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Two Promising Social Accountability Approaches to Improve Health in Malawi: Community Score Cards, and National Health Budget Consultation, Analysis and Advocacy

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MCSP is a global USAID initiative to introduce and support high-impact health interventions in 25 priority countries to help prevent child and maternal deaths. MCSP supports programming in maternal, newborn, and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment. MCSP will tackle these issues through approaches that also focus on household and community mobilization, gender integration, and digital health, among others.

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Acknowledgments

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Abbreviations

CSC	community score card
CSO	civil society organization
DHMTs	district health management teams
DIPs	district implementation plans
FGD	focus group discussion
iNGO	international nongovernmental organization
MCSP	Maternal and Child Survival Program
MoFEPD	Ministry of Finance, Economic Planning and Development
MOH	Ministry of Health
NGO	nongovernmental organization
PQI	Performance Quality Improvement
RMNCAH	reproductive, maternal, newborn, child, and adolescent health
RMNCH	reproductive, maternal, newborn, and child health
SAcc EWEC	Social Accountability for Every Woman, Every Child
USAID	United States Agency for International Development
WHO	World Health Organization

Abstract

This document summarizes two social accountability approaches that have been applied in Malawi for over a decade, with measurable successes. The authors' intent is to further promote the engagement of civil society to strengthen national health systems, and to share useful experiences more broadly with colleagues within the United States Agency for International Development (USAID) as well as the wider global health community. This is part of a larger effort by the Maternal and Child Survival Program (MCSP) to encourage the incorporation of civil society engagement and the institutionalization of community health programming into the context of national health system strengthening.

The selection of social accountability case study topics was conducted collaboratively with USAID/Malawi, UNICEF, CARE's Community Score Card Consulting Group, the Malawi Health Equity Network (MHEN), and the Malawi Social Accountability Task Force, among others. As a result of this in-country consultation, and based on explicit selection criteria agreed to by all parties, two topics were identified:

- Community score card
- National Health Budget Participative Formulation (Consultation), Analysis, Monitoring, and Review

MCSP created an analytic framework to guide the work case of data collection, analysis, and activities. This framework aimed to document these two approaches for engaging civil society for social accountability, and to identify strategies and factors that either facilitate or hinder the implementation of the approach.

For each case study topic, the processes that have been developed are described, and selected results presented and discussed.

The authors conclude that more research is needed in order to better understand which elements of the two social accountability approaches described herein may contribute most to desired outcomes. Future implementation research should also focus explicitly on linking local social accountability activities to national health advocacy strategies in order to link citizen participation to systematic national health system strengthening. This will require an integrated local-to-national social accountability strategy with a supportive national government, and a resourced and capable convening civil society structure.

Introduction

In tandem with the launch of the Sustainable Development Goals in September 2015, the United Nations Secretary-General released an updated version of the Global Strategy of Women's, Children's and Adolescents' Health (GS 2.0). A critical priority identified in the Global Strategy was the need to promote greater accountability regarding commitments on behalf of reproductive, maternal, newborn, child, and adolescent health (RMNCAH) (Anthrologica/UNICEF 2018).

UNICEF, with funding from the Bill & Melinda Gates Foundation, implemented the "Social Accountability for Every Woman Every Child" (SAcc EWEC) project. The project focused on two of the four main actions proposed in the GS 2.0 operational framework—accountability and advocacy—and was conducted in four high burden "focus" countries: Malawi, Nigeria, Tanzania, and India. Through supporting country-led efforts to mobilize public demand for social accountability around RMNCAH, the project aimed to accelerate results for women and children by strengthening national mechanisms for greater accountability around commitments to GS 2.0 and related RMNCAH targets. The key learning activity of the SAcc EWEC project in Malawi was "to analyze the context and social accountability gaps and barriers at community, structural and institutional levels, and understand the multiple levels of influence that affect decision-making in the country." The project worked to facilitate community as well as civil society organization (CSO) platforms to carry out constructive engagement for social accountability at different levels of the system through evidence generation, dialogue, and debate for responsiveness and quality delivery of RMNCAH services based on duty bearers' responsibilities. The specific outputs of the SAcc EWEC project included:

- Outcome 1: Participatory platforms will be identified, activated, and supported in order to enhance public transparency and accountability with regard to progress made in fulfilling Global Strategy 2.0 and the commitments made on behalf of women and children. The project will document national decision-making processes around RMNCAH activities and will emphasize the political and social contexts that inform the emergence of activities undertaken by RMNCAH activists and advocates. Lessons learned will offer insights into coalition building around RMNCAH policy at national and subnational levels.
- Outcome 2 : Inclusive citizen feedback mechanisms focusing on selected RMNCAH-related issues will be deployed and expanded. The project will document how these mechanisms can be used effectively for social accountability efforts through civil society, media, and other channels, and will demonstrate their potential role in strengthening social accountability for health.
- Outcome 3 : Civil society organizations/coalitions will have the knowledge, tools, and messaging needed to increase their reach and impact, and to articulate a common "mass advocacy" campaign for targeted healthcare spending, legislation, policy and other actions.

USAID collaborated with UNICEF to convene key social accountability stakeholders (May 2016) to build consensus and coordination for joint learning focusing on social accountability for EWEC in Malawi.

USAID (through MCSP) and UNICEF completed a complementary set of case studies focusing on promising civil society social accountability participatory approaches, linking dialogue and action from community to facility to district and national levels in Malawi and with links to with global directions in social accountability. The focus of the case studies is highlighted in the summary table below.

CSO	Approach	Systems-level interaction	Documentation lead
PACHI	MCHN dashboards QUIC survey assessments Bwalo Forum (community, district)	Community health facility, district, national	UNICEF/Anthrologica

CSO	Approach	Systems-level interaction	Documentation lead
YONECO	Radio Listening Club Theater for Development Open Data Kit Yoneco Radio	Community, health facility, national	UNICEF/Anthrologica
Malawi Health Equity Network (MHEN)	Health budget analysis, tracking, and training (district) Health budget analysis (national) Meetings with Parliamentary Health Committee, cabinet ministers, etc. CSO task force chair	District, national (Note: MHEN through CSO members has reach to community level through MotherCare Groups)	UNICEF/Anthrologica and USAID/MCSP
Multiple CSOs, including CARE	Community score card System level: community, health provider, and district	Community, health facility, district	USAID/MCSP

This case study collaboration included a political economy analysis (Anthrologica/UNICEF 2018) and global reviews of evidence (UNICEF 2018, Shanklin and Tan 2016) and tools (Wilcox and Shanklin 2017) to position approaches within a systems frame of reference. The case study collaboration was complemented by broader global efforts to systematize civil society engagement (MCSP 2016a, Garba and Mutunga 2017) and coordination (MCSP 2016b) to support the Global Strategy for Women's, Children's and Adolescents' Health/EWEC.

Malawi is at a critical juncture to take stock of efforts (past and current) to integrate, scale, and monitor social accountability for healthy communities as an opportunity to support the Government of Malawi to effectively decentralize the health system. There is a growing interest and momentum in Malawi to refine and collectively advance a common agenda to integrate social accountability in health and community systems (with a focus on design considerations, participatory monitoring, and refined roles of key actors at different levels). This momentum in Malawi includes (but is not restricted to) the convergence of the following:

- The development and rollout of a new community health strategy, synergized with the HSSP2, with an aspirational vision for the community health team and its roles in the district health system;
- USAID's bilateral investment in strengthening health and community systems (Organized Network of Services for Everyone's Health) in 16 districts, local governance and accountability (Local Government Accountability and Performance) in eight districts, and testing novel processes to enhance agency of actors in local systems (LocalWorks);
- A new UNICEF country plan (2019–2023) with a focus on community health systems as one of three pillars; and
- Emerging interest of and investment by philanthropic organizations in innovating and scaling community health systems strengthening in Malawi with a focus on mhealth/information flows.

A stakeholder roundtable, co-sponsored by USAID and UNICEF, will take place in September 2018 to enable key social accountability actors in Malawi to discuss and debate directions in social accountability for health in decentralized district health systems, strengthened through collaboration of key social accountability actors, with clear roles and linkages to optimize performance of systems and with participatory monitoring built in to address persisting challenges and harness new opportunities to integrate and scale social accountability.

In 2016 and 2017, MCSP provided technical assistance to USAID/Malawi with the intention of better understanding the implementation and functioning of selected social accountability approaches. The objectives of this task were to further promote the engagement of civil society to strengthen the national health system and to share useful experiences more broadly with colleagues within USAID as well as the wider global health community.

The scope of work of this activity included:

- Compile documented experiences/reports/mapping exercises of social accountability approaches in Malawi;
- Review these documents and, in consultation with in-country stakeholders, identify promising topics to describe in selected case studies;
- Conduct the case studies; and
- Host a dissemination event in Malawi to share results.

Rationale

There is growing recognition that social accountability approaches are an important part of functioning national health systems, and can enhance the relationships between governments, civil society, and citizens. However, gaps remain in evidence about which governance and social accountability approaches work best, the underlying principles for success, including contextual factors, and the facilitators and barriers to implementation and outcomes.

Strong health systems are essential to achieving health and development goals. "A health system consists of all organizations, people and actions whose **primary intent** is to promote, restore or maintain health" (WHO 2007, p. 2). MCSP considers that the **primary intent** of a health system is to improve the health status of the population and to do so in ways that are responsive, equitable, and efficient. MCSP aims to institutionalize community health systems, including civil society and community engagement, as part of the national health system. Civil society engagement has been demonstrated to improve health service demand, service quality (through social accountability and advocacy), and health outcomes and impact (Shanklin and Tan 2016). All effective national health strategies have formalized mechanisms for such engagement, yet many countries, donor agencies, and service implementers remain resistant to civil society participation within systems that would most benefit from their presence. MCSP has also advanced civil society engagement and social accountability by conducting a literature review on Civil Society Engagement to Strengthen National Health Systems to End Preventable Child and Maternal Deaths (Shanklin and Tan 2016), developed a Civil Society Engagement Strategy (MCSP 2016a), and published a Social Accountability Tools and Resources Guide (Wilcox and Shanklin 2017).

Figure 1. MCSP's viable, integrated community health platform diagram

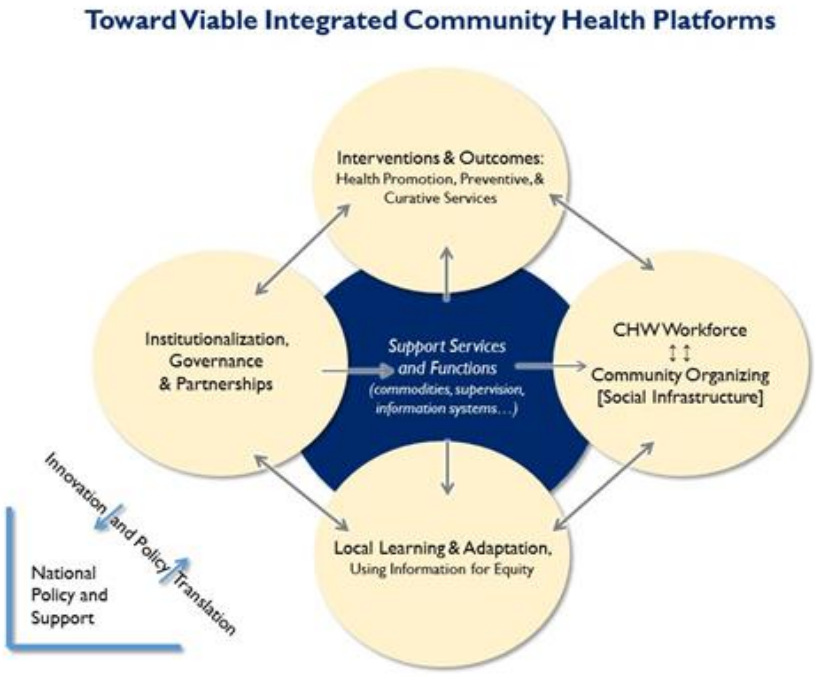


Figure 1 describes MCSP's approach for strengthening national institutionalization of community health. The component "lenses" of this model are intended to illuminate essential elements that community health strategies need to systematically address to advance comprehensiveness of services, sustainability, and high-quality care. These elements include:

- Optimizing integrated packages of reproductive, maternal, newborn, and child health (RMNCH) interventions at the community level;
- Strengthening the community health workforce and its support through community infrastructure, including effective community engagement and participation;
- Supporting more effective government, civil society, and private partnerships to institutionalize and coordinate community health and to build capacity and shared ownership; and
- Placing emphasis on use of local information for equity, learning, and adaptation.

In Malawi, effective participation and community voice in health programming remains an obstacle as communities do not have knowledge of their rights and it is unclear how much autonomy local district councils have in health budget planning and allocation, and how feedback from communities is being incorporated. There is downward pressure on health sector spending, currently reported to only be 9.8% of gross domestic product instead of 15% as per the Abuja Declaration. Although there are many public and civil society players in the health sector, there is a lack of communication, coordination, and integration at both the district and national levels. There is limited training of service providers (both community and facility based), support and supervision of health facility staff and community workers/volunteers, poor monitoring and evaluation, and limited or no action planning based on local data. Additionally, rampant corruption, indifference, and disrespect from health professional staff, and poor quality of services have been reported to have a negative impact on RMNCH services. There is a need to strengthen CSOs', communities' and individuals' ability to use information from the local level to the national level in order to hold duty bearers accountable.

Process for Selecting Case Study Topics

During a 2-week visit to Malawi in April 2016, MCSP staff met with multiple social accountability implementers and donors, and identified more than 40 documents describing various social accountability approaches functioning at local, district, and national levels. Using a standardized, pre-tested review form, reviewers recorded the following for each document:

- Source of information
- Report date or dates of data collection
- Document type (study, project report, technical volume, data summary, etc.)
- Target group(s)
- Evidence of effectiveness
- Reported outcomes and successes
- Reported and observed limitations and challenges
- Preliminary indication of the approach's promise as a case study topic

An April 2017 visit to Malawi provided an opportunity for MCSP staff to meet again with social accountability stakeholders, make a presentation to the Malawi Social Accountability Task Force, discuss findings with USAID/Malawi, and finalize selection of case study topics. The team used explicit case study selection criteria for this process:

- The approach features civil society engagement for social accountability, with effective representation and empowerment of community constituencies.
- The approach is measurable and is currently a functional program in Malawi.
- There is reasonable evidence of its effectiveness, and it has the potential to illustrate facilitators and barriers to implementation.
- There is acceptability and engagement among key public and civil society stakeholders.
- There is potential for scale up.
- The implementing agencies express willingness to actively participate in the case study.
- It compliments the other selected case study approaches to reflect a range of strategies across the national, district, or local levels, with the possibility of linkages across these functional levels.
- The findings from the case study approach could be applicable in other contexts and settings.

As a result of this in-country consultation, two topics were identified:

- Community score card (CSC)
- National Health Budget Participative Formulation (Consultation), Analysis, Monitoring, and Review

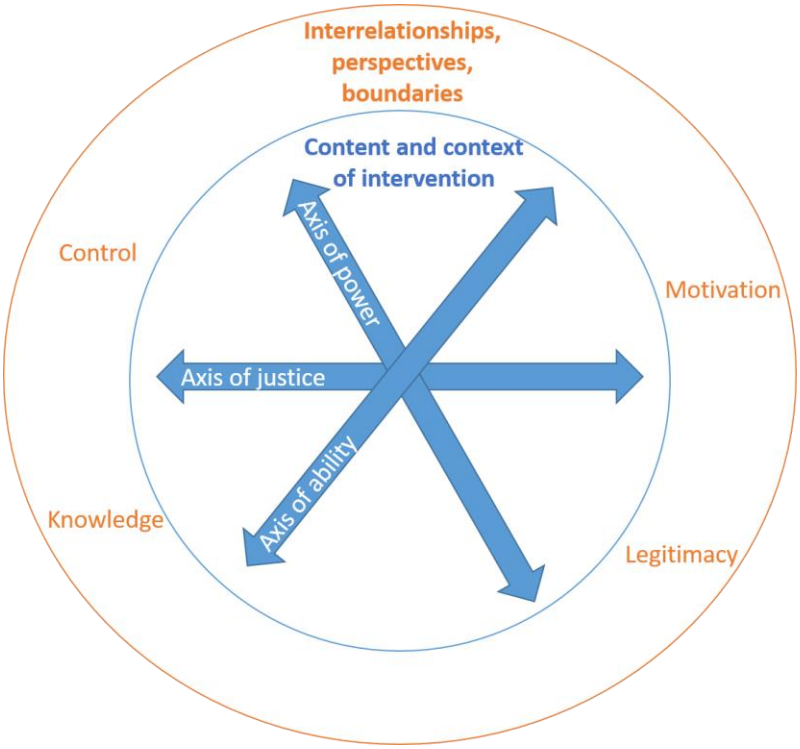
For each theme, the team identified two primary implementing agencies in-country and established contacts for working cooperatively on the case studies. In the case of the CSC, MCSP worked with the Community Score Card Consulting Group, a social enterprise operating as part of CARE International in Malawi. The second case study was developed in cooperation with the MHEN. Data were collected in July 2017. This report summarizes the findings.

Methodology and Protocol

MCSP created an analytic framework to guide MCSP case study development of data collection, analysis, and activities, led by Ligia Paina of the Johns Hopkins Bloomberg School of Public Health (Paina 2016). This framework aimed to:

- Document the process of implementing key initiatives for engaging civil society for social accountability; and
- Identify strategies and factors that either facilitate or hinder the implementation of the approach.

Figure 2. Adapted analytical framework



Source: Paina L. 2016. Learning from the implementation of interventions to engage civil society organizations for increasing social accountability Malawi: analytical framework and case study protocol. September. Unpublished manuscript.

For this work, Paina blended the accountability framework elaborated by George et al. (2016) with the critical systems heuristic approach for systems analysis, which is a "framework for reflective practice based on practical philosophy and systems thinking" (Ulrich 2005, p 1.). Whereas George et al. propose a theoretical framework for understanding accountability, the critical systems approach adds a systematic way to understand interrelationships, perspectives, and boundaries related to a particular intervention. Specifically, the team is interested in sources of motivation, power, knowledge, and legitimation in an effort to understand the present state of affairs ("what/who is") and the envisioned/ideal state of affairs ("what/who ought"). The differences between what is and what ought to be then point to unresolved issues that may need further exploration.

A key element of the data collection protocol was a process mapping exercise that describes the logical flow of activities for the selected social accountability approach, from preconditions for success to its logical conclusion. This mapping begins with a desktop review of available documentation of the approach by MCSP, which then shares the documentation with relevant field personnel in Malawi who are familiar with the approach. Additions, changes, and details are added to the map to provide a full descriptive summary of

the approach. The completed map is followed by individual interviews and observations to explore key steps, alternative perspectives of stakeholders, and issues around enablers and barriers to success.

Prior to data collection, case study authors reviewed agreed-upon skills needed for data collection and developed a common understanding and terminology for the national health system and its many elements. Key informant interviews, usually lasting between 45 minutes and 1 hour, were conducted with stakeholders. Where possible, two team members conducted the interviews together. Interviews were documented in detailed notes, which were anonymized to protect the confidentiality of respondents.

For these case studies, the authors compared multiple responses to the same questions to identify potential discrepancies. Existing literature and data were also reviewed to confirm (or call into question) the consistency of reported results.

Community Score Card Approach

CARE began developing CSCs in 2002 in Malawi, and has evolved the approach over the last 15 years. Many other organizations have adopted and adapted CSCs during this time period, in Malawi and elsewhere, and in sectors both within and beyond health. Published results of some of these activities are discussed in the "Results" section.

CSCs were originally designed as a tool to establish consensus priorities for health in communities where CARE was working (CARE 2014). They have since been primarily identified as an effective tool for social accountability. Additional purposes include:

- Building skills and confidence of community members (local empowerment);
- Creating neutral spaces where citizens and duty bearers can meet and agree on health priorities;
- Learning through a facilitated self-discovery process, and co-sharing local solutions and responsibilities;
- Sharing information related to the rights and responsibilities of citizens and duty bearers;
- Facilitating shared problem solving while avoiding confrontational activities that further polarize potential partners; and
- Creating partnerships in which stakeholders can move together (rather than passively respond to prescribed priorities).

Eventually, CSCs may also be used to broaden social change at scale.

The CSC process provides a platform for structured interface meetings between stakeholders with the aim of bringing about change. The process has evolved to consist of five steps:

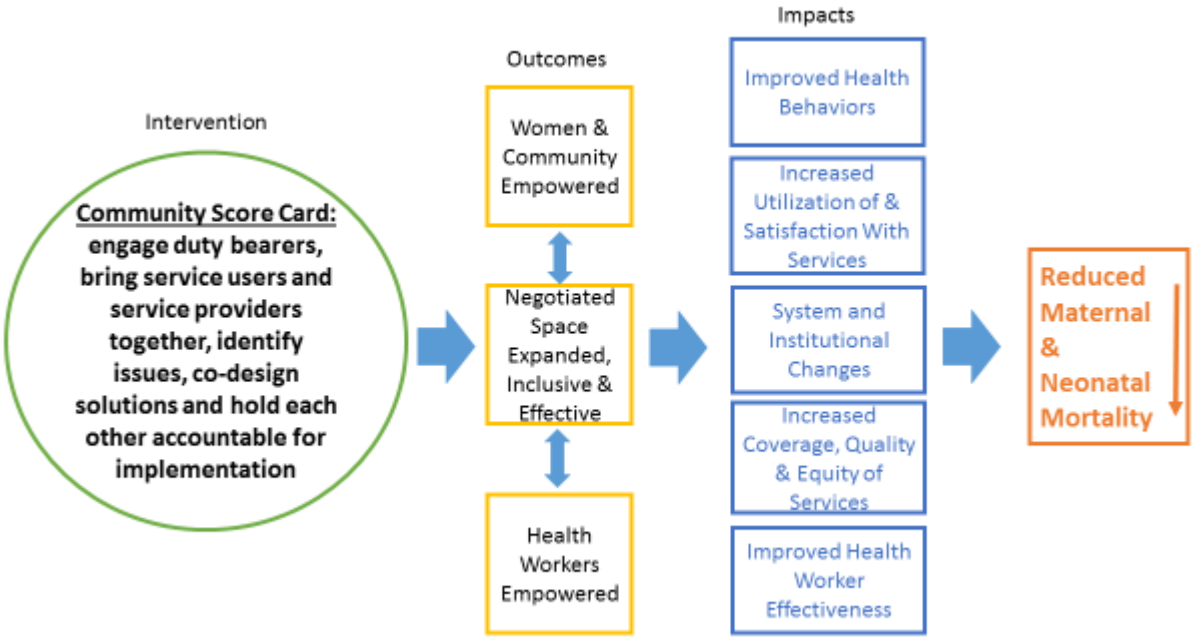
1. Preparatory work
2. Conduct the score card with the community
3. Conduct the score card with service providers
4. Hold an interface meeting and create action plans
5. Follow up locally and with higher levels of decision-makers

We begin with a brief summary of the theory of change that CARE developed for the CSC, followed by the preconditions for success, which were identified by case study interviewees.

Theory of Change

CARE's theory of change for the CSC is based on a set of assumptions that suggest a significant, positive link between citizens' empowerment, health staff cooperation, and improved service delivery outcomes. As such, it offers a theory of how the CSC works in practice and how it can be measured. Figure 3 presents a graphic summary of this theory. The "Discussion" section of this report considers implications of the theory of change in terms of both currently reported results and future research.

Figure 3. CARE's Community Score Card Theory of Change



Source: Reprinted with permission from David Waller. In: Gullo S, Galavotti C, Sebert Kuhlmann A, Msiska T, Hastings P, Marti CN. 2017. Effects of a social accountability approach, CARE's Community Score Card, on reproductive health-related outcomes in Malawi: a cluster-randomized controlled evaluation. *PLoS One*. 12(2):e0171316. doi:10.1371/journal.pone.0171316.

Preconditions for Success

Three preconditions are required for CSC success. First, the process requires civil society, duty bearers (for example, health providers), and a neutral facilitator. Second, it requires a problem or issue that needs addressing. Finally, the capacity for partner buy-in is essential. This begins with the neutral convener, who has the agility to recognize what is possible to achieve with buy-in given current contextual factors. In some cases, there may be such hostility among local partners that its application is not possible.

Preparatory Work

For CSC to be successful, the implementing team will need to:

- Identify potential partners and build relationships, taking the time to locate individuals who are motivated to participate;
- Negotiate buy-in to create a neutral "safe" space necessary for community members to meet, identify issues, and discuss these issues with service providers and duty bearers without fear of reprisal; and
- Obtain commitment from duty bearers to implement actions agreed on through the CSC process. Experience has shown that where this commitment has not been obtained, the changes agreed to in the action plan are all too often not implemented and community members lose motivation to engage in a process that does not achieve the results they are seeking.

In addition, to overcome the concerns of those in authority, well-trained facilitators who can manage and minimize conflictive issues in a constructive manner are essential to all aspects of this preparatory work.

To implement this preparatory phase effectively, the implementing partner must collect background information, including the following:

- Identify key players and structures;
- Acknowledge local sensitivities;
- Understand power relationships;
- Identify political and administrative processes, and help authorities to understand the CSC's purpose;
- Identify basic assumed standards (comparing published policies and practices with the actual situation locally);
- Raise community awareness regarding basic RMNCH issues and potential solutions;
- Track inputs of key players (such as health facility standards and capacity); and
- Identify both local champions to facilitate gaining buy-in and individuals who may be resistant so they can be properly engaged.

This process is key to identifying the potential capacities (and limitations) of users and providers, managing expectations for change, and selecting and training CSC facilitators. Although this preparatory phase takes a considerable amount of time and investment, it is critical if CSC is to be effective.

Stakeholders Involved in the Approach

CSC stakeholders belong to four groups:

- **Convening/implementing agency.** This agency is usually a nongovernmental or civil society organization (NGO/CSO), but could also be a government or private sector player. The neutrality of the convening partner is crucial, requiring extra effort and sensitivity if a public sector program is chosen, such as a district health (government paid) office.
- **Authorities.** In the Malawi health context, multiple local authorities should be considered for inclusion: Members of Parliament (locally elected national government representatives, who together with district councils manage Constituency Development Funds), district councilors (elected representatives who manage Local Development Funds), civil authorities (usually district government representatives, including councils with local leadership), and traditional authorities (such as village chiefs, who are viewed as the last line of welfare in the traditional patronage system found in Malawi).
- **Citizens.** The convening agency implements a social mapping exercise during the preparatory period. Although the exact process varies from application to application, it usually includes drawing a physical map of the area and identifying water sources, other natural resources, public facilities (health and other), chiefs, social groups (especially minority groupings), types of households (women with young children, child-headed, single parent, with disabled persons, etc.), and transportation resources.
- **Service providers.** These health workers may reach to the district or even national levels, and come from one or more local facilities. They may and often do include administrative officials, support staff, and facility-managed community health volunteers if present and active.

Facilitator Training

During this period of preparatory work, the implementing agency identifies and selects individuals to be trained as CSC facilitators. These individuals may come from the communities themselves, health facilities or government authorities, or the implementing partner, among others. Frontline government community development workers (who are not therefore part of the health delivery system) often have the skills, experience, and perceived neutrality to fulfill the facilitation role effectively.

Not all individuals selected for training must become facilitators; they may also be trained so as to better understand the process for future engagement (for example, government or civilian decision-makers). Interviewees widely agreed that the degree to which facilitator training is conducted well and thoroughly determines the effectiveness of the subsequent intervention.

Training may proceed either as a training of trainers to cascade training to expand reach, or as a training of facilitators for direct implementation within a smaller coverage area (CARE 2013). For example, as Hellen Mwale noted in an email communication dated September 12, 2017, in the Support for Service Delivery—Integration project, an initial training was offered to the higher-level health officials who would ultimately be responsible for continuing the approach in health facilities. In either approach, generally about 20 individuals are trained at any one time. Training should last from 7 to 10 days and include 3 days of CSC theory and 3 days of practical training as part of local implementation of a complete CSC exercise in one community or location.

Also during the training process, the implementing agency gains further evidence from the trainees and directly from the community about what works and what doesn't, and how the CSC approach will be adapted to the context of the project and community in question. It prepares an adaptation report summarizing issues for facilitators to be aware of in order to maximize their effectiveness. Case study interviewees reported that shortening the training (usually due to constrained budget or time limits) will affect the quality of facilitator capacity. Further, not all trainees will become competent facilitators, and post-training assessments are important to cull poor-performing trainees.

Conduct the Score Card with the Community

During this step, barriers and indicators for improvement to health care are identified, largely through a series of community focus group discussions (FGDs), resulting in the development of a draft 6-month action plan.

An initial community meeting is called using local means of notification, such as posters, community meetings, and religious gatherings. It is not unusual for large numbers of people to attend this public forum. Meetings usually last all day and, aside from refreshments, which are often provided, no incentives are offered.

During the meeting, the CSC process is described and focus groupings are identified. Some groupings are suggested by convening agency staff, and some may be suggested by citizens. The groupings usually include women, men, youth (grouped by gender), and community leaders. Some programs will further differentiate on the basis of more specific age groups, or on other criteria, such as minority status, language, or disabilities. Community members self-select which FGD they will take part in. Health facility staff are consulted separately.

Two CSC facilitators lead each FGD, which may last up to 2 hours. The group then engages in "issue generation" to identify the issues and barriers experienced by particular groups within the community. Multiple (perhaps eight or more) facilitators will participate in these day-long events so several FGDs can take place at once, reducing the time that community members need to be involved.

When CSC activities are focused around health facility performance, and the facility provides health services to multiple villages, a sample of villages may be visited and the FGD process repeated in each, or representatives of the different villages can attend a single session, for example, at the health facility. Getting this right will be especially important if different populations live in different locations. For example, some populations may live further away from the facility, or some subgroups, such as pastoralists, may engage in different livelihoods.

Typically, 10 to 20 individuals will attend a FGD, but with large crowds it may be difficult to control the actual number sitting in. Where a program has specific (and sometimes numerous) performance indicators

against which it will be measured, facilitators may be tempted to ask detailed questions to address them. In reality, asking the following three questions related to local health will generate sufficient detail, while allowing community members to explain their priorities and issues in their own words:

- What is working well?
- What is not working well?
- What is needed to improve?

Once the written lists of issues are collected from the FGDs, facilitators transfer them to index cards for all community FGDs, and separately for the health facility FGD. Indictors are then developed as facilitators cluster the issues around common themes. During the early days of the approach, it was not uncommon for facilitators to identify up to 50 indicators, which proved unwieldy to sort through and prioritize. With experience, facilitators now typically identify about 7 to 13 indicators that reflect the clusters of issues raised. These issues will usually be at a higher level than the many discrete issues raised by the FGDs. The process typically requires about 3 to 4 hours to complete. At the end of this process, facilitators will have developed two sets of "perception-based indicators" to share with community members and participating health staff and volunteers.

Following this initial indicator development, facilitators return to the same communities and call for the formation of the same FGDs. Individual participation may vary for each group, as some community members may be replaced by others who did not previously attend. Nevertheless, with a repeated explanation of the process, these follow-up FGDs should proceed smoothly. After a discussion of the indicators (and the reasons for their selection), groups decide on a scoring process to establish a baseline estimate of performance. Such measurement scales may include a series of drawn facial expressions, numbers of stones, a 1-to-10 or 1-to-100 scale, or percentages. Then, through discussion, the group establishes a consensus score for each indicator.

For each community, representatives are identified for each FGD, and together with the facilitators, they reconsider these indicator scores through dialogue and develop composite scores for each indicator. These composite scores are not averages per se, but rather a reflection of the group's best estimate based on the many comments and discussions shared during the FGDs. Score cards listing the indicators, their scores, and sample reasons for each score, are developed. These cards will be applied for a period of 6 months. A variation on this theme may be the development of separate score cards for particular subgroups who feel they need separately tracked indicators, such as youth, pastoralists, or other distinct groupings of people.

Conduct the Score Card with Service Providers

A similar process is followed in the health facility FGD, although it is simplified since only one set of issues is developed based on the group's output. Service providers and facilitators review the issues and develop indicators and composite scores.

Following these two processes with community members and health facility participants, facilitators identify potential actions (often pulled from the issues raised during community and health facility participant discussions and FGDs) that will make up the two 6-month action plans. Because of the many issues and indicators that will have been identified, not all indicators will have an individual action item. Attempts are made to create actions that will address multiple community concerns.

Prior to implementing the next step of the CSC approach, a pre-interface meeting is held with higher-level health providers to sensitize them to the issues and indicators raised by communities. These meetings may also be held among communities if there are particularly contentious issues to be discussed with health staff. The purpose of these meetings is to minimize conflict that could arise through heated and intemperate comments made during the larger interface meeting to come and to remind all involved of the commitments made during the preparatory phase to ensure implementation of the agreed actions.

Hold an Interface Meeting and Create Action Plans

Next, the implementing agency calls an interface meeting[1] that includes community members, health facility participants, additional higher-level health representatives, local government decision-makers, and other NGOs/CSOs. The CSC process is reviewed to avoid any confusion about process, representation, and transparency, as well as to encourage respectful discussions, consensus building, and the establishment of trust across all participants. Representatives are selected to speak for each of the two score cards.

It is not uncommon for some individuals to "vent" frustrations or to be argumentative or defensive. The job of facilitators is to manage these discussions and guide the exchanges toward productive conclusions.

During the interface meeting, local representatives present the CSC and health facility score card with the baseline composite scores. Scores may vary for similar indicators across the two score cards, and these differences are discussed. The purpose of the interface meeting and discussion is not for service providers and community members to reach consensus on the scores. Rather, the process provides an open space for discussion, and is often the first time community members feel empowered to bring forth their own perspectives in such a setting. After these discussions, participants consider the recommended actions (and reasons for selecting them), and alternative suggestions are heard.

Finally, two 6-month action plans are developed—one for the CSC, and the other for the health facility score card. Each plan will include the following information:

- Action items (usually three to five)
- Process and responsible person or institution (to undertake the action item)
- Resources (needed to complete the action item)
- Time frame

Some action items will be long term (beyond 6 months), and intermediate measures of progress will be developed to track progress (such as building a new structure).

Follow Up

A task team is formed locally to follow up and reinforce the action plans during the implementation period. These teams are composed of local participants in the interface meeting who demonstrated interest and commitment to the action plans. About 6 months later, the convening agency/facilitators reconvene community and health facility participants to review the indicators, ask if any new issues have emerged, and/or reconsider current indicators. (For example, are they considered stationary, or much improved?) The time period may vary from 3 to 12 months, but interviewees generally agreed that 6 months is an optimal implementation period.

Thus, this cycle is repeated (minus the initial planning and preparation stage) every 6 months—communities and service providers reconvene to discuss issues (and generate new ones, if needed), re-score the indicators, and discuss reasons for changes, and then gather in an interface meeting to review their respective score cards—creating an ongoing cycle of problem identification, solution generation, improvement implementation, and mutual accountability (Gullo et al. 2017). The process also provides an opportunity to identify barriers to progress beyond local solutions that can be addressed upstream through other means. It may be particularly relevant to do this after two or three rounds of the CSC process, when progress has been made in addressing local issues and community members have developed the skills and confidence they need to engage with higher-level decision-makers.

[1] Interface meetings may have different names when implemented by different partners, such as "public health auditoriums" or "collaborative public spaces."

Results

Over time, evidence has accumulated in support of the effectiveness of the CSC approach. These sources have typically included reviews of the score cards by communities and health facility staff themselves as part of the CSC 6-month process, documented testimonials by stakeholders, and written reports prepared by staff of the convening agency. In an effort to provide more scientific rigor, external evaluators have conducted more recent evaluations, and in at least one case, a randomized control trial was conducted and published. Further, research has been conducted on the effectiveness of selected elements of the CSC in combination with other social accountability approaches, such as World Vision's Citizen Voice and Action. A selection of these reports and results are summarized here.

CSC Explicit Research

In a series of reports released by CARE since 2011, program results have been reported from at least four countries, and described in terms of both research design rigor and the broader social accountability literature.

In their perceptive report, Wild and Harris (2011) noted that the realities of incentives and power dynamics in Malawi may not correspond with assumed links between citizen empowerment and improved service delivery, "where service delivery remains significantly shaped by a range of patronage relationships … In this context, the incentives of service providers can be much more strongly focused on responding to demands from the centre [sic] than from citizens, even where information on service gaps is available" (p. 21). They go on to conclude that "going to scale" will also require working at systematic and/or national levels. Wales and Wild (2015) continued this line of thinking, stating that "social accountability programmes [sic] must engage with the state as well as civil society and concentrate on building links and alliances within these groups and between them—fostering an environment in which co-operation can occur … This [may seem] counter-intuitive—and can mean that organizations like [CARE should] invest as much time and effort in building relationships with state officials as with community groups" (p. 30).

In a 2015 synthesis report, Wild and Wales (2015) provided a comparative analysis across four country programs: Ethiopia, Malawi, Rwanda, and Tanzania. They analyzed how the variation in national context influenced impact, using a political economy lens to map some of the key features interacting with CARE's CSC programming in each country. They observed that top-down pressure for reform from the central government helped CSC programs to achieve tangible outcomes, whereas in states lacking these conditions, such changes often were sustained only at the community level. They confirmed that buy-in from public decision-makers needs to be secured early on and maintained, with a strong emphasis on service delivery improvements. Multistakeholder partnerships are key to achieving impacts, and some stakeholder groups may need assistance to improve the functioning and communication within their own groups prior to multigroup participation.

In Malawi, "dual administration" exists, in which there is divergence between how health systems and decision-making should officially take place, and how they occur in practice, resulting in overlap and fragmentation within local governance, and leading to high levels of policy incoherence (Wild and Wales 2015). Further, officials and politicians tend to communicate downward rather than allow feedback and effective participation by communities. Ultimately, downward accountability of health service providers and government to communities is weak, and local government is not seen as responsive to civic pressure. The authors concluded, "Our evidence supports the 'accountability sandwich' hypothesis, and emphasizes the importance of framing a CSC programme [sic] in terms of building collaboration and collective interests, rather than a focus only on citizen voice and empowerment" (Wild and Wales 2015, p. 33).

Gullo et al. (2016) reviewed CARE program CSC data collected over a period of more than 10 years, and reported that "despite the evaluations' limitations, the consistency of the results and the range of outcomes reported are impressive and suggest that the CSC contributes to significant governance- and service-related

outcomes" (p. 10). Among the results were increases in citizens' knowledge, as well as service provider and power holder openness, transparency, and communication with citizens. The CSC approach attempts to ensure that segments of the community with less power have a voice in the process, and CSC effectiveness may be a result of avoiding oppositional tactics and improving communication, shared expectations, and collaboration, leading to "social accountability as learning to build trust-based relationships" (Tembo 2013, p. ix).

In February 2017, Gullo et al. published the first study using a rigorous cluster-randomized controlled design to evaluate the effectiveness of CARE's CSC on reproductive health outcomes in Malawi. The authors reported that the CSC intervention increased community health worker visits to women during pregnancy by 20% and during the postnatal period by 6%, compared to control. Further, women's satisfaction with reproductive health services increased significantly, compared with control areas. In addition, their analysis suggests that the CSC also had a significant effect on use of modern contraception, with an estimated 57% greater use in the intervention versus control area by the end of the study. The 13 CSC indicators developed by community members and health providers to drive reproductive health progress also improved during the randomized control trial, many significantly. Among these were substantial increases of male involvement in maternal newborn health and family planning (33 points), level of youth involvement (23 points), and availability and accessibility of information (22 points).

In detailed documentation of a CSC project in Tanzania, MCSP studied a joint partnership with CSOs to implement the CSC process in 12 wards in Mara and 14 wards in Kagera, where MCSP was working with the government health system to recruit, train, and supervise community health workers (MCSP 2016c). An interesting feature of this work was the development of a simple evaluation framework for assessing three dimensions of facilitation:

- **Logistical:** Make arrangements for the community meeting and follow-up on implementation of the action plans.
- **Relational:** Strengthen relationships between the different stakeholders who need to work together to improve health at the community level.
- **Technical**: Ensure that the information provided and the actions included in the action plans are effective and compatible with best practices in RMNCH and community health care delivery.

The documentation suggested that both regions had positive and negative examples of facilitation in each of these three dimensions, with positive outnumbering negative.

There were encouraging results in sites with strong facilitation, but also in sites with weaker facilitation. Where facilitation was weaker, much less progress seems to have been made in improving the functioning of health facilities and addressing governance and functioning of committees. Notable strengths of CSC were the low cost of implementation compared to other interventions, the high level of participation, increased accountability on the part of all stakeholders because of participation, the fact that some problems were addressed immediately (since the key decision-makers were all present), and the ability to provide feedback from one group of participants to another right at the time of the meeting.

Notable weaknesses were the long duration of the interface meeting, especially if not facilitated well, the risk of discussions between stakeholders becoming confrontational if not well facilitated, and the unrealistic expectations that some community members may have of the process. Some respondents stated that the meeting should be shorter, whereas other respondents stated that it proved impossible to complete all the activities in 1 day. They said that people need time to talk, and it is difficult to cut people off.

The MCSP, health staff, and CSO respondents generally viewed the CSC approach as highly sustainable relative to other community-level activities. The main concern related to sustainability was insufficient engagement and training of health staff. For the CSC to have a lasting impact, follow-up of the action plans is

key. The village and community appreciated the CSC process and indicated that it helped them to address long-standing problems with no obvious solutions.

Research on CSC in Combination with Other Social Accountability Activities and Approaches

The terms "score cards" and "community score cards" have been applied in a number of public health applications. For example, the African Leader's Malaria Alliance secretariat, sometimes together with other partners, such as UNICEF, has worked with ministries of health (MOHs) in more than 20 African countries to create RMNCAH score cards, which serve as national dashboards for tracking selected RMNCAH indicators, generated through national health management information systems or similar sources. These focus on holding the provincial or district level accountable to higher levels of the public health system. Sometimes they are shared with political leaders so health services are also held accountable to local leaders. They do not reach the health facility or community level.

Elements of the CSC described herein also have been applied in combination with (or absent from) other CSC activities. World Vision recently published a journal article that describes the application of the CSC interface meetings (and the use of a scoring mechanism) together with its Citizen Voice and Action approach (Otchere et al. 2017, Sebert Kuhlmann et al. 2016). Results suggest that progress was achieved, although it is not clear from this and other reports reviewed for this case study what mix of social accountability activities constitutes the most efficient and effective approach.

In the USAID-funded Malawi project, Support for Service Delivery—Integration, the CSC was introduced as an innovative community-based health concept (as part of a large bilateral health project), and was applied from October 2012 to 2016, as Hellen Mwale noted in an email communication dated September 12, 2017. A linkage was created between the CSC and the Performance Quality Improvement (PQI) strategy implemented in health facilities, applying PQI standards to assess the quality of care through both direct observation and a quarterly review of documentation. (This is clearly a different application from the process described elsewhere in this case document.) The idea was to bring together the demand side (service user) and supply side (service provider) of particular health facilities to jointly analyze issues underlying service delivery problems and find common and shared ways of addressing them.

Considerable scale was achieved in the project, with a total of 190 people trained as trainers and 158 CSC facilitators placed in the field, and reaching all 15 supported districts by 2013. The project target was that 50% of facilities in the districts would apply this version of the CSC approach. However, this mostly was not achieved due to health staff turnover and budget constraints. The final assessment scores of individual facilities were reported to have varied greatly. On the whole, it was noted that communities generally performed better at addressing their action points than facilities and district health offices due to the government's financial constraints. By the end of the project, project staff had developed criteria for selecting CSC committees, which would continue to follow up on issues and find solutions to new issues to sustain improvements in quality of care over time.

Currently, CARE is exploring with Keystone Accountability how it could develop surveys to track perceived changes in community health over time. This is intended to generate "performance management data" to improve local progress of partners and the facilitating agency during implementation. In recent years, CARE Malawi staff report that in some cases, local CSC capacity has been applied spontaneously by community members for other topics, such as agriculture improvement, and youth seeking improvements to local education.

Discussion

Although there appears to be a global drive for more citizen direction in national governance, many in the public sector remain skeptical, and view such engagement as potentially frightening or threatening. Currently, social accountability is viewed as a remedy for weaknesses in public sector performance, and figures in many international donor-funded projects (Brinkerhoff and Wetterberg 2015).

The CSC, as described in this report, is a defined social accountability approach designed to strengthen local health systems, with the intent of improving overall service use, client satisfaction, health equity, and health outcomes. A series of steps for effective implementation are described, and materials have been developed to fully support the process. Interviewees suggested that poor implementation of the CSC may be worse than doing nothing at all, since such failure may undermine basic relationships between communities and local public health providers and confidence in the CSC itself.

Other organizations have adapted the interface meeting for use with their "branded" social accountability approaches, as if these approaches are interchangeable, which they do not appear to be. This begs the question, what are the elements or principles of this approach that require strict attention and fidelity? CARE has identified the elements it believes to be essential to effective CSC interventions in its copyrighted approach (CARE 2014).

During this case study, essential steps appeared to include:

- A capable and resourced convening partner
- Full buy-in and commitment of health workers, local public officials, and civil society partners
- High-quality facilitator training and support
- Capacity-building of citizens and health workers to constructively participate in interface meetings and other interactions
- Ongoing local tracking of 6-month work plans
- Maintenance of partner relationships and dialogue over time

The CARE theory of change describes the probable causal relationship between inputs, actions, and outcomes. Basically, the CSC process should result in empowered community members and health workers who work in a neutral social space conducive to building mutual trust, and leading to a series of improved health outcomes and conditions. Given the importance of contextual factors to CSC practice in the field, the theory of change should be viewed as a logical starting point, rather than a definitive map for success.

One typical example of a contextual constraint is limited and unpredictable health facility financial resources, coupled with conflicting top-down directions of the health system with limited opportunity for upward feedback to district and national health administrators. The use of a theory of change, then, should be viewed as a point of departure from which to learn and grow. The development and use of process indicators (of CSC implementation itself, including facilitator training) is necessary to learn from local experiences and build on successes and failures. A comprehensive list of actions, indicators, and feedback processes will be necessary if partners are to consistently learn from local experience, build outward, and scale up implementation.

The CSC approach facilitates and supports communities to identify health issues instead of being told their health priorities by external "experts." The co-creation of CSC indicators at both community and facility levels can make standardization of indictors across score card areas difficult, and forcing such standardization can be undesirable if it imposes an external framework and undermines full community buy-in. However, although the specific **issues** confronting a community may vary, the **indicators** that summarize those issues

are more consistent and frequently can be used to compare different communities and the health services they receive. Linking the CSC to health management information systems will not therefore be simply a case of using a top-down standardized set of indicators managed through a document-and-control dynamic; rather, with some creativity, this kind of bottom-up process can be used to complement the numbers generated by these systems to provide a more nuanced understanding of why those numbers vary between communities and over time.

What types of issues can CSC be used to address?

CSC is well suited to address problems where you need:

1. Even the most marginalized and passive of community members to engage through:
    - Articulating their concerns, particularly those that a formal health management information system will not capture, such as staff behaviors and attitudes and drug theft;
    - Helping to co-create solutions to solve them;
    - Mobilizing the community to help deliver those solutions;
    - Holding duty bearers and fellow citizens to account for their performance;
    - Changing their own behaviors to make better use of the services offered;
    - Participating in community-level accountability structures;
    - Using the CSC approach to analyze other priorities that they identify; and
    - Increased understanding of their rights …
    - … and confidence and skills to be able to demand they be respected

2. Decision-makers (governmental, NGO, and donor) to
    - Understand the lived reality of those they are responsible for helping;
    - Understand:
        - how their different interventions work and don't work, and
        - the gaps, overlaps, and contradictions between multiple interventions and policies;
    - Co-create (rather than impose) solutions through listening and discussing with service users;
    - Be held to account and hold each other and the community to account for implementation of the agreed actions;
    - Engage in dialogue with the community that allows them to explain the constraints that they are having to manage (e.g., lack of funds or externally defined policies);
    - Collect qualitative evidence of community priorities that can be used for planning purposes; and
    - Mobilize community members to contribute their own resources to priorities that cannot be funded from other sources.

The CSC approach requires cooperative partnering rather than confrontational advocacy or political mobilization. As a result, having competent facilitators is crucial. Further, the process emphasizes leveling the playing field in terms of power dynamics among a diverse group of players. For many, the concept of partnerships implies the continuation of unequal partner relationships, where one partner holds power/control/decision-making over the other. To achieve meaningful cooperation, the convening partner must be perceived as a neutral broker of space, power, and social accountability resources. Some argue that the public sector may be in the best position to provide this facilitation, while others vigorously object to paid public health service staff also playing the role of neutral convener, an apparent direct conflict of interest. Frontline government community development workers (who are not part of the health delivery system) may have the skills, experience, and perceived neutrality to fulfill the facilitation role effectively.

Scaling up the CSC approach seems to imply repeating the basic community/facility approach across time and geography, rather than implementing it as a top-down, national strategy with a standardized process and measures. The approach's horizontal spread also has been reported anecdotally through its spontaneous adaptation by community groups to other themes, such as education and youth employment.

Fox (2015) argues that the CSC does not influence higher levels of health system functioning (e.g., districts, national-level decision-makers, donors, and development powerholders). This clearly seems to be the case, based on the information reviewed in this report. Importantly, systemic health problems (i.e., supply chain stockouts) will remain unresolved in even well-implemented local CSC efforts. In addition, the vertical spread of CSCs seems less likely with limited or no engagement at the national level. Therefore, future implementation research should focus on consciously linking local CSC applications to national health strategies and civil society engagement. This may imply an organized program with a supportive national government, and/or working with other national social accountability efforts, such as the Malawi Social Accountability Task Force or the MHEN's national health budget tracking and advocacy. Further discussions on social accountability sustainability will require disaggregating issues (and measurement) around elements of social accountability that should be sustained: health outputs, health outcomes, facilitation skills, the social accountability process itself, public and civil society sector capacities, etc.

National Health Budget Consultation, Analysis, and Advocacy

Background

This case study focuses on the Malawi government's national health budget, and on the role that CSOs can play in holding governments accountable for how resources are raised, allocated, and spent. The health budget reflects governmental commitment to safeguarding health and affects the strength and sustainability of the health system. Through health budget advocacy, a social accountability approach, CSOs can strategically engage in the budget process to keep governments accountable to the health needs and priorities of the population, and how resources are raised, allocated, and spent.

In Malawi, one CSO—the MHEN—has been carrying out national-level health budget consultation, analysis, and advocacy for more than a decade.

The Malawi Health Equity Network

MHEN is an independent alliance of CSOs and individuals working to promote equity and quality in health for all people in Malawi. Formed in 2000 and officially registered in 2004, the network now comprises over 60 organizations, coalitions, training institutions, and professional associations of health providers. MHEN originally received funding as part of the Gavi CSO network, through Catholic Relief Services, to establish a CSO network in Malawi. Its mission is to advocate and lobby for the health policies and systems that promote the delivery of equitable and quality health care services by influencing policy and practice through research, monitoring, and evaluation.

MHEN attempts to work throughout Malawi to improve the distribution and quality of, and access to, health services at both the district and national levels. MHEN seeks to accomplish this by influencing government policy and practice, as well as activities of donors and CSOs, through advocacy, networking, research, civic education, information dissemination, and budget monitoring.

MHEN is uniquely positioned in Malawi due to its network members, existing relationships with the Parliamentary Health Committee, the MOH, and the Ministry of Finance, Economic Planning and Development (MoFEPD), and technical capacity to analyze the national budget and translate the complex information into formats more easily understood by other officials and the general public.

Examples of MHEN's budget-related activities include:

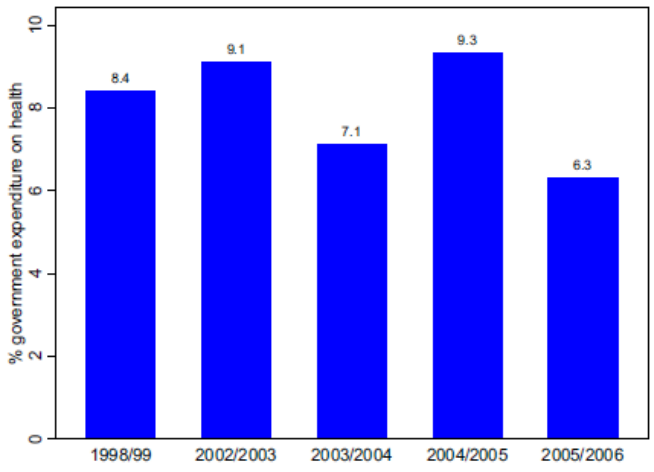
- National health sector budget consultation, analysis, and advocacy (focusing on gender equity, reaching Sustainable Development Goal targets, and timely disbursement from national to district level);
- Serving as a public interface to identify governance and allocation issues at the national and district levels;
- Analysis and monitoring of selected district health budgets; and
- Training of selected district health teams in budget analysis and tracking, especially for gender equity and specific health needs.

Malawi's Health Expenditures

In 2001, the heads of 89 countries (including Malawi) signed the Abuja Declaration, pledging to allocate at least 15% of their governments' annual budgets to improving health (WHO 2011a). According to WHO, as of 2011, only Rwanda and South Africa had achieved that target. Meanwhile, Malawi was one of seven countries that actually reduced the percentage of their national budgets going to health (see Figure 4) during the 2001–2011 period (WHO 2011b). In 2012, Malawi's total health expenditure per capita (USD 39)

remained lower than all but one Southern African country (Mozambique) and well below the regional average of USD 147 (Malawi MOH 2014). For the 2017–2018 fiscal year, Malawi's national health budget is only 9.9% of the overall budget.

Figure 4. Government expenditure on health as percentage of total government expenditure



Source: Zere E, Walker O, Kirigia J, Zawaira F, Magombo F, Kataika E. 2010. Health financing in Malawi: evidence from National Health Accounts. *BMC Int Health Hum Rights*. 10:27. doi: 10.1186/1472-698X-10-27. Reproduced under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/2.0).

In Malawi, government commitments to safeguard and improve health are laid out in several official documents, including:

- *The Constitution of the Republic of Malawi*
- *Vision 2020* (National Economic Council 1998)
- *Malawi Growth and Development Strategy III* (GoM 2017a)
- *Malawi Health Sector Strategic Plan II* (2017-2022) (GoM 2017b)
- *National Community Health Strategy* (2017-2022) (Malawi MOH 2017)

Role of CSOs

The goal of national health budget consultation, analysis, and advocacy is to influence the size and allocation of government health budgets, and CSO engagement in health budget advocacy can have any of several important impacts:

- Increase the share of the overall health budget relative to other government spending;
- Change allocations within the health budget, increasing funding for a specific issue;
- Help ensure that government meets its obligation to govern in the best interests of the citizens; and
- Monitor government commitments and hold public officials accountable for resource allocations and utilization, making sure that funds are disbursed and used as planned. This is particularly relevant where national governments have delegated budgetary authority to local-level authorities, through the process of decentralization or devolution.

However, budget consultation, analysis, and advocacy is often a difficult role for CSOs, due to a limited understanding of the budget cycle and limited government transparency in budget preparation and execution. Public guidelines on the government budget cycle and where to intervene for maximum impact are often

lacking. Furthermore, many CSOs do not have the capacity to obtain and adequately analyze complex health budgets, relative to overall government spending.

In Malawi, CSOs are actively intervening in the national budget process, along with monitoring and reporting on public expenditures, due to recent public fraud and corruption scandals. Along with the health budget review and analysis conducted by MHEN, several other civil society organizational networks (such as the Malawi Economic Justice Network and the Civil Society Education Coalition) also participate in the national budget process for their respective sectors. The set of interventions used by MHEN include:

- Analyzing budgets
- Producing simplified versions of the budget (for both government officials and the public)
- Engaging with government officials during the budget development process
- Participating in a public consultation phase of the budget process
- Playing a watchdog role
- Tracking expenditures at both local and national levels
- Advocating for increased spending and specific budget requests
- Improving overall transparency and accountability

Malawi, in particular, may be more open to CSO engagement in national health budget analysis, monitoring, and advocacy due to the recent "cashgate" scandals and other similar types of fraudulent activity. From 2013–2014, it was found that around USD 32M (almost 1% of Malawi's annual GDP) was looted by public officials in just 6 months. This widely publicized scandal led to the arrest of hundreds of public officials and widespread anger and distrust of the government by citizens and donor agencies. More recent evidence suggests that the theft of public monies may have been going on since 2009 and that more than USD 250M may have been stolen (Bacarese 2015). After cashgate, MHEN recommended that fiscal audits of health budget be done at the district councils, which is now part of its program approach.

There is pressure—from the general public, CSOs, and donor agencies—on government officials to be transparent and accountable to the citizens and provide accessible, quality, equitable services according to national policies and strategies. MHEN mobilizes village health advisory committees and educates community members on basic health rights so that they are aware of what services should be provided.

Malawi has technically been a decentralized system since 1998, with district councils having the authority to implement national laws and policies as well as their own budgets. However, national-level officials are still unwilling to concede power for genuine autonomy at the district level. Also, many district councils are not entirely sure of their roles and responsibilities and lack the capacity to fully engage with the citizens in a meaningful way. As a result, MHEN works in certain districts to:

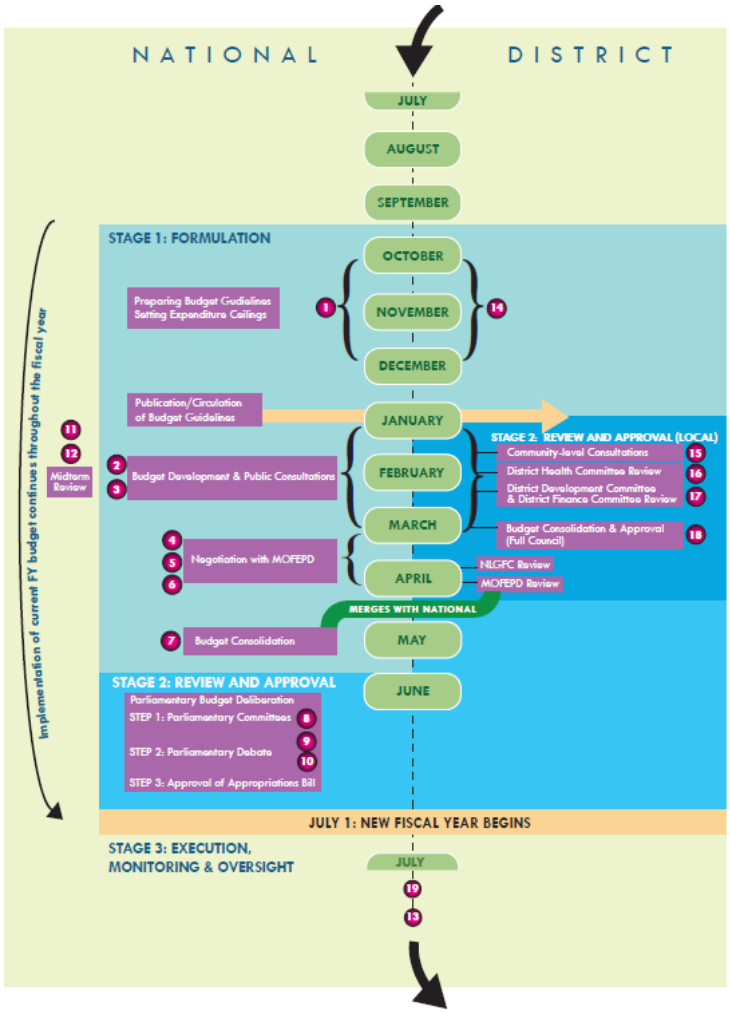
- Build the capacity of district health management teams (DHMTs) to analyze their own health budgets;
- Share information on what is in the national health budgets and what support the districts should expect from the national level; and
- Teach DHMTs how to advocate through the district implementation plans (DIPs) on health.

MHEN's Process of Health Budget Consultation, Analysis, and Advocacy

Development of Malawi's National Health Budget

The Malawi national health budget is developed in three stages, as explained in *Health Budget Advocacy: A Guide for Civil Society in Malawi* (Mbuya-Brown and Sapuwa 2015). During the budget development cycle, there are several different entry points for CSOs to get involved and exert influence on the health budget's size and allocation. MHEN attempts to advocate during each of the stages of the budget cycle, as outlined below.

Figure 5. Malawi national budget cycle



Source: Mbuya-Brown R, Sapuwa H. 2015. Health Budget Advocacy: A Guide for Civil Society in Malawi. Washington, DC: Futures Group, Health Policy Project.

Formulation

During the formulation stage, the MoFEPD reviews the previous year's expenditures and develops a forecast for the upcoming year based on available resources. Based on this information, budget guidelines (which include expenditure ceilings) are developed and shared with each sector. At this point, MHEN meets with the MoFEPD to advocate for overall increased health expenditure. MHEN also coordinates meetings with high-level MOH officials to present information related to district-level health needs. MHEN has developed and maintained trusted, professional relationships with high-level MOH and MoFEPD officials and, as a result, is able to coordinate these types of budget advocacy meetings.

Through its network members, MHEN has a presence throughout Malawi and unique knowledge of what is happening on the ground, gathered by network members through interactions with village health advisory committees and DHMTs. During the formulation stage, MHEN shares this information with the national audience as a way of advocating for additional health expenditures and allocations for specific health needs, such as additional funding at the district level for hospital beds, ambulances, or medical supplies.

At the district level, MHEN is invited to attend the DIP development meetings, which are coordinated by the DHMT along with the district health officer and the district environmental health officer. Each DIP has a budget associated with it that is supposed to inform the national budget development process, although it is questionable to what extent this actually happens.

During the budget formulation stage, the MoFEPD also solicits inputs from various stakeholders and interest groups through a public consultation period. At the public budget consultation meeting, MHEN's executive director is requested to present the evidence on health gaps and priority issues. Again, this request is due to the strong relationships and trust that MHEN has nurtured over the years.

Once the MoFEPD receives draft budgets from each of Malawi's government ministries, it holds a consultation with each government ministry to discuss the proposed budget requests. During this process, MHEN helps coordinate the face-to-face dialogue between the MOH and the MoFEPD budget director. At this point, MHEN has already presented the MOH with information from the districts on health needs and priorities, and the MOH uses this information to advocate for the health budget to the MoFEPD budget director.

Review and Approval

After the consultations, the MoFEPD consolidates the draft budgets into a national budget and prepares budget documents to be submitted to the Parliament. The minister of finance formally presents the budget to the members of Parliament in June during the "budget speech," which includes an overview of the budget as well as any specific sectors that the minister of finance feels inclined to highlight or that members of Parliament want additional information on. MHEN works proactively before the budget speech to make sure that members of Parliament and the minister of finance are all aware of the health budget requests. This is done through a series of advocacy meetings, in particular with the MoFEPD budget director and the Parliamentary Health Committee. MHEN has strong relations with the Parliamentary Health Committee's members, who actually now rely on MHEN's health budget analysis to guide them through the budget approval phase.

Once the minister of finance presents the budget by sector during the parliamentary budget session, MHEN immediately obtains this information and analyzes it. Typically, the budget speech occurs on a Friday afternoon and MHEN prepares its initial budget analysis over the weekend that follows.

MHEN conducts a desk review of the government health budget documents, resource disbursement reports, sectoral work plans and report, and council work plans and reports. During the desk review and budget analysis, particular attention is paid to reviewing allocations for specific health needs—such as malaria, nutrition, and HIV/AIDS—as well as gender equity. Face-to-face interviews are also conducted with key government officials who are directly involved in developing the national budget, budget planning, and monitoring and evaluation, including officials with the MOH and MoFEPD. MHEN also interviews key officials with district health offices to ascertain whether district-level requests were included in the national budget.

Following this process, the Parliamentary Health Committee requests a presentation of MHEN's health budget analysis, since the committee members don't have the technical capacity or experience to conduct these types of budget analyses themselves. The health budget is not a simple line item nor is it found in just one place in the overall national budget. The budgets for the MOH and National AIDS Commission are analyzed as well as the money allocated directly to the district councils for health. There are several additional

types of budget documents that need to be reviewed, including the budget statement, economic report, financial statement, output-based budget for the MOH (which includes the budget summary by line item and outputs and activities), and detailed budget estimate (which includes the specific expenditures broken down by outputs and activities).

As stated, MHEN is able to share its health budget analysis and help the Parliamentary Health Committee recognize whether the health budget meets the needs of the citizens and the obligations of the government. The budget analysis includes information on whether the health budget accords with national policies and guidelines as well as international recommendations (e.g., Abuja Declaration). It also includes information on whether specific issues raised through the DIP have been adequately addressed, a gender analysis, and a commodity-specific analysis. The health budget analysis also looks at whether recommendations from previous years are being addressed; for example, the recommendation made by MHEN that there should be a budget for health staff recruitment, development, and training within the national health budget. Lastly, the health budget analysis examines whether there is sufficient budget allocation to the district level, since that is the level where the district councils and DHMTs should manage the health budget. MHEN also produces policy briefs and media packets containing the implications of the current health budget as well as its own recommendations on the health budget, all of which are shared widely.

Execution, Monitoring, and Oversight

MHEN tasks itself with holding several different meetings throughout the year that help to strengthen its relationships with various members of Parliament as well as high-level MOH and MoFEPD officials. Twice a year, the MHEN executive director and the minister of health co-chair a meeting that includes top MOH staff and the Parliamentary Health Committee. During these meetings, MHEN provides evidence from the district level on emerging health issues and overall trends on health, and current health budget implementation/spending which MHEN has to obtain from the MoFEPD for the midyear budget review). This midyear budget review is also conducted by MHEN and shared with MOH and the Parliamentary Health Committee. These twice-yearly meetings provide a safe and neutral space for interaction and an opportunity for the MOH and the Parliament to address issues and revise the budget as needed.

Through its ongoing advocacy with the Parliamentary Health Committee, MHEN has also mobilized some of the members of Parliament to champion for the health budget. These vocal and influential members of Parliament can advocate for additional health budget or increased spending for a specific program area (for instance, maternal and newborn health) during the public parliamentary debate on the budget.

MHEN also maintains close contact with members of the national media. In Malawi, the independent newspapers and public radio are often accused of being overzealous watchdogs and frequently publicize the scandals and fraud of politicians. In the past, it was common for MHEN to utilize the media as the avenue for directing change or influence over the health budget process or on health issues. However, now MHEN finds it more productive to first approach its contacts at the MOH or in Parliament with potential issues, before going to the media.

To monitor budget implementation, MHEN works with the DHMTs to ensure that they were allocated their health budgets according to the national budgets and that these funds were actually disbursed to the district level. Often, disbursements of health funds from the national to district level are delayed or not aligned with the DIP. MHEN obtains the monthly expenditures at the district level from the district councils' account department to help DHMTs analyze their health budget by line item. MHEN has also trained health advisory committees on how to track supplies of drugs, commodities, and medical equipment using the Public Expenditure Tracking Surveys methodology. When the health advisory committees notice discrepancies between what is supplied versus what has been allocated, this information is reported to the district health officer. Financial reports are produced, summarized, and publicized on notice boards at the district council secretariat.

Results Summary

Given the complex and multilayered process of national health budget development and implementation, it is difficult to causally attribute results and outcomes to social accountability activities or a given approach. Currently there is not an established set of global indicators or quantitative research methods that can be used to demonstrate the effectiveness of national health budget consultation, analysis, and advocacy. During this case study period, however, there was anecdotal evidence of progress in Malawi, including:

- In the 2016–2017 fiscal year, the MHEN executive director testified at the public consultation that there was no increase in the drug budgets at the district level. MHEN had evidence from the districts that they had previously depleted their monthly allocations for the drug budget and that this remained a pressing concern. This led to an overall increase in the drug budget of MWK 1 billion (about USD 1.3 million).
- The national health budget was increased by MWK 7.4 billion in the 2014–2015 fiscal year, through MHEN's advocacy efforts with members of Parliament who were considered "health champions."
- In May 2017, MHEN received a call that an ambulance without sufficient fuel had dropped off a dead body at the village without taking it to the hospital morgue. The person reporting this incident wanted to take the information to the local media. Instead, MHEN got in touch with the district health officer, district council, and the principal secretary of health (MOH). The district council was provided with additional resources to ensure that all ambulances in the district had sufficient fuel supplies. Once the issue was resolved, MHEN worked with the media to report on the story, highlighting the partnership between district and national levels and lessons learned.

Discussion

In Malawi, the Access to Information Act was only passed in 2017; before that, there was no legal obligation to make approved national health budgets available to the public. Although MHEN has been able to obtain this information through its relationships with parliamentary officials, it remains a key constraint for other CSOs in Malawi. Obviously, if accurate and up-to-date budget and expenditure information are not publicly available, it is nearly impossible to conduct this type of budgetary analysis.

Advocacy with evidence and information is much stronger than advocacy alone. MHEN has a broad reach to the district level through its own activities as well as its network of CSOs. This allows MHEN the ability to get information, in real time, on what is happening at the district level related to health service provision, quality, access, and budgets. MHEN can then use this information at the national level for advocacy and accountability, and national-level policymakers understand and trust that the information MHEN is presenting is credible.

Through its experience, MHEN has also found that a more objective—rather than militant or confrontational—approach is more palatable to and effective with government officials and policymakers. Again, this would depend on country context; in some situations, when the government is completely unresponsive or uninterested in CSO engagement on the health budget, it may require a more confrontational approach to produce results. It is also quite possible that having a relationship that is too close with the government would prevent a CSO from being objective and holding the government accountable to its duties as it should.

Since the national health budget process is part of the national political system and the participants include politicians and other elected officials, it is important that organizations (such as MHEN) that are implementing these types of social accountability approaches remain apolitical. Although it may be difficult to retain a neutral position, it is critical in order for the approach to be effective and not construed as political attacks against one political group or affiliation.

Although MHEN claims to have an extensive network of local CSOs as part of its membership, it is unclear exactly what role each member plays and what credit they obtain. Since MHEN was formed to be a network of national (or local) CSOs, there is a lack of participation from international NGOs (iNGOs). Given that over 70% of Malawi's health budget still comes from external donor agencies, with much of this funding flowing through iNGOs, MHEN should coordinate with iNGOs during the national health budget process.

Developing relationships with government officials and policymakers takes time and such relationships can be tenuous given competing priorities, scarce resources, political unrest, and frequent changes in staff and political leadership. For these reasons, an ongoing strategy of engagement at all levels of the political infrastructure is required. MHEN has been working at the national and district levels for many years to cultivate trusted relationships, nurture health champions in the Parliament, and be seen as the go-to technical partner for budgetary analysis and information.

Using the technical capacity it has developed in budget analysis, MHEN has started training other partners, including district-level government staff, but training has required considerable time and external resources. MHEN received support from external partners and donors in order to form its network and build the network's capacity to perform budget analysis and advocacy. It is unlikely that another local CSO could build a similar level of technical capacity or have the funding to start health budget analysis and advocacy without considerable external support. For MHEN to continue its operations and program activities, it will require continued financial support, especially to expand to other districts in Malawi. National governments are unlikely to provide CSOs with the financial support required to participate and actively monitor their actions, and even if they did, it may present a conflict of interest. In general, social accountability approaches require external support, both technical and financial, since there is a lack of national impetus for such activities. As CSOs become proficient at social accountability, such as MHEN's current technical capacity for national health budget review and analysis, they can brand themselves as the go-to organization in-country for external donors and internal partners.

Another key issue is that while MHEN supposedly represents the interests of the citizens, there is no explicit participatory or consensus-building method used during the process. It is unclear how, or if, MHEN gathers evidence and perspectives on what citizens and communities consider priorities for the health budget and issues with budget allocation and disbursement as users of the health services. It is possible that CSOs could use the budget process to further their own agendas, without necessarily increasing citizen voice and government accountability. It is recommended that CSOs considering a similar approach incorporate some type of participatory process to gather information directly from citizens and communities that will inform the national health budget process. Conversely, budgets should be provided or communicated in a simplified fashion for citizens and their elected officials to understand, and clear public expenditure information should similarly be shared with them. Even now, members of Parliament rely on MHEN's analysis of the health budget because government documents are too complex for them to understand or act upon. Similarly, district councils do not have the capacity to decipher the national health budget and understand what their district's allocations are and whether the appropriate amounts have been disbursed to them. In decentralization, more training and capacity-building is required on health budget review and monitoring at the subnational level.

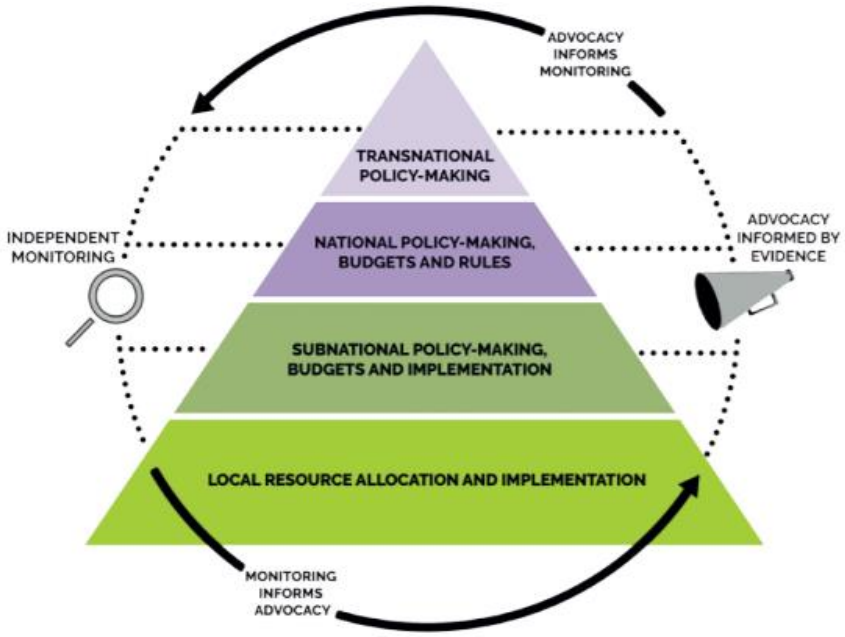
And finally, as is the case with many social accountability approaches, for this approach to be maximally effective, there should be mutual accountability and the application of sanctions as needed. As Fox stated in 2015, "The challenge facing social accountability strategies is how to break low-accountability traps by triggering virtuous circles in which enabling environments embolden citizens to exercise voice, which in turn can trigger and empower reforms, which can then encourage more voice. That is, **voice needs teeth to have bite—but teeth may not bite without voice**."

Conclusions and Recommendations

Community Score Card

Interviews, discussions, and document reviews conducted for this case study consistently support the CSC as an effective and potentially sustainable social accountability approach. An expressed concern is insufficient engagement, support, and training of health staff. For the CSC to have a lasting impact, follow-up of the action plans is key. Another limitation to its effectiveness reported by Fox (2015) is the lack of vertical integration with national health programs and budgets, which potentially could be overcome by linking CSC to national social accountability efforts.

Figure 6. Scaling accountability through vertically integrated civil society policy monitoring and advocacy



Source: Fox J, Halloran B, ed. with Levy A, Aceron J, van Zyl A. 2016. Connecting the Dots for Accountability: Civil Society Policy Monitoring and Advocacy Strategies. Report from international workshop, June 18–20, 2015, Washington DC, London: Transparency and Accountability Initiative, School of International Service, American University, International Budget Partnership, Government Watch, SIMLab. Reproduced under terms of the Creative Commons Attribution 4.0 International Public License.

The CSC approach attempts to ensure that segments of the community with less power have an equal voice in the process, and CSC effectiveness may be a result of avoiding oppositional tactics and improving communication, shared expectations, and collaboration, leading to trust-based relationships.

During this case study, essential steps appeared to include:

- A capable and resourced convening partner
- Full buy-in and commitment of health workers, local public officials, and civil society partners
- High-quality facilitator training and support
- Capacity-building of citizens and health workers to constructively participate in interface meetings and other interactions
- Ongoing local tracking of 6-month work plans
- Maintenance of partner relationships and dialogue over time

To achieve meaningful cooperation, the convening partner must be perceived as a neutral broker of space, power, and social accountability resources. Some argue that the public sector may be in the best position to provide this facilitation, while others vigorously object to paid public health service staff also playing the role of neutral convener, an apparent conflict of interest. Frontline government community development workers (where they exist, and who are not part of the health delivery system) may have the skills, experience, and perceived neutrality to fulfill the facilitation role effectively.

Linking the CSC to health management information systems likewise will not be simply a case of using a top-down standardized set of indicators managed through a document-and-control dynamic. Rather, with some creativity, a bottom-up process is needed to complement the numbers generated by a health management information system to provide a more nuanced understanding of why numbers vary within and between communities, and over time.

Going to scale will also require working at systematic and/or national levels. Convening organizations should invest as much time and effort in building relationships with state officials as with community groups. Top-down pressure for reform from the central government helped CSC programs to achieve tangible outcomes, whereas in states lacking these conditions, such changes often were sustained only at the community level. Results confirmed that buy-in from public decision-makers needs to be secured early on and maintained, with a strong emphasis on service delivery improvements and building collaboration and collective interests, rather than a focus only on citizen voice and empowerment.

National Health Budget Consultation, Analysis, and Advocacy

This case study describes a national-level health budget social accountability approach that the MHEN has been carrying out for more than a decade. MHEN attempts to improve the distribution and quality of, and access to, basic health services at both the district and national levels based on the belief that advocacy with evidence and information is much stronger than advocacy alone.

Working through its network members, MHEN reports that it has a national presence, and a unique knowledge of what is happening on the ground through interactions with village health advisory committees and DHMTs. During the formulation stage, MHEN shares this information with a national audience as a way of advocating for additional health expenditures and allocations for specific health needs, such as additional funding at the district level for hospital beds, ambulances, or medical supplies.

MHEN also conducts desk reviews of government health budget documents, resource disbursement reports, sectoral work plans and report, and council work plans and reports. During desk review and budget analysis, particular attention is paid to reviewing allocations for specific health needs. Face-to-face interviews also are conducted with key government officials. At public budget consultation meetings, MHEN presents the evidence on health gaps and priority issues which has led to changes in the budget based on this process of open dialogue and communication.

MHEN shares its health budget analysis with the national Parliamentary Health Committee to review whether the health budget meets the needs of the citizens and the obligations of the government, mobilizing some members of Parliament to become champions for the health budget. These members of Parliament then can advocate for an increased health budget, or more spending for a specific program area (for instance, maternal and newborn health) during public parliamentary debates.

To monitor budget implementation, MHEN, through its member CSOs, works with the DHMTs to ensure that they are allocating their health budgets according to the national budgets and policies, and that these funds are actually disbursed to the district level. MHEN has also trained health advisory committees on how to track supplies of drugs, commodities, and medical equipment using the Public Expenditure Tracking Surveys methodology.

MHEN maintains close contact with members of the national media, working to report stories that convey constructive progress whenever possible, rather than exploiting more political or confrontational stories and events.

Challenges of MHEN's social accountability approach include the difficulty of attributing budgetary improvements to the activities of MHEN and its partners, given the multifactorial nature of this complex and lengthy public process. Another issue is that while MHEN attempts to represent the interests of citizens, there is not an explicit consensus-building process among citizens to establish priorities. Nor are there sanctions in cases when the government does not fulfill its budgetary obligations. Finally, while MHEN has survived and prospered in its national advocacy efforts, there are not clear lessons learned on how other CSOs in Malawi or elsewhere could duplicate and/or improve upon this approach.

Recommendations of These Case Studies

More research is needed to better understand which elements of the two social accountability approaches described herein may contribute most to desired outcomes. The development and use of process indicators (e.g., implementation itself, such as CSC facilitator training, or training of health advisory committees to track district health expenditures) are necessary to learn from social accountability approaches, and to build on measured (and as far as possible, standardized) indicators. In the future, an agreed-upon list of actions, indicators, and feedback processes will be necessary if partners are to consistently learn from local experience, build outward, and scale up implementation.

Future implementation research also should focus explicitly on linking local social accountability activities to national health advocacy strategies in order to link citizen participation to systematic national health system strengthening. This will require an integrated local-to-national social accountability strategy with a supportive national government, and a resourced and capable convening civil society structure.

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