Decentralisation, social accountability and family planning services

The cases of Uganda, Kenya and Tanzania

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I Abstract

Investments into non-medical activities such as civic education, local advocacy and dialogue with decision makers at decentralised governance levels may bring high returns in improving the performance of reproductive health and family planning (RH/FP) services. To achieve results, the RH/FP community should reach out to good governance experts and implement civic education activities that empower citizens to demand for quality services from their leaders. Strong civic awareness and action from the citizenry is important in improving governance and thereby services.
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## Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ASHR</td>
<td>Adolescent Sexual and Reproductive Health</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>DDC</td>
<td>District Development Committee</td>
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<td>DFRD</td>
<td>District Focus for Rural Development</td>
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<td>DSW</td>
<td>Deutsche Stiftung Weltbevoelkerung</td>
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<td>EU</td>
<td>The European Union</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HUMC</td>
<td>Health Unit Management Committee</td>
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<td>IED</td>
<td>Institute for Education in Democracy</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<td>KHFP</td>
<td>Kenya Health Policy Framework</td>
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<td>KHSWAp</td>
<td>Kenya Health Sector-Wide Approach</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MOMS</td>
<td>Ministry of Medical Services, Kenya</td>
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<td>MOPHS</td>
<td>Ministry of Public Health and Sanitation, Kenya</td>
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<td>NAYA</td>
<td>Network for Adolescent and Youth of Africa</td>
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<td>NAWMP</td>
<td>Uganda’s Network of African Women Ministers and Parliamentarians</td>
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<tr>
<td>NCAPD</td>
<td>National Coordinating Agency for Population and Development</td>
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<tr>
<td>OECD</td>
<td>Organisation of Economic and Development Cooperation</td>
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<td>OECD DAC</td>
<td>OECD Development Assistance Committee</td>
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<tr>
<td>PEAP</td>
<td>Poverty Eradication Action Plan</td>
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<td>PSI</td>
<td>Population Services International</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>RH/FP</td>
<td>Reproductive Health/Family Planning</td>
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<td>RHU</td>
<td>Reproductive Health Uganda</td>
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<td>SRDP</td>
<td>Special Rural Development Programme</td>
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<tr>
<td>STIPA</td>
<td>Support for Tropical Initiatives in Poverty Alleviations</td>
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<tr>
<td>TAPAC</td>
<td>Tanzania Parliamentarians AIDS Coalition</td>
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<td>TAPAMA</td>
<td>Tanzania Parliamentarians against Malaria</td>
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<td>ULGA</td>
<td>Uganda Local Governments Association</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>WAMATA</td>
<td>Walio katika mapambano na AIDS Tanzania (People fight Against AIDS in Tanzania)</td>
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III Introduction

“People are not simply beneficiaries of economic and social progress in a society, but are active agents of change”1.

The latest United Nations Millennium Development Goals reports2 have highlighted a lack of progress in achieving health related targets in East Africa and are cautious about future prospects. Considering the high amount of investments in the health sector this has puzzled observers.

The World Bank has emphasised the links between a country’s governance and its respective development performance3. To overcome the under-provision of key public goods—which has been indicated in several studies as largely a problem of governance—a greater focus on external accountability can lead to improved governance and public services4.

Many of the public goods that are essential to economic growth and poverty reduction are provided at a local level of government, if they are provided at all5. Worldwide, decentralisation has given local authorities greater discretion to respond to the preferences and needs of their constituents. Their flexibility to respond to local needs has increased due to their greater political power to draft policies, fiscal power to collect and use revenue and administrative power to provide services6. It is expected that good governance can increase the performance of health systems and health outcomes. The concept of good governance entails responsive, effective and efficient services providing adequate mechanisms of accountability, equipping citizens with ‘legitimacy and voice’ and ensuring accountability of decision-makers to the public through transparency and respect for the rule of law. Theoretically, decisions are made closer to the beneficiary who in turn can monitor services and demand for accountability more easily. However, this is based on the assumption that citizens have an influence on the decisions made by local governments8.

This essay shows how decentralisation and greater citizen involvement in Kenya, Tanzania and Uganda can increase the availability and quality of reproductive health and family planning services (RH/FP). It analyses DSW’s9 and a group of Non Governmental Organisations’ (NGOs) experience in improving reproductive health and family planning services through advocacy and civic education at local levels of decision-making. Initial outcomes have stunned implementers and observers. Therefore, the authors chose to document and reflect upon the intervention.

In its first chapter, this essay begins with an analysis of the current state of knowledge in social accountability programmes. The paper leans towards the definition of Malena et al. who understand social accountability to be “an approach towards building accountability that relies on civic engagement, i.e., in which it is ordinary citizens and/or civil society organisations who participate directly or indirectly in exacting accountability”10. There are different opinions among scholars regarding the extent of accountability. Some argue that accountability is mainly an ex-post phenomenon while this paper and others emphasise that the principles of accountability should be applied at various stages throughout the formulation, implementation, monitoring and evaluation of government programmes11. The essay then explains the different components of social accountability. This includes identifying areas of improvement, gathering information, holding discussions, building alliances to have a common voice, negotiating through interface meetings and monitoring long-term outcomes.

1 Fukuda-Parr (2003)
2 http://www.undp.org/mdg/reports.shtml
3 World Bank (2006)
4 Ahmad (2008)
5 Booth (2010)
6 Mitchell/Bosser (2010)
7 United Nations Development Programme (1997)
8 Mitchell/Bosser (2010)
9 DSW (Deutsche Stiftung Weltbevoelkerung) is a German based NGO with offices in Europe and East Africa.
10 Malena et al. (2004)
11 Ackermann (2004)
The second chapter narrates DSW and partners’ experience in Kenya, Tanzania, and Uganda. After describing the countries’ political trajectories, their state of decentralisation and the system’s impact on health service provision including reproductive health and family planning, this chapter describes four sets of activities and the outcomes obtained to date:

- Increasing access to information on health and family planning budgets and policies;
- Creation of local civil society coalitions for a greater voice;
- The implementation of civic education campaigns raising the population’s awareness on its rights and obligations while creating awareness of the importance of reproductive health and family planning;
- The roll out of dialogues at village, district, and national levels to increase transparency in decision-making and allow poor segments of society to have a voice.

The final chapter reflects this experience by first validating the expectations formulated in the theoretical chapter. Indeed, the case study supports different social accountability theories. It then shows the high relevance of the narrated experience, a proxy indicator being the high participation and reactivity of communities. Then, it analyses contextual factors, which have had a bearing on the effectiveness of the intervention. This includes the degree of actual decentralisation, the acknowledged role of civil society in decision-making and the impact of bureaucracy. Thereafter, it looks at government and civil society as key stakeholders in the social accountability process. Working with both stakeholders brings challenges and opportunities. Lessons show that it is important to work in close collaboration with governmental decision makers to facilitate meaningful dialogue. Working with locally-rooted civil society organisations is equally important in order to gain trust with communities and with local decision makers.

**Methodology**

The paper uses findings from activities in 13 East African districts between 2010 to 2011. DSW has contracted an external independent evaluator to review and evaluate inputs, processes, outputs, outcomes and impacts of each activity. In addition to desk reviews of reports, management and information systems, and project documents, the methodology uses face-to-face key informant interviews as well as self-administered questionnaires and telephone interviews to collect information from stakeholders.

**Key findings and lessons**

Preliminary findings show that the creation of civil society advocacy coalitions has led to increased coordination, experience sharing and learning from each other. The process of engaging officials on budgets and work plans has served as an eye opener for many Civil Society Organisations (CSOs) on their role as a broker between community interests and local governments. Since then, several CSOs have re-organised themselves to include advocacy into their strategic plans. The data collection process has increased district officials’ understanding social accountability and has increased transparency in decision-making. Ongoing dialogues with decision makers do enhance their understanding of RH/FP and it is expected that budgets and activities related to RH/FP will increase throughout the year.

Investments into non-medical activities such as civic education, local advocacy and dialogue with decision makers at decentralised levels may bring high returns in improving the performance of RH/FP services. To achieve results, the RH/FP community should reach out to good governance experts and implement civic education activities where citizens are empowered to demand for quality services from their leaders. Strong civic awareness and action of citizenry is a key to improving governance and thereby services. Another lesson relates to the degree of decentralization in decision-making. In many cases, systems which are considered “decentralised” retain a high degree of centralisation. It is important to assess how flexible local officials are in taking decisions according to their constituents’ needs. In Uganda for example, the financial transfer “system has become complex (…) often allowing local councils limited scope for choice in relation to local circumstances”\(^\text{12}\).

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\(^{12}\) Devas/Grant (2003)
IV The theory

How accountability can improve health service delivery – a theoretical approach

The general correlation between increased public expenditure and development outcomes or improvements in service delivery (e.g. health, education) is weak, as research has shown\(^{13}\). This correlation gap reflects the serious absence of accountability for citizens and especially for the poor. In 1979, the International Conference on Primary Health Care (Declaration of Alma-Ata)\(^ {14}\) identified community participation as one of the mechanisms to improve health care services. Views from the communities, which reflect the priorities, the needs and problems of the public, are quite important for improving health care systems\(^ {15}\).

The World Development Report 1993 observes that “fostering greater involvement of communities and households in promoting healthier behaviour on their own part and in managing their local health services” is an integral element for reforming the health sector\(^ {16}\). A few years later, the World Bank emphasised, “decentralized delivery is based on the simple concept of getting resources to where they are needed”\(^ {17}\).

In the last century, the World Bank has begun to support several social accountability initiatives, ranging from community scorecards in the Gambia and Malawi and citizen report cards in the Philippines, Albania and Uganda to the development of a system of social accountability in Peru\(^ {18}\). Nowadays, there is a general agreement that electoral and participatory democracy, citizen participation in local decision-making, transparency, accountability, and effective and efficient service delivery are main attributes of good local governance\(^ {19}\). Through community participation, services can meet the needs of the communities they serve. At the same time, the process of participation can empower individuals and strengthen the democratic process. Through monitoring, government performance and the demand for transparency corruption can be minimised\(^ {20}\).

Social accountability: increasing the responsiveness of governments through citizen participation

Understanding the term social accountability appropriately, first requires a definition of accountability. “Accountability can be defined as the obligation of power-holders to take responsibility for their actions”, towards the citizens who have the right to demand\(^ {21}\). The concept of accountability implies both answerability and enforceability\(^ {22}\). There are different opinions among scholars regarding the extent of accountability. Some argue that accountability is mainly an ex-post phenomenon while others emphasise that the principles of accountability should be applied at various stages throughout the formulation, implementation, monitoring and evaluation of public authorities’ programmes\(^ {23}\). According to the World Development Report 2004 accountability has five features\(^ {24}\) as described in graph 1.

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\(^{13}\) Singh and Shah (2003)
\(^{14}\) www.who.int/hpr/NPH/docs/declaration_almaata.pdf
\(^{15}\) Bruni et al. (2008)
\(^{16}\) World Bank (1993)
\(^{17}\) World Bank (2000)
\(^{18}\) Ackermann (2005)
\(^{19}\) Kiyaga-Nsubugapage (2009)
\(^{20}\) Klugmann (2004); Ahmad (2008)
\(^{21}\) Malena et al. (2004)
\(^{22}\) Cornwall et al. (2000)
\(^{23}\) Ackermann (2004)
Accountability can be strengthened through enhanced citizen participation and is identified as a key to increasing the responsiveness of local government to the poor as well as making development more pro-poor.

Malena et al. define social accountability “as an approach towards building accountability that relies on civic engagement, i.e., in which it is ordinary citizens and/or civil society organisations who participate directly or indirectly in exacting accountability.” The term social accountability raises several questions: Who is accountable to whom, for what purposes, for whose benefit, by which means, and with what consequences? Who, whom, and whose represent “the traditional trio of agent, principal, and beneficiary in political and organisational theory.” Three categories emerge from answering the question “accountable for what?” The financial accountability is to control the misuse and abuse of public resources or authority. Secondly, performance accountability is to promote improved service delivery. The third category, political/democratic accountability “has to do with the institutions, procedures, and mechanisms that seek to ensure that government delivers on electoral promises, fulfills the public trust, aggregates and represents citizens’ interests, and responds to ongoing and emerging societal needs and concerns.”

One important mechanism of accountability is elections. Elections only allow citizens to choose among a limited number of political parties and individuals. After the elections, citizens have no sanction mechanisms to ensure that promises made are being implemented, except until the next elections. Therefore, citizens are not able to express their opinions concerning specific topics or to hold power-holders accountable for their decisions or their behaviours. So, elections and institutional checks and balances, the traditional forms of political accountability, have not often ensured an effective monitoring of public authority.

In contrast, “social accountability is expected to be more effective because it works in the period between elections using both institutional and non-institutional channels.” Social accountability differs from the traditional accountability mechanisms in that it doesn’t bind political decision makers. “Those who are targets of social accountability strategies are not required to concede; it is assumed that the force of media, public debate, reputational damage and the triggering of traditional accountability mechanisms will have the intended effects.”

Others broaden this perspective by suggesting that social accountability is not only about responding to others but also about “taking responsibility” for oneself. One has to keep in mind that social accountability is as much about changing mentalities and developing capabilities as it is about...
technical tools. Before designing social accountability, a stakeholder analysis is needed to identify the relevant players\textsuperscript{34}.

The relevance of social accountability can be underlined by three main factors: Improved governance, empowerment and increased development effectiveness. Accountability as a cornerstone of good governance can raise the legitimacy of the government, enhance transparency and expose government failures\textsuperscript{35}. By providing information on rights and entitlements, the voice of disadvantaged, vulnerable and poor groups can be raised\textsuperscript{36}.

**The concept of downward accountability**

As put by Devas and Grant, there are three different directions of accountability:

- Horizontal accountability of local governments to elected representatives;
- Upward accountability of local governments to central government; and
- Downward accountability of (local) governments and elected representatives to local citizens\textsuperscript{37}.

For downward accountability to be effective, political leaders should have benchmarks against which they can be judged\textsuperscript{38} by citizens, media and civil society. Especially a lively civil society that is able to monitor local government’s decisions and behaviour is indispensable to enhance downward accountability. A number of initiatives could attempt to engage citizens in the process of downward accountability. The mechanisms of social accountability are very often demand-driven (demand spaces), but can also be initiated and supported by policy makers and health planners (invited spaces)\textsuperscript{39}. If the control of the processes for participation is in the hands of governmental institutions, it easily could “become a barrier for effective involvement of citizens”\textsuperscript{40}. Downwards accountability requires that citizens “have accurate and accessible information about local government: about available resources, performance, service levels, budgets, accounts and other financial indicators”\textsuperscript{41}. However, due to low literacy levels and lack of civic education it is doubtful whether citizens can accurately interpret the provided information on local issues\textsuperscript{42}.

Local media plays a key role for spreading political news and public information as well as informing citizens and monitoring government performance. However, more often than not radio stations do not have resources to undertake investigative journalism. Nevertheless, radio (private and community radio) can be a key medium at the local level, whereby ordinary citizens can voice their opinions and discuss public issues\textsuperscript{43}. The extent to which media is independent and ownership is pluralistic (versus concentrated in a few hands) are important factors that can contribute to the accountability of the political system\textsuperscript{44}.

Progressing from lower to higher levels of participation (from information, consultation, decision-making to management), participatory processes become more complex and demand many types of skills as knowledge, leadership, managerial capabilities and experience\textsuperscript{45}.

If carefully implemented, public meetings could also be very useful for spreading information and discussing public issues. However, governments can easily manipulate these public meetings if they fear them. For example, holding meetings in remote areas or in inappropriate times will reduce the public participation.

\textsuperscript{34} Agarwal et al. (2009)
\textsuperscript{35} Malena et al. (2004)
\textsuperscript{36} Singh and Shah (2003)
\textsuperscript{37} Devas/Grant (2003)
\textsuperscript{38} Kiyaga-Nsubuga/Olum (2009)
\textsuperscript{39} Cornwall et al. (2000)
\textsuperscript{40} Gaventa/Valderrama (1999)
\textsuperscript{41} Devas/Grant (2003)
\textsuperscript{42} Kiyaga-Nsubuga/Olum (2009)
\textsuperscript{43} Devas/Grant (2003)
\textsuperscript{44} Malena et al. (2004)
\textsuperscript{45} Gaventa (1999)
To measure citizen satisfaction with government behaviour, political leaders can utilise opinion surveys or suggestion boxes. Another mechanism citizens and CSOs can use to hold local governments and service providers accountable are citizen report cards, community score cards and citizen participation in terms of public policy planning, participatory planning, campaigning and advocacy as well as monitoring of public service delivery. Yet, even if governments have some form of complaints system for the local citizens, it does not mean that the citizens actually make use of it or that political authorities take any notice of the suggestions.

Using formal and informal rewards and sanctions is another key feature of social accountability. While formal mechanisms include elections, informal mechanisms usually rely upon creating public pressure through press releases, media coverage, public displays of support or protest and petitions. In addition, strengthening the capacity of civil society’s organisations is also a mechanism to improve social accountability within societies. Hereby, several factors are central to the success of social accountability activities of CSOs, e.g. the level of internal organisation as well as their technical and advocacy skills.

In summary, accountability initiatives have to include both state and societal actors and focus on the interface between them to achieve the most productive results.

**Social accountability in the health sector faces asymmetries among service providers, users and oversight bodies**

Why is accountability in the health sector needed? In (poor) rural areas (local) government health services often struggle to deliver care in the context of corruption, overwhelming staff vacancies and poor infrastructure. Despite its emerging importance, however, few apart from Cornwall and George have examined how social accountability actually operates in health care. In a hierarchical system, accountability measures therefore typically mediate relationships between unequal partners. Therefore, a critical function of accountability is to control the arbitrary use of power by those who wield it.

Achieving social accountability in the health sector faces many challenges. Health services are often “characterized by strong asymmetries among service providers, users and oversight bodies in terms of information, expertise and access to services.” The users, especially the poor, are often in a weak position to confront the providers who determine who receives what care. In the field of health care, knowledge is mainly specialised. Usually, health providers know more about health and health care than their patients do, and the information they provide about diagnosis and treatment options can powerfully determine the experience of illness and care.

In addition, there can be divergences between private and public interests in terms of the level of care. Policymakers focus mostly on providing a minimum level of care while service users have an understandable interest in receiving the maximum amount of care. The outcome could be conflicting demands for accountability.

Existing capacity gaps often limit possibilities to measure quality and to enforce sanctions. Serious accountability problems result from the lack of “ability to identify who works there, where they are at a given time, and what they are doing” as well as the inability to track and report on budget and pharmaceutical purchases. Involving citizens into oversight of facility and practitioner performance should be the first steps towards holding staff accountable for their behaviour and improve performances.

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46 Yimenu (2011)
47 Malena et al. (2004)
48 Malena et al. (2004)
49 Ackerman (2004)
50 George (2003b)
51 Brinkerhoff (2004)
52 George (2003b)
53 Brinkerhoff (2004)
Brinkerhoff creates a framework for analysing and categorising health system issues associated with the three types of accountability and then identifies the dominant purposes of accountability associated with these issues.

<table>
<thead>
<tr>
<th>Type of Accountability</th>
<th>Illustrative Health Service Delivery Issues</th>
<th>Dominant Purposes of Accountability</th>
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<tbody>
<tr>
<td>Financial</td>
<td>Cost accounting/budgeting for: Personel, Operations, Pharmaceuticals/supplies, Definition of basic benefits packages, Contract oversight</td>
<td>▲ Control and assurance are dominant. ▲ Focus is on compliance with prescribed input and procedural standards; cost control; resource efficiency measures; elimination of waste, fraud, and corruption.</td>
</tr>
<tr>
<td>Performance</td>
<td>Patient involvement in medical decision-making, Quality of care, Service provider behavior, Regulation by professional bodies, Contracting out</td>
<td>▲ Assurance and improvement/learning are dominant. ▲ Assurance purpose emphasizes adherence to the legal, regulatory, and policy framework; professional service delivery procedures, norms, and values; and quality of care standards and audits. ▲ Improvement/learning purpose focuses on benchmarking, standard setting, quality management, operations research, monitoring and evaluation.</td>
</tr>
<tr>
<td>Political/democratic</td>
<td>Service delivery equity/fairness, Transparency, Responsiveness to citizens, Service user trust, Dispute resolution</td>
<td>▲ Control and assurance purposes are emphasized. ▲ Control relates to citizen/voter satisfaction, use of taxpayer funds, addressing market failure and distribution of services (disadvantaged populations). ▲ Assurance focuses on principal-agent dynamics for oversight; availability and dissemination of relevant information; adherence to quality standards, professional norms, and societal values.</td>
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Table 1: Framework for Analysing Health Systems
V The case study

Investing in civic education, local advocacy and dialogue with decision makers

Between January 2010 and November 2011, a consortium of non governmental organisations has put in place an intervention aimed at improving health budgets and policies including reproductive health and family planning in Kenya, Tanzania and Uganda. The case informs how decentralisation and greater citizen involvement in Kenya, Tanzania and Uganda can increase the availability and quality of services. It analyses the experience in improving services through advocacy and civic education at local level presenting four areas of work:

- Increasing access to information on health and family planning budgets and policies;
- Creation of local civil society coalitions for greater voice;
- The implementation of civic education campaigns raising the population’s awareness on its rights and obligations while creating awareness of the importance of reproductive health and family planning;
- The roll out of dialogues at village, district and national levels to increase transparency in decision-making and allow poor segments of society to have a voice.

These four areas of work are in line with Yimenu\(^5\), who summarises the main accountability mechanisms as follows:

- Identifying areas of improvement;
- Gathering information;
- Holding discussions;
- Building alliances to have a common voice;
- Negotiating through interface meetings; and
- Monitoring and evaluating long-term outcomes.

Strengthening local accountability requires to focus on state-society connections and to set up or foster communication and cooperation channels between local government, CSOs and citizens\(^6\). Hence, the key strategy was to empower CSOs by increasing their capacity to formulate policy priorities, monitor their implementation and hold decision-makers to account. The decentralisation trend in Kenya, Tanzania and Uganda has provided opportunities to promote social accountability at multiple layers of decision-making.

The local government context in Uganda, Kenya and Tanzania: opportunities for social accountability

The intervention was implemented at central level as well as in 13 districts of Kenya, Tanzania and Uganda. Understanding opportunities for social accountability requires information concerning the political context and the health systems in place.

Uganda

After the end of the civil war in 1986, the Ugandan government established political decentralisation by introducing “Resistance Councils” at sub national levels for increasing local participation as well as strengthening democracy. In 1993, the legislation of the decentralisation was provided through the Local Government Statute. Two years later the content was incorporated in the 1995 Constitution and again two years later the programme was enshrined in the Local Government Act of 1997, whereby several political, administrative and fiscal powers were devolved to local governments. Both the constitution and the Local Government Act “specify five levels of local government – district, county,
sub-county, parish and village\textsuperscript{57}. Strengthening local institutions and improving service deliveries were steps to foster good governance\textsuperscript{58}. By now, Uganda has by far the most clearly outlined local government legislation in comparison to Kenya and Tanzania. Ugandan local governments manage approximately 25% of public expenditure, and have also wide-range service delivery responsibilities. In 2006, the Uganda Local Governments Association (ULGA) has developed a Charter on Accountability and Ethical Code of Conduct. The objective is to enhance accountability, transparency and integrity within local governments\textsuperscript{59}. In addition, the central government has recognised the importance of bottom-up accountability and incorporated this within its poverty eradication strategies\textsuperscript{60}.

Despite the decentralisation, within the health sector some responsibilities remained at the central level of decision-making. While district funding comes mainly from the central government in Kampala as conditional grants with intended, the staffing decisions are made at the district levels\textsuperscript{61}. In Uganda, the health districts do not map onto administrative districts and the latter are constantly changed by presidential decisions. This seems to be a main factor for the almost non-existent involvement of local administrators and politicians in monitoring and quality control of health centres\textsuperscript{62}.

Four types of facilities compose the health sector in Uganda: Hospitals, health centres, dispensaries (mostly rural) and aid posts or sub dispensaries. All of them can be government or private (profit or non-profit) operated and owned. Within the decentralised health sector, a number of actors are responsible for controlling the lowest tier of the health system, the dispensaries. Each dispensary has a Health Unit Management Committee (HUMC) which “is supposed to be the main link between the community and the facility” and each “consists of both health workers and non-political representatives from the community”\textsuperscript{63}. The HUMC is responsible to monitor the day-to-day running of the dispensary but is not allowed to sanction workers. The Health sub-district, the next level, should monitor funds, drugs and service delivery at the dispensary but often the monitoring is infrequent. The Health Sub-district has no authority to dismiss staff for indiscipline. In severe cases, the errand will be delegated to the next level in the institutional hierarchy, the Chief Administrative Officer of the District and the District Service Commission, who have the authority to suspend or dismiss staff.

**Kenya**

Due to poor delivery of services, a national conference suggested in 1971 the need to have a bottom up approach to foster development planning and service delivery to develop the rural areas. Therefore, three years later, the Special Rural Development Programme (SRDP) was developed. Due to limitations of resources, the SRDP was not well operationalised. In 1983, the District Focus for Rural Development (DFRD) was initiated with the goal of institutionalising participatory bottom-up approach development. District Development Committees (DDCs) were established with the aim to serve as the forum for all stakeholders in the respective district. In 2008, the DFRD strategy was revised. Its First Medium Term Plan (2008-2012) has a strong emphasis on political decentralisation.

On 27\textsuperscript{th} August 2010, a new constitution was proclaimed in Kenya. The aim of the decentralisation adopted in the constitution was to give Kenyans greater democratic space that would allow them to participate effectively and efficiently in local, institutional and national level governance and management as well as in decision-making processes. As a radical departure from the centralised structure of government that Kenya had experienced for almost 50 years, the new constitution embraces decentralisation as the primary structure of government. The constitution established 47 county governments (in line with the districts that were defined by the Provinces and Districts Act of 1992) in addition to the national government. The existing local authorities would interact with the new county governments. To ensure efficiency and avoid the pitfalls faced by previous attempts of decentralisation, the constitution has clearly defined the structures, mandates and rights of both the national and the county governments (Schedule 4 of the constitution): The county governments have to decentralise their services to the extent that it is efficient and practicable to do so (Article 176(2)).

\textsuperscript{57} Muriisa (2008)
\textsuperscript{58} Ahmad et al. (2006); Okidi/Guloba (2006)
\textsuperscript{59} Kiyaga-Nsubuga/Ohlum (2009)
\textsuperscript{60} Sarker/Hassan (2010)
\textsuperscript{61} Muriisa (2008)
\textsuperscript{62} Kawooya-Ssebunya (2010)
\textsuperscript{63} Bioerkman/Svensson (2008)
Nevertheless, the national government has to ensure access to its services in all parts of Kenya (Article 6(3)).

One of the county functions defined also in Schedule 4 of the constitution are health services. In detail, county health services include:

- county health facilities and pharmacies;
- ambulance services;
- promotion of primary health care;
- licensing and control of undertakings that sell food to the public;
- veterinary services (excluding regulation of the profession);
- cemeteries, funeral parlours and crematoria; and
- refuse removal, refuse dumps and solid waste disposal.

The Kenya Health Policy Framework (KHPF 1994 – 2010\(^{64}\)) formulated the health imperatives and the guiding actions in the health sector. Under the strategic theme ‘Investing in health’ the overall stated goal was to promote and improve the health of all Kenyans and make all health services more accessible and affordable. Medium-Term focus to guide movement towards these policy imperatives was defined in Medium Term Strategic Plans, the 2\(^{nd}\) National Health Sector Strategic Plan of the KHPF (NHSSP II, 2005 – 2011)\(^{65}\). Another current one is the Ministry of Medical Services Strategic Plan (2008-2012)\(^{66}\).

Two Ministries provide leadership in Health – the Ministry of Medical Services (MOMS) and the Ministry of Public Health and Sanitation (MOPHS). Coordination of service delivery is done through the Kenya Health Sector-Wide Approach (KHSWAp) that brings together all stakeholders working in the health sector and is managed through a partnership instrument: the Code of Conduct. The Code works through coordination mechanisms at all management levels and brings together all stakeholders to discuss and agree on sector focus. Governance structures exist through boards at the respective service delivery levels (hospitals and districts). A common framework for planning and implementation is in place, with decentralised sector wide annual work plans, and monitoring processes in place and applied. However, capacity gaps still exist in leadership and governance. Harmonisation of health laws around an updated Health Act is not completed. The leadership and management skills mix is still patchy, particularly at the sub national levels. Incomplete adoption of partnership processes at some levels of the sector implies that some key partners are not appropriately engaged when required.

Health Service Delivery is organised around six levels of care, from the community to the national level. Each level has both service delivery, and management functions. Similarly, the management function is physically distinct from the service delivery function at district level (Office of the District Medical Officer), province level (Office of the Provincial Medical Officer), and the national level (MOH Headquarters). The management level has expanded over time, and has increasing capacity for development of policies, guidelines and regulations, conduct of evaluations, analyses and studies.

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\(^{64}\) Government of Kenya (1994)  
Graph 2: Kenya’s Health System

**MOH HQ’S**

**HOSPITAL MANAGEMENT TEAM**

**NATIONAL REFERRAL SERVICES**
Comprise all secondary and tertiary referral facilities, which provide highly specialized services. These include (1) General specialization (KNH, Moi TRH), (2) Discipline specialization (Spinal Injury, Mathare), and (3) Geographical / Regional Specialization (7 Provincial facilities). Should focus on provision of:

**COUNTY REFERRAL SERVICES**
Comprise all level 4 (primary) referral hospitals in the county, including NGO/ private.
- Comprehensive in patient medical and surgical care, including reproductive health services

**PRIMARY CARE SERVICES**
Comprise all level 2 (dispensary) and 3 (Health Centres) facilities in the county,
- Disease prevention services, such as immunization
- Basic outpatient medical and surgical services,
- Limited inpatient services for emergency clients awaiting referral, clients for day observation, and normal delivery services
- Facilitate referral of clients from Communities, and to Level 3 facilities

**COMMUNITY HEALTH SERVICES**
Comprise community units in the county. Should focus on
- Ensuring individuals, households and communities carry out appropriate healthy behaviours, and recognize signs and symptoms of conditions that

Comprise community units in the county. Should focus on providing:
- Ensuring individuals, households and communities carry out appropriate healthy behaviours, and recognize signs and symptoms of conditions that

**Referral services**

Referral services
**Tanzania**

Decentralisation in Tanzania is an ongoing process having its origins in the one-party system established in the 1960s which increased community participation in local government. The current decentralisation process dates back to the enactment of the 1983 Local Government Act. Local governments were given responsibility for delivering basic health services at the district hospital level and below. “Devolution has a farreaching impact on the health sector, whereby Local Government Authorities have become responsible and the Ministry of Health and Social Welfare (MOHSW) has withdrawn from direct service provision at district and municipal level”67.

Currently, mainland Tanzania (without Zanzibar) is divided into 21 administrative regions and 113 districts with 133 councils. Primary Health Care was adopted as a guiding framework in the late 1970s and is still a point of reference in the health sector as also seen in the names of organisations and committees. In the early 1990s, the Tanzanian government adopted health sector reforms to improve efficiency, quality and resource mobilisation at all levels in the health system through decentralisation of health services, as well as financial reforms68.

Predominantly, health services in Tanzania are provided through the government, despite a growing private sector, which includes CSOs, Faith Based Organisations and Private-for-Profit providers. These days, the Tanzanian government owns 60% of all health facilities. Within the public sector, health services are delivered through a pyramidal referral system69.

![Graph 3: Tanzania's Health System](image)

In Tanzania, Village Health Services are the lowest level of health care delivery. They essentially provide preventive services, which can be offered in homes. Usually each village health post has two village health workers chosen by the village government and who are given a short training before they start providing services. The second stage of health services, the Dispensary Services cater for between 6,000 to 10,000 people and supervise all the village health posts in one ward. A higher Health Centre is expected to cater for 50,000 people, which is approximately the population of one administrative division. The district is a very important level in the provision of health services and

67 The Government of the United Republic of Tanzania (2009)
68 Maluka et al. (2010)
69 The Government of the United Republic of Tanzania (2009)
therefore each district is supposed to have at least one district hospital. In addition, every region is supposed to have a hospital. These Regional Hospitals offer similar services as those agreed at district level, however regional hospitals have specialists in various fields and offer additional services, which are not provided at district hospitals. The presently highest level of hospital services in the country, the ‘Referral/Consultant Hospitals’, cater for all of the four geographic zones within Tanzania.

The implementers: four organisations with long standing roots in the three East African countries

Activities were implemented by four organisations with long standing roots in the three East African countries.

Deutsche Stiftung Weltbevoelkerung (DSW)\(^{70}\) is an international development and advocacy organisation. Its aim is to empower young people and communities in low- and middle-income countries by addressing the issues of population dynamics and by improving health as a way to achieve sustainable development. It seeks to encourage decision-makers to place greater importance on health care, particularly in the area of reproductive health, and to make more financial resources available. DSW is politically and religiously independent.

Reproductive Health Uganda (RHU)\(^{71}\) is a non-governmental organisation registered under the Trustees Incorporation Act of Uganda. RHU is dedicated to address the unmet demand for quality sexual reproductive health services and promotes sexual reproductive health and reproductive rights in a gender sensitive manner, with primary focus on adolescents and the youth. It is affiliated to the International Planned Parenthood Federation (IPPF) the largest NGO promoting and providing sexual and reproductive health and rights in the world.

The Institute for Education in Democracy (IED)\(^{72}\) is a NGO providing leadership in the democratisation and governance process in Africa through programmes in the electoral process, civic and voter education, research and dissemination, and provision of technical assistance and support. IED provides non-partisan and gender balanced information and skills to empower citizens, especially women and youth, to participate effectively and efficiently in governance and democratic processes.

Tanzania 4H\(^{73}\), established in 1976, provides pre-professional practical education to young people including leadership and management skills that are not provided by the formal school curriculum. Rooted in the concept of "learning by doing" and "earning by learning," the organisation now has over 30,000 members in six regions of Tanzania.

Districts of operations

Activities were carried out at national level in the capitals Nairobi, Dodoma/ Dar Es Salaam and Kampala and in selected districts. Districts were chosen due to their high poverty indexes and poor health indicators with various levels of local-governance structures in place. In Kenya, the target districts are Rongo and Gucha in the Nyanza region and Mombasa and Kilifi in the coastal belt. In Tanzania, the districts are Moshi rural and Hai district, as well as Meru and Korogwe districts. In Uganda the districts are Wakiso, Mukono, Mityana (Central) and Kamuli and Busia (Eastern). These districts have been chosen due to the implementers’ strong presence, good relationships with local authorities and host communities. They also built on strong partnerships with local civil society organisations and with area parliamentarians.

Working through local civil society organisations

In Uganda, Kenya and Tanzania, the intervention mainly works through national and locally rooted CSOs who have some initial advocacy experience and understand the raison d’être of civil society’s watchdog role. They cover a diverse range of topics including health, population and development, gender, human rights and governance to ensure diversity and cross-fertilisation. They subscribe to a culture of networking and understand the value of sharing information and collaborating. Their coverage of grassroots is good, so that civic education activities at the community level is more

\(^{70}\) http://www.dsw-online.org/
\(^{71}\) http://www.rhu.or.ug/
\(^{72}\) http://www.iedafrica.org/
\(^{73}\) http://www.4htanzania.com/
effective and to expand the constituency of the intervention. By involving coalition and network secretariats, the intervention is able to reach out to more CSOs. There is a balanced mix of small, medium and large CSOs, so that strong CSOs can mentor small CSOs and pull them along while small CSOs have committed to work on skills gaps.

So far, the experience gives good insights in how downward accountability can improve family planning services. First results are highly encouraging. Normally, advocacy interventions take long to substantiate into concrete outcomes. With this background, the immediate results of the intervention have stunned implementers. Follow up actions have been noted at many levels.

**Promoting access to information**

Citizens’ information on what service standards they are entitled to in the health sector is poor in Kenya, Tanzania and Uganda. Even fewer know what family planning services should be availed to them. This relates to the rare popularisation of policies and the complexity and lack of transparency of government budgets from the central level to the lowest levels of governance. Since downwards accountability requires that citizens have accurate and accessible information about available resources, budgets and policies, DSW decided to promote the analysis of national budgets and policies. With this information, citizens are able to make an informed opinion on local health plans and budgets. Three studies were conducted following a harmonised structure with slight national variations.

The studies are structured as follows: After describing the respective country’s health situation, they look at the government’s international and national policy commitments. Then, they analyse the levels of health funding and compare them to commitments. A regional chapter juxtaposes findings in the different countries and then digs deeper into reproductive health and family planning funding and analyses the official data, which was in many cases found to be incomplete. The studies also provide cases of selected districts to show how funds trickle down from central to decentralised budgets. A final chapter summarises the studies’ findings and provides key recommendations.

Preparing the budget studies was a highly participatory process involving civil society organisations as well as district decision makers. CSOs defined research topics during two workshops in each country. Quantitative and qualitative data were collected using standardised tools. A regional consultative process helped develop data analysis tools and questionnaires, as well as a standard structure for the final report. CSOs later reviewed and amended the report structure and agreed on research methodology. Official government documents were analysed. Domestic budget data were extracted from government reports, while donor information came from OECD DAC, Creditor Reporting System. At district level, the research involved analysis of a range of district plans and budgets.

Access to data was poor in most cases. Comparatively, the government of Uganda ensured the best access to data, since budgetary data are partly published online. However, this was not consistent and missing documents had to be consulted in Ministry libraries. However, the library of the Ministry of Finance did not have an inventory of all budget documents since 2005. Some documents were missing and needed to be requested from civil servants’ offices. In Kenya, all national budget data were accessed from the Ministry of Finance but only after confidence building measures that researchers are not spies. The government of Tanzania had the worst track record in providing information. Some incomplete information was available on the web portal of development partners working groups. The portal did not list all official documents and Ministries needed to be consulted in person. Accessing the performance evaluation report for the year 2009/10 was particularly cumbersome. Civil servants and ministerial officials were afraid of being reprimanded or sacked if they disclose confident data. They did not know what can be disclosed and therefore preferred to hide all data. Recently, a minister was sacked after giving budgetary information to the public, increasing civil servants’ fear. In all the three countries, data on district budgets was very fragmentary in Ministry libraries. Few district plans or budgets were stored at central level and often these documents did not coincide with what was available from district authorities.

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74 Devas/Grant (2003)  
75 Kiyaga-Nsubuga/Olum (2009)
Therefore, interviews were conducted in the districts to access further data and qualitative information. Interviews were conducted with district officials and medical officers and exit interviews were conducted with users. Collected data was triangulated using official government documents on health expenditure and, more importantly, the health sector performance reports. A core team of researchers involving project implementers and CSOs conducted analysis of the data. A group of CSOs reviewed the summary report. Theme groups discussed and amended each chapter and refined key messages and recommendations.

In Kenya, there were four field trips outside Nairobi and three research meetings within Nairobi. Each time, CSOs were first trained in how to administer and analyse the questionnaires and tools. Then, CSOs were accompanied to review books and conduct interviews. In total, ten district officials were interviewed as well as four health facility administrators. In addition, more than 30 exit interviews were conducted with users in selected health facilities. After compiling and analysing the data set, a first paper with preliminary findings was presented at the National Leaders Conference and feedback of the audience was incorporated. The final draft was reviewed by a USAID health advisor.

In Tanzania, four districts were visited. In each district in-depth interviews with seven district officials, two local leaders, two dispensary and health centre in charge and two community members were conducted using structured questionnaires. The list of interviewees from district officials, local leaders and health facilities were provided during the briefing meetings with district councils, while community members were chosen randomly during visits at the health facilities. Data collection was highly participatory; in all districts CSOs were oriented on how to administer the questionnaires and budget template. The same participated in data collection throughout the study. Finally, meetings were held in three districts to discuss and share the final report.

In Uganda, CSOs were invited to a first meeting to start the process by allocating roles and responsibilities. During 12 data collection trips, CSOs were mentored to administer the questionnaires in five districts. During data collection, five working meetings were held to resolve definition problems, review data, develop strategies to access data from district offices, which do not cooperate and analyse the findings. A second meeting reviewed the first draft where participants asked for amendments and refined the main messages of the study.

The studies are aimed at decision makers and community leaders. Hence, emphasis was put on making technical information understandable to lay people. Highly technical terms are avoided. Metaphors and examples are used.

As Kiyaga-Nsubuga/Olum (2009) mentioned, benchmarks are needed to judge political leaders and to put meaning to budget figures. For example, the Abuja declaration was signed by the three governments. This allows one to compare findings against the target of allocating 15% of national resources to the health sector. Another benchmark is the per capita health spending as recommended by the World Health Organisation. The studies clearly identify avenues of improvement as well as recommendations.

The data collection process has built CSOs’ skills in collecting, presenting and analysing budget data and enabled them to compare budgets with policy commitments. As George (2003a) mentioned, access to information is not only essential “for improving health awareness and access, it is impossible to mobilise for change without it”, because people need information to know what they are entitled to.

Strengthening the capacity of CSOs in formulating policy and budget recommendations is a further main mechanism to improve social accountability within societies. The process increased data transparency; after confidence building measures, district officials understood that district budgets and plans were public documents, which should be availed to the public. They realised that budget analysis and advocacy is not confrontational or about ‘spying’. The data collection process created a collaborative relationship with officials. Today, most of them freely share district plans and budgets. The process was also about advocacy. While analysing data, CSOs raised difficult questions to decision makers regarding low health budgets, dilapidated health facilities and unsatisfactory services.

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76 Kiyaga-Nsubuga/Olum (2009)
77 George (2003a)
Building civil society coalitions increases voice

As Malena et al. pointed out in their theory, several factors are central to the success of social accountability activities of CSOs:

- the level of internal organisation;
- the breadth of their membership;
- their technical and advocacy skills;
- their capacity to mobilise and effectively use media;
- their legitimacy; and
- their level of accountability to their own members.  

A lively civil society that is able to hold governments decisions and behaviour to account is indispensable to enhance downward accountability. Thus, building alliances to increase a common voice was crucial for the intervention. This was coupled with capacity building of CSOs.

Central to this activity was the organisation of regular networking meetings and CSOs were encouraged to share information and step up cooperation. Dr Abeja Apunyo notes in her evaluation that participation in the networks was one of the greatest benefits CSOs had realised. This has improved linkages among CSOs who have implemented numerous joint advocacy interventions since then.

The activity has helped reaching out to wider networks and disseminating messages to a wider audience, securing the support of a large variety of change agents for the advocacy campaign. For example, CSOs met a total of 552 decision makers to discuss the findings of their budget analysis, a number which one CSO alone would never have reached. In addition, CSOs attended 102 external network meetings reaching 8,920 civil society representatives and community members with their messages.

In addition, 83 CSOs benefited from several capacity building trainings. A first series of trainings aimed at strengthening the understanding of the link between setting priorities, costing exercises, and allocating resources over the short and medium term; understanding how budgets and medium term expenditure frameworks are produced, the budget cycle and role of domestic funding and other sources; committing towards evidence-based action, and identifying how to approach and advocate towards decision-makers. A second series of trainings aimed at strengthening CSOs’ role in decentralised decision-making. CSOs are potentially excellent vehicles to connect citizens to decision-makers. It is necessary for CSOs to be inclusive and reach out to the communities themselves to encourage greater participation in local processes affecting the allocation of resources to health programmes, and act as a medium to channel their messages to local and national levels of decision-making. Thus, the trainings helped CSOs to act as channel between district authorities and community members. CSOs learned how to enable community members and community organisations to monitor and interact with local governments and health institutions. The trainings acquainted community members with the functioning of local governments, including their powers and budgets (theoretically) vested in them. It explained community members’ role and responsibilities to participate effectively in decision-making processes.

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78 Malena et al. (2004)
79 Dr. Abeja Apunyo is a consultant with vast expertise in the field of reproductive health and family planning in sub-Saharan Africa.
Facilitating dialogue between communities and decision makers yields immediate change

In the three countries, the intervention has facilitated discussions at different levels.

In the communities

At community level, civic education activities helped raise the population’s awareness on its rights and obligations while creating awareness of the importance of reproductive health and family planning. Going beyond a mere rights approach, it broadened the perspective by suggesting that accountability is not only about responding to others but also about taking responsibility for oneself. As described previously social accountability has an external dimension - the obligation to keep standards of behaviour - and an internal dimension - the responsibility to demand. 

The first interaction with communities is through edutainment activities, which have provided community members with information on their rights and obligations. The method includes drama, film, rap and sports. Using edutainment aims to raise awareness and stimulate debate on health service provision, health systems and leadership/governance issues in health service provision. Alternatively, the method of community mapping is used to achieve the same outputs.

After the edutainment sessions, community discussions were conducted helping community members reflect on what they have seen and understand whether they were facing similar challenges. In this process, participants have analysed their situation and identified areas of improvement. The target groups for these discussions have involved community leaders from cultural and religious institutions as well as ordinary community members.

The community dialogues organised in Leguruki ward, Tanzania, ignited the following actions, improving performance accountability. The major issue there was the remoteness of the villages with no ambulance to carry patients into nearby hospitals. Shortly after the dialogue, the District Medical Officer delivered one examination bed to Shishtone village dispensary. The bed was taken to the village on 7th September 2011 together with one mattress, bed sheet and different drug supplies to cater for three months. The same officer briefed service providers about friendliness and opening health facility throughout the weekend. The district hospital decided to offer a mobile clinic in the three villages for pregnant women and under five children and also to organise family planning services with Population Services International (PSI) and Marie Stopes International. In addition, villagers have agreed to contribute blood to the blood bank at the referral hospital. This is an indicator that messages of rights and obligations have been internalised by those attending the community sessions.

In the district

Having raised awareness on rights and obligations, the next step was to create a conducive environment for dialogue between community members and decision makers. The roll out of dialogues at district and national levels increased transparency in decision-making and allowed poor segments of society to have a voice. As Singh and Shah pointed out in their theory, poor people have the most to gain from social accountability activities since they are most reliant on (local) government services and least equipped to hold the policy leaders to account.

The intervention organised consultative forums, where community members are able to interface with district decision makers. As the theory suggests, these forums were carefully prepared by programme implementers with prior meetings and visits with district officials paving the way for meaningful interaction. CSOs are an integral part of these forums and are tasked with either hosting, planning or facilitating the event. Table 2 provides an overview of stakeholders involved and preliminary

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80 Cornwall et al. (2000)
81 http://www.psi.org/
82 http://www.mariestopes.org.uk/
outcomes. The dialogues have been conducted in very constructive and non-confrontational ways, and all sides have provided very positive feedback.

Officials in charge of health services have used the opportunity to explain the causes for low standards in health services, and community members understood that they need to demand for better services from district leadership, parliamentarians and central governments, as an exchange of opinion between a community member and a district official, during the community dialogue in Nansana (Wakiso district, Uganda) shows:

--- “Who is to blame for poor health services in the country and the persistent drug stock out?”
--- “You should blame your Member of Parliament for the drug stock outs because he is the one who gets a chance to critically look at it, discuss and eventually pass it. It is imperative that the community demands for better health services from their leaders. The more the community demands, the more the services will get better.”

Impact can be noted from activities at the district. 4H and four CSOs from Tanga region, Tanzania, were involved in the budgeting process — the so called financial accountability — and helped prioritise the city health budget. This has led to the prioritisation of health, as participants agreed to allocate funds as follows: 5% of city budget funds allocated to procure utilities for private healthy facilities and 5% allocated to special groups like orphans and vulnerable children, people living with HIV and people with disability. Another meeting held with Meru district authorities, Tanzania, and the full council led to recruitment of 25 new medical attendants to address the shortage of human resources within the district. It also resulted in a budget allocation for refresher trainings for medical attendants on antenatal care, as well as for the purchase of delivery kits. 2011/2012 was the first time, the community in Korogwe, Tanzania, was involved in the budgeting process.

Community demands led to progress at the district hospital in Rongo, Kenya, as more health workers have been recruited and a theatre has been constructed in the facility. Decision makers agreed to follow up on the provider-patient relationship in Gucha, Kenya, that is curtailing healthcare seeking behaviour, and improve service delivery at the district hospital including increased funding for basic services. The Constituency Development Fund has constructed a health facility in Mombasa, Kenya, and a corner for youth friendly reproductive health services was committed by the fund. This will be replicated for every future construction of facilities.

In Mukono, Uganda, the district's budget for 2011-12 improved its commitments to reproductive health and family planning substantially. Expected outputs include availing information on adolescent sexual and reproductive health (ASRH), prioritising ASRH in the sub-county and district plans and advocating for youth friendly corners in the health centres.

In addition to igniting many cases of independent actions, the effectiveness of the intervention can also be induced from several other outcomes.

Stakeholders from all sides have called for more interventions of this type. In Kenya, the activities have eliminated district health official’s and decentralised funds officials’ suspicion. In the past, officials have been very fidgety when interacting with communities. In the target districts, officials have appreciated the intervention and asked for more. In many cases, community members interacted with officials for the first time and have asked for more opportunities to dialogue.

Understanding the governments’ under-investments into reproductive health and family planning, stakeholders have committed to continue organising discussions independently of funding from DSW and partners. In Kilifi, Kenya, ‘health action’ days are now organised every month by the district health office. Community sessions have been incorporated into the community health strategy in Mombasa, Kenya, and meetings between communities and officials are incorporated into the district plan in Mukono, Uganda.

Commitments go further than dialogue. In Meru, Tanzania, the District Commissioner ensured that the district workplan has health as a first priority. She promised to follow up and ensure the 2012 district budget considers health as a top priority. Mukono district, Uganda, has promised to prioritise maternal and adolescent reproductive health (RH) in the future. In Kamuli, Uganda, cultural and religious
leaders agreed to better get involved into district decision-making. As a way forward, they convened to start sensitising the people of Kamuli about low health spending including on reproductive health and family planning. They would translate findings from the budget study into Lusoga so that people understand better which issues are at stake. Religious leaders said they would incorporate accountability message into their sermons. The protestant leaders decided to call a pastors’ meeting, provide feedback to all pastors and then target the Resident District Commissioner. Finally, the Kingdom of Busoga decided to call all the clan leaders and disseminate the information received this day.

Several CSOs reported that they have carried out independent advocacy and civic education actions, with their own resources and utilising the knowledge and skills they acquired from the intervention. According to the theory, advocacy and technical skills are indispensable for the success of social accountability activities of CSOs.

The intervention has disseminated information and increased knowledge. For the first time, community members heard about the budgets available for health services. There also was a strong awareness raising aspect where villagers learnt about available services including the roles of village health teams. It helped reduce barriers for service provision e.g. in using family planning services. In addition, district officials learnt about the state of health services in their district, which they did not know. In Rongo, Kenya, the district medical officer learned about lack of supplies and examination beds. Officials learnt about missing examination beds in Meru, Tanzania, and in Kenya, decentralised funds officials received information to prioritise their funds.

Table 2: Overview of consultative forums

<table>
<thead>
<tr>
<th>Location and date</th>
<th>CSOs involved</th>
<th>Decision makers involved</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mombasa, Kenya, 20th April 2011</td>
<td>MTG&lt;sup&gt;84&lt;/sup&gt;, KWETU&lt;sup&gt;85&lt;/sup&gt;, FHOK&lt;sup&gt;86&lt;/sup&gt;, CWID&lt;sup&gt;87&lt;/sup&gt;</td>
<td>Ministry of Public Health and Sanitation, Community Development Fund representatives, Local government representatives, District youth officer, District development officer, Ministry of Medical services, Health Sector Services Fund representative</td>
<td>All health facilities in the constituency developed by Community Development Funds should provide provisions for youth friendly services; the local authority will organise forums in which they can explain to the public the reason development project from the council cannot be accounted for.</td>
</tr>
<tr>
<td>Kilifi, Kenya, 21st April 2011</td>
<td>MTG, KWETU, FHOK, CWID</td>
<td></td>
<td>The District youth officer realised that youth didn’t know about opportunities available in the youth fund and promised to give more information and organise outreach activities; the Ministry of Health lauded the relevance of such meetings and promised to organise more to make community members aware of their health rights and responsibilities.</td>
</tr>
<tr>
<td>Rongo, Kenya, 14th July 2011</td>
<td>SEP Kenya&lt;sup&gt;88&lt;/sup&gt;, Chuny Thuolo</td>
<td></td>
<td>There has been progress at the district hospital as more health workers have been recruited and theatre has been constructed in the facility.</td>
</tr>
<tr>
<td>Gucha, Kenya, 14th July 2011</td>
<td>YWCA&lt;sup&gt;89&lt;/sup&gt;, ATFAMICARE&lt;sup&gt;90&lt;/sup&gt;</td>
<td></td>
<td>Decision makers agreed to follow up on the provider-patient relationship that is curtailing healthcare seeking behaviour.</td>
</tr>
</tbody>
</table>

84 Moving the Goalposts; http://www.mtgk.org/
85 Kwetu Training Centre; http://www.kwetukenya.org/
86 Family Health Options Kenya; http://www.fhok.org/
87 Coast Health Options Kenya; http://www.coastwomen.com/
88 Special Education Professionals; http://www.sepkenya.com/
89 Young Women’s Christian Association; http://www.ywcakenya.org/
90 Action Times Family Care; http://www.atfamicare.org/
### 2011

<table>
<thead>
<tr>
<th>Location</th>
<th>Community or Organization</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magoma, Tanzania, 12 May 2011</td>
<td>Magunga HBC(^91), TAWG Korogwe(^92)</td>
<td>and improve service delivery at the district hospital including increased funding for basic services.</td>
</tr>
<tr>
<td>Leguruki, Meru, Tanzania, 2 Sept 2011</td>
<td>WOCHIVI(^93), TUPO(^94), WAMATA(^95), WODSTA(^96), PATHFINDER(^97), ELCT-SELIANI AIDS CONTROL PROGRAMME</td>
<td>District reproductive health coordinator, District community development officer, Ward Councilor, Ward executive officers and village executive officer. Provision of examination/delivery bed to health dispensary in Shistone village, repair of the door and cleaning the environment surroundings, community members to contribute to the Community Health Fund with income gained in this harvesting period and disciplinary action taken against medical attendant of the X-ray department at the district hospital. Other concerns include people over 60 years being charged while seeking health services and the issue of exemption cards, RH budgets and staff shortages will be addressed at the tripartite meeting scheduled 16th September 2011.</td>
</tr>
<tr>
<td>Nansana, Wakiso, Uganda, 2 July 2011</td>
<td>Inspector of Drugs, Senior Nursing Officer, Deputy District Health Officer</td>
<td>District officials recognise poor state of health system and attribute it to inadequate funding from central government and non availability of drugs. They recommended that MPs and higher level decision makers needed to be invited.</td>
</tr>
<tr>
<td>Busia, Uganda, 12 August 2011</td>
<td>FOC-REV(^98), NACWOLA(^99)</td>
<td>5 officials from the District Health Office, Principal Accountant, Officer from the Planning Unit, 3 LC III representatives, 1 LC II representative, Parish Chief, District Councilor, Woman District Councilor. District officials recognise poor state of health system and attribute it to inadequate funding from central government. In addition, it was agreed to deal with the absenteeism of health personnel through the health management committee, which has community representatives. Community understood that they need to work closely with these representatives.</td>
</tr>
<tr>
<td>Busia, Uganda, October, 13th and 14th</td>
<td>RHU(^100), FOC-REV</td>
<td>Community Leaders, School Leaders. Edutainment session including dance and drama, creating awareness on Maternal Health and Teenage pregnancies.</td>
</tr>
<tr>
<td>Mityana, Uganda, 10th October</td>
<td>Muvubuka Agunjuse(^101), AGHA(^102), Religious leaders and Cultural Leaders</td>
<td>These leaders recognised the importance of adolescent health and also creating awareness in the community on health</td>
</tr>
</tbody>
</table>

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\(^91\) Magunga Home Based Care  
\(^92\) Tanga AIDS Working Group Korogwe  
\(^93\) Turnaini Positive Test Club; http://www.tupo.co.tz  
\(^94\) Walio katika mapambano na AIDS Tanzania; http://www.wamatatz.org/  
\(^95\) Women Development for Science and Technology; http://www.wodsta.org/  
\(^96\) Pathfinder International Tanzania; http://www.pathfind.org/site/PageServer?pagename=Programs_Tanzania  
\(^97\) Friends of Christ Revival Ministries  
\(^98\) National Community of Women living with HIV/AIDS; http://www.nacwola.or.ug  
\(^99\) Reproductive Health Uganda; www.rhu.or.ug/  
\(^100\) Muvubuka Agunjuse Adolescents Reproductive Health Centre  
At central level

Providing evidence-based input into policies and strategies at national level is a key component of the intervention. Implementers coordinated CSOs’ input into 19 policies and strategies (political accountability) summarised in the box as well as input into budget processes (financial accountability). CSOs act as conduits between the communities and decision makers.

In Kenya, a roundtable was organised under the auspices of the Kenya Health Budget Network, a coalition of 20 Kenyan CSOs. Participants interacted with key decision makers, including the Ministry of Finance, and tabled issues of concern regarding the 2011/12 budget draft and health financing processes. The network submitted a cabinet memorandum to the Ministry of Medical Services for presentation to parliament during discussions of the 2011/2012 budget. It was followed by a special audience with the Minister for Medical Services to discuss operationalisation of the proposed National Social Health Insurance Fund.

DSW and other CSOs participated in the National Leaders Conference in Kenya. During this conference, national stakeholders started drafting Kenya’s population policy for the period 2011-2020. The conference reviewed the population policy, identified leaders’ roles, and informed and shaped the development of a national population plan of action. DSW and other CSOs set the pace in ensuring that the country’s new population policy adequately addresses the financing needs for reproductive health. Two case studies on district health funding were extracted from the health budget study and presented to over 1,000 people. On the policy side, one of the intervention’s most important contributions was the participation in the sub-committee that suggested themes and sub-themes for the National Leaders Conference, which informed Kenya’s population policy for the period 2011-2020. The conference reviewed the population policy, identified leaders’ roles, and informed and shaped the

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103 Naguru Teenage Information and Health Centre
104 Uganda Media Women’s Association; http://www.umwamamafm.co.ug/
105 Uganda Youth Development Link; http://www.uydel.org/

development of a national population plan of action. Mini-workshops allowed implementers to interact with key decision makers, including parliamentarians and Permanent Secretaries in the Ministries of Medical Services, and Public Health and Sanitation. Since November 2010, DSW has continuously engaged in finalising the population policy. DSW took part in three meetings organised by the Ministry of Planning, National Development and Vision 2030 to adopt the report of the National Leaders’ Conference and develop an action plan emanating from the conference. This input will be incorporated into the final policy document.

A follow up parliamentary retreat held in Mombasa provided opportunity for discussion between decision makers & CSOs. DSW sat in working groups with Members of Parliament to discuss maternal and child mortality and how to respond to reproductive health needs. Two CSOs participated in working groups on measures to mitigate gender imbalances in the provision of health care.

As a result of advocacy and dialogue activities, the National Coordinating Agency for Population and Development (NCAPD) in Kenya benefitted from a double budget increase. The government also introduced an allocation for sanitary towels into the 2011/12 budget.

This strong involvement of CSOs in these Kenyan processes had been preceded by a series of meetings within which DSW was able to articulate and push community concerns and advocate for CSO participation. These meetings have been critical in framing the public debate on reproductive health and family planning:

- Steering Committee for planning the National Leaders Conference;
- Technical Committee to plan World Population Day;
- Technical Committee to plan launch of the State of World Population;
- Technical Committee to Award exemplary journalism in population and RH;
- Technical Committee for World Contraception Day; and
- Donors and Development Partners Roundtable during National Leaders Conference.

In Uganda, CSOs participated in the CSO budget dialogue meeting for fiscal year 2011/12 and ensured that the health sector was adequately represented. The Civil Society Advocacy Group convened a dialogue meeting with the Ministry of Finance, Planning and Economic Development regarding the upcoming budget, which was attended by over 100 CSOs. In his speech, the Commissioner for budget and planning responded to CSOs’ position paper on the budget and strongly recommended to also take dialogues down to district level.

DSW and RHU worked with Uganda’s Network of African Women Ministers and Parliamentarians (NAWMP) and the National Youth Council and Uganda Aids Council. NAWMP has benefitted from DSW’s and RHU’s ongoing technical support. During the reporting period, RHU organised a meeting to discuss Uganda’s World Bank loan to improve maternal health. After the formation of the 9th Parliament, in-depth technical assistance was provided to draft the network’s new strategic plan. Further, RHU participated in a workshop to induct new network members on their role as parliamentarians, especially on issues of law-making and budgets. RHU and DSW – in partnership with National Women Parliamentary Network and other CSOs – held a meeting with the State Minister of Health, the Assistant Commissioner in charge of reproductive health and several top officials from the Ministry of Health. The purpose was to follow up on a World Bank loan earmarked for maternal and reproductive health. Shortly after, RHU helped parliamentarians hold a press conference in which they pledged to track the expenditure to ensure it is in line with agreed-upon activities. RHU and DSW also attended a CSOs presidential debate on health. It brought together presidential aspirants from various parties who discussed ways to improve health.

At the time of writing this report, thanks to information from the project, Ugandan parliamentarians were fighting the misplaced priorities within the proposed health budget.

In Tanzania, implementers liaised with Tanzania Parliamentarians AIDS Coalition (TAPAC) and Tanzania Parliamentarians against Malaria (TAPAMA). DSW organised week long networking meetings with parliamentarians. This provided an opportunity to orient and share project activities, progress and deliverables.

The following box summarises the input provided into policies and strategies in the three countries:
**Kenya:** New national population policy; review of the national reproductive health policy; progress report of the sixth annual operation plan of the department of reproductive health and development of annual operations plan 7; national youth volunteer policy; health policy framework 2011 – 2013; Government of Kenya proposal towards the EU’s MDG initiative.

**Tanzania:** Implementation matrix of the future poverty reduction strategy; review of HIV/AIDS plans for 2011/12; RH supplies situation in Tanzania; Tanga City health budget; Government of Tanzania proposal towards the EU’s MDG initiative.

**Uganda:** Young people communiqué during African Youth Forum; National Youth Council’s next five year strategic plan 2011-2015; review of national youth policy, health sector strategic plan 3; national adolescent health policy, strategy and service standards; essential drugs list; Inter Parliamentary Union’s access to health as a basic right.

Box 1: Input provided by the Implementers
VI Way forward: Civic participation allow to extract accountability in providing reproductive health services

The case study supports different social accountability theories. In those theories, social accountability is understood as a process in which citizens and civic organisations participate directly or indirectly in exacting accountability. These theories identify community participation as one of the mechanisms to improve service delivery that meet the needs of the communities. Citizen participation in local decision-making, transparency, accountability, and efficient service delivery are main attributes of good local governance and finally, these elements can strengthen the democracy process. The theories divide social accountability into three types: financial accountability, political accountability and performance accountability. As the case study has shown, the interventions in Uganda, Kenya and Tanzania cover all of them. In the theory as well as in the intervention, the focus lies on downwards social accountability. Local government and elected representatives have the obligation to keep certain standards of behaviour, whereas the citizens have the responsibility to demand.

In the field of health services, social accountability faces many challenges, because health services are often characterised by strong information asymmetries among service providers and users. Knowledge is mainly specialised and usually health providers know more about health and health care than their patients. Therefore, the users are often in a weak position to confront the providers who determine who receive what treatment. Last but not least, there can be divergences between private and public interests. Mostly, policy makers focus on providing a minimum level of care while users have an understandable interest in receiving the maximum amount of care.

The intervention has proven relevant in improving reproductive health and family planning services. While a range of other actors focus on civic education and voters programmes, few have focused on social accountability in the health sector and no known intervention has aimed at improving social accountability as regards reproductive health and family planning.

This explains why in all three East African countries, stakeholders have applauded the activities and the acceptability is high. A proxy indicator for the relevance of the proposed strategy is the high participation and reactivity of communities. In many cases, this is the first opportunity for community members to ask questions to their leaders. For district officials, in many cases this is also the first opportunity they are allowed to explain budgets and work plans in a non-confrontational way. That is why the intervention is innovative. It moves away from the patronising approach used by governments. Getting community members to analyse their situation, think about where change is needed, and advocate for themselves is new and highly successful. Throughout, implementers are mere facilitators ensuring that all participants are free to discuss what they want and make their own conclusions. Working through locally rooted civil society is key as rapport between CSOs, the communities, and local authorities does already exist.

The effectiveness of the intervention depends on several external factors. Successfully influencing budgets and policies requires to work within government processes. In Kenya, Tanzania and Uganda, legislation foresees consultations with constituents and there are many opportunities to participate in decision-making. Unfortunately, in many cases cooperation projects depend on donor funding and project cycles which do not necessarily coincide with government calendars.

Success also requires a good understanding of the degree of decentralisation in the countries of operation. The three Eastern African countries have very different trajectories which include conducive and hampering factors. Uganda’s district and local council system, has been a pioneer in decentralisation for more than 20 years. However, recent years have witnessed a dismemberment of the districts, leading to smaller and poorer entities with weakened capacity to handle participatory decision-making processes. In Kenya, the new constitution, which was promulgated in 2010, has brought decentralisation, with multiple avenues for local decision-making. However, the situation is very new and in flux. Local authorities do not know yet where and how to use their new powers. Often times, funds that were meant to be spent on locally set priorities are sent back to the treasury. In Tanzania, decentralisation has taken the form of central appointees with large powers at the local level. Local government plans and budgets are dominated by centrally funded mandates – such as
constructing health centres. Venugopal and Yilmaz (2010) note that “central control over administrative functions has ensured that administrative decentralisation is yet to occur”\textsuperscript{106}.

Then, effective interventions need to grasp the situation beyond what is possible on paper. While decentralisation provides local authorities with larger discretion on setting priorities, funding may still be determined largely at the central level. For example, Uganda has seen a notable increase in funds channelled through local governments, which has allowed local councils to improve services and make new investments. Yet, most resources transferred are in the form of specified grants over which there is relatively little local choice. When facilitating dialogue between local authorities and communities, it is important to understand that only some transfers — notably the Local Government Development Programme — offer real choices in decision-making.

Similarly, Uganda’s local council system was designed to create opportunities for participatory decision-making at all levels. There are multiple opportunities for citizens to participate in public meetings and elections, from the village level up to the district. Nevertheless, the system has its weaknesses\textsuperscript{107}. The level of participation is much less than suggested by legislation. There are citizens consultation at lower levels of representation – even if not as frequently as they should. This tends to reduce as one moves to higher levels in the government hierarchy, i.e. to the level of the district. Relatively few citizens attend budget conferences, and the language and style of these effectively exclude many.

It is a great advantage that the three East African governments acknowledge community participation as beneficial to governance. It is good that processes have been enshrined in legislation. This allows to plan civic education processes as well as dialogues in conjuncture with local decision makers. Yet, experience shows that the key lies in understanding to what degree decision makers are able and willing to take up community suggestions. This assessment has to happen before consultations and dialogues are organised in order to avoid frustrations among participants.

Another challenge relates to an overboarding bureaucracy which affects the collection of official data and information. In order to be effective, the case shows that findings need to be validated officially, so that they cannot be challenged on grounds of inaccuracy. In all three countries, DSW chose to seek approval from either parliamentarians and/or Ministries. Unfortunately, this has led to delays in releasing publications. Bureaucratic processes have been overcome through alliances with multiple contacts. In one case, a Kenyan CSO has invited the district medical officer to join its board. This has promoted its advocacy efforts at the local level.

Contacts are key and experience shows that gaining support of line ministries and area parliamentarians helps increase the effectiveness of the intervention. As shown by the Kenya case, data collection within Ministries can be eased with the support of high level decision makers. Ministries and parliamentarians also can introduce the implementers at the district. Most importantly, work at the district needs to be rooted in long standing cooperation with local authorities. Rapport with officials has to be built over time, proving that the intervention is not a one off activity. Confidence building measures need to be enacted ranging from attending official functions, offering health services or information campaigns and at a later stage approaching government with advocacy purposes in mind. The strategy needs to work gradually. Before aiming at policy change, it is important to change attitudes of decision makers.

In many cases, legally enshrined participation has taken the form of a pseudo participation of civil society organisations where government-initiated involvement consists of consenting to what has already been decided. In many cases, CSO participation in key decision-making institutions has focused more on formal representation than substantive contributions that could involve various societal groups and foster more inclusive consultations. However, it was paramount to the case’s success, that in all three countries the role of CSOs is well articulated in health policies and recognised by government. This has allowed implementers to create real space to voice opinions and mobilise for change. It seems that in neighbouring countries such as Ethiopia or Rwanda space for

\textsuperscript{106} Venugopal/Yilmaz (2010)  
\textsuperscript{107} Konrad Adenauer Stiftung (2010); Devas/Grant (2003)
public participation is much more restrained. Hence, the strategies described in this paper can only be implemented when participation is officially acknowledged and supported by government.

Strategies using CSOs as main conduit between communities and government authorities require the availability of a nascent civil society movement which has understood its watchdog role. In the present case, Dr Abeja Apunyo notes that CSOs reported that they gained greatest capacity in understanding the formulation of health policies, the budgeting process as well as the advocacy process. This has urged several of them to re-organise themselves and provide for advocacy positions. This openness to embrace advocacy has been a major factor explaining different degrees of success in the three countries. Indeed, civil society is vibrant in Uganda and Kenya, while it is burgeoning in Tanzania.

Working with CSOs brings a range of challenges which include high staff turnover, loss of contacts and skills. Thus, cooperation needs to be lifted from individual level to institutional level, which is difficult in cases where very new advocacy activities are driven by a few personalities. While the intervention has gained from working with diverse organisations, this has also brought challenges. For example, working with governance organisations was challenging as they lacked knowledge on health topics and hence their legitimacy was questioned when discussing with health officials. Therefore, any intervention needs to incorporate a capacity building component. Organisations specialised in health need to learn about governance issues, while governance organisations need to learn about health.

Evidence based advocacy requires access to information. Different layers of governments need to open their books. However, this entails that governments also request CSOs to play with open cards. Where does their funding come from? Where do they operate? From where do they derive legitimacy? Transparency is not a one-way-street. Capacity building activities need to incorporate organisational strengthening.

While networks and coalitions are paramount to strengthen CSOs’ voice, the coordination of informal networks brings challenges. How can informal networks be kept alive without developing new secretariats who have the tendency to mutate into full fledged NGOs. The suggested strategy involves rotating chairs, hosts and meeting venues, so that NGOs’ ownership of the network increases.

First experience, shows a high sustainability of activities. Local governments have participated in activities as equal partners. Their strong interest in the methodology has motivated them to incorporate health consultations into their work plans. In addition, many CSOs have strengthened their advocacy components, indicating that the activities have been lifted from individual working relationships and entered CSOs’ institutional set up. For example, CSOs such as Coast Women in Development and Maendeleo ya Wanawake in Kenya have independently organised the International Day for Action of Women’s Health. These CSOs have sought independent funding for this initiative and two UNDP proposals have been funded for community interventions using civic education activities. Other CSOs with existing funding have changed their programmes to incorporate civic education and advocacy for health or have used their own funds to implement such activities in other districts as was the case with NAYA in Kisumu, Kenya. Similarly, the organisation STIPA approached international funders to scale up the intervention in Western Kenya and promote community advocacy for community led health insurance schemes. In Uganda, the organisations TASO and NACWOLA think about bringing civic education and health a step further by incorporating the topic into their existing trainings. In Tanzania, WAMATA will conduct community sessions in other areas of Meru district.

In summary, activities are very relevant to all stakeholders. Thanks to a high acceptability of all sides, immediate effects have been noted at village, district and national level, allowing for improved reproductive health and family planning services.

While not serving as a blueprint for replication, the intervention has proven highly effective and a range of lessons can be drawn for future similar actions.
VII References


