

Literature review on how accountability platforms, mechanisms, actions, or activities carried out by stakeholders (public, private, or partners) impact systems performance, health outcomes, and/or health-relevant SDG outcomes in countries

Report for the UN SG's Independent Accountability Panel for Every Woman, Every Child, Every Adolescent (IAP)

Laura Frost & Beth Anne Pratt
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I. Introduction

The Independent Accountability Panel for Every Woman, Every Child, Every Adolescent (IAP) conducts independent and transparent review of the implementation progress of the 2016-30 Global Strategy for Women’s, Children’s, and Adolescents’ Health (the Strategy) and determines and advocates for actions that are required to reach the Strategy’s goals. Appointed by the UN Secretary-General in 2015, the IAP builds on two previous initiatives—the Commission on Information and Accountability (CoIA) (2010-2011) and the independent Expert Review Group (iERG) for the first EVEC Global Strategy (2010-2015). The Strategy’s unified accountability framework (UAF) builds on a framework first articulated by CoIA and serves as the foundation for the IAP’s review process (see Figure 1).

Figure 1: Unified Accountability Framework for Global Strategy for Women’s, Children’s and Adolescents’ Health [1].



Organized around three guiding principles—**monitor, review, remedy and action**—the UAF outlines key institutions, activities, and stakeholders involved in ensuring evidence related to a country’s performance with respect to its citizens’ health, development, and rights is collected, shared, and mobilized for response. By *monitor*, the UAF refers, first, to the tracking of national and global resources, results, and rights related to the Strategy’s objectives as outlined in the Global Strategy Indicator and Monitoring Framework (including the disaggregation of data to detect disparities) and, second, to the alignment of accountability systems that facilitate this tracking and encourage participation by a broad range of stakeholders. By *review*, it refers to independent review processes that are critical for highlighting those laws, policies, and programs that are working well, as well as those that can be strengthened. The third guiding principle of the UAF is *remedy and action*, and this expands upon the concept of “remedial action” used by the iERP. Remedy and action refers to administrative, judicial, and legal remedies required to protect rights and meet commitments to the Global Strategy and UHC [1-3].¹

¹ For more information on the UAF framework and the IAP, see IAP Member Alicia Ely Yamin’s video on *Accountability and Global Health and the Sustainable Development Goals (SDGs)*: <https://www.youtube.com/watch?v=5XRIduSIIUM&feature=youtu.be&fbclid=IwAR0swOFI7ekv-JXZIIJFCpMFQpusVee-SQELYafW38SVjICEXu5rUaCPxvk>

The objective of the UAF, then, is to streamline and strengthen national and global accountability processes with respect to results, resources, and rights. As such, the UAF's role within the Strategy is to:

1. Provide support for Strategy-related country-led plans and investments
2. Improve multi-stakeholder engagement and harmonization, including alignment of reporting, as well as active participation by stakeholders
3. Strengthen accountability at all levels by improving linkages to various monitoring mechanisms and supporting technical inputs into the review process [4].

In summary, then, the UAF is meant to strengthen the planning, implementation, and monitoring of *specifically* the Strategy and other intersecting strategies (e.g. the SDGs, Countdown to 2030).

Beyond the Strategy, however, accountability has long been a focus of both national and global stakeholders; thus, the UAF necessarily sits alongside a number of other initiatives, many of which draw from frameworks derived from good governance initiatives dating back to the late-1990s and stem from research on civil society, democratization, decentralization, and corruption.

The UAF overlaps in fundamental ways with many of these frameworks. For example, many frameworks are seen as consisting of three separate foundational principles: **transparency**, **answerability**, and **controllability** [5-10].² Transparency refers to decisions and actions being taken openly, and information being made freely and easily available. Answerability refers to coherent and articulated justification of reasons for actions. Controllability refers to mechanisms that sanction actions and decisions that fail to adhere to standards or mandates. So commonplace is the use of these categories as a starting point for studies of accountability that they are typically not accompanied by a source citation.

Beyond these foundational concepts, however, different frameworks approach accountability in different ways. For example, a significant segment of accountability literature frames its analysis around three questions [11]: 1) Who is accountable? 2) To what are they accountable? 3) To whom are they accountable? Such frameworks—framed around the positionality of relationships between duty-bearers and rights holders—conceptualize accountability as **vertical**, **horizontal**, and, in some instances, **social** and **external** to describe the differences between: 1) the accountability that those in authority put in place to be answerable to citizens (vertical); 2) the accountability that exists between institutions within authority (horizontal); 3) the bottom-up accountability mechanisms that citizens use to hold authority accountable (social); and 4) the top-up accountability mechanisms that hold state actors accountable to global institutions, compacts, and initiatives (external) [12].

Other accountability frameworks frame their analysis differently. Rather than asking 'accountable to whom by who?', such frameworks instead ask "accountable to what?" For example, while a framework

² "Transparency, answerability, and controllability" as foundational principles are most frequently attributed to work by Jonathon Koppell in the early 2000s, e.g. 2003's *The Politics of Quasi-Governance: Hybrid Organizations and the Dynamics of Bureaucratic Control* (Cambridge University Press) and 2005's *World Rule: Accountability, Legitimacy, and the Design of Global Governance* (University of Chicago Press). These terms, however, were used by others prior to these publications.

developed by Brinkerhoff (2004) understands accountability in health systems as being about “answerability” and “having the obligation to answer questions regarding decisions and/or actions” (372), it then redirects the focus onto 1) the fora that enable these questions to be asked and 2) the incentive/disincentive structures that necessitate those questions to be answered [13]. These fora and structures depend on what sort of accountability is being sought. Brinkerhoff identifies three categories with differing purposes, each of which have different sets of platforms, processes, structures, and incentives/disincentives: 1) **financial accountability** (i.e. are systems in place to track and report on proper allocation, disbursement and utilization of financial resources?); 2) **performance accountability** (i.e. are those responsible for the production of goods and/or services accountable to performance targets?); 3) **political/democratic accountability** (i.e. are elected officials accountable to the electorate and are voices heard?).³

Ultimately, all of these frameworks presume that accountability measures trigger the implementation of processes and the roll out of structures, tools, and mechanisms that will create measurable improvements to both accountability and, in the case of Brinkerhoff, health. One gap in these frameworks, however, is that they are less clear about what such actions should consist of. For example: What do remedies and actions actually look like? And do they look the same everywhere, in every context and for every country? While remedies and actions are seen as necessary, the concrete steps that countries might take to improve responsiveness and transparency and measure impact are either far less likely to be articulated or, alternately, universalized and decontextualized.⁴

It is also sometimes difficult to pinpoint the utility of these frameworks for health program design, as the platforms, tools, and activities required for a measurably accountable health system may involve much more than the frameworks’ primary emphasis on a free flow of information, a platform for monitoring and review, a structure of performance incentives and disincentives, and an amplification of citizens’ ‘voice.’ Indeed, in the absence of linking these things—information, review, incentives, voice—to health outcomes it is difficult to fully establish their impact on health systems.

One possible way around these analytical gaps is to shift the focus of “What does accountability consist of?” to “How does accountability work in practice?” and “To what ends?”, i.e. to shift the analysis towards the actions that need to be taken to enable measurable progress on accountability. For example, Swinburn et al’s (2014) framework for accountability in healthy food systems (developed in support of the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases (NCDs) 2013–2020), is action-based and emphasizes that accountability involves activities that take

³ Other work on public accountability not specifically tied to the health sector greatly expands these categories to include areas such as legal, professional, and administrative, as well as collective, individual, and hierarchical. See, for example, Bovens, M. (2005). Public Accountability. *The Oxford Handbook of Public Management*. A. Ferlie, L. L.E. and C. Pollitt. Oxford, Oxford University Press.

⁴ For example, in a 2015 BMJ article describing the country-level “act” component of the framework, the list of examples of processes include health sector reviews, parliamentary committees, citizen hearings, various audits, etc., all of which are important fora through which countries can be held to account for performance. However, in the absence of specific interventions targeting how institutions and individuals function, these review processes are insufficient to ensure government and its partners follow through with evidence and commitments, and actually guarantee accountability to their citizens. See Schweitzer J. Accountability in the 2015 Global Strategy for Women’s, Children’s and Adolescents’ Health BMJ 2015; 351 :h4248.

place with respect to: 1) assessment of evidence and information (“**take** the account”); 2) communication and participatory engagement of evidence and information with stakeholders (“**share** the account”); 3) enforcement of incentives and disincentives to influence change (“**hold** the account”); 4) and remedial action and monitoring of action to ensure improved accountability (“**respond** to the account”) [14].

This framework shifts the focus strongly towards “doing accountability” and the outcomes that result. It separates the implementation of incentive structures from the implementation of activities, with the recognition that the actions themselves are meant to create measurable change, while incentive structures create an enabling environment within which change can take place. At the same time, by reducing “accountability” to mainly a set of actions tied to results, the drivers of those actions—the motivations, expectations, responsibilities and relationships that are inherent in the “who,” “what” and “to whom” captured in the frameworks that focus on positionality and purpose—get lost.

Most importantly, in all of the above frameworks, one critical element that shapes accountability—and one that often exists beyond the immediate control of the stakeholders engaged in establishing, implementing, monitoring, dis/incentivizing, and acting on accountability measures—remains uncaptured: that of **context**. Indeed, one of the most significant findings in the wave of political and development science studies that were produced in the wake of the ‘good governance’ and ‘aid effectiveness’ agendas emerging at the turn of the millennium was that, in fact, externally-driven accountability initiatives are often either undone or enabled by the political, economic, and socio-cultural context in which they are implemented [15, 16]. Indeed, often those contexts themselves involve stakeholders simultaneously—although not always successfully—juggling multiple modalities of accountability, as state- or externally-introduced, objective, non-personalized principles and practices of accountability frequently sit alongside deeply-felt, culturally-relevant, highly personalized systems of traditional or religious accountability. Moreover, these different modalities often comfortably contradict each other, even as they co-exist [17, 18].

2. Objective of the Literature Review

A decade on from the first Every Woman, Every Child Global Strategy (EWEC), the need for effective and empowered accountability mechanisms to secure progress on women’s, children’s, and adolescents’ health and other SDG-related rights is more urgent than ever [19]. Going forward, IAP argues for more rigorous examination of shared understandings of accountability, as well as a better understanding of the impact that national-level accountability initiatives have had with respect to health, health systems, and SDG outcomes. The IAP has thus commissioned a literature review alongside several other research projects to help further explore these issues.

The objective of the review is to examine *how* national and sub-national accountability platforms, mechanisms, actions, or activities carried out by key country-level stakeholders (whether from civil society, public sector, private sector, or partners) may or may not influence systems’ performance,

health outcomes, and/or multisectoral SDG outcomes at the national level within the context of universal health coverage (UHC) and primary health care (PHC), as well as across the life course.⁵

3. Methods

The scope of this review is concerned with where and how measurable health or health-related outcomes were achieved by accountability mechanisms implemented at national and subnational levels. Alternately, if outcomes were not achieved, the review was tasked with analyzing why. Specifically, the literature review was asked to examine “the campfire”—what do accountability mechanisms look like on the ground? How do they work? Indeed, do they work and, if so, in what contexts? The scope, then, focuses on the downstream level and on citizens themselves and their relationship to the state rather than higher-level, global mechanisms for accountability. The review also focuses primarily on health, development, and governance fields as these are disproportionately represented in the literature with respect to richly described downstream examples tied to outcomes. Other fields—for example, law and human rights—also have a vital interest in, particular perspective of, and vast literature on accountability; however, the bulk of the literature from these fields did not meet the inclusion criteria for the study.

This literature review is a narrative review and *not* a systematic meta-review in which examples of accountability mechanisms are identified in the literature, selected for evidence of demonstrated outcomes, and measured with respect to demonstrated significance both in relation to other like and not-like mechanisms. A meta-review such as this would be an extremely difficult exercise as even mechanisms like scorecards or maternal death audits are implemented in vastly different contexts for different purposes through different entry points and therefore the outcomes are non-comparable (see, for example, the case of CARE’s experience with scorecards in Rwanda [20]).

Thus, the intent of this literature review was not to weigh in on which mechanisms “work better” than others, or which are more effective at creating change. In fact, as will become clear throughout the review, no single mechanism in itself is catalytic in creating change in the absence of an overarching edifice of accountability made up of multiple frameworks, structures, processes, inputs, and citizens’ pathways.

This narrative literature review drew from English language articles, reports, and other literature published between January 2000 and September 2019, a time frame selected to span the adoption of the MDGs through the SDGs. Publicly available databases were searched, including PubMed, Transparency International, Corruption Watch, ODI, World Bank, Aspen Institute, Harvard Business Case Studies, Stanford Social Innovation Review and other relevant sources. These databases were searched

⁵ There are a host of global accountability platforms—for example, independent review panels such as the IAP—that serve as mechanisms by which international bodies hold states accountable to global commitments. These platforms were not included in the scope of this literature review, and would be difficult to include in a health-outcome focused study since attributing movement on indicators specifically to independent review would be a difficult case to make. However, going forward, a clear monitoring, evaluation and learning plan linking global accountability work to national outcomes (even processual ones)—as recommended in the 2019 UNFPA-led evaluation of the IAP—is essential (see <https://iapewec.org/wp-content/uploads/2019/12/IAP-EVALUATION-FINAL.pdf>).

purposively for articles that specifically focused on accountability mechanisms' linkage to health systems performance, health outcomes, and/or health-relevant SDG outcomes, with an emphasis on *how* these worked. Examples of mechanisms that were searched for purposively can be found in Table 1; these were drawn from existing accountability frameworks, established lists of accountability indicators, and documents provided to the research team by IAP.

Once identified in the literature, the full-text of documents was included in the review based on the following criteria:

1. The document was within the timeframe of January 2000 to September 2019 (covering the periods of the Millennium Development Goals (MDGs) and the Sustainable Development Goals (SDGs) until the time this review started)
2. The document focused on **how** accountability platforms, mechanisms, actions, or activities carried out by stakeholders (public, private, or partners) impact systems performance, health outcomes, and/or health-relevant SDG outcomes at the national level.

Initially, the review attempted to use thematic analysis to code accountability platforms, mechanisms, actions, or activities identified in the literature using broader categories derived from a consolidation of the frameworks discussed in the introduction. Hence, we sought to analyze literature with respect to:

- “Accountable to what” (e.g. financial, performance, and political/democratic)
- “Accountable via what process” (e.g. take, share, hold, respond)
- “Accountable by who and to whom” (e.g. vertical, horizontal, social, external)
- “Accountable to what end” (i.e. outcomes)

We also attempted to code the literature using the three guiding principles of the UAF framework (monitor, review, remedy and action). However, we found that it was difficult to apply traditional frameworks to the literature we were reading. For example, vertical accountability and social accountability are often used to refer to, in the former case, the accountability of states to their citizens and, in the latter, the demand for accountability by states from citizens. Horizontal accountability, by contrast, was described as the accountability of the state to itself, and external accountability as the accountability of states to outside parties.

By contrast, many of the articles we reviewed made it clear that the efficacy of one sort of, for example, social accountability mechanism (e.g. citizens' score cards) was wholly dependent upon the presence of a so-called 'vertical' accountability mechanism (e.g. public sector reform, legislation on women's rights) or, alternately, transformations already taking place within the enabling environment (e.g. improved women's education, expansion of the middle class). Additionally, often a single mechanism sat across multiple categories. For example, if citizens' dispute resolution courts are institutionalized by the state, are they examples of social or vertical accountability? Would maternal death audits, for example, be horizontal or social accountability if the audit serves simultaneously community-, facility-, and district-based social and performance accountability needs?

Organizing the literature according to purpose—financial, performance, democratic—was also not particularly helpful for the objectives of this literature review. In many instances, the purpose of the mechanism either depended on how and through whom it was implemented (e.g. a mechanism like a community scorecard could be implemented in the same country by two different NGOs and, depending on the objectives of the NGO, be focused on performance accountability in one instance and democratic accountability in the other) or served multiple purposes at the same time. Focusing on “actions” around accountability (‘take’, ‘share’, ‘hold’, ‘act’) also proved difficult since many mechanisms did not fall neatly under a single category and were meant to do multiple things at the same time (for example, how would a radio call-in show be classified, or a facility-based mortality audit?). Also, in many instances, intervening context and other issues meant big gaps between a mechanism’s intentions and how it actually worked in practice. Additionally, the UAF framework was difficult to apply to the literature that described how mechanisms work on the ground.

In summary, many of the frameworks we examined were either not fit to purpose with respect to the analytical requirements of the literature review or, alternately, forced us to treat accountability either as a linear and/or stepwise process, or as something that exists within silos. The literature we read, however, suggested that accountability emerges from a host of interwoven, interdependent, rather messy principles and practices that, ideally, combine to allow, first, citizens to demand good health and accompanying rights and, second, states to provide these things to citizens efficiently, effectively, and with maximum transparency and goodwill.

For this reason, our review is **not** organized around the concepts found in traditional accountability frameworks—nor around the UAF—but rather around a set of ideas that made analytical sense based on the subject matter of the articles pulled in the search, and the purpose for which we were reading the literature.

Ultimately, we ended up organizing both our search and our findings around a different framework adapted from O’Neil, Foresti and Hudson’s (2007) review of donor approaches for strengthening voice and accountability [15]. This framework identifies four classifications of donor mechanisms for accountability:

1. Mechanisms related to overarching ‘institutional frameworks’ (e.g. the umbrella of policies, laws, and larger commitments that mandate accountability)
2. Mechanisms related to national or local state/public institutions (e.g. the structures by which the state implements or enacts these mandates)
3. Mechanisms related to channels through which citizens participate and seek their voice to be heard (e.g. the activities, organizations, venues, and fora citizens can use to demand rights)
4. Mechanisms related to strengthening the enabling environment (e.g. the context) [15].

In this framework, accountability emerges from the interlinkages between: 1) institutional frameworks; 2) public institutions (which, hopefully, are structured in such a way to ensure receptivity and responsiveness of the state to its citizens); and 3) various channels which, in turn, support citizens in leveraging such receptivity and responsiveness to ensure their voices are heard. At the same time, frameworks, institutions, and channels depend on and are influenced by the enabling environment for

accountability, i.e. the political, economic, socio-cultural, and educational context in which citizens and states interact.

For the purpose of this literature review, we adapted this framework by analyzing literature based on four questions we felt were necessary to ask in order to understand the ‘how’ of accountability:

1. What legal foundations need to exist to buttress the work of other mechanisms?
2. What institutional and bureaucratic structures need to be put in place to bring such foundation to fruition and ensure that other mechanisms work?
3. What routes are available for citizens to demand that foundation and structures work for them?
4. What sorts of contexts impede, facilitate, or influence all of the above?

We organized the answers to these questions around the following four concepts:

1. Foundations—the infrastructure for accountability laid out via processes/mechanisms embedded either constitutionally or in legislation, laws, or external commitments that ensure bureaucratic, democratic, and other mechanisms are both mandated and legally actionable.
2. Structures—the institutional, organizational, or bureaucratic processes/mechanisms for accountability which states put in place with the goal of better serving citizens
3. Pathways—the channels through which citizens are able to participate and give voice to concerns
4. Context—the enabling environment within which accountability initiatives sit

We reiterate, however, that the boundaries between these categories—foundations, structures, pathways, and context—are not mutually exclusive. Indeed, we assume that the categories are, instead, overlapping and mutually dependent, and the examples we provide from the literature and the lessons we draw from them reflect these assumptions. In many instances, outcomes were derived from different mechanisms at different levels working together. As such, this literature review seeks to tell ‘accountability stories.’

Table 1: Examples of Processes/Mechanisms/Interventions Included in the Literature Review Search

<ul style="list-style-type: none"> • Ratified international human rights treaties • IHP+ commitments • FPOS-compliant SDG data reports • Country <i>Countdown</i> event • Mechanisms for reporting to human rights treaty bodies • Multi-stakeholder SDG monitoring frameworks • Legal frameworks to prevent sex discrimination • Constitutional, statutory, and/or policy guarantees for public access to information • Policies/mechanisms for improved demographic representation 	<ul style="list-style-type: none"> • Fully funded national statistics plan • Parliamentary committees • National Commissions for Health and Development • Anti-corruption agencies • National human rights institutions compliant to Paris Principles • Principles for stopping close door meetings • Receipting and documentation systems • Financial audits • Performance assessment • Performance ranking (ie district league tables) • QA/QI interventions • Annual health sector review • Health issue-specific reviews 	<ul style="list-style-type: none"> • Ombudsmen • Country partner coordinating committees • Health Information Systems • Vital statistics • Gender assessments • Maternal death surveillance and response • Mortality and health audits • Health service charters • Health facility committees • Social audits • Scorecards • Mechanisms for individual complaints procedures and remedial action • Citizen hearings 	<ul style="list-style-type: none"> • Media and advocacy for increasing awareness and disseminating information • Budget tracking • Participatory budgeting • Helplines and hotlines • UHC • Service coverage (e.g. EMOC, FP) scale up • Adolescent- and women-friendly services • ICC/BCC for key issues (GBV, child rights/survival, male involvement) • Women's economic empowerment initiatives • OVC programs • Social safety nets • Voter registration
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4. Findings

4.1 Foundations

The literature emphasizes the importance of laying the foundation for accountability through a country's **constitution or in legislation, laws, or external commitments**. The foundation for accountability, then, refers to those overarching legal frameworks that both mandate the monitoring and review of accountability mechanisms and must be in place to ensure these are actionable, enforceable, and remedial, such as those mechanisms detailed in the sections on structures (3.2) and pathways (3.3). Legal frameworks are also essential for the setting of norms for women's, children's, and adolescents' health and for UHC.

Because this literature review was focused on country examples of accountability tied to outcomes, the vast majority of articles reviewed did not provide detailed case studies of how to lay the foundation for accountability. Key issues are covered in other IAP reports including the 2018 IAP Report on the private sector which notes the importance of government strengthening legislation and ensuring oversight for the enforcement of policies and regulations regarding private sector health providers, the pharmaceutical industry, the food and beverage industry, and other for-profit private sector actors [21].⁶

⁶ Additionally, a separate literature review on the private sector and accountability has been, at the same time as this literature review, commissioned by David Clarke, WHO Advisor for Health Systems, Law and Governance

The articles identified for this literature review emphasized that insufficient legal foundations can impede the effectiveness of accountability mechanisms. For example, in 2007, the Free Maternal and Child Healthcare Programme (FMCHP) was introduced in Enugu State, Nigeria. The FMCHP was designed to include two accountability mechanisms to ensure the participation and voice of citizens—complaint systems and health facility committees (HFCs). HFCs consisted of facility staff and community representatives (selected by their communities) and their responsibilities included monitoring free service delivery, identifying eligible users, raising awareness of free services, consulting with and mobilizing community members, and overseeing facility resources and implementation of the complaint system [22]. A study found that though HFCs were the primary social accountability mechanism in FMCHP, they lacked power to govern free health services and were not involved in revenue generation or the overseeing of facility resources [22]. A major constraint was that the foundation was not sufficiently laid for the accountability mechanism. Specifically, the legal framework for the HFCs' participation in FMCHP was weak and this meant that their ability to demand a larger role in health service governance, including through the MoH's own multi-stakeholder Steering Committee that had pooling and fund management functions, was limited.

Country Example: Judicial Foundations for Accountability in Bangladesh

Initiatives to raise women's awareness of rights and improve their participation in local dispute courts in Bangladesh serve as examples of how important appropriate legal and constitutional frameworks are for the roll out of downstream accountability mechanisms, as well as the limits to both. Activating Village Courts in Bangladesh (AVCB) and Nagorik Uddyog's (NU's) Grassroots' Women's Leadership Network (GWLN) leveraged constitutional and legal reform to encourage and legitimize individual and collective activism at the local level and change institutional dynamics [23]. For example, AVCB which worked via the Ministry of Local Government sought to develop capacity of village court members, increase and diversify court representation in order to clear court backlogs, and increase access to courts by citizens [23]. These efforts were supported by key 2013 amendments to the Village Court Act that sought to improve female representation as panel judges on village courts [23]. Efforts were partially successful. More women became panel judges, but were often shouldered aside to deal specifically with conflicts that were perceived as "domestic." When it came to other issues involving land and resource distribution, women and poorer men—while present—were less likely to have influence [23]. Thus, women participated but did not really have influence. Similarly, NU created alternative courts (*shalishes*) mandating one-third female participation to help improve representation by women in grassroots dispute settlement. The establishment of such courts relied upon key legislative changes such as the passage of the 2010 Domestic Violence Act [23]. As with the example of village courts, efforts saw increasing numbers of women sitting in on *shalishes*, although—like with the AVCB initiative—female *shalishars*' ability to contribute meaningfully to dispute resolution was less than that of men [23]. Both projects necessarily and successfully leveraged legal mandates to improve representation, but were far better at increasing women's presence than increasing influence. External factors—as will be highlighted elsewhere in this paper—often intervened to dampen gains made through architectural reform. Such factors included household economic status and level of education, as well as whether or not women

and Team Lead for the UHC and Health Systems Law Team. To avoid duplication of a parallel commissioned work, we will not be addressing private sector regulation in detail here.

participants had simultaneous family responsibilities, were politically connected, or were formally affiliated with the AVCB or NU [23].

Another example of both the importance of a clear legal foundation for accountability, as well its limits, is in Vietnam where the “right to complain” is established in the country’s Constitution (1992) and the Law on Complaints and Denunciations (adopted in 1998 and amended in both 2004 and 2005). The MoH in 2005 created guidelines for the implementation of these laws in the health sector through Decision N44/2005. This regulation set out areas for complaints in the health sector and steps for verification and resolution. A study of complaint handling processes in the health sector was conducted in two provinces in Vietnam and found that, despite the existence of these constitutional and legal mandates for complaint processes, there was limited utilization by citizens due to health system and socio-cultural issues [24]. These included lack of sufficient resources for and monitoring of complaint processes, as well as patients’ limited awareness of the procedures and view that they did not possess the power to make changes [24].

In summary, legal foundations are critical facilitators for ensuring accountability for health but are not on their own sufficient. As will be discussed next, the design and implementation of accountability mechanisms (as discussed in structures and pathways) is critical for operationalizing accountability, as is an enabling political, economic, and sociocultural context.

4.2 Structures

“Structures” refers to the institutional, organizational, or bureaucratic processes and mechanisms for accountability that states put in place with the goal of better serving citizens. A range of different mechanisms and processes have been used by states, including **committees (at the parliamentary and health facility levels), health assemblies, commissions and agencies (such as anti-corruption agencies), reviews and assessments, service charters and audits, quality improvement approaches, and health information, vital statistics, and death surveillance and response systems**. The effectiveness of these accountability mechanisms depends on the legal foundations that exist to support and enforce them and the context in which they are designed and implemented, as well as the capacity and willingness of states to use these mechanisms to be responsive to citizens (through pathways). These findings are echoed in other reviews of the accountability literature [15].

For example, **health service charters** are an accountability tool that provide information to users about the services offered by a health facility and their costs. An assessment of experiences with service charters in Kericho District, Kenya, placed in health facilities by the MoH, found that charters did indeed give information on services and costs, provided a way for users to protect against overcharging, and helped users plan expenses prior to receiving a service [25]. The linkage of service charters to health outcomes, however, was not examined. Despite these positive benefits, the study also found challenges with service charters including lack of adherence to charter provisions by health workers, language and socio-cultural limitations, and limited time for users to read and understand the charters. These findings align with those of other studies, such as a study of patients’ rights charters in South Africa [26]. The

authors conclude that better outcomes would be realized through enforcement of official guidelines and raising awareness amongst potential users about the charters [25].

Country Example: Establishing Structures for Accountability in West and Central Africa

A mechanism for increasing accountability at subnational levels is **health facility committees (HFCs)** which involve the community in the management of primary public health facilities. A study of 11 HFCs in three countries (Benin, Guinea, and DR Congo) found that the majority of the HFCs engaged with health providers to talk through failures in services, leading to improvements in service quality such as increased presence by health workers, the institutionalization of night shifts, the provision of information about drug prices, and the replacement of health workers who were not functioning effectively [27]. As with health service charters, the linkage of HFCs to health outcomes is not examined. In the study, comparison of HFC experiences across the countries demonstrated that their success depended on HFC leadership and harmonization with other structures in the community. The study also found that there is the potential for marginalization of certain groups given the informal and individualized nature of HFC practices, and the lack of systematic community consultation. Like the experiences of HFCs in Nigeria described in the earlier section [22], the authors argue for strengthened legal mandate of HFC in the governance of health services (foundation), as well as improved opportunities for community input (pathways) [27].

District league tables (DLTs) provide another example of an accountability tool, one based on performance ranking techniques. Ghana in 2014—through a partnership between UNICEF, the Ghana Centre for Democratic Development, the Ministry of Local Government and Rural Development, the Office of Head of Local Government Service, and the University of Ghana—established a DLT index that ranks all of the country’s 216 districts to give an overall picture of social development in the country [28]. The DLT provides evidence on disparities and inequities among districts, encourages evidence-based dialogue, and supports actors to direct resources where they are most needed. The 2018-2019 report found that in health, highest-scoring districts had 100 percent skilled birth attendance (SBA) at delivery while the lowest-scoring district had 10.5 percent SBA [28]. The authors invited relevant stakeholders to begin constructive dialogue to agree on steps forward for addressing these and other inequities highlighted in the report [28]. Likewise, the Ugandan MoH introduced the DLT into the health sector in 2003 to assess the performance of individual districts. A study of the Ugandan DLT found that it was published annually and that some decisions have taken place in the health sector as a result of the DLT including by MOH supervision teams, by the MOH and some districts for improved planning and management practices, and by development partners to determine priority districts for their support [29]. However, the study found no explicit documentation on how the DLT was to effect change in the Ugandan health system and concluded that despite some positive influences, overall there was limited use of DLT information for decision-making in the health sector [29]. Additionally, like many accountability mechanisms implemented in complex systems there were also unintended consequences including embarrassment and resentment amongst managers in reported “low-performing” districts [29].

Also using performance ranking techniques, the Moroccan MoH in 2005 decided to implement a **quality improvement (QI) intervention** called the “Quality Contest” in its public health facilities (health district offices, regional and district hospitals and primary health centers) with the

objectives of changing the management culture of the public health service and increasing transparency and accountability through the dissemination of results [30]. QI approaches are used to strengthen accountability and focus on systematic actions over time to improve the quality of care in health services (both outputs and outcomes) and increase health status of and improved accountability to the targeted population. The “Quality Contest” was a cyclical process of 18 months including two components: first, evaluation (including self-assessment) with performance ranking and disclosure; and second, improvement. Results from the contest were disseminated to health professionals, rather than the general population, with the goal of encouraging professionals to feel accountable for their behavior due to reputation amongst superiors and peers rather than through population pressure. The case study examined implementation of the contest between 2007 and 2012 and found that it led to significant improvements in management performance and had additional positive benefits including increasing communication both horizontally and vertically within the MoH [30]. Factors in these improvements were that the contest: 1) involved participatory development of the assessment tools which meant that it was suitable to the Moroccan context; 2) offered the opportunity for communication and learning; 3) included a prize for improvement, called the “Improvement Effort Prize,” which motivated facilities to implement their improvement plans; and 4) was conducted within a favorable political environment with high-level commitment and adequate funding (see section 3.4 on Context) [30].

A final example is **health assemblies**, most notably Thailand’s National Health Assembly (NHA) which was first held in the early 2000s. The NHA is founded on a unique model that brings together three groups—the government sector, the people sector, and the knowledge sector—and combines top-down and bottom-up methods with the goal of furthering progress and reform. Resolutions in the NHA are passed on consensus; they are not binding, but the NHA seeks to achieve action and compliance through its broad stakeholder involvement. A case study of the NHA, though it did not focus on health outcomes, found that the NHA process has successfully, and impressively, harnessed “the power” of stakeholder groups coming together and concluded that citizen’s voice can make an important contribution to policy-making when appropriate channels and fora are provided to them (see the next section for more examples of citizen pathways) [31]. Importantly, the NHA is possible because it is part of a broader health reform movement with a legal framework—the NHA sat within the Health Systems Reform Office’s mandate prior to 2007 and then it became a key component of the National Health Act of 2007—and sits within an enabling social and political environment that prioritizes open, citizen-state engagement [31]. Other countries are institutionalizing health assemblies at local, provincial, and national levels. For example, between 2017 and 2018, the Ministry of Health and Medical Education (MoHME) in the Islamic Republic of Iran supported local and provincial health authorities in conducting 266 local health assemblies and all but one of the 31 provinces conducted a provincial health assembly [32]. Moreover, the first national health assembly was launched in 2017 [32].

4.3 Pathways

Pathways refer to the channels through which citizens are able to participate in governance, make their voices heard, and hold leadership accountable. Under traditional accountability models, these channels refer to activities initiated by citizens or civil society to hold government, service providers, and public officials to account. Upon reading the literature, however, we felt these definitions were a bit limiting, as

it was rare for any mechanism—outside of popular protest—to exist purely separate from other spheres of society.

Mechanisms seeking to empower citizens with information, amplify their voices, and enable them to engage the state were not infrequently financed by and received technical support from external parties. Moreover, looking closely, there was often either tacit or explicit support from political representatives or other public officials (with or without formal government backing), and some sort of link to one or more levels of government (whether traditional, local or central). It was often very difficult to tease out the impetus, source, and drivers of such mechanisms so, as a solution, we group them as being similar in function. No matter who initiates a scorecard or a participatory budget, a hotline or a media campaign, a social audit or a protest march, they all serve the same purpose: to make citizens' voices heard by the people and institutions with the power to effect change and trigger positive transformation. A number of mechanisms exist to do this and the vast majority of articles we identified were pathway focused.

For example, **citizen and community scorecards and report cards** are tools implemented at the community level to monitor and evaluate services, service providers, and public officials with respect to quality, efficiency, and transparency, and feed back information to decision-makers [20]. They have been used in a diverse range of settings across low-, middle- and high-income countries, and are often leveraged in health care settings to empower patients to have a say in their own health. Documented outcomes include improved service coverage, increased self-reported utilization of health and rights services, improved perception in quality of services and improved self-reported confidence and willingness to discuss and hold to account, although improved morbidity and mortality outcomes are far harder to identify [33-41]. Scorecards can also have vastly different outcomes depending on the context in which they are implemented and, as is reiterated throughout the literature, are effective only insofar as they are linked to effective institutional, regulatory, and legal structures to ensure citizens' feedback is acted upon and documented barriers to accountability are remedied.

Country Example: Citizen Scorecards and Pathways in Rwanda

CARE has long implemented citizens' scorecards in a number of countries, targeting several different health issues relevant to EWEC [20]. In Rwanda, for example, a Gender-Based Violence (GBV) initiative was launched utilizing community scorecards. The scorecards were implemented through two very different regional programs—Isaro Governance Initiative (funded by DfID/Norad) and Umugore Arumvwa ("A Woman is Listened To") (UA) via the EU-financed NGO Haguruka NGO (funded by the EU) [20]. In each instance, the scorecards were tailored to the goals and entry points used by the implementers. In the case of Isaro, the focus was on community members within existing Village Savings and Loan Associations (VSLAs) and the goal was to improve GBV services delivered by public servants such as health workers and police [42]. The VSLAs had case managers in place who were responsible to existing government performance management structures (*imihigo*) and, thus, who: a) could enforce the mandate of the scorecards; b) were answerable to larger institutions [42]. In the case of UA, Haguruka had a human rights focus, and the goal was to work through existing community leadership structures to improve problem identification, awareness raising, and mobilization to prevent GBV in the community [42]. UA was implemented through community animators who were essentially volunteers with no contractual obligations to the state or to CARE [42]. Scorecards led to outcomes for both programs, but these differed with the objectives of the implementer. Both reported improvements in women's

voice and confidence. However, in the case of the service-focused Isaro, outcomes included rooms in health centers being set aside for GBV services, attitude change by health workers, increased follow-up by police, and increased demand for and use of both health and police services [42]. UA, by contrast, resulted in better awareness and knowledge of GBV within families as measured by an increased number of discussions of GBV issues, increased confidence in women, increased trust of local authorities and a perceived reduction in GBV.

Social audits are participatory activities—initiated by the government or a public agency or organization—that involve communities in indicator identification, data collection, and analysis of the extent to which the specific institution has performed vis-a-vis its values and objectives [43, 44]. Social audits have been used in countries across a range of income classifications—with much of the documentation originating from South Asia, in particular India where social auditing was a primary tenant in the Mahatma Gandhi National Rural Employment Guarantee Act and several states, notably Andhra Pradesh, have institutionalized social audit in quasi-independent government departments [45]. While much of the literature focuses on presenting the findings of social audits [46], a few studies document evidence demonstrating that—where and when social audits take place regularly—there can be annual increases in coverage of services and expenditures [45, 47, 48], as well as a parallel decrease in financial irregularities in local government accounting [49]. Other studies show an increase in awareness raising of, and dialogue about, health issues [50-52], along with establishment of planning processes to solve problems (e.g. for corruption) [53]. For example, a project in Pakistan found that, where communities reviewed social audit evidence on immunization and engaged in post-review planning, immunization rates were twice that of control communities [53]. A number of authors note, however, that mobilizing public participation can be an issue [54], that the process can be co-opted by elites and undermine citizens' voice [55], and that, in spite of the fact that audits are supposedly initiated by government, their ability to trigger response is not guaranteed [47, 52, 56].

Budget tracking and participatory budgeting represent two other citizens' pathways to participation. **Budget tracking** is when civil society organizations track public funding flows through government to intended beneficiaries, and then disseminate findings to the public to argue for improved oversight, highlight possible mismanagement or corruption, and advocate for increased financing for specific health issues [57-59]. Budget tracking mechanisms are common tools used by civil society organizations (CSOs) around the world, and are often deployed for monitoring the health sector. For example, Maharashtra State's Support for Advocacy and Training to Health Initiatives (SATHI) has been engaging in, among other things, budget tracking with respect to Indian's National Rural Health Mission (NRHM) for more than a decade, by managing and coordinating NRHM's Community-Based Monitoring Programme (CBMP) to ensure budget allocations are set aside for public health activities and are fit-to-purpose [57]. Budget tracking when coupled with advocacy campaigns and evidence dissemination have been shown to result in the opening of policy windows, increased political and media attention, increased budgets set aside for particular health issues and improved service coverage [58, 60]. White Ribbon Alliance, for instance, has been successful in some countries at securing increased local and national funding for maternal health activities, even in the context of overall sector budget cuts [61]. It is harder to identify improvements to morbidity or mortality or other non-process indicator outcomes. Even early overviews commissioned on behalf of the Strategy for monitoring budget commitments for women's and children's health against allocations did not link to health outcomes [62]. Some challenges

have included lack of transparent or detailed information about public budgets, low capacity of CSOs to review and interpret budgets, lack of diverse representation within CSOs and siloed interests due to external financing or, alternately, highly personalized interests surrounding issues deemed as immediate concerns [63-65].

Participatory budgeting refers to citizen participation in the budget process itself, where members of the public are involved in evidence gathering, planning, decision making and budgeting of public monies [66]. Participatory budgeting was introduced in Brazil in the late 1980s and has been implemented in mostly middle- and high-income countries in the Americas, Asia, and Europe [66]. A recent systematic review of the impact of participatory budgeting on health and well-being found that many participatory budget activities have not been evaluated [66]. Most that have been evaluated report mixed or improved civic participation and engagement by those categories of citizens targeted [66]. With respect to economic outcomes, some evaluations found positive outcomes with respect to both spending on and coverage of critical services (e.g. water and sanitation), while others found no change [66]. With respect to health and social outcomes, 7 of the 37 evaluations reviewed—all of which were from participatory budgeting activities taking place in Brazil—found either mixed or improved results with respect to infant mortality, poverty reduction, literacy and/or school attendance, and access to sanitation [66-70].

It is important to note that pathways are rarely unilinear. In rare instances where health outcomes can be identified, initiatives involved many different types of pathways—alongside accountability foundation and structures—all working together to amplify citizens' voices.

Country Example: Participatory Budgeting and Citizen Pathways in Mexico

Since 2000, both the Mexican government and civil society implemented a number of initiatives that led to an annual five percent reduction in maternal mortality from 66 maternal deaths per 100,000 live births in 2003 to 33 per 100,000 in 2017 [71, 72]. Central to Mexico's achievements was the rolling out of an extension program for social inclusion (*PROSPERA*) and a strong national health insurance system (*Seguro Popular*) [71, 73]. However, these social programs did not take place in a vacuum. CSOs played a critical role in: a) ensuring maternal mortality remained on the agenda; b) developing relevant indicators and appropriately disaggregated data; c) tracking annual government budget expenditures for maternal health and tying these to advocacy. For example, the CSO, *Fundar*, and its partners played a critical role in ensuring that maternal health was prioritized within these mechanisms. By carrying out participatory budget tracking, *Fundar* found that the budget set aside for maternal health was too low [73]. Moreover, funding was channelled through programs that did little to finance emergency obstetric care (EmOC) [73]. Through budget analysis, *Fundar* and its partners helped prove that EmOC could be incorporated into *Seguro Popular* in a way that was financially viable, resulting in EmOCs eventual inclusion in the program [73]. *Fundar's* work on budget tracking has also exposed lack of regional equity with respect to per capita expenditure, with women in poor, rural, and indigenous communities receiving far less budget and having far worse health outcomes [73]. Likewise, the multistakeholder Observatory of Maternal Mortality (OMM), made up of a coalition of Mexican CSOs and research and public institutes, was established to create a system of indicators to measure the effectiveness of these policies and services on maternal mortality and hold government accountable [71]. *Fundar* was a partner within OMM and worked to disseminate findings both upstream to policy makers and downstream to citizens [71].

Pathways such as scorecards, participatory budgeting and public dissemination of information and advocacy work in the context of a responsive state. That is, in the many examples provided above, the amplification of citizens' voice triggered action because they were developed in relation to functioning state institutions (e.g. *imihigo* performance management structures in Rwanda, *Seguro Popular* and *PROSPERO* in Mexico). When technical initiatives are designed to bypass institutions and create more direct lines of accountability, however, political, economic, and socio-cultural context can sometimes intervene to derail efforts.

A number of initiatives, for example, have sought to capitalize on the “mobile phone revolution,” utilizing mobile phone apps to amplify citizens' voice for initiatives as wide ranging as disseminating health information, reporting corruption, advocating for maternal health, and mobilizing protest [74]. The promise of such apps has been met with tremendous enthusiasm within the health, development and human rights and governance sectors and, indeed, such apps can achieve massive coverage of citizens' pathways for participation and engagement. For instance, UNICEF's U-Report initiative rolled out in 55 countries, including Uganda, Nigeria, Indonesia and India, uses mobile phone technology to collect, collate and feedback information from “u-Reporters” (i.e. citizens engaging with the app) to government [75]. U-report has been used to conduct polls through a public dashboard, engage in live chats to share information, mobilize collective action and self-educate [75]. However, for such pathways to be trusted, they should, ideally, be effective in triggering a positive response. In instances where they do not—where states just ignore information coming from citizens—mobile platforms may actually undermine political participation and accountability of government.

A study from West Equatoria, South Sudan found that, in the absence of higher-level accountability structures—institutions, policies, judicial mechanisms—mobile technologies led to greater dissatisfaction and disillusionment, more distrust of government and increased unwillingness to participate: people knew that their leadership would not (and did not have to) respond and that “having a voice” through mobile phone and mobile app coverage meant very little [76]. This problem—that “voice” does not equate to “accountability” if states do not listen to their citizens—is reiterated throughout the literature [15, 51, 77].

4.4 Context

The case studies identified in this literature review emphasize the importance of **political, economic and sociocultural context**. Specifically, they demonstrate how the context within which accountability mechanisms are designed and implemented shapes or is shaped by these mechanisms, and often in unexpected ways.

A case study in urban Tanzania examined a participatory, multisectoral budgeting initiative in Ilala Municipality of Dar es Salaam [78]. To align with government policy directives and legislation and to address citizen concerns, the Ilala Municipal Council (IMC) began a participatory planning and budgeting process in 2000 that involved the participation of community members in public meetings and included training and capacity building of community members in participatory mechanisms, technical planning and budgeting skills. By 2003, 60 percent of the projects that the IMC implemented had been initially

proposed by the community through the participatory process [78]. The case study found that the initiative led to increased satisfaction with services, greater transparency and equity in allocating public resources, and improved IMC performance in good governance. The study authors conclude that the participatory budgeting process contributed to a 53 percent increase of IMC's own-source, primarily tax-based revenue between 2002 and 2005 [78]. The political, economic, and socio-cultural contexts at both the national and local levels were cited as key factors in these successes including a **beneficial national political context that supported civic participation at central and local governmental levels** [78]. This encouragement of civic participation began in Tanzania in the 1960s with the development of new structures to support community initiatives at the subnational level and deepened in the late 1960s with a focus on good relations with citizens during the *Ujamaa* (African socialism) period. The institutional and regulatory environment was also conducive with laws—such as the constitution and Local Government Acts Nos. 7 and 8—directing local government autonomy and citizen participation at local administrative levels (see Section 3.1 for additional examples of how legal foundations support other accountability mechanisms). The **socio-economic context** in Ilala was also enabling in that the municipality had enough own-source revenue to kick-start the participatory budgeting initiative [78]. Moreover, community members had enough economic resources and capacity to participate in the initiative, and the diverse groups in this urban setting had little history of conflict as well as previous experiences with community participation.

Likewise, by 2015, Ghana had seen massive improvements in child health indicators, including being among the top performers in Africa with respect to reduction in childhood stunting and increased vitamin A consumption, measles immunization, and other indicators [79]. The country had not only rolled out UHC and universal education but also had the highest school enrolment rates in Africa and experienced an annual reduction of multidimensional poverty over more than a decade [79]. With respect to the World Governance Index, it also had made some of the largest progress in "voice and accountability," ranking 68th out of 167 countries in democratic performance, with both comparatively free and fair elections and freedom of the press [79]. A case study of Ghana's progress expressly links these accountability gains to the pressure placed by citizens on the state for not only improved service provision, but also continuity in service provision (that is, *sustained* progress with respect to delivering on promises made regarding health and education). The authors, however, note that improved voice and accountability did not just emerge out of nowhere. Pre-colonial Ghana had a **vibrant tradition of civil society and redistributive political structures** which, though they have evolved over time, continue to play a role in expectations by citizens toward the state, and the country continues to have relatively **high social cohesion** and a strong sense of national identity [79]. The authors also point out that **UHC and universal education** were introduced as part of the political discourse from the time of independence creating long-held public expectations that such policy goals were worthwhile and would be delivered. Additionally, they note the long history of **political competition** in the country since elections and electoral oversight reform in the early 1990s, as well as the role played by **populist political movements in mobilizing citizens** [79]. Finally, as Ghana became wealthier, its **middle class** grew and this particular social strata became key in driving demands for improved, sustained services [79]. Therefore, the foundation for "voice" and accountability (as well as for progress on health and education) was laid in Ghana over the course of decades, and is embedded in the political, cultural, social, and economic history of the country. Many other studies in the literature review—including a case study of a participatory budgeting process in Fissel, Senegal

[80]—similarly found that political, socio-cultural, and economic context lays the foundation for and facilitates accountability mechanisms.

Context is a facilitator for accountability mechanisms, but can also act as a barrier. This is highlighted in a qualitative study of health systems governance in “opposition controlled areas” in Syria⁷ where health services are delivered by Health Directorates (HDs) and NGOs. The study found that both HDs and NGOs had internal and external accountability mechanisms—including audits and beneficiary feedback mechanisms—but **security problems** (daily shelling by Syrian regime) and **funding shortfalls** (for services and salaries) meant that the effectiveness of these mechanisms was unsatisfactory and unlikely to improve in the current political and economic environment [81].

Country Example: The Maternal Death Surveillance and Response System and Political Context in Ethiopia

A case study of maternal health in Ethiopia provides another example of how political context can impede accountability mechanisms [82]. In 2013, backed by strong political commitment and technical support from WHO and Evidence for Action [83], Ethiopia rolled out a maternal death surveillance and response (MSDR) system—a mechanism that combines maternal death surveillance with analysis of patterns and trends that can be addressed through actions in the community, at health centers, in hospitals and more broadly at the policy level. To date, however, only ten percent of the expected maternal deaths in Ethiopia have been reported; thus, the MSDR system has not yet led to the desired health outcomes [82]. The authors point to the political environment in Ethiopia—in which maternal mortality is a key indicator of health system performance, and maternal deaths have become equated amongst health professionals and decision-makers with failure—as one of several constraints to the full implementation of the MSDR [82]. The politicized nature of maternal deaths has limited accurate reporting of these deaths, with health workers reporting in ways that minimize the number of deaths and personal responsibility for poor outcomes—for example by attributing deaths to factors that are beyond their control (such as community and infrastructural factors). The authors posit that this may lead to the design in the health sector of remedial actions that are not fit to real problems, and that the work of implementing accountability mechanisms is rarely a neutral exercise.

5. Discussion and Conclusion

The scope of this literature review was to address the ‘how’ of accountability: to look at where, within the published and grey literature, *measurable* outcomes—primarily, health or SDG outcomes—were achieved by accountability inputs (and where not), and describe what these outcomes looked like ‘on the ground’. In particular, we were tasked expressly with addressing “the campfire”—that is, what really happens when accountability measures are implemented at the national and sub-national levels, what works and what does not?

The scope—as well as the prioritization of examples with documented outcomes—did not allow for a discussion of global mechanisms. Additionally, the review focused primarily on literature related to

⁷ The authors use this term to refer to “areas of Syria controlled militarily by civil and former Syrian army groups (eg, Free Syria Army) in active conflict with the Syrian regime, but not those areas controlled by Kurdish People’s Protection Units (YPG) or foreign forces, eg, ‘Islamic State’” (Douedari and Howard, 2019; p. 233-234).

perspectives of accountability coming from the fields of health, development, and governance, for it is these fields that are disproportionately represented when it comes to richly described documentation of outcomes on the ground. As mentioned in the methods section, other fields play an important role in ensuring that states are accountable to both citizens and to global compacts and commitments; however, the body of literature documenting these perspectives fell outside the inclusion criteria for this review.

The intent of this literature review was not, then, to weigh in on which mechanisms are better than others, or through which academic or professional perspective accountability should be approached. The intent was also not to measure individual mechanisms' effectiveness, as might be done using systematic review methodology. Indeed, such an exercise might be recommended, although would need to be done for each and every individual mechanism (such as those in Table 1) and—if the few instances of reviews of accountability mechanisms we identified are anything to judge by—would be limited in the ability to assess impact given the variability of indicators, the limited number of studies with matched control groups, and the variability of outcomes due to context [84].

Our goal in this literature review, rather, was to focus on the people at the heart of accountability and health outcomes: citizens. Hence, this review has an overarching focus on the downstream, and on people and their relationship to the policies, institutions, processes, and activities that mediate people's relationship to the state.

For this review, we spent a great deal of time thinking about how to conceptualize accountability in a way that made sense for the literature we were reading. One of the biggest issues we encountered was that the language of accountability was not standardized. There is no exact equivalent for the word "accountability" in some languages—for example, in Arabic, "accountability" generally suggests investigation and mistrust [81]. Even with respect to common terminology (e.g. vertical, horizontal, social, democratic), many authors utilized these terms quite differently. Alternately, authors used terminology that did not neatly capture what was happening in their own case study. The best example was the term "social accountability" which rarely, if ever, referred to an activity that emerged sui generis from citizens; with the exception of popular movements, examples of "social accountability" were almost always mediated by external stakeholders and either included links to—or fully leveraged some level of—foundations or structures to achieve greater state responsiveness.

Thus, for this literature review it was more helpful to visualize accountability mechanisms—which are often conceived of as ephemeral concepts, actions, or functions—as tangibles that fit together to create an edifice, sitting in an environment, fully inhabited by people. Imagining accountability in this way enabled us to both meaningfully classify the literature as well as identify **five primary lessons**.

First: Context often matters more than accountability mechanisms.

Context influences—and often determines—the design, implementation, and outcomes of almost every mechanism identified in the literature regardless of whether the mechanism targeted legal foundations,

structures, citizen pathways or the political, economic, socio-cultural, and/or bureaucratic context within which it sat. This is why the outcome of the same scorecards initiated by the same international NGO (CARE) on the same subject (GBV) in Rwanda had entirely different outcomes depending on the NGO doing the implementation, as well as on the contractual relationship (or lack thereof) between their implementers and the established state performance management structures. Other literature reviews report similar findings; for example a review of transparency and accountability initiatives noted that where positive evidence of impact is found in one setting, these findings are not substantiated in other settings [85]. It is also why maternal death surveillance in Ethiopia has not yet worked as planned as both maternal deaths themselves, as well as the culture of reporting maternal deaths, was politicized and did not sit comfortably with the impersonal reporting of data required by the accountability mechanism.

Second: Accountability exists within a series of interconnected and extremely complex systems.

Multiple mechanisms *reinforce each other* and *require enabling environments* often brought on by still other accountability mechanisms. Inputs to multiple systems may therefore be essential for both the design and implementation of accountability mechanisms and the avoidance of unintended consequences. This finding is echoed across multiple literature reviews [16]. O’Meally’s study of demand-side governance and social accountability approaches, for instance, advocates for *thinking “politically”* when designing and implementing approaches in each context rather than treating accountability as a technical exercise with predetermined blueprints [16]. McGee and Gaventa note that accountability initiatives often treat stakeholders as uniform and singular categories, rather than examining differences between and within stakeholder groups in terms of power, position, behaviors, and incentives [85].

Moreover, the implementation of accountability mechanisms often requires a more lengthy time horizon and an adaptable “learning-by-doing” approach [16]. This need for an adaptive approach with sufficient time is emphasized in the case study of participatory planning and budgeting in Tanzania in which the first, early attempt in 2000 led to unclear priorities with unrealistic budgets [78]. After project adaptations (including training) and additional rounds of the process over subsequent years, the priorities that emerged from the participatory process became more clear and budgets more realistic [78].

Third: ‘Doing accountability,’ requires a deep understanding not only of these complex systems, but also their intersections and occasional contradictions.

For example, Wild and Foresti (2013) highlight a body of scholarship that assumes a “tipping point” exists between personalized and non-personalized service delivery: if only correct “institutional mechanisms” can be put in place to ensure accountability, then objective measures of how states respond to citizens can be deployed and problems with patronage, nepotism, parochialism, and self-

interest that are deemed typical of “unaccountable systems” will disappear [86, 87]. However, work done by the authors and others at the UK’s Overseas Development Institute (ODI) has served to highlight the fact that, in much of the world, this tipping point never occurs. Rather, in many countries it is possible for multiple *modalities* of accountability to exist at the same time. Duty bearers and rights’ holders can, and often do, operate across these multiple modalities—even with respect to the very same set of issues—simultaneously and with varying degrees of comfort.

For example, a health worker might also be a community leader and might also be a church leader and might also be an elder in his or her family [18]. The expectations, responsibilities, and assumptions about this individual with respect to his or her accountability to others, then, might be vastly different depending on the modality and his or her role within [17, 18]. The health worker who is accountable within an objective, non-personalized modality of service delivery may have, as his or her role, the delivery of transparent, objective maternity services as mandated by the state and as expected by citizens. At the same time, this same individual might also be embedded in a whole host of other relationships within which accountability is also derived from the redistribution of resources or the prioritization of family ties. Within this modality, a health worker delivering quality medical care in the absence of, say, being able to move one’s father’s sister to the front of the queue actually be judged as lacking in the accountability mandated by culture and expected by community members. A citizen’s score card implemented in an environment such as this one—where a single person may operate within different, simultaneous modalities, each with its separate, potentially contradictory, set of expectations, roles, responsibilities, and rights—may be difficult to interpret. What is and is not being measured with a mechanism such as scorecard? What does and does not count as accountability for the communities whose voice is being sought?

Fourth: Process is measured in the literature, outcomes less so.

Most of the literature measured “success” of accountability mechanisms with respect to: a) improvements in service coverage; b) improvements to *perceived* service quality; c) participation or “presence” of citizens; d) improved general awareness of issues by either citizens, civil society actors, or the state; and/or e) *perceived* empowerment or “voice.” Does accountability, however, lead to improved maternal and child survival? Where accountability mechanisms exist, are people healthier? Is their well-being enhanced?

There is some indication that where overall accountability exists—that is, where *all* the elements of the accountability edifice (foundation, structures, pathways) are put in place within a context that sustains them—then there is movement with respect to both maternal health and child survival indicators (e.g. the example of Mexico and progress on maternal mortality). But, for the most part, authors either did not focus on, or were unable to show, change in child and maternal health indicators.

The larger question, of course, is whether measurable health outcomes are even necessary to justify measures by the health sector to enhance accountability and citizens’ voice or whether there is an

inherent moral value in investing in the foundations, structures, pathways, and contextual changes that support citizens' securement of basic rights, regardless of whether or not health indicators improve? Ultimately, good health can be—and often is—achieved in the absolute absence of democracy and a number of countries which have seen remarkable progress on women's and children's health and health-related SDGs can, nevertheless, be classified objectively as authoritarian autocracies. Too often, their accomplishments are lauded by global health practitioners, while a blind eye is turned to the cost of such achievements in personal, social, and political freedoms.

Fifth: As such, “voice” is insufficient without a responsive “ear” to hear it.

Much of the accountability literature emphasizes that without a responsive state, investment in accountability mechanisms, at whatever level, not only will have little impact, but may actually undermine citizen engagement. Foundations—constitutional acts, laws, statutes, and international commitments—are essential to provide a mandate for the creation of the structures and pathways for accountability. Structures—the bureaucratic structures, systems, processes, guidelines—operationalizes those policies, strategies, and obligations and gives good intentions a platform for action. Pathways create the links between citizens and these structures and make platforms for action *actionable*. However, none of these are meaningful if the state lacks the political will to listen to its citizens and secure their rights. Throughout the literature, authors emphasized that accountability mechanisms must trigger actions by state actors that lead to meaningful, positive changes with respect to citizens' health, well-being and human rights, and, as importantly, sustains them [88].

Frequently, however, articles documented the ways in which accountability mechanisms did not trigger response. Sometimes this was due to adverse, difficult humanitarian settings (such as in opposition controlled areas of Syria) [81]. Other authors attributed it to ineffective civil service codes and high level of interference/political interests both at central and local levels [89, 90]. Still others chronicled a disconnect between civil society mechanisms' power vis-a-vis the state and the actual set of accountability activities tasked to them by external parties. A number of papers emphasized that mechanisms were introduced externally and tended to be project-based and short term [91, 92] and lacked government ownership and had an absence of political will [23, 88, 93].

Ultimately, the literature on accountability initiatives in support of health, health systems, and SDG outcomes is vast, diverse, and cover a range of mechanisms and country settings. The lessons, however, remain the same: **accountability represents a complex, often contradictory, context-dependent system in which political will is vital to sustained progress, and for which a clear, moral justification can be made independent of measurable change in health outcomes.** Approaches to accountability, then, must not only be health and SDG outcomes-focused, but also be systemic, multisectoral, and deeply sensitive to the perspectives, concerns, desires, and constraints faced by the communities whose voice such mechanisms seek to amplify and whose rights they seek to secure.

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