

# Accountability, Health Governance, and Health Systems: Uncovering the Linkages



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Marshalling the  
Evidence for Health  
Governance  
Thematic Working  
Group Report

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## ACRONYMS

<b>ATI</b>	Access to Information
<b>BVS</b>	Beneficiary Verification System
<b>DFID</b>	Department for International Development, United Kingdom
<b>DPC</b>	District People’s Council
<b>DPCOM</b>	District People’s Committee
<b>ESID</b>	Effective States and Inclusive Development Research Program
<b>FOI</b>	Freedom Of Information
<b>GAPP</b>	Governance, Accountability, Participation, and Performance Project
<b>GPS</b>	Global Positioning System
<b>HFC</b>	Health Facility Committee
<b>HFG</b>	Health Finance and Governance Project
<b>HMIS</b>	Health Management Information System
<b>ICT</b>	Information and Communication Technology
<b>MNH</b>	Maternal Newborn Health
<b>MSF</b>	Multi-Stakeholder Forum
<b>NGO</b>	Nongovernmental Organization
<b>PAQ</b>	Community Partnership for Quality Improvement
<b>PB</b>	Participatory Budgeting
<b>QAPC</b>	Quality Assurance Partnership Committee
<b>QCA</b>	Qualitative Comparative Analysis
<b>RCT</b>	Randomized Controlled Trial
<b>SMS</b>	Short Message Service
<b>TOC</b>	Theory Of Change
<b>TWG</b>	Technical Working Group
<b>USAID/GH/OHS</b>	U. S. Agency for International Development, Global Health Bureau, Office of Health Systems
<b>VHSC</b>	Village Health and Sanitation Committee
<b>WHO</b>	World Health Organization



## EXECUTIVE SUMMARY

This report presents findings and analysis related to accountability, its connections to health governance, and links to health system performance. As part of a series on governance interventions that contribute to health system performance, this report aims to increase awareness and understanding of the evidence of what works and why. The report categorizes and reviews evidence from the literature, further informed by several technical experts across a several types of accountability interventions.

The extent and strength of evidence varies considerably by category and intervention type. Nevertheless, some clear patterns and findings emerge. A major implication of this evidence review is that accountability interventions matter considerably to health governance. However, the extent and nature of their impacts depend greatly on *how* interventions are carried out. Numerous studies confirm that increased access to information, social accountability efforts (e.g. citizen scorecards, user committees), increased effective health reporting, pay-for-performance financing, and financial audits, and others are associated with improved accountability and health system performance. This is more often true when multiple techniques are used together and when the overall effort is tailored (through dialogue created by the interventions) to fit the social and institutional context and is sustained over a long enough time period to move from answerability to sanctions.

Across the report, the most consistent findings are the importance of context and how it influences particular intervention designs and their implementation. These interactions hold at the macro-context level, where political economy and power dynamics as well as institutional incentives and structures dictate why and how specific interventions may operate. They also hold at the micro-context level, where particular features of local actors' interactions shape outcomes. Success may require longer engagement, although in settings with good governance, quicker results may be obtained from particular accountability interventions. Critically, this should inform how policymakers understand and describe their own efforts, as framing has independent effects and often entails reaching beyond the health sector.

The evidence points to effective ways to integrate contextual considerations into accountability efforts by using multiple tactics and techniques, understanding change as systemic, expecting to iterate and adjust, and leveraging local meanings of accountability to inform programming. This report should assist policymakers to consider these issues both generally and in relation to particular types of accountability intervention. There remains ample room for further research on accountability and health governance, particular where interventions' interaction with context is more deliberately examined as part of an explicit theory of change.

## BACKGROUND AND PURPOSE

The importance of governance for effectively functioning health systems is broadly recognized. Despite this recognition, governance definitions continue to be disputed, and arguments and confusion persist about how governance interventions influence health system performance and health outcomes. Governance-related linkages or interventions are often poorly understood and weakly documented. This lack of evidence can result in reticence to invest in health governance improvements or overreliance on a limited set of governance interventions that are deemed to be successful. As development partners and governments increase their focus on achieving universal health coverage through strengthening country policies and institutions, the perceived salience of governance in contributing to health systems improvements is growing, and the need for this evidence becomes more pressing.

In September 2016, the United States Agency for International Development's Office of Health Systems (USAID/GH/OHS), the World Health Organization (WHO), and the Health Finance and Governance (HFG) Project addressed the evidence gap and launched *Marshalling the Evidence for Health Governance* on how governance contributes to health system performance and improves health outcomes.<sup>1</sup> The objective of the initiative is to increase awareness and understanding of the evidence of what works and why concerning governance contributions to health system performance and of how countries are pursuing health governance interventions.

The initiative formed thematic working groups (TWGs) to identify and consolidate evidence by conducting literature reviews and key informant interviews in four governance-related areas: accountability, policy and regulation, public financial management, and the use of knowledge in health systems. These areas were chosen because of their comprehensive nature and importance in all health systems, and because of the lack of international consensus on priority interventions. The TWGs consisted of a small group of experts from policy and practitioner organizations and academic institutions from around the world. Each TWG was led by two co-chairs from different organizations, and each included a member from WHO and the HFG project.

This report is one of five written products from the initiative: one for each TWG governance-related area and a synthesis document. Here, we present findings and analysis related to accountability, its connections to health governance, and its links to health system performance.<sup>2</sup> The paper begins with a brief explanation of our conceptual framework, which provides the structure for the paper's presentation and analysis. Our taxonomy distinguishes among three categories of accountability—democratic/political, performance, and financial—and differentiates how accountability operates in terms of state-society relations (vertical accountability) and within the state and across branches of government (horizontal accountability). We review findings from the literature on a set of accountability mechanisms and processes in each of these categories, and summarize what those findings indicate regarding successes and failures. We then turn to implications for policymakers of themes that emerged from the review and interviews. These are organized under the impacts of macro-contexts, the importance of micro-contexts, how time horizons affect evaluations of success, and issues that emerge

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<sup>1</sup> See: <https://www.hfgproject.org/marshalling-evidence-health-governance/>

<sup>2</sup> The reports of the other TWGs and the synthesis report can be found at: <https://www.hfgproject.org/better-health-governance-better-health-systems-evidence-resources/>



from how accountability is framed. We include recommendations for policymakers, in both donor agencies and country governments, and for practitioners interested in pursuing accountability-enhancing interventions in the health sector.

## CONCEPTUAL FRAMEWORK

Weak or failed accountability is frequently cited as contributing to dysfunctional governance and the inability of national health systems to deliver services and protect the health of citizens. Yet calling for more and better accountability provides few clues on the specifics of what to do and how to do it, and often a precise definition of accountability is missing from these demands. All health systems contain multiple accountability relationships, which can be characterized by two core elements. The first is answerability: the obligation to answer questions regarding decisions and actions. The second is sanctions: some form of punishment for transgression or failure, or of positive reward for proper behavior and actions (Brinkerhoff 2004).

Three theoretical frames are relevant to mapping and understanding accountability relationships. The first of these is principal-agent theory, whose key premise is that goals of principals and agents are divergent and conflicting. Agents seek to maximize their interests at the expense of principals' aims, while principals seek to increase their control over agents (Brinkerhoff and Bossert 2014). Principal-agent dynamics drive the parameters of answerability and sanctions (whether "hard" or "soft") in a given accountability relationship. The second is collective action theory, which argues that getting groups to cooperate to achieve a shared objective of benefit to all must deal with "free riders," those who profit from the actions of the group but do not contribute to those actions. The capacity to deal with "free riders" is dependent upon the size of the group; the larger the group, the tougher it is to craft an objective that all members feel strongly committed to, and the harder it is to prevent "free riding." A key collective action problem for accountability is the often-misplaced assumption that accountability principals share common interests (Booth 2012). The third is the institutionalist perspective, whose relevance here is the focus on how institutional structures and processes distribute power, roles, and responsibilities among accountability actors to manage principal-agent relationships and collective action problems (Brinkerhoff and Bossert 2014, Abimbola et al. 2017).

Clarifying accountability requires determining what health system actors and/or institutions are accountable for. We relied on a broadly applied taxonomy that includes: democratic (political), performance, and financial accountability. For each category, accountability can be divided into policies, practices, and mechanisms that connect the government to society and citizens—so called vertical accountability—and those that operate within the confines of state institutions, from one part of the state to another, which is termed horizontal accountability (Schedler 1999, cited in Brinkerhoff 2004). Vertical accountability directly addresses the state being accountable to the society, while horizontal accountability reflects the way that roles and functions within government are balanced to ensure accountability as part of regular performance, even absent direct citizen engagement.

The vast accountability literature identifies a broad range of governance results relevant for health systems and health outcomes, both instrumental and normative (Brinkerhoff and Bossert 2014, Abimbola et al. 2017). In this study, we focused on the following: transparency, responsiveness, voice, empowerment, reduced corruption, efficiency and effectiveness, improved service delivery, and equity (cf. Siddiqi et al. 2009). For evidence mapping purposes, we created a matrix that arrays the accountability categories (democratic/political, performance, and financial), distinguishing between vertical and horizontal, along with particular policies, practices and mechanisms; and the expected health governance results (see Annex A). This matrix provided us with the cells that guided our literature search, the intent being to identify studies that addressed as many of the cells as possible. The stylized theory of change reflected in the matrix is that the accountability policies, practices, and mechanisms contribute to one or more of the health governance results, which in turn contribute to health system

strengthening and ultimately to health outcomes. The nature and degree of such contributions are mediated by:

- Logics of how accountability policies, practices, or mechanisms work, whether primarily through sanctioning bad behavior, through creating or making transparent information in ways that change incentives for future action (principal-agent and collective action models), or other logics (for example, norms and values)
- Contextual factors at various levels (national to local)
- Interactions between the context (e.g., actors inside and outside the health system, power dynamics) and accountability policies, practices, and mechanisms (issues of fit)
- The implementation of specific accountability policies, practices, and mechanisms

## METHODOLOGY

We conducted a literature review during January–June 2017 to identify publications and reports that addressed accountability in the health sector primarily (though not exclusively) in countries falling into the World Bank’s low-income and lower middle-income groupings. We used the categories and terms in the evidence matrix as input to key word searches, complemented by sources suggested by members of the accountability technical working group. The emphasis in the review was on empirical studies—both quantitative and qualitative—though we did not exclude conceptual and applied theoretical work. We focused on relatively recent sources from the past 10 to 15 years, though again this was not exclusive. While we comment to some extent on the type of study and analysis, we do not assess the details of study designs and did not use type of research design as a criterion for inclusion or exclusion. Our analysis is qualitative and does not include the kinds of metrics included in formal systematic reviews. The limitations of the literature reviewed were considered and are reflected in the discussion below.

Besides the literature review, the team conducted 19 key informant interviews with a mix of academics, donor agency staff, country health officials, and nongovernmental organizations (NGOs) (see Annex B). Key informants were selected based on the TWG’s recommendations of people with knowledge of and experience with accountability and the health sector. Interview questions focused on evidence of the impacts of accountability interventions, lessons learned from practical application or analysis, contextual factors influencing successful accountability efforts, and knowledge gaps (see Annex C). Several key informants also suggested relevant sources from the literature. Key informant comments that bear on the discussion of evidence are incorporated into the report to add detail and nuance to the review.



## STRUCTURE

For each of the six categories in this review, a compilation of evidence is presented. Under each category, we review evidence around relevant accountability mechanisms, policies, or interventions, including relevant insights from key informants. Where there are sub-categories with large amounts of research, those sub-categories are identified and literature clustered under a heading for each. All six sections close with a short discussion of “what works, what doesn’t” that describes strong findings from the literature and assesses what can be said about that category overall.



## MAJOR FINDINGS

The following sections present a distillation of the major findings from our review, organized by the categories in our evidence matrix (Annex A). Commentary from selected key informants is included as well.

### Vertical Democratic Accountability

*Accountability mechanisms: Elections, Freedom of Information laws, open government initiatives, public interest lawsuits, demonstrations and protests, media and investigative journalism*

Elections are the classic democratic accountability mechanism, but they are well recognized as a relatively blunt instrument in targeting feedback or punishment to public officials regarding particular services or issues. To the extent that governance systems protect basic democratic freedoms such as freedom of expression and of assembly, the media, civil society, and public interest lawyers can engage in actions that seek to enforce accountability. Freedom of information (FOI) laws serve as a foundation of the transparency necessary for accountability to function effectively. Open government initiatives move beyond FOI to actively promote increased information transparency as a routine practice and to facilitate easier exchange between citizens and public actors. Literature in this category that connects to health issues is relatively rare.

#### *Elections*

Though elections are not commonly analyzed in terms of their impacts on health outcomes, one study in Brazil traced the effects on health spending and selected health service indicators of enfranchising the poor in municipal elections. Taking advantage of the natural experiment created by the Brazilian federal government's phased introduction of new municipal electronic voting systems, Fujiwara (2015) used regression analysis to examine the effects of the new system on electoral participation of poor and illiterate voters, election outcomes, health spending, and maternal and child health services. He found that electronic voting increased numbers of valid ballots cast by poor populations whose votes had been uncounted in cases where their paper ballots had errors or blanks. The resulting enfranchisement of the poor led to the election of left-of-center candidates who increased health spending in their municipalities. The increased spending led to statistically significant increases in prenatal visits by healthcare professionals and reductions in low-weight births among less educated women. This case demonstrates the accountability impacts of increased political participation by poor voters on redistributive policies and programs.

#### *Freedom of Information Laws*

Of the studies identified for this literature review, the type of intervention most broadly researched within this category of accountability is access to information through FOI laws. FOI laws establish legal/policy frameworks that define the rights of the public to access categories of information and the requirements on information holders associated with those rights. Often these interventions are not specifically evaluated with respect to health outcomes, but focus on service delivery across sectors and on government responsiveness. It is common for access to information to be considered from two sides: supply of and demand for information. FOI studies identify several intermediary factors that influence whether information legislation ultimately can yield positive impacts on transparency and



accountability. These factors include the quality and specifics of the FOI law, existing levels of relevant knowledge, accessibility or complexity of the shared information, levels of civic participation, quality and functioning of local governance, degree of trust in public institutions, and perceptions of public services. Societal divides (e.g., power, income, social class, education, gender, geographic location) are found to play an important role in the extent to which citizens actually use FOI laws and engage in activities intended to hold government actors to account.

Calland and Bentley (2013) examine two cases where community groups used FOI laws to gain access to services. In India, they summarize the efforts of the Association for the Empowerment of Workers and Farmers to use FOI to uncover corruption anti-poverty schemes (minimum wage payments on public works projects and distribution of subsidized food and commodities). The Association mobilized poor communities to conduct group social audits that exposed local officials to “naming and shaming.” Early success was followed by increased bureaucratic resistance, demonstrating the limits of demand-driven accountability efforts, though Indian civil society activists have persisted in efforts to use FOI to address corrupt practices. In South Africa, the Open Democracy Advice Centre used provisions in the constitution to mobilize the poor to use FOI to lobby public officials to honor socio-economic rights and access to services. Unlike the India example where the early success of the Association spawned a variety of grassroots FOI movements, the Centre has struggled in South Africa to generate momentum from its local democracy efforts to continue to press for public access to information. The authors conclude that the following variables are key to success or failure of FOI as an accountability tool: the scale and intensity of grassroots mobilization, skills and resources of civil society groups supporting citizens, accessibility and affordability of information, and the power of public officials to pose resistance.

Michener (2015) provides an analysis of case studies from 16 Latin American countries that have adopted FOI laws since the early 2000s and offers insight as to whether the de jure laws and de facto responsiveness and operability align and further how these affect transparency and corruption. While the transparency outcomes identified are not explicitly tied to health, there are implications for when FOI laws may and may not be most effective within a set of political circumstances. Michener (2015, 96) argues that “the strength of FOI Regimes tends to be inversely related to majority control under single-party or small-coalition governments, but positively so under large-coalition majorities.”

Skoufias et al. (2014) report on the findings of a World Bank-supported pilot project to raise awareness of the Access to Information (ATI) law in seven poor municipalities in the Dominican Republic. On the supply side, the project worked with local government agencies to raise awareness of the importance of complying with the law and helped them to set up management information systems to enable compliance. On the demand side, the project engaged with local community organizations to teach awareness and offer training on how to use the ATI law to request information and hold local governments accountable. To evaluate the results of the pilot, researchers selected seven treatment and seven control municipalities across five provinces, using a sample-matching methodology, and collected quantitative and qualitative data in all sites.

Their evaluation found that the ATI awareness-building project increased government consultation of citizens regarding investment decisions, and those decisions led to expenditures that matched citizens’ preferences. It increased trust in local government, as citizens perceived mayors and other local officials to be more responsive to their concerns. Regarding impacts on services, the project positively affected satisfaction with public parks, but no statistically significant effects were found on other sectoral services. The interpretation was that citizens valued highly visible services and saw their major targets for accountability to be local budget decisions. The study identified the demand-side awareness building through community organizations as explaining more of the outcomes than the supply-side

interventions. The authors note that in the Dominican Republic, community organizations have received good governance capacity-building support for the past decade and have been the main conduit for demand for accountability and responsiveness. Awareness of the ATI law on the part of average citizens may enhance empowerment, they conclude, but its impact is secondary to increased capacity of community organizations to exercise voice.

## *Open Government/Open Data*

Open government initiatives refer to efforts to make government data more easily available to the public, and/or make public input to decision-making processes easier to provide, through various channels. They function to improve accountability primarily by enabling citizens to act on information. They can also improve the accuracy of information available to higher-level government decision makers, though this is more of a horizontal than vertical accountability tool and generally a secondary rather than primary causal logic of interventions. Several studies look at both open data and open government initiatives and a few trace their effects on health outcomes. Young et al. (2016) offer several case studies. Uruguay's program *A Tu Servicio*, for example, based on provision of open government data, allows citizens to access information about health services so citizens can better hold health care providers accountable. The government of Uruguay seems on board and has encouraged other ministries to implement similar projects. The authors also acknowledge the challenges; because *A Tu Servicio* provides information about healthcare providers, the users only opt to use the open data platform when they can change service providers and are trying to decide to whom to switch, rendering it useful to a subset of the population and during only a small window of time. Outreach and communication constitute another challenge; certain portions of the population lack access to internet, and it is estimated that less than one percent of all Uruguayans access *A Tu Servicio*. However, the tool serves to demonstrate the potential of open government platforms.

Young et al.'s Sierra Leone case study looks at the country's response to Ebola using open data. Prior to the outbreak, there had been limited information sharing across national government, aid agencies, and health facilities. The country adopted three open data initiatives that were especially critical in its response to Ebola. These were: the National Ebola Response Centre, the United Nation's Humanitarian Data Exchange, and the Ebola GeoNode. Each used data transparency to try to accelerate and improve Ebola response, and each played a different role in making data accessible and actionable: sharing information, visualizing information that could then be digested by citizens and the media, and arming decision makers with evidence based in data. This type of response was then modeled in other situations, such as Nepal post-earthquake response in 2015. The open data initiatives led to better coordination among responders to the Ebola crisis, with more lives saved and fewer outbreaks. A final case study (discussed further in vertical democratic accountability) details how Singapore used open data to track dengue clusters on a publicly available online map as part of the fight to prevent dengue fever by conveying to users which parts of the country may be most vulnerable to outbreaks. In Singapore, the data enabled vector control programs to target mosquito breeding sites and to inform citizens in affected areas of necessary precautions to avoid dengue infections.

Grossman et al. (2017) report the results of an evaluation of an open-government intervention conducted by the USAID/Uganda-funded Governance, Accountability, Participation, and Performance (GAPP) project to use a cell-phone platform (U-Bridge) to enable citizens to send free and anonymous messages to local government officials regarding their priorities and concerns about services. Despite robust interest, the study did not find statistically significant impacts on outcomes, defined as increased monitoring, increased effort, and increased resources, although it documented examples of targeted improvements and evidence of increased responsiveness. Interestingly, they did find that information

about U-Bridge and use of the platform tended to flow through village networks to a much greater extent than foreseen. The authors' recommendations for the use of information and communication technology (ICT) platforms for open government initiatives emphasize making the information that is shared more actionable (citizens to identify specific issues or concerns for remediation), and sharing information with citizens on government responsibilities so that they can better target messages to the appropriate officials. On the supply side, assisting local officials to develop standard protocols to triage messages and follow up also is suggested.

Madon (2014) compares four interventions in Karnataka state in India to increase the use of information to improve primary health care accountability: two ICTs and two non-ICTs. The first ICT intervention leveraged Karnataka's integrated health management information system (HMIS) that in 2008 created a Web-based portal to enable aggregation of information from the facility level to the central level to facilitate evidence-based decision-making. The second ICT intervention was the beneficiary verification system (BVS) launched in 2012, whose accountability objectives included building capacity that would strengthen monitoring and management for results, and enable local voices to be heard by local governments regarding services and outcomes. The BVS pilot tested multiple technologies: touch screens, smart cards, fingerprint authentication, GPS systems, voice input and recognition, and cameras. The two non-ICT interventions were community monitoring scorecards and the creation of village health and sanitation committees (VHSCs). The VHSCs are an official committee of the gram panchayat (village council), mandated to include 15 members composed of a mix of state, political, and civil society representatives. All VHSCs in the country receive three monthly allocations of Rs 10,000 (US\$167) in untied funds from central government.

Madon's findings point to several features relevant to the contribution of open data and open government to accountability and governance. First is the importance of data quality; the HMIS suffered from incomplete and inaccurate data, with changed reporting formats over the years so that aggregation was difficult. Data were usually entered manually, which led to numerous errors. Second, use of the data for learning and decision making was poor. Third, the BVS technologies led to some increases in data transparency in primary healthcare that enhanced service delivery, as real-time data on performance outputs and outcomes saw use by health supervisors to ensure that services reach the intended beneficiaries. Fourth, the VHSCs offered the strongest opportunities for local engagement and empowerment related to accountability for services. Madon concludes that by noting the interpenetration of ICT and non-ICT interventions and observing that in terms of the factors that enable ICTs to contribute to accountability and empowerment, the technology itself is the least relevant factor.

Case reviews by Hrynick and Waldman (2017) point to potential for ICT-informed approaches to improve accountability, generally when building on good relationships and supported by other stakeholders such as health workers, and when complemented by offline work in support of the same objectives. They note that the specific expectations and framework for accountability in each of the seven cases studied are meaningfully different, though often sharing an underlying assumption that ICTs automatically enhance accountability by making data more accurate and timely. In the cases that worked, the programs took advantage of pre-existing structures for discussion and coordination. Further, some successful efforts proved to be limited by the enabling conditions at higher levels – for example, in Indonesia, the SMS Gateway was integrated into the district government's own agenda to reduce maternal mortality. It was supported initially, but support waned when political shifts at the national level restricted district government funding.

Peixoto and Fox (2016) provide a meta-analysis of ICT's contribution to accountability and government responsiveness. They review evidence from 23 ICT platforms to distinguish between the roles that information and transparency platforms can have in informing upwards accountability and bolstering

downwards accountability through either individual feedback or collective action. They assess the cases in terms of citizen uptake of the ICT platforms and institutional response, rating user uptake high in eight cases, institutional response high in seven cases and medium in three. In the remaining 13 cases, response was low or non-existent. Regarding vertical accountability, they found that ICT platforms can contribute both to upwards accountability (frontline to higher officials), helping senior managers to address service delivery issues, and to downwards accountability (frontline to citizens). This latter result depends upon whether the ICT feedback was shared publicly among citizens. A second finding is that institutional capacity to respond to citizen input can be usefully distinguished from motivation. In several of the cases, senior officials were personally committed to acting upon the ICT-enabled feedback, but it is a challenge to craft institutional incentives to encourage all officials to care about responding to citizen input.

Top-down open government policies can serve as one source of incentives to communicate with citizens. Key informant Mohammed Lamine Yansané noted the impact of government policies in Guinea on information sharing and transparency. He reported that each ministry is required to conduct press briefings, which are televised and broadcast on the radio. For the Ministry of Health, this communications outreach has helped establish a foundation for democratic accountability for health.

### *What Works, What Doesn't in Vertical Democratic Accountability*

As demonstrated by the above studies, when it comes to FOI, there are likely to be disparities in who accesses the information, and changes in legal status or promotion of use of these mechanisms will interact with several other political-economic factors in ways that influence impact. Theories of change that plan to leverage increasing information availability to improve accountability should therefore be nuanced by more explicit incorporation of power dynamics relative to information and responsiveness. Even advanced industrial countries with democratic governance systems place restrictions on access to information. Some scholars have investigated these power dynamics and its ability to motivate collective action to improve public service delivery (Booth 2012).

As will be apparent throughout this report, what does not work is treating accountability interventions of any sort as contextually independent and readily transferable tools. This point is made in most of the sources reviewed for this study and in the wider accountability and governance literature (Bukonya et al. 2012, Brinkerhoff and Wetterberg 2016a, Brinkerhoff and Bossert 2014, Edstrom 2015, Fox 2015 and 2016, Grandvoinet et al. 2015, Joshi 2013 and 2014, O'Meally et al. 2017, Wetterberg et al. 2016).

Passing FOI laws and increasing access to information, from a governance perspective, contribute to establishing a democratic enabling environment that can support accountability actions on the part of citizens. As Fox (2015) points out and our review confirms, there are few studies that relate these interventions to service delivery improvements, whether in health or other sectors. It is important to discriminate between access to information and availability. The existence of FOI laws may, in principle, provide access. However, availability—as the studies reviewed here indicate—is mediated by institutional and social factors that limit the extent to which average citizens can obtain timely and comprehensible information that they can or may be motivated to use for accountability purposes. Citizen action is based on wider sets of norms and expectations, as well as their ability to understand the particular information shared. This may mean that increasing legal or actual access to information may yield widely different accountability outcomes—sometimes catalyzing change, but being heavily dependent on other factors besides information access.

Open government initiatives and ICT platforms for increased transparency and accountability offer tantalizing possibilities for enhancing service delivery accountability. As Madon (2014) shows, ICT tools

can be combined with non-ICT ones, which may enhance their utility across a wider range of institutional settings. As Peixoto and Fox (2016) point out, we need to take care in making assumptions about the causal links between voice, enhanced through open government and ICT platforms, and government response. This is a subset of the question of unpacking the relationship between transparency and accountability. As Grossman et al. (2017) remind us, the specific qualities of the information and of government management of citizen feedback are often decisive in what effects an ICT platform can yield, and so narrower specification of how the information sharing is expected to change behaviors is required for any such effort to lead to increased accountability. The Making Voices Count case studies reinforce the importance of linking ICT-enabled accountability mechanisms to supportive public officials at local and national levels (Hyrnick and Waldman 2017).

An implicit assumption in the studies reviewed is that democratic state-society relations are foundational for accountability in health systems. For this sample of studies, this assumption is an instrumental one, linking to health system performance; but in the wider literature there exists a normative version of this assumption that addresses good health governance (Brinkerhoff and Bossert 2014). Key informant William Savedoff commented on this issue and offered this perspective that questions the extent to which democratic governance can automatically be assumed to enable service-delivery accountability:

*One thing that used to be settled, but is now questioned, is the conviction that more democratic institutions are uniformly better for health system performance and accountability. The tendency to define good governance in terms of performance drives this. But if we look at China's performance as a metric, what does this say about whether democracy and health services go together?*

Many of the performance accountability interventions discussed might prove effective in autocratic or hybrid regimes, but clearer articulation of the dependence of performance accountability efforts on state structure or other macro-contextual factors would strengthen understandings of the evidence in this area. Below, we discuss the implications for policymakers and highlight the links between accountability interventions and their macro-context as conditioning the potential for achieving intended objectives and for sustainability.

## Horizontal Democratic Accountability

Accountability mechanisms: *Parliamentary oversight, ombudsman offices, courts, political decentralization*

Horizontal accountability refers to the structure of the state that ensures checks and balances across branches of government (legislative, executive, judicial) and among state institutions. Decentralization can serve this function by distributing authorities and responsibilities across central to local levels of government. Most states include public institutions whose mandate is to curb abuses by other public agencies and branches of government; these are called “agencies of restraint.” Courts, audit commissions, and ombudsman offices are common examples, and when effectively connected to civil society organizations and the media, they can play an important role in giving “teeth” to social accountability, discussed below.

Political decentralization can reinforce democratic accountability and improve health governance, but the drivers of decentralization decisions usually combine a mix of agendas and motivations that involve a range of actors, which in many cases includes the donors that fund reforms. Smoke (2015) argues that treating decentralization as a discrete governance intervention with uniform features across sites or countries ignores the multiplicity of goals, diversity of forms, and the variations in integration of its political, administration, and financial dimensions. Thus, comparing decentralization experiences to seek causal effects is problematic, and drawing conclusions requires caution.

Besides analyses focused on decentralization, we found relatively few studies within the horizontal democratic accountability category that addressed the health sector in terms of explicit causal inferences. One explanation is that many of the mechanisms and processes within this category may be difficult to evaluate as outcomes using quantitative methods. Mechanisms such as parliamentary oversight or ombudsman offices are not typically amenable to randomized controlled trials, although they can and have been extensively analyzed in the public administration, law, and political science literatures (e.g., Scott 2000).

One health-specific analytic stream that includes attention to horizontal democratic accountability structures and processes is research on corruption in the health sector (see the section below on horizontal financial accountability). DiTella and Savedoff’s (2001) book on hospital corruption in Latin America is one well-known example. Various chapter contributors note the importance of horizontal accountability exercised through effective government oversight and enforcement to combatting corruption in health facilities.

Another example in this category is a study published by the Varieties of Democracy Project, which uses a newly collected dataset covering 173 countries over the years 1900–2012 to parse the effects of democratic accountability on health and identify causal mechanisms that could bear on accountability interventions (Wang et al. 2014). Their results suggest that across governance models with various specifications, democratic regime type has a more consistent effect than measures of quality of government on health outcomes throughout the period. They find that the positive effects of democracy on services are especially salient once the level of democracy has achieved a certain threshold, and further, that the positive effects of democracy are especially stable when both vertical and horizontal accountability are improved. Their findings suggest a positive answer to Bill Savedoff’s question (quoted above) regarding the link between democracy and health system performance: democracy matters in aggregate, but its significance in any particular instance depends on the details of accountability within the state rather than just the topline attribute of being a democracy.

## *Decentralization*

The literature on decentralization is voluminous, and a substantial stream of analysis concentrates on decentralization in the health sector. We are necessarily selective here in our choice of sources. Mills (1994), for example, offers a review of decentralization options with a focus on accountability relationships. Mills notes that the balance between accountability upward to the center versus downward to local entities and citizens depends upon how authorities and resource generation and allocation are distributed and what incentives that distribution creates. A case in point is Gilson et al.'s (1994) study of health-sector decentralization in Tanzania, where local public health services faced multiple and confusing accountability relationships with higher levels of government. Also, public health services had limited authority to take the managerial actions necessary to fulfill the decentralized responsibilities that had been assigned to them. Numerous studies have explored this analytic terrain; a recent example is Bossert and Mitchell's (2011) analysis of accountability in decentralized health structures in Pakistan.

A few studies identified examine the effects of decentralization on health outcomes; these fall under the category of horizontal financial accountability and are discussed below. In terms of democratic accountability, the studies reviewed focus on oversight mechanisms and local political dynamics. Avelino et al. (2013) examine the role of municipal health councils in overseeing disbursements from federal grants for health services, with the outcome variable being level of corruption. Creation of the councils was a requirement for those municipalities receiving grants, and once formed they were charged with basic financial management tasks such as monitoring health budget and expenditures. The study found that the management capacity of the council, as proxy-measured by council age, to exercise horizontal accountability was significantly related to levels of corruption. Municipalities with higher-capacity health councils had less corruption.

Another study related to local management capacity is Kim et al. (2016), which examines the influence of decentralized structures in promoting community-based health interventions from the perspective of the role of leadership in promoting social capital. In their study of six villages in Lao DPR, they found that local leaders who were perceived to be fair and transparent strengthened social capital and enhanced participation in community-based health interventions. In villages where leaders were perceived to be corrupt or did not engage communities in participatory planning, social capital and community participation in health interventions were lower. In this case, improving capacity of local leaders in participatory planning and communication was considered valuable to community-based health programming.

Pruce (2016), summarizing the results of a study conducted by the University of Manchester's Effective States and Inclusive Development (ESID) research program, reports on the impacts of district-level political dynamics on a set of maternal and child health outcome measures. The study looked at two districts: one where political rivalry led to dysfunction, tensions, and citizen dissatisfaction, and one characterized by unified and harmonious local leadership and cooperation with citizens. In the latter district, officials formed a health coalition involving representatives from different social groups. Performance on the outcome measures was much worse in the conflict-ridden district as compared to the collaborative one. The conclusions are that the politics of decentralization can have an important impact on service delivery, and the particulars of individual contexts can affect governance and accountability mechanisms, as other studies have pointed out (Joshi 2014, Brinkerhoff and Wetterberg 2016a, Wetterberg et al. 2017).

The debates in the health-sector decentralization literature and among practitioners are whether the presumed benefits of decentralization—in terms of preference matching, allocative efficiency, and local

accountability—necessarily produce desirable health outcomes for society. Mitchell and Bossert (2010) apply decision-space analysis to six countries (Bolivia, Chile, India, Pakistan, the Philippines, and Uganda). The authors map patterns of discretionary autonomy across health system functions. They discuss how the balance of authorities and responsibilities between central and local health officials can promote achievement of health system outcomes: improved health status, financial risk protection, consumer satisfaction, and equity. However, they also argue that from a perspective that foregrounds health system performance, decentralization can produce some negative outcomes—improvement is not automatic, and depends on how the decision space is structured.

Malesky et al. (2014) also call into question the automatic assumption about decentralization’s beneficial results. Their study took advantage of a natural experiment to assess the effects of recentralization where the government of Vietnam undertook a staged process of abolishing District People’s Councils (DPCs) in 10 provinces prior to national rollout of the institutional change. DPCs were assigned important fiscal and administrative authorities including a horizontal accountability relationship with District People’s Committees (DPCOMs). The recentralization reform left the DPCOMs in place, but substituted provincial-level oversight. The sophisticated empirical analysis demonstrated that recentralization improved the delivery of services favored by central government, which included health. This improvement resulted from the reform’s impact on limiting the power of local elites to dominate investment and spending decisions and profit from corruption. In essence, the reform reallocated accountability to the center, away from the local level.

Several key informants cited the importance of efforts to overcome coordination challenges related to decentralization. That is, rather than decentralization serving as a form of intervention, more helpful was support to make decentralization function better within whatever terms it had been rolled out. Examples included a Joint Annual Health Sector Review process in several countries which brings together local and district actors with central-level decision makers across multiple ministries, noted as having a significant effect on health system performance where the annual sector review was well-run.

### *What Works, What Doesn’t in Horizontal Democratic Accountability*

There is little robust evidence around activities that use ombudsman offices, engage parliamentary committees or MPs, or use litigation and court intervention specifically to achieve better health governance. Key informants did give one example where pressure from parliament was part of a larger story of improvements in health governance. And clearly there is evidence that more consolidated democracies achieve better health outcomes over time.

There has been much more work around political decentralization, with mixed results tied to health governance specifically. While some instances showed decreased corruption, others showed that reductions in decentralization correlated with greater investments in health. The politics of decentralization, the characteristics of particular health services, and the intent of donors that support country decentralization seem to explain to a large extent these mixed results (see Smoke 2015).

## Vertical Performance Accountability

Accountability mechanisms: *Citizen scorecards/report cards, citizen-provider committees, civil society watchdogs, professional associations, media: awareness and citizen education*

This category of accountability contains the literature on what is called social accountability, defined as those actions and mechanisms—short of elections and voting—that citizens employ to hold state actors



and their designates to account. This literature is extensive, and includes a range of studies that seek to connect social accountability with performance and several types of outcomes: service delivery, governance, and citizen empowerment (see the reviews in Fox 2015, Edstrom 2015, and Marsten et al. 2013). Differing taxonomies seek to categorize social accountability actions and mechanisms. Fox (2007) distinguishes between soft and hard accountability, with soft accountability requiring answerability while hard accountability includes answerability plus sanctions for violations. Brinkerhoff and Wetterberg (2016b) develop a continuum of actions: transparency-related, collaborative/co-production-focused, collaborative/compliance-focused, contentious/confrontational.

## *Citizen Scorecards*

Studies assessing the use of report cards or scorecards to monitor health providers or facilities have documented a number of successes. Research employing RCTs to report on successful outcomes has been widely cited, and has garnered both kudos and criticism. Among the most widely cited studies is Björkman and Svensson's (2009) randomized experiment with community participation in monitoring of public primary health providers in 50 facilities in Uganda revealed important health and accountability results. Supported by local NGOs, researchers engaged an NGO to conduct a review of services in the form of a report card, which compared facility performance with national standards and averages. Then the report card data was shared in three meetings. First meeting was with community members alone, second meeting was with health facility providers alone, and the third meeting brought the two groups together to do planning that was based on the report card. Representatives in treatment villages worked with health providers to develop community "contracts" for service improvements and then used subsequent report cards to monitor progress. After a year, treatment and control communities were compared. The study documented a 33 percent reduction in child under-five mortality, as well as several other positive impacts on service utilization and health outcomes. Treatment communities were more engaged in holding providers accountable through monitoring, and health worker behaviors changed to be more responsive to serving community health needs. Notably, communities that were more homogeneous in terms of ethnicity had larger effects, likely indicating that collective action is harder in heterogeneous groups.

Bauhoff et al. (2015) brought in community members in Tajikistan to help identify which indicators should be used on scorecards, with the goal of improving health provider performance. The authors used qualitative research methods to learn about citizens' health care concerns and priorities for giving feedback. They considered both parties involved (citizens and providers) as well as feedback and information channels between them. Though this study did not test the effectiveness of score cards developed with citizen and provider participation against other scorecards, the authors emphasized the importance of localized priority setting on scorecards to accommodate differences in population preferences (e.g., for equipment and service priorities) and factors such as gender and access to transportation.

A study in the education sector investigated the impact of training citizens on how to use scorecards (Zeitlin et al. 2011). The findings could reasonably be extrapolated to the health sector. The research team conducted an evaluation in Uganda of scorecard effects on education outcomes that compared two different approaches to use of the scorecards and found that participatory training in using scorecards for community monitoring led to statistically significant effects on teacher and student absenteeism and on student scores beyond the use scorecards without the participatory training.

Gullo et al. (2017) examine a social accountability initiative in Malawi, implemented by CARE, a large international NGO. CARE introduced community scorecards to track maternal and reproductive health

services through three main processes: empowerment of the service receiver (women in particular), empowerment of the service provider (health workers), and safe space for negotiation. Community members and service providers developed 12 indicators to track progress, for example, reception of clients at the facility, level of male involvement in maternal newborn health (MNH) issues, and availability of transportation for referrals during labor and delivery. Citizens and service providers generated similar issues, but from their different perspectives. For example, “relationship with providers” was an indicator for both: from the community side this referred to how providers treated them, whereas from the provider’s side, it referred to things like patients not listening to them, or following their guidance. The service providers also generated one additional indicator—availability of supervisory support—for a total of 13 Score Card indicators. In an open discussion, participants agreed on scores for each indicator using a scale from 0–100. Thus, the development and discussion around the scorecard was itself the primary form of intervention.

The researchers measured effects on outcomes including modern contraceptive use, antenatal and postnatal care service utilization, and service satisfaction; they also evaluated changes in indicators developed by community members and service providers in the intervention areas. In terms of outcomes, a significantly higher proportion of pregnant women received a home visit during pregnancy in the intervention area, and there was an estimated 57% greater use of modern family planning in the intervention area. No other health outcomes appeared to be different between intervention and control areas at endline, possibly also reflecting strong underlying health outcomes at baseline. With respect to the community score card indicators, upon the conclusion of the cluster-randomized trial of community scorecards, all 13 indicators saw improvements over the course of the study. This improvement occurred through the deployment of locally developed solutions. Notable strengths of scorecards were the relationship they built between community members and health care providers, and their contribution to enabling responses to the self-identified community needs. Sara Gullo a key informant, commenting on her research, noted that:

*CARE has reconceptualized performance accountability as depending on three interacting factors: approaches need to empower communities and citizens (knowledge, willingness to voice needs, collective action behavior), need to cultivate service provider responsiveness and accountability (listening to communities), and need to create spaces for dialogue and negotiation between communities and providers. The framework came out of CARE’s experience to distill key domains of work necessary to social accountability. CARE finds that all three ingredients need to be cultivated to effect changes in accountability relationships.*

Key informant Asha George described an initiative that worked on both the supply and demand sides of accountability and made good use of scorecards. The NGO facilitated community- based action addressed demand and supply side constraints through three key strategies: raising awareness, community monitoring, and dialogue with government health providers and authorities based on report cards, including participatory development of project tools and facilitated community monitoring using those tools and dialogue with authorities around results. She observed that:

*Constant dialogue is needed with government providers and authorities. Tensions particularly with frontline providers whose performance is being monitored and called into question need to be negotiated so that, leaving aside egregious errors, the structural constraints that inhibit service delivery and its quality be addressed. Community and NGO initiative in monitoring access to services with the express intent of addressing marginalized women’s needs and entitlements proved to be an important starting point for dialogue with providers on how to improve service*

*delivery. Acknowledgement and cooperation from government health providers and authorities is critical for these dialogues to translate into effective action.*

## *Citizen-provider Committees*

A commonly used mechanism to implement citizen accountability is a committee that combines community members with providers and/or health facility managers. These are sometimes formally created under government auspices, and sometimes formed informally through the efforts of providers, citizens, or other civic actors (often subsumed in scorecard or report card process as discussed above). In many if not most of these structures, citizen participation fulfills a service-delivery enhancement role as well as an accountability function. Goodman et al. (2011), in their study of 30 health facilities in one province in Kenya, report on the experience of Health Facility Committees (HFCs), which have been set up as part of a 1998 government policy to engage citizens in health care. The HFCs' roles and responsibilities combine facility oversight, community representation and resource mobilization, and outreach. With the advent of direct district funding for health facilities, the HFCs took on an additional role of budget management. The establishment of such committees is often a feature of donor-funded health projects: for example, Quality Assurance Partnership Committees (QAPCs) in the Philippines (Brinkerhoff and Wetterberg 2016a), and Community Partnerships for Quality Improvement (PAQs) in Rwanda (Lipsky 2016), and Multi-stakeholder Forums (MSFs) in Indonesia (Wetterberg et al. 2017). Our country-level key informants also mentioned them: for example, district health committees in Guinea include community representatives, elected officials, and providers. A study of corruption in South Africa by Rispel et al. (2016) similarly found that while participatory committees existed in paper at different levels, they were not in meaningful use.

Common themes from the findings of these studies include lack of clarity and/or consistency regarding roles responsibilities, conflicting perspectives among stakeholders of those roles and responsibilities, difficulties in maintaining engagement of community volunteer members, insufficient resources, skill requirements for community members and providers, and weak connections between committees and the larger community. In the case of the QAPCs, for example, community members were uncomfortable with their oversight role, and much preferred to consider the committees as facilitating the delivery of health services rather than exercising accountability. The Indonesia study, conducted in 15 health centers in four districts, found substantial variation across the centers in how facility staff and members of the MSFs perceived the role of citizens in accountability. The study found that even in centers where staff felt that citizens should have a relatively minor role in enforcing accountability, interviewees reported service delivery improvements.

Motivation emerged as a concern in several of the studies. Interviews with PAQ members revealed disappointment when facility staff did not respond to PAQ concerns and suggestions. Interestingly, in the Indonesia study, past negative interactions between facility staff and citizens was not a consistent predictor of the adoption and use of social accountability mechanisms. Resource issues for committees were discussed particularly in the context of donor-funded initiatives, where it was unclear how committees would be sustained absent external sources of funding. Concerning skills, in the case of the PAQs, health service quality tended to be defined by facility staff in medical terms, and community members felt ill-equipped to engage in this domain.

Key informant Cathy Green commented on the narrow accountability reach of citizen committees, echoing the consensus in the literature that bottom-up accountability mechanisms are insufficient in sustaining changed citizen-provider relationships without broader governance changes. She observed that:

*Despite limitations (such as few women representatives), Health Committees led to visible improvements and the solving of small problems, were useful in nudging providers to respond and the community to express needs. However, they only changed incentives at the facility level – you can promote and achieve positive change at the facility level, but if problems are systemic there will be limited impact.*

## Media

Though the accountability role of the media did not appear as part of many evaluations, several case studies offer some findings. El-Jardali et al. (2015) conducted a media review, key informant interviews, and a validation workshop in an examination of health reporting and its influence on health policy in Lebanon. Several themes emerged from the study. First, health journalism was not necessarily prioritized in the culture the way other journalism topics may be. Second, the quality of health care reporting was low, and health care media stories were not necessarily informed by evidence. Finally, journalists felt distance between themselves and policymakers limited their access to relevant information. The findings acknowledged barriers between media and journalists. Further, the authors recommend instituting a link between researchers, media, and policymakers to minimize the disconnect among them and increase the use of evidence in informing policy action.

Young et al. (2016) document an example of collaboration among journalists, policymakers, and citizens using an open data mechanism. As part of its response to record outbreaks of dengue fever, Singapore's government began using open data to track clusters of dengue outbreaks on a publicly available map to minimize new infections. Citizens communicated information on new cases to the government, at which point it was added to the map. Citizens then had access to the map, enabling them to track outbreaks in their communities and take precautionary measures. The authors estimate an average of 1,000 hits on the dengue website each day. Singapore's context is exceptional in that its citizens generally have a high rate of internet connectivity and access to technology, so they may be more able and likely to seek information. Such an initiative may not work in a less technologically advanced country. The government's responsiveness to outbreaks improved. However, the authors note that for such a tool to be relevant, the data it captures need to be accurate and timely, particularly if they are informing government action. Journalists have come to rely on the website for accurate information about outbreaks.

Where investigation and free media are more commonplace, there are examples of publications that disseminate information on even hidden topics related to accountability and health governance. For example, Anticorruption Action Centre Ukraine (2013) was able to publish a detailed report on "Who makes money on HIV/AIDS and tuberculosis in Ukraine" describing particular practices used to corrupt the drug procurement system and linking these techniques to limited availability and high cost of medicines.

## What Works, What Doesn't in Vertical Performance Accountability

This category of accountability has been the strongest focus of research employing RCTs to evaluate outcomes, which in the views of some researchers has led to treating social accountability mechanisms as "widgets," transferrable tools that will produce similar results wherever they are applied (Joshi and Houtzager 2012). As key informant Lynn Freedman cautioned:

*There's a lot of "faux" accountability efforts out there; think of suggestion boxes in facilities where there are never any entries submitted, and if there are, no one in the facility reads them.*

*We think we've done accountability programming when we do accountability "widgets" like complaint boxes, maternal death audits, etc. There's a tendency to accept form over function; it looks like accountability but doesn't act like it—isomorphic mimicry.*

Fox offers an instructive caveat on interpreting what works in social accountability. Rather than asking does it work, we should question “the degree to which – and the conditions under which – an institutional change initiative would work” (2015, 348). He also cautions that the does-it-work question implies that social accountability interventions are assumed to yield tangible results absent other governance reforms.

Taking Fox's advice, researchers have sought to identify the contextual factors that influence social accountability to achieve intended outcomes. O'Meally's mapping of contextual factors is probably the most comprehensive treatment (2013). Incorporating context and identifying contingencies regarding social accountability impacts, along with the variation in how mechanisms are defined and implemented, has led researchers to be cautious regarding causality and attribution (see, for example, Edstrom 2015). In addition, as Grandvoinet et al. (2015) note, determinations of whether social accountability works or not is conditional in one sense on the value placed on the results achieved. Sector specialists tend to privilege service delivery and sector-specific outcomes, and treat other results, such as governance and citizen empowerment, as instrumental.

To the extent that there is a consensus on how to enhance the prospects for social accountability to achieve results (service delivery, governance, or citizen empowerment), analysts and practitioners recommend variations on Fox's (2015) sandwich strategy, which marries bottom-up advocacy and collective action from below with top-down bureaucratic pressure and support from above. Sustainable results are more likely to be achieved when demand-side and supply-side interventions are pursued in tandem in ways that are mutually reinforcing (Wetterberg et al. 2016, Fox 2016). O'Meally et al. (2017) make the point that combining the top-down/supply and bottom-up/demand pressures calls for bringing together often disparate and unconnected activities and resources, which lead them to characterize the task as “making sandwiches out of spaghetti.”

There is some support in the literature for the value of independent media in supporting accountability in some instances, and the studies of FOI initiatives cited above usually addressed the role of the media in successfully publicizing information regarding government programs and actions. Several of our key informants mentioned media capacity building initiatives to increase health literacy. Often, however, the degree of press freedom and dynamism is treated as one element of context rather than as a target for intervention to improve accountability in the health sector, and so the evidence over the value of such interventions is limited.

More work is needed on specifying the conditions under which social accountability contributes to governance and service delivery results, and on the complementary investments that enhance those results. An important step in that direction is a macro study of social accountability conducted for the UK's Department for International Development that used qualitative comparative analysis (QCA) to explore this issue (Holland et al. 2016). The study analyzed 13 cases and sheds some light on the specifics of top-down and bottom-up intervention strategies. Among their findings are the following. Social accountability, on its own, is effective in improving local-level service delivery, but has a limited effect at scale. Adding formal, invited citizen participation, as part of an integrated and institutionalized policy and program framework enhances the prospects of social accountability impacts at higher levels of service delivery. Social accountability can contribute to improving access to services for marginalized populations, but for sustained impact it needs to be accompanied by supply-side measures that directly target these populations.

## Horizontal Performance Accountability

Accountability mechanisms: Standard-setting and accreditation, regulatory enforcement, self-policing/codes of conduct, performance-based budgeting, and internal management control systems, performance contracts, performance audits, and parliamentary oversight

In this category the largest number of sources are from the extensive and growing literature on pay-for-performance as a donor tool for programming and as a health sector-specific tool (Eichler et al. 2009), which tends to be the most evaluable mechanism of horizontal performance accountability. We review here selected studies on pay-for-performance, performance-based budgeting, performance contracts, and performance audits. We look at two analyses of accreditation and one study of regulatory enforcement that overview the issues for developing countries. To the extent that state-centric mechanisms can also be implemented by non-state actors, either as complements to these mechanisms or as alternatives to them, vertical performance accountability can overlap with this category.

### *Performance-based Mechanisms*

In the Philippines, Peabody et al. (2010) conducted a study of the effect of financial incentives on physicians' delivery of health services to children under five. In 10 provinces in the Visayas and Mindanao regions, 30 district public hospitals were surveyed, with a total study population of 617 doctors. Hospitals were randomly selected for two forms of performance-based financial incentives. At bonus intervention hospitals, salary bonus payments went directly to physicians based on clinical competence scores, facility caseloads, and average patient satisfaction measures. At expanded insurance intervention hospitals, facilities received increased revenue from the national health insurance scheme for treating patients for a set of common conditions; in these sites physicians' financial incentives were indirect. Surveys were conducted every six months for 3.5 years. The researchers found that quality of care, as measured by clinical performance vignette scores, was improved by both the direct bonuses to doctors and the indirect facility-level expanded insurance incentives. They also found that after three years, performance scores at the control group hospitals improved as well, suggesting the possibility of delayed dissemination effects of the interventions.

In Lesotho, Vian and Bicknell (2014, summarized in Brinkerhoff and Bossert 2014) examined accountability and performance incentives in performance-based financial management reforms in four hospitals. They measured implementation progress in terms of four factors: existence of performance-based plans, existence of performance-based budgets, evidence of performance monitoring and reporting, and evidence that management decision making used performance data for resource allocation and accountability. Implementation in the four hospitals was overall quite weak; managers made the most progress in developing performance-based plans and the least in using performance data for decision making and oversight. The authors identified several factors that explained reform failure. First, the reforms called for capacities in data collection, information processing and costing of services that were beyond those available in the hospitals or the health ministry. Second, the technical components of the reforms conflicted with the informal governance practices that enabled the hospitals to deal with their capacity deficits. Third, dysfunctions in the principal-agent relationships among ministry and hospital actors (lack of trust, professional silos and weak leadership) weakened incentives to pursue the reforms. The reform design took best practices from similar reforms, but did not adjust them to Lesotho's context.

Ssengooba et al. (2012) conducted a study of performance-based contracting in Uganda, which assessed whether the provision of financial bonuses resulted in improved performance. The study found that the

bonuses had little to no impact on performance. The authors attributed the failure of the intervention to poor design and faulty adaptation during implementation. To improve the design of performance-based contracting, they proposed addressing four issues: capacity of participants to achieve performance targets, perceived value of the bonuses, quality of performance audits, and extent and quality of communication regarding performance requirements and evaluations. They concluded that performance-based contracting interventions require significant attention to operational detail, sufficient financial and technical support and capacity within local systems, and systemic incentive structures that motivate performance improvement.

Similar to the Uganda experiment, a pay-for-performance scheme was introduced in Afghanistan to improve five dimensions of maternal and child services. The cluster-randomized trial found no significant results in the maternal and child services, but the pay-for-performance scheme did have a significant effect on other indicators, such as time spent with patients (Edward et al. 2011). The authors identified the following factors as explaining the negative results: lack of understanding related to the financial incentives on the part of recipients, and general lack of communication with providers about the quality of care they provided.

Afghanistan has seen success with the use of a balanced scorecard as an internal organizational performance tool, distinct from citizens' use of scorecards (Peters et al. 2007). Actors in the health sector (Ministry of Public Health, NGOs, etc.) relied on balanced scorecards developed by the Ministry of Public Health to assess performance of health facilities across the country and measure the ministry's progress against its strategy. Afghanistan's health ministry incorporated the scorecard into its monitoring and evaluation system, and NGOs used the results to inform decision making. The indicators gave insight into how provinces were performing on an individual level—some succeeding in areas where others had failed—and suggest the importance of scorecards tailored to each specific region to account for challenges in infrastructure and geography unique to those places.

## *Accreditation and Regulation*

Accreditation as a tool for service delivery quality assurance has a long history of application in developing countries, with USAID being among the donors supporting such programs. Rooney and van Ostenberg (1999) outline the role of licensure and accreditation in providing the basis for assessing and improving health services quality through the development, monitoring, and application of standards. They cite several country examples of accreditation projects from the 1990s, such as Egypt's Gold Star system for family planning facilities and Zambia's Health Accreditation Council. While the discussion does not explicitly address accountability, the authors present principles and programs revealing that licensure and accreditation create a transparent and systematic information base that can serve the twin accountability dimensions of answerability and enforcement.

Mate et al. (2014) provide a more recent discussion of accreditation, and these authors raise issues of governance directly, noting the importance of collaboration between licensing authorities and accreditation bodies to reinforce regulatory compliance and assure sustained attention to performance standards and quality of services. Citing other research, they note that in developing countries ministries of health tend to fulfill accreditation functions, whereas in the industrialized world it is usually non-governmental bodies that do so. They discuss the importance of effective management of accreditation programs, citing transparency of standards, objective application of those standards by surveyors, and the integrity of the accreditation process, along with data validity and quality. Incentives for accreditation are also recognized as key to the effective use of this mechanism for accountability and service quality purposes.

Mok et al. (2010) offer a tour of regulatory mechanisms and approaches with commentary on the issues that developing countries face in applying them. Among traditional approaches are administrative searches and inspections, plus licensing, in conjunction with penalties for non-compliance. Searches and inspections call for trained inspectors, time and travel commitments, and documentation costs. Licensure similarly can be administratively costly and can require inspections for monitoring and enforcement. These mechanisms also create opportunities for rent-seeking and corruption, which are serious drawbacks and undermine their accountability function. The authors suggest several lower cost options that may be useful, including formal notices of violations and public disclosure of improper and/or illegal behavior. As substitutes for recourse to the court system in cases of violations, the authors suggest alternative dispute resolution, ombudsmen, negotiated rule-making, and self-regulation as potentially more effective, given the capacity and performance constraints of most developing country legal systems. In a comparable vein, Brinkerhoff (2010) discusses regulatory strategies that seek to offset state capacity deficits by offering regulatory alternatives to punitive enforcement as the default and engaging non-state actors as partners in regulation.

Mackintosh et al. (2016) discuss the role of the private sector in health provision and offer considerations of when the characteristics of health provision (and related accountability) will be shaped more by the private sector than by public provision, with implications for efforts at regulation. They compare unlike country cases and identify three key metrics that shape a mixed health system: private share in total health expenditure, private share in primary and secondary care episodes, and extent of reliance of the public sector on private fee payment. They suggest that because private sectors cannot be understood except within their context of mixed health systems, efforts to promote particular policies and secure accountability for their application will need to be adjusted to fit the mixed health system and attend to these metrics in particular.

Regulation of the private sector and questions about the interface between government regulation and private service provision are addressed in Leonard et al. (2013) in their review of asymmetric information and health services. They emphasize the importance of the macro-institutional context as a form of path dependence, which shapes the possibilities for solutions that can work at a micro level. They argue that a distinction between public and private sectors is not helpful, as in most developing countries it is common for informal fees to be charged in public sector settings and for much of the health services accessed to be bought in a private sector setting. As a result, the public and private sectors face similar and overlapping institutional issues related to information, access, and quality. Within the micro-context, the authors search for institutional arrangements that have best mediated the relationship between service providers and recipients to ensure the quality of goods and services purchased by recipients. They find that no single set of institutional arrangements is consistently effective, but they do find that organizations with “other-regarding institutional values” as well as an investment in their reputation and some degree of devolved control are best placed to create and support arrangements that serve the poor.

Bloom et al. (2014) examine mixed health markets and suggest that questions of regulation of complex health systems through licensing and other administrative controls has not been effective at ensuring end-user safety and access. Since much regulation focuses on the supply of products and services, the efficacy of the approach depends on the value chain beyond the point of regulation where supplies reach the end user. This chain includes many informal sector actors and weak linkages in many developing countries. They offer a conceptual framework that looks across health goods and services at supply and demand, mediated by providers and payment, to inform efforts to improve health value chains. They introduce the idea of health goods and services being provided through a lengthy value chain that exists as a complex adaptive system, suggesting that “the design and implementation of



effective and efficient regulation requires that the broad set of actors within markets for health products and services are brought together in processes of structured learning and coalition-building.” Successful regulations would thus need to be co-created by diverse health market actors, which the authors note is challenging to do in practice without capture by interest groups. They categorize several regulatory strategies that go beyond input regulation and argue that a multi-tiered approach freestanding of a single type of regulation is more likely to prove effective.

### *What Works, What Doesn't in Horizontal Performance Accountability*

The broader literature as well as the studies cited here demonstrates some empirical support for the utility and effectiveness of performance-based contracting and related pay-for-performance schemes. As key informant Randolph Augustin summed up:

*There is enough experience over the last ten years that results-based financing and pay-for-performance, while in different models, clearly work when there are clear and appropriate expectations, compensation directly to frontline workers, and transparent and public data around performance. It's not just around funding, but around institutional processes that generate results. The mutual accountability effect in facilities with community engagement is well proven.*

The literature and our key informants caution that successful implementation of performance tools is subject to numerous caveats. The Augustin quote identifies some of these. Eichler et al.'s comprehensive review (2009) captures the essence of these warnings, arguing that the question is not whether performance incentives can change behaviors and improve services, but rather under what conditions do they fulfill their potential? To answer this question, they propose the following:

The first step is a diagnostic: to understand and determine the major problems affecting performance and to identify incentives that have the potential to inspire the changes in behavior and systems needed to generate positive results. The second is to select service providers and beneficiaries, the results to be rewarded, and the mechanisms to monitor performance. Terms of contractual arrangements, including how recipients will be monitored and performance rewarded, need to be clearly specified. Staff and systems to administer performance-based payments need to be organized, and both technical and financial resources need to be dedicated to assessing, learning, and revising the approach (Eichler et al. 2009, 51-52).

The Uganda performance-based contracting case and the pay-for-performance scheme introduced in Afghanistan demonstrated the price to be paid in failing to follow these steps. In these two cases, problems that limited achievement of desired outcomes included failure to tailor pay-for-performance schemes to the levels of capacity, poor understanding of financial incentives, and personal incentive structures embedded in the health system. One of our key informants noted that pay-for-performance schemes, while holding promise, are often imported in ways that are too fully formed or too scripted to match health system functions on paper rather than health systems as they actually are. The Lesotho performance budgeting example is a case in point.

Notably, many of the examples of effective programs cited by practitioners addressed multiple areas of performance accountability, spanning vertical and horizontal simultaneously. For example, effective approaches combined working on service charters and quality assurance reviews to reinforce horizontal accountability between levels of government, while also using the same charters, health facility committees, and integrated supportive supervision (including community representatives and local

government representatives on supervision teams) to embed vertical accountability (e.g., Mackintosh et al. 2016). An emphasis on using accountability tools to foster dialogue between communities, providers, and government at different levels also was a hallmark of well-regarded practitioner efforts. In parallel, the analyses of regulatory strategies also included collaboration between state and non-state actors. These success features are echoed in the social accountability literature reviewed above.

Many of these studies of regulation identified the blurred boundaries in practice between the public and private sectors, which can introduce ambiguities and opacity into regulatory strategies as instruments of increased oversight and accountability (e.g., Leonard et al. 2013). Since most health systems combine a mix of public and private providers, these considerations of factors that constrain effective accountability are critically important. As Bloom et al. (2014) highlight, viewing regulation from a systems perspective can enhance its effectiveness as an accountability tool.

## Vertical Financial Accountability

*Accountability mechanisms: Public expenditure tracking surveys, participatory budgeting and planning, budget transparency initiatives, citizen-led anti-corruption campaigns*

Involving citizens in accountability for finances requires their understanding of processes that determine what expenditures are expected, enabling them to follow up regarding whether funds are allocated, used, and documented in line with their expectations. Some of the interventions, such as participatory budgeting and planning, involve citizen input into these plans, while other efforts focus on making budgets and financial flows more transparent or increasing citizens' demand for greater financial accountability.

Boulding and Wampler (2010) investigated whether a participatory budgeting (PB) program in Brazil led to increased social spending, such as on health or education programs. The authors expected to see greater budget allocations (and consequently improved service delivery) in places where PB had been adopted compared to those using traditional budgeting. Based on statistical analysis of data from 220 of Brazil's largest cities, they found spending on health was higher in municipalities that had adopted PB than those that had not. Because increased spending did not necessarily correlate with improved health outcomes, they also looked at indicators of well-being. The authors found that municipalities using PB spend more of their budget on health and education programs, but also found that those municipalities benefit more from increased per capita government budgets, making it unclear if PB was the reason for the improved spending. They found the average per capita budget rather than the presence of PB may be a more accurate indicator of improvements in human well-being. Although human well-being as these authors consider it is not explicitly a health outcome within our framework, it may be tied to intermediate outcomes such as improved service delivery, efficiency and effectiveness, or equity. Certainly, participatory budgeting enables increased transparency and responsiveness to citizens' needs and demands.

Gonçalves (2014) offers results from her analysis of the same participatory budgeting in Brazil in which she too found differences between municipalities where PB was and was not being used. She presents information as to why participatory budgeting would lead to increased spending allocated to health and sanitation (rather than education) and tests whether health outcomes improved. She found a two-three percentage point increase in spending on programs such as health and sanitation in municipalities that had adopted participatory budgeting.

Another vertical financial accountability intervention is public expenditure tracking. Reinikka and Svensson (2011) examined whether availability of information (published in newspapers) regarding how

much money a school should be receiving in capitation grants has any impact on enrollment and educational attainment. The authors found that with granting the public access to that financial information, local corruption decreased, and enrollment in local schools increased. There was also a slight improvement in students' test scores, though it was not as significant as the other results. Their intervention was in an educational context, and still there are certainly lessons that may be worth extracting to draw on in a health setting, although as various analyses have warned, information transparency alone is insufficient to produce accountability increases (Fox 2007).

As Olken (2007) demonstrates, some accountability interventions complement each other well. His randomized controlled field experiment in Indonesia involved components of both vertical and horizontal financial accountability. Olken examined the effect of potential external audits by the central government audit agency, in combination with a grassroots monitoring campaign (discussed more in horizontal financial accountability), on corruption levels in village infrastructure projects. For some villages, the results of those audits may then be read aloud during a village meeting, and this did reduce corruption; missing expenditures decreased by eight percentage points. He concluded that, overall, central-level audits were more effective than community monitoring in addressing corruption.

### *What Works, What Doesn't in Vertical Financial Accountability*

Interventions in the vertical financial accountability category yielded mixed results in the sense that while there was typically some improvement, the magnitude of the results was not as significant as was expected. The evidence suggests that to some degree, public expenditure tracking can support improvements in transparency and reduced corruption, though studies indicate that citizen engagement in public expenditure tracking faces capacity, power, data quality, and incentives issues (Tolmie 2013). These issues notwithstanding, a focus on budgets and financial flows provides concrete accountability targets around which citizens can mobilize demand, particularly if they are supported by capable NGOs that can serve as translators and simplifiers of complex budget and procedural information. Key informant Sue Cant reinforced this point:

*Information about government processes and standards is often a critical missing piece in moving from simple community-driven development and participatory programming to something more robust.*

The evidence suggests that participatory budgeting is an important health governance mechanism. It increases citizen voice in decision making and leads to greater responsiveness in resource allocation in line with citizen preferences. It is not clear the extent to which these increases in participation lead to improvements in service-delivery efficiency, but they are associated with expanded citizen empowerment. Several of our key informants stressed that power and capacity dynamics are especially central to budgeting and spending systems and that citizens, either as individuals or collectively, are limited in their ability to push for accountability. As key informant Simon O'Meally said:

*For me the bottom line – if I had to choose one factor – is power. How it is shared, distributed, marshalled, etc. makes or breaks any accountability initiative. I have no knowledge of a “technical” intervention being sufficient.*

## Horizontal Financial Accountability

Accountability mechanisms: *Fiscal decentralization, government-led anti-corruption campaigns, financial audits, improved public procurement systems, budget autonomy for health providers*

Horizontal financial accountability is another category where most studies explore governance issues, and relatively few studies seek to directly relate accountability interventions to health outcomes. However, within the fiscal financial literature, there are some analyses that make this latter link. For example, Cantarero and Pascual (2008) conduct a regression analysis to assess the impact of decentralization on health in Spain. Using data from 1992–2003, with infant mortality and life expectancy as the dependent variables, they find that decentralization, income, and health resources each had a significant impact on health. The literature review in Goryakin et al. (2017) identifies six studies on low-income countries that offer corroborating empirical findings on the link between fiscal decentralization and health outcomes, with the caveat that the relationship is mediated by local institutional capacity. The same review found limited evidence that improvements in public procurement improved health outcomes, primarily through cost reduction, but the tradeoff was lead times to complete procurement. Several of these studies also use infant mortality as the dependent variable.

A financial audit, either top-down by a formal independent audit office or its contractor or bottom-up by a community monitoring scheme, can serve as a strong deterrent for the misuse of funds. The studies reviewed here found some improvements in addressing corruption as a result of audits. Fiscal decentralization and improved public procurement systems too have been shown to decrease corruption, as the literature reviewed by Goryakin et al. (2017) demonstrates.

In addition to external audits, Olken’s field experiment in Indonesia (mentioned above in the section on vertical financial accountability) looked at monitoring of investments in village projects at the grassroots level. The monitoring initiative successfully increased community participation by approximately 40% in village-level meetings where project spending was reported, though there was no (statistically significant) reduction in corruption associated with that change. Olken cautions that there may still have been some corruption in other forms, as workers may have chosen to employ their family members. He suggests that similar grassroots monitoring may see greater success in instances such as health or education, "where individual citizens have a personal stake in ensuring that the goods are delivered and that theft is minimized" (2007, 244).

Avelino et al. (2013), using data from audit reports, assessed management of health resources in Brazilian municipalities. They found that more decentralized management of health resources by municipal health councils led to reduced corruption at the local level. The findings "suggest that the experience of health municipal councils is correlated with reductions in the incidence of corruption in public health programmes" (695). They also found a statistically significant relationship between the age of the health council (used as a proxy for experience) and likeliness of corruption, meaning the more experienced the health council was, the less corruption there was likely to be.

Transparency International (2017) examined several case studies on open contracting in the health sector, and of note were Honduras, Nigeria, and Ukraine. The study provided evidence on how open contracting has influenced procurement in the health sector. In Honduras, a social movement, "Transformemos Honduras," used FOI laws to expose corruption in the procurement of medicines. In both Nigeria and Ukraine, open contracting has been used to improve transparency in bidding for contracts, as well as procurement. All three cases saw positive results from open contracting in the forms of increased transparency and reduced corruption, resulting in cost savings in the health sector.

### *What Works, What Doesn't in Horizontal Financial Accountability*

Though evidence overall is limited, financial audits seem to improve transparency, reduce corruption, and contribute to improvements in efficiency, though their value for money may be variable. Open

contracting also appears to improve transparency as expected, and to reduce corruption, albeit with variable changes to timeliness. Among the caveats is that information transparency is insufficient on its own to increase accountability; where and how the information is made available, who has access to the information under what circumstances and governed by which rules are all important issues.

Decentralization studies, as noted earlier, offer mixed evidence for the effectiveness of horizontal financial accountability. Much depends upon the features of individual subnational governments, their allocation of delegated responsibilities and authorities, along with intergovernmental relations and resource transfers. The Brazil municipal health council study points to the importance of the quality and capacity of local government in influencing what works. There is some evidence that under the right conditions, fiscal and financial decentralization can improve responsiveness, increase efficiency, and limit corruption.

## IMPLICATIONS OF THE FINDINGS FOR POLICYMAKERS

**Interventions aiming to improve accountability can have positive results on health governance, which can contribute to strengthening health systems.**

A major implication of this evidence review is that accountability interventions matter considerably to health governance. However, the extent and nature of their impacts depend greatly on *how* interventions are carried out. A key message is that the individual interventions selected may be less decisive than their interactions with contextual factors such as power dynamics, institutional mandates, and sociocultural histories. As key informant Judith Edstrom noted:

*As Tolstoy's Anna Karenina said when referring to families, successful (social) accountability efforts are all alike; each unsuccessful effort fails in its own way. Relative success is not based on one particular silver bullet mechanism, but on a range of positive conditions and factors all being present: conducive enabling environment, a reasonably well-executed accountability approach or technique, a sense of empowerment by citizens, and commitment **and** capacity of public officials and health service providers to respond. Failure of any one of these is enough to result in ineffectiveness of an accountability effort.*

The findings of this study confirm that countries interested in improving health governance have a relatively solid evidence base on the variety of accountability interventions that have been tried and tested, and on the factors that affect the prospects for achieving health governance and health system results. Certain areas of programming and research on accountability have a stronger evidence base than others. Social accountability efforts, for example, have benefitted from the greater collective experience of researchers pursuing studies of those interventions. Tools such as citizen report cards, service charters, multi-stakeholder committees, participatory budgeting, and pay-for-performance have been studied across a wide range of contexts. Components of governance systems' architecture as they affect the health sector have also been extensively studied, including for example, decentralization, agencies of restraint (especially with regard to anti-corruption), and state-society relations both national and local. It is likely that other areas of accountability interventions with mixed evidence will be clarified by greater research efforts with an emphasis on context, which can help to nuance the understanding of the conditions under which those interventions achieve outcomes in health governance.

We have acknowledged those areas where the evidence of what works and what does not is inconclusive and have stressed that studies do not provide straightforward or simple guidelines to follow. Nevertheless, the literature and our key informants concur in finding that accountability interventions can contribute to robust improvements in health governance and health systems, and indirectly to health outcomes.

### Accountability and the Macro-Context

**Context matters and must be considered when planning and implementing accountability interventions.**

Distinct from meta-studies of clinical trials, the assumption that treatments are invariant across applications does not hold for investigations of sociotechnical interventions like accountability mechanisms and governance reforms. These interventions are affected by contextual factors whose influence looms large in conditioning the prospects for initial success, scale-up, and sustainability.

The significance of context means that the evidence for the impacts of discrete accountability interventions is often mixed, making it difficult to draw relevant lessons for a country's own program.

Our findings thus direct policy and program decision makers to prioritizing a more profound understanding of the macro- and micro-contexts when planning and executing any accountability intervention. In practice, this means that more resources and attention need to be spent on understanding and constantly probing the factors that matter in the setting where accountability interventions are located. Regular questioning and reformulating the key issues around the target intervention, as well as the target interventions themselves, require flexibility, which can be a major constraining factor in donor-funded projects. Similarly, government policymakers may not find it easy to pursue flexible programming and implementation within rigid bureaucratic structures.

The challenge with paying attention to the macro-context is deciding which features to accord analytic prominence among the myriad factors relevant to accountability interventions. Checklists lead to oversimplification and one-size-fits-all generalizations. However, the literature and several of our key informants suggest according priority to a few key aspects of the macro-context across most efforts to improve accountability. Foremost among these is the power dynamics that shape existing governance structures and state-society relations. These delimit the change spaces available to both public sector actors and civil society. Many successful efforts explicitly aim to shift power dynamics as a precursor to improving accountability or to build on such changes in power dynamics from other sources, and so effectively embed their work in the macro-context. Relatedly, civil society capacity to exploit the available change space and the state's capacity to respond positively are two additional macro-contextual elements commonly identified with successful accountability interventions (see, for example, Holland et al. 2016).

**Political economy and power dynamics are crucial components of context.**

Simon O'Meally's (2013) study of accountability dynamics defines six characteristics of context that shape the prospects for vertical or social accountability: political society capacity and willingness, civil society capacity and willingness, the political settlement among elites, the social contract of the state, inequality and relations within society, and global dimensions around the state. Political settlements, or the ways in which elites informally agree in practice on the distribution of power in a state, are a critical power structure that shapes how a country's formal governance system operates. The role of political settlements was referenced in various forms by many of our key informants. Several also highlighted the role of national-level ideologies that informed accountability efforts. State-society relations, legitimacy of the state, and perceived fairness of its actions set expectations that frame the social construction of accountability and shape the roles and relationships of actors in the health system.

Key informants also highlighted the role of national-level ideologies that informed accountability efforts. State-society relations, legitimacy of the state and perceived fairness of its actions set expectations that frame the social construction of accountability and shape the roles and relationships of actors in the health system. As key informant Walter Flores stated:

*We know that a technocratic approach to accountability and health systems doesn't work. Politics and power are important, but just recognizing that isn't enough. We need better frameworks for understanding, and better tools to support actions that make horizontal accountability/checks and balances work better. We need structures that address conflicts of interest. A lot of corruption derives from lack of rules and regulations, which enables discretionary power at various levels. Authorities don't have an interest in closing these pockets of discretion. Every place where decisions about resources are possible, the possibility of conflicts*

*of interest and corruption arises. We need to put in place governance structures at multiple levels.*

### **Health policymakers seeking to improve accountability must reach beyond the health sector.**

Mr. Flores' comment demonstrates how considering politics and power affect health will lead reformers to focus beyond the health sector. Promoting accountability calls for awareness of these broader structures and processes, and for engagement and collaboration with other sector actors. Sustainable reforms require building relationships across stakeholder groups and sectors. Key informant Nils Mueller offered:

*It's a bit strange to talk about "health governance," as governance that leads to health outcomes is not just health governance. This can be a factor for why certain activities do not achieve the results that we want them to. At the local service level in particular, you cannot separate actors in the health system (e.g., the district health officer or supervisors of facilities) from integrated local government structures. Efforts to do training and strengthening of just those ones does not work because they are still just a cog in a wider system of governance at district level...The wider system shapes time, budget, and other allocations that cannot be dealt with solely from a health perspective.*

### **Systems perspectives highlight the importance of networks inside and outside the health system to understand accountability relationships and identify intervention pathways.**

Halloran (2016) notes that using the lens of an "accountability ecosystem" can help us to see the complexity of roles and relationships that are the backdrop in which interventions are staged. Use of this lens also introduces ideas from systems thinking that can contribute to the design of more effective accountability programs. Among the applicable systems concepts is emergence, the notion that relationships and behaviors are a product of the interactions among system actors and cannot be fully predicted prior to those interactions. This is meaningful because it implies that agents' roles cannot be held constant over time or defined purely by functions within the health system, given the web of other relationships that connect them. As key informant Judith Edstrom noted:

*A recent integrated health project in the Democratic Republic of Congo demonstrates the multiple pathways to improved health outcomes. Social accountability initiatives aimed at strengthening health services—along with supply of physical inputs and staff training-- are stimulating increased use of health facilities. At the same time, user groups have encouraged community members to directly improve their own health-seeking behaviors, which in turn incites them to visit health centers and to independently improve their own health practices and outcomes.*

Actors in a health system are simultaneously involved in numerous relationships with each other, including many beyond the health system, in ways that cause new behaviors to emerge as accountability interventions are tried. Interventions featuring deep understanding of those ecosystems, and/or anticipating and reacting to emergent behavior in them, show promise of greater effectiveness. Key informant Walter Flores commented on the systemic nature of effective accountability work:

*The biggest changes we've seen in Guatemala are the creation of new channels of engagement that didn't exist before, and how the process has moved up from local to provincial level. It's currently moving up to the national level. Our data are showing that discrimination has been reduced, illegal payments have almost disappeared, and resource transfers to the local level from the center have increased. We see evidence of increased responsiveness by local and provincial authorities, increased collective action among community members, and better local*



*planning that is linked to the center...At the beginning, we tried to work only within the MOH, but we realized that we were blocked by conflicts of interest in addressing bottlenecks. So we started to engage with parliament, the ombudsman office, and the judiciary. We learned how to use the system of checks and balances to address the conflicts of interest.*

Human relationships are molded by social factors that may shape providers' accountability to service users/consumers. Berlan and Shiffman (2012) identify consumer power and information levels, and provider beliefs related to accountability. Several key informants highlighted the social aspects of accountability:

*What is neglected in the current state of the art of accountability programming is attention to the construction of social meaning as the basis for accountability. Current thinking on accountability forgets that politics defines what officials will be held accountable for, and what citizen expectations are. So, for example, if officials take steps to address health provider absenteeism, but don't do anything improve services, citizens may not be positively inclined toward them since their focus is on the services they receive (William Savedoff).*

*We've known it but haven't articulated or categorized it well: social cohesion and reciprocity outcomes are vital to the work [on accountability] but have been left as intangible byproducts (Sue Cant).*

Linked to webs of relationships and their influence on accountability is Tembo (2013)'s identification of "interlocutors," defined as individuals or organizations who play a crucial role in overcoming obstacles to collective action that limit transforming citizen-state accountability relationships. Interlocutors build on existing trust relationships as a primary driver of change and work within the power dynamics of local political systems. He draws upon the experience of a DFID-funded multi-country social accountability program in Ethiopia, Ghana, Malawi, Sierra Leone, Uganda, and Zambia to document how a power-sensitive approach to collective action that focuses on shifting incentives can gradually move accountability logics from responsiveness to answerability. Tembo's examples demonstrate how accountability relationships can move beyond Fox's (2007) soft accountability to harder forms. The health governance outcomes achieved by an accountability intervention can evolve over time, from improving responsiveness to imposing sanctions; as trust increases, costs for collective action are lowered, and incentives are modified.

The pathways to positive outcomes are not always clear. One of our key informants, Gerry Bloom, offered an example of the difficulties in mobilizing effective collective action:

*In Bangladesh, the government sought to bring informal providers into the health system. First they tried training, but this didn't work. Then they tried accreditation through an association of informal providers, but that didn't work well either. They found they needed to look at the pharmaceutical industry's role in supplying informal providers with their medicines. Most treatments involved providing a couple of antibiotics and a steroid; this is what people expect. So even if you convinced some providers not to offer these, people would simply go to another provider until they found a willing one. The underlying incentive structure needs to be addressed if you're going to have an impact on accountability.*

From a principal-agent perspective on social factors and the web of human relationships, expected sanctions and incentives for enforcement of accountability work are often informal. Key informant Simon O'Meally summarized it succinctly by commenting:

*"Teeth" often reside in the informal practices of elite bargaining, patronage, and kinship, as well as in locally specific values of legitimacy and social justice.*

## Attending to the Micro-Context

**The local contextual features of interactions among accountability actors contribute to shaping accountability and health governance outcomes.**

Beyond the characteristics that shape the macro-context, attributes of the particular health services being examined and the associated politics often play a key role in the degree and scale of success of an effort to enhance accountability. For example, the past history of citizens' engagement with healthcare providers influences the capacity and incentives of both citizens and providers to adjust to new accountability mechanisms, and can inform how reforms are designed and implemented.

Among the salient features of the micro-context for accountability are the characteristics of the services being delivered. Batley and Mcloughlin (2015) examine the politics of public services through a service characteristics approach. They identify critical aspects such as the nature of the good, type of market failure, tasks involved in delivery, and demand for a service, all of which directly affect political commitment, provider control, and user power in ways that can strongly shape accountability. Their work suggests that the political incentive to provide or improve a service is greater in particular situations: when benefits go to private users (e.g. household water connections versus mains sewerage), where users benefit directly (e.g. water supply rather than disease vector control), in cases of monopolies with greater control (e.g. urban water supply over decentralized rural systems), where the provided service is visible (e.g. construction of schools or clinics rather than improving maintenance) and where there is high demand and provision can be targeted at selected populations. They also take note of how the predictable and regular use of a service can make it easier for users to organize and demand accountability for that service (e.g. primary schooling versus hospital health care). Finally, they also note that accountability is easier when the information about the service is widely understandable and involves less discretion (e.g., vaccinations rather than obstetric care).

Joshi (2014) writes on the interplay between macro-level factors such as those outlined by O'Meally (2013), and micro-level factors similar to those identified by Batley and Mcloughlin (2015). She outlines a process of devising causal chains or a set of mini-causal pathways that shape the accountability intervention. She recommends breaking apart the discrete aspects of an accountability intervention (e.g. awareness raising, information demands, etc.) and learning more intentionally from how those efforts have fit into the context previously. Along a similar line of inquiry, Wetterberg et al. (2017), in their study of accountability mechanisms in district health facilities in Indonesia, investigated how citizens' prior experiences with holding health facilities accountable influenced facility motivation to use social accountability tools and affected facility responsiveness to citizens' concerns.

## Time Horizons

**Be patient; successful accountability interventions call for long time periods and long-haul engagement.**

Those who promote increases in accountability must adjust their expectations of time horizons to match a strategic and dynamic reform process. Most case examples of change at scale where increased accountability has both taken hold within the health system and led to improvements in health outcomes have played out over several years. Even effective accountability interventions that may yield relatively quick results seem to need a broader, sustained set of changes over a longer period of time to ensure that those gains are not lost. Our key informants' perspectives reinforced the need for extended

horizons and emphasized that achieving and sustaining improvements in accountability is a long-term endeavor:

*Only foolish people think that solving accountability problems is a short-term issue. People will always find ways around whatever rules are put in place, so you need to learn, to identify innovative approaches. The answers will come from experimentation and learning, not necessarily from research. We need to encourage donors to learn in dialogue with national government and localities (Gerry Bloom).*

*Donors need more patience for the long-term, and more recognition of the non-linear nature of social change. In projects, we get results measured on a timeline that doesn't match what's required for genuine accountability (Lynn Freedman).*

This point on longer time horizons for accountability interventions is clearly linked to other lessons coming out of this study: it takes time to understand the political context and the various roles and relationships between health stakeholders. Being flexible and changing course based on new insights mean rethinking a new intervention or restarting an old one, all of which take time. Being context-sensitive means adjusting and adapting to moments of stagnation and periods of pause when the situation may not be conducive for continuing the work as planned. Embedding implementation research into accountability interventions means trying and testing them through iterative interrogation of emerging results among stakeholders. This kind of adaptive action research is often constrained by donor needs for presentation of tangible and “sellable” results in the short term.

**Quicker results can be achieved in settings with good governance, where accountability interventions do not depend upon systemic changes.**

The Young et al. (2016) study of open data usage in Singapore took place within an environment of relatively mature accountability structures and incentives. In such cases where effective governance systems exist, short-term interventions can lead to measurable impact. However, in less conducive settings, the timespan for transformational change is longer because accountability depends on so many contextual constraints to be addressed. Key informant Cathy Green, in discussing introduction of facility health committees in Northern Nigeria noted:

*When there is a total absence of redress and accountability, introducing one is a major step...You can't go from nothing to perfect too quickly, you need to go step-by-step.*

Achieving systemic change seems to be closely linked to deploying multiple accountability approaches over an extended time horizon. Accountability interventions are most effective when they are integrated, using and adapting different tools as incentives and context change. Key informant Joy Acheron contrasted the relative ease of localized social accountability efforts with broader, long-term accountability changes:

*Voice and monitoring initiatives in Philippines are somehow easy – getting community engagement and dialogue is not hard because of the long history of citizen engagement and national standards make it fairly simple to monitor compliance. Systemic change is the problem. How do you ensure good policies are adopted and implemented and those violating laws and/or abusing powers are sanctioned? For example, family planning medicines had to be constantly asserted by advocates. Medicine distribution was highly contested. There was a need to combine monitoring efforts with advocacy from other citizen groups. This speaks to the importance of a combination of interventions.*

In practice, attempting to influence the macro policy level while simultaneously conducting projects at the grassroots and regional levels seems to be necessary to sustain the potentially quicker gains made in

communities and districts. Likewise, working with a broad set of stakeholders and ensuring platforms for dialogue at all levels can help institutionalize mechanisms which can facilitate more sustainable change and harness the synergies from gains made on individual interventions. This process will surely experience setbacks and periods of inaction. However, working on different interventions at different levels at the same time means that progress can likely still be made on some accountability issues while others are put on the backburner until a new window of opportunity arises.

## Framing

### **The way an accountability effort is framed influences its potential to achieve results.**

As noted previously, there are multiple frames through which accountability can be defined and analyzed, including principal-agent, collective action, and institutionalist perspectives. Ensuring that roles are considered holistically and that multiple frames are used can reinforce a planned accountability intervention to make it more robust. The multiple relationships among health system actors also imply that the framing of accountability and efforts to enhance it will have an influence on effectiveness of those efforts. The evidence seems to support this idea.

Beyond analysis, the way accountability itself as an intervention goal (or as a tactic to achieve other goals) is discussed and disseminated by those intervening will have an influence on prospects for implementation. Framing shapes how the actors involved think about what it is they are doing and why, and affects whether accountability reforms are accepted as desirable or necessary. A proposed reform contains an embedded perspective on what is meant by accountability and a normative rationale for why behaviors should change. As Koon et al. (2016) note, frames provide the cognitive means of making sense of the social world, but discord among them can foment policy contestation.

Every effort to improve health governance outcomes and then to leverage improvements in one or more areas of accountability begins with normative statements relevant to the situation to be affected (in terms of core health models focused on stewardship and health system). While this is useful in defining goals, such framing, particularly if it results from a donor-led exercise, may not align with how country actors understand accountability and the rationale for intervention. The social meaning of accountability depends on contextual factors and citizens' beliefs, which may differ from or reinforce the goals set by health policymakers.

For effectiveness, then, this “purpose statement” that outlines the rationale for attempting to increase accountability should be open for modification, based on analysis of contextual factors. This openness and flexibility will allow for selecting and tailoring intervention(s) to context, including appropriate framing. Key informant Judith Edstrom commented on this issue:

*To achieve accountability improvements that support health outcomes, it is vital to promote a shift in the mindset of health service providers from viewing involvement of citizens as “utilitarian participation” to one of active engagement to improve their health outcomes. The traditional health mentality around stewardship tends to think of citizen engagement as inducing behavioral change by “telling them what they need or should have” rather than by listening. No one would dispute that some behaviors, such as respecting child vaccination timetables, must be based not on community consensus but on medical science. But more often, improvement of overall health outcomes requires that citizens becoming genuinely engaged.*

Key informant Mohammed Lamine Yansané offered a country-specific example of framing:

*When Guinea had a polio epidemic, most health stakeholders did not seem to see it as their responsibility to deal with it, including development partners. Finally the MOH, together with development partners and local health administrators, put together an “accountability framework.” The discussions around this framework as well as all parties’ signed commitment to it led to more efforts being made on all sides to ensure that each vaccination campaign led to 95% of targeted children receiving the immunization.*

## CONCLUSIONS

This review offers significant indications that accountability interventions can contribute greatly to improved health governance and stronger health systems. The evidence for the impacts of specific accountability interventions, however, is often mixed. The preponderant consensus in the literature and among practitioners is that contextual factors loom large in affecting the prospects for initial success, scale-up, and sustainability. We have distilled from the review a set of implications for policymakers that contains some actions that could be undertaken to inform the design, implementation, and/or evaluation of accountability interventions. Resonating throughout the studies reviewed and from our key informants is the familiar mantra in all international development sectors that context matters.

Politics and power and institutional incentives and structures were among the contextual factors mentioned with the most frequency. Key informants provided illustrative anecdotes of how these can make or break an accountability intervention. Our African informants located in health ministries highlighted institutional and legal frameworks and the pivotal role of government leadership in ensuring sustainability in accountability gains. National/district health councils, coordination/steering committees, dialogue forums, ministry monitoring committees, annual health sector reviews, and facility oversight missions were among the entities cited whose functioning (or failing) contributed to what works for accountability and health governance.

For policymakers, a serious challenge to more successful accountability interventions remains the perpetual pressures of results-based programming and management. The drive for results leads in many cases to overly simplistic theories of change that hold everything constant save for a limited number of reforms and associated behavior changes linked to improved accountability. Inevitably, these fail to describe the multiple ways in which accountability interventions, even when narrowly defined, interact with and are influenced by their context. Our review offers food for thought to fuel discussion about elaborate theories of change for accountability interventions that are context-sensitive and focus on contribution to intended outcomes rather than direct cause-effect attribution.

Many donor-funded accountability initiatives operate within a three- to five-year project cycle. Our study confirms that accountability reforms must be long-term from the outset, with slow and careful steps founded on purposeful reflection on the previous steps, leading to iterative adaptations. This characteristic is also problematic for many country governments seeking rapid and visible results before the next budget cycle or election.

Accountability interventions are more likely to achieve concrete and sustained impacts on health governance and health systems when they employ multiple tactics and techniques, understand the change process as systemic rather than tinkering at the margins, seek to go to scale over time, expect to iterate and learn, and link to local framings relevant to accountability rather than imposing frames defined by external actors. Health system actors' understanding of how accountability advances is itself an area for improvement. Accountability reformers can improve the efficacy of their interventions and reduce unrealistic expectations by avoiding the oversimplified perspective that imagines accountability as the product of a discrete project, an isolated change in information availability, or the use of a particular accountability mechanism.

For researchers, this picture points in the direction of continued effort to identify and specify how particular aspects of accountability interventions work in a given setting, learning against that specific theory of change, and supporting better and more granular articulation of theories of change based on empirically proven findings that query context as well as intervention technique. Research that can better measure empirically the importance of interactions between tactics of accountability, and

between those tactics and specified contextual features, will help unpack similarities or differences across contexts that can better explain why particular dynamics of accountability interventions yield the results they do. Theory-building research, rather than theory-testing research, is in demand around accountability for health governance.

More implementation research is crucial to narrowing down context-sensitivity in accountability interventions to a manageable set of factors that can feasibly be taken into consideration. As we mentioned, taking context into account requires flexibility to reprogram and reorient intervention details. Flexibility in course redirection is linked to empirical observations and an attempt to objectively understand the situation. This suggests the need for implementation research to be embedded in accountability programming.

It is difficult to attribute changes in health outcomes at the population level to changes in accountability, although this review uncovered a few studies that sought to make this link. However, the cumulative weight of the evidence supports the conclusion that there is real value in effective accountability interventions, and the interviews with key informants suggest that there is broad interest in such approaches at multiple levels. The search for credible evidence of the links among accountability, health governance, health systems, and health outcomes will continue. We hope that this study has made a contribution to that search.

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## ANNEX A: EVIDENCE MAPPING FRAMEWORK: ACCOUNTABILITY

Types of Accountability by Category		Accountability Policies, Practices, & Mechanisms	Expected Health Governance Results							Health System Effects & Health Outcomes
			Transparency	Responsiveness	Voice	Empowerment	Reduced corruption	Efficiency & Effectiveness	Improved Service Delivery	
Democratic Accountability	Vertical-External	Elections								The stylized TOC is that the accountability policies, practices, and mechanisms contribute to one or more of the health governance results, which in turn contribute to health system strengthening and ultimately to health outcomes.
		Freedom of information laws								
		Open government initiatives*								
		Public interest lawsuits								
		Demonstrations and protests								
	Media: investigative journalism									
	Horizontal-Internal	Parliamentary oversight*								
		Ombudsman offices								
		Courts**								
Political decentralization										
Performance Accountability	Vertical-External	Citizen-provider committees								System effects discussed by TWG: Sustainability UHC Stewardship Resilience (e.g., Ebola) Disaster preparedness  Health outcomes: Various service delivery measures (availability, access, quality, distribution, utilization) Disease-specific (e.g., epidemics, HIV, TB, NTDs,
		Satisfaction surveys/report cards								
		Service charters								
		Civil society watchdogs								
		Professional associations								
	Media: awareness, citizen education									
	Horizontal-Internal	Standard-setting, quality assurance, accreditation								
		Regulatory enforcement**								
		Self-policing, codes of conduct**								
		Program-based budgeting*								
Internal management control										



<b>Financial Accountability</b>	<b>Vertical-external</b>	systems*									NCDs, etc.) Sector-specific (MCH, FP/RH, pharmaceuticals, etc.)
		Performance contracts									
		Performance audits*									
		Parliamentary oversight*									
	<b>Horizontal-Internal</b>	Public expenditure tracking surveys									
		Participatory budgeting and planning									
		Budget transparency initiatives									
		Citizen-led anti-corruption campaigns									
		Fiscal decentralization*									
		Government-led anti-corruption campaigns									
		Financial audits*									
Improved public procurement systems*											
Budget autonomy for health providers (e.g., hospital autonomy)*											

Note: \* Denotes overlap with Public Financial Management TWG  
 \*\* Denotes overlap with Policy and Regulation TWG

## ANNEX B: KEY INFORMANTS

Name	Affiliation
Joy Aceron	Government Watch Philippines
Randolph Augustin	USAID/Kenya
Gerry Bloom	Institute of Development Studies, University of Sussex
Victoria Boydell	International Planned Parenthood Federation
Sue Cant	World Vision International
Judith Edstrom	Partnership for Transparency Fund
Walter Flores	Center for the Study of Equity and Governance in Health Systems
Lynn Freedman	Mailman School of Public Health, Columbia University
Asha George	School of Public Health, University of the Western Cape
Cathy Green	Health Partners International
Sara Gullo	CARE International
Hippolyte Kalambay	WHO Inter-Country Support Team for Central Africa
Nils Mueller	USAID/Uganda
Simon O'Meally	World Bank
Farba Lamine Sall	Ministry of Health, Government of Senegal
William Savedoff	Center for Global Development
Ahadi Simbi	Ministry of Health, Government of Democratic Republic of Congo
Mohammed Lamine Yansané	Ministry of Health, Government of Guinea
Shannon Young	USAID/Tanzania



## ANNEX C: KEY INFORMANT INTERVIEW QUESTIONS

*Purpose: To gather information from those with more tacit and experiential knowledge regarding the state of the art in programming to promote accountability and how it affects broader health governance/health outcomes.*

*Biographical information (role in accountability and health governance, countries of work experience, etc.)*

1. Our starting point is a hypothesis that interventions aiming to enhance accountability can improve the governance of the health sector, and ultimately health outcomes, in developing countries. What are some of the efforts to promote accountability around health governance that you've supported or examined (from direct experience working on, evaluating, or other engagement, or similar in-depth study)?
2. Can you tell me about documented evidence that you have of the impact of accountability interventions? What have been the most meaningful changes they've achieved? What have been the biggest setbacks or disappointments?
3. What lessons do you have around how accountability programming works in practice? Why do they succeed? Why do they not succeed?
4. *If context raised in answer to 3/4:* From your experience, how are effective accountability programs made to fit to their context? What sorts of lessons do you have from this aspect of the work?
5. What else should we know about the state of the art in accountability programming?
6. From your experience, are there aspects of accountability for health governance where you think there is clear evidence and the debates are settled?
7. What do you consider to be the most important unanswered questions around accountability and health governance?