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Integrating Social Accountability in Healthcare Delivery Lessons Drawn from Kenya

This policy note provides observations from a pilot that tested integration of social accountability mechanisms in healthcare delivery in Kenya between 2011 and 2013..

1. Devolution of health services

The Constitution of Kenya (2010) provides that most functions of the State are decentralised in a devolution process. Health is one of the key sectors whose functions have been devolved. The 47 county governments elected in March 2013 are responsible for managing all aspects of service delivery while the central government is responsible for regulation through policy formulation and monitoring. These provisions in the Constitution were formulated with the goal of boosting efficiency and accountability.

> Devolution is at the heart of the new Constitution and a key vehicle for addressing spatial inequities. A more decentralized government makes eminent sense given Kenya's diversity and past experience with political use of central power. Decentralization has been increasingly seen and adopted worldwide as a guarantee against discretionary use of power by central elites, as well as a way to enhance the efficiency of social service provision, by allowing for a closer match between public policies and the desires and needs of local constituencies. Kenya's Constitution entrenches devolved government by guaranteeing a minimum unconditional transfer to counties under the new dispensation. (World Bank 2012)

The devolved health system is four tiered: community health services, primary care services, county referral services and national referral services. All but national referral services are managed at county level. Table 1 details the responsibilities of the national and county governments under the new dispensation (KPMG 2013).

TABLE 1: RESPONSIBILITIES OF NATIONAL AND COUNTY GOVERNMENTS IN THE HEALTH SECTOR

National Ministry Responsible for Health	County Department Responsible for Health
• Health policy • Financing • National referral hospitals • Quality assurance and standards • Health information, communication and technology • National public health laboratories • Public-private partnerships • Monitoring and evaluation • Planning and budgeting for national health services • Services provided by the Kenya Medical Supplies Agency (KEMSA), National Hospital Insurance Fund (NHIF), Kenya Medical Training College (KMTC) and the Kenya Medical Research Institute (KEMRI) • Ports, boundaries and trans-boundary areas • Major disease control (malaria, TB, leprosy)	• County health facilities and pharmacies • Ambulance services • Promotion of primary health care • Licensing and control of agencies that sell food to the public • Disease surveillance and response • Veterinary services (excluding regulation of veterinary professionals) • Cemeteries, funeral homes, crematoria, refuse dumps, solid waste disposal • Control of drugs of abuse and pornography • Disaster management • Public health and sanitation

Source: 4th Schedule of the Constitution of Kenya

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However, even though roles and responsibilities are elaborately outlined, in practice the transition from national to county governments has been marred by inconsistency, poor understanding of the system, management challenges and lack of coordination between the national and county governments. At national level, poor management and inefficiencies in resource distribution have largely contributed to poor working conditions at county level including delays in salary payments.

Additionally, there are still misconceptions on roles and responsibilities of the two levels of government. Limited knowledge on devolution by health care workers at all levels, and especially county level, has contributed to this.

A survey conducted by the Center for Health Solutions (CHS) among health care workers in Central Kenya revealed that only 11 percent have a full understanding of the devolved health system, 78 per cent partly understood, while 9 per cent had no understanding. Though this survey may not be representative of Kenya, it is indicative that without training and sensitisation, effective delivery of healthcare services may not be realised.

2. Contextualising social accountability in the health sector

Leading up to devolution, the Government of Kenya acknowledged that the packaging and delivery of healthcare services (supply-side) reforms have to be complemented by strengthening access and utilization ("demand-side") to assure quality, acceptability and effectiveness of health care services.

Health service managers and providers are increasingly having to contend with populations demanding answers on the quality of and access to health care services they are entitled to receive. The traditional approach to service delivery has been supply-side (provider) driven with little or no input from the demand-side (clients). Moreover, up and until very recently, there has been minimal collaboration with other interested parties such as Civil Society Organisations (CSOs) and other stakeholders in engaging with users to address the challenges that the health sector faces.

Demand-side approaches focus on increasing the 'voice' and capacity of citizens to demand greater accountability from public officials and service providers and to improve responsiveness in service delivery. This can be achieved through active engagement with clients in the whole spectrum of service delivery, planning, implementation and review.

Various international and regional conventions; the Universal Declaration of Human Rights, the African Charter on Human and People's Rights, the Constitution of Kenya, and various legislations such as the County Government Act 2012 explicitly or implicitly require mainstreaming of the practice of social accountability in service delivery.

Accountability is the obligation of power holders to take responsibility and be answerable for their actions. Social accountability is a concept in governance that denotes "being answerable for" and refers to strategies that employ information and participation to demand fairer, more effective public services, responsive to the people. It is an approach toward building accountability that relies on civic engagement ensuring direct and/or indirect participation of citizens and/or CSOs in exacting accountability (Malena, Forster et al. 2004).

Social accountability has in other countries been shown to result in improvements in governance in the health sector,

improvements in performance and empowerment of health care workers and communities and effective development through optimal management of available resources with benefits to service providers and clients as well as other health stakeholders

In the Kenyan health sector context, social accountability is now being integrated to respond to the needs and wants of communities, and aspirations of service providers, including health care providers, in their desire to provide services that are responsive to the client needs as envisaged in Vision 2030, the Kenya Health Policy 2013-2030, and more importantly, as enshrined in the Constitution and the County Government Act 2012.

Social accountability is one of the principles of health service delivery provided for in the Health Policy (Ministry of Health 2014). Other principles include equity in distribution of health and health interventions, people–centred approach to health and health interventions, participatory approaches to delivery of interventions, and multi-sectoral approach to maximising health goals and efficiency in application of health technologies. This is expected to translate ultimately into better health in a responsive manner.

International and National Commitments to Human Rights Based Approach to Healthcare Services

Kenya has adopted human rights based approach to healthcare service delivery based on the Universal Declaration of Human Rights to which Kenya is a signatory. In addition, the Constitution of Kenya, Article 43 (1) (a) states that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.

The Human Rights-Based Approach (HRBA) is also explicitly expressed in Vision 2030, performance contracts of all Cabinet Secretaries and the Constitution of Kenya which provides for devolution of health services, and has allocated the larger proportion of the delivery of health services to Counties. This means that Counties have a duty of planning, financing, coordinating delivery and monitoring of health services toward the fulfilment of these rights.

The national values and principles of governance in Article 10 (2) (b) of the Constitution include, human dignity, equity, social justice, inclusiveness, equality, human rights, non-discrimination and protection of the marginalised. For the health sector, this means ensuring inclusiveness in policy, planning and budgeting, and accessibility of all services for all citizens, including the youth, women and the disabled. This implicitly requires mainstreaming strategies particularly targeting these groups.

SAc is also anchored in various articles of the Constitution including; Article 27 on equality and freedom from discrimination, 35 on access to information, 43 on economic and social rights, 56 on minorities and marginalized groups, 174 on objects of devolution and 232 on the values and principles of public Service.

It is recognised that the realisation of the highest attainable standards of health (Article 43 of the Constitution) can only be achieved by harnessing and meeting public perceptions, needs, awareness, transparency and public participation in decision making on health related matters. Embracing SAc practices is one of the means by which this can be achieved. This is further elaborated in the County Government Act that places much focus on citizen participation and information sharing in service delivery (County Government Act, 2012).

Various sections in the Public Finance Management (PFM) Act 2012 provide for public participation in public financial management. In particular, the County Budget and Economic Forums provide a platform for public participation in county planning and budgeting.

Vision 2030 (Government of the Republic of Kenya 2007) envisages "equitable and affordable health care of the highest standard" through undertaking programmes that entail the public taking charge of their lives in ways that will improve the health status of individuals, families and communities.

3. KHSSP's Social Accountability Pilot

The Kenya Health Sector Support Project (KHSSP) approved in June 2010 was initiated to address poor quality service delivery and poor governance in the health sector. The project proposed to address these deficiencies in part by funding primary health care facilities directly through a Health Sector Services Fund, bypassing the inefficient district-level and local level bureaucracies. New social accountability mechanisms were to be introduced to promote greater community awareness of services, enhance their participation in management, accountability, oversight and client satisfaction.

The project has two basic objectives: enhance the delivery of essential health services, especially to the poor, and improve the availability of essential drugs and medical supplied to local health facilities and dispensaries.

Social accountability was identified as a critical mechanism for improving health outcomes and governance of the health sector. A Health Sector Community Strategy stressed the importance of strengthening communities to realise their rights for accessible and quality care and seek accountability from facility-based health services. KHSSP was developed to increase citizen demand for health services and improve access. Three goals were identified:

- Improve service delivery, access, quality, efficiency and equity;
- Promote social inclusion and community empowerment to enhance accountability of health providers and improve governance; and
- Help manage decentralisation and devolution of health services through community engagement - development planning, management and community feedback.

Mainstreaming social accountability in health care delivery systems aimed to result in: improved governance in health, empowerment of communities and optimal management of available resources for health (Figure 1).

FIGURE 1: OBJECTIVES AND ANTICIPATED OUTCOMES OF THE SOCIAL ACCOUNTABILITY PILOT

The World Bank provided technical assistance to the Sector Wide Approach (SWAp) secretariat of the Ministries of Public Health and Sanitation and Medical Services[1] to integrate social accountability approaches in the Health Sector Services Fund as a means of improving transparency in sharing information about services and participation of communities in planning and effective complaint redress. The pilot was intended to build on other initiatives that had been implemented by the health sector. Table 2 details these initiatives and their results thus far.

TABLE 2: SOCIAL ACCOUNTABILITY EXPERIENCES IN THE HEALTH SECTOR

	Activity	Sub-activity	Results
1.	Community Strategy, 2010	Evaluation of the community strategy	Acceptance and support, increased sense of ownership and demand for services. Improved collaboration and therefore sustainability.
2.	Public Expenditure Tracking Surveys (PETS)	PETS-2003, 2008.	Only a fraction of funds meant for primary health facilities actually reached those facilities. Adoption of Direct Facility Funding (DFF) approach 2007 where communities are involved in management of the funds through their HFMCs
3.	Public Expenditure Tracking and Service Delivery Indicator Survey (PETS+/SDI)	PETS – 2013	Community representation in Health Facility Management Committees (HFMC) is not always through democratic avenues. Only financial information is being shared with communities; this sharing is mainly given verbally during meetings, very few facilities use posters and boards.

Source: Ministry of Health, 2014

The social accountability pilot was carried out over 16 months[2] in nine disparate communities representing a wide range of cultural, economic, social, environmental and political settings in Kenya. The nine districts[3] (and corresponding health centres) were Kirinyaga South (Mutithi), Lamu (Mokowe), Naivasha (Maiella), Garissa (Medina), Turkana South (Makutano), Mbooni (Kalawa), Suba (Tom Mboya Memorial), Msambweni (Lunga Lunga) and Nairobi West (Riruta).

The goal of the pilot was to assess the operational feasibility of improving transparency in sharing information about health services, enhancing community participation in health service planning and delivery and introducing effective complaint redress mechanisms targeting the user communities. The pilot was focused on low-income communities primarily in rural areas and only one urban area.

A civil society institution, the African Development and Emergency Organization (ADEO), was contracted by the Ministry of Public Health and Sanitation to carry out the pilot. ADEO had the dual responsibility of helping the community implement the social accountability-related aspects of the pilot and monitoring the results. The pilot included two Community Scorecard exercises at the beginning and end of the pilot to encourage dialogue between the community and the health facilities and track changes over time. The CSCs tracked three social accountability-related components: information sharing, complaints handling and community participation.

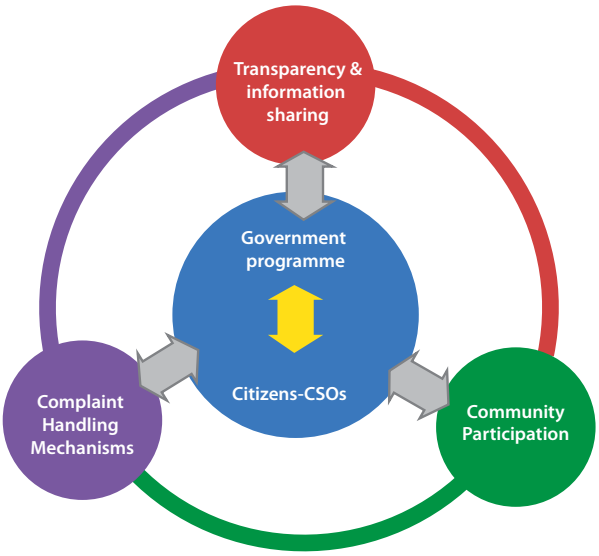
The total cost of the pilot was KES 21,323,890 (US$ 247,449). Of this amount, about eighty percent, KES 16,889,250 (US$ 195,988) was incurred by the implementing agency, ADEO. The balance, KES 4,434,640 (US$51,461) was incurred directly by the nine participating health facilities. Hence, each facility incurred about KES 492,738 (US$ 5,718) in expenditure.

[1] *The Ministry of Public Health and Sanitation (MoPHS) and the Ministry of Medical Services (MoMS), were in 2014 merged to form the now Ministry of Health (MoH).*
[2] *November 2011 to February 2013.*
[3] *The pilot ran before the devolved system had been implemented.*

4. Components of Social Accountability Piloted

Three interlinked components of social accountability; information sharing, community participation and compliment/complaint handling mechanisms were identified as being key in mainstreaming the practice of social accountability into healthcare service delivery systems (Figure 3).

FIGURE 3. THREE COMPONENTS OF SOCIAL ACCOUNTABILITY



4.1 Information sharing

Information sharing by service providers is a legal obligation recognised under Article 35 of the Constitution. It refers to a process of interactive information sharing and disclosure using multiple media. Information sharing and disclosure is meant to increase transparency in the health sector and give citizens information about the services they receive so as to make informed choices and take informed action.

Information sharing created awareness about citizens' rights, the type and quality of services that they should expect, and supported citizens in demanding accountability from service providers. Healthcare providers on the other hand benefitted from feedback shared with them by citizens and were influenced to change their behaviour towards them, ultimately influencing decisions by District Health Management Teams. Information sharing also influenced the quality of community participation.

Specifically, the pilot evaluated the extent to which information made available at the health facility's display board; the format of the Service Charter; funds received and expenditures made; working hours, services provided and outreach activities planned; results of health *barazas*[4] (meetings) reflected in services and outreach; user fee charges; names of members of the health facility management committees; and latest supplies of drugs and medical supplies received from the Kenya Medical Supplies Agency (KEMSA), the government pharmaceutical supplier.

4.2 Community Participation

Community participation enhances answerability and responsibility towards health service delivery. By engaging with the community, the basis for what, how and whom are benefiting from existing health programs is laid. Westergaard (1986), a key pioneer in theorising community participation, defined it as "collective efforts to increase and exercise control over resources and institutions on the part of groups and movements of those hitherto excluded from control".

Mechanism for ensuring community participation include use of participatory data collection and analysis tools, for example, Community Score Cards, Citizen Report Cards, Customer Satisfaction Surveys, among others.

[4] *A Baraza is a community meeting typically convened by local administrators such as Chiefs.*

The following elements of participation were critical for the pilot:

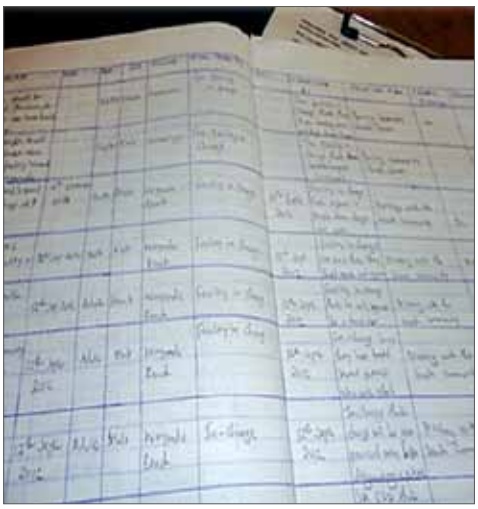
- Platforms for participation e.g. *barazas* were conducted;
- Provision and disclosure of public information was practiced;
- Dialogue occurred in an environment free of intimidation, public participation on equal terms was encouraged;
- Inclusiveness: representation of all groups in the community including vulnerable and marginalised groups was proactively assured;
- Community Scorecards (Table 3) were in place to validate that participation had taken place. The community generated the performance criteria, distinct for each health facility;
- Recourse/redress mechanisms for the community to channel complaints, compliments and suggestions for improved service delivery existed; and
- The community participated in planning, budgeting, monitoring and evaluations (for example, during development of Annual Operational Plans); their feedback reflected in the planning of outreach activities;the health facility management committees met at least quarterly and the minutes of these meetings were available.

TABLE 3: COMMUNITY SCORECARD FROM MUTITHI HEALTH CENTRE

Performance Criteria	1st Score[5]	2nd Score	Remarks
1. Positive attitude of staff			
1.1 Punctuality of staff	60	70	Come early but still start work late. Agreed to change this, the in charge explained that at times he has errands pertaining to the facility which he first has to attend to
1.2 Polite behaviour	73	82	This has tremendously improved
1.3 Listening to patients' problems	90	95	Staff listen attentively to our problems
1.4 Respect for patients	80	85	The staff respect patients except for a few instances. The in charge to look into it
1.5 Respect for patients' privacy	90	97	Privacy and confidentiality observed
2. Management of health facility			
2.1 Cleanliness	85	97	The health centre is clean and neat
2.2 Observing working hours	83	60	4 to 6 pm services are slow or negligible. Agreed to change
3. Quality of services provided			
3.1 Change (observed) to availability of drugs	52	65	Some drugs are available but others are not. List of available drugs to be displayed on the notice board
3.2 Adequate equipment	60	90	Most needed equipment at this level are available
3.3 Adequate and qualified staff	70	70	Staff are qualified but not enough
3.4 Providing multiple services every day	73	80	The services are provided well during the weekdays but not over the weekends
3.5 Emergency transport services	0	0	There is no ambulance assigned to the facility
3.6 Communication facilities (telephone, wireless)	50	50	There is a phone number which shall be displayed on the notice board
4. Equal access to health services for all members of the community			
4.1 No discrimination in providing drugs to the patients	95	95	Wherever drugs are available they are given to all patients equally
4.2 No preferential treatment	95	95	All are treated equally
4.3 Maintaining a first come-first serve policy	75	70	It is a requirement for patients coming from the lab to wait
5. Community role			
5.1 Offer volunteer services	0	100	Offer various volunteer services
5.2 Participates in meetings and monitoring funds and services offered	0	75	The community has since started being involved in such activities
5.3 Utilise the suggestion box for compliments and complaints	0	90	This has improved due to the community sensitisation on suggestion box usage and grievances redress mechanism

[5] *The community scored each criterion out of 100.*

4.3 Compliment/complaint handling mechanisms



In voicing their concerns, during the pilot, clients expected to be heard and be taken seriously. On the supply side, health service providers and administrators were encouraged to convince people that they can voice grievances and work to resolve them without retaliation or victimisation.

The pilot measured to what extent the following mechanisms were available at the community level: compliments/complaints box, mobile phone number posted on the noticeboards, usage of the telephone number,display of names of local people authorised to receive grievances,maintenance of complaint register and follow up/action on complaints by duty bearers.

5. Results of the pilot

The World Bank assessed[6] the level of effective implementation of community engagement-related activities in eight of the nine communities. Nineteen indicators were (Table 3)generated based on key emerging issues identified during social accountability community activities such as community sensitisation and CSC meetings. Even though some indicators were considered more significant than others, the significance varied between sites. Hence, for uniformity, there were no weights attached to the indicators.

TABLE 4: SOCIAL ACCOUNTABILITY INDICATORS

Social Accountability Mechanism	Indicator
Transparency and Information Sharing	1. Are main elements of Service Charter prominently and publicly displayed in Kiswahili and relevant vernacular language? 2. Information on funds received and expenditure posted on the board 3. Information on working hours, services provided and outreach activities planned posted on the board 4. Information on services provided and outreach services provided shared in the Health *Baraza* 5. Does the Facility display approved GOK user fee charges? 6. List of HFMC members displayed at the facility 7. Information on last date supplies received from KEMSA is displayed and updated
Grievance Redress Mechanism	8. Complaint box(es) available 9. Toll free mobile phone number for complaints displayed 10. Toll-free number used (data supported) 11. Names of persons assigned to receive grievances at community level posted on notice board 12. Complaint register maintained and actions logged and reports checked by DHMT? 13. Evidence of action taken against confirmed complaints
Community Participation	14. Health *baraza* held 15. AOP includes key priorities identified by health *baraza* 16. First scorecard completed and results made public 17. Community feedback is reflected in the planning of health outreach activities 18. Does the Facility Management Committee hold regular (Quarterly) meetings? 19. Are minutes of such meeting available at facility level and availed to the District Health Management Teams (DHMTs)?

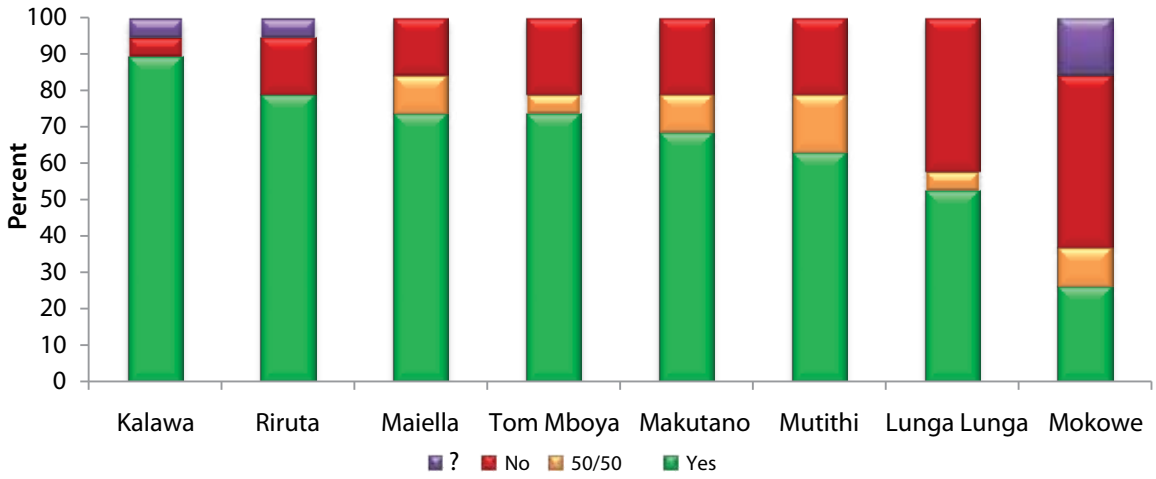
[6] *Machira, Y. W. (2013). Piloting Integration of Social Accountability Approaches in the Health Sector Services Fund (HSSF): Brief of Visits to Eight (8) Pilot Sites between September and December 2012. Nairobi, World Bank.*

For each indicator, there were four possible responses:

- Yes, which meant all requirements of the indicator had been fulfilled;
- 50/50, which meant some/half of the requirements had been met, further explanations to justify this score were provided;
- No, meaning that none of the indicator's requirements had been met; and
- ?, which meant that requirements for the indicator could not be confirmed and/or corroboration of the same from other sources was not possible at the time.

Overall, the best performing sites were: Kalawa (89%), Riruta (79%), Maiella (74%) and Tom Mboya (74%). Makutano (68%) and Mutithi (63%) scored well on about two thirds of the indicators while Lunga Lunga (53%) and Mokowe (26%) had the poorest performances respectively. Overall site performance is illustrated in Figure 4.

FIGURE 4: OVERALL SITE PERFORMANCE



It was evident that CSO support in Mokowe was under par hence the poor performance; most of the indicator requirements were not fulfilled and on further interrogation it was revealed that the appointed CSO's presence at the site was minimal. Lunga Lunga's poor performance was attributable to lack of CSO support for five months, between June and November 2012, due to contractual issues with ADEO. In essence, there was no support even during the first score card forum which was key to setting the pilot in motion. During the said visit, renewed activity intensity was visible following the CSO's return in November.

Of the three social accountability components, complaint handling mechanism performed best with an average of 75 per cent while community participation performed poorest with an average score of 56 per cent. Information sharing had an average of 68 per cent, and recorded the least score in Lunga Lunga (29%), but also recorded three of the highest possible scores (100%) in Kalawa, Riruta and Maiella.

Where performance was leveraged on number of sites performing well, above 70 percent, rather than on the basis of average score, Information Sharing was the best performing SAc element for a majority (56%) of the sites, followed by CHM for 44 percent of the sites. Community Participation still performed poorest based on this perspective with only one site (Kalawa) scoring above the minimum at an impressive 83 percent.

With regard to information sharing, all the facilities displayed approved user fees and the facility's service charter. All but one displayed the members of the HFMC. Information on funds received and expenditures were posted on the billboard of 75 percent of the facilities. Information on latest drug supplies delivered was displayed in 5 of the 8 facilities. Services available, working hours and outreach activities planned were found in less than half the facilities.

Complaints Handling Mechanisms were installed in every facility. All eight had a complaint box and a toll free mobile phone number for complaints displayed. Most had the name of the focal point for complaints posted. The Bank found evidence that complaints had been acted upon in 75 percent of the communities.

Community participation showed the least favourable results. All communities held pre-project *Barazas* and the HFMCs met regularly. All but one had the results of the first community scorecard made public. But the actual impact of the participation was limited. Only 2 of the 8 communities reported that the community feedback was reflected in the planning of health outreach facilities.

There were also serious supply side problems that limited citizen satisfaction—delayed disbursement of HSSF, drug stock outs and understaffing being the most prominent.

At the same time, the KHSSP Mid-Term review in September 2013 indicated that in part because of the intensive involvement of the Consultants in the pilot, communities were sensitised to the goals of the project and HFMCs received capacity development support. The SAc approach "holds considerable promise for achieving better local governance and heath service delivery." It cited the uptake in facilities use, reduced citizen scepticism as a result of information sharing, opportunities to complain (and compliment) and a greater sense of community responsibility for health services. (Ritchie 2014).

In addition to the pilot-supported community score cards in the nine communities, Citizen Report Cards were undertaken by and NGO, Family Care International (FCI) in two Districts for the project as a whole. The Report Cards indicated that the majority of users indicated that the overall quality of service, waiting time, cleanliness and state of the health centres had improved compared to the previous year. Because of the relatively high cost, there are no plans for continuing Citizen Report Card surveys.

6. On Challenges and Sustainability: Lessons from the SAc Pilot

Although the evidence of SAc impact is primarily related to citizen perceptions (and facility utilisation rates), it appears that the KHSSP has been effective in applying SAc tools to build confidence in the health system at the local level (Ritchie 2014). A number of factors that have contributed to its useful application of SAc in KHSSP reveal that:

- *There was a degree of client ownership and vested interest in the result.* There was a degree of shared responsibility and interest by the MoH and the Bank. The Ministry assigned a senior staff as the Focal Person for Social Accountability, an Assistant Director of Medical Services, to lead the pilot. This was especially critical as he understood the nuts and bolts of the health sector and was able to navigate difficult issues together with the SWAp Secretariat team.
- *DHMTs, health facility staff and HFMC members, were especially receptive as the pilot progressed.* The SAc pilot "broke the ice" between citizens and health facilities, improved service, created greater job satisfaction among service providers, increased utilisation rates and increased client satisfaction. While challenges remain, especially in the competence of HFMCs and some resistance within lower levels of the Ministry, the SAc effort can be sustained.

- *The national environment was propitious.* As mentioned above, Kenya's new Constitution embraces citizen involvement and the country has a vigorous civil society, sophisticated ICT capacity to expand citizen action though social media, and a growing demand among citizens to curb endemic and systemic corruption.

  In addition, the pilot made use of the *Baraza* system and tweaked it to the needs of SAc processes by using local administrators to call *Barazas* that would principally discuss health matters.
- *The World Bank was genuinely committed at all levels, with strong leadership and capacity.* The Bank TTL who has been with the project since its inception is a health sector specialist but committed to promoting citizen participation. A Senior Social Sector Specialist in the Nairobi office provided technical support. The Bank provided funding for Technical assistance from a Consultant who provided intimate support to the pilot activity.
- *The Project design was appropriate.* The KHSSP was clear in its principal goals recognised the potential value of SAc and tailored the mechanisms to the capacity of MoH and citizen groups.

In all sites, there were several success factors observed, Health Management Teams need to be involved at every level and this was illustrated in successful health centres such as Tom Mboya whose District Health Management Team's support was unwavering. The community's relationship with the in-charge largely affects SAc's success (Mokowe, Tom Mboya, Mutithi) and buy-in of all health facility staff is necessary for SAc to be well integrated in all processes and services. From an activity standpoint, a more detailed lessons of emerging lessons per component are illustrated in Figure 5.

FIGURE 5: LESSONS LEARNT FROM THE PILOT

Information Sharing

- Display of a facility's financial information has raised security concerns (Lunga Lunga)
- Display of drugs available has helped quell suspicions from the community
- There are still a lot of misperceptions/misunderstanding on HSSF—also confused with NHIF (Maiella)

Complaint Handling Mechanism

- Suggestion boxes are not in active use; verbal communication is preferred to written, across the board
- Preferred complaint channels are Opinion Leaders (OLs), HFMC members, Chiefs, and DHMT members
- Illiteracy is a big factor for understanding CHM and SAc as a whole, more so in the success of complaint channels such as sms
- Complaints can demoralise HF staff, tactful management is required in addressing them
- Gender relations and other socio-cultural considerations impact how complaints are raised (Makutano, Medina)

Community Participation

- Inarguably, even though CP was most difficult to implement and measure, it has empowered the community more than ever before where health services are concerned
- Enhanced understanding, by the community, of problems of the health system and those affecting their health facility
- It has also enhanced HF ownership, from *'hiyo hospitali'* to *'hospitali yetu'* / *'hospitali ya community'*
- Social cohesion, *'mapendeleano',* in rural areas favours CP and SAc as a whole but also hampers some SAc aspects e.g. service on a 1st come, 1st served basis
- Though more innovative mobilisation is required for an urban community, they are/become 'more informed' and willing to demand their rights
- In some circles, it was suggested that scoring ride on other community events for a better turnout
- There was confusion in some sites over the scorecard performance criteria – standardised or customised?
- Determination of scorecard criteria should be led by an objective person to avoid acquiescence
- Score cards should be translated to the local language
- HFMC members should be excluded from the scoring process
- It was evident that comprehending the scoring – more so with a different audience – was difficult
- Reception for the score card has been better at district than facility level

From a structural standpoint, there are four key lessons:

- *Social accountability needs an adequate budget.* The KHSSP Project would not have been able to introduce SAc elements had it not been for additional funding from Trust Funds, bi-lateral donor grants (DANIDA) and supplemental supervision budget from the Social Development Unit of the World Bank. The normal budget coefficients for project preparation and supervision would not have sufficed. SAc takes more time and resources than conventional project activities, as it deals with changing attitudes, behaviours, power relationships and other intangibles that tend to be under-appreciated because they cannot be readily measured.
- *SAc is location-specific.* The SAc pilot was particularly instructive in that the results varied dramatically among the nine sites around the country. Based on the indicators listed earlier, the outcomes in terms of SAc indicators ranged from 85 percent compliant to 25 percent. The nine sites were selected because they represented the full range of economic, social and physical diversity of Kenya. The results suggest the importance of understanding the local environment and avoiding pre-determined solutions. It is imperative to understand the local situation, the potential winners and losers, allies, incentives to participate and risks. SAc cannot be applied as a standard solution without first understanding reality at the local level.
- *Build Bank capacity locally.* Having an experienced and committed TTL located in the World Bank country office was a significant factor in the adoption of SAc mechanisms. He was supported by two Social Development Specialists who had good understanding of SAc mechanisms and what was needed in the Kenyan context and were able to provide technical support. Together the team helped build the trust and confidence of national-level government officials and supported champions within the health ministries. Senior-level, experienced sector and social development staff in the country office contributed to the adoption of the new approach to health service delivery.
- *Support the "Supply Side."* The biggest obstacle to implementation of the SAc pilot was not from citizens, but from the "supply side"—the healthcare workers at all levels who did not welcome the concept of greater citizen engagement. They feared loss of control, authority, resources (especially if they had been used to informal service fees) and greater accountability. The SAc pilot has demonstrated the value of constructive engagement between the public sector and citizens where both sides benefit from genuine dialogue and shared ownership of the health facilities.

7. How the Devolved Government can benefit from Integrating Social Accountability

County governments can benefit significantly by incorporating SAc. A SAc component that has been demonstrated to be effective in India (Garg and Laskar 2010), in monitoring performance of national health programmes is community participation through Community-based Monitoring (CBM) i.e. involvement of local beneficiaries. Experience from Latin America (Hevia 1977) and other parts of the world has demonstrated that active and organised community participation in health activities is the best guarantee of success in implementing integral health programmes.

Community participation requires consideration of the establishment of interrelationships between local health agencies and the community: a local health system; a participating health team; respect for the community; contact with community organisations; and contact with private and governmental organizations at a local level (Hevia 1977). Based on global experiences highlighting implementation of SAc,Table 4 lists common key benefits realised from SAc practices.

In a devolved health system, SAc, alongside other citizen engagement interventions, is expected to contribute to improvement in outcomes at five levels; policy (and the regulatory environment), governance, community health, service provision and community empowerment. These are illustrated in Figure 6.

TABLE 4: BENEFICIARIES AND BENEFITS OF SAC PRACTICES	
Beneficiary	**Benefits**
Community	• Enhances ownership of the health facility (HF) • Improves interaction with the HF • Improves communication between the community and HF staff • Improves health seeking behaviour
Service Providers	• Enhancing trust between service providers and the community • Improved performance • Improved job satisfaction amongst HCWs • Improved motivation amongst HCWs • Enhanced team work within the HF • Eases supervision by HMTs • Enhances integrity of HCWs/HMTs
Civil Society	• Improves sustainability of initiatives • Makes it easier to source data • Makes it easy to monitor health service delivery • Improves credibility
Development partners	• Aid effectiveness
Government	• Credibility • Development effectiveness

FIGURE 6: STRUCTURAL OUTCOMES OF SOCIAL ACCOUNTABILITY

8. Recommendations for SAc Implementation

It is important that an integrated approach is adopted in mainstreaming SAc into the devolved health care service delivery systems. There are at least, but not limited to, three pre-requisites for the integration of SAc, a supportive policy environment, an effective coordination structure at all levels of the health system, and government commitment, through buy in.

8.1 Policy Environment

A SAc policy brief should be developed at the national level in order to inform its practice at County and other levels. SAc should form part of the county monitoring framework. For SAc to be enhanced so as to contribute to improved service provision, government commitment should be secured through advocacy and lobbying.

8.2 Coordination

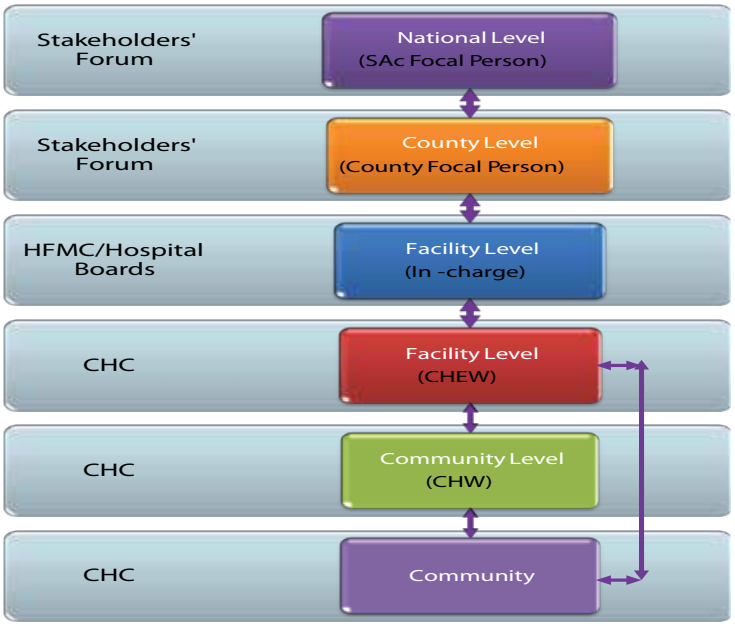
The SAc agenda should be one of the key levers at all levels of health care service delivery. Coordination should be provided within the existing management and service provision structures through identified focal persons. At the national level, the SAc Focal Person should be identified from the Directorate of Policy, Planning and Healthcare Financing and be supported by a forum that includes non-state actors with an interest in SAc in Health. This forum will act as a Technical Working Group (TWG). The identified person should collaborate with rights, youth, gender and disability (equalities) mainstreaming focal persons or units at national level. At the county and sub-county level it is suggested that the Community Strategy Focal Person or any other identified worker with interest, such as the Public Health Officer, is identified as SAc focal person. Figure 7 provides a suggested outline on the coordination arrangements for mainstreaming SAc.

At national level there should be a SAc focal person from the Directorate of planning chairing the SAc stakeholders' forum (i.e. the TWG). This structure is suggested to be replicated at the county level where the SAc focal person is suggested to be the community strategy focal person. At the county level, it is also suggested that a stakeholders' forum consisting of county level partners is formed. At sub-County level, again, the SAc focal person is suggested to be the Community Strategy Focal Person. At facility levels the proposed coordination is twofold: at hospital level the focal person is the Medical Superintendent backed up by the hospital's board and at health centre and dispensary level it is the Health Facility Management Committee (HFMC) that should identify a CHEW and a CHW as SAc champions. At the community level CHEW and CHW may identify interested community members to serve as community representatives. These can be locally known and respected persons such as religious and opinion leaders.

8.3 Government Commitment

For SAc to be enhanced so as to contribute to improved service provision, political commitment should be secured through relevant legal and legislative commitments. This commitment will lead to prioritisation on SAc and equalities resource mobilisation for the processes at the County level.

FIGURE 7: PROPOSED SAC COORDINATION STRUCTURE



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