members. The knowledge of female members about reproductive tract infections (RTIs) was higher compared to the male members. The female members could provide some explanation about RTIs. Seventy-eight percent of the male members and 23% of the female members viewed sexually transmitted diseases (STDs) as a bad disease. The male members than the female members had more knowledge about acquired immune deficiency syndrome (AIDS) as a dreadful disease for which there is no cure and HIV as a germ causing AIDS.

The members of thana committees were more literate than the union committee members. Sixty percent of the thana committee members had higher secondary grade education, and it was 22% among the union committee members. Fourteen percent of the union committee members had no formal education. The proportion of owners of cultivable land was higher among the union committee members than among the thana committee members. Although there was an equal representation from the poor socioeconomic group and females in both the committees, they were selected mainly from working areas of facilitating NGOs (four NGOs facilitated Stakeholder Committee activities in intervention areas).

Although there was no major opposition from the service providers, the thana level managers of MOHFW were reluctant to cooperate with the committees. Some managers of MOHFW felt to be disgraceful in monitoring the activities of health centres by the committees. The Stakeholder Committees did not follow any standard procedures in implementing their activities. Absence of monitoring by the NSC and lack of necessary funds affected implementation of committee activities.

Considering the shorter period of operation of stakeholder committees, it was too early to expect any significant change in terms of quality of services, transparency, and accountability. However, the committees demonstrated their strength in addressing the commonly-discussed barriers to quality of care, such as negative attitudes/behaviours of service providers, poor interactions between clients and service providers, and lack of essential drugs and supplies in the facilities. Although it was not possible to assess the level of sensitivity of committee members on gender issues, their efforts to minimise social barriers to acceptance of TT immunisation during pregnancy and the effects of adolescent marriage had positive impression on the committee activities.

In Bangladesh Citizens Leave a Legacy in Health
Mahmud, S. 2009. Citizenship DRC Case Study Series.
http://www.drc-citizenship.org/system/assets/1052734343/original/1052734343-benequista_etal.2009-in.pdf?1288872986

This case study looks at two community health programmes: 1) community-owned and managed health clinics, and 2) Health Watch Committees set up by NGOs. Most of the community owned clinics were abandoned but some of the committees survived.

New participatory institutions set up by the state can provide opportunities for more inclusive forms of representation, bolster community acceptance and create real pressure for progressive policy change. Research on these particular health institutions in Bangladesh, however, found that unless citizens are politically aware and mobilised prior to participation in these government initiatives, these new spaces for citizen participation can quickly lose their attraction for citizens. The research also found that governments have an interest in ensuring that citizens arrive informed and mobilised. Without these conditions, participatory spaces will fail to provide the legitimacy and efficiency that officials hope to obtain. Furthermore, if these initiatives for public participation are to deliver on their promise of strengthening accountability, they must allow for direct engagement between citizens, public providers and local and state officials.

Research found that the processes of recruitment to the two different initiatives differed significantly. Selection for the management of the clinics was neither transparent nor participatory. Membership was biased towards better-off and professional classes. The wives of wealthy men were usually selected to fill the spots reserved for women. This bias towards the elite limited its legitimacy among the rest of the community. Selection to Health Watch Committees, in contrast, was fairly transparent and more participatory, conducted through popular voting at an open workshop attended by a range of social classes and affiliates of Nijera Kori.

The selection process had far-reaching consequences for how these organisations have functioned. Social inequalities were still present among the members of the Health Watch Committees, but efforts have been made to overcome them. As one woman said, "I think that we always try to participate equally in the meetings, but there are differences in educational level and status, so there is a difference in people's ability to think and talk. However, if a member is remarkably silent, then we encourage them to speak up."

Another striking difference between the two institutions is in their impact on the participants and on service delivery. The community health clinics, most of which soon disappeared, had little positive impact or outcomes, while the Health Watch Committees produced a series of interesting outcomes. At the community level, people have become more aware of what services are available, as evidence by rising numbers of people in those areas seeking maternal healthcare, immunisation and family planning. Awareness of nutrition, hygiene and sanitation also improved. As one woman member of a Health Watch Committee said, "People are now…conscious about healthcare in general. When people refer to us in the hospital they

get better attention. Now they get medicines more often. And when they don't get proper healthcare and complain to me, then I go to the hospital and speak to the doctors."

Citizen Participation and Voice in the Health Sector in Bangladesh
Thomas, D. et al. 2003. Options, DFID, phd.
http://lcgbangladesh.org/HealthandPopulation/reports/Final%20report.doc

This study was initiated at the request of the Ministry of Health and Family Welfare (MOHFW) to contribute to the development of the Ministry's stakeholder participation strategy. The study documents the experience of 14 citizen participation and voice initiatives in the health sector, and their achievements and failures in improving the responsiveness of health providers and policy makers.

The study focuses on the dynamic relationship between citizen voice on the demand side and provider responsiveness on the supply side and the nature and strength of the accountability relationships produced by this dynamic. The four key themes that emerge from the study are: the social constraints to citizen participation and voice; the structural barriers that constrain the influence of voice; the political constraints to citizen participation and voice; and relationships of accountability.

We conclude that significant political and institutional changes will be required to release the bottlenecks on citizen voice and participation so that it can support the Government's health sector reform agenda. Foremost among these is high-level political commitment. Without stronger political commitment and ownership there is a high risk that efforts by the MOHFW to strengthen and expand citizen participation will result in hollow and superficial initiatives that fail to harness their potential contribution. Second, institutional change, both structural and cultural is essential to enable the state to respond, and equip the service to engage in citizen participation.

Civil Society Participation in Health Sector Reforms in Bangladesh
International Women's Health Coalition (IWHC) Webpage accessed 30/5/2013
http://www.iwhc.org/index.php?option=com_content&task=view&id=2246&Itemid=540

Following the Cairo conference, which changed population policy and where the Bangladesh government played a significant role, IWHC worked on behalf of the Swedish government to redesign Bangladesh's population policy from a conventionally narrow emphasis on family planning services alone to inclusion of essential obstetric care, improved antenatal services, attention to adolescents and young married couples, and initiation of an HIV/AIDS program along with other STD services.

Thanks to this coordinated government and civil society initiative, the percentage of women receiving antenatal care rose from 26 percent to 56 percent, female life expectancy increased from 58 to 60 years, and the maternal mortality ratio fell from 440 maternal deaths per 100,000 live births to 322, between 1998 and 2003. The use of emergency obstetric care rose from 5% to 27%, and the mortality rate for children under five in Bangladesh also dropped significantly.

While health indicators for women and girls generally continue to improve, women's and other civil society groups continue to be excluded from policy design and implementation. For example, a draft Health Law was recently created by the government, which had no input from civil society.

IWHC has worked to build civil society participation in Bangladesh to have a stronger voice in impacting health policy and programming. This continues to be important as donor funding for

reproductive health has fallen dramatically in recent years in the country. A 2006 IWHC-supported research project focused attention on the need to involve civil society throughout the reform process. Through documentation, public advocacy, and a series of workshops and dialogues on reproductive health with civil society, village health watch committee members, government officials, researchers, service providers, and the press, the project built local advocacy capacity to hold government accountable.

Researchers affiliated with IWHC's work in Bangladesh established a National Health Watch which is housed in the Bangladesh Rural Advancement Committee (BRAC) School of Public Health, to ensure implementation of the national health agenda. The Health Watch hosts national meetings bringing together health activists, policy makers and researchers to address gaps in policy. IWHC has also supported researchers at BRAC to train civil society to integrate a human rights and sexuality approach to their health advocacy.

## 4. Models of voice and accountability

Evaluation of Citizens' Voice and Accountability. Review of the Literature and Donor Approaches Report
O'Neil, T., Foresti, M. & Hudson, A. 2007. DFID.
http://www.odi.org.uk/sites/odi.org.uk/files/odi-assets/publications-opinion-files/237.pdf

Accountability refers to the nature of a relationship between two parties. A relationship may be characterised as lacking in accountability or highly accountable. In a relationship between two parties, A is accountable to B, if A is obliged to explain and justify her actions to B, and B is able to sanction A if her conduct, or explanation for it, is found to be unsatisfactory. These are the two dimensions of accountability – answerability and enforceability (also called controllability or sanction) – which must exist for there to be real accountability. In addition, both dimensions of accountability require that there is transparency; in the absence of reliable and timely information, there is no basis for demanding answers or for enforcing sanctions.

Figure 1: The accountability relationship: a static model (page 3 of the report)
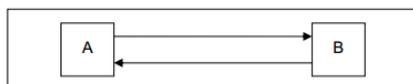
Beyond the A←→B model of accountability, commentators from different traditions use different vocabularies to talk about the roles within an accountability relationship. Borrowing from the language of economics, some commentators refer to the demand and supply sides of accountability, with the demandeurs being those who ask for answers and enforce sanctions. This language is prevalent within the donor community. Alternatively, from a human rights perspective, accountability is about the relationship between a bearer of a right or a legitimate claim and the agents or agencies responsible for fulfilling or respecting that right. A further way of talking about accountability is in terms of an accounter and an accountee, with the accounter being the agent that demands answers and enforces sanctions.

Whilst voice and accountability are intimately related, they are not the same. Voice is about people expressing their opinions. Accountability is about the relationship between two agents, one of which makes decisions which have an impact on the other and/or which the other has delegated to them. Voice and accountability come together at the point where those exercising voice seek accountability. It is also important to note that voice can strengthen accountability, including by pushing for greater transparency, whilst accountability can encourage voice by demonstrating that exercising voice can make a difference. In this respect, there is a two-way relationship between voice and accountability.

The landscape of and for voice and accountability is more complex than a simple model of accountability and its relationship to voice suggests. Rather, there are various levels and forms of accountability, and the formal rules of accountability can be in tension with informal rules. In recent years, complexity has increased with the proliferation of actors engaged in accountability struggles, and the emergence of new arenas or jurisdictions for such struggles. In short, voice and accountability are dynamic and complex rather than static and simple; actors play different roles differently, depending on the context.

Voice and Accountability for Improved Service Delivery
UNDP. 2010.
http://www.undp.org/content/rbas/en/home/presscenter/events/2012/November/regional_governance_week/_jcr_content/centerparsys/download_17/file.res/VA_background_paper_final.pdf

The accountability relationships between government, service providers and citizens are complex. The 2004 World Development Report, Making Services Work for the Poor, provides a useful framework for exploring this complexity. It also offers a way of assessing V&A mechanisms that are appropriate for enhancing voice and accountability in different contexts.

The framework highlights three key sets of actors in the delivery of services:
1. Citizens/clients: individuals and households are simultaneously citizens and clients of services (e.g. healthcare, education, electricity).
2. Politicians/policymakers: Politicians are elected or unelected officials who regulate, legislate and tax, while policy makers implement and enforce these 'rules of the game'.
3. Providers can include public line ministries, departments, agencies or bureaus; autonomous public enterprises; non-profits (e.g. religious schools); or for-profit organisations (e.g. bus companies, private hospitals). Frontline providers are those who come into direct contact with clients (e.g. teachers, doctors, police, engineers).
'In an ideal situation, these actors are linked in relationships of power and accountability'

Fig. 2
Accountability mechanism and accountability relations

The state

➤Improved information about policies and budgets (e.g. participatory auditing) Advocacy & lobbying
➤Protest
➤Participatory planning
➤Participatory budget monitoring & auditing

➤Performance management
➤Improved information on performance & service delivery
➤Registration & licensing providers
➤Setting & enforcing service standards
➤Promoting competition by enabling development of private sector providers

Citizens/ clients

Providers
➤Increased information about services & providers
➤Choice competition & choice of service providers
➤Feedback mechanisms: Citizen report cards & Community score cards
➤Community service planning & management committees (e.g. PTAs)
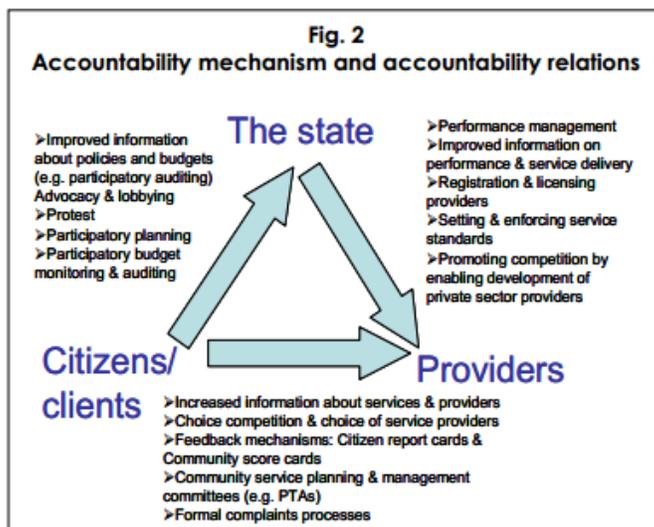➤Formal complaints processes

Figure 2 illustrates that different actors can draw on different tools and mechanisms to strengthen the accountability of other actors in this framework. Citizens, for instance, might improve the accountability of service providers by accessing more and better quality information about the quality of services. They might utilise feedback mechanisms such as

citizen report cards to comment on the performance of service providers. Citizens can also create user groups and community planning and management committees to engage directly in the planning and monitoring of services.

Accountability and Health Systems: Overview, Framework, and Strategies
Brinkerhoff, D. 2003. Partners for Health Reformplus.
http://www.who.int/management/partnerships/accountability/AccountabilityHealthSystemsOverview.pdf

This paper elaborates a definition of accountability in terms of answerability and sanctions, and distinguishes three types of accountability: financial, performance, and political/democratic. The role of health sector actors in accountability is reviewed. An accountability-mapping tool is proposed that identifies linkages among health sector actors and assesses capacity to demand and supply information. The paper describes three accountability-enhancing strategies: reducing abuse, assuring compliance with procedures and standards, and improving performance/learning. Using an accountability lens can: a) help to generate a system-wide perspective on health sector reform, and b) identify connections among individual improvement interventions. These results can support synergistic outcomes, enhance system performance, and contribute to sustainability.

Understanding and Improving Accountability in Education: A Conceptual Framework and Guideposts from Three Decentralization Reform Experiences in Latin America
Gershberg, A.I. 2012. World Development, 40 (5).
http://www.sciencedirect.com/science/article/pii/S0305750X11002981

Many countries have emphasised hierarchical control or different exit and voice mechanisms to increase accountability of educational systems. We build a framework for understanding accountability reforms and develop three illustrative Latin American cases representing distinct approaches (Chile, Nicaragua, and Bogotá, Colombia). We highlight the complexity of institutional change and the value of flexible reform models. Using an institutional perspective we examine the components of accountability; their complex interrelationships; and the importance of design details, implementation, and monitoring. We argue for balancing clear and efficient top-down monitoring and enforcement with other, less punitive accountability mechanisms including strong local quality support systems.

Measuring Change and Results in Voice and Accountability Work
Holland, J. & Thirkell, A. with Trepanier, E. & Earle, E. 2009. DFID Working Paper
https://www1.oecd.org/derec/unitedkingdom/44463612.pdf

Voice and accountability programmes can adopt a very wide range of approaches, and operate in very diverse situations and contexts. This diversity of approach presents challenges for evaluation, since few common methods or models exist. So, while programmes often demonstrate high levels of innovation, there are a lot of inconsistencies in evaluation quality and the type of indicators used.

5. Additional information

Author
This query response was prepared by **Laura Bolton and Geraldine Foster**

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