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Engaging Citizens in Health Service Delivery

A Review of the Literature

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Abbreviations and Acronyms

ACCU	Anti Corruption Coalition of Uganda
ATI	Access to Information
CBO	Community Based Organization
CE	Citizen Engagement
CHW	Community Health Workers
CRC	Citizen Report Cards
CSO	Civil Society Organization
GRM	Grievance Redress Mechanism
HDR	Human Development Reports
KGH	Kenya School of Government
MOH	Ministry of Health
NGO	Non-Governmental Organization
OECD	Organisation for Economic Co-operation and Development
PTF	Partnership for Transparency Fund
RBA	Rights-Based Approach
RCT	Random Control Trial
RTI	Right to Information
SAcc	Social Accountability
UN	United Nations
USAID	US Agency for International Development
WB	World Bank
WDR	World Development Report
WHO	World Health Organization

Executive Summary

This literature review summarizes the current findings on citizen engagement instruments in health service delivery and examines whether these interventions have contributed to enhanced health practices and ultimately on improved health outcomes. The inclusion of citizen engagement in development programs, including those supporting the health sector, is based on the premise that giving citizens a voice will help ensure that programs are tailored to their needs, will build a greater sense of ownership by the community, and will make service delivery more accountable, all of which will contribute to more effective service delivery.

Earlier generation health projects emphasized training or information (“talking at” individuals or communities) to induce behavior change and to thereby improve health outcomes. These are now giving way to more focus on empowering citizens to take responsibility for their health decisions and practices, to collaborate with health providers, and to hold providers accountable for increased access to and quality of health services.

Reviews of evidence of impact of citizen engagement instruments on health service delivery and health outcomes are consistently cautionary in drawing conclusions regarding the impact of any single citizen engagement instrument or even a group of instruments. Moreover, because programs generally employ a variety of citizen engagement mechanisms concurrently, such as health committees or groups and structured feedback mechanisms like scorecards or grievance redress mechanisms, outcomes are generally not attributable to any single citizen engagement instrument.

These limitations notwithstanding, research evidence confirms the potentially positive, although variable, impact of citizen engagement on health outcomes, but generally only when they complement a broader package of services. Successful interventions usually focus on raising community awareness of targeted health issues and encouraging dialogue and community ownership. Building and sustaining trust within the community was often cited as an important contributor to successful outcomes.

The literature also reveals that outcomes are highly contextual, based on socio-economic and cultural factors and the overall enabling socio-political environment. Many well-intended initiatives to engage citizens fail to gain traction due to information and power asymmetries between service providers and citizens, resulting in elite capture or neglect of poorer community members. Other challenges to effective citizen engagement relate to lack of government capacity for oversight and downward accountability, project design that fails to understand the local context, and inadequate implementation monitoring.

Key factors that have contributed to overcoming these constraints include *buy-in by political authorities and agencies responsible for service delivery*, a *propitious enabling environment* in terms of a national framework that embraces citizen involvement and presence of dynamic CSOs/NGOs, and an *appropriate project design* that tailors interventions to local contexts. Inclusion of dedicated citizen engagement monitoring indicators in projects, as well as strong operational guidance and support during both project design and implementation, are critical to building meaningful citizen voice to achieve improved health service delivery and health outcomes.

1. Introduction

This literature review examines the current knowledge base on use and impact of citizen engagement (CE) instruments to improve health service delivery and ultimately health outcomes in developing countries. It draws on documented assessments of these approaches, relying primarily on secondary reviews and evaluations carried out by practitioners or researchers in government, bilateral and multilateral agencies and academic institutions working in this field. The review is expected to provide context for advancing propositions and drawing conclusions about how citizen engagement initiatives in the health projects to be examined in two case studies in Peru and Democratic Republic of Congo may have impacted overall project outcomes.

The analysis is presented in the following five sections:

- Section II explains the rationale for citizen engagement in health service delivery and summarizes the evolution of CE broadly and within the health sector.
- Section III surveys the different citizen engagement instruments that have been employed in health programs.
- Section IV describes a number of cross-cutting initiatives that donors often finance to support these CE instruments.
- Section V synthesizes the findings of the analytical literature on what overall impact citizen engagement initiatives have had on improving health service delivery, including a discussion of both challenges and factors contributing to successful citizen engagement outcomes.
- Section VI concludes with brief remarks on the implications for future citizen engagement initiatives in health.

2. Rationale for Citizen Engagement in Health Service Delivery

The inclusion of some form of citizen engagement in development programs, including those supporting health service delivery, is based on the premise that giving citizens a voice will ensure that programs are tailored to their needs, will build a greater sense of ownership by the community, and will make service delivery more accountable, all of which will contribute to more effective service delivery, ultimately producing improved development outcomes.

About the LMG Project

Funded by the USAID, the Leadership, Management and Governance (LMG) Project (2011-2016) is collaborating with health leaders, managers and policy-makers at all levels to show that investments in leadership, management and governance lead to stronger health systems and improved health. The LMG Project embraces the principles of country ownership, gender equity, and evidence-driven approaches. Emphasis is also placed on good governance in the health sector – the ultimate commitment to improving service delivery, and fostering sustainability through accountability, engagement, transparency, and stewardship. Led by Management Sciences for Health (MSH), the LMG consortium includes Amref Health Africa; International Planned Parenthood Federation (IPPF); Johns Hopkins University Bloomberg School of Public Health (JHSPH); Medic Mobile; and Yale University Global Health Leadership Institute (GHLI).

Evolution of Citizen Engagement in Development Programs

Development projects have included multi-stakeholder engagement and participatory approaches for several decades. In general, however, people who were impacted by projects were traditionally viewed as either “beneficiaries” or as individuals whose behaviors needed to be modified to improve development outcomes, as determined by technical authorities dispensing services, notably government agencies.

A landmark shift in conceiving state-citizen/beneficiary relations was articulated in the World Bank’s (WB) 1997 World Development Report (WDR) on the role of the state which referred for the first time—certainly within the Bank’s development conceptual framework—to creating greater accountability and responsiveness of the state through participation of citizens as partners. In the early 2000s, the good governance agenda took hold and “demand-side governance,” through citizen action focused on transparency and accountability, began to complement traditional “supply-side” governance measures such as to capacity strengthening and more technocratic accountability mechanisms like audits and inspectors. At the same time, some development practitioners began to argue for participation as a fundamental human right and prerequisite to making other rights claims (Ferguson 1999), recasting the state and citizenry as duty-bearers and rights-holders respectively. These notions were enshrined in two United Nations (UN) Human Development Reports (HDR): the 2000 HDR on Human Rights and Human Development which introduced the rights-based approach (RBA) into much of the UN’s development work, and the 2002 HDR on Deepening Democracy, which emphasized the importance of public accountability beyond the electoral system. The World Bank’s 2004 WDR on Making Services Work for Poor People further embedded citizen voice and public accountability into service delivery.

The focus on governance and public accountability has given rise to a stronger emphasis on “*social accountability*,” defined as “the broad range of actions and mechanisms beyond voting that citizens can use to hold the state to account, as well as actions on the part of government, civil society, media and other societal actors that promote or facilitate these efforts” (McNeil and Malena 2010. p.6). As such, social accountability (often referred to as “SAcc”) is a subset of citizen engagement. The latter can be defined as “the two-way interaction between citizens and governments or the private sector. . . . that gives citizens a stake in decision-making with the objective of improving the intermediate and final development outcomes of the intervention” (World Bank 2014 (ii), p.8). In this framework, “citizens” can act as individuals or be organized in affinity groups such as non-governmental organizations (NGOs), civil society organizations (CSOs), or community based organizations (CBOs). Moreover, the term “citizen” does not reflect the legal status of the individual.

Citizen Engagement Approach in Health Programs

It is likely that among government services for citizens, health service delivery has the greatest interface with the public, and certainly touches very directly on people’s welfare. As such, some form of involvement with communities has been a hallmark of health projects and programs well before citizen engagement mechanisms became more common in other sectors or programs. The World Health Organization (WHO) has long argued for the importance of community “participation” in health service provision and utilization. The Alma Ata Declaration of 1978 declared health to be a human right and that care must be made “accessible to individuals and families through their full participation” (WHO 1978). However “participation” generally translated to training community

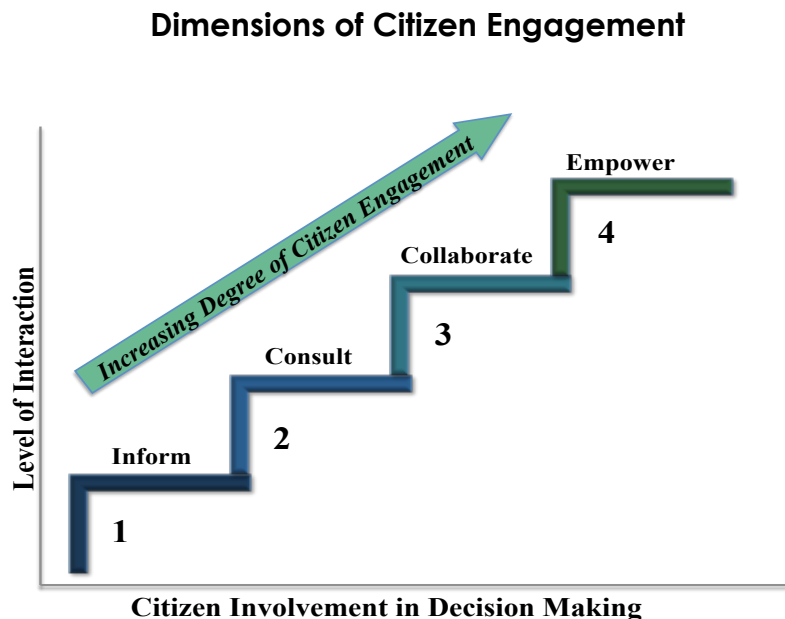
health workers (CHWs) to extend services to previously uncovered, difficult to reach areas. Traditional birth attendants, “barefoot doctors” and community health promoters were trained to improve their skills and serve as the arms and eyes of the public health system in locales that public resources could not reach. CHWs were viewed as contributors of labor, not of views and ideas, and were essentially not given a voice. In this context, it is not surprising that citizen “voice” also played no role.

With time, community participation in health came to include actions designed to modify beneficiaries’ behavior in order to make them aware of the benefits of health services and practices, facilitating their ability to exercise their right to health, while still expecting their participation in its provision. As expressed by a WHO Study Group in 1991, “[community involvement in health] actively promotes people’s involvement and encourages them to take an interest in, to contribute to and take some responsibility for the provision of services to promote health” (Oakley et al 1999, p.10).

While most health programs are still focused on inducing behavior change to improve health practices and outcomes, there are an increasing number of programs where a greater voice is being given to communities in the design, management and direction of health services. Cornwall observed in 2000 that the shift in health service delivery is “away from users as recipients of services designed for their benefit, towards communities being active makers and shapers of services, exercising their preferences as consumers and their rights as citizens.” (Cornwall et al 2000). Some of these approaches are described more fully in the following paragraphs.

3. Citizen Engagement Interventions in Health Programs

Citizen engagement instruments are often categorized by their degree of engagement or empowerment of citizens in the process, with information/consultation at one end of the spectrum, and empowerment or self-management at the other. It can be depicted as follows:



1. Inform – Providing citizens with balanced and objective information to assist them in understanding the problem, alternatives, opportunities, solutions
2. Consult – Obtaining citizen feedback on analyses, alternatives, decisions
3. Collaborate – Partnering with citizens in parts or all of decision-making
4. Empower – Final decision-making in the hands of the citizens

Source: adapted from "IAP2 Spectrum of Public Participation," International Association for Public Participation

The above schematic is particularly suited for programs involving resource allocation and management, for example, for community infrastructure funds, in which specified aspects of final decision-making may be in the hands of citizens; these may be limited, as in cases of collaboration depicted in the above graphic, or more comprehensive, as referred to above as empowerment. However, in health service delivery, where government bears ultimate responsibility for decision-making regarding resource allocation and facility management, the degree of citizen partnering, decision making and empowerment with regard to facility management is likely to be more limited. These terms are therefore sometimes used to refer to the degree of engagement of citizens and communities in taking responsibility for their family health practices.

Moreover, because of the observed difficulty of ascertaining within some CE instruments applied in the health sector whether they are consultative or collaborative (described more fully below), the following discussion groups these two ascending "steps" together, resulting in three clusters corresponding to the above graphic:

- Information provision (inform)
- Consultation/participation (consult/collaborate)
- Citizen empowerment (empower)

The operational characteristics of citizen engagement instruments in these areas typically observed in health programs are described below. An examination of the outcomes and impacts of these citizen engagement interventions is provided in the subsequent section of the report. Definitions of the instruments described below that are commonly used in citizen engagement literature are provided in Annex 1.

One further definitional caveat is important to consider in developing a typology of citizen engagement instruments in the health sector. Health service providers, including volunteers at community level, have generally always sought to "engage" or educate citizens in some manner to promote healthy behaviors, whether by talking at them or with them. However, "citizen engagement," as defined at the beginning of this review, conveys a somewhat more structured, often collective, exchange aimed at given citizens a greater stake in decision-making and outcomes. As will arise frequently in the discussion throughout this review, some authorities conflate "engaging" and "engagement" while others dismiss traditional forms of "engaging" (for example, those involved in health promotion) as not qualifying as citizen engagement. Moreover, as will also be discussed, empowerment is often defined differently in the health sector relative to the terminology used more generally in the citizen engagement literature. This review therefore takes a relatively inclusive approach to approaches to engaging citizens in health service delivery, as suggested by its title.

Information Provision

While information provision is not deemed to constitute citizen engagement per se, availability and transparency of information is an important prerequisite to social accountability and citizen empowerment. Applying the definition from the above graphic, information is theoretically intended to provide citizens with “balanced and objective information to assist them in understanding [health] problems, alternatives, opportunities and solutions.” However, the kinds of health information provided as part of health promotion efforts are not normally considered information for purposes of citizen engagement.¹

Some forms of information provided in health service delivery do provide a framework for social accountability in the sector. Provision of information can provide the basis for a more activist stance by citizens when it “informs citizens, either individually or collectively, about their rights, the services and benefits they are entitled to receive, the performance standards they should expect, and the grievance redress channels they can use when things go wrong. . . Information implicitly encourages citizens to demand better services by publicizing information about rights, standards, and performance”(Ringold et al 2013, p.71). In health programs, these have included informing citizens either by posting notices at clinics and/or through mass media about what they should expect at the clinic, such as staffing, hours, timetables for arrival of pharmaceuticals or vaccines, provision of MCH clinic sessions, and costs of various services, including those that are supposed to be free. Information on what citizens should expect from health services have sometimes taken the form of “citizen charters,” initially developed by the National Health Service in the United Kingdom, in which health clinics post service standards for patient care.

At a more macro level, Access to Information (ATI)² legislation, providing for public access to budgets and expenditures, procurement decisions, contract awards, parliamentary proceedings and other information recorded by government services have sometimes been valuable in holding government services accountable on the transparency front, particularly to uncover or prevent corruption or to monitor shifts between projected and actual (promised) expenditure, including in the health sector.

Consultation/Participation

While health communications and information to improve knowledge have been reported to be instrumental in behavior modification, there is growing awareness that these are more effective when they involve dialogue and strengthen problem-solving skills (Rosato et al 2008), (Wallerstein 1992). USAID’s Maternal Health Vision for Action for Ending Preventable Maternal Mortality (USAID 2015) notes evidence that participatory or empowering approaches support longer-term processes to enable communities to be actively involved in shaping their health (Rifkin 1996). The application

¹ Health promotion embraces a broad spectrum of approaches designed to stimulate behavior change. These range from individual personal communication transmitted by a community-based worker/health promoter during a home visit, to small group talks in the community, brochures and posters, and messages transmitted by village leaders in community events, to well organized communication campaigns including radio and television spots, billboards, street theatre and health fairs, to name a few. Some health promotion interventions may provide a platform for more targeted CE approaches, as when they inform people of their rights or encourage communities to mobilize collectively, but these need to be considered on the merits of the individual intervention.

² Terminology varies by country: Right to Information (RTI) or Freedom of Information (FOI) are also used to convey access to information.

of CE terminology and concepts in the health sector, including by these above-cited authorities, is nonetheless somewhat blurry: for example, “dialogue” is not considered “consultation” under some definitions (see Annex 1’s differentiation between the two terms).

A large number of citizen engagement measures in health projects represent some form of consultation and/or participation. Although these two are different, the latter suggesting more involvement or voice in program design or implementation, some of the same instruments in the health field support both, and vary only in their intensity of community involvement. Moreover, documentation on them often fails to record the degree of engagement, or simply conflates the two terms.

Surveys or ad hoc consultations carried out to improve health program design, focus group discussions on emerging health issues, or town hall meetings that discuss health priorities have generally been means of engaging in two-way conversation, and are most clearly forms of consultation rather than participation. Committees and groups generally contain elements of both, as do more structured social accountability instruments for feedback, described below.

Health committees and user groups. Establishment of citizen health committees, women’s groups or other means for carrying out dialogue on an ongoing basis has in some contexts been restricted to two-way communication (consultation). Some have involved these groups in community-based service delivery, distributing either information or in some cases medications. In the best of cases, these groups have been involved in more concerted citizen action, such as joint preparation and monitoring of health action plans, mobilizing transport to health facilities or generating supplementary community resources for health infrastructure or supplies, all of which are more genuine forms of participation (Marston et al 2013).

Identification and training of community volunteers to carry out health services that would have otherwise been performed by health staff, such as birth attendants or distributors of contraceptives, iron pills or deworming tablets, is not considered a form of citizen engagement. However, in cases in which these volunteers provide feedback to health services, they play a role in facilitating consultation.

Structured feedback and monitoring instruments Structured feedback and monitoring instruments can bring a more formal and legitimized means for citizens to report their satisfaction, or lack thereof, with the performance of health services, relative to some of the participatory approaches cited above. As such, they can strengthen citizen voice to ensure public accountability. The most frequently used instruments include the following:

- **Citizen/community surveys and scorecards.** Structured citizen feedback, through citizen satisfaction surveys, social audits, community scorecards and citizen report cards (CRCs) (see Annex 1 for definitions³) have become more frequently used in health projects to provide feedback and to incentivize health service providers to perform according to standards simply by their awareness that their performance is being monitored. These are generally executed by local health NGOs or community CSOs. International NGOs have fostered the use of some of these; for example, over 400 World Vision programs in 42 countries applied scorecards as of 2014 (Hoffman 2014). Among these, community scorecards appear to have been most commonly used in health programs as they generally entail communication between citizens and service providers at the local or health center level and tend to be lower-cost than instruments employing more quantitative data collection and analysis.

³ Some of these labels are used interchangeably, or are defined differently, in different programs.

- **Third party monitoring by citizen groups.** Third party monitoring consists of citizen-led tracking of development programs, project implementation, procurement tracking or budget monitoring, and generally connotes monitoring *over time* rather than the one-off nature of many of the structured citizen feedback instruments cited in the previous section. In cases in which surveys or scorecards are repeated or are entrusted to a citizen oversight group like a health committee, they take on characteristics of third party monitoring. An example of this is the Health Facility Management Committees in the decentralized Kenya health services that are responsible for monitoring work programs and budgets of health facilities.
- **Grievance redress mechanisms.** Mechanisms to file complaints and grievances and seek resolution can be located either within government institutions or health facilities or established independently. Complaint boxes at health centers or district health departments are an example of the former. Independent channels, usually under the auspices of NGOs and CSOs, have often established communication mechanisms like grievance hotlines or SMS (text message) alert systems, although some local governments have also established these.

Citizen Empowerment

The literature on citizen engagement and social accountability defines citizen (or community) empowerment as community management of resources and control of the decision-making process over their use. As cited earlier, the opportunity for this degree of community ownership and autonomy is normally reserved to programs like community investment funds, conditional cash transfer programs or what some institutions refer to as community driven development programs. Some health programs have modest citizen management control mechanisms such as citizen health facility management committees, as in Nigeria (Bamako Initiative) that theoretically approve health center work programs and budgets.

In contrast to these management frameworks as a manifestation of empowerment, the broader concept of empowerment in health is more conceptual and possibly intangible in that it relates to communities or individuals feeling empowered to take charge of their own health outcomes. This is sometimes referred to as social empowerment, particularly in the context of programs to combat non-communicable diseases in which lifestyle and diet are prime contributors to these diseases. A healthy communities project in Peru specifically seeks to establish a measurable continuum of empowerment of community neighborhood committees. Measurement of empowerment in this context is nonetheless particularly challenging.

4. Cross-Cutting Support to Citizen Engagement

Donor-financed initiatives to strengthen citizen engagement often include cross-cutting components that support multiple CE instruments within the same project. Sometimes the same component seeks to strengthen both the supply and demand sides—health services and citizen accountability programs.

Building capacity of citizens to engage. Probably the most common form of assistance to establish or strengthen citizen groups is through training, normally via short training programs or workshops targeted at health committee members, volunteer facilitators or other community champions. Sometimes both service providers and citizen representatives are included in the same training to

foster understanding of the roles of each. When training is designed purely to permit volunteers to transmit technical health messages or carry out functions as proxies for health service providers, it is not CE. To be effective, training of individuals or groups carrying out CE initiatives needs to be followed up through advisory services, practical guidance and support to individuals or groups trained, and opportunity for continuing dialogue.

Support to the media. The media is often viewed, or are able to serve, as an extension of civil society and, as such, can be a useful adjunct to a number of CE instruments. When it is used only as part of an information campaign to provide one-way information, it performs more as an extension of the line services of health ministries to inform citizens, and may not serve to genuinely engage citizens. That said, well-designed campaigns using the media can reach beyond information “blasts.” Both print media and radio or television, through articles, talk shows and interviews, can work to incite greater citizen engagement. When the media expose corruption or report on poor performance by health services, it serves in more of a public/social accountability role.

Interventions at different levels of service delivery. While the majority of CE instruments are applied at the facility or local level, some citizen engagement strategies, particularly those that use CSOs at local level supported by national umbrella organizations, seek to advocate at both local and national levels. In these cases they serve to engender more effective and sustainable national support and greater coordination between different levels of health service delivery. For example, a GIZ program to promote civil society organizations to support health delivery in Tanzania assists youth organizations at the local level to stimulate dialogue on health issues of importance to young people; at the same time, it supports national organizations such as the National Coordination Council of the Global Fund to Fight AIDs, Tuberculosis and Malaria to provide technical support to local CSOs and to lobby national health authorities to strengthen national legislation or increase funding for the health activities in their area of interest.

Use of information and communication technology (ICT). Information technology is being used increasingly for two-way communication between citizens and service providers. Particularly common is use of text messaging either to alert citizens to health messages (one-way communication from health authorities) or as a tool for citizens to comment or complain about health services (a form of social accountability). The latter are often mounted or monitored by CSOs, as in the case of two initiatives in Uganda—a “stop-stock-outs” campaign to improve availability of drugs at health centers, and a complaints hotline to report on health clinic performance or corruption.

As the above uses suggest, project components that purport to support citizen engagement are sometimes in reality more traditional training or one-way communications to “talk at” citizens with the intent of changing behaviors. While these may still be useful interventions, they should not be confused with more authentic engagement and involvement of communities.

5. Outcomes and Impact of Citizen Engagement on Improvement of Health Service Delivery

Limitations to Assessing Outcomes related to Citizen Engagement

Reviews of evidence of impact of citizen engagement instruments on health service delivery and health outcomes are consistently cautionary in drawing conclusions regarding the impact of any

single citizen engagement instrument or group of instruments. Several large-scale reviews of the existing literature have been carried out in the following areas: community participation and health outcomes (Rifkin 2014); effects of community participation on maternal and newborn health (Marsten et al 2013); community accountability and improved service delivery (Molyneux et al 2012), (Rocha Menocal and Sharma 2008), (World Bank 2014(ii)); and effects of participation on development outcomes in general, including health outcomes (Mansuri and Rao 2013). While this is not an exhaustive list, all reviews point to the relative dearth of consistent evidence on outcomes (Gaventa and Barrett 2010).

Overall, these reviews note that very few systematic studies employing consistent methodologies have been carried out. Where empirical evidence on outcomes actually exists, it is difficult to attribute causality and results are often contradictory. Definitions of what is considered citizen or community engagement, as well as other relevant terms such as “voice,” have varied, as have the associated methodologies. Studies employing quantitative data using measurable impact indicators are limited and those that exist have not been complemented with ancillary qualitative methods to help determine or understand causality. Very few assessments utilize randomized controlled trial approaches. Others rely solely on anecdotal evidence of interviewer or “community” perceptions. Moreover, programs generally employ a variety of citizen engagement mechanisms concurrently, making it difficult to isolate the effects of individual instruments. Contexts also vary, so comparison of outcomes across countries or even regions is challenging. As a result, it is difficult to present a clear picture of the impact of citizen engagement on health service delivery, and even less on the impact of citizen engagement on health outcomes.

Outcomes in Selected Citizen Engagement Interventions

Cognizant of the cautionary attribution of health outcomes to citizen engagement measures, the table in Annex 2 presents some of the relatively more robust findings on outcomes of citizen engagement interventions in a number of health programs or projects. Most of the CE interventions evaluated were observed in MCH or family health programs at the clinic level, and many involved a combination of strengthening health services, activating groups, and using community based, usually volunteer, facilitators to coordinate groups, build trust and liaise with formal health services. Because of the multiplicity of participatory mechanisms within each health program, outcomes are generally not attributable to any single CE instrument.

The Annex table draws heavily on Marsten’s work that surveyed specific evaluations that used random control trials (RCTs) or other rigorous research methodology to examine the effect of community participation on specific health outcomes, notably the uptake of skilled care during pregnancy, childbirth and after birth (in the 28 days after birth) and any data on maternal mortality, maternal morbidity or neonatal mortality. The table also includes other research findings authenticated by authoritative sources (Mansuri and Rao 2013), (World Bank 2014 (ii)), (McNeil and Malena 2010), (Kahssay and Oakley 1999), noting the original source and, where available, the research method that yielded the data presented.

Overall Outcomes

Research evidence confirms the potentially positive, although variable, impact of citizen engagement on health outcomes, but generally only when they complement a broader package of services. The mixed (or missing) outcomes in health mirror those for citizen engagement interventions more generally. As demonstrated by the variable outcomes of similar projects, such as

the innovative Warmi health project in Bolivia that was replicated in some form in other countries and yielded varying results, outcomes are highly contextual, based on socio-economic and cultural factors and the overall enabling socio-political environment.

Marsten's review concluded that community engagement had largely positive impacts on maternal and newborn health if undertaken as part of a larger package of services, but not necessarily on uptake of skilled care. Successful interventions all involved raising community awareness of maternal and newborn health problems and frequently involved citizens being involved in designing and sometimes implementing solutions. Successful interventions—those that resulted in positive maternal and neonatal outcomes—focused on raising community awareness of maternal and newborn health issues and encouraging dialogue, rather than simply providing information. However, not all interventions that included community-awareness building yielded positive results.

With regard to the locus of resource management, some studies suggest significantly greater effectiveness of management of community-based programs and responsiveness to citizen engagement when they are undertaken by local governments rather than central Ministries of Health (MoH) (Mansuri and Rao 2013). However, Brinkerhoff and Wetterburg (2014) note that the success of decentralization to serve as a catalyst for accountable service delivery depends on a number of highly contextual factors. The evidence of impact of including health incentives in the allocations of resources within social funds, conditional cash transfers or community development funds is also limited; a study of a Zambia social fund yielded some limited positive outcomes (Chase and Sherburne-Benz 2001) but results are somewhat inconclusive.⁴

Outcomes for Specific Instruments

As noted earlier, CE instruments are almost always coupled with supply-side measures to strengthen health services, and in many cases multiple CE instruments are employed over the same timeframe, thereby making definitive attribution difficult or impossible. However researchers make qualified observations about the degree of success of some of these, as described below.

Information

Citizen charters. In a local governance project in Indonesia, these proved to be particularly suitable for health services (relative to education, for example), providing a significant breakthrough in terms of committing clinics to apply minimum service standards and improve coverage and customer satisfaction (USAID 2009). However, the use of patients' rights charters in South Africa created resentment by health workers who saw it as imposing standards that exceeded the capacity of the health center to deliver (London et al 2006).

Access to information. A 2011 review of national ATI legislation in developing countries did not uncover any country with specific sectoral ATI legislation related to health (DGRU 2011). Citizens have nonetheless leveraged national ATI legislation to obtain information health sector information, as occurred in India when the RTI Act and other consumer protection legislation was determined by the law ministry to provide for citizen rights to obtain their medical records (*Economic Times* 2014).

⁴ In the Zambia project, in instances in which citizens prioritized rehabilitation of health facilities, citizens were more likely to report an illness. But they were no more likely to seek treatment than those in control groups. There may have been modest increase in vaccination rates in localities with rehabilitated health posts.

Consultation/Participation

Health committees.⁵ Establishment of health committees was the most common form of community accountability mechanism observed by Molyneux. Relative to community (often women's) groups cited in the subsequent section, the mandates of committees she reviewed focused on greater dialogue with government health providers on accountability-related health service management issues rather than on facilitation by committee members of community groups on health issues.

The use of citizen health committees in a health project in Zambia demonstrated positive outcomes for awareness raising of public health issues, but did not directly increase allocation of resources toward poor and vulnerable groups or significantly improve health service responsiveness or health worker behavior, due to low knowledge and understanding of health issues by citizen members, which limited their capacity to demand change (Ngulube et al 2004). A small sample of districts in Zimbabwe that had health center committees, whose mandate included identifying priority health problems in the community, improved their service coverage, level of resources and community health indicators over the same number of districts that did not have health committees (Lowenson et al 2004). Community engagement in resource management through budget oversight by citizen-led management committees in a Kenya health project did not appear to impact outcomes, probably because of the limited knowledge of budget issues by community committee members. In Nigeria, health committees stimulated the provision of equipment and identification of community members deserving of fee exemption, but perceived that their management involvement was limited to second-tier issues in health facility management.

Molyneux details a large number of stumbling blocks to successful use of citizen committees. Selection and composition of committees were rarely democratic and often suffered from elite capture. In some instances, they were co-opted by health facility staff who used them to endorse what management intended to do anyhow, or who simply ignored them. In others, committee members used their office to seek additional benefits for themselves and their families. In many cases, frictions arose between committee members and health workers on facility management. Members often cited lack of incentives for their time investment, and gradually reduced their involvement. Finally, the sustainability of committees once donor funding ended is questionable, and since monitoring of their work ends with the conclusion of the project, their sustainability is invariably not measured.

Community volunteer facilitators and groups. Relative to committees, these groups, generally facilitated by a volunteer facilitator, focused on discussing health issues and priorities among community members, often women's groups or directly with women. One of the more successful use of volunteers was in a project in Cambodia using volunteers from local monasteries ("Pagoda volunteers") to manage a local fund for stimulating access of the poor to health services; a significant increase in community participation was attributed to the trust the community placed in credible community members. The approach also appeared to be relatively sustainable (Jacobs et al 2007). In a health intervention in Nepal where local facilitators were nominated by the community to conduct monthly women's group meetings in hospital wards, they were able to identify and prioritize health issues and potential solutions. When coupled with strengthening of health services, there were significant improvements in a number of health indicators. In all of these cases, building

⁵ The observations on health committees and facilitated health groups are presented separately, but the nomenclature in some projects conflates the two.

and sustaining trust within the community was often cited as an important contributor to successful outcomes. Sustainability of these facilitated groups as well as of health committees was observed to be enhanced when existing community organizations were used and when members were esteemed members of the community (Molyneux 2012).

Structured feedback and monitoring instruments. Positive outcome have been noted in a number of programs, albeit with variability.

- **Citizen report cards (CRCs)/community scorecards.** Use of these instruments was documented to have produced improved health services in a number of cases. Field testing in Uganda in 50 communities reported significant improvements in health service delivery (less absenteeism, shorter waiting times) and health indicators (reduction in under-five mortality), that the researchers attributed to improved accountability (information and clarification of expectations) (Bjorkman and Svensson 2009); this corroborated a 2006 study. Use of scorecards was coupled with NGO-facilitated meetings with community and health staff that led to more community involvement. In a Kenya health project, a second round of community scorecards produced enhanced results on 10 of 13 indicators for service standards (one center only; authors reported that results in other centers were similar) (Kenya School of Government [KSG] 2015). In contrast, three rounds of scorecards used in a Madagascar health project produced no visible results (Brinkerhof and Keener 2003). The primary challenge presented by CRCs and scorecards is the degree to which they independently incite better performance by health providers or simply report on changes brought about by investments in physical and human infrastructure or by other CE instruments.
- **Third party monitoring.** No systematic reviews of citizen monitoring programs were found as part of this review, but a considerable number of NGOs and CSOs undertake some of these, in addition to the monitoring role performed by some citizen health committees. For example, the Anti Corruption Coalition of Uganda (ACCU), with its regional affiliates, monitored the drug supply chain at national and local levels to reduce leakage of malaria medicines. Clinics subsequently reported that stocks of drugs now last 2-4 weeks, versus less than a week as occurred earlier (Partnership for Transparency Fund [PTF] 2014). Programs for community monitoring of health service performance in Bolivia and Vietnam are reported to have raised community awareness of key demand-side barriers and helped to ensure that services met community needs (Hoffman 2014).
- **Grievance redress mechanisms.** A World Bank review uncovered no evaluations or empirical studies on the relationship between complaints-handling systems and the quality of service delivery in human development sectors in either OECD countries or developing countries (Ringold et al 2013). Anecdotal evidence suggests that poor people hesitated to use channels that would reveal their identity, for example, text messaging to convey complaints in Uganda health monitoring project. Nonetheless, the combination of a number of different GRM instruments in a Kenya health project produced improved performance relative to other community participation instruments (or at least improved citizen satisfaction); a review by the World Bank found evidence that complaints had been acted upon in 75 percent of the pilot communities (KSG, 2015). Placement of “anti-corruption” boxes in a number of target health facilities in Moldova, along with establishment of codes of conduct and sensitization of staff on ethics issues, resulted in a drop in the percentage of respondents who reported having to give bribes to doctors from 81 per cent to 26 per cent; other responses revealed a significant decrease in respondents who confronted corrupt practices by other health staff (PTF 2014).

Citizen Empowerment

There are few if any examples of community empowerment cited in the above referenced survey reviews in which final decision-making at health facilities is in the hands of citizens (who are not performing as subcontractors or private entities). However, one example that embraces significant community empowerment is a program of reforms introduced by the Peruvian Government in the 1980s and 1990s that introduced "co-management" of primary care centers by the community, including oversight, participation in planning and overall administration. A study that analyzed implementation up to around 2003 compared communities where this model was functioning with those that were still under the traditional model. It found that service delivery per inhabitant in co-management areas was more than double that in traditional areas. The study also found that co-managed facilities enjoyed greater coverage and greater efficiency. Users of co-managed facilities reported greater satisfaction with services than those in the traditional model (Cotlear 2008).

Challenges to Successful Citizen Engagement

As noted in the above paragraphs, there are significant challenges to ensuring effective citizen voice in improving health outcomes, almost all of which are related to the context in which they are implemented.

Many of these challenges are due to what observers refer to as *information and power asymmetries*. It is sometimes assumed that citizens are well placed to become effective monitors of and advocates for quality health services at clinic level. Relative to education, for example, where parents may not be able to judge the quality of the learning that takes place over time in the classroom, people visiting a clinic ostensibly can more easily judge whether they have received a service they need, by the presence or absence of personnel, supplies and drugs, and by the manner in which they are treated (Khemani 2008). Moreover, health care at clinic level, relative to more complex services provided in a hospital context, is deemed to be have a lower level of technology and complexity and is therefore easier to understand and to provide feedback to service providers (Goetz and Gaventa 2001), (Commins 2007).

While local health services may appear to be the logical locus for effective involvement of citizens, analytical work on health service delivery failures shows many roadblocks to effective community participation at this level. Communities may not recognize quality services when they have never experienced them. In Peru, the government sought to increase accountability of public services but found quality did not improve because citizens did not know what to demand (Cotlear 2008).

Moreover, poor people may not want to challenge health personnel so they do not ask questions. They may fear reprisals from reporting wrongdoing that could prevent them or their families from receiving health services thereafter. They often do not have the time to participate in monitoring groups or to attend town hall meetings. They may be unable to ascertain cause and effect (as in between being vaccinated and not getting the disease) and can therefore feel threatened by their lack of understanding of an issue, so they do not speak up. And they may not know how to proceed without an immediate action plan (Mansuri and Rao 2013).

Moreover, health service providers often ignore citizen feedback whether delivered by individuals or CSOs. Examples abound of international support to local CSOs or ad hoc citizen groups to monitor health services that fall on deaf ears if the local or national health authorities are simply not

interested and know that there are no sanctions if they ignore citizens (Landell-Mills 2013). Not only has this resulted in the absence of improvements to health services but it has created citizen fatigue in providing feedback or participating in accountability forums.

Mansuri and Rao cite several further challenges to effective participation, all of which are applicable to health service delivery. These include elite capture of services, lack of government capacity for oversight and downward accountability, project design that failed to understand the local context, and inadequate implementation monitoring.

A review of citizen engagement approaches in projects (in all sectors) in the World Bank's Africa Region found that relatively few projects with CE components established monitoring indicators to track performance on those components; where CE indicators were established, they were process indicators (e.g. did the town hall meeting take place?; was a citizen committee established?). Moreover, even when indicators were included, they tended to get overlooked during project implementation due to a constrained implementation support budget or distractions by other project implementation problems deemed to be more important (World Bank 2014 (i)).

Factors Contributing to Successful Citizen Engagement Outcomes

These constraints notwithstanding, some reviews provide insights into some of the key factors that have contributed to successful implementation of citizen engagement approaches in health programs. Those cited in a 2015 evaluation of a pilot program to introduce SAcc mechanisms in health service delivery in Kenya were echoed by observations from other sources (World Bank 2014 (i)). They include the following:

- *Buy-in by political authorities and agencies responsible for service delivery:* these may include central authorities of Ministry of Health, but possibly more important the commitment by service providers—local health personnel—to engage citizens genuinely in health delivery. Where government services are decentralized, the support of mayors and other local authorities has been invaluable in holding health departments and technical services to account.
- *A propitious enabling environment* in terms of a national framework that embraces citizen involvement, and presence of dynamic CSOs and NGOs to lobby at national level for anti-corruption, pro-health measures and greater citizen voice, and to organize and represent citizens at the local level.
- *An appropriate project design* that tailors interventions to local contexts (which may vary in different regions within a country) and includes (i) strong up-front analysis to identify opportunities and constraints; (ii) flexibility to respond to citizen priorities and service provider capacity; (iii) a monitoring and evaluation system that includes monitorable indicators for citizen engagement and that permits ex-post evaluation of both *whether* and *how* CE measures achieved their objectives; and (iv) an implementation budget that supports the additional attention that CE measures often entail.

Moreover, the contextual environment in which the CE initiative is being implemented needs to be continuously reassessed during implementation to adjust program design to varying conditions.

6. Implications for Future Citizen Engagement Initiatives in Health

Perhaps not surprisingly, researchers in this field emphasize the need for more empirical evidence on the effect of CE approaches to health outcomes. Many argue for more evaluations using randomized control methods. Marsten urges complementing these with application of more qualitative analysis to make better sense of quantitative data in terms of not only whether certain CE activities were carried out but *how* they impacted health service delivery and outcomes.

Measuring impacts requires building into project design rigorous pre- and post-survey instruments as well as creation of control groups. USAID's strategy to reduce maternal mortality has committed to conducting rigorous evaluations where no evidence exists and/or the findings of an evaluation are needed (USAID 2015). However, in the majority of health projects, it is often unrealistic for financial or operational reasons to include academic research-quality evaluation mechanisms, particularly if the project is small. In these circumstances, operational guidance needs to be provided to design the component and establish monitoring/evaluation mechanisms most tailored to the project objectives and scope. Health project design can benefit from guidance on design of citizen engagement and social accountability mechanisms more generally.

Observers agree that empowerment of citizens to engage in improvement in their own health outcomes is a long-term process that goes beyond the "utilitarian participation" of early generations of health projects. The time frame for investments in creating such an environment needs to be planned accordingly.

Annex 1. Overview of Citizen Engagement Mechanisms, Definitions and Uses

(Instruments Cited in Literature Review)

Citizen charter is a document that informs citizens about the service entitlements they have as users of a public service; the standards they can expect for a service (timeframe and quality); remedies available for the non-adherence to standards; and the procedures, costs, and charges of service. The charters entitle users to an explanation (and in some cases compensation) if the standards are not met.

Citizen report card is an assessment of public services by the users (citizens) through client feedback surveys. It goes beyond data collection to being an instrument for exacting public accountability through extensive media coverage and civil society advocacy that accompanies the process.

Citizen satisfaction surveys provide quantitative assessment of government performance and service delivery based on citizen's experience. Depending on the objective, the surveys can collect data on a variety of topics ranging from perceptions of performance service delivery and elected officials to desires for new capital projects.

Community monitoring is system of measuring, recording, collecting and analyzing information; and communicating and acting on that information to improve performance. It holds government institutions accountable, provides ongoing feedback. Shares control over M&E, engages in identifying and/or taking corrective actions, and seeks to facilitate dialogue between citizens and project authorities.

Community scorecard is a community-based monitoring tool that assesses services, projects, and government performance by analyzing qualitative data obtained through focus group discussions with the community. It usually includes interface meetings between service providers and users to formulate an action plan to address any identified problems and shortcomings.

Consultation as distinct from dialogue, is a structured exchange in which the convener commits to "active listening" and to carefully consider the comments, ideas, and recommendations received. Good practice consultations provide feedback on what was heard, and what was or was not incorporated any why to ensure that consultations contribute to improved policies and programs.

Grievance redress mechanism (or complaints-handling mechanism) is a system by which queries or clarifications about the project are responded to, problems with implementation are resolved, and complaints and grievances addressed efficiently and effectively.

Public displays of information refers to the posting of government information, usually about projects or services, in public areas such as billboards or government offices, schools, health centers, community centers, project sites, and other places where communities receive services or discuss government affairs.

Social Audit (also called social accounting) is a monitoring process through which organizational or project information is collected, analyzed and shared publicly in a participatory fashion. Community members conduct investigative work at the end of which findings are shared and discussed publicly.

User management committees refer to consumer groups taking on long-term management roles to initiate, implement, operate, and maintain services. User management committees are for increasing participation as much as they are for accountability and financial controls.

Source: World Bank. 2014. *Strategic Framework For Mainstreaming Citizen Engagement*. Washington, DC: World Bank.

Annex 2. Outcomes in Selected Citizen Engagement Interventions

Country: Project/program (partners) objective	CE instrument/ approaches	Impact on service delivery or health outcomes	Research method/source
Bolivia: Warmi Project (WHO, Save the Children/Bolivia, USAID) Reduce maternal and perinatal mortality at the community level in isolated rural areas with limited access to health services.	Women's community groups with a focus on safe birthing techniques.	Reduction in perinatal mortality (52 percent lower in areas receiving primary-health-care program). Prenatal care, breastfeeding, immunization and other behaviors improved.	Randomized Study (O'Rourke, et al, 1998) (Gonzalez, et al, 1998)
Ghana: Community Health and Family Planning Project (Navrongo Health Research Centre) Reduce child and infant mortality rates.	Community groups with a focus on assessing, designing and monitoring health services.	Under-five child mortality decreased. (Infant mortality rate fell on average by 8.6 deaths per year in the MOH area, by 7.0 deaths per year in the combined area, and by 4.4 deaths per year in the comparison area).	Randomized pilot study (Blinka et al 2007) (Phillips, et al., 2006)
Nepal: (MIRA Mother & Infant Research Activities) (modeled after Bolivia Warmi Project) Reduce neonatal and maternal mortality.	Community groups with a focus on defining local problems and addressing the needs of women and newborn infants.	Birth outcomes improved significantly. Large reductions in neonatal mortality and maternal mortality. [26.2 per 1000 (76 deaths per 2899 livebirths) in intervention clusters compared with 36.9 per 1000 (119 deaths per 3226 livebirths)].	Randomized Clinical Trial (Manandhar et al 2004) (Morrison et al 2008)
Uganda: Community Based Monitoring (Partner Unknown) Increase the quality and quantity of primary health care provision.	Community-based monitoring and reporting of health services via citizen report cards (CRC).	Large increases in health service utilization. (16 percent increase in outpatient service utilization). Reduction in child mortality and increases in child weight. (33 percent reduction in child	Randomized Study (Bjorkman & Swensson)

		deaths in the treatment communities).	
Nigeria: Bamako Initiative (UNICEF) Improve quality of maternal health services.	Community level decision making on management of revenue profits and human resources.	55% percent increase in utilization of maternal child health services after project during the first two years of the project. No mention of health outcomes.	Study duration of only one year (Scuzochukwu, et al, 2002)
Kenya: District health system performance improvement (MOH, Great Lakes University of Kisumu and Communities) Improve the health status of poor households served.	Community participation in surveys on health services. Community level decision making between citizens and health service providers.	Increased immunization coverage. Increased usage of insecticide treated nets. No mention of health outcomes.	(Marsten et al, 2013)
Zambia: ZAMSIF/Reduction of poverty (Zambia Social Investment Fund) Reduce morbidity and mortality rates.	Community participation in focus groups/committees and household surveys. Communities have decision making power in selection of infrastructure (e.g. rehabilitation of health centers)	Increase in staff attendance to maternal and child health clinics Increase in personnel of personnel attending births. Malnutrition reduced 10 percent. Increased availability to HIV/AIDS counseling and information.	Strategy document (O'Malley, 2013) (World Bank, 2000)
Senegal: Senegal Nutrition Enhancement Project. Improve growth and nutrition of young children.	Community groups with a focus on nutrition.	Health care practices improved. Increase in nutritional status of children.	Randomized trial (Alderman et al, 2009)
Jharkhand and Orissa, India: Participatory women's group intervention (Health Foundation, UK Department for International Development, UK).	Community groups with a focus on health service delivery, improving or extending to mothers and newborns.	Reduced neonatal mortality rate. Decrease in moderate maternal depression.	Randomized trial (Tripathy et al, 2010)

Improve birth outcomes and reduce maternal depression.			
Zimbabwe: Health Centre Committee/HCC (Ministry of Health and Child Welfare) Improve overall health services and outcomes	Community focus groups using participatory appraisal tools and community surveys to elicit community inputs. Men women and children participated in focus groups.	<i>Increase in health knowledge and utilization of services. Increased utilization of Oral Rehydration Solutions (ORS) in clinic wards with HCCs. Fewer instances of diarrhea in clinic wards with HCCs.</i>	Case control study (Loewenson, et al, 2005)

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