Bilingual/Bi-annual Pakistan studies, English / Urdu Research Journal VOl.No.03, Issue No. 01
January – June 2016

GLOBAL SOCIAL ACCOUNTABILITY INITIATIVES: REVIEW OF STUDIES CONDUCTED TO ADDRESS QUALITY IMPROVEMENT IN MATERNAL AND CHILD HEALTH

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'Empowering Clients and Sensitizing Providers to Increase Uptake of Maternal and Neonatal Healthcare Services' is a project funded by the Maternal and Newborn Health Programme - Research and Advocacy Fund (RAF), and is implemented by the Centre of Peace and Development (CPD).

ABSTRACT

The World Health Organization (WHO) defines a client-centred health care system and its providers as whereby clients/users are "facilitated to identify, demand and receive services, supplies, information and emotional support they need". The focus on clients' perception of quality ensures continued uptake and better health outcomes. In responding to the need for responsive and quality public service provision, human development researchers and planners have identified "social accountability" as a valuable tool that ensures the effective provision of public services. We conducted a review and synthesis of literature to

identify findings in the conduct and gaps in research surrounding social accountability and health outcomes in general and specifically in Pakistan. A literature search was conducted using search engines of pubmed initially and followed by google/scholar on the topic of quality improvement following a social accountability model focusing on health globally and in Pakistan specifically. A saturated keyword approach was followed moving on to various combinations of search terms. All search terms and the results were recorded. To ensure all important literature is captured, the search was conducted by two researchers that were trained on the search guidelines.

The key prerequisites for the successful implementation of any SA model, regardless of the service sector being addressed, are similar concerning the major stakeholders namely the government/policy makers, citizens and service providers. Social accountability initiatives are most likely to succeed if these are sanctioned and encouraged by the government in an effort to improve service delivery for its citizens. Civil society organizations function effectively when the government invites and institutionalizes these giving them a legal or official status to conduct oversight activities.

INTRODUCTION:

Public services quality improvement initiatives have an integral component of better accountability while better accountability leads to better quality of services making the two processes complementary and a requisite for one another (Brinkerhoff, 2004). The ultimate goal of both quality improvement and social accountability initiatives is to ensure that resources are effectively used to address the needs of intended recipients all the while achieving better outcomes and user satisfaction.

In health care systems dominated by culture of resistance; initiatives to improve the quality of care are more likely to fail. These reasons namely resource mismanagement, staff absenteeism, political patronage, corruption and lack of incentives to perform better are to name a few that prevent quality initiatives from reaching maximum potential and be sustainable (World Bank, 2003). Quality initiatives which are directed towards enacting key improvements in health must address and respond to all aspects of health generation and sustainability processes (Andersen, 1995).

The use of maternal health services consisting of ante-natal care, skilled birth attendance, institutional delivery and post-natal care have proven their merit in reducing morbidity and mortality among child bearing women globally (REF). Understanding the determinants of maternal health and mortality (Caldwell, 1993; Gwatkin et al., 2007; Habicht & Kunst, 2005) several initiatives have been undertaken in Pakistan to increase uptake of MNCH services for better health outcome. The uptake of maternal health services in Pakistan shows a rising trend but the overall increase has been slow. According to the most recent Pakistan Social and Living Standards Measurement (PSLM) 2010-11 survey, 64% of women received ante-natal care during pregnancy, 45% of women had a skilled birth attendance (doctor, nurse, trained midwife) and 28% of women received post-natal care at a health facility compared to the 58% ante-natal, 33% skilled birth attendant and 25% post-natal care as seen in the PSLM 2008-9 survey. In responding to the need for responsive and high-quality public health service provision, human development researchers and planners have identified “social accountability” (SA) as a valuable tool that ensures the effective provision of public sector services to citizens. There are several process and concepts through which social

accountability is achieved. Every social accountability process and concept places particular emphasis on the needs of the poor, vulnerable, and marginalized (World Bank, 2003).

Social accountability is one of the means of overcoming the challenges in public service provision and should be the final outcome of all policy and programs geared towards citizens especially women and children. Social accountability is achieved by actions and mechanisms that citizens, communities, independent media, and civil society organizations can use to monitor and hold public officials accountable for provision of quality services. The provision of services, in public as well as private sector, takes place as a result of interaction among various actors or stakeholders functioning along several pathways (Ringold et al., 2012). The various stakeholders in this process related to health or other public services are: a) citizens/clients (e.g.: service users, patients, parents, voters etc.); b) politicians/policymakers (e.g.: president, prime minister, parliamentarians, minister and secretary health and mayors); c) organizational providers (e.g.: departments of health, water and sanitation, welfare etc.) and d) frontline providers (e.g.: doctors, nurses, teachers, engineers etc.).

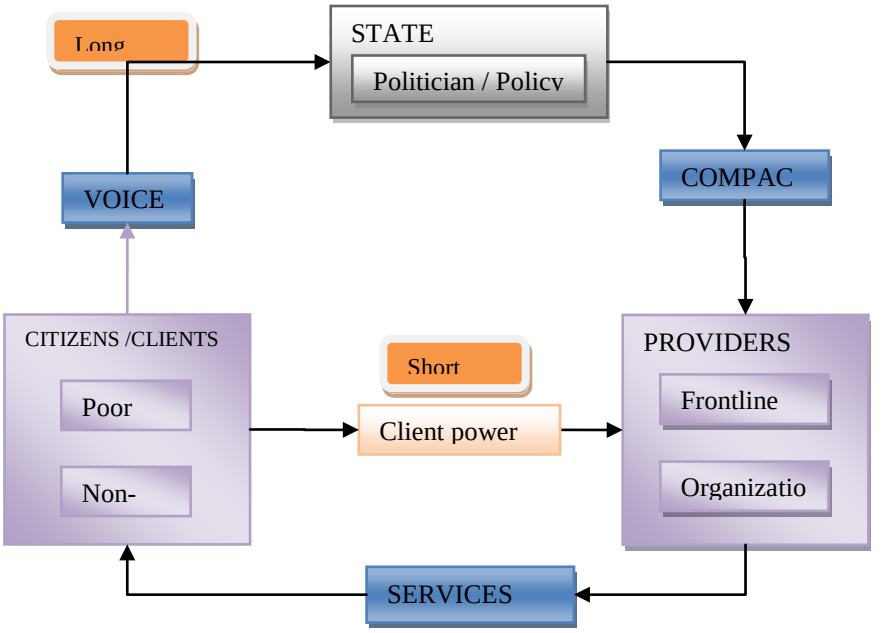
To ensure socio-economic growth and development, all stakeholders must play an active role keeping checks and balances (e.g. proper use of capital and human resources, streamlining service provision activities and ensuring day to day activities take place unhindered) in the process to ensure effective service delivery to every segment of the society. The efficient provision of these services can be ensured through a system that has inbuilt an accountability mechanisms. Citizens can take the relatively slower “long route” of accountability and exercise their individual or collective power of “voice” to hold the policy makers accountable through their votes and advocacy. Simultaneously citizens can also take the

quicker “short route” of accountability and hold the service providers accountable through citizen “client power” of exercising their choice in selecting a service provider, participation in service delivery, governance or a combination of any of the above. The use of client power is also termed as “side-ways” accountability as the clients can chose competitors and peer service providers. While citizens employ the mechanisms of voice and client power, politicians and policy makers have a compact (which is an understanding and may not be written in a manual) with service providers, as opposed to just a contract, that allows for the former to regulate and hold accountable the later to perform a set of delegated tasks of service provision (Ringold et al., 2012). In this “top-down” approach top officials like policy makers and managers influence service provision by their vested powers over service providers. In “external” accountability the stakeholders also include international organizations and foreign states, which can ensure that states are better responsive towards the needs of their population.

Ensuring that policy and programs are structured to meet the needs of the population and that citizen, poor or otherwise, are empowered to demand services can be achieved by implementing the doctrines of social accountability (World Bank, 2003). In all instances, citizens, through non-governmental organization (NGO), civil society organization (CSO) and a responsive media, play the pivotal role in social accountability in service provision sector.

Empirical construct of a social-accountability model

Figure 1: Empirical Framework for Social Accountability (Ringold, Holla, Koziol, & Srinivasan, 2012)



The objective of this literature review is to identify the various SA initiatives, undertaken specifically to improve community health, in different parts of the world. As there is a paucity of health related SA initiatives in Pakistan we reviewed the various SA initiatives carried out in the country in various public sectors, to identify the facilitators and barrier in each instance and model.

Methods

The search was conducted using online global search databases such as PubMed, Scopus and Google scholar to identify peer reviewed publications, reports and third party evaluation reports on SA models and books. Websites of groups and organization that have worked in the areas of social accountability methods, focusing on access to information and redress mechanisms were searched for case studies and reports.

Inclusion criteria

Social accountability initiatives and studies, specifically focused on population health were included in the final review. These interventions/studies were examined in detail to identify the design components and facilitators and barrier factors pertaining to the socio-demographic characteristics of individuals and communities, political environment, and technological access. Various health quality improvement initiatives that build on SA as a guiding principal but did not have detail description of the facilitating and barrier factors to implementation were not included in the review.

Data extraction

Two researchers conducted an independent online search that generated two lists of papers. The title of the papers was screened to identify potential papers whose abstracts were then selected for review. In case the abstracts provided details on the use of SA as a quality improvement initiative, then the manuscript was selected for reading. The data was entered into a matrix listing the various SA models horizontally and vertically each SA model was assessed for basic design, components,

facilitating and barrier factors. Analysis of the information was carried out by comparing the outcomes of the various SA initiatives and the facilitating and barriers factors compared to those present in Pakistan in general and Balochistan specifically.

The following keywords/search terms were used to access information. “Social accountability” “public accountability” “civic engagement” and “service provision” were entered in the search engine and relevant studies were selected. In addition to this reference lists from relevant studies were scanned visually to identify other relevant studies. We searched individual SA models and initiatives carried out in the health and used key words like “citizen report cards” “social audit” “community score cards” and “access to information legislature” to identify relevant published works. We included in our search peer reviewed published literature, reports by organization and books on the topic. In addition we read through key conference proceedings and study authors and experts in the field of SA in Pakistan were contacted. Global, regional and national peer reviewed papers, case studies and evaluation reports of SA mechanism/models in health and development sector published in the past ten years and in English language were read. Studies reported in languages other than English and earlier then 2002 were not included in the review.

Results

Among 77 abstracts identified, only five papers/documents were had a detailed description of the social accountability initiative and had implemented quality improvement mechanisms to for health outcome. There was one study from Kenya where the Citizen Report Card survey was conducted to assess the quality of health care services but the subsequent program to improve the quality of services as a result of the

survey findings was not described. We reviewed social accountability initiatives in public sectors and each of the models used were evaluated for identifying the facilitating and barrier factors for successful implementation.

A detailed description of the studies is provided below.

Improving maternal health through social accountability:

A case study from Orissa, India

In Orissa, India the program was undertaken to improve maternal health outcomes through making women more aware of their entitlements, and demand change in system and improve their health seeking behaviours(320 Papp, S.A. 2012;). The study assessed the effectiveness of the public hearings and explored what components are required to bring about a positive change. The other components of the larger initiative included maternal death audits via verbal autopsy, and a health facility checklist.

They reported that the social accountability initiative was able to create a positive change among women, policy makers and providers. It was further noted that even a single tool like a public hearing need to be used in combination with other tools that involve top down and bottom up efforts on a continuous basis, to address the issues that perpetuate the inequalities in the society. They identified that by generating demand for quality services, leveraging intermediaries and sensitizing leaders and providers to the health needs of women, open dialogue via public hearing would act as the facilitating factors for the social accountability initiative to be effective. A major barrier that was identified and that has to be overcome is the mind-set among marginalized women, providers and

policy makers. A mind-set that does not see the need for quality health service has to be changed for SA initiatives to be successful.

Improving governance the participatory way:

A pilot study of maternal health services for urban poor in Bangalore:

In Bangalore, Karnataka state of India, the Public Affairs Center (PAC) undertook multi-stage Citizen Report Card initiative over a period of three years in order to improve the functioning of the public maternity homes (Nair, 2012). They also aimed to build the capacity of community groups and mobilize communities to demand better quality of care, and to create partnerships between NGOs and the government. They employed a number of social accountability tools to achieve their objectives by using i) Citizen report card survey, ii) budget and outcome analysis and iii) Community score card. All the activities were followed up vigorously for evaluation. Following the CRC exercise several recommendations were made and followed through namely: formation of a citizen oversight bodies, citizen's charter and cost sharing of the services by the users. Other measures like outsourcing of maternity home linen and cleaning services, formation of patient help desks and publicizing patients' rights and entitlements through the media were also instrumental in improving the overall quality of services. To further improve the quality of services fully qualified nurses were hired to deliver services and replace untrained personal. The evaluation of the social accountability initiative to improve the quality of services in maternity homes showed reduction in corruption and an improvement in cleanliness. The introduction of a minor user fee, which was utilized to further improve the services, also gave the users a bigger say in demanding quality services. However the participation by

community volunteers forming the Board of Visitors (BoV) to oversee the functioning of the maternity homes was not consistent over time showing a gradual decline. The major facilitators of the process were the group of civil society organizations that had capacity and wiliness to work on the agenda. Also there was buy-in by the government and those service providers and policy makers who were supportive of the initiative. The major barriers listed in the study were 1) community organizations keeping a check on the functioning of maternity homes lacked the capacity to understand and track budgets and 2) loss of interest and motivation of the Board of Visitors (BoV) from the community entrusted for ensuring that maternity homes provide quality services on a continuous basis.

Voice and Accountability

The Role of Maternal, Neonatal and Child Health Committee

The Research and Evaluation Division (RED) BRAC, Bangladesh evaluated the effectiveness of maternal, neonatal and child health (MNCH) committees' effectiveness and their efforts to increase community participation in MNCH promoting activities, empower communities to shape services to be more responsive and thereby reduce maternal and child mortality (Leppard, 2011).

The study showed that MNCH committees have modest success izAn improving community uptake of MNCH services as these also have a limited scope in helping community to voice demand for better services. The report stated that community participation always improves health outcomes to some extent but the committee activities were not consistent in the different areas where that program was implemented. Overall community awareness about neonatal risks improved and thus resulting in

an increase in the health seeking behaviour of the people who came into contact with the MNCH committees. However the committee activities benefits were limited to members close in kin to them and their neighbourhoods.

Building Civil Society's Budget monitoring capacity of HIV and AIDS resources in Southern and Eastern Africa

In response to the growing epidemic of HIV & AIDS in Africa despite allocation of funds for the continent, the Centre for Economic Governance and AIDS in Africa (CEGAA) undertook the initiative to train and build the capacity of Civil Society Organizations (CSO) to Monitor HIV & AIDS budget from local up to national level in order to generate greater accountability. The CEGAA employed a number of mechanisms by which it could carry out the implementation of economic governance through budget analysis (Guthrie, Ndlovu, Wanjiru, & Chiwangu, 2010). The study reported that the initiative resulted in increase in capacity of the CSO to track budgets and this can bring improvement in resource management but warned that the process is slow in bringing about change.

The authors of the study identified several facilitator factors for a wide initiative such as this which included 1) a strong political will, 2) well trained technical staff to carry out the training and capacity building of CSO and institutions and 3) adequate funds to support the activities.

The major barriers identified to this type of activity were 1) authoritarian states and organizations, 2) disconnect between government and CSO, 3) lack of transparency for financial management and processes within the government and CSO.

"Power to the People"

Evidence from a Randomized Experiment of a Citizen Report Card Project in Uganda

To increase service utilization and improve the health outcomes of mothers and children, the CRC initiative was carried out in nine districts in Uganda a collaborative project by the Uganda Ministry of Health, the World Bank, Stockholm University and Swedish International Development Agency. The project employed a number of tools during the initiative, not limiting them to the CRC even though it was in the title of the program. The research team modified the Citizen report card survey to include a Participatory rural appraisal (PRA) to assess the needs of the community. During the assessment survey the health care needs and experiences of the communities was assessed and analysis was provided of the challenges faced by the health care providers. Following the survey, a client-provider interface meeting was conducted to formulate a joint action plan. The interface meeting was carried out in an innovative way as the community member and the providers conducted role-play where the community members acted to be service providers and vice versa (Bjorkman & Svensonn, 2007).

One year after the improved quality of services as outlined in the action plan a marked increase was seen in the overall health of the population. Compared to districts where the intervention was not carried out and which acted as the control group, in districts where the intervention was implemented there was increase in service utilization at the health facility seen for the following; 16% in outpatient services, 68% institutional delivery, 20% antenatal care, 63% family planning. Also there was an increase in the birth weight of the infants and reduction in infant mortality.

They identified the following facilitators i) increasing provider incentive to serve the poor improves quality of services, ii) robust civil society organizations, iii) elected Health Unit Management Committee (HUMC) to monitor the function of the health posts. A major barrier identified from the study was the loss of momentum for action by the elected health unit management committees.

Quality improvement initiatives in health in Pakistan

Increasing uptake through quality improvement initiatives such as improving women's ability to demand services have not been the focus of health programs implemented in the public sector in Pakistan. There is no documented evidence from the major public health programs running in the country that have attempted to empower women especially the marginalized to voice their demands for quality MNH services in the public and private health care system.

The Partnership Defined Quality Initiative (PDQ) tool developed by Save the Children (US) was used to assess community perceptions of quality of care and it has been implemented in order to improve the quality of MNH services and care in Pakistan. The tool takes into account the community's expectations from health programs but does not give them the voice or citizen power to hold the state and provider institutions accountable. We are awaiting the results and program evaluation of the initiative to be published.

The People's Primary Healthcare Initiative (PPHI), being implemented in about 60% of the Basic Health Units (BHU) in Pakistan, is an innovative approach to increasing MNH services. The PPHI guides the process

whereby provincial governments' contract and delegates to their respective Provincial Rural Support Program (RSP) the management of the First Level Health Care Facilities (FLCF). The first Third Party Evaluation (TPE) of the PPHI has been released in 2011 with encouraging results. The evaluation survey conducted household surveys as well as exit interviews with PPHI clients. According to the survey, the changes brought about by the PPHI ranked high on population perception of quality of care. Compared to BHUs managed by District Departments of Health (DDOH), 44% of the PPHI clients stated better quality of services as the reason for visiting the BHU managed by PPHI. However client satisfaction with staff ranked low only 1.7% of the clients stated "concerned staff" as the reason for visiting PPHI managed facilities. In Balochistan province all the BHUs are directed according to the PPHI therefore a before and after comparison was made while analysing the survey results. In Balochistan, 74% of the respondents stated improved quality of service after the PPHI implementation (Technical Resource Facility (TRF), 2010). The results show increase access and affordability of the services but their client satisfaction scores are low. Also the results of these surveys have not been incorporated into any advocacy initiative by the civil society organizations and there is no documented evidence that these were used for internal evaluation. The PPHI requires all BHUs to have a suggestion/complaint boxes at the facility to address the issues raised by the clients. With the advancement of mobile phone technology plans are underway to introduce a cell phone based grievances redress and feedback mechanism. However neither the TPE report nor the publicly available monthly meeting (MM) minutes of the PPHI health centres (the MM reports are available online only for the province of Sindh) address the issue of low rating of client-provider interaction or incorporating client

feed into further improving quality of services (People's Primary Healthcare Initiative, Sindh, 2012). These findings, identify the existing disconnect between Pakistan's quality initiatives in health and robust social accountability.

DISCUSSION:

We tried to integrate the framework for quality improvement and social accountability together to direct our understanding of using the principles of social accountability to improve the quality of maternal, neonatal and child health. We have used the framework to help us identify studies documenting and or evaluating programs and policy interventions that have been successful in improving the health outcomes of communities through quality improvement. We have specifically looked at interventions that have used social accountability as a guiding principal to direct quality improvement initiatives in health. Review of the selected publications allows us to comment on the SA models that are best suited for improving quality of health care services.

The one aspect common to all of the reviewed SA initiatives was that they used more than one social accountability tool to approach the health problem and each from a different platform. The tools used by the various initiatives were similar in design with modification in execution. Also the models involved all the stakeholders in the chain of service provision to account for the multifaceted nature of services generation. The CRC based models in Uganda and Bangalore both used a survey to initially assess the quality of services. Both the initiatives tackled staff absenteeism by placing duty rosters of health care workers and concentrated on improving the basic infrastructure and processes like cleanliness and staff behaviour.

The initiative in Uganda proceeded with bringing together service providers and clients to come up with a joint plan of action to improve the quality of services. The Maternity home initiative in Bangalore proceeded with bringing about legislative change to introduce user fee in addition to introducing structural changes in the management of maternity homes. The initiative in Bangalore is working towards introducing budgetary monitoring of maternity homes by building CSO capacity to comprehend and evaluate financial management. Similar to Bangalore the South and East African HIV & AIDS aim to improve resource utilization by building regulation institutional capacity to track and evaluate the use funds earmarked for HIV in Africa. As more and more institutions and programs are utilizing financial transparency in SA it is emerging as a promising tool in ensuring that resources are not wasted and abused. With the rapid development in Internet based information dissemination financial transparency is perpetuated to new dimensions. Though it use in health has been limited but examples of posting all government procurement and subcontracting financial information on the internet for public viewing has had a great impact on corruption reduction in the country with minimal resources.

Social accountability initiatives carried out in isolation are less likely to develop momentum necessary to bring change and ensure sustainability. The health services accountability through public hearings in Orissa (India) and the MNCH committees' initiative by BARC in Bangladesh were each part of a larger national program intended to improve the health of mothers and children. The Orissa public hearing SA project is part of National Rural Health Mission (NRHM) program initiated since 2005 by the government of India to reduce maternal and infant mortality. Similarly MNCH committees in Bangladesh were part of the BRAC's Maternal,

Neonatal and Child health (MNCH) program running since 1990s, both of these programs were part of larger national programs committed to improving the health of mothers and children. These two programs drew not only from the technical resource pool of larger national programs but were also are sustained for a longer time by the larger national programs. The Karachi Water and Sanitation Board CRC exercise did not progress beyond the initial assessment phase and the and the community score card initiative in education in Pakistan did not develop scalability on a national level because these were limited donor funded programs without connections to a large scale initiative on a national level.

As stated earlier in the paper all quality initiatives have an element of accountability to ensure their successful implementation and sustainability. Our review of the literature supports our hypothesis and we propose that program planner and managers planning on improving the quality of health services in countries where resistance to change is prevalent, need to plan their programs with-in light of the framework for social accountability.

Interventions have a tendency to fall to the effects of elitism, whereby more affluent and or educated members of the society reap maximum benefits from the intervention and with limited impact for the poor members of the community. This can be corrected by reaching out to the poor clients for their input for program planning, implementation and evaluation. However the perceived health care needs of the marginalized factions may not be aligned for better health outcomes as prescribed by international health care standards. To overcome this limitation it is important that community members, both poor and non-poor, be informed of their health rights, privileges and standards of health care.

We have been able to compile a comprehensive list and examined social accountability driven quality improvement initiatives undertaken globally in health into a single document. We have been able to identify the facilitating and barrier factors to relating to their success to be able to select a model that best suites the ground realities where a quality improvement initiative is intended.

The decentralization initiative in Pakistan was mandated by the then-military regime as a sector wide change across all the four provinces with varying results in each. The elected local governments focused mainly on infrastructure like roads and sanitation as these provided a more visible and immediate results. The health and education sector were least focused, as these were not a high priority of the local communities (Hasnain, 2008). Several researchers and international organizations have initiated various SA initiatives in Pakistan in the public service sector with varying success. The reason these initiatives did not prove success and sustainability beyond the pilot phase is because during the design phase the facilitators and barriers were not fully accounted for which were crucial for effectiveness. We have made an effort to design a framework that facilitates in identifying the right fit between the selected model and the ground realities of the socio-demographic, political and technological context.

Key components for a sustainable SA program

Reviewing the literature on social accountability in general and the studies specific to social accountability in health we have identified the key factors necessary for any given SA model. The key prerequisites for the successful implementation of any SA model, regardless of the service sector being addressed, are similar concerning the major stakeholders

namely the government/policy makers, citizens and service providers. Social accountability initiatives are most likely to succeed if these are sanctioned and encouraged by the government in an effort to improve service delivery for its citizens. Civil society organizations function effectively when the government invites and institutionalizes these giving them a legal or official status to conduct oversight activities. The post-apartheid constitution of South Africa makes provision for such institutions to ensure that citizen rights are realized outside of the document and functional in reality. The oversight bodies, referred to as “chapter nine institutions”, have a constitutional mandate and status to oversee governmental activities and these provide an example to be followed. SA initiatives are most effective when there is transparency in governmental fiscal and budgetary conduct and the information is easily accessible to citizens and CSO. Having laws in place that allow CSO in public policy process along with the involvement of political parties and legislative ensures accountability is maintained state activities. Governments can ensure sustainability of any social accountability model by institutionalizing accountability at various levels of the state and its functions.

For SA initiatives to be successful and sustainable overtime it is paramount that citizens, both poor and non-poor, should be actively engaged to pursue social goals in light of an existing social demand for better services. Demand for better services is created when there is awareness among citizens of their rights and privileges and quality standards. Before a SA initiative is put into action citizen clients must be informed. In case of information asymmetry where citizens or the principal is unaware of its rights and privileges and the agents or the service providers withhold such information SA cannot be exercised.

Information becomes effective only when citizens make an effort to voice their demand either individually or collectively. Voicing their demands is one of the mea s citizens can generate accountability the other being the availability of choice. When citizens are given a choice they use their client power to select better providers. Justice and equality for all without discrimination and marginalization is the key to the establishment of progressive societies but it is also instrumental in ensuring social accountability.

The citizenry pool also gives rise to civil society organizations and media to initiate promote and perpetuate social accountability. The CSOs emerging from within the communities are better informed about its needs and tuned to the challenges faced by citizens to receive quality services. Due to their close proximity to the communities CSO are better equipped to give a collective voice to the demands of the community as well as monitor the progress of a SA initiative. A robust and informed CSO can champion the rights and privileges of the marginalized and vulnerable segments of the society all the while ensuring good for all. An informed and impartial media complements the functions of CSO but it can create the impetus to mobilize the communities towards a cause.

Service providers, one of the three key actors in service provision, create services and are instrumental in maintaining the quality of these services. Service provision is affected by the technical capacity, available resources and delegated authority of service providers to begin with. But in addition to the above providers who are sensitive to the needs of the citizens and are incentivized to change for performance improvements are key in any SA initiative. Service providers are citizen clients outside of their own trade sector, therefore awareness of their own rights and entitlements as well as of others are critical to social accountability.

According to the social accountability framework citizens, policy makers and services providers are differentiated for the sake of functionality and clarity but we one must bear in mind that all these stakeholders emerge from the same community for most of the part. For SA to be successfully implemented and made sustainable all the major stakeholders need to have a complete buy in of the initiative. Social accountability initiatives can be effective only when all the three stakeholders work in union to ensure that mechanisms are in place to prevent failure in service provision.

Information and communication technology

An emerging tools and venues for Social Accountability

The use of information and communication technology is influencing every sphere our life at an unprecedented rate and SA is no exception, therefore it is necessary to address this topic in further detail. The use of information and communication technology for the use in SA is relatively new but it is a promising platform to implement initiatives improves quality and quantity of public service provision in all sectors including health. Its use has been increasing in other sectors like E-procurement of government tenders, internet portals giving details of public works projects, online grievance redress tracking system, online blacklists and news databases (325 Arroyo, D. 2005;). There are emerging success stories of information and communication technology use in public sector accountability but its use in health has had limited use. An innovative and promising use of communication technology comes from Uganda Coalition for Health Promotion and Social Development, as it uses text messages from citizens to report stock out of medical supplies in a given health post. This information is feed into real time interactive maps for

program planners to identify the problem in time. The increased infiltration of the information and communication technology into our societies holds a promising new venue for the introduction and implementation of new and improved SA initiatives.

Strengths and weaknesses

Our study is limited by the fact that we could only include in the review studies and reports that are published and available in the public domain. Also social accountability initiatives published in languages other than English were missed by our study. We were not able to evaluate the success and barriers of the initiatives reported in the review. We relied on reports and papers which documented the views and ideas of the publishing individuals and institutions therefore we cannot control for any biases in reporting.

The strength of our study is that we have reviewed social accountability initiatives from various service sectors and not limited to only understanding how the process works in health. This has allowed us to draw on various scenarios in which a SA tool was used and be able to recommend its use in health.

CONCLUSIONS

All Social accountability initiatives have the basic prerequisites of a strong citizenry made up of informed citizens, robust civil society organizations and an impartial media. Though the functions of the media follow later in the course of a SA initiative its importance cannot be overemphasized especially in the current era when we reply on it for all our information needs and let it shape our opinions and choices. Authoritarian states and

insensitive service provision machinery pose the greatest challenges for a SA initiative but with innovation windows of opportunity can be created even in dare circumstances.

Before the design of a social accountability initiative it is essential to understand needs and priorities of the community and in absence of awareness for quality services it is essential to create the demand for it. After the selection of the SA model and tools for implementation it is crucial that the grass root CSO working in the areas have the capacity to execute the initiative. Capacity building of the CSO is as successful as selecting the right selection of tools. SA initiatives are susceptible to losing momentum in absence of constant support for continuity. Therefore SA initiatives that are not part of a greater program from which these can draw technical and moral support are more difficult to sustain. Institutionalizing accountability at all levels of the working machinery of the state is the sure way to sustain SA initiatives but in the absence of such a setup it is important to constantly create awareness and demand for better quality of service.

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