Accountability Can Transform Health (ACT Health)

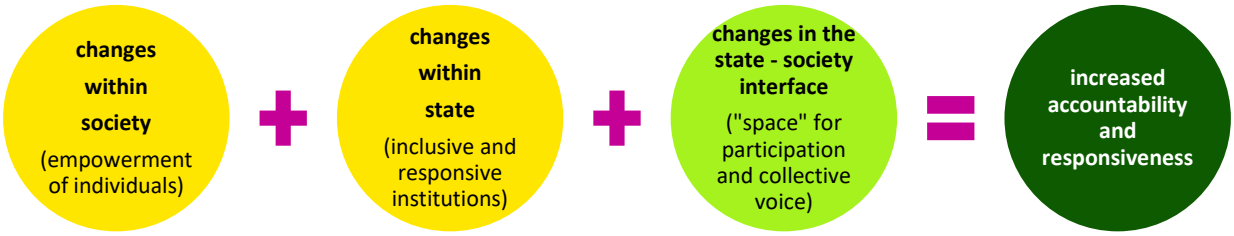
Our Theory of Change – Working Version

VERSION: July 17, 2012

Contents

What is social accountability?

In many countries, power is abused by authorities and limited resources intended for development are misused. Formal mechanisms (elections, audits, balances of power, etc.) designed to balance power relationships between the **state**, **civil society** and **market institutions** often fail to reinforce accountability. In much of the developing world, public institutions are captured by the powerful, with the **poor lacking representation and access to services**. Because of these accountability failures, economic growth by itself is not sufficient to alleviate poverty and "pro-poor reforms require **changes** in three distinct arenas: **within the state itself**, **within society** and at the **state-society interface**" (Fox 2005).



There is an increasing interest in practical interventions that rebalance the relationships between state (policy makers, service providers, duty-bearers) and clients (citizens, rights-holders, users of services). Some efforts strengthen the **spaces** and for direct linkages between **citizens** to **providers** in the hopes of having a quicker impact on quality of services. **Meaningful participation** and access to these spaces requires individual and collective **empowerment**. Women's empowerment is especially important; women are often unable to make decisions regarding their own health and development.

The increasing discussion of **weak governance** and **accountability failures** which lead to **poor service** delivery has led to more programming to empower citizens to engage in decisions affecting their own development. Essentially, **social accountability initiatives** (often called citizen voice and accountability) **include citizens** and **civil-society** in the **processes** of **monitoring** and **decision making for public services**. These interventions (there are about 20 major types/tools) can be directed at policy level, budget level or at service provision points. Social accountability approaches are increasingly seen as very important interventions to contribute to improvements in the **relevance**, **quality** and **accessibility** of **government health services**.

Guiding principles for ACT Health programme design and implementation

Based on an extensive literature review on best practices in social accountability programs, interviews with many civil society and government stakeholders and GOAL's organisational philosophy, the following have been identified as important principles to guide the implementation of the programme. These principles guide decision about the methodology and approach for the programme, which will be implemented in partnership with Ugandan civil society organisations at the national and local levels.

1. Collaborative approach: implementation in consortium

a. Build from previous experience of all partners
b. Use available research, evidence and knowledge
c. Build consensus
d. Learn together
e. Coordinate information and evidence from many communities
f. Leverage work of Civil Society Organisations (CSOs), media and other key actors to promote accountability and good governance

2. Keep a positive and constructive focus: benefit many stakeholders

a. Use appreciative enquiry approaches to bring out the good things in health service provision
b. Enhance community knowledge of service standards and entitlements
c. Use objective information and data as basis of discussions
d. Promote community ownership over services
e. Build mutual understanding between health workers and community members
f. Help Government of Uganda (GoU) and Ministry of Health achieve goals of participation, accountability and improved service delivery

3. Means to an end: social accountability as a way to improve access to quality health services

a. Keep with GOAL's organisational focus: tangible results
b. Emphasise monitoring which contributes to services which are responsive to citizen needs and accountable
c. Encourage more utilization of services through awareness creation
d. Contribute to improved health outcomes (indicators) in communities
e. Manage expectations about the speed of change

4. Broad participation: people should speak for themselves

a. Find the **agents of change** in communities willing to participate **without** facilitation & material motivation
b. Engage **women** and **girls**
c. Engage **youth**
d. Engage **users** of services
e. Engage **non-users** of services

5. Focus on existing structures: Village Health Teams (VHT), Health Unit Management Committees (HUMCs, District Health Office (DHO) and Community Development Office (CDO)

a. Use local knowledge
b. Promote ownership
c. Avoid creating parallel structures
d. Strengthen existing community structures within their mandates
e. Focus on sustainability

6. Programme evolution: build from the participatory monitoring

a. Make and follow-up joint action plans
b. Promote skills for community members and CSOs to participate meaningfully in planning
c. Enable people-centred advocacy at district level
d. Share information with national level advocacy organisations and GoU structures for onward advocacy

7. Formal research: learning and sharing

a. Build capacity of GOAL, HEPS and implementing CSOs for rigorous monitoring of the approach
b. Ensure rigorous, on-going qualitative monitoring of the work
c. Partner with an academic institution
d. Demonstrate effects and outcomes of the programme
e. Contribute to gaps in knowledge and share learning for benefit of all stakeholders

What is a Theory of Change?

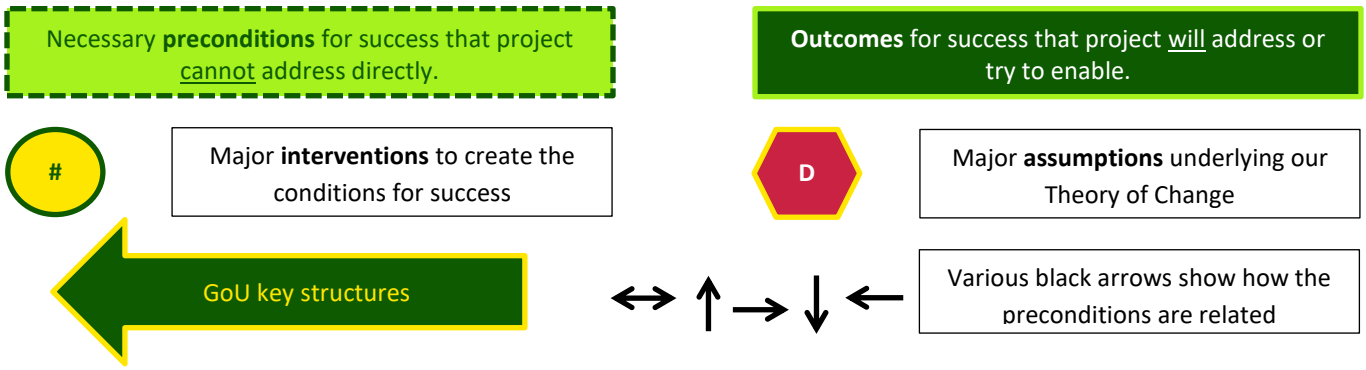
Most **standard project design tools** (such as logframes) are **not sufficient** to explain project logic for very complex programmes. For many programmes with long causal chains, "… it is necessary to surface and make explicit the **pathways** via which complex initiatives, destined to take effect in complex circumstances, are **expected** to have their effect and to **continuously revisit** this throughout the initiative, in recognition that social contexts and processes are always in flux, with emergent issues, unforeseen risks and surprises arising throughout." (McGee & Gaventa 2010: 28)

A theory of change can be a helpful tool for developing solutions to **complex social problems**. At its most basic, a theory of change explains how a group of early and intermediate accomplishments sets the stage for producing long-range results. A more complete theory of change articulates the assumptions about the process through which change will occur, and specifies the ways in which all of the required **early and intermediate outcomes (or conditions) necessary** to achieve the **desired long-term change** will be **fostered**, **monitored** and **documented** (Anderson 2005: 5).

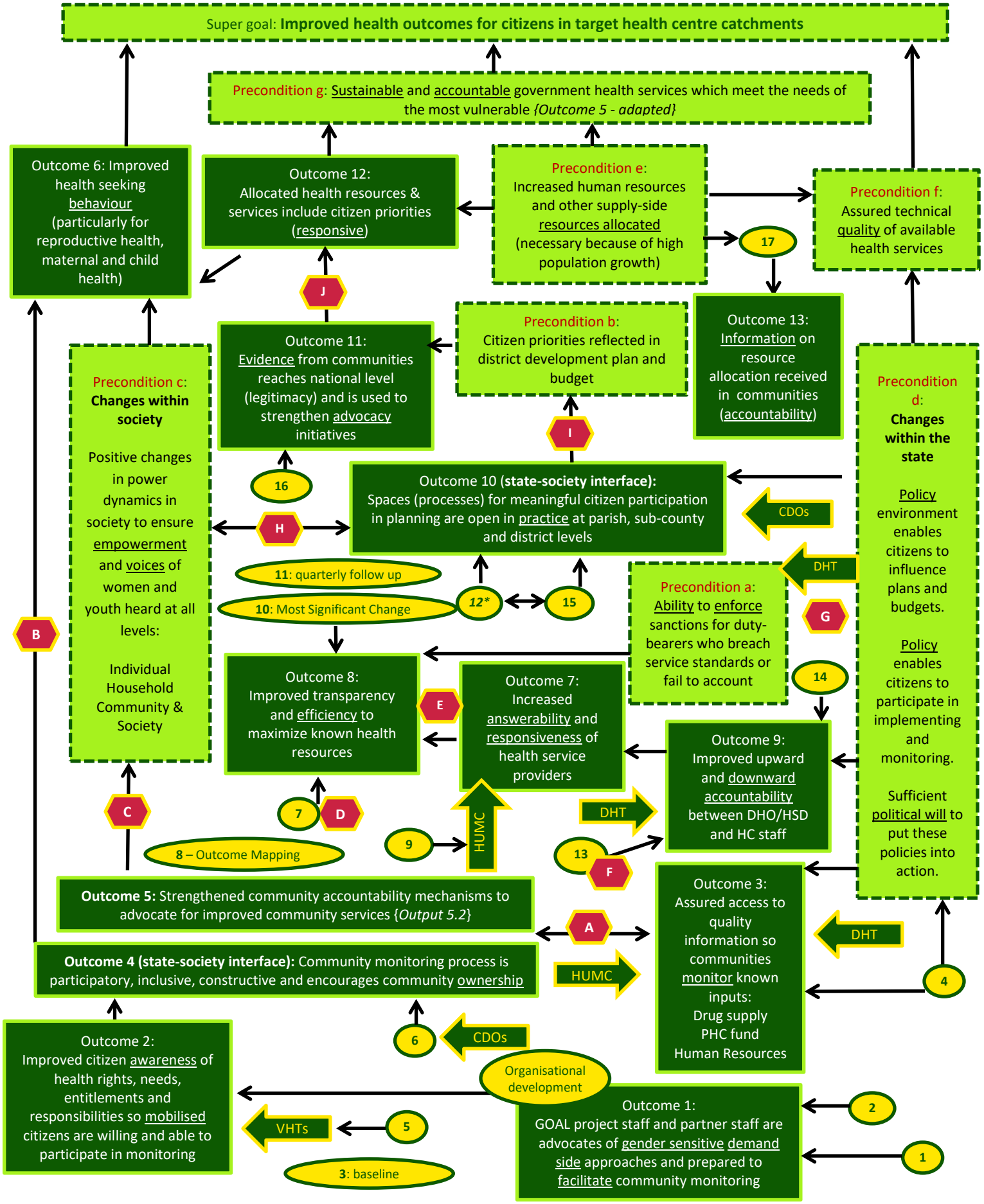
The main document used in preparing this *Theory of Change was The Community Builder's Approach to Theory of Change: A Practical Guide to Theory Development* (Anderson 2005). These definitions are drawn from this manual.

- **Assumptions:** Statements about how and why we expect a set of conditions (outcomes) shown in the pathway of change to come about. These statements can reflect understandings of the change process taken from research, or they can be taken from practical experience. They should reflect an understanding of the context within which a program operates.
- **Indicators:** Concepts that will be used to assess the extent to which outcomes are achieved. In our case, the indicators are at the outcome level and will reflect more complex ideas or changes in behaviour that must be observed qualitatively.
- **Interventions:** Activities that will be put in place to bring about the particular precondition(s) or outcome(s). Interventions can be projects or programmes. Some interventions can contribute to more than one outcome or precondition.
- **Outcomes:** These are the building blocks of the change process. These are the conditions, or states of being, that must be in place in the early and intermediate stages of the change process in order for long-term goals to be reached. We use the terms outcome and precondition interchangeably, but find that it is easiest to think about early and intermediate states of being as early and intermediate outcomes.
- **Pathway of Change:** This is a map that explains how long-term outcomes are brought about by illustrating the complex relationships between outcomes and preconditions. Long-term changes are brought about by reaching intermediate preconditions; intermediate changes are brought about by reaching early preconditions. The pathway of change is the skeleton on which all of the other details are added. It summarizes the theory but does not (and cannot) tell the whole story.
- **Preconditions:** Everything on a pathway of change can be understood as a precondition (precursor or requirement) for the next outcome above it on the map. Preconditions must be achieved in order for the next logical task in the sequence to be achieved. We identify preconditions by asking "What are the conditions that must exist in order for our outcome to be achieved?" This question is posed for long-term and intermediate outcomes leading to the ultimate change.

The key below will help as you look at the Pathway of Change on the next page.



ACT Health Pathway of Change



Major activities to create the conditions for success

The activities are designed to target accountability relationships between community members and service providers (health workers) and between health workers and government officials. Please note that there are two optional activities projected at this stage (#7 and #10). In implementing ACT Health we need to maintain flexibility and agility. We have designed the major activities we think will contribute to these outcomes, but we must critically reflect on what is happening in communities in order to make sure our actions contribute to the outcomes we want to see.

Stage	Major Activities	Timeframe
Preparation activities	Activity 1 – Designing project and establishing partnerships Activity 2 – Planning & training Activity 3 – Baseline and generating report cards Activity 4 – On-going process of trust and relationship building Activity 5 – Training for community structures (VHTs/HUMCs) and mobilisation of community	2012
Using report cards to stimulate community monitoring and action	Activity 6 – Participatory monitoring and action in health centres	2012 – 2015
Communities implement action plans on-going basis	Activity 7 – Rolling implementation of action plans	2013 – 2015
Follow-up and Light Touch Monitoring	Activity 8 – Outcome Mapping Activity 9 – HUMC training Activity 10 – Training on Most Significant Change Activity 11 – Quarterly follow-up interface dialogues using MSC and OM *Activity 12* – Community trainings (optional/as needed)*	2013 –2015
Evidence-based dialogue and monitoring at the district level	Activity 13 – Participatory monitoring and action at District level Activity 14 – Follow-up with outcome mapping	2014 – 2015
Using evidence to develop people-centred advocacy priorities and provide feedback to communities	Activity 15 – Advocacy priorities at Bugiri level Activity 16 – District ACT Health evidence used at national level Activity 17 – Provide feedback to communities about DDPs and budgets	2014 – 2015

This Theory of Change document has the broad outline of all major activities. The narrative proposal also has implementation notes that provide additional advice and direction on planning and executing activities.

Preparation activities	
1 **Designing project and establishing partnerships**	1. GOAL leads design of an evidence-based social accountability project. 2. GOAL develops a consortium of partner CSOs based on objective and transparent criteria and with some mandate or experience in similar programming areas (rights-based, participatory monitoring, etc.). 3. GOAL solicits, shortlists, scores and selects CSO Expressions of Interest (**April – June 2012**). 4. GOAL hosts workshop in Bugiri for CSOs to establish common understanding of programming (**May 2012**). 5. GOAL signs agreements with all formal partners. This should be done by **September 2012** for **one year** agreements for the period **October 1, 2012 – September 30, 2013**.

2 **Planning & training**	1. GOAL outsources training on power and gender dynamics and importance of including women, young women and youth voices and concerns. 2. HEPS develops specific Resource Guide (one handbook) on rights-based approaches, participation and gender sensitive implementation of the ACT Health project (support from GOAL). ▪ *Modules for Bugiri partner learning & modules for implementing in communities.* ▪ *Modules to be delivered in community will need to have picture-based examples and easy-to-use tools.* 3. HEPS provides workshop for Bugiri partners (**7 days** intensive workshop). Bugiri partner staff to be trained will be the staff who are implementing the ACT Health project in communities. Note that this practical workshop will also serve as the opportunity to "pre-test" the training materials in communities and revise before mass production. Broad topics to be included are: ▪ *Health needs, entitlements and responsibilities* ▪ *Understanding community groups and reflecting on the role of civil society* ▪ *Mobilising communities and building relationships* ▪ *Promoting meaningful participation and ownership in communities* ▪ *Understanding the importance of objective evidence and reading report cards* ▪ *Facilitating Dialogues* ▪ *Action Planning and Basic follow-up strategies (light touch monitoring)* 4. During the practical workshop, Bugiri partners will develop training materials to be used for sharing information with community structures. These materials will be jointly developed by all and integrated into the Resource Guide: ▪ *"Action Card" to communicate about ACT Health with stakeholders (**activity 4**)* ▪ *Translations of key terms into Lusoga and Lusamia* ▪ *Training for community structures (**activity 5**)* ▪ *IEC images and tools to share Report Cards with stakeholders (**activity 6**)*
3 **Baseline and generating report cards**	1. GOAL leads information gathering (designing HH survey, HMIS review, HC records and health worker interviews). 2. GOAL selects and trains enumerators to ensure quality of data collection (if possible, including Bugiri partner staff as enumerators). 3. GOAL ensures that a report card is prepared for each health facility catchment selected for implementation. 1. Each targeted health centre will have its' own unique report card.
4 **On-going process of trust and relationship building**	1. During the practical workshop (**activity 2**), all partners work together to develop a one page "Action Card." This will have the basic information on the ACT Health project in simple terms so that all partner staff will speak with a common voice when approaching stakeholders. 2. Consortium partners (GOAL, HEPS, Bugiri partners) sensitise the GoU stakeholders understand the program logic/purpose. 3. This will need to be accomplished through formal and informal discussions and relationship building on an on-going basis. 5. Ensure political leaders (LCI, LCIII & LCV) understand the program. 6. Ensure technical officials (CAO, CDO, DGO, DHT/HSD) understand the program and share information. 4. Ensure that health workers and community structures (HUMCs, VHTs) are willing and able to participate.
5 **Training for community structures (VHTs/HUMCs) and mobilisation of community**	1. Bugiri partners facilitate **1 day** training for community structures (VHTs and/or HUMCs) so that the members of community structures are prepared to play an active role in the ACT Health project. 2. Community structures (VHTs/HUMCs) should be trained in their own health centre catchment to keep costs low, reduce the time commitment of VHTs and also to show communities that this process is going on. 3. Bugiri partners and community structures (VHTs/HUMCs) target users, non-users and community members that are traditionally less empowered (women, young women, male youth, etc.) in the mobilisation. 5. Community Structures (VHTs/HUMCs) actively participate in awareness-raising and mobilisation in target communities in public health centre catchments.
Using Report Cards to stimulate community monitoring and action	
6 **Participatory monitoring and action at health centres**	**Bugiri partners** facilitate 1st round of participatory monitoring in health centre catchment **(5km radius of HCII)** in stages. Facilitation is very important here. Bugiri partner staff should mediate the discussions, but community stakeholders should drive the process. 1. Bugiri partners facilitate one initial leaders dialogue on Report Cards (**½ day**). This can be done at the S/C HQ level so that leaders review and discuss the Report Cards for all the targeted HCs in the S/C on the same day. We do realise that leaders are part of the community. However, it is ideal to target them in a separate dialogue so that they well understand ACT Health and the baseline results for their sub-county. In addition,

	if the leaders are present during community meetings, the leaders may overtake the agenda or make it difficult for community members to express their ideas. 2. Bugiri partners facilitate one initial health worker dialogue on Report Card (**½ day**) at HC. There should be one dialogue at each targeted HC. HUMC members are also welcome to attend the health worker meeting. 3. Bugiri partners facilitate one initial community dialogue on Report Card (**½ day**) at HC. The community dialogue will bring together a diverse group of community members from all the villages that rely on the targeted HC. During this meeting, it will be important to have a lot of specific focus groups (young men, men, young women, women, older women) so that each group feels comfortable expressing their own ideas and unique health needs. The dialogues are most appropriate for community members **15** years and older. 4. After the individual dialogues described above, Bugiri partners will facilitate interface dialogues at each HC. We estimate between **100 and 200** participants per interface dialogue. The interface dialogue and development of action plan will take place over **2 days (½ day sessions**). During the interface meeting, health workers and community members to discuss possible solutions and develop action plans. 5. The outcome of the interface meeting is an action plan. Action plans will clearly assign roles, responsibilities and timeframes, these should be realistic.
Communities implement action plans on-going basis	
7 **Rolling implementation of action plans**	1. Communities implement their cost action plan. 2. Note that no funding will be provided to communities for their action plans. 3. Major responsibility for following up on the action plan rests in community. This responsibility as agreed by each community – may be specific individuals or a small committee – depending on local preferences
Follow-up and Light Touch Monitoring	
8 **Outcome Mapping**	1. GOAL develops materials and trains all partners in Outcome Mapping (OM) as a rigorous monitoring approach. 2. GOAL guides all partners in the development of expect to see, like to see, love to see progress markers – drawing from the action plans in communities and district level. 3. GOAL and all partners collectively establish outcome journals for each progress marker identified from action plans.
9 **HUMC training**	1. Consortium and political and technical leaders remain open to the possibility that some HUMCs may be reconstituted or re-elected after the monitoring process is initiated. 2. HEPS/GOAL support Bugiri partners (with DHT/HSD and CDO) to adapt existing government training materials for HUMC roles/responsibilities. 3. Bugiri partners, DHO/HSD and CDO jointly provide community-based trainings for HUMCs on roles and responsibilities. 4. Bugiri partners train HUMCs to carry-out critical monitoring functions in the health facilities in line with their mandate and their responsibilities in the action plan. Examples could be – training to check stock cards, training on managing a suggestion box, training on accounting for the PHC fund, etc. 5. Training should be simple and basic, located in health centre catchment to minimise costs and maximise visibility of the training.
10 **Training on Most Significant Change**	1. Leadership of GOAL and HEPS demonstrate commitment to use the Most Significant Change (MSC) approach for systematic qualitative monitoring of programme. 2. GOAL develops training modules and trains Bugiri partners in MSC technique. 3. GOAL mentors the district CBO staff in participatory use of MSC approach.
11 **Quarterly follow-up interface dialogues using MSC and OM**	1. Bugiri partners facilitate quarterly follow-up interface dialogues (½ day session) between community members and health workers. 2. Community members, health workers and DLG stakeholders make revisions to action plan, if mutually agreed. 3. Bugiri partners use MSC semi-annually to systematically document information about significant changes in communities.
12* ***Community Trainings (optional/as needed)***	1. **Baseline** information and progress against earlier outcome indicators will determine necessity of this activity. It is possible that **Action Plans**, **Outcome Mapping** and **follow-up meetings** will identify different types of training that communities and **Agents of Change** prioritise. 2. The ACT Health team needs to be very aware of the dynamic needs, progress against outcomes and decide accordingly on what activity will be most beneficial. This activity would probably happen in year two or three of implementation.
Evidence-based dialogue and monitoring at the District level	
13	1. GOAL to compile District level data on district health performance from project baseline and also district information (NSDS, AHSPR, etc.) compared to national service delivery standards.

Participatory monitoring and action at District level	2. Create an opportunity for higher level interface between health workers and District Health Team (DHT), Health Sub-District (HSD) and other key actors in District Local Government (DLG) to interface and discuss the performance compared to formal obligations and expectations. 3. Consider the option of including a citizen representative in the dialogue 4. GOAL/HEPS to determine how facilitate the dialogue between health workers (OICs) and key DLG offices (DHT, HSD, Service Commission, Social Service Committee of LCV, for example). 5. DLG and health workers develop action plan with agreed upon roles, responsibilities and timeframes for action. 6. GOAL guides partners in the development of *expect* to see, *like* to see, *love* to see progress markers – drawing from district level action plan. 7. GOAL and partners collectively establish outcome journals for each progress marker identified. 8. Partners in use of outcome journals, collecting and reviewing them on a regular basis.
14 **Follow-up with outcome mapping**	1. District CBO and HEPS follow-up dialogue (**after 6 months**) on the district-level action plan between DHT/HSD/DLG and health workers. The follow-up dialogue would be a **½ day** session. 2. Bugiri partners, HEPS and GOAL use outcome journals to track progress against the ***expect to see***, ***like to see***, ***love to see*** progress markers derived from action plans.
Using evidence to develop people-centred advocacy priorities and provide feedback to communities	
15 **Advocacy priorities at Bugiri level**	*NOTE: Likely to be introduced in year two (2), depends on progress against various outcomes in Theory of Change.* 1. Bugiri partners (with support from HEPS) coordinate evidence-base (from monitoring process at community level and interface between health workers and DHT/DLG). 2. Bugiri partners (supported by HEPS) develop people-centred advocacy priorities and strategy at district level.
16 **District ACT Health evidence used at national level**	1. HEPS and other advocacy groups use information from Bugiri people-centred advocacy agendas in the national level advocacy work so citizen priorities reach highest levels. 2. Target relevant Line Ministries (Health, Finance, etc.) and key directorates within those ministries. 3. Advocacy efforts can supplement the district development plans and budgets submitted for funding and approval to the national level.
17 **Provide feedback to communities about DDPs and budgets**	1. Bugiri partners work together to ensure an effective feedback mechanism from national → district → S/C → community about what was funded and what was not with explanations. This should happen on annual basis after the DDP is approved. 2. Bugiri partners, CDOs and LCs should share summary of DDP or S/C Plan with community leaders? 3. This will increase transparency and also manage expectations in communities, hopefully encouraging them to participate in future monitoring (of known inputs) and participation in planning processes. 4. It also contributes, at a higher level, to monitoring of known resources.

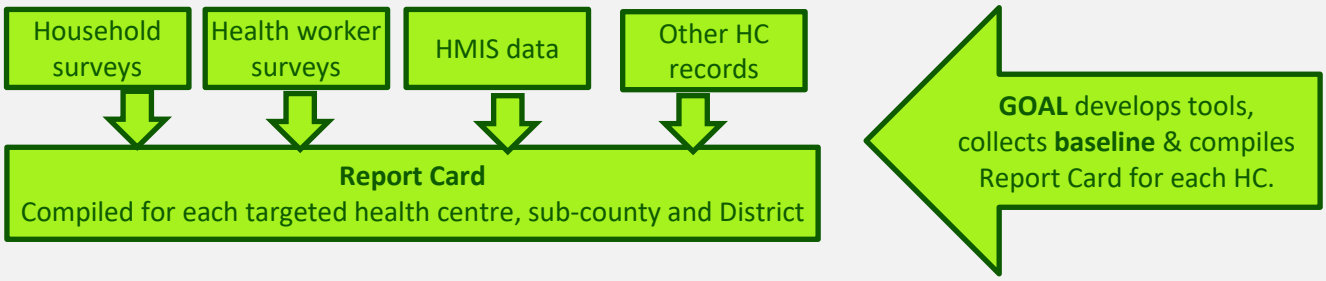
On-going Organisational Development (OD) support for partners

GOAL and HEPS will provide workshops and mentoring in key technical areas as identified in the activities above – specifically in understanding report cards, mediating community discussions, using Most Significant Change and Outcome Mapping. Additionally, GOAL will provide Organisational Development (OD) support to partners as follows:

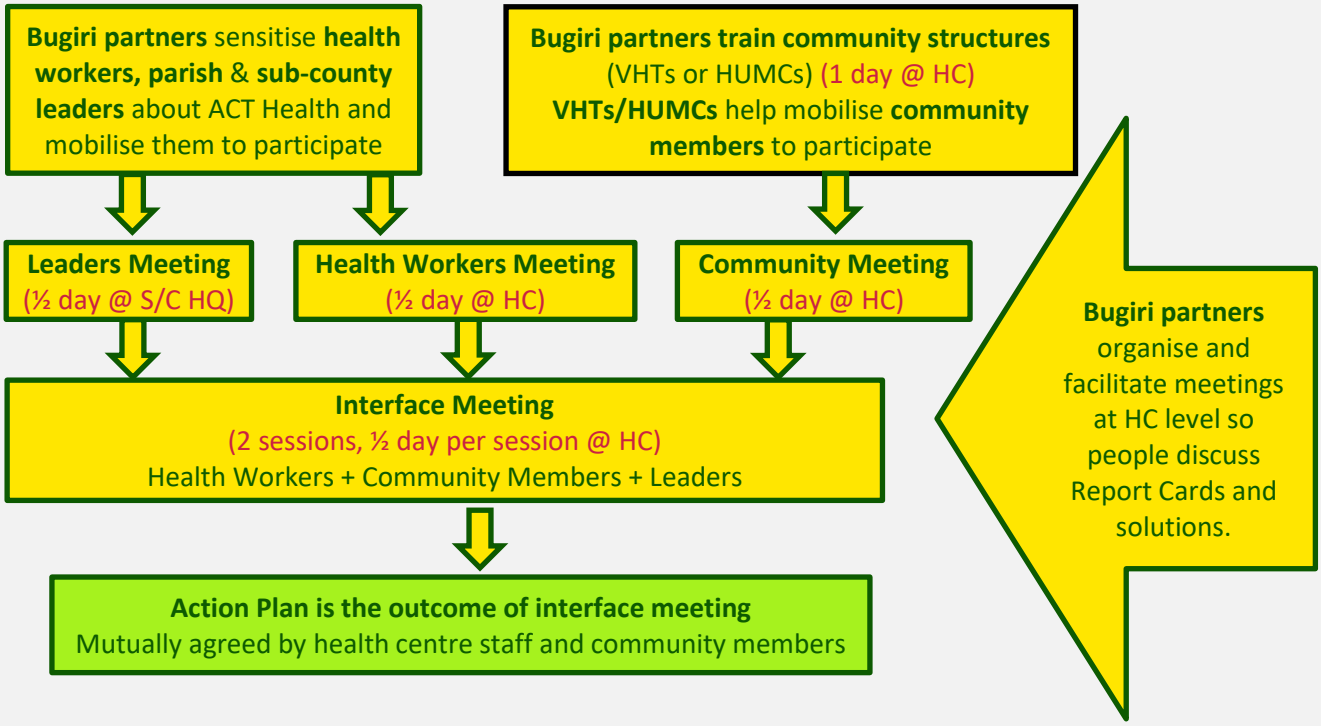
1. **GOAL** provides on-going organisational development (OD) support for partners based on needs as identified in organisational capacity assessments (OCA).
2. **GOAL** may organise some formal trainings, but more likely on the job feedback during GOAL OD & Grants team partner visits.
3. **GOAL** facilitates organisation capacity assessments (OCA) with partners, Partners develop work plans highlighting areas of improvement based on the OCA findings.
4. **GOAL** to organise formal training on Governance, finance, HR and Management.
5. **GOAL** conducts regular monitoring support visits.

Resource Box: **What ACT Health looks like**

1. Baseline & Report Cards

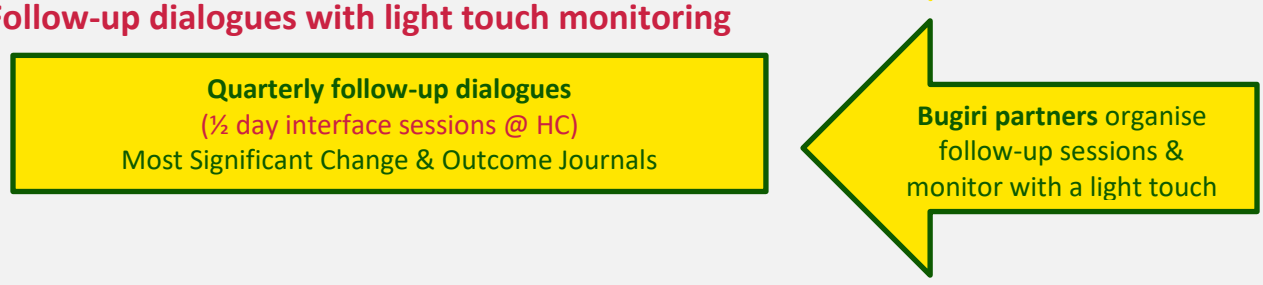


2. Preparing, dialogues & developing action plans



3. Implementing Action Plans

4. Follow-up dialogues with light touch monitoring



A Major assumptions underlying our Theory of Change

One caveat/acknowledgement is that there is a large amount of funding from USAID, DFID and other basket funds for rights-based social accountability work in Uganda, including Bugiri district. This does pose an overall risk of overwhelming civil society and duplication of activities. GOAL and partners will actively network and coordinate to mitigate these risks.

	Assumptions
A	▪ Some basic information on drug supply, primary health care fund (PHC) and human resources (these are the tracer issues) must be available and provided by district, sub-county and facility. ▪ HMIS data and other information at facility level PLUS household survey AND discussions about performance from the community perspective will enrich the availability (quantity) and quality of information.
B	▪ Based on evaluation of citizen report card (Bjorkman and Svennson) we believe that the awareness about rights/entitlements and/or the participation in the monitoring process has some effect on health seeking behaviour. ▪ It is not clear where the causality lies or if both have an effect on health seeking behaviour.
C	▪ By focusing on community monitoring that is broadly inclusive and reinforces the need and right of women's participation in particular, there is a link between community monitoring and power dynamics in communities. ▪ However, this link is probably not strong enough to say that we can measurably affect the precondition on changes within society (power dynamics) with this programme.
D	▪ Main responsibility for follow up on action plans must rest in the **community**, **Bugiri partners** should **not** lead. ▪ Designated **individual(s)** or **structures** would be the focal point for this monitoring/follow-up of action plan. ▪ **Bugiri partners** adapt a very light touch monitoring approach for follow-up with **communities**.
E	▪ In the short term, participatory community monitoring will help improve the efficiency and effectiveness of utilisation of already allocated resources. These changes should be: less leakage of drugs, less absenteeism of health workers, etc. ▪ It is not until higher level participation or future planning cycles with citizen participation that we may see increased allocations to health services. ▪ Uganda's central government still has a large say in resource allocation at local levels, so increasing allocations or changing their use districts will take time (see assumption **J**).
F	▪ Focus on relationship between DLG/DHT as service "providers" and health workers/centres as "consumers" of services. ▪ Introducing this innovation here should have a very positive effect on the relationship of downward accountability to the health facilities for the "services" the DHT is mandated to provide to each health centre. From our research and conversations, this does not seem to be in practice in Uganda, or elsewhere. ▪ We also note there are power dynamics in the relationship between health workers and the DHT/HSD, in particular. The design of the programme and interface at this level will flow from the community level processes, hopefully giving health workers more confidence and skills to interface with the district.
G	▪ Project cannot affect the ability of duty-bearers to be held accountable. ▪ In some cases, consequences for breaches of accountability (instances of corruption) may not be enforceable because district officials cannot afford to fire or transfer a staff person from a health centre where there are only limited staff.
H	▪ The arrows go two ways here because some think that participation → empowerment while others theorize that empowerment → participation. ▪ The relationship between empowerment and participation is likely mutually reinforcing: empowerment ←→participation
I	▪ GoU invites citizens to participate at parish/sub-county/district level ▪ Citizens participate in a meaningful way and this can lead to the inclusion of their priorities in district development plans. ▪ This is probably a longer term outcome than we can feasibly contribute to with this programme.
J	▪ Relationship between needs and resource allocations are complicated. ▪ Citizen priorities must be included in the district development plan and otherwise (through lobbying) reach national level. ▪ Because districts are over **80%** dependent on national levels for fund allocations, they may not necessarily be able to respond at the district level without approval from higher levels. ▪ Expression of needs likely to outstrip resources available. ▪ This is a longer term outcome and depends on many factors outside the influence of this programme.

Key Government of Uganda stakeholders

This is not an exhaustive list of all the potential stakeholders to be targeted and included in the implementation of this programme. However, it highlights the main actors and institutions which, when significantly targeted and engaged can contribute to the preconditions we want to see.

	Brief information on the mandates of Government of Uganda stakeholders to be targeted
Village Health Team (VHT)	*NOTE: This project will target VHTs as they are the representatives of the MoH which have the deepest knowledge of their community member health seeking practices and can encourage community members to engage in dialogues and action.* ▪ In **2001**, the MoH developed the VHT Strategy to strengthen the delivery of health services at household level. ▪ According to the policy, a VHT has four to five people selected by popular vote, with each member serving **25-30** households. ▪ VHTs work together to promote healthy practices or advocate for increased community uptake of prevention interventions. ▪ While the majority of villages in Uganda have trained VHTs, most operate without support items such as registers and medicine boxes or drugs as the MoH has not allocated funds to support VHTs non-cash incentives (as per the MoH policy), review meetings or supervision.
Health Unit Management Committee (HUMC)	*NOTE: This project will target the HUMCs as agents of change in communities – representatives of the community perspective and a conduit for information gathering and monitoring.* ▪ Strategy of establishing HUMCs at each facility was imbedded in the First National Health Policy in **2001**. ▪ Members of the HUMCs are consumers of health services and are also mandated by GoU policy to play a critical role in community-driven monitoring of health inputs and service delivery standards. ▪ All of the major health sector policy documents rely on the role of well-functioning HUMCs to serve as a bridge between the community of consumers and their health service providers. ▪ The policy environment in Uganda is highly conducive to empower the HUMCs. ▪ Vitalisation of these structures provides a major opportunity to leverage this critical, community level nexus of civil society and formal government.
Community Development Office (CDO)	*NOTE: This project will engage and include the representatives of the CDO as appropriate for their role as key duty bearers who must be involved in community monitoring and action.* ▪ At the local level, the District Community Development Office (CDO) is the primary channel for ensuring community benefits from government programs and services, generally through a network of sub-county CDOs. ▪ They are mandated to perform a critical role in bringing services to people through community education, community mobilization for immunization drives, and so forth. ▪ Outreach and transfer of information is mostly in one direction – top-down – with no regular or formal mechanisms for soliciting community feedback, input, or ideas except through the annual planning process. ▪ CDO generally has the smallest share of the district government's budget, and its power within the district office, relative to offices with much larger budgets, seems to be limited. ▪ CDOs report a shortage of staff at the sub-county level and express frustration that their offices are underutilised vis-à-vis their mandate.
District Health Team (DHT)	*NOTE: This project will specifically engage the DHT in dialogues to address downward accountability of the DHT and other district local government officials to health workers and communities. Project also aims to increase flow of information from community levels to district decision-makers.* ▪ The DHT is supervised by the Chief Administrative Officer (CAO) and is typically comprised of seven members. ▪ The DHT is mandated to participate in planning, budgeting, monitoring of health service delivery. ▪ The mandate for these functions generally emanates from the Local Government Act of **1997** which established decentralised governance in Uganda. ▪ The positions on the DHT are staffed by health technicians, the main challenges in health service delivery are planning, drug supply management and management of human and financial resources. ▪ At present, weak enforcement of upward and downward accountability compromise quality follow-up of technical and service delivery outcomes from the CAO to the DHO and from the DHO to lower levels.
Health Sub-District (HSD)	*NOTE: Engagement of the HSD will be very similar to that with the DHT – to reinforce downward accountability.* ▪ HSD which is mandated by the MoH to perform similar functions to the DHT and reports upward to the DHT. ▪ HSD is a county level MoH structure which functions from the hospital or HCIV.

	▪ HSD is mandated to support the lower level health centres (HCII and HCIII) across the county. ▪ HSD is most relevant in Districts with two or more counties (such as Bugiri).

Overview of Learning Strategy: Light touch monitoring and robust qualitative approaches

Social accountability approaches are seen as contributing to improvements in the relevance, quality and accessibility of government health services. GOAL has developed the pathway of change based on academic research practical lessons from civil society experts. While there are strong indications of effectiveness, the programme has been designed so that we can contribute to some of these unanswered questions. A full set of outcome indicators and accompanying monitoring strategy has been developed.

Among the many challenges in Uganda, there are multiple layers and levels of administration (technical and elected officials) which have shared or overlapping mandates. In addition to accountability between **citizens** + **health workers**, we will introduce activities that focus on accountability between **health workers** (Officers-In-Charge) + **District Health Team** and **Health Sub-District** (which are supposed to provide services to health centres). Service providers from the different health facilities will collectively approach the District, using a very similar evidence-based dialogue approach and action plan used at the community level.

- **Acknowledging the importance of objective information:** The **Report Cards** generated for each facility, sub-county and District will be the cornerstone of the Act Health project. Given the importance of providing objective information as a basis for discussions and action plans in communities, GOAL will make a significant investment in the baseline data collection. Thus, compiling quantitative information is necessary for project implementation and also to measure the degree of effectiveness.

- **Collect baseline data:** Will include HH survey, health worker survey, review of HMIS and health facility data. In addition to questions on health, GOAL will design the survey tools to assess women's priorities and governance trends in communities. GOAL Uganda has worked to develop a relationship with Professor Martina Bjorkman, an author of prominent research on Citizen Report Cards in Uganda, which has been cited above. Professor Bjorkman has shared the household and health worker surveys used in World Bank sponsored research with GOAL and these shall be adapted for the ACT Health project.

- **End line data collection:** GOAL will manage this process, as they did with the baseline activities. The end line will be collected **24** months after the baseline (in **August 2014**), using similar survey tools as those used for baseline. The reason for doing the collection at that point is to understand progress to date. This will enable all partners to reflect on findings and also have time to make changes in the final year of the project, if necessary. Often, end line data collection or final evaluations happen too late in the project to actually incorporate lessons or changes. This strategy is designed to enable partners to make adaptations to evolve the programme approach.

- **Triangulate with government policy documents**: For some indicators it will be necessary to analyse District development plans, budgets and records at sub-county, District and national levels will be necessary. The programme will utilise information from health management information system (HMIS), and other health facility level records as necessary.

- **External end of project evaluation:** Given the exhaustive end line data collection planned 24 months after the baseline, GOAL does not plan to do another data collection exercise at the end of the project. GOAL would only invest in another significant data collection if there had been major changes introduced after the end line. At the proposal development stage, GOAL envisions an external end of project evaluation. The evaluator would take quantitative (baseline and end line) and qualitative data (Outcome Journals and MSC stories) and work with GOAL to answer the research questions highlighted below.

- **Rigorous qualitative monitoring applied with a light touch:** Monitoring and evaluating the effectiveness of social accountability interventions is difficult (much like measuring the effectiveness of any development project or initiative). However, many experts suggest methods like Most Significant Change and Outcome Mapping. Rather than attribution, these approaches focus more on contribution to the creation of conditions necessary for desired changes (answerability, enforceability, participation and responsiveness). These rigorous qualitative methods started to "spread in alternative monitoring and evaluation circles occurred just when donor exigencies are driving implementers towards 'harder' and more

generalisable evidence, rather than approaches which capture nuances, complexity and messiness."[1] MSC and OM are increasingly seen as valuable monitoring methods to explain the "how" and "why" of projects.

To ensure that communities are driving the action plans, implementing partners will adapt a very light touch monitoring strategy in communities. The follow-up will be limited to quarterly dialogues sessions of ½ day each (which bring together all stakeholders).

The literature review helped to isolate some of the major unanswered questions about the effectiveness of social accountability approaches in influencing service delivery and social development indicators. GOAL first determined the type of programming we were likely to implement based on our super goal and desired outcomes. From that, we isolated some of the areas where, if appropriately measured and researched, GOAL can contribute to learning on social accountability. After the GOAL team discussed the possible research questions, the four possible research questions were vetted among civil society partner organisations and also researchers such as the Country Director for Innovations for Poverty Action and also Martina Bjorkman. Based on feedback from all of these consultations, GOAL settled on the two research questions below which we will endeavour to answer with rigorous quality control over the implementation and monitoring of ACT Health.

Research Questions
Does the ACT Health programme lead to greater access to services (changes in health seeking behaviour)? If so, why? What are the specific elements of the programme design which contributed to this – information sharing about health rights/entitlements, participation in dialogues and action planning, engagement in monitoring, etc.?
Does the ACT Health programme contribute to downwards accountability among duty-bearers for health services?

GOAL has three main motivations for establishing a partnership with an academic institution. These are:

1. Lend legitimacy to the project design, baseline collection and monitoring strategy
2. Facilitate peer review, publishing and dissemination of findings on the effectiveness of ACT Health
3. At the global level, such a relationships bridge the gap between academics and development practitioners, ultimately enriching the work and effectiveness of each

[1] McGee, R. And Gaventa, J., 2010, 'Review of Impact and Effectiveness of Accountability and Transparency Initiatives', IDS p 31