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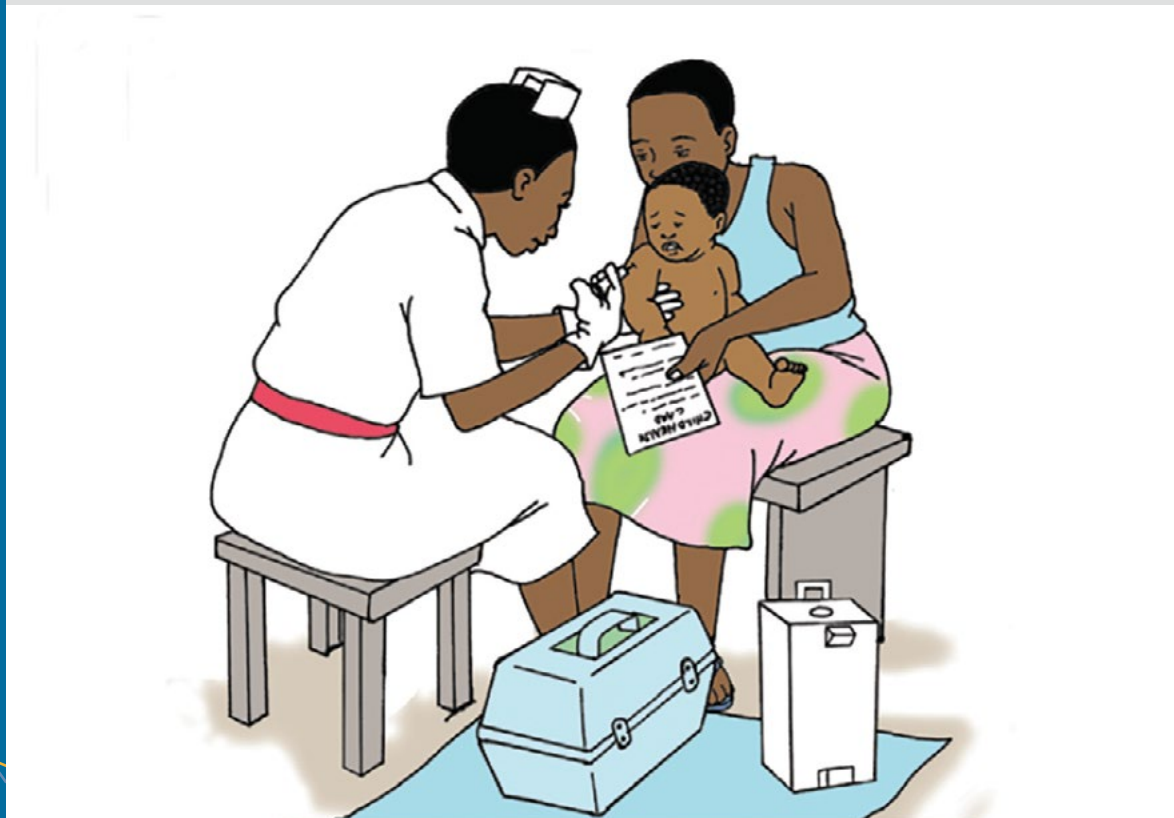
Accountability Working Paper



Bottom-up Accountability in Uganda: Learning from People-centered, Multi-level Health Advocacy Campaigns

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with a Preface by Prima Kazoora



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Keywords: *Health accountability, Health advocacy, Social accountability, People-centered advocacy, Multi-level strategies, Participatory governance, Randomized control trials, Process monitoring, Citizen report cards*

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About the Authors



Angela Bailey began working at the [Accountability Research Center](#) (ARC), an action-research incubator based at American University in Washington, DC, in August of 2016. Prior to joining ARC, Angela worked for international NGOs in various capacities in Liberia and Uganda. From April 2014 to June 2016, Angela worked with GOAL as program director of the Accountability Can Transform Health (ACT Health) program in Uganda. Angela holds a Master's in International Affairs from Columbia University's School of International and Public Affairs.
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I began working in Uganda in 2009 and during an eight-month consultancy in 2012, I helped GOAL to develop the ACT Health program approach. I compiled a literature review, conducted key informant interviews, and co-created the initial theory of change. When GOAL secured a larger grant to expand the ACT Health program, I was hired as the ACT Health program director and oversaw all aspects of planning, implementation, monitoring, and learning. I also worked closely with my co-author Vincent Mujune during the initial year of planning, preparing, and piloting of the people-centered advocacy approach before leaving Uganda in June 2016. In February 2018, I re-engaged with Ugandan colleagues and community advocates to better understand the processes and outcomes of the people-centered advocacy campaigns accompanied by the ACT Health program. While I have an intellectual stake in this analysis given my role in the program's design and implementation, the time and physical distance enable me to critically examine and reflect on the effects of the people-centered advocacy work.



Vincent Mujune led GOAL's people-centered health advocacy work in Uganda from May 2016 to December 2020. He supported community-led processes using participatory evidence-generation and analysis methods to engage affected communities, build their capacities and strengthen the influence of marginalized households on the health system. Vincent is a member of Uganda's Civil Society Budget Advocacy Group and has trained civil society actors on people-centered advocacy in Sri Lanka, Malawi, and Sierra Leone.
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I started working with GOAL in 2014, initially supporting organizational development among GOAL's many civil society partners. In 2015, based on my experience supporting direct advocacy by persons with lived experience of mental ill health, I began to develop materials and pilot the people-centered advocacy work in Bugiri District in 2015. In May 2016, I became Deputy Director of the ACT Health program. I was instrumental in supporting and guiding civil society organization (CSO) teams as they prepared community advocates to drive their own campaigns. This included refining training tools and processes, delivering workshops, and providing ongoing supervision and feedback to CSO staff in all districts.

Positionality: Practitioners as Authors

As co-authors of this paper, we acknowledge our roles as architects and stewards of the ACT Health program. Our closeness to the implementation brings strengths and weaknesses. As self-critical practitioners committed to learning and advancing participatory governance, our closeness to the ACT Health program enables us to bring to light multiple dimensions of a multi-level strategy and offer insights into the "black box of implementation."

Acknowledgements

First, we are in awe of the many health workers and citizens who engaged in this program and particularly the community advocates who took up the mantle of advocacy and boldly engaged government officials.

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- [Coalition for Health Promotion and Social Development](#) (HEPS Uganda)
- [GOAL, an international humanitarian organization](#) (GOAL)
- [Kabarole Research and Resource Centre](#) (KRC)
- [Multi-community Based Development Initiative](#) (MUCOBADI)

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Christina (Tina) Ntulo's technical stewardship helped the consortium to turn the vision for people-centered advocacy into practical steps and processes to help community advocates develop the critical skills that would deepen democracy and development. Tina's support was instrumental to the successes achieved. We also appreciate the enthusiastic and strategic thought partnership of Dr. Paul Kiwanuka-Mukiibi.

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We want to acknowledge the Principal Investigators Pia Raffler, Daniel Posner, and Doug Parkerson who designed the randomized control trial (RCT) evaluation. Innovations for Poverty Action (IPA) Uganda collected the RCT data.

We sincerely thank colleagues who read and commented on (many!) earlier versions of this paper: Jonathan Fox, Naomi Hossain, Julia Fischer-Mackey, Denis Kibira, Geraldine McCrossan, Elizabeth Allen, Marta Schaaf, Walter Flores, Victoria Boydell, and Courtney Tolmie. As authors, we take full responsibility for the content of this working paper.

Acronyms

To enhance readability for audiences unfamiliar with the Uganda context, we have reduced the number of acronyms and focused instead on our use of key terms in this paper.

ACT Health	Accountability Can Transform Health
CSO	civil society organization
NGO	non-governmental organization
PCA	people-centered advocacy
RCT	randomized control trial

Notes on Use of Terms

“Community” – We use the term “community” to refer to groups of people living in the villages served by health facilities where the program operated (“catchment area” in health systems terminology). Given that populations may not self-identify as “a” singular community for any number of reasons, we do use the common terminology while acknowledging its limits.

“Citizen” – Uses of the term “citizen” in this paper should be read as inclusive of all members of the broader community, including refugees or otherwise stateless persons, whether or not they are “citizens” of Uganda.

“Civil society organization” – We use the term “civil society organization” to describe both international non-governmental organizations (NGOs) and Ugandan NGOs. We do so while acknowledging the complex incentives, inherent tensions, and power dynamics among diverse non-state actors (formal organizations and grassroots movements, and between “international” and “domestic” organizations).

“People-centered advocacy” – The ACT Health consortium agreed to this operational definition in March 2015: *“People-centered advocacy is a systematic process owned and led by those affected by an issue using evidence to influence people with power at different levels to make sustainable change in practices, policies, laws, programs, services, social norms and values for the betterment of those affected by the issues.”* The work of John Samuel (2002, 2007) influenced the ACT Health program definition.

Drawing of a Ugandan Community



Credit: Mango Tree 2012 (commissioned by GOAL)

Preface

Prima Kazoora

**Manager of Community Empowerment Programme
Coalition for Health Promotion and Social Development (HEPS-Uganda)
February 2020**



The [Coalition for Health Promotion and Social Development](#) (HEPS-Uganda) was involved in the Accountability Can Transform Health (ACT Health) program from the time we developed a theory of change in 2012. Our partnership with GOAL grew from the early discussions, and I was personally involved in the piloting of the ACT Health approach in Bugiri District. As HEPS, we were excited to be part of the implementing consortium from 2014 – 2018. We have worked to advance health as a human right in Uganda since our registration in 2000. We have a special focus on working to increase access to essential medicines and rational use of medicines. HEPS Uganda works at national/ local government and at community level to reach out to the most vulnerable people in society. Even with many years of experience working in communities, the ACT Health program was unique and exciting for us—especially the people-centered advocacy approach. We are excited to see this rich Working Paper by our colleagues Angela and Vincent, and I am sharing some of the key learning for HEPS-Uganda from our work on the ACT Health program.

- 1. The people-centered advocacy approach (PCA) can catalyze and strengthen community participation in health sector governance.** This can be replicated in other sectors like education and livelihoods. Having affected people at the center of an intervention creates local ownership, which propels youth, women and men to creatively identify solutions to their challenges/problems. For example, the community advocates were able to passionately mobilize their local resources to collect evidence, coordinate processes and engage duty-bearers.
- 2. Duty-bearers were not used to appreciating local evidence/ reports on service delivery from ordinary community members.** They were used to reports from established local structures that are, most often, not accurate. There is untapped potential in the role that community members can play in providing duty-bearers with up-to-date information that can be used to strengthen monitoring and governance in service delivery. For example, community members can be very good sources of accurate information in monitoring workers' attendance (even when a biometric arrival system is in place), construction, staffing levels vis-à-vis ghost staff, and medicines monitoring in their facilities. Unfortunately, though, they are "*despised*" by most duty-bearers with unbecoming queries like "*Who are you to ask for that information?*" or "*Who are you to report such a thing?*" or "*What is your motive for doing this?*"
- 3. Local government staff are not properly supervised and sanctioned because District Service Commissions (DSCs) in all ACT Health districts are poorly facilitated.** In fact, they do not undertake any independent activities to follow up personnel reports, or monitor and evaluate human resource performance issues. These DSCs are only called to do so by district councils through the Chief Administrative Officer on special occasions, particularly recruitment. They often take two years to deliberate on performance of public servants. This is ineffective and leaves gaps in enforcement of Uganda's Public Service Code of Conduct 2010 guidelines.

4. **Provision of information to the community about the status of their health situation does not necessarily lead to increased demand for health services but definitely increases responsibility from health workers/duty-bearers in improving service delivery.** The health workers/public servants address community concerns once they are raised. They become more sensitive as they get to be mindful that the local people are conversant with their expectations and citizens are watching public servants.
5. **Community dialogues that are of low cost (meaning no money is given to participants as allowance or transport refund), gender-sensitive, and inclusive can enable communities to appreciate the fact that local meetings that address local development issues can be organized using local resources and structures, without strong external financial input (from NGOs, national or international) for community mobilization.** This is significant in our Uganda context, where government and CSOs have both contributed to a culture of “allowances” in exchange for participation and engagement.
6. **Continuous sensitization of communities about health rights and responsibilities, government laws, policies and guidelines empowers them over time.** This enhances their vigilance in monitoring service delivery and also boosts local initiatives among affected people to mobilize themselves and engage duty-bearers.

These key lessons have greatly influenced HEPS Uganda current work in communities as we only facilitate and support community members to take lead in addressing the identified health issues in their locality.

Summary

Uganda's laws, policies and health sector strategies codify openings for citizen participation in planning and monitoring government services, yet these spaces are often inaccessible in practice. In response to this, a consortium of civil society organizations led by GOAL designed and implemented the Accountability Can Transform Health (ACT Health) program in Uganda from 2012 to 2018. This paper draws on program monitoring data, empirical evidence, and supplementary interviews to analyze how and the extent to which the ACT Health multi-level, people-centered advocacy campaigns strengthened accountability for health from the bottom up.

The ACT Health program reviewed in this paper had two distinct phases. Phase 1, from 2014 to 2016, included a series of CSO-facilitated dialogues between community members and health workers in 282 government health facilities. These yielded action plans, which were then reviewed in follow-up meetings every six months. Phase 1 was designed to be evaluated through randomized control trial (RCT) research, which tested the impact of citizen report cards (information) and community-level dialogues on a series of 12 outcome indexes. Given the complexity of health system governance in Uganda, the ACT Health strategy anticipated that issues identified at the community-level would require coordinated citizen action to address bottlenecks above and beyond frontline health centers. After the RCT ended, Phase 2 of the program added a new approach: accompanying networks of volunteer grassroots community advocates from 98 health center catchments in 18 districts to organize, design, and deliver multi-level advocacy campaigns. In Phase 2, from 2016 to 2018, 396 community advocates identified advocacy priorities, then planned and delivered advocacy campaigns to a wide range of government officials up to the national level. In 14 districts, communities built advocacy campaigns around the complex issue of health worker absenteeism.

The RCT intervention tested in ACT Health Phase 1 was based on the influential "Power to the People" research published in 2009, which reported that improved information through citizen report cards and facilitated dialogues between community members and health workers dramatically improved health outcomes (Björkman and Svensson 2009). While the "Power to the People" study remains influential in the transparency, participation and accountability field, researchers tested the intervention in 25 health facilities, resulting in a statistically under-powered RCT. Ten years later, the ACT Health RCT re-tested the intervention in 282 health facilities, increasing the statistical power of the analysis. The ACT Health RCT findings published in 2019 detected modest improvements in "treatment quality" and "patient satisfaction", but found no evidence of improved health outcomes reported in the original "Power to the People" research a decade earlier (Raffler, Posner, and Parkerson 2019). The present paper reviews the ACT Health RCT findings, unpacking how key outcome measures such as "community monitoring" were operationalized and exploring the limits of the relatively "light touch" approach tested.

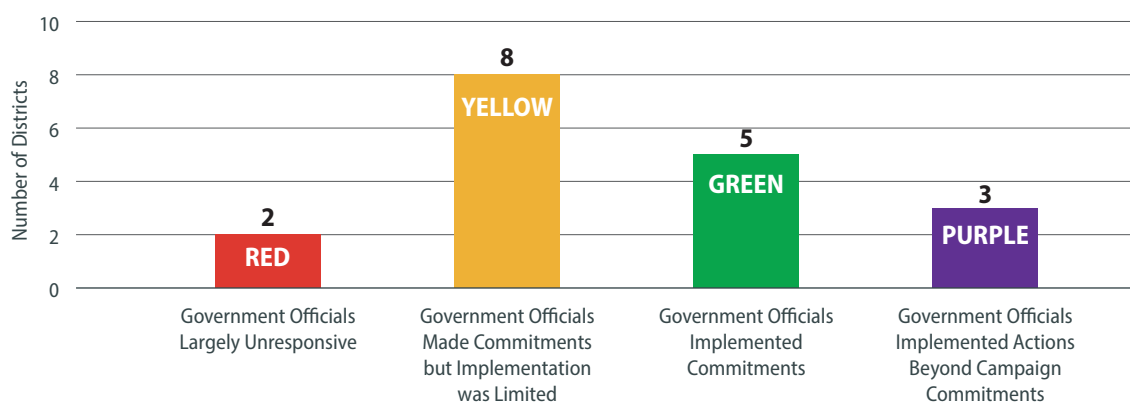
Support to collective, multi-level advocacy campaigns in Phase 2 of the ACT Health program was part of the strategy from the beginning—it was neither tied to nor contingent upon the RCT findings from the Phase 1 intervention. Starting in 2016, community advocates (selected by other community members) collected data through direct monitoring of health facilities, analyzed that data, developed petitions, recruited allies, mobilized resources, organized collective actions, and directly engaged government officials from the village to the national level. CSO staff helped community advocates conduct their own political economy analysis, tapping into advocates' knowledge of authorities and government systems. Independent monitoring of government services in Phase 2 was not a one-off exercise. Community advocates in 18 districts engaged in on-going monitoring to assess the effects of their advocacy campaigns. In almost half of the 98 health facility catchments, advocates leveraged their knowledge and skills to launch special advocacy campaigns to tackle additional challenges they had independently identified.

In this multi-level strategy, prior experience with community-level dialogues (in Phase 1 under the RCT) helped community advocates to develop advocacy campaigns targeting sub-county and district officials. These subnational campaigns, in turn, fed into coordinated national level campaign actions on health worker absenteeism. Most strikingly, advocates from 14 districts combined their efforts to amplify citizen voice on the problem of health worker absenteeism, reaching national-level actors such as line ministries and parliamentarians.

The impacts of these more strategic multi-level, people-centered advocacy campaigns were not studied by the RCT, which was designed instead to re-test the more limited, less intensive, and locally-bounded community-level intervention popularized in the earlier “Power to the People” study. The work in Phase 2 was more complex, as advocacy campaigns are dynamic and iterative processes whose elements cannot be rigidly programmed. This meant that the work in Phase 2 was not amenable to the experimental research methods used in RCTs, which are more appropriate for testing discrete and standardized interventions and short causal chains. This paper uses practitioner-led analysis of ACT Health program monitoring data to document outcomes and learning from these iterative advocacy processes in 18 districts. To capture the variation in government responsiveness, GOAL developed a “Heat Map” summarized here to show the scale and diversity of outcomes observed.

Community advocates were tenacious and creative through 18 months of engagement with subnational (district) government officials. **Figure S1** summarizes subnational government officials’ responsiveness to campaign asks as of June 2019 (one year after program funding ended). In five districts, government officials implemented commitments in response to citizen campaign asks. In three additional districts, officials went further and invited community advocates to extend their independent monitoring to other sectors (such as education and construction). While 8 districts responded very well to community advocates, in 10 districts, subnational officials were either unresponsive or made commitments, but implementation was relatively limited. The data reveal nuance and variation in subnational government responsiveness to advocacy campaigns. This nuance—and related insights around change dynamics—would have been invisible in an approach focused on aggregated quantitative averages.

Figure S1. Subnational Government Responsiveness to Community Advocates’ Campaigns in 18 Districts (as of June 2019)



Source: GOAL Uganda “Heat Map” compiled from multiple program monitoring sources.

Key reflections from the ACT Health program (2014 – 2018)

This working paper is a practitioner-led analysis of the full ACT Health program. The paper contextualizes key RCT findings, then explores outcomes and learning from the cycles of citizen-led engagements and government responses during Phase 2 advocacy campaigns. We anticipate that this study of people-centered advocacy will contribute to conversations about robust citizen-led engagements with the state, to incrementally deepen democracy in these universally challenging times.

- 1. The ACT Health RCT study provides limited insight into the ACT Health program approach.** The RCT studied only the first, locally-bound phase of the ACT Health strategy, *excluding* the more strategic multi-level monitoring and citizen-led advocacy work after the RCT ended. RCT researchers concluded that “bottom-up accountability” was inherently weak (Raffler, Posner, and Parkerson 2019), even though the RCT indicators were too indirect to measure whether independent community monitoring was actually done. In contrast, Phase 2 saw active bottom-up monitoring by networks of community advocates who coordinated health advocacy campaigns in 18 districts. Studies (such as the present one) of more strategic, iterative, intensive, and multi-level accountability work provide richer insights into the dynamics of accountability relationships than the RCT study of a single discrete tactical component embedded in a broader strategy.
- 2. Externally funded programs can support citizens’ strategic efforts to directly engage the state and strengthen accountability.** Rather than speaking *for* communities affected by poor service delivery, CSOs supported and accompanied citizen-led advocacy campaigns. Phase 2 of the program supported district networks of organized community advocates to: collaborate across multiple health facilities, deliberate and prioritize advocacy issues, orchestrate independent monitoring of multiple health facilities, analyze their findings, and direct evidence-based advocacy asks to government officials. ACT Health supported community-driven political economy analysis, expanding local advocates’ civic knowledge to develop context-specific strategies targeting powerful officials. In all 18 districts, community advocates directly engaged a range of government officials, meeting them in their offices, participating in budget planning meetings, going on the radio to ask officials to act, and many other creative tactics to capture attention of powerholders. As part of a joint campaign on absenteeism, advocates drew on material and analytical support from CSOs to overcome collective action barriers, navigate power dynamics, and directly engage national-level officials. Ensuring that advocacy agenda-setting power rests with citizens—the essence of the people-centered advocacy approach—proved possible even in an externally-funded project.
- 3. Independent, bottom-up monitoring and advocacy can trigger top-down system responses, changing accountability relationships.** The multi-level advocacy campaigns in Phase 2 triggered top-down oversight, activating responses with *potential* for broader changes. CSO coaching and mentoring helped community advocates prioritize and target powerholders—and advocates then navigated politics, leveraging checks and balances among subnational authorities during their campaigns. In some cases, advocates reached nationally mandated bodies, triggering Inspectorate of Government offices’ independent investigation when district-level officials were insufficiently responsive to advocates’ asks. Government responses included: increasing monitoring and oversight of health facilities, reporting findings of their monitoring back to citizens, increasing resource allocations, acknowledging the role of advocates through official letters, and sanctioning on health workers. Government officials’ reporting their findings and corrective actions back to advocates indicate degrees of answerability and downward accountability from the state to citizens. Community advocates’ engagement with higher level officials led to greater recognition, which appears to have mitigated health workers’ reprisals (backlash) against citizens. Government officials at the sub-county and district levels in 8 (of 18) districts implemented commitments that met or exceeded community advocates’ “asks”. The range of responses by subnational government officials to community advocates’ campaigns reveal the potential for shifting power and accountability relationships between citizens and the state.



I. Introduction

The 2004 World Development Report, *Making Services Work for Poor People*, suggested that enabling citizens to monitor public services and including citizen voices in policy-making could incentivize public service providers to improve performance. In 2009, the influential study, “Power to the People: Evidence from a Randomized Field Experiment on Community-Based Monitoring in Uganda,” reported statistically significant improvements in health outcomes due to the program including an estimated 33 percent reduction in child mortality (Björkman and Svensson 2009). However, this finding is based on a 90 percent confidence interval ($\alpha = .10$) that is quite wide, meaning the actual reduction in the under-five mortality rate lies in the wider range of 8 percent to 64 percent (Björkman and Svensson 2009:757). Despite this wide range, the figure of 33 percent is frequently cited in peer-reviewed and grey literature. It seems that in the absence of a broad evidence base, this experimental ‘gold standard’ research gained prominence and further spurred the proliferation of ‘social accountability’ interventions.

Figure 1. Meeting of Health Workers and Community Members



Credit: Mango Tree 2012 (commissioned by GOAL)

In 2012, against a backdrop of growing excitement and visibility of research and practice under the broad umbrella of “social accountability”, GOAL (an Irish non-governmental organization) began to explore health accountability work in Uganda. GOAL’s [literature review](#) and context analysis informed an initial [theory of change](#) for the Accountability Can Transform Health (ACT Health) approach. With funding from Irish Aid, GOAL piloted activities in Bugiri District, starting in late 2012. Based on this formative pilot work, UK Aid awarded a GOAL-led consortium £4.6 million to conduct a complex, large-scale RCT and implement a multi-level strategy from February 2014 to May 2018.¹

The ACT Health program included a new RCT (run from 2014-2016) which replicated the community-level intervention popularized by Power to the People. The ACT Health strategy anticipated that community-level dialogues might surface problems requiring engagement with government authorities at higher levels within the health service and other government departments/ministries. Thus, from 2016 to 2018, the ACT Health consortium accompanied people-centered health advocacy campaigns rooted in intensive community organizing and direct monitoring of government services. The approach aimed to shift agenda-setting power towards community advocates (and the communities they were working with) who were most directly affected by weak health service delivery. **Table 1** highlights the major activities during the pilot, Phase 1 and Phase 2 of the intervention.

Table 2 in Section 3 offers more detailed comparison of Phase 1 and Phase 2. **Figure 2** shows the districts of Uganda where ACT Health program activities were implemented.

Table 1. ACT Health Program Major Activities During Pilot, Phase 1, and Phase 2

Phase	Timeframe	Major Activities	Scale
Pilot ^a	2012 – 2015	<ul style="list-style-type: none"> • 2012: Literature review and initial theory of change • 2013-4: Pilot the community-level intervention (citizen report cards and dialogues) • 2015-6: Testing ground for supporting people-centered advocacy campaigns 	<ul style="list-style-type: none"> • One District • 33 government health facilities
Phase 1	2014 – 2016	<ul style="list-style-type: none"> • Community-level intervention using citizen report cards • Facilitated dialogues between community members and health workers • Process monitoring – reviews of progress against action plans in all intervention facilities • Randomized Control Trial research (baseline in 2014, midline in 2015, endline in 2016) 	<ul style="list-style-type: none"> • 16 Districts ^b • 282 government health facilities
Phase 2	2016 – 2018	<ul style="list-style-type: none"> • Accompaniment to subnational people-centered advocacy campaigns • Process monitoring across all districts “Heat Map” • Support to national level advocacy engagements 	<ul style="list-style-type: none"> • 18 Districts ^c • 98 government health facilities ^d • 396 community advocates

NOTES:

^a Learning from the pilot informed implementation of intervention studied in the RCT. When the RCT was ongoing, GOAL continued working in the pilot district testing materials designed to advance the people-centered advocacy work.

^b The ACT Health implementation districts were chosen based on a few criteria: ensuring robust sample of health centers with limited overlapping catchment areas for the RCT, selecting districts with high/medium/low performance rankings according to the Ministry of Health rankings, implementing in different regions of Uganda, and avoiding districts where a large-scale USAID-funded health advocacy project was to be implemented in a similar timeframe.

^c The number of districts increased from 16 to 18 between Phase 1 and Phase 2 due to ‘splitting’ of some districts during implementation.

^d The 98 government health facilities included in Phase 2 were selected from the 282 facilities in Phase 1.

Implementation Districts 2014 – 2018

Northern Uganda	Eastern Uganda	Western Uganda	Central Uganda
1. Agago	9. Tororo	13. Kabarole	17. Nakaseke
2. Gulu	10. Bukedea	14. Bundibugyo	18. Mubende
3. Pader	11. Katakwi	15. Kagadi (Kibaale)	
4. Apac	12. Manafwa/Namisindwa	16. Kakumiro (Kibaale)	
5. Kitgum			
6. Lira			
7. Lamwo			
8. Omoro			

1.1. Situating this paper in the accountability literature

The concept of “accountability” is broad and far-reaching. Multiple, ever-expanding bodies of literature from multiple fields address accountability. Broadly speaking, the literature can be grouped into a few categories, the full body of which constitutes explicit (codified) knowledge. However, much grounded, tacit knowledge—from engaged practice and learning-by-doing—is missing from these bodies of literature.

Conceptual work focused on the need to address context and confront power

A large part of the literature here focuses on the need to employ distinctly political approaches that can transform entrenched power hierarchies. Many conceptual pieces point to weaknesses in the tactical or more technocratic approaches to social accountability or widgets deployed in development projects (Joshi and Houtzager 2012; Shutt and McGee 2013; Joshi 2014; Fox 2015; Halloran 2016; Nelson, Bloom, and Shankland 2018; Waldman, Theobald, and Morgan 2018). Many scholars place increasing emphasis on context-driven approaches, stressing the importance of seeing interventions or processes in the context of larger histories of citizen–state engagement (Joshi 2014; Joshi 2017). Others critically question the capacity of project “interventions” to outweigh existing ongoing contexts and processes (Shutt and McGee 2013; Mannell and Davis 2019). While vital, this literature can be challenging to translate into practice.

A large and growing body of field experiments (especially RCTs)

This literature includes many RCTs that appear to show mixed results of transparency, participation, and accountability approaches on outcomes of interest. Experimental research—particularly RCTs—generally study tools (interventions) based on short causal chains amenable to standardization rather than testing broader change theories or dynamic social processes (Rifkin 2014; Shutt and McGee 2013; Woolcock 2013; Deaton and Cartwright 2018; Mannell and Davis 2019). Experimental social science approaches rarely discuss the program design constraints, yet their inherent

inflexibility may work against participatory governance approaches. Even in a mixed method evaluation, the RCT often shapes intervention design decisions, superseding more context-driven and power-shifting approaches discussed in other literature. In very few cases—such as the Transparency for Development project—mixed-methods research designs leverage the explanatory power of parallel qualitative research to better understand “what happened” during RCTs, surface deeper insights, and uncover subtle treatment effects more difficult to observe in surveys (Ananthpur et al. 2014; Rao et al. 2017; Arkedis et al. 2019; Creighton et al. 2020). Many scholars argue for critical interpretation of findings from experimental research due to its limited explanatory power (Ravallion 2018; Deaton and Cartwright 2018) or to the weak links between concepts measured and conclusions drawn (Fox 2015; Fox 2018). Others have noted that much of the experimental evaluation literature has focused on the role of NGOs in community-based monitoring rather than on processes undertaken by communities in demanding accountability (Balestra et al. 2018). NGO interventions tend to get more attention partly because of the resources available to organizations to engage in program evaluations and with independent researchers. For these reasons, we caution against over-reliance on experimental evaluations of interventions to surface significant insights to change in this field.

Reviews in various forms that collate findings from multiple studies

These include systematic reviews, realist-informed reviews, and meta-analyses. Each type of review has strengths and weaknesses linked to criteria for inclusion and exclusion. Reviews help collate findings from published literature, and attempt to distill achievements and challenges across programs and contexts, but meta-analyses offer very limited detail of the individual studies or approaches (Danhoundo, Nasiri, and Wiktorowicz 2018; George et al. 2015; Gullo, Galavotti, and Altman 2016). Realist-informed reviews start with theory, and consider empirical findings of multiple studies to, in turn, refine theories and describe promising pathways of change and learning for the broader field (Westhorp et al. 2014; Dewachter et al. 2018; Lodenstein et al. 2017). Meta reviews are of limited value for understanding distinct strategic approaches.

Much rarer are published papers with “thick descriptions” of more power-focused approaches

“Thick” description refers to a detailed account of field experiences, describing patterns of relationships in context and identifying conclusions that may be transferable to other contexts.² More complex and iterative approaches to health accountability include the work of Mahila Swasthya Adhikar Manch in India (Balestra et al. 2018), analysis of Center for Health, Human Rights and Development (CEHURD) in Uganda combining legal empowerment, strategic litigation and community engagement (Joshi 2017), and the work of health rights defenders in Guatemala pursuing action-reflection-action cycles (Flores and Hernandez 2018; Hernandez et al. 2019). Thick descriptions are rarer in peer reviewed literature, since journal word limits lead authors to privilege analysis of findings rather than detailed intervention descriptions.

These methodologically diverse and multi-disciplinary bodies of accountability literature have yielded mixed findings. Interpreting the mixed results across the literature is challenging because many studies omit detailed descriptions of design, causal theory, and/or the intervention approach. Multi-level approaches supported by CSOs are less represented in the social science literature on accountability, partly because they are more challenging to implement and study. Field experiments usually test “light-touch” approaches that are more amenable to RCT research even though they may be less likely to deliver desired impacts. A narrow focus on high-visibility RCT findings obfuscates the learning from more complex action strategies. The present study analyzes what happened *after* an RCT, when the ACT Health program transitioned from a bounded RCT experiment (Phase 1) to a multi-faceted strategy in Phase 2.

1.2. Structure of this paper

The ACT Health RCT focused only on Phase 1 of the program strategy, and this working paper provides thicker description of process and outcomes from the full ACT Health program. Critical analysis of program monitoring data highlights the outcomes of strategic accompaniment to community advocates’ campaigns.

To provide guideposts to readers who may be more interested in some facet(s) of this analysis than others, the rest of this paper is organized as follows:

Section 2 reviews the health governance context in Uganda. It highlights the recentralization of power that reduces subnational autonomy, and the constricting civic space, which constrains citizen engagement in decision-making. **Section 3** describes the principles guiding the ACT Health program and the maturation of these principles through practice from 2014 to 2018. Section 3 compares and contrasts the information-led community-level intervention studied in the RCT (Phase 1) with the support to community advocates’ multi-level campaigns during Phase 2. **Section 4** describes the process monitoring data sources used to track both the community-level intervention (Phase 1) and support to advocacy campaigns (Phase 2) and used in the present analysis.

Section 5 reviews the key findings of the ACT Health RCT, which replicated the influential Power to the People research. We first present analysis of the process monitoring during Phase 1, and then focus on the RCT findings. We discuss the weak indicator of “community monitoring” used in the RCT and the specious conclusions drawn by researchers about the general ineffectiveness of bottom-up monitoring.

Figure 3. Dialogue Between Health Workers and Community (Phase 1)



Community members and health workers at a health facility in Katakwi District reviewing their joint action plan during a follow-up dialogue in Phase 1. Credit: FOC-REV

Sections 6, 7 and 8 provide detailed examples of cycles of engagement between community advocates and subnational and national officials in Phase 2 of the ACT Health program. **Section 6** discusses the monitoring, planning, actions, and “asks” of community advocates and outcomes from a citizen perspective. **Section 7** provides an overview of government officials’ responsiveness across all 18 districts, followed by detailed empirical examples illustrating the nature of state responses. **Section 8** highlights two different types of national-level advocacy engagements. ACT Health supported coordinated advocacy on health worker absenteeism, targeting national stakeholders. In a few cases, community advocates directly targeted national-level

agencies (Inspectorate of Government)³ to request monitoring and oversight of district officials.

The final two sections of this paper—**Section 9** (Discussion) and **Section 10** (Conclusions)—offer some reflections for the field and suggestions on their implications for future accountability work, research, and learning. It also reflects on some limitations of the relatively “light-touch” intervention implemented at the community level under the constraints of an RCT. This analysis highlights the limits of learning from experimental evaluations while presenting rich findings from the overall ACT Health work.



II. Context: Health Governance in Uganda

This section describes key features of the Ugandan context that influenced the design and implementation of the ACT Health program strategy. Uganda's recent political landscape is dominated by recentralization of power, proliferation of subnational government entities, complex health governance, and narrowing civic space. Entrenched power dynamics and narrowing civic space restrict opportunities for CSOs and citizens to directly engage government actors. Taken together, entrenched social, political, and economic challenges around citizen empowerment, health-seeking behavior, government resource allocation, service delivery shortcomings, and weak health governance underlie poor health outcomes.

2.1. Power and politics

A history of political violence

Multiple, violent internal conflicts have shaped Uganda's political trajectory since independence in 1962. The National Resistance Movement (NRM) took power in 1986, under the leadership of current president Yoweri Museveni. Uganda reintroduced multi-party elections in 2006, but with 69 percent of Parliamentarians elected in 2016 from the ruling party, it can be argued that it is not a multi-party democracy in practice. The leader of one of the major opposition parties, Dr Kizza Besigye, was arrested multiple times between the 2011 and 2016 presidential elections. High profile opposition politician Robert Kyagulanyi Ssentamu (aka Bobi Wine) faced similar challenges for many months before the January 2021 election.

Limited subnational authority

The Local Governments Act of 1997 established five subnational government levels: (I) village; (II) parish; (III) sub-county; (IV) county; and (V) district. **Annex 1** highlights the mandates of executive, elected and appointed officials at each level. Uganda was an early innovator in decentralization, but in practice, Uganda's system is more "deconcentrated". In deconcentrated systems,

decision-making remains centralized and subnational units administer national policy priorities under direct supervision of line ministries (Rondinelli in Mullins 2004). A review of Uganda's performance in the education and health sectors under decentralization found health initiatives "were not based on locally generated ideas, objective assessments of the existing situations, or local adaptation of interventions tried elsewhere, but on pre-packaged interventions" (Pariyo et al. 2009 in Green 2015:498). Uganda's "bottom-up" planning process should enable subnational priority-setting, though in practice, resource allocation decisions are often decided at higher levels. In 2013, over 80 percent of local governments' funding was via conditional transfers from the central government (World Bank 2013). Without resources to plan programs, local governments act as the extensions of the central government, which reinforces recentralization (Myers 2014).

Proliferation of subnational governments (districts) diffuses power, reinforcing central control

In 2015, Uganda had "more highest-level local government units than any other country in the world" (Green 2015). Uganda had 33 districts when the current ruling party came to power in 1986. In 1997, when the Local Governments Act passed, Uganda had 47 districts. By 2017, there were 121 districts (a 267 percent increase from 1986). Proliferation of districts serves as a patronage tool and diffuses subnational power across many more administrative districts (Muhumuza 2008; Myers 2014; Green 2015). The 1997 Local Governments Act established the chief administrative officer as a position to be hired/fired by elected officials at the district level, though this was recentralized in 2005 (Green 2008). The resident district commissioner is a direct appointee by the President and *de jure* subnational representative of the central government. These trends reinforce Kampala's control over local governments, whereby the elected local council system "is less a check on the power of the central government than an extension of its control into local areas" (Green 2015).

2.2. Complex health system structures

Across sub-Saharan Africa, health outcomes such as child mortality and maternal mortality continue to improve at slower rates than every other region in the world (United Nations Department of Economic and Social Affairs (UNDESA) 2019). In Uganda, maternal mortality and under-five mortality rates have improved since 2005, largely due to technological innovations (such as expanded vaccine coverage) rather than changes to underlying power dynamics and deeper economic and political challenges driving system shortcomings (see, for example, Bollyky 2018). Many of these “wicked problems” are well known, but difficult to address because they defy straightforward technical solutions and are often socially and politically contentious (Rittel and Webber 1973). **Annex 1** includes the health structures referenced below.

Health service delivery

The Uganda National Minimum Health Care Package (UNMHCP) guides provision of services. The smallest public health facilities are designated Health Center II (HCII), typically located at parish level, with nine staff. HCII offer basic preventive and curative services for outpatients. They also coordinate outreach services through Village Health Teams (sometimes considered the HCI). At the sub-county level, a Health Center III (HCIII) should have up to 19 staff providing preventive and curative services (as per HCII) plus inpatient admissions, advanced family planning, HIV services, and maternity (delivery) services. Understaffing is a persistent challenge in Uganda, compounded by uneven distribution of health workers, which disadvantages rural health centers and facilities designated by the Ministry of Health as “hard to reach”.

Village Health Teams

In 2001, the Ministry of Health developed the Village Health Team (VHT) strategy to strengthen the delivery of health services at household level. By policy, each VHT should have 4–5 people selected by popular vote, with each team member serving 25–30 households. In Luganda-speaking districts of Uganda, it is common to

Figure 4. Drawing of Health Worker Vaccinating a Child



Credit: Mango Tree 2012 (commissioned by GOAL)

Figure 5. Couple Discussing Family Planning with a Health Worker



Credit: Mango Tree 2012 (commissioned by GOAL)

hear VHT members, who usually have minimal training, called “*musawo*” (doctor), which illustrates their power in social hierarchies. In practice, the primary role of VHTs is outreach and extension of services rather than a representational role in facility operations.⁴

Figure 6. VHT Member Community Outreach



Credit: Mango Tree 2012 (commissioned by GOAL)

Health Unit Management Committees

The 2001, the Government of Uganda established Health Unit Management Committees as a “bridge” between communities and health facilities, and their membership includes health workers and community members. By design, the Health Center In-Charge (the top-ranking staff member at each facility) serves as the Secretary of the Health Unit Management Committee, which is a relatively powerful role in the structure. From a governance perspective, some have noted that the hybrid Health Unit Management Committee structure that includes both health workers and citizens may limit the “oversight” role of the committees in practice (HEPS-Uganda 2015:26). The citizen members of these committees are, in many cases, appointed by local elected officials, rather than being elected by citizens, which means that their engagement becomes more an act of patronage than accountability. In an environment where there is limited awareness of the roles and responsibilities of these committees, they have limited functionality to serve both the bridging and oversight functions mandated to them (HEPS-Uganda 2015).

Administrative ambiguity impedes oversight and accountability

At the district level, a seven-member District Health Team (DHT) is supervised by the Chief Administrative

Officer (CAO). The DHT is mandated to participate in planning, budgeting, and monitoring of health service delivery. While oversight and accountability are challenges in all systems, deconcentrated systems often suffer from “dual subordination” where “lines of accountability can become confused where there are two hierarchies of professional and managerial staff” (Smith 1997). For example, a Health Center In-Charge is managed or supervised by multiple entities—the Health Unit Management Committee Chairperson, the Sub-county Chief (administrative appointee), and the District Health Officer (who reports to the centrally appointed Chief Administrative Officer)—but ultimate responsibility to reprimand poor performance lies with the District Service Commission. From the village to the district level, parallel structures (executive, legislative and technical) often have porous or overlapping mandates, and this administrative ambiguity creates space for abuse of authority and underperformance.

2.3. Invisible power and constricting civic space

Invisible power

Uganda’s “political culture and history had dictated obedience and deference towards people in positions of power and authority” and early opportunities for citizen participation did not erase memories of victimization by people in positions of power (Golooba-Mutebi 2005). King (2015) highlights the power dynamics embedded in norms and values “internalized by low-income groups and held by governance actors in relation to their own roles and their attitudes to low-income service users” (King 2015:898). Even when mandated for official government processes, “community participation” is frequently passive, with affected people consulted about pre-determined agendas, but rarely supported to advocate directly. CSO-led accountability work is prolific in Uganda, yet organizations and funders often underestimate the difficulties in chipping away at the “invisible power” that shapes the psychological and ideological boundaries of participation and the socialization which perpetuates existing power hierarchies (Veneklasen and Miller 2002; Gaventa 2006; King 2015).

Civil society landscape

Despite having a rich associational life characterized by affiliation with religious groups or self-help groups in communities, Uganda has few broad-based grassroots membership organizations or CSOs with strong civic constituencies (Selvaggio, Gariyo, and Oloya 2011). Formal CSOs have filled the civic space in Uganda, with approximately 11,500 registered CSOs (CIVICUS and FHRI 2016), many of which started supplementing service delivery in response to political violence—particularly the widespread disruption of life linked to the Lord’s Resistance Army activity in northern Uganda. The Ugandan government has welcomed CSOs engaged in service delivery, but maintained a negative perception of advocacy-oriented CSOs (Namisi 2009).

Constricting civic space

Two legal issuances, the Public Order Management Act of 2013 and the Non-Governmental Organizations Act of 2016, highlight shrinking civic space. The 2013 Act imposes restrictions on meetings and assemblies (CIVICUS and FHRI 2017). The 2016 Act imposes

detailed requirements for CSOs, including annual re-registration, allowing large discretion for the government-dominated review board to disaccredit CSOs (CIVICUS and FHRI 2016). Between 2012 and 2016, 24 CSOs had their offices broken into—particularly those working on “issues considered sensitive by authorities” (CIVICUS and FHRI 2017: 4). The government also shut down social media for multiple days around the February 2016 election, and imposed a “social media” tax with effect from July 2018, increasing the costs of communication between citizens. Days before the January 2021 presidential election, the Ugandan government shut off the internet (not just social media as in the 2016 elections).

Most recently, it has introduced curfews and restrictions on citizens’ movements as part of the COVID-19 response. The medium- to long-term consequences of this global pandemic will unfold over time, but there may be serious impacts on citizen and civil society organizing and ability to engage with government officials in Uganda and more broadly.



III. ACT Health Program Principles and Implementation




Key principles including the use of spaces, information, meaningful participation, collective voice, and multi-level action all appeared in the original 2012 theory of change. In early 2014, GOAL developed a frame called the “3 Rs” focusing on responsibility (health seeking behaviors in communities), responsiveness (of health workers to standards), and relationships (between health workers and community members). This balanced frame highlighted that all stakeholders have work to do to improve health. The touchstone principle of “people-centeredness” really came to life starting in 2015 with the planning for Phase 2 advocacy work. The CSO consortium’s conceptualization and application of the principles matured through joint reflection, planning, and practice.

The ACT Health strategy included both community-level activities and the people-centered advocacy work that supported citizens’ direct engagement with government officials up to the national level. The initial ACT Health strategy anticipated that community-level action would be *insufficient* to solve problems arising

from bottlenecks further up the system, beyond the control of communities or service providers. This established the principle of multi-level work within the ACT Health approach. UKAid supported the overall strategy—both the community-level RCT and the multi-level people-centered advocacy work in Phase 2. This arrangement appears unusual in project-based funding for social science research, where the bulk of the support is dedicated to the RCT study, with very limited funding for activities outside the scope of the formal research.⁵

This section highlights the evolution of the ACT Health guiding principles as practiced during implementation of the program’s two distinct phases: (1) community-level, information-led dialogues tested in the RCT; and (2) support to coordinated people-centered advocacy campaigns. **Table 2** contrasts the key features of each phase. **Table 3** presents the roles and responsibilities of CSO, citizens, and government officials in Phase 1 and Phase 2—the key difference is that in Phase 2, the people-centeredness put citizens in the advocacy agenda-setting role.

Figure 7. The “3 Rs” Frame for ACT Health: Responsibility, Responsiveness, and Relationships

Responsibility	Responsiveness	Relationships
Individuals and households have good health-seeking behavior. They seek preventive care (antenatal care, immunizations, testing, etc.) and go early for treatment of illness to avoid complications.	Health center staff use resources effectively and provide care as per Ministry of Health standards in the Uganda National Minimum Health Care Package.	Mutual understanding and trust between community members and health center staff. Includes better understanding of each other’s constraints and barriers.
		

Credits: Mango Tree, commissioned by GOAL in 2012.

Table 2. Key program elements of the ACT Health strategy in Phase 1 and Phase 2

Program elements	Phase 1 – community-level intervention	Phase 2 – support to advocacy campaigns
Timeframe	• 2014–2016	• 2016–2018
Scale	• 282 intervention health facilities	• 98 health facilities (selected from the 282 in Phase 1)
Level(s) of intervention	• 16 districts • Community-level (limited engagement of sub-county officials)	• 18 districts (due to administrative bifurcation during implementation) • Community, sub-county, district, and national levels
Main features	• Citizen report cards • Health worker meetings • Community member meetings • Dialogues (between community members and health workers) • Action plans for every intervention facility	• Training and accompaniment to 396 community advocates (39% women) • Accompaniment support included regular training sessions, workshops, mentorship, phone calls and review meetings • People-centered advocacy campaigns in 18 districts
Data / information on service provision	• Drawn from 2014 baseline survey • Provided by researchers as input to dialogues	• Generated and analyzed by community advocates as inputs to advocacy petitions
Degree of operational flexibility	• Very low due to the RCT	• Relatively high – iterative approach, adapting campaigns based on successes, failures and learning
Frequency of CSO staff contact with community members	• Every six months (light touch) • RCT design prevented contact with intervention communities between formal activities	• Four multi-day workshops for planning and analysis • Regular review meetings during campaign cycle • Phone contact between formal trainings and meetings
Government officials engaged	• Health workers • Local councilors I (elected) • Sub-county chiefs (administrative appointees) attended dialogues as <i>observers</i> • RCT design prevented district level officials from attending community-level dialogues	• Health workers • Local councilors I–IV (elected) • Sub-county chiefs (administrative appointees) • District Chief Administrative Officers (administrative appointees) • District Health Teams • Resident district commissioners (executive appointees) • Parliament of Uganda and several national line ministries and agencies
Horizontal organizing: collaboration/ organization of monitoring and advocacy across multiple health facility catchments	• Mobilized participants from 3 villages within the health facility catchment (due to RCT design)	• Intra-district: Active collaboration of citizens across multiple health center catchment areas for joint advocacy work in districts. In each district, a minimum of five health centers had active community advocates collaborating on a joint advocacy campaign • Inter-district: organizing of advocates from multiple districts to engage national level officials
Independent community-led monitoring of government service delivery	• Limited evidence of monitoring in between induced activities	• Robust direct monitoring by citizens to build evidence base for priority advocacy issue • Ongoing monitoring of change by citizens during advocacy campaigns • In most districts (almost half of the targeted catchment areas), community advocates collected data for ‘special campaigns’

Program elements	Phase 1 – community-level intervention	Phase 2 – support to advocacy campaigns
Monitoring, evaluation, and learning focus	<ul style="list-style-type: none"> Randomized control trial research (Innovations for Poverty Action under direction of principal investigators) Process monitoring (CSO consortium) Most Significant Change (2014-2016)⁶ 	<ul style="list-style-type: none"> Learning-by-doing (CSO consortium learning with community advocates) Primary documentation by community advocates (ie, commitment logs) CSO staff compiled process monitoring data On-going collection of empirical evidence (photos, letters, newspaper articles) Regular reflection in review/strategy meetings during advocacy campaigns Heat Map summary narratives of campaigns across 18 districts

Table 3. Roles of key stakeholder groups in the ACT Health strategy – Phase 1 and Phase 2

Key Stakeholders	Phase 1 – community-level intervention	Phase 2 – support to advocacy campaigns
Role of CSOs	<ul style="list-style-type: none"> Convening dialogues Facilitating dialogues (every six months) Documenting action-plan progress reported by participants in community-level dialogues 	<ul style="list-style-type: none"> Convening / training / mentorship / coaching in planning meetings Facilitating discussions about priorities for joint advocacy Advising on citizen monitoring and data collection strategy Assisting advocates' analysis of independent monitoring data Supporting community-led political economy analysis and advocacy targeting Assistance in planning advocacy campaigns Convening review meetings with advocates to discuss progress and strategy Supporting documentation of outcomes
Role of Citizens	<ul style="list-style-type: none"> Attending community-level dialogues Contributing to community-level action plans Follow-up on actions in between meetings Rating community-level action plan progress Selecting community advocates for Phase 2 	<ul style="list-style-type: none"> Setting advocacy agendas Monitoring government health facilities Political economy analysis Developing and carrying out iterative advocacy campaigns targeting village, parish, sub-county, district, and national-level government officials Learning-by-doing and adapting tactical approaches Reflecting, adapting, and documenting progress
Role of government health workers	<ul style="list-style-type: none"> Attending community-level dialogues Contributing to community-level action plans Follow-up on actions in between meetings Rating community-level action plan progress 	<ul style="list-style-type: none"> In 14 districts, community advocates monitored health workers attendance (ultimately majority of health workers came to see the value of direct engagement with advocates who had successfully brokered relationships with higher-level officials) In a few cases, community advocates collaborated with health workers to advocate for something of mutual benefit (ie, Manafwa / Namisindwa District advocacy to improve lighting / infrastructure in facilities)
Role of other government officials	<ul style="list-style-type: none"> Village, parish and sub-county officials invited to attend dialogues 	<ul style="list-style-type: none"> Sub-county officials in some districts (i.e., Katakwi and Manafwa/ Namisindwa) the key targets of advocacy asks District officials (elected, technical, and appointed) from all branches of government were direct targets of advocacy campaign asks National officials from parliament and line ministries received advocates

3.1. Principles guiding the ACT Health program

The working definition of accountability in the 2012 ACT Health strategy was that “someone has an obligation to meet certain commitments or standards, and if these are not met, there will be consequences” (Schnell and Coetzee 2010:9). The [original 2012 strategy](#) outlined several key building blocks and principles informing the work throughout the ACT Health program.⁷ These principles evolved as implementation progressed from the pilot to Phase 1 and Phase 2. The framing of the approach around the “3 R’s” of responsibility, responsiveness, and relationships (**Figure 7**) emerged from planning discussions in 2014. The people-centered advocacy principle came to life starting in 2015, with the participatory planning for Phase 2 (post RCT) activities.

Using spaces for state-society interface

The original 2012 ACT Health strategy built on changes in three domains: (1) within society (empowerment of individuals); (2) within the state (inclusive and responsive institutions); and (3) the state–society interface (“space” for participation and collective voice) (Fox 2004). While the combination of all three was theorized to increase accountability and responsiveness, ACT Health focused primarily on creating spaces for state–society interfaces. The strategy focused on use of “spaces” defined broadly as “opportunities, moments and channels where citizens can act to affect policies, discourses, decisions and relationships that affect their lives and interests” (Gaventa 2006:26).⁸ During Phase 1, the strategy focused on creating spaces via CSO-convened dialogues in communities, because the few government-invited spaces were often inaccessible or offered limited substantive agenda-setting opportunities for citizens. The theory anticipated that creating spaces for meaningful engagement between citizens and health workers could indirectly enhance citizen empowerment and strengthened implementation of state commitments to citizen participation. As Phase 2 began, the approach expanded to include planning on how to enter higher-level government-invited spaces, such as government budget planning meetings, to systematically advance advocacy agendas.

Information

For Phase 1, information (citizen report cards) was one input to a broader process of community-level dialogues between community members and health workers. Each citizen report card was specific to one health facility. The combination of objective information and facilitated dialogues was expected to foster mutual understanding, priority-setting, and joint problem-solving at the facility level. In Phase 2, community advocates collected their own monitoring information, analyzed the data, and used that evidence to inform their petitions and “asks” delivered to higher-level authorities. In contrast to citizen report cards based on data from one facility, in Phase 2 community advocates coordinated their independent monitoring and then consolidated and analyzed evidence from multiple health facilities to demonstrate the scale of problems and support their advocacy asks.

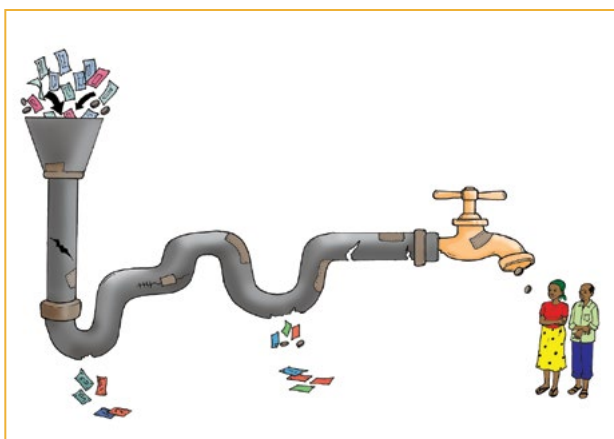
Meaningful participation

Tackling entrenched power dynamics, like those described in **Section 2.3**, requires deep and intentional focus. One key principle—participation—was informed by Sherry Arnstein’s Ladder of Participation, with three general levels (non-participation, degrees of tokenism, and degrees of citizen power). Informing citizens citizens of their rights and consulting them on predetermined issues may be steps toward participation, but Arnstein argued that does not necessarily foster negotiations between citizens and power-holders (Arnstein 1969:221). Despite many years of work around the world, much participation is passive (particularly in donor-funded projects and in government-created spaces). In Phase 1, the ACT Health program sought to create spaces for negotiation that would gradually shift the balance of power between citizens and power-holders. Program materials, CSO training, and ongoing mentorship focused heavily on maximizing participation in community-level dialogue spaces. In Phase 2, the explicit strategic focus was to ensure that community advocates were central to agenda-setting, and supported to directly engage government officials rather than having CSOs as intermediaries speaking for communities.

Organizing collective voice and multi-level action

The original strategy anticipated that community-level efforts would be insufficient to tackle issues beyond the mandate or authority of health workers or other local actors. Problems felt most acutely by citizens at the point of service are often caused by issues higher up the system. ACT Health materials used the image of a ‘leaky tap’ to illustrate this concept (see **Figure 8**). One early premise of the ACT Health program was that while additional resources are necessary to improve public services in under resourced settings, adding funds without fixing the weak points in the system may not improve the citizen experience of public services. In 2012, [Geoffrey Opio](#) (then GOAL ACT Health Manager) developed the ‘leaky tap’ concept to illustrate the bottlenecks and potential loss of precious resources.

Figure 8. The ‘leaky tap’ illustrates problems along public service provision pipeline



Credit: Mango Tree 2012 (commissioned by GOAL)

Given the entrenched power dynamics in Uganda, we hypothesized that horizontal organizing (convening citizens from multiple health centers) could catalyze collective voice (people’s ability to work together and exert influence). Coordinated citizen engagement (by citizens from multiple health facility catchments) with government officials beyond the point of service provision, would be necessary to trigger state responsiveness. These principles reflect the need for “citizen action

coordinated across territorial arenas (across districts and provinces) and levels (from local to subnational to national)” (Fox 2016:9).

During Phase 1 of ACT Health, the RCT design only allowed for mobilizing community members from three villages in each health center catchment area. The small number of villages was to minimize the “spill-over” between facilities assigned to different RCT treatment arms. In contrast, the approach in Phase 2 was to actively support **intra-district organizing** (bringing community members from at least five facility catchment areas together for joint advocacy) and ultimately **inter-district organizing** (organizing advocates across 14 districts) for national-level campaign activities. In Phase 1, the RCT design prohibited the multi-level approach whereas during Phase 2 advocacy campaigns explicitly targeted government officials across all 5 levels of Uganda’s governance system.

The “3 Rs”: Responsibility, Responsiveness, and Relationships

Accountability work is heavily relational, and power dynamics between citizens and the state manifest in day-to-day actions affecting health service delivery, utilization and, ultimately, health outcomes. Many social accountability interventions are designed to foster ‘collaborative’ problem-solving between government actors and community members, and ACT Health was no exception.⁹ In 2014, GOAL developed a framework to acknowledge relational complexities and emphasize shared accountability using the “3 Rs” of responsibility, responsiveness, and relationships (**Figure 7**). We defined each concept within the ACT Health approach—highlighting responsibilities of community members to seek health services, need for health facility responsiveness to citizens, and the importance of relationships between health workers and communities. The 3R’s emerged during the preparation for community-level activities under the RCT and it offered a balanced framing which created a safe starting point for citizens to engage power-holders—from health workers up to national officials. Feedback from CSO staff and government stakeholders throughout implementation indicated that government officials appreciated this balanced frame as a starting point for dialogue with citizens.

3.2. Phase 1 implementation: Information-led dialogues at community-level (with RCT)

The Power to the People research was rooted in the logic of the principal agent paradigm, testing the basic idea that “providing citizens with information about service delivery shortfalls, along with information allowing them to compare local outcomes with national standards and with outcomes in other communities, will put them in a position to monitor and apply pressure on underperforming service providers” (Raffler et al. 2019:2).¹⁰ Information in the form of citizen report cards (see **Box 1**) was a key input tested in both the Power to the People and ACT Health RCTs.

Implemented a decade after the original Power to the People research, the ACT Health RCT was more robust than the original RCT for two reasons: (1) its larger sample size; and (2) a factorial research design that tested multiple versions of the program.¹¹ Power to the People tested the intervention in 25 facilities, comparing findings against 25 “control” facilities, whereas the ACT Health RCT tested three different variations of the intervention in 282 health facility catchments. To understand what might drive detected effects, the ACT Health RCT tested two versions of the program with citizen report cards (the information component). In two versions, CSO staff facilitated meetings between community members and health workers, while one version of the program excluded these meetings. **Table 4** summarizes the combination of intervention components tested.

Table 4. Three Program Versions Tested in the ACT Health RCT (2014–2016)

Program version	Intervention elements			Sample size
	Citizen report card information	Health workers and community members met separately and generated “ <u>action plans</u> ”	Health workers and community members met together and generated a “ <u>social contract</u> ”	Number of health facilities
1 – Full program (modelled on Power to the People)	YES	YES	YES	92
2 – Interface only	NO	NO	YES	97
3 – Information only	YES	YES	NO	93
Total Intervention				282
4 – Control (no intervention)	NO	NO	NO	95
Intervention + Control				377

Source: Author’s summary based on research design

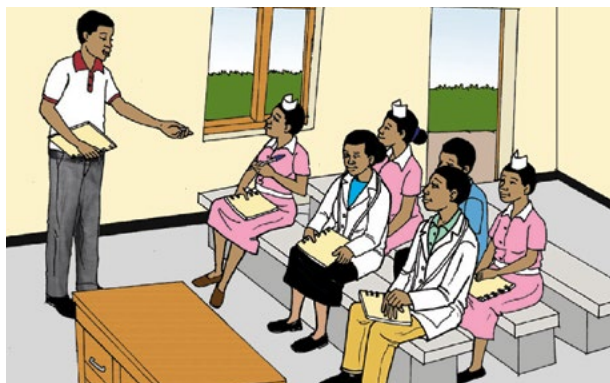
Because multiple treatment arms were implemented as part of the ACT Health RCT study, each had a [detailed protocol](#). This implementation description focuses on the “full program” version of ACT Health modeled on the original Power to the People intervention. The “full program” started with a series of three half-day dialogues:

1. **Health worker meeting:** CSO facilitators shared printed copies of [citizen report cards](#) (**Figure 15a**) and used a [series of large posters](#) (**Figures 15b and 15c**) to present data and encourage participants to discuss the data. Health workers identified priority issues they wanted to work on and actions they thought might help resolve the issues. Health workers developed an action plan to take into a meeting with community members.

2. **Community member meeting:** CSO facilitators shared printed copies of citizen report cards and used a series of large posters to present data and encourage participants to discuss the data as a group. Community members then split into multiple groups according to age and gender (older women, younger women, older men, and younger men) and each group came up with priority issues and actions. The sub-groups presented their priority issues in a plenary discussion for all participants. Participants then developed an action plan to take into a meeting with health workers.

3. **Dialogue between health workers and community members:** CSO facilitators convened health workers and community members (selected by participants in the community meeting) for dialogues. Community members and health workers both presented their respective action plans. All participants deliberated and identified the priorities from each plan that they wanted to include in the joint plan. In the program, this joint plan was called a “social contract” to differentiate it from an “action plan” developed exclusively by one group of stakeholders (either community or health workers). Each interface produced a mutually agreed social contract with approximately seven issues. Each issue had at least one action designed to mitigate the issue, with a person responsible, deadline, and measure of success to be reviewed in follow-up dialogues. See **Annex 2** for a sample 'social contract' from the program.

Figure 9. Health worker meeting



Credit: Mango Tree 2012 (commissioned by GOAL)

Figure 10. Community member meeting



Credit: Mango Tree 2012 (commissioned by GOAL)

Figure 11. Dialogue between health workers and community members



Credit: Mango Tree 2012 (commissioned by GOAL)

Figure 12. Meeting of Community Members and Health Workers (Phase 1)



This was an interface meeting (Phase 1) between community members and health workers in Busunga Health Centre II in Bundibugyo District. Credit: Jack Nyakairu

For each intervention facility, participants generated action plans in the initial dialogues. Participants kept their “action plans” or “social contracts” in the community or in the health center (depending on the agreement of participants). After the initial dialogues and action-planning sessions, CSO staff facilitated four rounds of follow-up at six-month intervals. Between February 2015 and November 2017, each follow-up dialogue centered on a few key activities:

- reviewing the progress on action plans/social contracts
- recording progress (as reported by health workers and citizens) rating issues and actions (achieved, partly achieved or not achieved)
- updating the action plans

Figure 13. Community Members Reviewing and Reporting on Action Plan Progress During a Follow-Up Meeting



Participants in a community-level follow-up dialogue in Kabarole District in 2016. Credit: Angela Bailey

Figure 14. Community-level Dialogue in Phase 1



A sub-county chief (standing) during a Phase 1 meeting of community members in Kijura Health Center III in Kabarole District. Credit: Jack Nyakairu

The implementation of multiple versions of the program by more than 30 facilitators (staff from four CSOs) across intervention areas demanded incredibly precise planning. The CSO staff worked in seven major languages spoken in the 16 districts and facilitated a total of 2,059 community-level dialogues in 282 health facility catchments. GOAL developed [detailed manuals](#) for each version of the program tested, then provided a two-week pre-intervention training for CSO facilitators. After the initial training, GOAL placed two staff (a monitoring officer and a mentor manager) with each CSO implementation team. GOAL staff supported planning, provided ongoing mentorship, observed activities and provided feedback to CSO officers within two days of the activity.¹²

The approach required incredibly detailed planning and significant thought leadership, technical support, and supervision throughout. The implementation was precisely timed to ensure that each treatment facility received the same “dose” (number of follow-ups) between the RCT data collection points (baseline, midline and endline—2014, 2015 and 2016 respectively). Each intervention health facility had a second and third follow-up dialogue between the midline and endline data collection. The fourth (and final) community-level dialogues took place after endline data collection. CSO officers documented all activities (and action plans) using standardized reports (more on this in **Section 4**).

Box 1. Citizen Report Cards in the ACT Health Program

A citizen report card is one of many tools used under the umbrella of “social accountability”. While references to citizen report cards are ubiquitous in the literature, the term has no standard definition. The citizen report cards developed for ACT Health were based on those used in the Power to the People research (Björkman and Svensson 2009).

Designing the citizen report cards. The citizen report cards used in ACT Health included various indicators aligned to Ugandan Ministry of Health standards ([see an example of a report card used by the program](#)). The indicators compared survey findings to the Ministry of Health standards in order to enhance transparency about facility performance vis-à-vis established standards. Based on 2014 Ministry of Health standards, ACT Health citizen report cards included information on: (1) health rights and responsibilities; (2) services available at the facility; (3) health facility general use patterns; (4) use of antenatal care and delivery services; (5) use of family planning services; (6) staff attendance; (7) drug availability; (8) user fees; and (9) satisfaction with waiting times, Health Unit Management Committees and the relationships between the community and health facility staff. The program used two different versions of the citizen report cards—one for Health Center II and one for Health Center III—because each level of facility provides slightly different package of services. Whenever possible, indicators were calculated using the same numerator and denominator as used by the Ministry of Health.

Data collection. From September to December 2014, enumerators hired by Innovations for Poverty Action (IPA) collected baseline information to calculate the indicators in the citizen report cards. The design of the ACT Health RCT called for independent researchers to collect the data (as opposed to having implementing organizations or community participants collect the data). The data sources included: (1) health facility staff interviews; (2) health facility spot checks (including attendance); (3) review of facility records (drug stock cards); and (4) catchment area surveys (including users and non-users of government health services). In total, enumerators conducted over 15,000 household surveys (45 per facility) and surveyed 377 health facilities. IPA staff collected data, cleaned it, and provided data for the standard set of citizen report card indicators to GOAL. GOAL staff then prepared a *unique* citizen report card for each of the 185 facilities randomly assigned to receive information as part of the community-level intervention tested in the RCT research.

Using citizen report card data to identify priorities for action. Citizen report cards (information) were a key input into a participatory dialogue process. Facilitators provided printed copies during meetings and used [a series of large, reusable posters](#) to display key indicators of facility performance and service utilization. In essence, the information was used to stimulate discussions between health workers and citizens on issues, to review performance vis-à-vis government standards, to collectively plan actions to address challenges, and to commit to carry out these actions. For many indicators, the data from households was juxtaposed against health facility responses (for example, how long citizens reported waiting versus how long staff reported that patients wait). For several indicators, the facility data were compared to district averages calculated using the baseline data from all facilities surveyed.

For a sense of this process, please see figure 15a, 15b, and 15c.

Figure 15a. Citizen Report Card Page on Drug Availability

This image is one page from citizen report card used in Phase 1 of the ACT Health project. This image highlights information about drug availability from community survey responses and health facility survey data.

What community says about drug availability

Household rating of drug availability

Household rating of drug availability at Lira Kato health Center	
Patients who received drugs at their last visit	92%
Drugs are <u>always</u> available	6%
Drugs are <u>sometimes</u> available	67%
Drugs are <u>rarely</u> available	27%

Do community members know when drugs are received?

Health issue	Households say	Health Center says
Do you know when drugs are delivered to Lira Kato health Center ?	33% yes	Yes, Lira Kato do distribute information on drug deliveries

Households reporting about the drugs they have

Average number of type/brands of drugs received per visit per person	2
Percentage of patients who say it was clearly explained how to take the drugs	77%

GOVERNMENT STANDARD = All six (6) items should be available at all times

Health Center reporting stock outs of the following tracer items in the last 3 months

1. Cotrimoxazole (CTX)	No
2. Artemether/Lumefantrine	Yes
3. Oral Rehydration salts (ORS)	Yes
4. Depo Provera	No
5. Measles Vaccine	No
6. Sulfadoxine and Pyrimethamine (SP)	No


Minimum standard drug storage conditions

Method in place to control temperature	Yes
Windows that can be opened or there are air vents	Yes
Direct sunlight cannot enter the area	Yes
Area is free from moisture	Yes
Cold storage in the healthCenter	Yes
Medicines are stored directly on the floor	No
There is no evidence of pests in the area	Yes

Figure 15b. Poster Used to Present Citizen Report Card Data in Community-Level Meetings

One of a [series of 13 large, reusable vinyl posters](#) used to display key citizen report card findings in community meetings. Facilitators would fill in the boxes with the data specific to a facility.


What community says about drug availability



%

--	--	--	--	--	--	--	--	--	--


Patients who received drugs at the last visit



%

--	--	--	--	--	--	--	--	--	--


Drugs are always available



%

--	--	--	--	--	--	--	--	--	--

Drugs are sometimes available




%

--	--	--	--	--	--	--	--	--	--

Drugs are rarely available

Do community members know when drugs are received?



%

--	--	--	--	--	--	--	--	--	--

Yes, we know when drugs are received

Figure 15c. Poster Used to Display Citizen Report Card Findings in Community-Level Meetings



This photograph depicts the use of large posters to display information from citizen report cards in community-level meetings. This photo is from the pilot work in Bugiri District in 2013 where a CSO staff member is putting information from citizen report cards onto the poster.

Credit: Geoff Opio

3.3. Phase 2 implementation: Accompaniment to people-centered advocacy campaigns

After Innovations for Poverty Action completed RCT endline data collection in 2016, the ACT Health implementing consortium continued into Phase 2 of the program: support to multi-level advocacy campaigns that placed citizens in the agenda-setting and action roles. The advocacy support work in Phase 2 included 98 health facilities (35 percent of the RCT facilities) across all intervention districts.¹³ ACT Health accompaniment and support to people-centered advocacy campaigns offers a stark contrast to the “light-touch” intervention tested by the RCT. Key features of Phase 2 included developing the people-centered advocacy definition as a touchstone, intra and inter-district organizing, and accompaniment to multi-level campaigns.

People-centeredness as a touchstone

People-centered advocacy focuses on expanding knowledge and skills to enable community advocates to directly engage government actors rather than having CSO staff “speak for” communities (Samuel 2002; Dewachter et al. 2018; Balestra et al. 2018).¹⁴ In Uganda, advocacy is often driven by formal CSOs that gather information and convey it to decision-makers, speaking for communities.¹⁵ The ACT Health program principle included supporting citizens to directly engage power-holders about priority issues facing their community. This shift required a significant amount of “unlearning” among all CSO staff to support people-centered advocacy (see **Box 2**). This began with a participatory workshop in March 2015 facilitated by an external advisor experienced in people-centered advocacy approaches in Uganda.¹⁶ The workshop culminated in the ACT Health consortium’s operational definition of people-centered advocacy:

“People-centered advocacy is a systematic process owned and led by those affected by an issue using evidence to influence people with power at different levels to make sustainable change in practices, policies, laws, programs, services, social norms and values for the betterment of those affected by the issues.”

This consensus-based definition guided the planning for the people-centered advocacy work. The planning evolved in a highly participatory way, as the community-level interventions and RCT were wrapping up. In 2015, GOAL tested a very preliminary version of materials for training and support to people-centered advocacy in Bugiri District (where the community-level intervention was piloted in 2013–2014). In 2016, the ACT Health implementing consortium began more intensive accompaniment of people-centered advocacy campaigns. The consortium initially focused on four districts, engaging all staff and community advocates in learning-by-doing. This learning fed into the updated processes, tools and resources used to scale up support to people-centered advocacy campaigns in 18 implementation districts.

Figure 16. Drawing of Community Meeting with Facilitator in the Background



Credit: Mango Tree 2012 (Commissioned by GOAL)

Horizontal organizing (intra-district and inter-district) for collective voice

Each district had a team of community advocates (between 20 and 32 people) representing a minimum of five health center catchment areas per district (a total of 98 health centers across the 18 districts). Throughout the planning and delivery of their campaigns, 396 community advocates worked across geographic boundaries to coordinate independent community monitoring of multiple health facilities to support collective voice and power vis-à-vis government officials. The horizontal organizing strategy in the advocacy phase had two elements:

- **Intra-district:** bringing community advocates from multiple health facility catchments within a district together for joint subnational (district) campaigns.
- **Inter-district:** bringing representatives of community advocates from multiple districts together for national campaign engagements.

Such organizing and collective action is costly for community members, as it involves transportation, communication, and time. It is also risky and challenging given the constricting civic space in Uganda. Multi-part participatory training sessions (**Annex 3**) also advanced the horizontal organizing because it allowed

community advocates time to build relationships based on joint problem analysis, agenda-setting, planning, monitoring of health services, data analysis, and advocacy engagements.

Intensive accompaniment to iterative multi-level campaigns

Support to community advocates included regular training sessions, workshops, mentorship, phone calls and review meetings.¹⁷ **Annex 3** summarizes the modules designed as multi-part practical, iterative training delivered over a period of 3–5 months. The Phase 2 training and mentorship focused on expanding community advocates' knowledge of government policies, structures, and mandates vis-à-vis their specific health advocacy campaign issues. After the trainings, the program supported regular review meetings for community advocates to support joint reflection and create space to problem-solve, re-strategize, and think about new ways to engage government officials, whether village or district officials, Members of Parliament (MPs) and other national-level officials. At a minimum, community advocates convened quarterly, but during peak campaign activity, many convened monthly to discuss the varying degrees of responsiveness from government officials at the health facility, village, sub-county and district levels.

This has provided only a brief overview of ACT Health activities after the RCT ended. We explain much more about community advocates' actions and their cycles of engagement with power-holders in **Section 6**, and trace patterns of government officials' responses in **Section 7**. For a flavor of a full advocacy campaign, see **Box 4 (Section 6.1)** on Katakwi District, which summarizes the people-centered advocacy campaign engagements.

Box 2. CSO Unlearning: Shifting Power to Change Development Practice

As practitioners, partners in the ACT Health implementing consortium were alert to the many practical challenges involved in supporting a people-centered advocacy approach, particularly in donor-funded intervention-based models. The internalization of power dynamics affects citizens, government officials and staff from civil society organizations (CSOs) alike. Thus, shifting advocacy agenda-setting power from CSOs to citizens was a huge lift.

Writing on social accountability initiatives in Uganda, King (2015) finds that such initiatives demonstrate “underestimations by staff and donors about the complexity and level of skill required for effective facilitation of transformational participatory methodologies, aimed at accumulating more power and influence for disadvantaged groups” (King 2015:895). Even with strong theory and ideological orientation to community-led agenda-setting and organizing, this is incredibly difficult to operationalize in the short term in a context like Uganda, where many CSO staff are skeptical of the willingness and ability of community advocates to directly engage government officials.

A significant amount of “unlearning” of more conventional intervention-based approaches was necessary along the way, with active learning-by-doing to push CSO staff into uncharted territory to truly shift agenda-setting to community advocates. In the case of ACT Health, strong principles guided the overall approach, yet constant mentorship and support from GOAL and external consultants was necessary to ensure adherence to these principles in practice.



IV. Data Sources

This section explains the major process monitoring tools used by the ACT Health consortium to monitor the outcomes of Phase 1 community-level dialogues and Phase 2 people-centered advocacy campaigns. For the community-level dialogues, the aggregated tracking of progress against action plans across 282 health facilities over the course of the five dialogues (initial and four follow-ups) in a bespoke database appears somewhat unique among the published literature. Tracking of 18 different advocacy campaigns provides for an interesting subnational comparison. This section describes the consolidation of the data, coding, and analytical review processes.

4.1. Phase 1 monitoring: Community-level intervention data (parallel to RCT)

GOAL designed standard process monitoring tools to systematically capture information across the 282 intervention health facilities. As noted in **Section 3.2**, the main documented output of community-level dialogues was an action plan with priority issues, actions to address the issue, responsible person(s), indicator of progress, and deadlines. After each community-level dialogue, CSO staff completed a one-page report with a summary of attendance (disaggregated by gender, age and type of participant—community member, health worker, Village Health Team member, sub-county observer, etc.) and brief notes on the dialogue (challenges, successes, etc.). During follow-up dialogues, community-level participants reviewed all issues and actions in the action plan and rated each as achieved (resolved), partially achieved (partially resolved), or not achieved (not resolved).

GOAL built a project management information system (MIS) based on the Ugandan Ministry of Health platform and staff entered data from the original action plans, action plan reviews, and dialogue reports into the MIS. The database includes progress ratings of **2,581** issues and **4,940** actions generated from dialogues in the **282** intervention health facilities. The scale of this process

monitoring appears unique in the literature. During follow-up dialogues, CSO facilitators probed for explanations and evidence to support each rating, which they captured in the activity report for entry into the database. The RCT design prevented CSO staff from having any contact with intervention communities between formal project dialogues, so participant reported progress during dialogues captures what we know about health worker and community actions in between project-induced dialogue meetings.

The ACT Health consortium used the coded database entries for all 282 intervention facilities to understand patterns and rates of resolution of actions and issues. GOAL staff coded all the issues and actions directly in the database according to 20 different themes (see **Annex 4**). GOAL staff also coded all issues according to broader domains of the “3 Rs” (responsibility, responsiveness, and relationships) (see **Figure 7**). After each round of follow-up dialogue was completed, coded MIS data was disaggregated and analyzed to identify any patterns related to:

- Health facility level—were rates of action/issue resolution different by level of facility (HCII versus HCIII)?
- RCT treatment arm—were rates of action/issue resolution different based on the specific intervention implemented?
- Type of issue—was there a difference in rate of resolution by type of issue?
- Person responsible—did some categories of actors (health workers, local leaders, community structures, community members) report higher/lower rates of achievement?
- Intervention district—did resolution of actions vary by district of implementation?

For cumulative analysis of issue frequency and participant-reported resolution by the final follow-up dialogue, see **Annex 4**. GOAL used this information for internal analysis, for joint reflection during consortium-wide review meetings, and for reports to funders. There was also a “feedback loop” to community advocates at

the beginning of district-level campaigns. Community advocates used the data on community-level progress as one input to the process of identifying priorities for advocacy with higher-level authorities.

4.2. Phase 2 monitoring: “Heat Map” tracking government responses to advocacy campaigns

The accompaniment and support offered to people-centered advocacy campaigns, although structured, was more iterative, and thus less conducive to standard monitoring tools than the standardized community-level intervention activities. Due to the highly relational nature of advocacy, tracing the direct causal impact of advocacy campaigns is challenging (Buffardi et al. 2017), yet vitally important. Each campaign had a monitoring plan – specifying what changes the advocates expected as a result of their engagements. The community advocates led all campaign engagements, using report formats such as commitment logs (**Annex 5**) to document contacts with government officials and record power-holders’ reactions, commitments and actions. During regular campaign review meetings, advocates discussed progress towards the *expected* changes. The data from commitment logs and other reports generated by community advocates fed into joint reflection and revision of advocacy strategies during community advocates’ regular (approximately monthly) campaign review meetings. CSO staff also kept their own records and documented their trainings, review meetings, and interactions with community advocates.

All these primary documents fed into a “Heat Map”, summarizing key actions of community advocates and reactions of government officials across all 18 districts. GOAL program director Elizabeth Allen designed the Heat Map as an internal monitoring and external reporting tool. The Heat Map combines primary documentation by advocates, data collected by advocates, facilitator notes from campaign review meetings, and ad hoc communications from CSO officers about campaign progress. GOAL produced a summary of the Heat Map at three points in time: December 2017, May

2018, and December 2018. The original Heat Map rated responsiveness of subnational government officials as red (non-responsive), yellow (commitments made) or green (commitments implemented). During the program, ACT Health staff used this consolidated, district-level information to understand how all 18 campaigns were evolving through their cycles of interaction between citizens and officials, changing and adapting the support they offered to community advocates as needed.

The December 2018 Heat Map was the starting point for Phase 2 analysis. For this paper, we reviewed the December 2018 Heat Map and the rankings of each district, returning to source documents to significantly expand the descriptions to capture all critical empirical details and key developments in all 18 district campaigns. The volume of documentation throughout Phase 2 was significant, but varied in consistency, level of detail and quality—phenomena well documented about the challenges of tracing impact of advocacy (Buffardi et al. 2017). To address the variable quality of documentation, all updates to the Heat Map for this analysis relied on significant triangulation across sources. Primary evidence—including photographs, newspaper articles, letters from government officials and other evidence—helped triangulate documentation from community advocates and CSO staff and are used throughout this paper to illustrate campaign dynamics and outcomes. In June of 2018, the authors conducted small focus groups with community advocates and interviews with government officials in three implementation districts. The lead author also completed an extensive interview with the CSO staff of one implementing partner organization. Triangulated against program records, the responses from advocates, government officials, and CSO staff were consistent with the program records, and they also contributed unique insights to the overall analysis. Finally, to capture campaign continuation after formal project support ended, the data include reports from community advocates (often in the form of WhatsApp messages, text messages or phone calls) received up to June 2019.



V. ACT Health RCT: Study of a Community-level Intervention

This section first presents analysis of participant-reported progress on issues and actions at the community-level based on program process monitoring data. It then reviews the limited findings of the ACT Health RCT, highlighting weaknesses in several measures used to assess outcomes—particularly the measure of “community monitoring”. While shedding light on the implementation of the community-level intervention, this section argues for a cautious interpretation of RCT findings.

5.1. Outcomes of community-level dialogues (from process monitoring)

Participation

At the beginning of the community-level intervention, CSO staff met the Local Council I (elected representative), the Health Facility In-Charge, and at least one Village Health Team member. CSO staff provided a “Community Mobilization List” and requested assistance from local leaders in mobilizing a diverse group of community members for dialogues. A total of 22,624 community participants and 1,158 health facility staff attended initial dialogues.¹⁸ Dialogues had an average of 80 community participants per meeting, which is high compared to contemporaneous interventions noting an average of 15–16 participants (Creighton et al. 2020:6). Program records traced participation of health workers against the number of staff assigned to facilities, finding that between 50 percent and 65 percent of assigned health workers attended each round of follow-up dialogues. Over 15,000 community participants (around half of them female) attended each of the four follow-up dialogues. Youth constituted 11 percent of participants in the follow-up dialogues. The RCT midline data collection (2015) found that 20 percent of household survey respondents had heard of the citizen report cards or community meetings (Raffler et al. 2019).

The RCT research design prevented inclusion of district-level government officials in dialogues, because the research was designed to exclusively test the impacts of community-level pressure applied directly on front-line service providers. The concern from researchers was the unpredictability of district-level officials’ treatment of health facilities assigned to different treatment arms. The study design did allow for the presence of sub-county-level officials (elected and administrative appointees) as observers to offer clarifications on government policy. As a result, 175 sub-county officials attended the initial dialogues, and an average of 90 attended each round of follow-up dialogue.

Participant reported progress on community-level issues and actions

Issues prioritized in community-level action plans:

Once the action plan data had been entered into the project MIS database, GOAL staff used standard guidelines to code all 2,581 issues included in 282 community-level action plans. Of the 2,581 issues, 47 percent related to the top five categories: absenteeism, access

Figure 17. Documenting Action Plan Progress

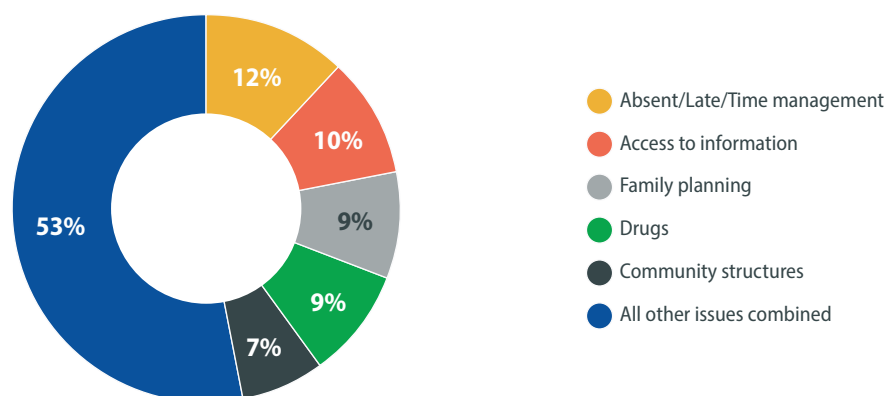


Community member documenting progress against the action plan during a follow-up dialogue in Phase 1 in Kabarole District. Credit: Kabarole Research and Resource Center.

to information, family planning, drugs, and community structures (**Figure 18**). For a full list of all issue codes, frequency of occurrence, and reported achievement rates see **Annex 4**. Staff coded all issues related to the “3 Rs” framing parameters (Relationships, Responsibility and

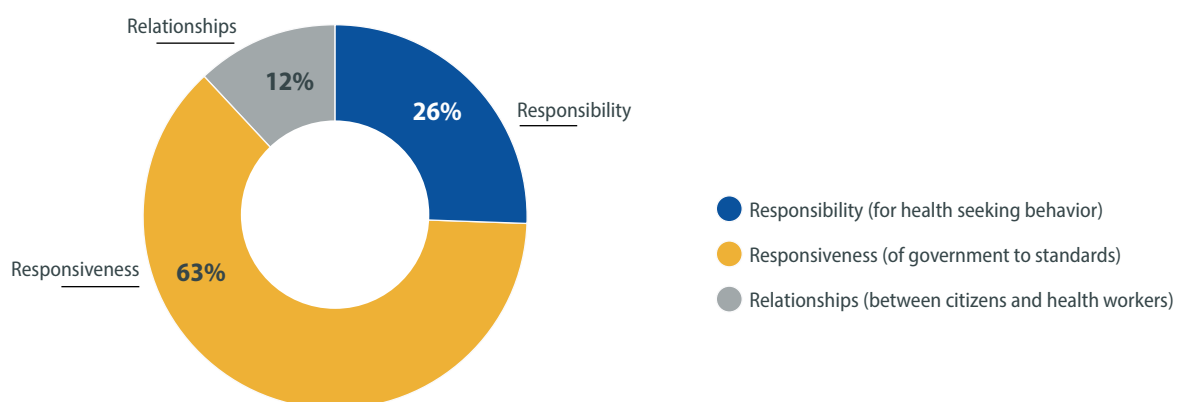
Responsiveness as per **Figure 7**) and found that 12 percent of issues related to relationships between community members and health workers, 26 percent of issues focused on citizen responsibility, and 63 percent were related to health system responsiveness (**Figure 19**).

Figure 18. Main Categories of Issues Included in Action Plans (ACT Health Phase 1)



Source: GOAL ACT Health Management Information System (MIS) database.

Figure 19. Issues Included in Action Plans Classified by Relationships, Responsibility, and Responsiveness (ACT Health Phase 1)



Source: GOAL ACT Health Management Information System (MIS) database.

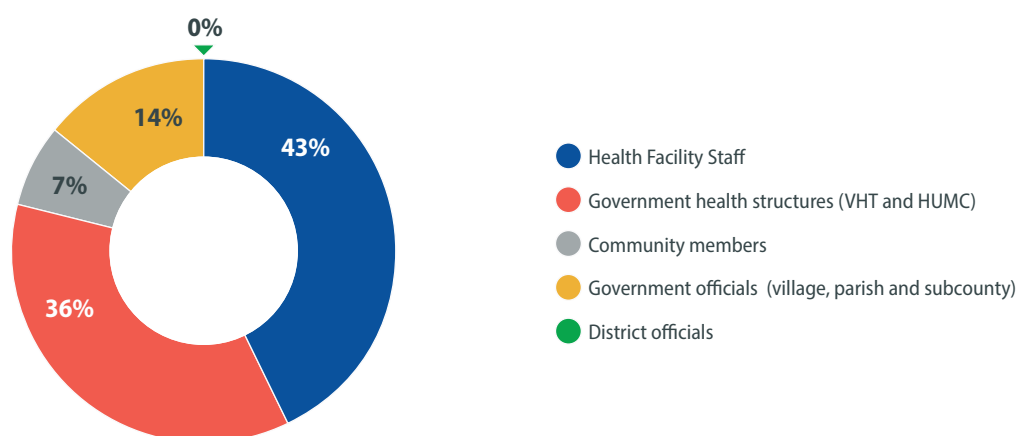
Responsibility for actions at the community level: Across the 282 intervention health facilities, dialogue participants committed to 4,940 “actions” to address priority issues identified. As per **Figure 20**, participants assigned 43 percent of all actions to health workers, 36 percent to government health structures

(Village Health Teams and Health Unit Management Committees), and 7 percent to other community members. Only 14 percent were assigned to other sub-national government officials (8 percent to village, 4 percent to sub-county, and 2 percent to parish officials). Across the intervention, participants assigned only 19

(out of 4,940) actions to district-level officials. There are two main complementary explanations for the low number of actions assigned to government officials above the community-level under the RCT: (1) district officials were not invited to attend community-level dialogues and sub-county officials attended primarily as observers; and (2) facilitation guidelines encouraged

assignment of responsibility for actions to those who were present in meetings (and district officials could not attend). In summary, since the RCT intervention precluded addressing service delivery agendas requiring the involvement of higher-levels officials, the action plans produced by the RCT's dialogue meetings did not focus on higher-level issues or decision-makers.

Figure 20. Assignment of Actions by Stakeholder Category (ACT Health Phase 1)



Source: GOAL ACT Health Management Information System (MIS) database.

Participant-reported progress on action plans by the fourth (final) follow-up dialogue: The project Management Information System (MIS) database and systematic coding enabled comparisons of reported progress across all 282 health facilities at four points in time. By the final round of follow-up dialogues, participants reported that 55 percent of actions and 74 percent of the issues were achieved (resolved) (**Table 5**).

Interestingly, absenteeism was the most frequently occurring issue in community-level action plans in Phase 1, with community-level participants reporting that 85 percent of the absenteeism issues had been resolved by the final follow-up dialogue. Despite this, many Phase 2 advocacy campaigns focused on absenteeism (**Section 6**).

Table 5. Participant Reported Progress on Community-level Issues and Actions (After 4 Follow-Up Dialogues)

	Total (#)	Achieved (resolved)	Partially achieved (partially resolved)	Not achieved (not resolved)
Issues	2,581	74%	12%	12%
Actions	4,940	55%	24%	21%
Absenteeism	301	85%	8%	4%

Source: GOAL ACT Health Management Information System (MIS) database.

5.2. Key findings of the ACT Health randomized control trial

The ACT Health RCT aimed to study the “strengths, limitations and operation of the causal pathway that P2P [Power to the People] popularized” (Raffler, Posner, and Parkerson 2019:3). The Power to the People pathway focused on information provision and dialogues between community members and health facility staff. As discussed in **Section 3.2**, the RCT replication drove many decisions about community-level activities in Phase 1.

The ACT Health RCT measured five main outcome indices: 1) utilization, 2) treatment quality, 3) patient satisfaction, 4) health outcomes, and 5) child mortality. It also measured seven intermediate outcomes: 1) citizen knowledge, 2) health center staff knowledge, 3) efficacy, 4) community responsibility, 5) community monitoring, 6) relationship between health care workers and the community, and 7) health center staff transparency. The key findings highlighted by the ACT Health RCT principal investigators (Raffler et. al. 2019) included:

- modest improvements in “treatment quality” and “patient satisfaction” (Raffler et. al. 2019), with improved drug availability driving the “treatment quality” improvements (page 19)
- no impacts on health facility utilization, or health outcomes such as weight for height/age among children aged 0–36 months, or child mortality, casting “doubt on the ability of information to generate community monitoring or improvements in bottom-line health outcomes” (page 4)
- “little evidence that the intervention caused citizens to increase their monitoring or sanctioning of health care workers” (page 4).

Understanding how the ACT Health RCT operationalized a few key indicators (community monitoring, treatment quality, and patient satisfaction) provides a nuanced understanding of the RCT findings.¹⁹ Critical analysis of these indices reveals several weaknesses that should inform any conclusions drawn from the RCT itself. Raffler et al. concluded that “top-down monitoring by government officials may be a more powerful tool for changing health workers’ behavior than bottom-up monitoring by citizens” (page 4). The RCT authors

interpreted the lack of impact on health outcomes as evidence of the weakness of “bottom-up accountability” efforts, yet their indicators measured neither monitoring or sanctioning of health care workers.

RCT indicators of “community monitoring”, “efficacy”, and “community responsibility”

Raffler et al.’s RCT used terms such as “bottom-up”, “pressure”, “citizen monitoring”, “monitoring”, “health worker behavior”, “provider behavior”, “information” and “top-down”, but many terms were underspecified or used interchangeably. In some ways, this reflects an implicit assumption that the external “intervention” (which focused on administering information) is the “community monitoring”. The more optimistic hope in theories of change for such approaches is that the “intervention” (dialogues) triggers additional oversight and monitoring by community members.

Given the centrality of “community monitoring” to the intervention tested in the RCT, it is useful to examine how the RCT researchers operationalized this intermediate outcome index. The ACT Health RCT community monitoring index includes four indicators (see **Table 6**). Two “community monitoring” indicators in the index measure hypotheticals about how household survey respondents “*think* engaged community members *would*” find out about health worker performance. Only one of the 12 indicators across these three indices addresses actual community monitoring (see indicator #2 under “community monitoring”). Based primarily on this “community monitoring” index, the ACT Health RCT found no evidence that the “intervention caused citizens to increase their monitoring or sanctioning of health care workers” (Raffler et al. 2019:4).

The researchers’ interpretation of the RCT data and broad conclusion about the general weakness of bottom-up monitoring is unsupported by weak measures of community monitoring. Based on these indicators, researchers did not measure any actual community monitoring, yet the title of their widely presented 2019 paper broadly declares that bottom-up monitoring is weak. A more appropriate inference would be that this intervention failed to trigger bottom-up monitoring, but the conclusion that bottom-up monitoring is inherently weak is unsubstantiated.

Table 6. ACT Health RCT Indices for “Efficacy”, “Community responsibility” and “Community monitoring”

“Efficacy” (intermediate outcome)	“Community responsibility” (intermediate outcome)	“Community monitoring” (intermediate outcome)
<ol style="list-style-type: none"> Whether household head <i>thinks</i> she has “a lot”/“some” power to improve quality of health care at local HC Whether household head <i>thinks</i> she would be able to pressure a health worker to exert better effort Whether household head <i>thinks</i> she would be able to pressure a health worker to report to work on time Whether household head <i>thinks</i> she has “a lot”/“some” influence in making village a better place to live Whether household head agrees that “people like you have a say about how the government provides health care to your community” Whether household head agrees that “people like you have a say about how health facilities provide health care to your community” 	<ol style="list-style-type: none"> Whether household head <i>thinks</i> she is responsible for making sure health workers come to work and provide high-quality health services Whether household head <i>thinks</i> community members are responsible for making sure health workers come to work and provide high-quality health services 	<ol style="list-style-type: none"> Whether household members report having attended [Local Council I] LCI meetings in the last year Whether household members who attended LCI meeting report that local health center was discussed Whether household members <i>think</i> engaged community members <i>would</i> find out if a health worker did not provide the effort that he/she should in caring for his/her patients Whether household members <i>think</i> engaged community members <i>would</i> find out if a health worker did not report for work

Source: Raffler et al. 2019: Appendix A

We now turn to an exploration of the people-centered advocacy campaigns supported in Phase 2, after the RCT had concluded. Here, it is useful to contrast the “community monitoring”, “efficacy” and “community responsibility” indices with a more robust definition of community monitoring and action: “the community is given the opportunity to participate in monitoring service delivery: observing and assessing providers’

performance to provide feedback to providers and politicians” (Molina et al. 2016:3). The work carried out by ACT Health in Phase 2 highlights the many ways that community advocates actively monitored and collected independent data to escalate issues to officials above and beyond the health facility, illustrating bottom-up monitoring which effectively triggered more top-down oversight and a range of state responses.



VI. Subnational Advocacy Campaigns: Citizen Actions and Outcomes

With the ACT Health RCT endline data collection complete, ACT Health moved into Phase 2, supporting multi-faceted, multi-level advocacy campaigns. Advocacy is rarely a linear process, and complex accountability relationships and power dynamics shift based on actions and responses. This highly iterative advocacy phase saw many cycles of engagement between community advocates and government officials. Iterative cycles of action and response are less commonly described and studied in the formal and grey literature on health accountability (Flores and Hernandez 2018; Hernandez et al. 2019).

Through training, mentorship and accompaniment, the ACT Health program supported community advocates to: organize across health facility catchments; identify priorities for joint advocacy; conduct coordinated and intensive monitoring of government facilities; and use the evidence they gathered to advance their own health advocacy campaigns targeting government officials at multiple levels. In what amounts to community-driven political economy analysis, community advocates mapped officials and targeted messages to strategic

allies and advocacy audiences. This section highlights the cycles of citizen action and government responses during the 18 subnational (district) campaigns. Phase 2 was implemented in the same districts where the RCT was conducted—supporting community advocates from 98 of the health facility catchments targeted in Phase 1. These campaigns used the community-level work of Phase 1 as a starting point, yet Phase 2 demonstrates more complex and iterative approaches to participatory governance than those tested in the community-level RCT. Community advocates began working in all districts by late 2016, and while formal ACT Health program support ended in May 2018, we continued to track progress and outcomes reported up to June 2019.

6.1. Bottom-up accountability: Citizen-led multi-level health advocacy campaigns

Community members defined criteria and identified community advocates

During the last round of Phase 1 community-level follow-up dialogues in the 98 health facilities, participants developed selection criteria and identified community advocates. Some common criteria across all the districts included: having good relationships with other members of the community; honesty and trustworthiness; ability to read and write; and ability and willingness to “*speak up and stand firm on matters that pain the community*” without fear. Lira District participants wanted advocates showing “*a love for other people*”. In Kabarole District, dialogue participants cited independence—defined as “*having no ties to a health center or public office*”—as a key selection criteria. In several districts, dialogue participants suggested that members of government structures (such as Village Health Team members and Health Unit Management Committee members) should not be selected as “community advocates” because they had not fully delivered on actions

Figure 21. Kagadi District Community Advocates



Group photo after the final PCA training. Kagadi District community advocates with CSO staff Hillary Kwesiga (Kabarole Research & Resource Center), Sarah Akampurira (GOAL Uganda), and Conrad Kahuma (GOAL Uganda)..
Credit: Fortunate Nyakahuma

they had committed to during Phase 1. Given the potential for such processes to be captured by elites (Gaventa and Barrett 2012; Joshi 2014; Schaaf et al. 2017), these selection criteria show the subtle ways that communities themselves can minimize elite capture.

Across 18 districts, dialogue participants selected 396 community advocates (39 percent female, 58 percent youth under 35 years). In an attempt to address the limits of their “representativeness”, each community advocate signed a pledge, agreeing “to provide continuous feedback to the community that sent them”. The pledge asked each community advocate to describe three civic spaces in which they would deliver that commitment (for example, giving feedback during religious services or community meetings).

Citizen-led problem analysis and agenda-setting

The people-centered advocacy approach prioritizes community members as agents of change capable of identifying and prioritizing their own problems/solutions (Hernandez et al. 2019; Gram, Daruwalla, and Osrin 2019). By design, the community-level intervention tested in the RCT encouraged local, low-cost actions to address health issues. Initial dialogues were a few hours long, so there was limited time to dig into the root causes of the issues. In Phase 2, the support to community advocates created space for much deeper problem analysis. CSO staff facilitated multi-day workshops to support community advocates to deliberate

and prioritize problems for collective advocacy to government officials beyond health workers and local leaders they had engaged in Phase 1. The database of issues/actions progress during community-level interventions was one input to this process, but the problem analysis was not limited to the data from Phase 1. This process is significant because it appears that relatively few studies explicitly enable citizens’ agenda-setting power (George et al. 2015:2).

In the advocacy agenda-setting meetings in Phase 2, advocates in 14 of the 18 districts identified “absenteeism, late coming and early departure of health facility staff” as the main concern. The 14 advocacy campaigns focused on this particularly complex and power-laden issue (see **Box 3**) feature heavily in this Working Paper. The campaigns in these districts varied, addressing the specific causes and effects that community advocates had identified. For example, in Bukedea District, advocates had identified limited staff accommodation at health facilities, and centered their advocacy asks around building staff housing for three facilities. Advocates in most districts specifically sought to trigger more robust oversight, monitoring, and corrective actions for health workers found systematically absent from duty.

Four of the 18 districts identified different priorities other than absenteeism for their advocacy work. **Annex 6** presents all 18 district-level campaign objectives in the words of community advocates. Campaigns in two districts in northern Uganda—Agago and

Figure 22. Excerpt from Citizen Report Card Poster on Staff Availability



Kitgum—focused on health facility understaffing. Community advocates in Manafwa/Namisindwa District campaigned to improve health facility electricity/lighting. In Katakwi District, community advocates decided to tackle issues of environmental degradation (see case study **Box 4**). Advocates in Katakwi originally identified absenteeism as a priority issue, but after

initial monitoring and consultations with more community members, they decided that lax enforcement of policies to mitigate environmental degradation were a more urgent concern. The Katakwi District campaign highlights the flexibility embedded in the people-centered agenda-setting approach.

Box 3. Absenteeism: A “Wicked Problem” and Complex Advocacy Agenda

Health worker absenteeism in Uganda is a complex issue to ‘solve’ because it emanates from multiple systemic weaknesses beyond the ability of community members to address. When ACT Health was designed in 2012, health worker absenteeism was identified as the biggest source of leakage in the sector, estimated to cost \$10 million per year (Okwero et al. 2010:47). Absenteeism is often driven by dissatisfaction or insufficient resource support from the broader health system. Human resources for health—including often opaque systems for posting and transfer and absenteeism—are very challenging to address (Sheikh et al. 2015). In real terms, absenteeism is an everyday abuse of power felt most directly by citizens who cannot access government services as a result.

Uganda has several laws and policies designed to prevent and address absenteeism, yet implementation falters. Several studies have explored the systemic drivers of low motivation and poor work attendance of public servants. What has been missing from the studies and policy debates are the voices of citizens who are most affected by absenteeism (Ntulo 2017). The Chief Administrative Officer of one district explained “... to have a strong evidence that pins absentee health workers, we would require people like you our partners to give us data from your dialogues which indicates which health worker is absent. We would also need the sub county to provide reports from their support supervision clearly pinning the health workers who are absent but this is not consistently done” (Ntulo 2017).

The most frequently occurring issue in Phase 1 action plans was absenteeism, including late-coming and early departure (which affect health facility operating hours but are even more difficult to track through standard top-down monitoring and measures of absenteeism). Community-level dialogue participants reported that 85 percent of the absenteeism issues were achieved (resolved) by the fourth and final dialogue in Phase 1 (see **Table 5**). Unfortunately, there are no findings specific to the discrete indicator of absenteeism as reported in the RCT paper (Raffler et al. 2019), as “absenteeism” is wrapped into the “treatment quality” index used by principal investigators. Despite reporting that 85 percent of the absenteeism issues were “resolved” through community-level actions in Phase 1, 14 of 18 community advocates’ campaigns in Phase 2 continued to focus on absenteeism and late-coming because these issues had clearly persisted.

The issue of health worker absenteeism is a particularly difficult issue to tackle from the bottom up because of how complex webs of power and interest intersect. Yet the bottom-up monitoring may bring to bear the most concrete and specific evidence of daily absenteeism. The cycles of citizen action and iterative engagements with government officials highlight the intractability of this type of issue. It is important that so many community advocates focused their advocacy campaigns on such a “wicked” problem, and their campaign successes must be interpreted through this lens.

Independent community monitoring of government services

In contrast to the RCT's community-level dialogues which used externally produced citizen report cards, community advocates collected their own monitoring data to build and advance their agendas in Phase 2. Advocates worked through initial fears and embraced the process of collecting data, organizing information, and analyzing evidence. With their issues identified, advocates first decided *what* evidence to collect and *how* to collect it. Advocates coordinated monitoring of multiple facilities in each district as part of their joint data collection efforts. Advocates focusing on absenteeism monitored health worker attendance for a minimum of 14 days (in Mubende District advocates monitored 7 facilities for 30 days each). One by one, day after day, advocates went to facilities and collected detailed information: staff names, titles, arrival times, and departure times. In contrast to the RCT's weak measure of "community monitoring" (Section 5.2), community advocates' direct monitoring aligns with a broader definition, wherein "the community is given the opportunity to participate in monitoring service delivery: observing and assessing providers' performance to provide feedback to providers and politicians" (Molina et al. 2016:3).

While most community advocates had engaged with health workers during Phase 1 dialogues, these early monitoring efforts in Phase 2 put health workers "on notice" of intentions to take concerns to higher-level officials. Many Health Center In-Charges were initially

dismissive, asking community advocates **"Who do you think you are? Do you want to become our supervisors? We don't even know you!"**. These comments reflect the broad powers health workers have over community members. Community advocates went to monitor facilities expecting resistance and challenges—which they had prepared for using role plays during the training and planning. See **Section 7.2** for a description of 'backlash' and changing accountability dynamics experienced during the Phase 2 of the program.

"We used different tactics. We asked the Village Health Team (VHT) members to help us get the names, qualifications, and duties of staff. We had to explain that we are not working for any organization, but for the community."

Pader District community advocate, February 2018

During their independent monitoring, advocates experimented with different tactics to obtain the information they sought (as per quote from the Pader District community advocate). In addition to highlighting the creative tactics employed to access information, this quote illustrates a degree of ownership over the campaign. The advocate's assurance that they were acting on behalf of the community may have been directed to government stakeholders skeptical of CSOs.

Figure 23. Community Advocates During a Campaign Review Meeting (Phase 2)



During a people-centered advocacy review meeting in Omoro District, a community advocate reports on the progress made in their health center as a result of the advocacy work on absenteeism. Credit: Jackson Bagabirwa, GOAL Uganda

Box 4. Case Study of Advocacy for Implementation of Environmental Laws in Katakwi District

The people-centered advocacy cycle in Katakwi District was unique. Advocates originally wanted to work on absenteeism, but pivoted to environmental issues which they linked to poor health and nutrition outcomes. The Katakwi experience illustrates: 1) the extent to which advocates set their own agendas and 2) the flexibility of a learning-by-doing and adaptative approach to support advocates' strategic preferences.

Katakwi community advocates originally wanted to work on absenteeism, in line with 14 other districts. When community advocates initially monitored health facilities, they found that health workers generally reported for work and left work on time. In early 2017, the African Medical and Research Foundation (AMREF), a civil society organization, had recognized Katakwi District with an award for improvements in the health sector.

Community advocates then held feedback meetings in community spaces and shared the monitoring data. Satisfied that absenteeism and late-coming were *not* the priority issues, they pivoted to another pressing problem: charcoal burning. Charcoal burning negatively impacts forest cover, which poses environmental and human health risks. Advocates linked recent deaths in the district to persistent drought, water access, and food production challenges that are exacerbated by deforestation.

Community advocates focused their campaign on better implementation of existing environmental laws. They collected additional evidence to demonstrate the magnitude of environmental health issues. CSO staff helped advocates identify relevant standards to enrich the advocacy campaign. Community advocates invoked the National Environment Management Policy of 1994, the Katakwi District ordinance against transportation of commercial charcoal, and the National Forestry and Tree Planting Act 2003. Analysis revealed that the Katakwi District's 2016 Executive Committee Resolution to limit charcoal burning and selling recommended: (1) one to five bags be allowed to be transported; (2) no exporting of charcoal outside the district; and (3) any person found with more than five bags of charcoal would be charged 20,000 Ugandan shillings (UGX) per bag.

"In the month of July 2017 in five Sub-Counties of Palam, Katakwi, Magoro, Kapujan and Ongongonja it was found that twenty wetlands were destroyed in the last ten years. We also found out that, there was uncontrolled burning and selling of charcoal. The destruction of the forest cover is mainly because of the poor implementation of District ordinance as per the provisions of the Executive Committee resolution under minute No.4/2016 and the National Forestry and Tree Planting Act 2003 Article 14.1.2. Whereas the management of forests is decentralized; out of the 5 Sub-Counties, only 2 Sub-Counties have a by-law on tree cutting. The environmental degradation has led to food insecurity, drought and floods. On the 9th June, 2017 one child from Kokorio Parish, Kapujan Sub-County died as a result of starvation and in the same month of June, 2017, an HIV-positive old man from Ajamaka village, Magoro Parish, Magoro Sub-County also died as a result of starvation. In May 2017 the people of Toroma peacefully demonstrated and marched up to the district headquarters because of hitting famine."

Source: Katakwi Community Advocates Monitoring Data Report (excerpt)

Based on this monitoring work and policy analysis, Katakwi advocates set their advocacy goal: "By August 2018, there will be controlled tree cutting, charcoal burning and sale in the district because of proper implementation of environmental laws in Katakwi District". This informed a broad set of campaign objectives:

1. The Chief Administrative Officer to strengthen supervision of technical staff charged with implementing environmental-related laws in Katakwi.
2. The Chief Administrative Officer to recommend reprimand of those staff who do not implement the District Council resolution.

3. The District Police Commissioner to ensure that police arrest, investigate and forward all culprits who do not adhere to the environment policies for prosecution as guided by the National Policy for Disaster Management 2010.
4. The District Forest Officer to ensure that all the culprits who are working against the district resolution on charcoal burning and sale are forwarded to police for further action.
5. The District Production Officer to closely oversee production activities in the district to ensure they are environmentally friendly.
6. The District Production Officer to establish functional parish committees that will sensitize communities on appropriate agro-technologies.
7. The District Council to pass a resolution to reprimand technical staff who do not implement district resolutions on charcoal burning and sale.

Katakwi community advocates regularly monitored the police checkpoints across four sub-counties most affected by illegal charcoal burning. They delivered their petition first to the district police chief, who introduced them to the sub-county police commanders as allies. When advocates saw trucks, they would alert police. During about six months of monitoring, advocates noticed that police were taking bribes and letting trucks go (rather than impounding them)—and flagged this during a campaign review meeting. When advocates found that sub-county officials were slow to reprimand trucks transporting charcoal, they signaled this non-enforcement to district officials. The District Executive Committee called for a meeting with multiple district and sub-county officials about the resolution on charcoal burning. During the meeting, community advocates learned that some sub-county officials had never been sensitized about the resolution, which contributed to non-implementation and non-enforcement.

In 11 months of their campaign from April 2017 to February 2018, Katakwi District community advocates reported reaching more than 2,000 community members in their feedback meetings.

Community forum	Number of participants		Total
	Female	Male	
Churches	1,139	519	1,658
Village Saving and Loan Association group meetings	320	160	480
Karuma drinking joint	9	30	39
Total	1,468	709	2,177

Source: Katakwi District community advocates records.

About 12 months after launching their campaign, community advocates reported that the district had collected 7 million UGX (approximately \$2,000). In early 2018, Katakwi advocates documented more challenges, including: (1) lack of guidelines on use of revenues from fines; (2) the suspected involvement of some police and the District Forest Officer, who did not respond to community advocates' calls to investigate trucks that had been observed transporting charcoal; and (3) uneven coordination between sub-county and district officials. Even as progress was documented in terms of stopping trucks and issuing fines, new questions about how those funds were accounted for arose—which community advocates were well positioned to monitor.

This campaign illustrates the iterative cycles of interaction between community advocates' "asks" and sub-county and district officials' responses, bridging gaps between the two levels that had previously contributed to lax enforcement of regulations designed to protect people's health.

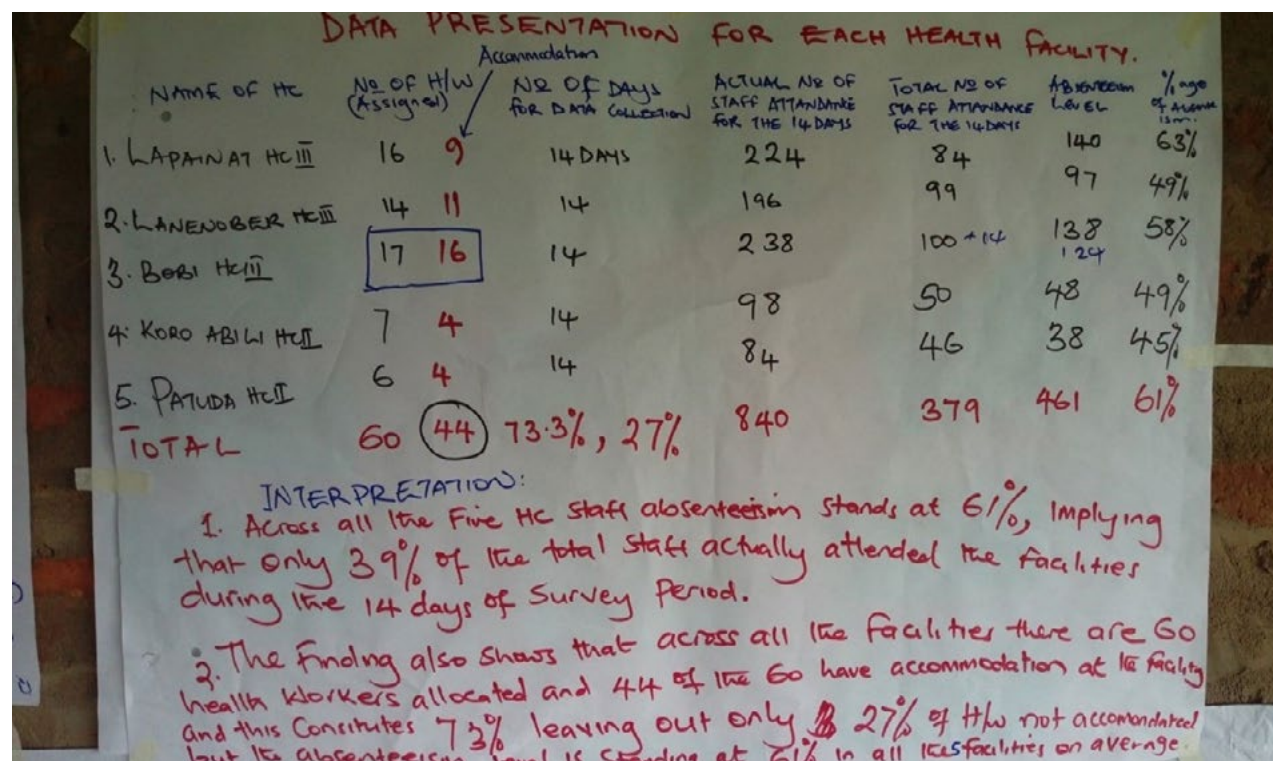
Advocates combined monitoring data from multiple facilities (Figure 25) and documented stories about the effects of staff absences on patients to demonstrate the magnitude of the problem. After the initial coordinated monitoring efforts, CSO staff coached advocates through compiling information from multiple health centers to calculate summaries, averages and percentages of on-time arrivals/departures. Community advocates' intensive monitoring in health facilities provided more realistic data than sporadic government supervision visits and staff record books, which are prone to abuse. Independent monitoring data also enabled advocates' petitions to go beyond general statements such as "health workers do not come to work". The extensive details made it very clear to government officials that the advocacy petitions were backed by significant monitoring efforts by community advocates. Advocates' reports also highlighted the limitations of existing monitoring practices for health worker attendance. For more on how government stakeholders received and acted on these petitions, see Section 7.2.

Figure 24. Excerpt from Lira District Advocacy Petition

"The evidence collected by community advocates in Lira district confirmed that patients were waiting for long hours to get treatment and some were missing treatment as a result. We found out that 85% of Health Centre staffs arrive late and leave duty early; on average at 10:34am and depart at 4:23pm. There are 81 staff employed in the health centre staff covered by the community advocates. We found 81 staff houses available in the six health facilities, but staff lived in only 41 of them. Examples in Ongica HC III, staff are sleeping in 13/16 houses, Barapwo HC III, staff are sleeping in 5/14 houses, Barr HC III, staff are sleeping in 9/14 houses, Anyangatir HC III, staff are sleeping in 2/12 houses and in Akangi HC II, staff are sleeping in 6/7 houses."

Source: Excerpt from Lira District Advocacy Petition

Figure 25. Community Advocates Compiled their Data from Monitoring Five Health Facilities



This image captures the data compiled by community advocates who systematically coordinated their monitoring of health worker attendance in five public health facilities in Omoro District. After data collection, community advocates convened with their primary data and CSO staff helped them to compile all their data for analysis. The detailed monitoring data anchored petitions and asks to government officials. Credit: Robert Ofiti, HEPS-Uganda

The process of gathering their own evidence instilled confidence and propelled advocates' campaigns. During the people-centered advocacy phase, monitoring was not a "one-off" exercise. Advocates collected evidence to monitor the progress with their advocacy issue throughout their campaigns. Towards the end of the UKAid funded program (March – April 2018), advocates from all the districts carried out a round of evidence collection to determine overall progress on their priority issues. In a sign of positive spillover effects, advocates in at least **seven** districts identified additional issues for advocacy and collected evidence to inform new / special campaigns (see below).²⁰ Some existing literature highlights the two-fold benefits of community-driven data collection observed in ACT Health: (1) community data collection is in itself an empowering process (Hernandez et al. 2018); and (2) citizen involvement can increase the credibility and reliability of data in the eyes of external officials (Joshi 2014; Flores 2018; Flores and Hernandez 2018).

Support to community-led political economy analysis

In Phase 2 of the ACT Health program, workshops for advocates focused on how health system decisions are made, which helped direct the advocates' work to engage government officials across multiple levels. Through a series of training sessions and interactions with CSO staff, community advocates learned details of government actor and agency mandates specific to their advocacy issues. CSO staff facilitated discussions about mandates of duty-bearers and those with influence over power-holders. Each group of community advocates mapped various authorities and influencers for each district campaign. This is a form of community-led political economy analysis, tapping community advocates' knowledge about institutional and individual power structures at subnational levels.

Community advocates planned campaigns targeting officials at village, sub-county, district, and national levels, using the data they had collected and analyzed. Throughout this process, CSO staff supported access to, interpretation of, and advice on integrating government policies and standards in petitions to duty-bearers. Community advocates crafted a series of tailored messages and petitions directed to a range of higher-level

officials based on targets' levels of authority and influence. Advocates also planned and designed campaigns based on deep contextual knowledge surfaced through training workshops and on-going accompaniment. As campaigns progressed, the advocates learned much more about the dynamics of power, influence and relationships between officials in their districts, using that new knowledge to adapt future actions.

The nature of the priority advocacy issue drove the community advocates' strategy—including which officials to target with their campaign asks. On the easier side of the spectrum, community advocates in Manafwa/ Namisindwa District focused on improving lighting/electricity infrastructure. The decision-space for resource allocation was within the remit of sub-county authorities. Sub-county officials responded positively and followed through on commitments, so advocates did not need to elevate their advocacy asks to district-level officials. Absenteeism is a much more intractable, power-laden issue (see **Box 3**). Absenteeism campaigns (in 14 of the 18 districts) revealed that district officials wielded more real power than sub-county officials, particularly because health workers are hired at the district level and see themselves as primarily answerable to district officials (upward accountability). In this very hierarchical system, many sub-county officials avoided 'sticky issues', preferring that punitive action is initiated by more senior officials. This illustrates the need for direct engagement of higher-level officials—something that was not possible in the intervention tested in Phase 1, which explicitly prevented district-level officials from participating in community meetings or otherwise hearing community demands directly.

Building advocates' civic knowledge of policy and decision-making (both *de jure* and *de facto*) and expanding their skills to directly engage officials can foster the emergence of democratic citizenship (Gaventa and Barrett 2012). While this may not link directly to sectoral outcomes in the short term, many argue that political learning, capabilities and the exercise of citizenship are important for more transformational longer-term change (King 2015; George et al. 2015; Schaaf et al. 2017; Balestra et al. 2018; Hernandez et al. 2019). In the Ugandan context, Namisi has described raising "civic competence" as "reawakening the sleeping giant" of a disempowered population (2009:129).

Mobilizing collective action and resources

Community advocates viewed themselves as the leaders and drivers of the campaigns for change and did a significant amount of organizing in between advocacy training sessions (see **Annex 3**). Throughout the campaign cycle, advocates held feedback meetings with others in their communities to solicit opinions and inputs, build consensus on the strategy, advance collective voice, share campaign progress, and re-strategize. This promoted accountability of advocates to their wider communities and helped mobilize others to join the campaign actions of trained advocates.

In Phase 2, the ACT Health program funded sessions for training and review, but did not provide any material incentives (money, supplies, transport, identification cards, t-shirts, etc.) to community advocates to execute their campaigns. This is very uncommon in Uganda (Ekirapa-Kiracho, Apolot, and Kiwanuka 2018), particularly in donor-funded projects. Across all 18 districts, community advocates used their own resources and mobilized money and in-kind support from community members and allies to implement district campaigns (see **Figure 26**).

Figure 26. Examples of Resources Mobilized by Community Advocates for District Campaigns

In Bundibugyo District, six community members joined community advocates in going to the district offices to deliver advocacy messages to duty-bearers.

In Gulu, some groups, including “Aneno Anyim” Village Saving and Loans Association (VSLA), gave financial contributions to facilitate the community advocates’ transport during follow-up visits to follow-up on commitments from district officials.

Various individuals (in Agago District, Otto Yakobo (a retired teacher), Komakech Mike and Nyeko Christopher; in Lamwo District, Nyeko Nelson; and in Bundibugyo District, Abudu Kahamba) gave bicycles and motorbikes to community advocates to enable them to implement their action plans.

Richard, an additional ally from Acuru District, provided community advocates with airtime for 2,000 UGX only for communication during follow-up of the advocacy petitions sent to district offices.

Some media houses publicized advocacy campaigns through radio talk shows in Agago District, recordings in Bundibugyo and Kabarole districts, and in newspapers, at no cost.

Source: ACT Health Consortium Participatory Data Analysis session April 2018

The district-level campaigns were organic, and bottom-up accountability efforts took off without any CSO funding. Two strong examples illustrate the potential of community-led efforts to mobilize broader community action without CSO financing. Advocates in Apac District mobilized 500 signatures on a petition to successfully prevent the transfer of a popular and well-liked Health Center In-Charge from Alado HCII. In Bundibugyo District, an estimated 130 community members delivered petitions to duty-bearers through a community march. Advocates from this district recalled: “We came to meet duty bearers, it was raining heavily but we still came. Hunger and transport are other challenges. For some allies, we the CAs [community advocates] transported them when we stormed the district.” (community advocate,

interview, Bundibugyo, June 2018). This collective action—significant for the Uganda context—received independent media coverage in one of Uganda’s leading daily newspapers, *The New Vision* (**Figure 27**). This march exemplifies community advocates creating new space to engage government officials. Neither CSO staff nor the supporting organization are mentioned in the newspaper article. The collective action in Apac highlights broad community collaboration in support of a health worker. The Bundibugyo advocates’ action is one of a series of actions demonstrating mounting pressure from community level. These robust examples of bottom-up accountability and pressure captured in Phase 2 process monitoring, offer more compelling evidence than the weak proxies deployed in the ACT Health RCT.

Figure 27. Independent Media Coverage of Delivery of Advocacy Petition in Bundibugyo District



It is important to understand the success of community advocates' local resource mobilization in the Ugandan context, in which induced participation in projectized approaches renders more organic coalition-building and organizing very challenging. Self-mobilization and self-financing propelled community advocates' activities after the program funding ended in May 2018. As of June 2019, community advocates had continued to work in multiple districts. This is a positive outcome and a modestly hopeful sign, given that volunteer fatigue and sustainability of processes are cited as key challenges in citizen-led accountability work (Schaaf et al. 2017; Danhondo et al. 2018; Future Health Systems 2016).

Claiming and creating spaces with creativity and tenacity

Community advocates' campaign strategies accounted for the complexity of Uganda's multiple levels of governance by starting with the officials most accessible to them. Community advocates often started campaign engagements with appeals to village elected leaders (Local Council I (LCIs)). LCIs were more inclined to lend their moral support to community advocates than to directly petition those above them in the governance hierarchy. Sub-county advocacy targets included elected chairpersons (Local Council III—LCIII) and chiefs (administrative appointees). At the district level, community advocates targeted a combination of officials including Resident District Commissioners (RDCs), elected district council (Local Council V (LCV)) members, Chief Administrative Officers (CAOs), District Health Offices (DHOs), and District Service Commissions (DSCs). See **Annex 1** for an overview of government mandates.

Across **18** districts, meeting higher-level officials proved challenging for community advocates. When duty-bearers cancelled or forgot appointments, this frustrated advocates who had often travelled long distances to district headquarters using their own resources. In some districts, officials asked community advocates: **"Who sent you? Who is financing your activities? Who gave you the powers to supervise the work of health workers?"** In addition to reflecting government officials' power over citizens, such questions highlight the skeptical perception that citizens cannot act without civil society support. Because of the power hierarchies involved, higher-level officials often asked what actions were taken before their office was approached. Community advocates routinely leveraged prior engagements (including actions during the RCT intervention) with health facility and sub-county officials to secure more credibility with higher-level officials.

Community advocates also engaged with government-invited spaces, including sub-county and district annual budget conferences and district council meetings where citizens can, in theory, directly access leaders. The Ministry of Finance, Planning and Economic Development holds annual budget consultative meetings for districts to account for prior year expenditures and plan priorities for the next financial year. While

invited spaces mandate citizen participation, they may be inaccessible to ordinary members of the community, be occupied by representatives of formal CSOs, or remain somewhat tokenistic/unresponsive in practice (Gaventa and Barrett 2012; Flores and Hernandez 2018). As campaigns evolved, increasingly savvy, skilled, and emboldened community advocates engaged governmental spaces such as district council meetings, budget meetings and conferences organized by the Ministry of Finance.

In their work, advocates generally found that budgeting processes allocate meagre resources for District Health Management Teams (DHMT) to fulfill their supervisory mandate. Advocates identified this as one cause of failure to monitor and support lower-level health facilities. According to program records, community advocates brought direct community input to 66 sub-county budget conferences, 17 district budget conferences and 7 regional budget consultative workshops. To reach above the district level, ACT Health worked with Uganda's Civil Society Budget Advocacy Group (CSBAG)²¹ to secure invitations for community advocates from 18 districts to attend the annual regional budget consultative meetings to amplify their campaign asks.

While GOAL supported advocates to attend at regional budget consultative workshops, at district and sub-county level, advocates secured their own invitations to attend budget conferences to follow up the budget allocations related to their priority advocacy issue.

As well as engaging in official spaces, community advocates repeatedly claimed and created new spaces, engaging recalcitrant state actors to secure commitments and actions from government officials. In several districts, community advocates called in to radio talk shows to ask questions or get feedback from duty-bearers whom they had petitioned. Innovative advocates also used community spaces and social events (such as weddings or funerals) to pass on campaign messages or put leaders on the spot. Elected Local Councilors (LCs) attend burials to listen, pay their respects, and contact constituents. This presents an opportunity to publicly engage officials. Advocates in Tororo District took advantage of this opportunity to engage officials in such public fora—especially those that had been stubborn or slow to commit or act on campaign asks. **Table 7** shows the intensity of engagements by community advocates in Katakwi District in a variety of spaces—invited, claimed and created.

Figure 28. Omoro District Community Advocates



Omoro District advocates photographed after completion of all training sessions of People Centered Advocacy (PCA) in April 2018. The 24 advocates represent six catchment areas. Government officials including the Resident District Commissioner, the Assistant District Health Officer, the District Local Council Secretary of Health, and the In-Charge of Bobi Health Center III facility witnessed the giving of certificates of completion after the training. Credit: Robert John Offiti HEPS-Uganda

Table 7. Katakwi District Community Advocates' Engagement Log Highlights Use of Diverse Spaces

Type of space	Type of meeting	Purpose	When	Where
Invited	Eastern Regional budget consultative meeting	Local Governments to share their budget performance monitoring findings for FY 2017/18 as well as setting budget priorities for the FY 2018/19.	28 th – 29 th Sept. 2017	Mbale Resort Hotel.
Created	A joint meeting between community advocates and the duty bearers (CAO, District Police Commissioner (DPC) & LC V Chairperson)	Community advocates to seek for commitments from the duty bearers based on the messages delivered to them regarding environmental degradation in Katakwi district.	10 th Oct. 2017	District boardroom – Katakwi
Invited	Magoro Sub-county Budget Conference	To share the sub-county budget performance for FY 2017/18 as well as setting budget priorities for the financial year 2018/19	30 th Oct. 2017	Magoro sub-county headquarters
Claimed	Meeting with officer In-Charge IC Kapujan Police Post	To resolve the standoff between the police officer and the community advocates	7 th Nov. 2017	Kapujan S/C Police post
Invited	Kapujan Sub-county Budget Conference.	To share the sub-county budget performance for FY 2017/18 as well as setting budget priorities for the financial year 2018/19	16 th Nov. 2017	Kapujan sub-county headquarters
Invited	Katakwi district Budget Conference	To share the district budget performance for FY 2017/18 as well as setting budget priorities for the financial year 2018/19	21 st Nov. 2017	Katakwi Primary School hall
Claimed	Olilim Primary School tree planting meeting.	To discuss the state of the school environment & need to plant more trees in the school compound.	7 th Dec. 2017	Olilim Primary School

Source: February 2018 participatory data analysis session in Katakwi District.

Special campaigns

Investments in training and support in Phase 2 helped expand advocates' skills and knowledge of government systems, policies, and processes, which had effects beyond the joint district advocacy campaigns. While working collectively on district-wide campaigns, advocates from approximately half of the 98 health facilities used their skills to initiate advocacy campaigns on additional issues. These "special campaigns" emerged even in districts where the joint district-wide campaign was less dynamic.²² Examples of special campaigns include:

- Community members from Nyantaboma HCIII engaged Kabarole District officials about the lack of safe water in Harugonjo sub-county, contributing to the building of **10** new wells.
- Bukedea community advocates collected data on the status of school classrooms in three primary schools (Malera, Kdongole, and Kachumbala

communities), finding average classroom sizes nearly twice the recommended teacher–pupil ratio. Community advocates developed advocacy messages and delivered them to sub-county officials and the District Education Officer.

- In Kabarole District, community advocates helped organize a marathon to fundraise for the construction of a maternity ward in Nyantaboma HCIII, building on community demands since November 2017. Government officials at the fundraising event pledged to rally support from elsewhere in government. By February 2019, the government had released funds to construct the ward and identified a contractor. District officials invited community advocates to witness the contract signing process as proof of the government's commitment to construct the ward. The facility was also upgraded from a HCII to a HCIII and construction of the new maternity ward was completed (see **Figure 29**).

Figure 29. Maternity Ward Constructed in Response to Advocates' Special Campaign



Newly constructed maternity ward at Nyantaboma Health Center in Kabarole District. This was an ask of a special campaign by community advocates. Credit: Richard Tusiime, Karabole Research and Resource Centre (KRC)

Community advocates' application of their civic knowledge, which has expanded actions beyond the campaigns accompanied by CSOs, is noteworthy. These special campaigns *may* signal community advocates' confidence in their own actions to generate results. Such outcomes may be hoped for in induced projects, yet the literature appears to have limited documented empirical evidence of such positive spillover effects.

6.2. Citizen outcomes: Community advocates as agenda-setters and leaders

Much accountability-related literature focuses on local-level interventions, so the multi-level, people-centered approach of ACT Health appears somewhat unique in the literature on project-based interventions. Multiple data sources (**Section 4.2**) reveal signs of deepening democratic citizenship among community advocates even in this induced, donor-funded strategy.

For many of the 396 community advocates, working on their campaigns also fostered a transformative journey that is difficult to quantify. The profile of Patricia Odongo from Tororo District (**Box 5**) illuminates the personal journey of one exceptionally dedicated advocate.

Interviews with advocates also reinforced some positive changes they experienced through the ACT Health program. On reaching district officials during their campaigns, one advocate said, *"We have engaged the CAO [Chief Administrative Officer], RDC [Resident District Commissioner], DSC [District Service Commission] and because of these achievements, I'm so confident I can even speak to the president about ACT Health people-centered advocacy – I'm very comfortable"* (community advocate, interview, Mubende, June 2018). For this advocate, the engagements were an empowering achievement, regardless of any further outcome. Another community advocate described his ACT Health journey using an analogy of formal education: *"The dialogues were nursery school. What we have done up to now with advocacy is primary school. Now, I want to go to secondary school"* (community advocate, interview, Kabarole, June 2018). As a follow-up, we asked advocates to assess the national level campaign, which another advocate said *"now, that one is university!"* (community advocate, interview, Kabarole, June 2018).

Box 5. The Journey of Patricia Odongo, Community Advocate from Tororo District

Patricia Odongo is a 52-year-old widow in Tororo District. Patricia is taller than an average Ugandan woman at about 5 feet 6 inches. She has five children and two grandchildren. She is a community elder, whose ability to communicate well in English affords her a certain degree of respect. Patricia earned Ordinary Certificate of Education (S.4), quite high for a Ugandan woman of her age.



In March 2016, participants in a dialogue at Maundo Health Center selected Patricia as a community advocate. Patricia knew this was not going to be easy, since the most common problem at their Health Center was health worker absenteeism and tardiness. Advocacy felt like reporting health workers to their bosses, and Patricia feared losing connections with health workers whom her family relies upon. Despite a prevailing culture of non-confrontation, Patricia committed to her role as a community advocate. In the first training, she learnt about the 1995 Constitution and many other policies, gaining a sense of her rights and responsibilities.

Patricia's trust in the health facility faded when the In-Charge initially refused to share the staff attendance book. She learnt from fellow advocates monitoring attendance in Mwello, Morkiswa, Makawari and Were health centers that health workers signed "present" even for days they were absent. In Patricia's local health center, their monitoring revealed that health workers devised a system of distributing 30 cards to patients each day. Staff asked patients arriving after the cards had been distributed to return the following day so that health workers could depart before the official facility closing time and attend to private work.

"When I was selected, at first I was worried if I would be able to represent the community. When we first went to the health center, we asked for documents like the supervision book even though we did not know what the documents should even look like. When we went to the technical people they would dodge around, and the district officials asked us what our qualifications were. If I have a problem does it matter if I have a qualification? If I don't have training, does it matter, because I'm suffering? Once district officials told us our letter was misplaced, so we gave them another copy. Eventually, we asked for signature as proof of delivery. I cannot ask them what they did but we are seeing changes. Even last week, we took messages of appreciations, but asking for more."

Tororo community advocates' first attempt to meet the Chief Administrative Officer and District Health Officer failed because they were out of the office, despite having confirmed the appointment. Advocates had used their meager resources to pay for this failed trip. Fellow community advocate Mr Wilberforce Owor (a retired civil servant) helped identify friends within the district who could act as "door openers" for meetings with officials.

After delivering their first petition to the district, community advocates kept monitoring health services at their respective health facilities to determine whether duty-bearers had acted. In Patricia's local health center, advocates began to see improvements in the time of arrival and departure by their only assigned health worker. By February 2018, the advocates from Maundo Health Center were satisfied with the services from their health worker. Using their collective voice and knowledge of systems, they petitioned government officials for an additional health worker and accommodation for health staff.

Patricia's commitment and determination led other advocates to recommend her as a representative from Tororo for the national-level campaign on absenteeism (see **Section 8**). Advocates chose Patricia as the deputy to the chief petitioner during meetings with national officials, including Members of Parliament, the parliamentary committee on health, the Inspector General of Government (Ombudsman), and the Speaker of the Parliament.

"Now I can see that there is a bigger job to be done at national level if we have to see long-lasting changes in the way health workers report for duty in our lower-level health centers."

As of June 2019, Patricia continued to work with other community members to follow up with the District Health Officer to allocate an additional staff member to their facility, alongside other health advocacy issues.



VII. Subnational Government Responses to Community-led Advocacy

A structured, analytical review of evidence on 18 subnational campaigns shows emerging patterns of government responsiveness to citizen-led advocacy. There appear to be relatively few similar approaches analyzed at this scale in the literature.²³ This section begins with an overview of the analysis from the Heat Map, rating the responsiveness of subnational officials in all 18 districts. After the overview summary, **Section 7.2** provides more detailed empirical examples illustrating the nature of responses: increased monitoring/oversight, downward accountability and proactive transparency; backlash; sanctions; resource allocations; and finally, the formal recognition of community advocates by government.

7.1. Heat Map analysis: Summary of subnational responsiveness to 18 campaigns

As noted in **Section 4.2**, multiple program monitoring processes and documentation fed into a Heat Map summarizing community advocates' work and the

responses from subnational officials (whether elected, appointed, or technical) across the 18 districts. The Heat Map analysis shows that in 8 of 18 districts officials either fulfilled or surpassed the commitments they made to community advocates.

The starting point for the analysis presented in this Working Paper was the December 2018 Heat Map. The study authors reviewed each district campaign description in depth, revisiting source documents or seeking additional clarification from involved parties (CSO staff or advocates themselves). In addition to fleshing out the district campaign descriptions, this iterative analytical review process led us to refine the criteria for classification of “red” (officials largely unresponsive), “yellow” (officials made commitments but implementation was limited), and “green” (officials implemented commitments) (see **Figure 30**). The data review revealed some cases where subnational government actors implemented actions beyond the “asks” of community advocates, leading us to add a fourth category—“purple” (officials implemented actions beyond campaign commitments).

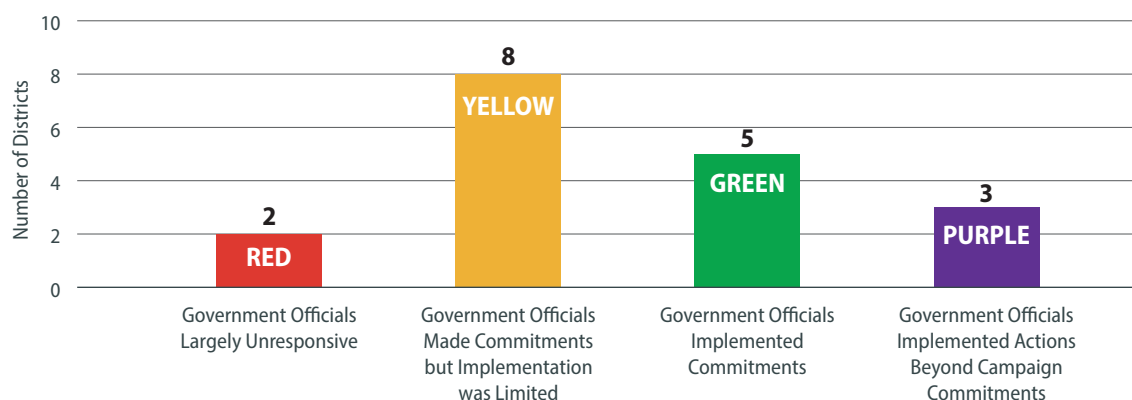
Figure 30. Four Categories of Government Responsiveness in the ACT Health Heat Map

RED (Government Officials Largely Unresponsive)	YELLOW (Government Officials Made Commitments, but Implementation was Limited)	GREEN (Government Officials Implemented Commitments)	PURPLE (Government Officials Implemented Actions Beyond Campaign Commitments)
Government officials did NOT make verbal commitments to investigate or rectify problems raised by the community advocates, OR made vague verbal commitments to “follow up,” but appeared disinclined to act.	Government officials made verbal commitments to investigate or rectify problems raised by the community advocates but did NOT implement SOLUTIONS in tangible ways that could be verified by external parties.	Government officials made verbal commitments to investigate or rectify problems raised by the community advocates AND implemented SOLUTIONS in tangible ways that could be verified by external parties.	Government officials implemented SOLUTIONS promised in initial campaign AND officials engaged community advocates beyond initial campaign, undertaking ACTIONS BEYOND asks or in other sectors.

Using the Heat Map's empirically backed summaries of each campaign, we reassessed the December 2018 "rating" for each district in June 2019. During this data validation, we took a very conservative approach and applied these definitions very strictly and revisited the rating of each district. In this process we downgraded earlier ratings for **eight** districts from green to yellow. We classified three districts under the new "purple" category to show that a few districts went above and beyond the requests and asks from advocates. Overall, the data analysis reveal **two** unresponsive districts (red), **eight** districts where officials made commitments (yellow), **five** districts where officials implemented commitments (green), and **three** purple where officials made commitments beyond the original campaign asks (**Figure 31**). **Figure 32** offers abridged advocacy campaign descriptions for one district rated in each category (red, yellow, green, and purple).

These ratings of subnational government responsiveness are based on a very critical and conservative application of the criteria. During review meetings, many advocates reported that their ongoing monitoring in facilities did not show significant improvements in attendance of health workers to the advocates' satisfaction, even when advocates reported officials' responsiveness to their campaign asks. This is unsurprising, given the complex nature of absenteeism and its measurement (see **Box 3** on absenteeism). The more observable outcomes emerged from the cycles of interaction between community advocates and progressively higher levels of government actors. **Section 7.2** explores more detailed examples of the types and range of responses from subnational officials.

Figure 31. Subnational Government Responsiveness to Community Advocates' Campaigns in 18 Districts (as of June 2019)



Source: GOAL Uganda "Heat Map" compiled from multiple program monitoring sources.

Figure 32. Abridged District Campaign Descriptions Illustrate Application of Heat Map Rankings

	RED (Unresponsive)	YELLOW (Limited Implementation)	GREEN (Commitments Implemented)	PURPLE (Actions beyond campaign commitments)
# of districts	2	8	5	3
Illustrative example summarizing the case of one district ranked in this category	<p>Nakaseke District experienced significant tumult during the campaign. Advocates secured audiences with the Chairperson of the District Service Commission, the Resident District Commissioner (RDC), Chief Administrative Officer (CAO), District Health Officer (DHO) and Local Council V (LCV) Chair. The CAO promised to follow up with calls and warnings to staff members who had been reported, but beyond that no administrative response was forthcoming. At the close of 2017 the district's DHO was suspended on charges of corruption and later reinstated following a court case, which he won. By August 2018, community advocates reported the following issues: still no substantive DHO after the suspension of the previous one. There is also information that the previous CAO was transferred too. By November 2018, community advocates proposed to collect new evidence to present to the district and report specific cases to the IGG Regional Office in Wakiso.</p>	<p>In Mubende District, community advocates first engaged the CAO, who summoned the DHO to investigate and respond. Despite 18 months of efforts—including repeated meetings with the CAO, DHO, and Chairpersons of the DSC and LCV—the campaign never moved power-holders to action because shortly after the CAO was transferred to another district. Community advocates engaged the district elected officials (political leaders) to influence the district health team to implement reforms but little progress was realized as there was limited support from the Resident District Commissioner (RDC) for the work of community advocates.</p>	<p>In Pader District in northern Uganda, community advocates monitoring health facilities revealed that 52 workers were out of duty station on extended leave that had not been approved, getting to a key root cause of absenteeism that was previously invisible to higher-level authorities. Advocates built their messages around this, beginning to engage district officials in mid-2017. The Assistant CAO issued formal warning letters to four health workers based on the evidence provided by the advocates. After further investigation, district officials summoned 52 health workers who were away from duty taking professional courses without giving notice to the district. As of April 2018, the LCV chair in Pader District was conducting supervision visits to all health centers in the district, not just those monitored by community advocates. Officials cleared the staff registers of all “ghost workers” (names of people still on the register who had left the district, died, or retired).</p>	<p>Community advocates contributed to Agago District removing 13 “ghost workers” from facilities the advocates were monitoring, and hiring 6 additional health workers for 2018. Advocates went on to petition the CAO and LCV to request that they hire more workers beyond the replacement of ghost employees. In April 2018 the LCV Chairperson committed to support advocates to present their case to the District Council's Health Committee. Community advocates continued to follow up on issues of unexplained staff absence, staff transfers without replacements, and granting of leave without due consideration of gaps, in three problematic facilities. Based on a request from the RDC, with effect from November 2018, the community advocates also took on monitoring of teachers' attendance in schools. The RDC provided training to advocates for them to use the district's teacher monitoring tools.</p>

Source: Abridged from the people-centered advocacy Heat Map compiled from multiple source monitoring documents.

7.2. Top-Down: Examples of subnational government responses

This section provides critical interpretation of empirical examples of subnational government responses (positive and negative) to district advocacy campaigns during Phase 2 of the ACT Health program. Joshi (2017) has pointed to gaps in our understanding about how contextual factors shape positive or negative responses from government actors. Some researchers make a strong case for interpreting government responses and outcomes in a contextually relevant way, as what is classed as superficial or significant depends on context and time (Lodenstein et al. 2017; Flores and Hernandez 2018; Hernandez et al. 2019). Some changes are subtle, and some raise expectations for potential to foster more system-wide change if sustained over time.

Increased monitoring/oversight by government officials

Community advocates' bottom-up monitoring and advocacy successfully triggered district officials' action. While support-supervision visits to health facilities are part of district officials' responsibilities, officials commonly complain that resource constraints impede this oversight function. It is much easier to prove that a light fixture is broken or a staff house unfinished than to verify health worker attendance, hence officials' interest in community advocates' data on attendance. In 13 of 14 districts focusing on absenteeism, district-level officials went to verify evidence presented by community advocates (see **Figure 33** for an example).

The high rate of follow-up investigations to verify advocates' reports and feedback from targeted officials indicate they were impressed by the detailed data collected and presented to their offices. When asked what motivated his office to act in response to the advocates requests, one official said *"One, it was the method and commitment to monitor every day for three weeks. Two, making a report to us. They didn't go to the papers as others do, but came to us first"* (District official, interview, Kabarole, June 2018). At least some senior officials are interested in oversight and take the initiative, largely appreciating the information and evidence generated through citizen monitoring.

Several tangible outcomes emerged directly from citizen monitoring data and advocacy. Through their own monitoring visits—triggered by advocates' evidence-based petitions—officials confirmed some of the informal practices health workers had put in place to abuse existing management tools for monitoring attendance. As one district official noted, *"As duty bearers, we have an oversight role, but we are limited and cannot always be there. We entrust those posted to manage their work. The biggest problem is 'organized absenteeism' where health workers make their own informal timetable. CAs helped us discover this practice. We have taken a serious intervention"* (District official, interview, Kabarole, June 2018). In multiple districts, community advocates' monitoring data helped officials identify and purge "ghost names" (employees listed on the payroll, but who were deceased, retired, or absent from duty for a long period of time) from staff registries. Community advocates in Pader District found 52 health workers that were absent from duty for extended periods because of unapproved study leave. Here, citizen monitoring exposed a root cause of absenteeism in the district.

Two examples illustrate how the skills of community advocates to monitor health facilities, compile reports, and engage higher-level officials may have positive spillover effects—reaching broader geographic areas or expanding the scope of monitoring work. In Apac District (rated yellow), district-level staff conducted spot checks in all health facilities—not just the facilities included in the community advocates' monitoring and petition. The round of top-down monitoring in response to data from advocates from only some facilities shows potential for accountability beyond a subset of facilities. In Agago District (rated purple), the Resident District Commissioner (a presidential appointee) provided training to community advocates and provided tools for them to monitor teachers' attendance, which commenced in November 2018. This illustrates an exciting opportunity for community advocates to build on their independent monitoring of health facilities, leveraging skills and knowledge as they expand their sectoral reach.

Figure 33. Manafwa Official in Disguise Conducts Health Facility Spot Check in Response to Advocates' Petition

In Butiru HCIII, the Resident District Commissioner (RDC) visited the facility in slippers and dirty torn clothes and sat in the waiting line like any other patient to get treatment. None of the Health Center staff recognized him. They took their own time doing their own things without attending to the patients waiting. None of the patients were attended to up to break time (10:30am).

The four nurses who were working in the absence of the In-Charge went for a break, while patients were still waiting. After break, they attended to a few patients, then went for lunch, with more patients still waiting. The RDC was seen after lunch. He was given a few Panadol and enough Coartem tabs for one day and told to buy the rest. He immediately summoned the In-Charge for a meeting, along with the staff. They were cautioned on their operations and warned that their salary would be docked if they did not work the prescribed time.

Since that incident, staff are now active at the facility and patients no longer wait so long for treatment. All these changes were attributed to the community advocates and Mr Wakhabi, a local councilor who informed the RDC about the challenges at the health facility.

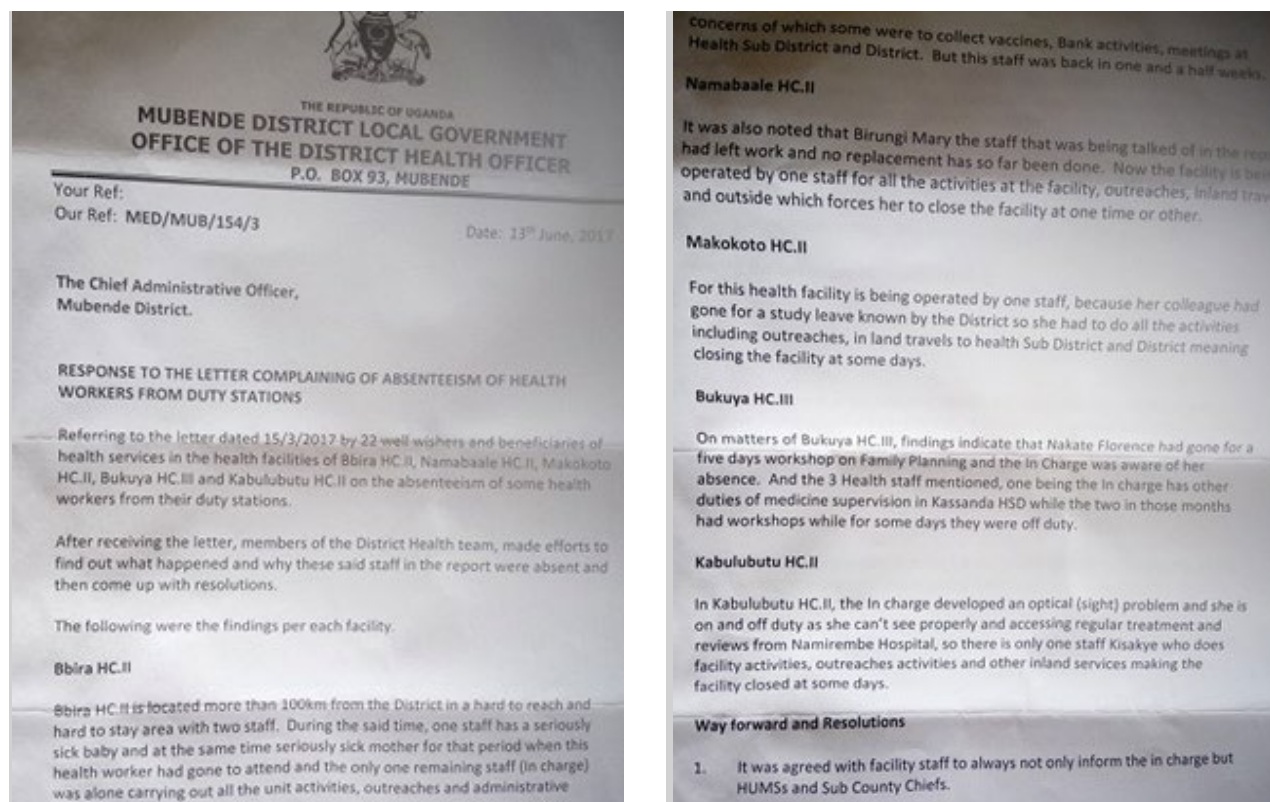
Source: Reported by community advocates during September 2017 review meeting.

Downward accountability and proactive transparency

In Phase 2, the ACT Health program documented evidence of higher-level officials providing post-monitoring feedback to advocates and/or wider communities. In Manafwa, after verifying the reports of community advocates, the Resident District Commissioner (a presidential appointee) went on the radio to share the outcomes of his visit to the health facilities (**Figure 33**). In Mubende District, the District Health Officer sent a letter back to the Chief Administrative Officer reporting the findings from the follow-up monitoring and verification visits (**Figure 34**). The Mubende District Health Officer also called health assemblies in all the five facilities to share his findings from the verification process. He publicly acknowledged the community advocates' role in triggering the monitoring investigation during public debrief sessions. These examples illustrate closing of the feedback loops (reporting back to those who requested action), and signal a degree of answerability / downward accountability (reporting back to community advocates rather than only to their own supervisors).

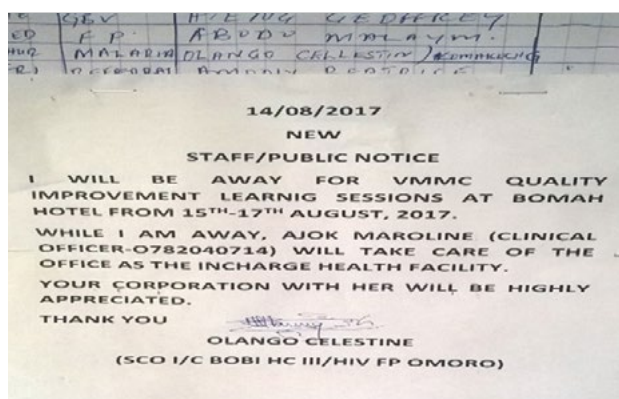
In at least **five** districts, the ACT Health program monitoring data reveals examples of proactive transparency. In response to advocates' petition, the District Health Officer in Kakumiro District summoned health workers to a meeting in which he instructed all In-Charges to publicly display all staff duty rosters, off-duty statuses and delegations, work plans, any critical events, and leave schedules. One community advocate recalled that health workers "never used to pin the HC [Health Center] roster,, schedule or names and titles of staff on the notice board and now they display all of these things. Now it is easy to tell the number of health workers allocated. If a health worker is on leave, it is easy to know and trace" (Community advocate, interview, Kabarole, June 2018). An In-Charge in Omoro District posted a notice (**Figure 35**) with dates and reason for absence and provided contact information for the person acting in her absence. This August 2017 notice was posted *after* community advocates took their petitions to district-level officials. Public officials initiating transparency measures can be interpreted as subtle emerging signs of downward accountability from health workers to community members—and micro shifts in power dynamics.

Figure 34. Report from Mubende District Chief Administrative Officer to Community Advocates



Letter from the Chief Administrative Officer of Mubende District reporting back to community advocates after the monitoring visit to investigate their claims regarding problems at multiple health facilities.

Figure 35. Transparency and Downward Accountability from Health Workers to the Community



Letter posted outside the health facility in August 2017 by the Health Center In-Charge to proactively disclose the reason and duration of her absence. This is a signal of downward transparency, from health worker to community members visiting the health facility. Credit: Vincent Mujene.

Backlash and changing accountability dynamics

Challenging vested interests and the status quo should be anticipated to trigger negative reaction, backlash, and possibly retaliation. While many social accountability approaches focus on forms of “constructive engagement”, even these can be perceived as a challenge to power-holders in hierarchical contexts (**Section 2**). Because hidden—deeply internalized—power dynamics often dictate the dynamics of state–society interactions in claimed and created spaces, simulations and role plays during training sessions and workshops helped prepare community advocates for possible pushback. The horizontal organizing—building strength in numbers within and between communities—can be important in counteracting backlash as well.

When community advocates began monitoring facilities, some health workers resisted and, in a few extreme cases, retaliated. In Kagadi District, two Health Center In-Charges whom the advocates had reported to district officials for negligence retaliated, telling an advocate not to return to the facility for treatment. In subsequent meetings at the district, the advocates reported these threats to the Resident District Commissioner, who held a meeting with the Assistant Chief Administrative Officer, the In-Charges in question, and the advocates. During this meeting, district officials put the In-Charges “on notice” that no one would be refused treatment for exercising their rights as community members and citizens. This shows the potential of community advocates to leverage new relationships with higher-level officials to protect themselves against further retaliation by local service providers—representing a shift in power dynamics between community members and health workers.

In a few districts (Kakumiro, Nakaseke, and Kagadi), government officials above health workers resisted community advocates’ efforts. Nakaseke’s Resident District Commissioner (a presidential appointee) appeared uncomfortable engaging directly with curious and demanding community advocates. After presenting the petition on health worker absenteeism, advocates asked what the Resident District Commissioner was planning to do about the problem and when they should follow up on those commitments. Although the official acknowledged there was a problem, he did not think himself responsible for answering to advocates (downward accountability), as he saw himself answerable only to his own manager (upward accountability). Nakaseke District is rated “red” (unresponsive) in the Heat Map.

Sometimes backlash came from district-level officials who were initially uncomfortable with community advocates’ monitoring and advocacy work. In Gulu District, after community advocates delivered the first petition to the elected Local Councilor, the District Health Office, the Chief Administrative Officer, the Resident District Commissioner (presidential appointee) and others, the District Health Officer issued a directive preventing health workers from providing any records without prior approval from his office. After this, health workers would not share facility records such as attendance books, which were crucial for advocates’ ongoing monitoring. Community advocates complained directly to the district’s highest elected official

(Local Council V Chairperson), because his office had welcomed the advocates more warmly than other officials. The District Chairperson wrote a letter granting advocates written clearance to collect additional evidence to confirm whether the situation of absenteeism had improved as a result of engagements with district officials. Here, advocates effectively worked “checks and balances” in the district administration but overall Gulu District is rated “yellow” (limited implementation of commitments).

Upon learning that advocates had succeeded in reaching district officials, some Health Center In-Charges called community advocates in to negotiate with them after having treated them badly in prior interactions. The In-Charge of a health center in Kabarole District was initially very negative. By early 2019 (over 12 months into their campaign), advocates reported that he had invited them to join a staff meeting, asking that health workers cooperate with the advocates. Advocates reported similar cases from some health workers in Mubende, Omoro, and Tororo districts. This is evidence of a gradual rebalancing of power between community advocates and state agents—the ability of advocates to reach higher level officials triggered these changing dynamics.

Overall, these examples reveal the types of backlash that can result even relatively “non-confrontational” citizen-led accountability work. In the best-case scenario, CSO staff can help citizens prepare for backlash and find strategies to deal with it, but even the best preparation will not prevent all incidents. During Phase 1, the ACT Health RCT prohibited CSO staff from contact with communities in the six months between dialogues, so CSO staff were not positioned to detect (let alone mitigate) cases of backlash or other negative consequences of the approach. During Phase 2, organizing within catchment areas and intra-district joint campaigns fostered a citizen support network, emboldening advocates to report and mitigate retaliation. CSO staff supported more indirectly—strategizing with advocates on how to address the backlash—acting as allies largely behind the scenes. The cycles of engagement during the advocacy phase expanded citizens’ relationships with multiple actors in the system, activating checks and balances, and leveraging new and/or strengthened relationships with higher government officials to protect advocates from further backlash.

Figure 36. Kabarole District Officials Discussing Health Worker Absenteeism in Response to Advocates' Petition and Monitoring Evidence



In September 2017, community advocates presented a petition to several high-level Kabarole District officials (including the elected Local Council V Chairperson, Chief Administrative Officer, Resident District Commissioner, and the District Health Officer). During their independent monitoring, community advocates found that health workers had “informal arrangements” to cover for colleagues absent from duty, in contravention of the Ministry of Public Service’s Public Service Standing Orders. In response, district officials cancelled informal arrangements of health workers absenting themselves from duty. Photo credit: Richard Tusiime, KRC.

Sanctions

Enforcement of sanctions can be retroactively punitive, which *may* also prevent repetition of abuse. In eight districts, officials summoned health workers implicated by community advocates to issue verbal warnings or instructions. In six districts, officials issued warning letters to errant staff. Omoro District officials planned to withdraw salaries for all health facility staff confirmed absent from duty for more than 15 days. In Omoro, the District Health Officer advocated to the Chief Administrative Officer to make the salary reductions. Health workers approached community advocates, upset that their advocacy had caused these deductions, which is strong evidence that the punitive action was executed. Two districts reinstated or reinvigorated Rewards and Sanctions Committees to take up disciplinary actions. However, the disciplinary mandate for government employees at the subnational level lies with the District Service Commission, which was not active in any district. This illustrates the complexities of Uganda’s local governance structures, and under-resourced mandates to enforce accountability.

Resource allocations

As noted in **Section 6.1**, in all districts, community advocates tried to influence the allocation of financial resources through advocacy in budget meetings. For the challenging issue of absenteeism, most advocates requested budget for more routine support-supervision visits to health facilities (consistent top-down oversight), but program records do not include comprehensive tracing of responses to the asks delivered specifically in budget meetings. Direct, causal impact claims linking any single budget advocacy effort to a resource allocation are not straightforward; this is not a new challenge in assessing advocacy impacts (Buffardi et al. 2017). Thus, it is useful to highlight the documented examples of resource allocations in response to community advocates’ campaigns in Manafwa/Namisindwa Districts and Bukedea District. We cannot claim that community advocates’ work was the *sole* impetus behind observed budget allocations, but these examples do show the power of informed citizen advocates and their campaigns.

As of May 2018, sub-county officials in Manafwa/Namisindwa districts took concrete actions to improve electricity and lighting in six of the seven health centers

community advocates included in their petitions. In this case, the improvements to physical infrastructure were probably relatively easy to fund in comparison to support-supervision (to improve top-down monitoring and oversight). Budget allocations to visible outputs (infrastructure) are more advantageous to power-holders. Regardless, resource allocation can signal state responsiveness to citizen preferences in the short term while enhancing facilities' ability to serve patients, which can in turn contribute to improved health outcomes over time.

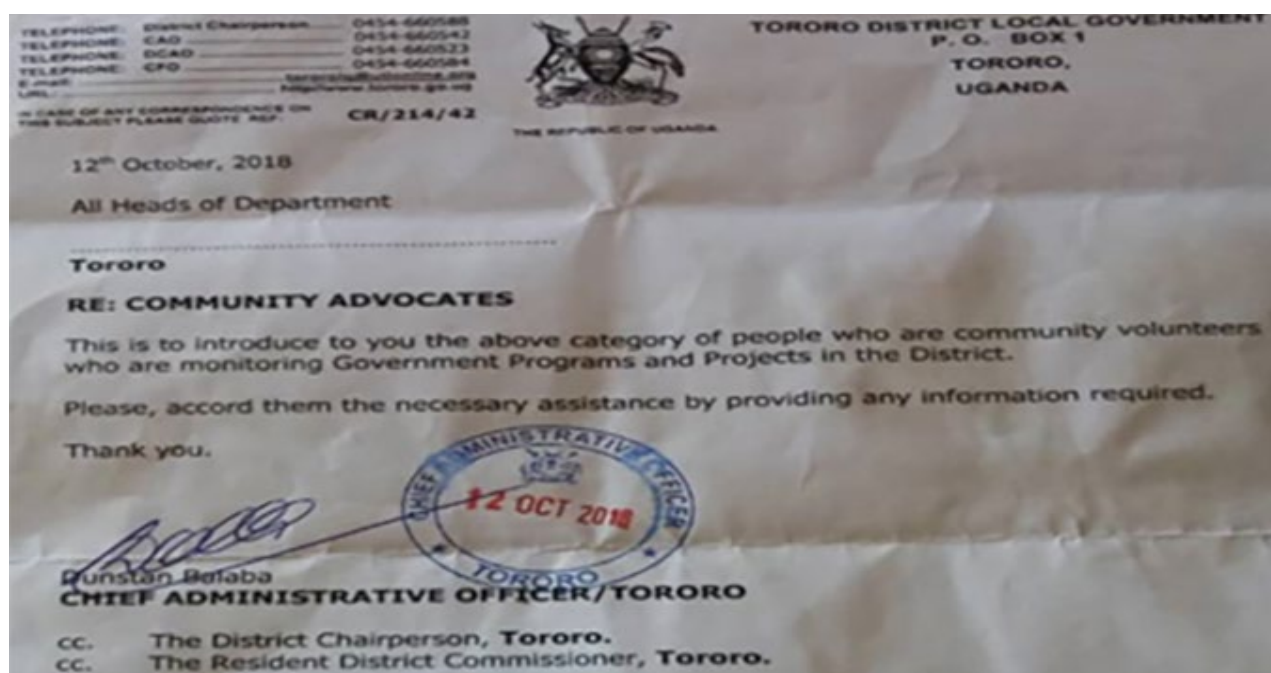
Community advocates in Bukedea District (rated purple on the Heat Map) identified limited staff accommodation at health facilities as a cause of absenteeism and late-coming, and centered their advocacy asks around building staff housing for three facilities. District officials planned, budgeted, and allocated district funds to provide three health facilities with staff housing quarters, as requested by the advocates. The sub-county chief, elected district councilor, and district engineer visited the facility, informed advocates of construction timelines, provided the technical specifications, and trained advocates in construction monitoring.

While monitoring construction, community advocates became concerned that the staff house in Kachumbala HCIII was designed to accommodate two staff but was only being built for one staff and they reported this to government officials. This shows the extent of community advocates' awareness of and engagement with government plans and officials.

Recognition by government: a double-edged sword?

During Phase 2 of the ACT Health program, government officials in 6 of the 18 districts provided letters introducing advocates as community volunteers. Advocates could present such letters as back-up to health workers or other lower-level officials, in case community advocates had difficulty accessing facilities for ongoing monitoring. Formal recognition of this kind is highly valued by citizens in the Ugandan context. **Figure 37** includes a letter from Tororo District officials issued in October 2018, two years after their community advocates' campaign started and five months after the formal project funding ended. Building relationships and winning this acknowledgement took considerable time.

Figure 37. Letter from Tororo District Chief Administrative Officer Introducing Community Advocates



Letter dated October 2018 from the Chief Administrative Officer of Tororo District identifying community advocates as volunteers monitoring government programs, and requesting the sharing of information requested in the course of this monitoring work.

However, this recognition may give rise to other challenges, including the transfer of monitoring responsibilities from mandated government officials to community advocates. Practice-based reflection from Mozambique highlights that the transfer of responsibilities from government to citizens inverts roles and can further minimize the state's performance of its mandated duties (Dias and Tomé 2018:35). On the other hand, it can be considered a form of co-production, whereby citizens and the state both share responsibility for monitoring in resource-scarce settings (Joshi and Moore 2004 in Westhorp et al. 2014; Creighton et al. 2020). In the Uganda context, higher level officials see advocates as their 'eyes and ears' in communities and may co-opt or exploit advocates' monitoring efforts in health facilities. Likewise, advocates may seek a closer affiliation with the state if they expect it may lead to opportunities for remuneration, formal employment, or other perceived benefits.

Beyond the transfer of responsibilities from the state to citizens, in this hyper-political environment government officials (particularly elected politicians) may also try to exploit the energy of community advocates for

political gain. Officials in one district indicated that advocates need to *"study the situation and understand the political environment and not get dragged into what they don't know"* (District government official, interview, Kabarole, June 21, 2020). District government officials may accept citizen monitoring of service provision points, but respond more defensively if citizen monitoring shines a spotlight on failures of higher-level officials. For more on those dynamics, see **Section 8** on the engagement with national-level actors.

While alert to these risks, the ACT Health consortium ultimately did not tackle this dilemma in the timeframe of the program. As the program wound down, the consensus was that the role of CSO staff was to encourage community advocates to think through the pros and cons of being more closely aligned to the state, but in the spirit of people-centeredness, the ultimate decision would rest with community advocates themselves.



VIII. Escalating Absenteeism Advocacy to National-level Officials

Citizen-led accountability interventions targeting multiple levels of governance appear somewhat unique in the literature. Much of the intervention-based research focuses primarily on localized provider–patient accountability dynamics (Gullo et al. 2016; Lodenstein et al. 2017; Nelson et al. 2018). Gullo et al. describe the challenges of reaching national-level actors in the CARE scorecard approach, other researchers note few examples of national-level change in the literature (Schaaf et al. 2017). The cycles of engagement between community advocates and subnational government officials discussed in section 6 and 7 built a foundation for the bottom-up campaign engagements with national level officials.

The original ACT Health program strategy acknowledged that the “end of the pipe” (see ‘leaky tap’ **Figure 8**) service delivery issues observed at lower levels often emanate from dysfunctionalities and bottlenecks higher up the system (Mitlin 2013 in King 2015; Fox 2015; Halloran 2016; Joshi 2017). From the design phase, the ACT Health strategy planned to connect community-level actors to national level officials.

In Phase 2, ACT Health accompaniment enabled advocates to carry their absenteeism campaign to the national level. The national-level campaigns took two main forms, both of which emerged from advocates’ actions and direct advocacy at lower levels: (1) an orchestrated escalation of the absenteeism campaign by community advocates from multiple districts (inter-district organizing); and (2) efforts by community advocates to directly reach regional and national bodies to apply top-down pressure on recalcitrant district officials. The national-level engagements were particularly challenging, and CSOs provided much more support to community advocates navigating the corridors of power on the complex, multi-stakeholder issue of absenteeism.

“Through community dialogues at health center level, we were able to solve a number of problems. However, we soon found out that some of the issues we identified were beyond our health workers’ health unit management committees’ and village health teams’ control or mandate, and that these could not be solved through community dialogues.”

Statement of community advocates during national level symposium (April 2018)

8.1. Joint (inter-district) advocacy engagements at the national level

With absenteeism identified as a campaign priority in most districts in 2017, the Coalition for Health Promotion and Social Development (HEPS) commissioned a review of several health sector laws and policies on this issue. The review included interviews with national-level health sector stakeholders such as the [Uganda Nurses and Midwives Council](#), the [Uganda Medical and Dental Practitioners Council](#), the [Health Service Commission](#), [Public Service Commission](#), and the [Allied Health Professional’s Council](#). The resulting report highlighted serious policy gaps that exacerbate absenteeism on the ground. Professional associations often blamed poor working conditions for health workers’ behavior, as one key informant explained: “Doctors who are willing to work upcountry are very few and where one has accepted, you can’t begin punishing them for absenteeism when government has not provided equipment to aid their work” (Ntulo 2017). Another informant noted: “Absenteeism is treated as an administrative issue and normally sanctioned with a caution. But even the person cautioning understands why the professional is absent” (Ntulo 2017). Multiple accountability failures contribute to absenteeism (**Box 3**), which advocates boldly prioritized.

The 2017 policy review indicated a critical need for an inter-sectoral advocacy strategy targeting multiple line ministries that develop parallel (and, in some cases, contradictory) laws, plans, and policies on public sector oversight and accountability. Opaque and overlapping mandates penetrate all levels of governance in Uganda, creating performance gaps felt most acutely by citizens using public services. By early 2018, the national campaign included community advocates from 14 districts with absenteeism campaigns. Advocates from each district selected representatives to join coordinated national-level engagements with potential allies, influencers, and government officials in multiple fora. HEPS helped community advocates access various audiences (allies and government agencies) and facilitated media coverage. With HEPS to help ‘open doors’, community advocates directly engaged the Speaker of Parliament, Inspectorate of Government, three key line ministries (Health, Public Service, and Local Government), and the Office of the Prime Minister.

Evidence from community advocates’ monitoring buttressed the policy analysis—together they demonstrated the effects of weak oversight and structural failures felt at the front line of health service delivery. The CSO consortium and advocates decided to focus on bold advocacy asks to “raise the dust” and command the attention of national-level stakeholders. During the joint campaign strategy formulation process, community advocates agreed on these 2 bold propositions as the ultimate advocacy asks for their national level campaign:

1. *Prosecute managers and all persons within the entire reporting chain who do not comply with standing orders, codes of conduct, laws, policies and procedures on prescribed working hours for health workers as accessories and accomplices to attempted murder or grievous bodily harm.*
2. *Establish structures at lower levels to enable community members to report/present grievances on the delivery of health services within their area.*

Advocates then developed variations of these asks, adjusting the specific details based on the primary audience and the mandates of secondary audiences they engaged. For example, the asks differed based on the mandates of the officials targeted—health sector duty bearers have different mandates than the Inspectorate of Government, MPs, or the Speaker of Parliament.²⁴

Orchestrated national-level engagement culminated in April 2018, when ACT Health organized a symposium (created space) for community advocates from 14 districts to engage a range of national stakeholders on a discussion of the role of increased community monitoring of primary health care (see **Table 8**). Advocates highlighted the systemic drivers of undermanagement of the health workforce, as illustrated by the excerpt from the advocacy statement delivered presented to the Speaker of Parliament in May 2018.

“The current structures are disappointing us because they do not work for us. They do not work for us because in too many instances, as we have seen, there are too many supervisors with too little power. When everyone is responsible, no one is held accountable.”

Statement of community advocates presented to the Speaker of Parliament (May 2018)

While the subnational (district) campaigns saw advocates meeting duty bearers in their offices as well as many informal spaces (community meetings), the national campaign engagements were more formal in many respects. The April 2018 symposium resulted in a draft framework acknowledging independent community monitoring beyond and alongside the formal government structures for community involvement such as Village Health Teams and Health Unit Management Committees.

Table 8. Summary of Community Advocates' Major National-level Campaign Engagements

Month/year	Major national-level events and convenings
June/August 2017	Two planning workshops convened for 15 community advocates to collaborate in the initial thinking about national-level advocacy.
February 2018	Community advocates held a series of meetings with potential allies. This included 18 civil society organizations and private sector associations working on health or otherwise interested in absenteeism or public sector performance.
February 2018	People-centred advocacy (PCA) "launch" in Kampala—36 (12 female) community advocates from each district attended along with 43 government officials from target districts. An additional 16 national-level actors (civil society and government) also attended. See Figure 38 .
March 2018	20 community advocates met with 7 Members of Parliament (MPs) from the Parliamentary Committee on Health and other MPs from their respective districts, requesting that the MPs back the issue in Parliament and before the Speaker.
April 2018	21 community advocates symposium engaged targeted 11 national level officials on role of community in improving health worker performance.
April 2018	Community advocates met with the Inspectorate of Government (IGG) office in Kampala. See Figure 39 .
May 2018	20 community advocates engaged the Speaker of Parliament, Rebecca Kadaga.

Figure 38. Community Advocates from Multiple Districts on a Panel Event in February 2018 in Kampala



In February 2018, the ACT Health consortium hosted a one-day "launch" event, bringing 36 community advocates to Kampala. Over 40 district officials came from each of the 18 districts. The event also included donors, 16 national-level government officials, representatives of CSOs, and funding agencies. A panel of community advocates (pictured above) opened the event, with advocates representing different districts describing their campaigns, their challenges, and successes.

Credit: Angela Bailey

Figure 39. Community Advocates Meeting the Inspectorate of Government in Kampala



In April 2018, community advocates representing 16 districts met the Inspectorate of Government in Kampala to ask for investigations into the performance of all relevant councils, commissions, and district management teams in relation to health worker absenteeism and, where necessary, to charge those who have neglected their duty as accessories to attempted murder or murder. The IGG heard their concerns and provided a copy of the Human Rights Report it had produced. Credit: Prima Kazoora, HEPS-Uganda

The advocates' engagement with national-level actors culminated in a formal meeting with the Hon. Speaker of Parliament, the Honorable Rebecca Kadaga. At this stage, the speaker implored Honorable Herbert Kinobere, leader of the Parliamentary Forum on Quality of Health Services, to work with members of parliament representing the 14 districts to present the advocates petition on the floor of Parliament. The advocates had the uphill task of following up with their MPs to ensure that the petition is presented to the whole house for debate – on “*absenteeism*”.

8.2. Community advocates trigger national officials' oversight of district officials

As the community advocates worked their campaigns across multiple levels, they developed new relationships and expanded their understanding of government accountability mechanisms—including the office of the Inspectorate of Government (IGG). The examples below highlight the ability of citizens to directly trigger the horizontal oversight mechanisms of the Inspectorate of Government, which some authors have highlighted as an important tactical approach to accountability (Fox 2004; Tembo and Wells 2007 in Tembo and Chapman 2014).

In Bundibugyo District, officials responded quickly when community advocates *threatened* to take their concerns to the regional office of the Inspectorate of Government. Positive responses from district officials during their 2017 absenteeism campaign created space for advocates to address suspected drug mismanagement in 2018. Advocates suspected that an In-Charge was stealing drugs, which they reported to multiple officials who took no substantial action. When community advocates *planned* to engage the IGG office, this grabbed the attention of the District Health Officer (DHO). The DHO held a meeting in the sub-county in July 2018 to investigate the drug theft reports, pledging to reprimand the In-Charge once the investigations concluded. Here, the *threat* of reaching higher authorities triggered district response to community advocates' asks. Bundibugyo District was rated “green” for the overall record of implementing commitments made to advocates.

In Mubende District (rated yellow), community advocates *did* petition the regional office of the IGG. By June 2018, the Chief Administrative Officer had a good understanding of petitions previously submitted by the advocates, but no district official had taken concrete action. In July 2018, advocates found themselves living in the new district of Kasanda and approached their new Chief Administrative Officer with asks. Seeing no action, in August 2018 they directly petitioned the central regional office of the IGG, which conducted its own investigation into health worker absenteeism in December 2018. In March 2019 (almost one year after the active CSO accompaniment of community advocates stopped), advocates confirmed that the Inspectorate of Government's office had investigated the issues they had reported. In response to the IGG report, district officials took immediate action on the unqualified and/or absent staff mentioned in the community advocates' petition. This escalation of concerns in response to subnational administrative inertia highlights the persistence and confidence of advocates to reach more senior government actors and trigger top-down action. ACT Health Phase 2 prepared community advocates to pursue these bold approaches.

For further exploration of the dynamics of citizen-state engagement, we turn to a broader discussion of implications from the findings of the present ACT Health study.



IX. Discussion

The successes reported in the Power to the People research (Björkman and Svensson 2009) generated enthusiasm about the prospects for simple, short interventions to dramatically improve health outcomes. While understandable, this enthusiasm is probably unrealistic. The null findings of the ACT Health RCT and other emerging research suggest that the dramatic positive findings of Power to the People on population health outcomes may be challenging to replicate.

In contrast, this study discusses lessons from the broader ACT Health program strategy, with emphasis on people-centered, multi-level advocacy campaigns. Building from evidence presented in the prior sections, we compare and contrast reflections from the light touch, community-level intervention tested (under the constraints of the RCT) to the accompaniment of advocacy campaigns in Phase 2, which enabled a more dynamic, reflective, and citizen-led approach to engaging the state. This discussion section addresses cross-cutting themes, including:

- the limits of information-driven interventions,
- the distinctions between facilitation and accompaniment (and the quality of both),
- the relevance of horizontal organizing among community advocates (inter and intra-district),
- moving beyond ‘light touch’ strategies and the potential of multi-level strategies, and
- finally exploring the dynamics of government responsiveness triggered by citizen-led advocacy.

9.1. Limits of information-driven interventions

Information is often a central feature of interventions in the transparency, participation, and accountability field. Modeled on Power to the People, “information” (in the form of citizen report cards on service delivery) was a central input tested in the ACT Health RCT. Researchers designed the RCT survey tools to measure performance on Ministry of Health indicators and

additional data for the RCT and citizen report cards (**Box 1**). External teams gathered data via household and health center surveys and compiled report cards. While an externally-led approach might make it easier to compare performance across multiple health facilities, it may not generate findings that community-level actors find to be credible, meaningful, compelling, or actionable. In ACT Health Phase 1, citizen report card information was not generated by “community monitoring” by those most directly affected.

To assess the impact of “information”, the ACT Health RCT tested three different “treatment arms”. Given the research design (described in **Section 3.2**) two treatment arms included exposure to externally-generated citizen report cards. Phase 1 process monitoring data reveals that community-level action plans prioritized similar issues—and reported similar rates of achievement—whether or not they were exposed to citizen report cards. One possible explanation may be that CSO facilitators influenced the issues prioritized by community-level dialogue participants based on knowledge of issues from other citizen report cards. Another possible explanation is that the citizen report card information had limited impact on community-level prioritization of issues.

“The dialogues were based on report cards, the difference is they were done by us and taken to communities. In PCA [people-centered advocacy], community raised issues and did research, which was more empowering. So in phase one, there was no empowerment, but in phase two communities were trained. It’s a more political process.”

NGO staff, interview, Kampala, June 22, 2018

In contrast, the advocacy phase ACT Health took a more locally embedded approach to information generation and use, focused on community-led monitoring and

data collection. During Phase 2, community advocates coordinated and executed independent monitoring of multiple health facilities in each district. Direct collection of evidence often required creativity on the part of advocates to get the information they needed to compile evidence from multiple facilities and present collective advocacy ‘asks’ to higher-level officials. The citizen-generated monitoring data—particularly on absenteeism—filled gaps in existing government tools to track health worker presence in facilities. The evidence-backed advocacy petitions drove government officials to action, which further empowered many advocates who continued data collection during their campaigns.

Information is still widely assumed to be a key input to accountability work (Tsai et al. 2019), but future research and practice needs to address what kinds of information and delivery processes are most relevant for change strategies.

9.2. Shifting from ‘facilitation’ to ‘accompaniment’

Who facilitates matters

In Power to the People, 18 community-based organizations (CBOs) collected data and implemented the intervention. Most of these CBOs had worked in the study areas prior to Power to the People, which may have magnified some of the experimental results (Donato and Mosquera 2019).²⁵ Real-world demands introduced by the ACT Health RCT design—the three treatment arms, the need for very standardized implementation, and the significantly larger scale of the RCT intervention—meant that ACT Health was implemented by larger CSOs that could cover larger geographic areas. While all ACT Health consortium implementing CSOs had prior experience supporting participatory health governance approaches, about half of the RCT districts were new geographic areas for the consortium. Even if the organization had prior experience, most staff were hired specifically for the ACT Health program and did not have prior relationships in intervention areas. As discussed in **Section 9.4** below, the light touch approach of Phase 1 made it challenging for external facilitators to build trust-based relationships in intervention areas. Some researchers (Schaaf et. al. 2017) have suggested

that the influence of organizational reputation of the CSO implementing these interventions is an understudied variable.

Quality of facilitation is a variable

The quality of facilitation matters greatly in participatory interventions (Tembo and Chapman 2014; King 2015; Gullo et al. 2016, Rao et al. 2017). Ethnographic observations in Tanzania indicated that facilitators at times act more like traditional teachers than as facilitators (Creighton et al. 2020), which was anticipated and observed in the ACT Health intervention. Significant training, guidelines, ongoing mentorship, structured observations, and direct feedback to ACT Health facilitators attempted to mitigate such tendencies during community-level activities. The challenge of facilitating meaningful participatory approaches cannot be overstated—particularly if facilitators are the among the least experienced and least empowered staff in CSO hierarchies. The quality and nature of facilitation may determine success of any given approach, and this is difficult to study with experimental or quantitative study designs.

Following the RCT, ACT-Health shifted from structured facilitation to flexible accompaniment

RCTs demand strict fidelity to program design, constraining practitioners’ ability to take an iterative approach, integrate learning, or adapt implementation (Mannell and Davis 2019:627). In practice, the community-level intervention was governed by very uniform procedures (standard agendas, standard prompts/probes for dialogues, standard documentation templates, etc.) codified in [detailed procedure manuals](#). The structure prescribed by the RCT research design may have limited facilitators’ creativity and flexibility. More nimble facilitation approaches might allow deeper dialogue on complex issues identified at the community-level, yet experimental evaluations such as RCTs curtail this kind of flexibility.

The end of RCT data collection relaxed the implementation constraints, and the people-centered approach in Phase 2 created more spaces for people most affected to be the primary advocates for change. For many CSO staff, standing behind citizens required a mindset and

practice shift (see **Box 2**). Facilitators needed flexible animation skills, strong understanding of government policies and plans, and the ability to help communities analyze complex problems and strategize on solutions. ‘Animation’ here brings a sense of vitality and vigor and this is exactly what CSO colleagues observed regarding Phase 2. CSO staff recognized that “advocacy needs regular following and flexibility to jump onto opportunities when they arise” (NGO staff, interview, Kampala, June 25, 2018) – in many cases these were skills that facilitators and advocates were developing together.

The flexible accompaniment processes in Phase 2 made the engagement cycles more dynamic and empowering. Reflections from CSO colleagues reinforce the importance of these changes between Phase 1 and Phase 2 for community advocates:

“The step-by-step process was really empowering. In first phase, we were more in control. In the second phase, we were more behind. This really needed a lot of work. It’s like raising a child and teaching it to feed itself. At first, you have to feed the child. But eventually you teach it how to feed itself. So that engagement is still very critical. With calculated moves, the person realizes a need to do it for him or herself.” (NGO staff, interview, Kampala, June 25, 2018)

“Dialogues were more inward looking. The sub-county observers didn’t understand so well. There was the issue of the [RCT] research which kept on haunting the dialogues so there was little flexibility to be creative. In PCA there was engagement of allies and a lot of flexibility and creativity. In PCA there was more learning, and it was very open to anything like changing directions or engaging different players.” (NGO staff, interview, Kampala, June 25, 2018)

“In PCA, we more or less stepped aside and this made them [advocates] very creative to use their own money and time. There has been a change of mind ‘we have the ability, indeed we can do it.’ Also, when they see results, it motivates them even more.” (NGO staff, interview, Kampala, June 25, 2018)

The flexible accompaniment in Phase 2 supported visible citizen advocacy which moved government officials to listen and respond (in most cases). This learning from

the full ACT Health strategy is so important for understanding change.

9.3. Horizontal organizing among community advocates (intra and inter-district)

The ACT Health RCT was designed to specifically test community-level interventions. But the broader ACT Health strategy fostered organizing of community advocates across multiple health facility catchments in each of the 18 districts. The horizontal organizing—both intra-district organizing across catchment areas in each district and inter-district for the national-level engagements—responds to the challenge of multi-level coalition-building observed in many contexts (Lodenstein et al. 2017). At subnational levels, while their efforts were expectedly uneven, most community advocates worked collectively to advance district campaigns. The joint agenda-setting process, coordinated monitoring of multiple facilities, and joint advocacy campaigns sustained were accomplishments in their own right.

Some community advocates developed or enhanced reputations as leaders. Interviews with advocates from three districts in June 2018 all surfaced examples of community members contributing resources (cash and in-kind) to campaigns, joining advocacy actions (such as the 130-person delegation deliver a petition to Bundibugyo District headquarters **Figure 27**), or reporting problems to advocates. The special campaigns (**Section 6.1**) initiated by advocates demonstrate continued use of knowledge and skills to expand the scope of their advocacy work.

During an off-cycle local council election in 2018, 47 community advocates (over 10 percent) were elected as village Local Councilors (LCIs).²⁶ While it is possible that the people interested in becoming community advocates would have sought elected office anyway, the people-centered advocacy process fostered an understanding of government policy and practice that may have enhanced their public service capabilities. This exercise of democratic citizenship may contribute to longer-term changes (Gaventa and Barrett 2012; Namisi 2009).

9.4. Beyond ‘light-touch’ interventions: The potential of multi-level strategies

Much accountability-related literature focuses exclusively on locally-bounded, project-based interventions, so ACT Health’s multi-level approach stands out as distinctive.²⁷ The intervention tested in the ACT Health RCT can be considered ‘low dose’ or ‘light touch’ as it was a series of four dialogues at six-month intervals, largely limited to community-level participants (community members and health workers). Here, we reflect on some possible limits of that approach and contrast it to the multi-level work after the RCT ended. The overall ACT Health program illustrates the distinction between ‘tactics’ (or tools) and ‘strategy’ which combines many tactical approaches to foster change (Fox 2015).

A light-touch, tool-based intervention tested a limited, community-level approach

The RCT intervention tested an accountability tool (citizen report card) that was by design light touch, low dose, and locally-bounded. Each of the 282 intervention catchments had five facilitated dialogues over two and a half years. Facilitated dialogues took place only at six-month intervals. Community-level dialogues lasted about 5 hours.²⁸ We can consider this a relatively ‘**low dose**’ exposure to an intervention. The ACT Health RCT sought to study the outcomes of household and health facility staff efforts *without* CSO involvement between dialogues. The RCT research design prohibited CSO staff contact with communities or health workers in the intervening months. This constitutes a relatively ‘**light touch**’ approach. The Phase 1 approach explicitly excluded district-level officials from participating in dialogues. The Phase 1 facilitation guidelines encouraged community-level dialogue participants to focus on low/no cost actions that could be implemented locally. For these reasons, we consider this a ‘**locally bounded**’ approach.

In brief and intermittent interactions, it is incredibly ambitious to ensure that participants dig deep enough to surface root causes of issues, let alone design community-level actions to address them. With limited time in communities and infrequent contact, facilitators may struggle to develop relationships or earn the trust of participants. Likewise, external facilitators must quickly

learn local power dynamics, which may be too much to expect in the confines of the induced activities at six-month intervals. In contrast, during Phase 2 advocacy campaigns CSO staff maintained regular contact with advocates in training workshops, review meetings, phone calls, visits, coaching, and mentoring. The nature of this accompaniment support helped community advocates analyze the root causes of their priority advocacy issues and target asks to powerholders. Sustained contact between CSOs and advocates helped to deepen solidarity relationships and strengthen campaign strategies. Sustained CSO accompaniment (coaching, mentoring and support) of advocates through the 18 months of campaigns fostered a “learning-by-doing”, starkly contrasts the relatively bounded intervention studied in the RCT.

Sustained citizen-led advocacy efforts directly engaged multiple subnational authorities

The overall ACT Health strategy emphasized citizens’ direct engagement with government officials at multiple levels, in contrast to the RCT, which by design excluded engagement with government officials beyond the sub-county level. As demonstrated in **Section 6** and **Section 7**, in all 18 districts, we find evidence of direct, sustained, citizen-led engagement with elected and appointed officials at the village, sub-county, and district levels. Despite many challenges, in many districts, community advocates persistently applied pressure on target audiences through multiple cycles of engagement. The evidence of citizens’ direct and sustained engagement with government officials across multiple levels is an achievement in and of itself in this context. Advocates themselves distinguished between community-level dialogues and the subsequent advocacy campaigns:

“There is a very big difference. With dialogues, we would stop at the sub-county – we were not known at higher levels. Now with PCA we open different offices at higher levels. RDC will recognize we are from a specific boma [neighborhood]. Now at the health center the lowest member gets treated fast and better and that was not happening during dialogues.” (Community advocate, interview, Kabarole, June 21, 2018)

“At the time of the dialogues, we didn’t see much change. We would discuss at the HC level, but things still didn’t change. It was not until we submitted petitions that actions were taken.” (Community advocate, interview, Bundibugyo, June 22, 2018)

While the literature suggests that it is especially difficult to pursue approaches that transcend the local level in weak or oppressive states (Gaventa and Barrett 2012), the ACT Health program shows that even in contexts dominated by complex political, administrative, and power hierarchies it is possible to create spaces for citizen–state engagement across multiple levels. Citizen-led engagement engendered commitments and actions in almost every district. In eight districts, government officials met or exceeded their commitments to action.

Building a bottom-up campaign to engage national-level officials requires time and technical accompaniment

The national campaign engagements differed from conventional CSO-led advocacy efforts because they were grounded in extensive prior work in districts. Building from district campaigns, the ACT Health consortium helped community advocates reach multiple audiences at the national level. This bottom-up approach to agenda-setting and multi-level advocacy really only began in late 2017. Coordinated, visible national-level campaign actions began in the last six months of the UK Aid-funded project. Given the short timeframe for the coordinated national campaign on absenteeism, no significant changes resulted from pledges by national-level duty-bearers.

While the process of intra-district organizing and executing 18 subnational campaigns was viable without material incentives to advocates, reaching the national level was more challenging. Many community advocates had never been to Kampala, let alone to Parliament. Significant technical support, accompaniment, and time were needed to research, target, and execute successful national-level advocacy. Support from CSOs and advocacy experts helped advocates unpack power dynamics, build relationships, and strategize. It is difficult, but ACT Health has shown that it is possible to open the doors of national government officials to citizens.

The high material costs of coordinated, collective advocacy at the national level mean that community-based advocates could not have convened in Kampala without support. Collective national-level engagements may require more resources than citizen groups can raise, yet the ACT Health program also demonstrates that national-level actors (for example the Inspectorate of Government) are within reach of coordinated district-wide campaigns. Advocates in at least 2 districts reached—or threatened to reach—national offices to request investigation and oversight of recalcitrant district-level officials. Community advocates’ independent engagement with the Inspectorate General of Government continued well after formal CSO accompaniment to advocates had ended.

9.5. Community-led advocacy triggered dynamics of state responsiveness

The empirical details in **Section 7.2** illustrate nature and types of responses of government officials to community advocates. Here, we discuss how community advocates’ campaigns *may* have triggered responses from government. Each of these is an area for further learning from strategic accountability approaches.

Community advocates navigated politics, activating checks and balances

Community advocates worked to activate subnational governmental checks and balances. District level campaigns had to navigate three parallel elected and appointed governance structures: the Chief Administrative Officer (a centrally appointed bureaucrat), the Local Council V Chairperson (elected), and the Resident District Commissioner (executive branch appointee). To activate checks and balances at the subnational level, and community advocates engaged leaders in all positions—often approaching one leader with requests to influence or pressure another duty bearer to act.

Recent studies from Uganda have highlighted the importance of political competition in a district as a driver of responsive government action (Dewachter et al. 2018; Grossman and Michelitch 2018) yet we observed the *opposite* from people-centered advocacy

campaigns. In ACT Health, districts with top leaders from the same political party were more likely to deliver on commitments/pledges to advocates. For example, Gulu District, rated yellow on the Heat Map (commitments made with limited implementation), illustrates the negative effects of top district-level officials from opposing political parties. The Gulu District Local Councilor (elected) was a prominent opposition leader who embraced the advocates and committed to engage other duty-bearers on absenteeism. Gulu's Resident District Commissioner (a presidential appointee and member of the ruling party) feared that community advocates were working against his party and disregarded the issue tabled by advocates.

Patterns in the ACT Health implementation districts seem more similar to findings of recent comparative work in Uganda suggesting that collaborative coalitions at district level—among politicians, bureaucrats, health sector professionals, and CSOs—“with the capacity and commitment to devise and enforce innovative approaches to governing the sector” drive good service delivery (Bukonya and Golooba-Mutebi 2019:2). It may be the case that public servants who already embrace the value of citizen involvement will be more responsive. The role of political party affiliation, competition, and coalitions of public servants on government responsiveness to citizens are areas for future studies.

People-centered advocacy campaigns triggered synergy between bottom-up and top-down approaches

The Power to the People and ACT Health RCTs both suggested that synergy between bottom-up and top-down approaches to accountability could be productive, yet neither chose to study those dynamics. The Power to the People researchers suggested that community monitoring could “play an important role in improving service delivery when traditional top-down supervision is ineffective... [but] it may also be the case that combining bottom-up monitoring with a reformed top-down approach could yield even better results” (Björkman and Svenson 2009:767). A decade later, the ACT Health RCT *explicitly avoided* testing any hypothesis related to “top-down” monitoring because the motivation was to re-test the original theory studied in Power to the People (Raffler et al. 2019:6–9).

The Phase 1 RCT study design's light touch approach explicitly prevented inclusion of district-level officials in community dialogues. While not tested in the RCT, ACT Health researchers observed that intervention effects on “treatment quality” nearly doubled when sub-county officials were present in intervention dialogues (Raffler et al. 2019:6–9). This finding is consistent with the broader ACT Health strategy, which anticipated that citizen engagement of higher-level officials to encourage top-down oversight would be necessary to trigger increased systemic responsiveness and accountability to citizens.

Phase 2 fostered experimenting with and encouraging synergy between bottom-up and top-down approaches. Advocates designed their campaigns to trigger top-down oversight and action from higher level officials. Some higher-level officials were initially skeptical or resistant, but many came to appreciate the earnest independence and the detailed monitoring work of advocates. In 13 of 14 districts, officials did their own independent monitoring to verify reports of health worker absenteeism—a clear example that advocates effectively triggered top-down oversight.

Government responsiveness revealed subtle changes in power relationships

When community advocates began monitoring facilities, some health workers resisted and, in a few extreme cases, retaliated (see backlash discussion in **Section 7.2**). Upon learning that advocates had reached district officials, some Health Center In-Charges called community advocates in to negotiate with them after having treated them badly in prior interactions. In Mubende, advocates were unsatisfied by limited responses from district officials and triggered an independent investigation by the Inspectorate of Government (top-down oversight from national to subnational officials). Community advocates in Bundibugyo threatened to appeal to the Inspectorate of Government, and that threat alone appears to have triggered district-level action (**Section 8.2**).

Examples of proactive transparency at health facilities (i.e., posting of staff names and duty rosters) and district-level officials reporting findings back to advocates after their rounds of top-down monitoring (completing feedback loops) are signs of downward accountability

to citizens. Feedback from interviews with community advocates informs the understanding of these possible drivers of responsiveness. Community advocates' own analysis echoes what is seen in the broader process monitoring data. For example:

"Community used to take the health workers as the president. Now, health workers know that the community knows their rights and responsibilities. The Relationship has changed greatly." (Community advocate, interview, Kabarole, June 2018)

"At start, people like the LCI [village elected local councilor], other community members and HC staff

couldn't believe we could go as far as the district government. They thought at most we would stop at the sub-county and now they hear we have gone to the RDC [Resident District Commissioner]. The RDC invited us to attend a meeting with state house and the LCV [district elected local councilor] started to respect us more after that" (Community advocate, interview, Kabarole, June 2018)

These examples illustrate some advocates' experiences of change—however incremental—in power and accountability dynamics. In this context, these subtle changes are significant, and *may* encourage citizens' continued engagement with the state.

X. Conclusions



The normative and empirical discussions about accountability efforts range far and wide. Expanded visibility of social accountability interventions since the early 2000s has driven practitioners and researchers to explore relationships between transparency, participation and accountability. While the influential Power to the People research results presented a narrative that a low-cost, light-touch interventions could have transformational effects on population health outcomes, more recent research dampens this enthusiasm. The ACT Health RCT tested some of the underlying assumptions of information-led, community-bound accountability work. The ACT Health strategy also supported multi-level, people-centered advocacy campaigns highlighting more complex, flexible and reflexive approaches to participatory governance not amenable to RCT research.

In 2014, ACT Health started with a large community-level intervention replicating the influential Power to the People research on an information-led approach to accountability. Beginning in 2016, the people-centered advocacy support included strategic action not tested in the RCT: 1) horizontal organizing of community advocates from multiple health facility catchments for joint district campaigns; 2) community selection of priority advocacy agendas; 3) coordinated community monitoring and data analysis; 4) training and mentorship on government policies, processes, and mandates; 5) community-led political economy analysis to identify key advocacy allies and target audiences; and 6) community advocates' direct engagement of government actors at multiple levels. Following the principle of people-centeredness, CSOs took a back seat, finding ways to support community advocates to directly engage district and national-level officials on the issues that mattered most to them and their communities.

Health worker absenteeism—the focus of 14 out of 18 subnational advocacy campaigns—results from a complex nexus of policy and practical negligence throughout the governance chain. Many accountability approaches, particularly those most visible in the literature, tend to focus on holding the least powerful actors

in such systems (front-line health workers) to account, and neglecting those with more power, higher up the system (Fox 2015; Nelson et al. 2018).²⁹ In contrast, the 396 community advocates from 18 districts worked collectively to engage government officials, from front-line health workers to district officials, the regional offices of the Inspectorate General of Government, and the Speaker of Parliament in Kampala. A central strategy of most advocates was to activate 'top-down' official oversight and downward accountability from government actors to citizens, which is critical for triggering responsiveness and more transformational changes.

Some of the most important change goals for community advocates are the hardest to measure—especially for outsiders. Process monitoring, including a Heat Map, made visible district level variation in government responsiveness. In 8 of the 18 districts, officials implemented commitments as per the advocates' campaign asks or went beyond the original campaign requests. The process monitoring/Heat Map approach revealed both breakthroughs and bottlenecks, which in turn informed campaign efforts. This rich data also grounds the analysis in this paper.

This study of people-centered advocacy highlights several limitations of the community-based intervention tested in the RCT. These limits caution against overemphasis on RCT findings in the greater body of literature and practice on accountability work. This brings us back to the literatures which challenge the assumptions that simple solutions and project interventions or tools can address deeply entrenched governance challenges where citizens have limited power to engage the state. The empirical findings and analysis in the discussion section reinforce some critical thinking about future support to and learning from strategic multi-level accountability work.

Research & Learning

It is vital to acknowledge that RCTs are often not amenable to the more flexible and reflective accountability work that many in the field increasingly see as

having more potential to move the needle on outcomes. Since TPA strategy and practice have evolved significantly in the past 15 years, intervention research should explore causal pathways, rather than re-test earlier theory. Context-specific strategy—rather than research method—should drive learning questions and research. If RCTs are pursued, parallel qualitative analysis can provide insights into the functioning of programs like these that RCTs are not designed to uncover. Mixed methods research design should seek balanced synergy between quantitative and qualitative data (not privilege one over the other). Most conventional qualitative data focuses on aggregating quantitative data and determining average treatment effects. Process monitoring or ethnographic work can surface more territorial variation in outcomes, the understanding of which is crucial for learning why something happens or does not. Investment in strong process monitoring and analysis can surface negative and positive outcomes—all of which are essential for learning about and fostering positive change. Finally, truly balanced collaborations between researchers and practitioners—in study design and analysis of findings—will enrich learning to advance change strategies.

Accountability Work

In the context of changing and constricting civic space (with underlying tensions between the state and civil society), citizen-led accountability work is very critical. CSOs must earn the trust of citizens. Civil society strategies must be responsive to context and implemented with flexibility and creativity. Rather than extracting information and speaking for citizens, CSOs can maximize efforts to put citizens most directly affected by problems in the agenda-setting and direct advocacy roles. CSOs can offer analytical accompaniment and support to offset the costs of organizing and collective action. CSOs must also prepare citizens to mitigate backlash, and CSOs must actively monitor and intervene if appropriate.

Enabling Strategic Approaches

To inform investments in work with the most meaningful change potential, it is vital to privilege learning and research from more strategic approaches to advancing state accountability to citizens. The more strategic approaches are unlikely to be short-term, light-touch, tool-led but to be longer-term, bottom-up approaches that shift power and expand citizen's direct engagement with the state. Funding mechanisms and timeframes must allow for flexibility, creativity, and reflexivity in implementation. Induced interventions can work under the right conditions, with the right scale, and strong strategy. A 5 to 6-year timeframe is likely a minimum to see and understand change. If funding research in the transparency, participation, and accountability space, practitioner-led research and mixed method designs are needed to inform future strategic practice.

Finally, as exciting as the cycles of citizen action and government responses evident from the people-centered advocacy approach are, as practitioners we are not naïve to the limits and risks of induced interventions. Independent monitoring by citizens alone (and in perpetuity) risks placing excessive burdens on those closest to problems, but with the least resources and authority to directly solve them. The right strategic support from funders and CSOs can create an enabling environment for horizontal organizing and collective voice, increasing the power of community members vis-à-vis government officials. Long-term, iterative and people-centered approaches targeting multiple levels of governance are much more likely to create conditions for deepening democracy and positive change.

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ANNEXES

Annex 1. Mandates of Uganda's executive, elected and appointed officials at various levels (focus on health)

Level	Government Health Service	General mandates	Executive	Legislative (elected)	Technical (appointed)
Central	<ul style="list-style-type: none"> Regional referral hospitals (managed centrally) 	<ul style="list-style-type: none"> Set strategy Make policy Establish guidelines Set budget guidelines 	<ul style="list-style-type: none"> President (elected) 	<ul style="list-style-type: none"> Member of Parliament (10 military MPs) 	<ul style="list-style-type: none"> Line ministries (Health, Gender, Education, Local Government, Finance, etc.)
Level V District	<ul style="list-style-type: none"> Hospital (not all districts have a hospital) 	<ul style="list-style-type: none"> Policy implementation Resource allocation Human resources (hiring, disciplinary functions) Drug management Monitoring services Support supervision 	<ul style="list-style-type: none"> Resident District Commissioner (RDC) appointed by the President 	<ul style="list-style-type: none"> Chairperson Local Council V (LCV) Women Member of Parliament (designated seats at district level) 	<ul style="list-style-type: none"> Chief Administrative Officer (CAO) District Health Officer (DHO) and other line ministry officials Commissions, authorities, planning units, etc.
Level IV County	<ul style="list-style-type: none"> Health Center IV (HCIV) 	<ul style="list-style-type: none"> Largely eliminated as districts have become more numerous 	<ul style="list-style-type: none"> Hospital management committees (appointed) 	<ul style="list-style-type: none"> Member of Parliament Local Council IV (LCIV) 	<ul style="list-style-type: none"> Largely eliminated as districts have become more numerous
Level III Sub-county	<ul style="list-style-type: none"> Health Center III (HCIII) offer curative and preventative in-patient and out-patient services, maternity services, and other specialized services 	<ul style="list-style-type: none"> Local planning Local budgeting Monitoring services HCIII offer same services as HCII plus in-patient ward, maternity services, lab services and HIV/TB HCIII staff coordinate VHTs 	<ul style="list-style-type: none"> Health Unit Management Committees (appointed) 	<ul style="list-style-type: none"> Chairperson Local Council III (LCIII) 	<ul style="list-style-type: none"> Sub-county Administrative Secretary (SAS) also called Sub-county Chief
Level II Parish	<ul style="list-style-type: none"> Health Center II (HCII) offer basic out-patient, curative and preventative services 	<ul style="list-style-type: none"> HCII offer basic out-patient services (preventative and curative) Referrals to higher level facilities HCII staff coordinate VHTs Parish Chief monitors service 	<ul style="list-style-type: none"> Health Unit Management Committees (appointed) 	<ul style="list-style-type: none"> Chairperson Local Council II (LCII) 	<ul style="list-style-type: none"> Parish Chief
Level I Village	<ul style="list-style-type: none"> Village Health Teams (community-based outreach, referrals to facilities, and in some districts treat pneumonia, diarrhea and malaria) 	<ul style="list-style-type: none"> Information provision Mobilize for campaigns (such as immunization) Community case management of diarrhea, pneumonia and malaria (where trained/supplied) Refer to facilities 		<ul style="list-style-type: none"> Local Council I (LCI) Village Health Team (VHT) 	<ul style="list-style-type: none"> Front-line workers (health workers, teachers, etc.)

Source: Compiled by authors from various Government of Uganda documents.

Annex 2. Sample Phase 1 Action Plan (generated by community members and health workers)

Issue	Action	Person Responsible	Expected Completion Date	Evidence of Progress on Action	Person Responsible for Monitoring Progress
Sanitation condition of the Health facility	Community should support in the cleaning to bathroom and latrines, sensitize community on the issue of sanitation	Community and VHTs	18-Mar-15	Improved sanitation, attendance and minute of the sensitization meeting on sanitation	Incharge
Relationship between health center staff and community	Health center staff to adhere to the standard time for work, community to observe time for services	Community & Health center staff	19-Mar-15	Feedback on improved time management, OPD register, Staff Attendance register	HUMC chairperson
HUMC	Write a letter to the subcounty Chief and LCIII requesting for the immediate appointment of HUMC	Incharge	3-Apr-15	A copy of the letter requesting for immediate appointment of the HUMC	HUMC chairperson
Service delivery	Health center staff to adhere to the standard time for work, Community to observe time for services, health center staff to improve on their attitude towards staff	Health center staff	18-Mar-15	Feedback from community on service delivery	LCIII / HUMC
Staff allocation	Write a letter to the DHO requesting for the replacement of staff transferred	Incharge	18-Jun-15	A copy of the letter requesting for replacement.	HUMC chairperson
Fees at the health facility	Organise a meeting between health center staff and community to address the issues of payment, cash payment and in kind payment at the health center	LCIs	18-Mar-15	Minute of the meeting	HUMC chairperson
Family planning services	Sensitize both men and women on the importance of family planning whenever they come for the service at the health facility and also during outreaches	VHTs, Health center staff	3-Apr-15	Attendance and minute of the meeting	VHT supervisor and Incharge

Annex 3. Overview of training for community advocates

Implementing the PCA approach required a significant shift in the way CSO partners approach advocacy. An iterative, four-step training prepared the ACT Health program staff (and ultimately community advocates) for this journey. Each step covered a number of lessons, or “modules” over the course of four days. After each step, community advocates held feedback meetings in their communities and tested their new skills in practice. This is a summary of the advocacy topics covered:

Step 1. Identifying the problem

Module 1. Why are we here?

Module 2. The community advocate’s mandate

Module 3. What problems should we advocate for?

Module 4. What evidence do we need to show the magnitude of the problem?

Step 2. Collecting and making sense of the data

Module 5: Making sense of the evidence we collected

Module 6. Choosing which issue to advocate for

Module 7. What shall we achieve if the issue is addressed? What will change?

Module 8. What needs to be done to influence/ make this change?

Step 3. Identifying campaign targets (drafting messages and developing plans to persuade allies)

Module 9. What is responsible for making this change? Who supports them? (Duty-bearers)

Module 10. Which friends can we call on to support our cause? (Allies)

Module 11. What shall we tell the duty-bearers and allies? (Messages)

Step 4. Developing and preparing a plan of action to approach duty-bearers and influencers

Module 12. What do we need to do to deliver these messages? (PCA plan)

Module 13. How shall we know that the situation has changed? (Monitoring plan)

Module 14. Practicing message delivery (role plays and practice delivering messages)

Module 15. Improving the messages

Step 5. Delivery of campaign messages to duty-bearers/ allies and follow-up to monitor commitments

The implementation phase started immediately after training was completed. Each district had a **complete advocacy strategy** with a plan by the end of the training process. Some of the key parts of the implementation phase included:

- Delivery of developed messages and “asks” to primary and secondary audiences
- Community feedback sessions
- Monthly/bi-monthly follow-up meetings with CSO officers to monitor and strategize on progress made (including setbacks)
- Participatory data analysis to review implementation activities and develop next steps, based on initial responses from district duty-bearers

The set of tools which were specifically developed during the ACT Health program for use by community advocates included:

- Campaign message delivery plan
- Resource mobilization plan
- Officers’ support plans
- Change monitoring plan
- Commitment/pledges log
- Contact logs

To access the guide and workbooks, see:

[People Centered Advocacy Management Guide](#) and [People Centered Advocacy Community Advocates Workbook](#).

Source: People-Centered Advocacy Management Guide (Ntulo, et al 2017)

Annex 4. Phase 1 Action Plan Summary – Frequency of Issues and Rates of Resolution

Issue code	Frequency	Reported 'achieved'	Examples of issues from action plans
Absent / Late / Time Mgmt	302 (12%)	257 (85%)	Staff attendance at the health center; work time schedule / time management; late-coming of health workers; early departure of health workers; health center opening and closing time; In-Charge away from the health center
Access to information	257 (10%)	201 (78%)	Information on rights and responsibilities; awareness of health rights and responsibilities; information on working hours; Information on services provided at the health center; community doesn't know about free services
Family planning	244 (9%)	201 (82%)	Low use of modern contraception/ family planning; family planning utilization; information on family planning services; attitude/ misconceptions/ fear side effects of family planning; male resistance / cultural pressure to have children; family planning uptake
Drugs	233 (9%)	188 (81%)	Drug stockouts in previous quarter; information on drug delivery at health center; information on what drugs available at which health centers; drug availability at the health center; community members come when they see the drugs have been delivered; community go to health center to get medicine when they are not sick (pre-stocking for later), which affects drug stocks/ supply management
Community structures	169 (7%)	125 (74%)	Health Unit Management Committees (HUMCs) not active; HUMCs not providing information to community; some VHTs not active; community do not understand HUMC roles; HUMC do not understand their roles/ not trained
Other	150 (6%)	73 (49%)	Any issue not fitting in the existing categories
Antenatal care (ANC)	148 (6%)	116 (78%)	Low ANC attendance/ need to increase ANC visits; women coming late for first ANC visit (making it difficult to complete 4); low male participation in ANC/ need to increase; ANC service utilization/ low ANC attendance; information on ANC
Self-treatment / adherence	132 (5%)	98 (74%)	Self-medication by community members; self-diagnosis; not completing treatment/ lack of adherence; sharing prescriptions; getting drugs when not sick
Health center management – other	122 (5%)	73 (60%)	Cleanliness of the health center; uncoordinated leave
Relationships	122 (5%)	111 (91%)	Rumors about health center staff
Staffing levels	108 (4%)	61 (56%)	No qualified midwife; number of staff at the health center; delayed recruitment of midwife/ staff; transfer of -In-Charge/ any staff
Utilization – Under 5s	92 (4%)	68 (74%)	Immunization vaccines at the health center; timeliness of immunization; treatment of children at the health center
Infrastructure	86 (3%)	35 (41%)	Health center has no maternity ward; no staff housing; no latrine; no water source; no incinerator/ placenta pit/ waste management; no power source/ electricity/ solar panels; non-functional lighting for the delivery room

Delivery in facility	82 (3%)	58 (71%)	Low number of deliveries at health center; prefer to deliver at home, with traditional birth attendant, delivered more quickly, etc.; information on delivery
Utilization – other	81 (3%)	62 (77%)	Late-coming by the community members; children going to health center with other children (alone); utilization of the health center
Staff conduct	71 (3%)	59 (83%)	Attitude of staff towards patients; health workers are rude; conduct of male health workers; sending away patients
Community hygiene	67 (3%)	38 (57%)	Patients not bathing before coming to the facility; household sanitation
Fees	52 (2%)	45 (87%)	Charging fees for delivery; charges for ANC; in-kind payments; voluntary payments; charges for drugs; charges for family planning; charges for immunization; cash payments; fees at the health center
UNMHCP service missing	39 (2%)	31 (79%)	ANC services not provided; delivery not provided; family planning not provided; prevention of mother-to-child transmission (PMTCT) services
Health center upgrade	18 (1%)	1 (6%)	Upgrading health center level (from II to III or from III to IV)
Primary health care (PHC) funds	6 (0%)	5 (83%)	Utilization of PHC funds; insufficient funds; information on primary health care (PHC) funds/ transparency of In-Charge
TOTAL	2,581	1,906 (74%)	Out of the 2,581 issues in action plans in 282 facilities, community-level participants reported that 1,906 (74%) of issues were resolved by the end of 4 follow-up dialogues.

Source: GOAL ACT Health Management Information System (MIS) database.

Annex 5. “Commitment log” recording community advocates’ actions and government responses

Date	Action taken	Target audience	Channel or medium used	Commitment/pledge made	Timeframe for Commitment	What shall we do to follow up this commitment /pledge	When shall we follow up	Who will follow up	Status of commitment (Achieved, Not Achieved, Partially Achieved)
16/3/2017	Meeting with the audience.	COA	Oral and written	The COA committed to come and meet up the CAs in their respective places so that he could follow up the issue that was raised.	2 weeks from the time of the meeting.	A physical follow up will be done on The CAO to see that he fulfills his commitment.	25/4/2017	Mr. Male Musa.	Not achieved -the CAO did not fulfill his commitment.
16/3/2018	Meeting with the audience.	DHO	Oral and written	The DHO to call for a meeting of the incharges of the five health centres to discuss the findings and also do more investigation.	2 weeks time.	A physical follow up will be done on The DHO to see that he fulfills his commitment.	25/4/2017	Mr. Male Musa.	Not achieved -the DHO had not done any thing to his commitments.
16/3/2019	Meeting with the audience.	Chairman service commission	Oral and written	To present the issue to the council in their forth coming meeting and also recommend for further investigations and to punish those that are involved.	1 month	The chairman service commission will be followed up physically.	25/4/2018	Mr. Male Musa.	Not achieved- there is nothing done to the that commitment proposed.
16/3/2020	Meeting with the audience.	DISO and the RDC.	Oral and written	To come and discuss on the data about the staff who have private clinics which he requested the CAs to gather.	2 weeks	A physical follow up will be conducted.	25/4/2019	Mr. Male Musa.	Not achieved- there is nothing done to the that commitment proposed.
16/3/2021	Meeting with the audience.	The District Chairman LCV.	Oral and written	To always mobilise for any meetings that the CAS will have requested to call upone and link different stake holders and dicision makers to them.	always	A physical follow up will be conducted.	25/4/2020	Mr. Male Musa.	Not achieved- the CAS have not yet proposed any assistance to his commitment.

Annex 6. Summary of 18 campaign statements and rating of government responsiveness (as of June 2019)

#	District	Issue	Campaign Statements as Written by Community Advocates	Rating
1	Agago	Staffing	Patients visiting HCIIIs and HCIIIs in Agago District are not fully attended to or miss treatment because many of the assigned health workers have either left, died, retired, or were posted but never reported, and have not been replaced.	PURPLE
2	Mubende	Absenteeism	People in Mubende District do not access health services because health workers are consistently absent from work or do not work the prescribed working hours.	YELLOW
3	Omoror*	Absenteeism	Health worker absenteeism and tardiness.	GREEN
4	Tororo	Absenteeism	Patients from Mwello, Were, Maundo, Makawari, Morikiswa HCII, do not fully access health services because health workers do not work the prescribed working hours (8:30am--5:00pm).	GREEN
5	Apac	Absenteeism	Patients in Apac District do not receive services at government health centers because staffs come late for work.	YELLOW
6	Bukedea	Absenteeism	Lack of adequate houses in HCIIIs of Kidongole, Malera and Kachumbala sub counties in Bukedea District has led to late-coming, absenteeism and neglect of duty by the health center staff resulting to long waiting time, complications and death of some patients.	PURPLE
7	Bundibugyo	Absenteeism	Patients spend a lot of time at in the health center of Ntandi, Bubukwanga, Buhanda, Bukangama and Bupomboli waiting for treatment because medical workers report late for duty and leave early before the time the government recommends.	GREEN
8	Gulu	Absenteeism	Many patients are not getting treatment because health center staffs are coming late and leaving early from duty.	YELLOW
9	Kabarole	Absenteeism	Patients spending a lot of time at the health center waiting for treatment because medical workers report late for duty, leave early before the time the government recommends, and most times they are absent from duty.	PURPLE
10	Kagadi (Kibaale)	Absenteeism	Absenteeism and late-coming of staff that has caused overcrowding and long waiting time of patients at the health centre hence some going home without treatment.	YELLOW
11	Kakumiro (Kibaale)	Absenteeism	Patients wait for long; others go back without receiving treatment because health workers report late at the HC and many others don't even report for work.	YELLOW
12	Katakwi	Environmental Degradation	Environmental degradation due to lax enforcement of district laws.	YELLOW
13	Kitgum	Staffing	Patients wait for long hours at the facility to get medical treatment because the health workers report late for work and depart early from work, others absent and or abscond them-selves from work without approved permission.	RED
14	Lamwo	Absenteeism	Patients in Lamwo District are not getting treatment effectively as required because medical staff start work late and close early, others absent themselves from duty, and other facilities have the name of staff in the staff register but the staff have never been seen at the facility, therefore the number of medical staff to attend to patients in those health facilities are not always enough. the staff have never been seen at the facility, case of Ogako Health Centre II where there is a name Owot.	YELLOW
15	Lira	Absenteeism	Patients from Barapwo HC III, Anyangatir HC III, Barr HC III, Ongica HC III, Akangi HC III and Aromo HC III in Lira District waited for long hours to get treatment and some miss treatment because 85% of HC staffs arrive late and leave duty early on average at 10:34am and depart at 4:23pm so we lose 3hrs 21mins.	YELLOW
16	Manafwa / Namisindwa	Lighting/ Infrastructure	In the six health centers of Nabitsikhi, Bunambale, Butiru, Bukhabusi, Bubutu and Bukewa HCIIIs, there is no lighting because the installed solar panels are not functional.	GREEN
17	Nakaseke	Absenteeism	Patients wait long hours and some miss treatment because health workers absent themselves from duty during working hours.	RED
18	Pader	Absenteeism	Late-coming, leaving work before time and absenteeism by health workers is responsible for patients going without treatment and overcrowding of patients at the health centers in Pader District.	GREEN

Source: GOAL Heat Map

Endnotes

- 1 The ACT Health program was funded by UKAid under component code 200779-113 and titled “Promoting Health Sector Accountability in Uganda Through Support to GOAL Uganda”. The implementing consortium included [GOAL, Coalition for Health Promotion and Social Development](#) (HEPS-Uganda), [Kabarole Research & Resource Centre](#) (KRC), and [Multi-Community Based Development Initiative](#) (MUCOBADI). [Innovations for Poverty Action](#) (IPA) carried out all data collection and cleaning under three principal investigators (Pia Raffler, Daniel Posner, and Doug Parkerson). GOAL coordinated the implementing consortium activities to maximize program fidelity, continuously building consensus around implementation tactics, challenges and solutions. GOAL also worked with researchers to ensure implementation did not compromise the RCT research, negotiating for maximum flexibility and space for the program to develop and evolve. As the prime recipient of funds, GOAL also developed a strong relationship with funders, who were always willing to discuss requests for programmatic changes, logframe updates, and budget realignments.
- 2 “Thick description” is often used in ethnographic research across social science disciplines. For more resources, see Robert Wood Johnson Foundation’s Qualitative Research Guidelines Project. <http://www.qualres.org/HomeThic-3697.html>.
- 3 Uganda’s Inspectorate of Government (<https://www.igg.go.ug/>) was initially established by the Inspector General of Government (IGG) statute in 1988. Chapter 13 of the 1995 Constitution prescribes Inspectorate of Government mandate, functions and powers. The Inspectorate of Government is an independent institution charged with the responsibility of eliminating corruption, abuse of authority and of public office.
- 4 For more on community health workers, see Schaaf, Marta, Caitlin Warthin, Amy Manning, and Stephanie Topp. 2018. “Report on the Think-In/On Community Health Worker Voice, Power, and Citizens Right to Health.” Accountability Research Center, Learning Exchange Report 3. <https://accountabilityresearch.org/publication/report-on-the-think-in-on-community-health-worker-voice-power-and-citizens-right-to-health/>.
- 5 In some cases, research is funded independently, rather than integrated holistically into broader implementation strategies. The bulk of funding goes to the formal research, with any activities coming after either dependent on the outcomes of the RCT (which can take years to produce) or receiving limited funding or treated as a “phase out” stage. Personal communication with Walter Flores, February 2020.
- 6 From 2014 – 2016, we conducted four (4) rounds of Most Significant Change (MSC) story selection. These four rounds stimulated interesting discussions about changes and the ACT Health approach, but we found the degree of time and effort expended on this did not match the expected levels of learning we had hoped to realize. The formal MSC process was too time intensive given the many demands of program delivery. In-depth discussion of this is beyond the scope of this paper, but for more discussion on the use of MSC in ACT Health, please contact Angela Bailey.
- 7 In 2012, we developed a theory of change for the ACT Health approach, which is available as a supplementary resource to this paper. It was guided by Andrea Anderson’s “The Community Builder’s Approach to Theory of Change: A Practical Guide to Theory Development”, published by The Aspen Institute in 2005.
- 8 ACT Health focused on creating/claiming spaces for direct citizen–state engagement based on the [powercube](#) and its dimensions of power, spaces and levels. In ‘*closed spaces*’ power-holders and influencers make decisions without the pretense of broader engagement (Gaventa 2006:26). In ‘*invited spaces*,’ authorities invite people to participate on the terms of the power-holders (Cornwall 2002 in Gaventa 2006). In ‘*claimed/created spaces*,’ less powerful actors either claim space from the powerful or create spaces to address common concerns (Gaventa 2006:27). In all spaces, power manifests in different ways: ‘*visible*’ (formal rules, structures, institutions, etc.); ‘*hidden*’ (powerful individuals and institutions maintain influence by controlling who is included in which decision-making processes); and ‘*invisible*’ (shapes the psychological and ideological boundaries of participation, whereby socialization perpetuates existing power hierarchies) (VeneKlasen and Miller 2002 in Gaventa 2006).
- 9 While some theorists and strategists argue that collaborative approaches are unlikely to change the status quo of entrenched power dynamics, confrontational approaches elicit significant fear in the Ugandan context (see **Section 2.3**). In reality, it is very difficult to clearly delineate ‘collaborative’ from ‘confrontational’ approaches. An action can be perceived as confrontational or collaborative, depending on one’s perspective. It is beyond the scope of this paper to address this critical issue for the TPA field.
- 10 The principal investigators of the ACT Health RCT describe the relationships between specific intervention elements (information and dialogues) tested as follows: “First, the receipt of information by both community members and health providers, via the CRC [citizen report card], should increase knowledge about issues related to health care, such as patients’ right and responsibilities, the services that are supposed to be offered at the local health center, and how the health outcomes and treatment practices at the local health center compare with those of other health facilities and with national standards. This information should put citizens in a stronger position

to evaluate whether their own health center is performing adequately and create common knowledge among community members and health center staff about the health center's performance. Second, the holding of meetings to mobilize community members and the development of action plans in light of the information provided in the CRC should allow citizens to identify concrete actions that they might take to improve health outcomes. The meetings may also generate efficacy among community members, foster a sense of responsibility for monitoring health workers to make sure they provide high quality services, and help overcome free riding problems within the community—all of which may be critical for generating bottom-up pressure by citizens and behavioral changes by health center staff (Barr et al., 2012; Lieberman, Posner and Tsai, 2014). Third, the interface meetings should provide opportunities for citizens to confront health providers directly and apply social sanctions to those revealed by the CRC to be underperforming. Alternatively, by providing a space for community members and health providers to discuss the problems and constraints they each face, the drafting of the joint social contract may generate improvements in the relationship between community members and health providers, which may in turn have positive downstream effects on utilization, service delivery, and health outcomes.” (Raffler et al. 2019:7-8).

11 The term “replication” does not yet have a standard definition in the social sciences (Clemens 2017). ACT Health RCT principal investigators highlight this in their paper: “Notwithstanding our attempt to model ACT Health as closely as possible on P2P, our discussion of the many differences across the two studies with respect to study populations, program implementation, variable operationalization, econometric specifications, and baseline conditions underscores just how challenging it is to replicate (and, by doing so, attempt to confirm or disconfirm the findings of) a prior field experiment. For these reasons, the ACT Health should be seen not as a “replication” of P2P but as what Clemens (2017) terms a “robustness test,” since it employs different code from that used in the original study and data gathered from both a different population and at a different time” (Raffler et al. 2019:35). For a complete description of the sampling, survey design, randomization, and all other technical details related to the ACT Health RCT, please refer to Raffler et al. 2019 directly.

12 GOAL monitoring officers, GOAL managers, CSO staff directors, and the GOAL Kampala-based team observed **47 percent** of community-level dialogues using structured “Observation checklists.” Observers shared their assessments with facilitators within two days of the activity, to ensure real-time feedback. After each round of activities, the GOAL team in Kampala compiled lessons from direct observations and provided refresher training to all field staff, provided new tips on improving participatory facilitation, and helping to streamline process documentation.

13 In 2016, IPA randomly selected 20 facilities in four initial districts to serve as learning and testing grounds for CSO facilitators and community advocates. For the remaining districts, GOAL purposively sampled the other 78 targeted facilities based on key criteria: (1) the majority were HCIIIs, because at that time discussions in the Ministry of Finance and Ministry of Health were leaning towards eliminating the HCII (lower-level) facilities; and (2) analysis of progress in community-level action plans which helped identify facilities that had unresolved issues requiring higher-level action.

14 The work of John Samuel was a key guidepost here. Samuel defines people-centered advocacy as an approach that enables affected people to directly advocate for social transformation by exercising their civil, political, economic, social and cultural rights (Samuel 2002:9). More recent literature highlights the critical distinction “between citizen-led social accountability and civil society-led social accountability initiatives. The latter refers to mediation of citizen demands through a civil society organization (for example, NGO, local association, social movement), whereas the former allows for direct interaction between citizens and policy makers” (Dewachter et al. 2018:160). Balestra et al. emphasize the importance of expanding research on processes undertaken by communities demanding accountability, rather than actions of CSOs (2018:1854).

15 Recent discussions about shifting power in the development industry have focused on shifting power from international NGOs to “local” counterparts (for example, the Oxfam “Power Shifts” project and multiple “From Poverty to Power” blogs). The ACT Health project focused on something deeper—shifting power over agenda-setting from CSOs to the communities most directly affected by problems in public service delivery.

16 Christina (Tina) Angela Ntulo was working as an independent consultant, and she responded to a call for proposals for a long-term consultant. Tina had previously worked for Basic Needs, which had long supported direct advocacy by people with lived experience of mental health in Uganda.

17 Initial draft processes and tools were tested in four workshops in Bugiri District from **April to November 2015**. This informed the first **People-Centered Advocacy (PCA) Manual (2016)**. We knew that the CSO staff supporting people-centered advocacy in the 18 districts also needed an opportunity to learn the approach by doing. To avoid disturbing the ongoing RCT, we negotiated with the principal investigators to randomly select 20 intervention health facilities (five per district) in Agago, Mubende, Omoro, and Tororo districts for people-centered advocacy. From these four districts, we realized the shift from CSO-led to people-centered advocacy was so great, that the “training of trainers” model was inadequate. From this learning, GOAL developed a simplified [PCA Management Guide](#) and a [PCA Community Workbook](#) (translated into seven languages) for community advocates to document their experiences, reflections, and observations of progress.

18 Many rightly question “who” participates in induced accountability interventions and speculate about the likelihood of elite capture (the risk that the most powerful and influential actors may dominate agenda-setting processes). While the guidelines and process

for mobilization prior to community-level dialogues were intended to maximize diversity of participants and perspectives, without knowing community dynamics it is impossible to determine the extent of success in this area. Schaaf et al. (2017:6) note that to some degree, elite capture may be inevitable as social accountability demands some degree of engagement with power-holders such as local leaders and members of government health structures such as Village Health Teams.

19 These indexes were compiled specifically for ACT Health by principal investigators (no input was accepted from GOAL staff or the implementing consortium), and are not directly comparable to the indicators measured in the Power to the People intervention.

20 According to program monitoring data, community advocates in these districts documented multiple rounds of data collection: Lira (January 2018), Kagadi, Gulu, Apac (November 2018), Tororo, Mubende (March 2018), Manafwa (April 2018, collecting data on water for new issue/side campaign).

21 For more on the Civil Society Budget Advocacy Group (CSBAG), see the organization's website www.csbag.org or Twitter feed @CSBAGUGANDA.

22 GOAL carried out a round of review meetings in October and November 2018 for all the 18 districts that had people-centered advocacy campaigns. These were intended to identify the progress advocates were making in their districts and health facilities after the main DFID-funded project ended in May 2018. In these meetings, community advocates shared their achievements at facility level using the people-centered advocacy skills to engage duty-bearers about emerging issues.

23 Schaaf et al. (2017) note the challenges of capturing contextual variation across geographic program areas, as this often requires deeper ethnographic sensibility or highly adept, iterative monitoring, which poses implementation challenges at scale. For an interesting and robust example, see the subnational qualitative comparative analysis of 29 municipal cases in Guatemala (Hernandez et al. 2019).

24 The version of the advocacy asks from community advocates to the Speaker of Uganda's Parliament on May 17, 2018 were tailored to her positionality and authority:

1. *After discussions with some Ministry officials and our Members of Parliament, we have agreed that first, Parliament should direct the three ministries—Health, Local Government, and Public Service—to work together towards coming up with a strategy that will eliminate health worker absenteeism within a given timeframe. We request Parliament to hold the sector's leaders accountable for the implementation of that strategy.*
2. *Second, we ask that this strategy include a provision that will enable communities to have direct access to duty-bearers at the community level where we can report health workers who absent themselves from duty. Right now, there is no office that we can go to unless someone dies. Health Unit Management Committees (HUMCs) are not empowered to reprimand health workers, while in most cases sub-county chiefs are too far away to provide daily supervision. Currently we have to wait for people to die before we can make reports at the police station. This is unacceptable as every person's life has value and should be respected. We would like to be able to access an office within our community that would have the authority to address these challenges as soon as they arise.*

25 The discussion of who implements an intervention is of vital importance, particularly in processes designed to foster trust and relationship-building as part of the action cycles. In the case of Power to the People and ACT Health, there has been some discussion of whether the choice of CSO implementers influenced different outcomes. Before the ACT Health RCT data were available, a pure replication study (re-running regression analysis using the original data) of Power to the People found that the presence of the implementing community-based organization prior to the intervention correlated strongly to measured effects on child mortality and nutrition (weight-for-age z-score) (Donato and Mosqueira 2019:982).

26 For more on the 2018 local council elections, see <https://www.myuganda.co.ug/about-uganda/local-council-elections-in-uganda>. During a series of district-level review meetings with community advocates in late 2018, GOAL staff documented the electoral victories of those selected as Local Council I (LCI).

27 In contrast to studies of project-based interventions, more organic, non-project-based multi-level accountability initiatives have been studied. See, for example: Joy Aceron (Ed.). 2018. [Going Vertical: Citizen-led Reform Campaigns in the Philippines](#) (Second Edition). Quezon City and Washington DC: Government Watch (G-Watch) and Accountability Research Center (ARC).

28 As per prevailing customs in Uganda, participants received snacks (usually a beverage and packet of cookies or a Uganda-style mandazi donut or chapati) but participants received no other incentives. No sitting fees, transport refunds, or any other remuneration were provided.

29 Nelson et al. (2018:12) argue that "Much of the current focus on accountability has been on monitoring the use of externally provided finance to health services (within a value for money framework). This can be seen as meeting the needs to an outside agency, and in support of accountability relationships that travel from top to bottom (with the least powerful actors within the system held to account, such as front-line community health workers)."

Accountability Research Center Publications

For all ARC publications, see www.accountabilityresearch.org/publications

Accountability Notes

- Rakshita Swamy. 2020. "From Peoples' Struggles to Public Policy: The Institutionalization of the Bhilwara Framework of Social Accountability in India." *Accountability Note 9*.
- Benilda Batzin, Paulina Culum, and Julia Fischer-Mackey. 2020. "Defending the Right to Health in Guatemala: Reflections of Two Indigenous Women on the Frontlines." *Accountability Note 8*.
- Benilda Batzin, Paulina Culum y Julia Fischer-Mackey. 2020. "Defendiendo el derecho a la salud en Guatemala: Reflexiones de dos indígenas de primera línea." *Accountability Note 8*.
- Daniela Rea. 2019. "The Women of Caltongo Who Opened the Government's Doors: Social Accountability at the Edge of Mexico City." *Accountability Note 7*.
- Rachel Sullivan Robinson. 2019. "Setting the Stage for Increased Accountability: The White Ribbon Alliance Nigeria Campaign to Improve Maternal, Newborn, and Child Health in Niger State." *Accountability Note 6*.
- Carlos García Jiménez. 2019. "Citizen Experiences and Challenges in Bringing Transparency and Accountability to Local Governments in Southern Mexico." *Accountability Note 5*.
- Carlos García Jiménez. 2019. "Experiencias y desafíos ciudadanos para instituir la transparencia y la rendición de cuentas en gobiernos locales del sur de México." *Accountability Note 5*.
- समीर गर्ग और शुची पांडे. 2018. "स्थायी बदलाव के लिए सीखने की रणनीतिकी भूमिका: भारत में मितानि समुदायिक स्वास्थ्य कार्यकर्ताओं द्वारा सावजनिक उत्तरदायित्व को बढ़ाने पर कार्य." *Accountability Note 4*.
- Samir Garg and Suchi Pande. 2018. "Learning to Sustain Change: Mitanin Community Health Workers Promote Public Accountability in India." *Accountability Note 4*.
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