Global Health Visions

COUNTRY CASE STUDY: UGANDA

In-depth landscape analysis of accountability for maternal and newborn health in Uganda

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This paper was developed with support from the Children's Investment Fund Foundation and the Bill & Melinda Gates Foundation. It was authored by Drake Rukundo and edited by Robyn K. Sneeringer, Susannah E. Canfield Hurd, and Kristen Cox Mehling.

This report does not provide a full review of theories, interventions, data, or findings related to MNH accountability efforts in Uganda. It relied heavily on the contributions of interviewees and, as a result, may include generalizations or differences of opinion. Any mistakes or discrepancies are the sole responsibility of the authors and editors.

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Introduction

While Uganda is on course to meet some of its commitments under the Millennium Development Goals (MDGs), it will miss key targets regarding the reduction of maternal, newborn, and child deaths, and a lot more needs to be done to strengthen the overall health system. Nevertheless, the health sector has registered some improving trends over the last 6 years due to concerted efforts of government, civil society, and the private sector in responding to health needs of the population.

According to the Uganda Demographic Health Survey (UDHS, 2011) Uganda's maternal mortality ratio went up from 435 per 100,000 live births in 2010 to 438 in 2011. It is therefore highly unlikely that Uganda will meet the MDG target of 131 deaths per 100,000 live births by the end of 2015. Uganda's under-five mortality rate reduced from 152 to 90 deaths per every 1,000 live births. This is against the MDG target of 56 deaths per 1,000 live births. Most respondents to this survey noted that it is very unlikely that Uganda will meet this MDG target by the end of this year. There has not been much documentation on trends in the neo-natal mortality rate in Uganda. However, the UDHS 2011 estimated the rate to be 27 per 1,000 live births. According to Uganda's second national development plan (NDP II), 75% of the cases of maternal mortality are the result of either hemorrhage during delivery, prolonged or obstructed labour, or complications related to unsafe abortion[i].

After Uganda's independence in the 1960s, accountability was a mandate of state authorities, district internal audits, and accounts committees. Over the years this evolved as the inspectorate function of government was instituted in the mid-1960s. Since the 1990s and the rise of monitoring and evaluation frameworks, public sector accountability has become more closely linked with the inspectorate and M&E functions of government. To complement government efforts, since the 1990s civil society organizations (CSOs) have also designed their own accountability mechanisms (mainly at the national level but with some work at district and community levels). Additionally, the Auditor General Report released in 2000 increased the spotlight and focus on public accountability among development partners. Together with a strong CSO effort – especially at the national level – since the mid-2000s the government has put an increased emphasis on grassroots accountability. The sub-county (lower district level) became the point of local service delivery necessitating accountability at that level. It is the Ministry of Health (through the sector wide group approach) that has focused specifically on RMNCH accountability, often with support of development partners. The push specifically for RMNCH accountability has mainly been driven by CSOs. Due to resource constraints, this advocacy and drive for citizen-led accountability has been mainly concentrated at the national level with references made to a few models piloted in a few of the 111 districts of Uganda. A significant shift took place in 2009 when the Office of the Prime Minister launched Barazas, which are citizen meetings at the grassroots level between local leaders and community members. Issues of health services delivery have been a key part of these grassroots' discussions.

Due to high levels of maternal and child mortality in Uganda, CSOs have led an array of advocacy efforts to push for increased allocation of both financial, human, and logistical resources to the health sector – with the anticipation that this would result in improved health indicators. However, this advocacy and push for accountability has mainly been top-down and concentrated at the national level. Overall, allocations to the health sector did not rise to the level needed to change health outcomes (though development partners and other non-state actors continued to support the sector). In 2009, it became imperative that government, civil society, private sector, and other non-state actors join together around a 'roadmap' for accelerating maternal and neonatal mortality in Uganda[ii]. This push was buoyed by the realization that most deaths are preventable and that strategic investments could bring about a

significant change overall. Together with development partners and other key stakeholders, the government is now implementing this road map as part of the third Health Sector Strategic and Investment Plan (HSSSP III) and the National Health Policy 2010-2020.

At the subnational and community levels, however, not much has been documented about RMNCH grassroots accountability efforts. The purpose of this report is to therefore outline these existing RMNCH accountability mechanisms at the grassroots level, and explore how they link to the broader Sustainable Development Goals (SDGs) that will succeed the MDGs after 2015.

National-level Accountability Programs and Players

The government of Uganda has set up an institutional framework to ensure public accountability in the provision of social services including RMNCH. To complement government efforts at the national level, CSOs have designed their own accountability efforts for implementation at the district and community levels. This section looks at national level accountability efforts.

Budgeting, Planning, and Accountability under Decentralization

At the national level, there is a formal process under Uganda's decentralization policy (1992) and Local Government Act of 1997 where citizens at the village, sub-county, and district levels are able to interface with their local leaders and demand responses regarding RMNCH services provision. Annually, the national government provides budget ceilings for districts to use in planning each financial year. With these figures, districts develop budget framework papers after consultations with sub-district level planning authorities. To agree on district plans, councilors who are local political representatives discuss the budget with technical district budget committees on key priorities along with a district budget that is approved later by the Ministry of Finance, Planning, and Economic Development (who also consults the associated line ministries – in this case the Ministry of Health – as well as the Local Government Budget Committee). During this process citizens are engaged through budget conferences to discuss priorities for the health sector. If planned interventions (such as financing for life saving commodities or recruitment of human resources for health) fail to receive adequate financial and logistical resources within the allotted budget ceiling for that year, they are then tabled for discussion in the subsequent financial year. Approved budgets are supposed to be discussed with communities through meetings at sub county levelsiii. However, resource constraints have typically prevented this process from being as comprehensive and consultative as desired, and in most cases not all communities provided feedback. This is a gap CSOs are now aiming to close.

The Health Sector Management – Working Group

The **Health Sector Working Group (SWG)** analyzes information and, together with analysis of sector performance data, supports the elaboration of the Annual Health Sector Performance Report – a key output of the Ministry of Health. This performance report is a key reference for the general public outlining the extent to which health sector priorities have been carried out. It details expenditure assignments against actual outputs produced in a particular financial year. At the bi-annual SWG meetings, various stakeholders (who include representatives from civil society, private service providers, local and international NGOs, media, academia, key sector heads, and partner line ministries such water and sanitation, education, and agriculture) discuss the health sector performance report. Over the last three years the focus on RMNCH has increased as stakeholders have pushed government to address

three key concerns to enable Uganda to meet its targets under MDGS 4 and 5: (1) ensuring that there is at least one qualified midwife at every health center IV (HCIV); (2) increasing procurement and supply of essential life-saving commodities, medicines, and equipment for HCIVs (at a level just below a referral hospital); and (3) placing more emphasis on strategic interventions like prevention of mother to child transmission of HIV (PMTCT) and early childhood nutrition. The annual performance report presents key recommendations that contribute to the planning process for subsequent national and district health sector plans. Its findings feed into the national review of government performance and the budget accountability and monitoring process as discussed in the sections below.

Ministry of Finance Budget Monitoring and Accountability Unit

All the key government sectors engage in a detailed budget planning process as well as the implementation of programs, leaving limited time for monitoring and evaluation. Gradually, it became apparent that government needed to monitor its programs. This led to the creation of the **Budget Accountability and Monitoring Unit (BMAU)** within the Ministry of Finance, mandated to undertake annual monitoring of government programs beginning with **National Priority Program Areas (NPPAs)** in education, health, agriculture, water, natural resources, roads, works, and transport. These reports provide actionable insights and recommendations to various sectors based on government performance trends, utilization of public resources, analysis performance against government expectations, and identified gaps in service delivery. Over the last three years, this BMAU annual report has become a reference point for national level advocacy for improvements in RMNCH service delivery for CSOs.

Office of the Auditor General

Annually the Office of the Auditor General is mandated by the Act of Parliament to produce the consolidated Government Audit report that highlights spending against received resources by all state ministries, agencies, departments, and local governments. With regard to RMNCH, the focus over the last three financial years has been mainly on financing an adequate level of human resources and staffing at health units. The report highlights key projects within the health sector with comments on performance and indications/cases of both good and bad resource utilization, as well as cases of resource misallocation and unspent funds. The Auditor General's report is submitted to the Speaker of Parliament and later made public both in hard copy and on-line via the Auditor General's website. The Public Accounts Committee of Parliament as well as the Inspector General of Government and other authorities take up any issues that arise as a result of the report. Over the last decade, this report has become a critical reference for both state and non-state actors in informing advocacy work for improvements in RMNCH service delivery.

Ministry of Public Service and Ministry of Health Client Charters

The Ministry of Public Service and the Ministry of Health produce client charters, which are social contracts between the government and citizens. These forms are checklists that citizens can use to document their level of satisfaction with the delivery of public services. The information is then consolidated, and the analysis provides feedback to the ministries on service performance. This data collection and analysis is conducted by technical staff at the district level and submitted to respective line ministries at the national level. These client service charters are a new phenomenon and still haven't gained traction on the ground. The CSOs are working to support their full implementation using community monitors to follow-up.

Ministry of Local Government

Annually, the **Ministry of Local Government (MoLG)** conducts assessments of the performance of local governments against a set of minimum conditions and performance measures in all sectors including health. There are a certain minimum requirements that every district must meet before they access the Local Development Grant (LDG). Once they meet this requirement and receive the funds, there are performance parameters against which districts are assessed every year. Districts that perform well get a 20% increment of the grant in the subsequent year and 20% less for poorly performing districts. Those whose performance is unchanged from the previous assessment keep receiving the same level of grant allocation[iv]. The national assessment exercise has gradually been broadened to cover sector grants to local governments such as the Primary Health Care Grant. Once the results of this assessment are released, there is peer pressure among districts to improve in areas where they performed poorly. CSOs and other non-state actors use these reports as reference points in demanding accountability for the provision of better health services, especially when presenting district petitions to District Councils. The annual assessment synthesis reports are being used by the general public and CSOs to put pressure on the government to support poorly performing districts and build their capacity, rather than simply penalizing them with reduced allocation of the development grant.

Office of the Prime Minister

The **Office of the Prime Minster (OPM)** is mandated to generate the **Government Annual Performance Report (GAPR)**, which provides a comprehensive assessment of Government's performance and the results of public spending in each financial year. This report focuses on the progress made in the implementation of key actions and the performance of Ministries, Departments, and Agencies against output targets across all sectors of Government. These include targets like: immunization coverage; percentage of districts supervised and mentored for improved quality of care in reproductive health services; progress in implementing the RMNCH roadmap; and health units providing PMTCT/VCT. The overall purpose of the GAPR is to provide a government accountability mechanism that can be used as a basis for annual policy reviews and a guide for planning resource allocation in the subsequent financial years.

The report uses a traffic lights methodology (green, yellow, and red) where red indicate targets not achieved, yellow represents very slow performance that could lead to missed targets, and green indicates on-track performance. The exercise is done bi-annually and annually and culminates in a cabinet retreat (chaired by the President or Prime Minister) with each line ministry presenting a response to performance results as documented. During the cabinet retreat where the report is discussed, permanent secretaries of various ministries are tasked to follow-up on recommendations made by the GAPR as they relate to their respective mandates. The report is compiled by the monitoring and evaluation department of the Office of the Prime Minister bi-annually and annually and is made public through the OPM website.

National and District Public Accounts Committees

The **Parliament's Public Accounts Committee (PAC)** has been very vocal over the last two Parliaments (8th and 9th Parliaments) on issues pertaining to proper resource utilization by the health sector. The Committee relies on the Auditor General report, feedback from the district level PACs (which are

decentralized versions of the Parliament's PAC), as well its own investigations (done by select committees of Parliament) to bring to the floor of parliament cases of sector underfunding, resource misappropriation, and other resource-related issues. After the discussion and investigations, a committee report is reviewed by Parliament and cases for further investigation are submitted to the government director of public prosecution (as necessary for further action). PACs at the district level, which are constituted by appointed members by the District Service Commission, discuss internal audit reports and reports by standing committees of district councils (which include committees of finance planning and administration, education, sports, health and sanitation, production, marketing, natural resources, works, roads, and water) as well as their own investigations to develop public accounts reports to send to the national level PAC for action.

It is important to note that while Parliament's PAC has the clout to follow-up on high profile cases (mostly involving corruption), the lower district PACs are under-resourced to carry out in-depth investigations and follow-up. CSOs have been calling upon Government to elevate the district PACs to a regional level so that instead of each of the 111 districts having a PAC there are instead regional PACs that would yield more oversight clout and potentially be more resourced. Copies of these reports from district level PACs also go to the Inspector General of Government and are made available to CSOs and the general public so that they can follow action taken.

Joint Assistance Framework (Government and Budget Support Donors)

Budget support development partners rally under the **Joint Assistance Framework (JAF)** to ensure that government keeps it commitments in financing critical sectors including health, water, and education. The JAF provides a shared set of actions and targets agreed upon jointly by Government and its Development Partners annually. Implementation progress is judged at the mid-point of the year and overall performance at the financial year-end, and is reported on through this Government Annual Performance Report. The performance against JAF indicators and actions is one trigger of financial releases made by the Development Partners that provide budget support. However, it is important to note that concerns over misappropriation of public funds related to high profile corruption cases have since 2011 undermined the relevance of the **Joint Budget Support Framework (JBSF)**. Development partners support many CSOs in Uganda and with their direct and indirect advocacy, the issues of RMNCH enter the JAF process especially on education and health. Quoting the 2008/09 JAF report: "drug stockouts and absenteeism of health staff were (and even today) key concerns as factors contributing to poor maternal and child health outcomes.

Citizen-level Accountability Programs and Players

While international RMNCH accountability efforts like the MDGs are well known, there is a lack of comprehensive knowledge and understanding of regional, national, and sub-national accountability efforts – particularly those led by or involving civil society. This chapter presents key citizen-led accountability efforts to shed light on what is happening to advance RMNCH in Uganda.

White Ribbon Alliance Uganda

White Ribbon Alliance (WRAU) is a global membership organization headquartered in Washington, D.C. Uganda has been a member of this organization since 2009 with an objective of promoting maternal health through advocacy, community mobilization and sensitization, and new partnership formation. In

2013, after conducting budget advocacy focusing on increasing funding for maternal and newborn health in Uganda, WRAU launched a new campaign called **Act Now to Save Mothers**. This campaign is implemented in three districts – Lira (in Northern Uganda), Mityana (in Central Uganda), and Kabale (in Western Uganda) – and is currently again underway in 2015. The purpose of the campaign is to hold both central and local government authorities accountable for their commitments to the provision of very basic emergency obstetric and newborn care in at least half of the health center IVs (HCIV).

WRAU develops checklists that a study team uses to assess the quantity and quality of RMNCH service provision at HCIII and HCIVs. This enables the district health teams that are part of the general assessment teams to see for themselves how the scores are arrived at and comment. After analyzing the data and visiting the health centers, district health officials, members of the **Health User Management Committees (HUMCs)**, local government leaders, and the research team meet to discuss the circumstances, including any shortfalls in delivery of services or commodities. This is done through advocacy made from inputs/analysis of the scorecard process. For instance, WRAU noted in the 2014 process that advocacy for improving financing to districts is important but it would be most beneficial to focus on operations and maintenance of infrastructure stock like ambulances and generators at HCIVs.

In the same year (2014), citizen representatives who also constituted the HUMCs and were part of the assessment team noted that accountability can only happen with informed citizens. Citizens often lack information on what resources are available, how they are used, and what their role is in terms of demanding accountability. Using the experience of advocacy for RMNCH in Lira, Mityana, and Kabale, WRAU has seen the efficacy of client and **District Health Team (DHT)** scorecards since they provide a record of service delivery performance and issues as identified by both citizens (who receive) and district health teams (who are in charge of service provision). These scorecards also reinforce data obtained from citizens' hearings, which provide a platform for citizens at the local levels to develop a clear pathway for citizen engagement in accountability mechanisms at the national and global levels. Citizens use these platforms to make known their concerns and duty bearers are able to notice gaps in service delivery that need to be closed in a spirit of dialogue and evidence-based consensus.

This assessment/scorecard is administered in a very participatory manner and has been appreciated by local leaders who, according to WRA, called the process "eye-opening" and one that avoided the approach of blaming health workers for not providing the required service while constructively seeking solutions and improvements in Emergency Obstetric and Newborn Care (EmONC) service provision. By engaging the local population in the assessment, the approach has also provided an entry point for communities to be aware of what services they ought to receive so that they are encouraged to play their part in demanding accountability. During the assessments of provision of EmONC services, WRAU records citizens' voices, takes photos of health facilities, and interviews health staff in video and audio recordings to elaborate the state of health service provision and issues facing care provision at their respective health units.[v]

Critical Factors and Challenges: Conducting this assessment jointly with health teams, health user committees, and local leaders helps in bridging the knowledge gap that exists among users of health services and service providers. This approach has demonstrated that CSOs are able to gather information about a particular health unit and match it against expected minimum service delivery standards that the citizens may not be able to do by themselves. It takes a substantial amount of resources to undertake grassroots accountability and requires an enabling environment that accepts that this process seeks only to showcase that what is being provided is what resources can permit – and that it is not a 'fault-finding' exercise. It is important to note that in the Lira, Mityana, and Kabale

districts of Uganda where WRAU has implemented this model, district health teams have appreciated the approach aimed "not just at finding out what is not right, but what can be done to make it right."[vi]

STRENGTHS

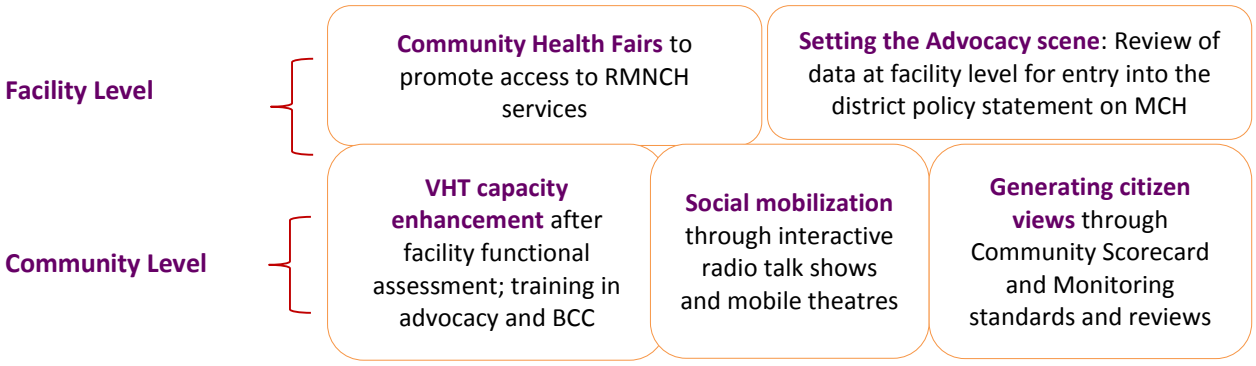
1. **Inclusive and Comprehensive.** Inclusion of media, community members, political leaders, and health management teams from the district level enables the model to be a comprehensive peer learning experience. The assessment team is able to document the state of service delivery and give scores under consensus of the entire team in a participatory, free, and fair manner. The model is able to achieve both assessment of the quality and quantity of service delivery and allow duty bearers a chance of self-assessment.

WEAKNESSES

1. **Key Stakeholders Can Be Reluctant to Participate:** For the scorecard to be effective it requires all key stakeholders to agree on the parameters. Since accountability and assessment "put the health services providers on the spot," they are often on the defensive and not as cooperative as required. Creating this enabling environment takes a lot of time and resource mobilization to prepare 'minds and attitudes' towards this process. Fortunately duty bearers have begun to appreciate the assessment.

World Vision Uganda Child Health Now! Campaign

In October 2010 **World Vision Uganda** launched the **Child Health Now! (CHN)** campaign to support the engagement of communities in holding their local and national leaders accountable for their commitments to reducing child mortality. The campaign follows the global level engagements that World Vision is undertaking to influence positions and government decisions to invest in the reduction of malaria and malnutrition among children. The overall goal is to contribute to the reduction of under-five mortality from 137 per every 1000 live births (presently) to 56 by the end of 2015, as well as to target critical investments to support neo-natal survivorship. To actualize this campaign, CHN's integrated model consists of a series of activities including: (1) collecting national and sub-national data on neonatal and child health; (2) conducting health financing research; (3) selecting a cohort of NGOs to partner with at the community level; (4) and conducting policy dialogues at the district level and mass campaigns through fairs, talk-shows, and mobile theatre outreaches. The aim is to ensure that this pressure results in policy changes to support improvements in health service provision focusing on child health. Below is an illustration of the integrated campaign model linking grass-root voices to national and global policy engagements.[vii]



One of the key outputs from the implementation of this model is the realization that issues of nutrition are pertinent to the health of children. Cognizant of this reality the campaign has focused on advocating for the formulation of a national multi-sectoral nutrition policy and plan. (Currently the Government is implementing a National Nutrition Action Plan overseen by the office of the Prime Minister, and UNICEF is spearheading a process to elaborate the Uganda Nutrition Policy and Plan before the end of 2015.) The evaluation report for this campaign is due to be released and will provide further insights on its performance.

CEHURD

The legal basis of the right to health is the National Constitution of 1995, which is the supreme law in Uganda. A section of the Constitution's **National Objectives and Directive Principles of State Policy (NODPSP)** is dedicated to the protection and promotion of fundamental human rights and other freedoms. In 2005, a Constitutional amendment introduced Article 8A, a provision which strengthens the application of the NODPSP and affirms their legal status. In Uganda, the NODPSP have been used to find that the right to life when read in conjunction with the NODPSP includes the right to a livelihood. In some cases the right to life has been defined to include the right to health. The right to health for women in general and reproductive health in particular is also to be found in Article 33 of the Constitution, which guarantees the rights of women. This provision guarantees the dignity of women and their equality with men, and provides them with special protection.

Since 2003, reports of women dying while giving birth became frequent and sparked a debate about the lack of a law and accompanying punitive measures for negligence on the part of service providers. Families of victims of these deaths petitioned local authorities but with no legal redress. In 2011, two widely reported deaths of women during delivery sparked a petition[viii] and accompanying advocacy campaign to draw attention to the issue and provide legal recourse for victims' families. **The Center for Health, Human rights and Development (CEHURD)** also petitioned the Supreme Court following a lot of civil society mobilization and demonstrations. Unfortunately, the Supreme Court did not concur with the petition and it was dismissed in June 2012 on legal and technical grounds. Revisions have since been made and another wave of court proceedings are to unfold with a new petition in late 2015. CEHURD is also in a drive to push for citizens to demand provision of safe abortion and post-abortion care at all health center IVs since unsafe abortion is a contributor to maternal deaths in Uganda.[ix]

HEPS – Uganda's Coalition for Health Promotion and Social Development

HEPS – Using Community Scorecards for Advocacy for Better Health[x]

Advocacy for better health was born out of a concern over inefficiencies and other weaknesses in the health delivery system that negatively impact the quality, accessibility, and availability of health and social services. Advocacy for better health is grounded in the belief that if citizens' knowledge and awareness of their rights and responsibilities were increased, and if CSOs were positioned to effectively empower and represent communities, then citizens would believe and have confidence that they can hold their leaders accountable and influence them to change health and social policies in their favor. It is being implemented in two cluster districts of Kiruhura and Ibanda as well as at the national level. It started in January 2015 and will implemented for 45 months. The overall goal of the project is to lead to improved quality, accessibility, and availability of health services in Uganda by fostering citizen demand and enhancing the capacity of CSOs to advocate for improved responsiveness and accountability by decision-makers and service providers. This is being done through the use of scorecards where select members are trained as Trainers of Trainers (TOT) who identify issues and use local action to fill out data forms on what health services are provided against what is required. The information is then used to develop action plans where activities that only the community has the capacity to implement are identified and worked on.

STRENGTHS

1. **Participatory Approach Engages the Community.** The model integrates a participatory and-rights based approach where citizens not only make demands but also take part in activities they identify themselves – which they can do on their own without HEPS financing or support. This approach is important for community self-assessment since citizens are able to view themselves not as beneficiaries but as rights holders.
2. **Helps Identify Local Solutions.** The approach by HEPS is not just to demand that duty bearers be accountable but to identify activities that they themselves can do that do not need district financing. For instance, cleaning at a health unit, or light repairs to hospital beds and public road works.

WEAKNESSES

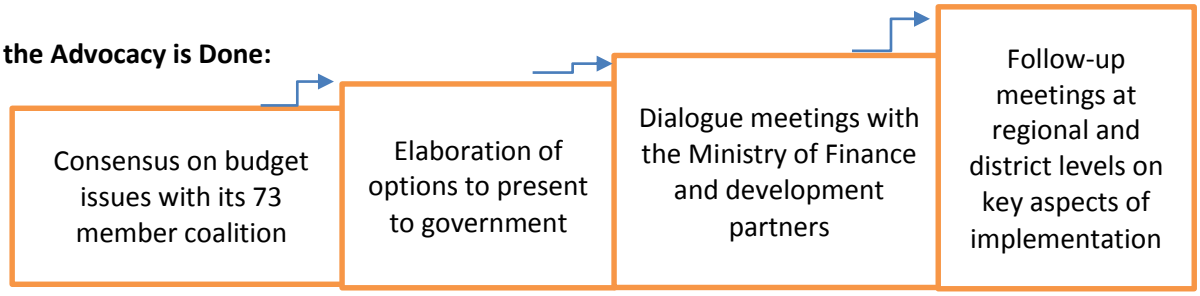
1. **Implementation is Resource Intensive.** Implementing this model requires enormous resource mobilization. Enforcing and sustaining the use of community scorecards is a very expensive undertaking, especially if the ambition is to reach as many districts as possible. It is recommended that a select community monitoring team in a few sub-counties is trained as trainers (TOT) so that they are independently able to carry on data analysis from the cards and report for CSOs routinely.
2. **Certain Aspects Can Be Very Expensive.** Medical practitioners and pharmacists are the only ones who can assess information on the quality of medicines and other life-saving commodities, and these are very few – especially at the district level. Verification of the quality of care is therefore a highly expensive undertaking since it requires hiring technical specialists. Similarly, grassroots accountability is also very expensive and HEPS has been trying to opt for activities where community members can be engaged themselves with very minimal investment.

CSBAG Budget Campaign

Over 70 CSOs form the **Civil Society Budget Advocacy Group (CSBAG)**. This advocacy and budget accountability platform, formed in May 2004, has brought together various voices at the national, district, and community levels around issues of budget allocations for the health sector. Under their budget campaign, CSBAG organizes pre- and post-budget dialogue meetings that bring together development partners, local and international NGOs, civil society, academia, media, and other non-state actors (especially the private sector) to discuss the budget.

The focus of the budget campaign is to ensure that allocations to the health sector are sufficient for comprehensive service provision – from preventative services to disease response. As seen in the chart below, during the budget consultative process, CSBAG proactively engages policy makers to ensure that health care budgeting is pro-poor, balanced, and adequate to meet the very minimum levels of care provision for expectant mothers, newly born children, and infants. This engagement with policy makers leads to a set of options that CSBAG presents to the Budget Committee of Parliament and the Ministry of Finance Planning and Economic Development. After reading of the budget, CSBAG hosts a post-budget dialogue focusing on health budget implementation.[xi]

How the Advocacy is Done:



This advocacy has begun to pay off. For instance, the government accepted a proposal for the increased recruitment of health workers countrywide after a push in Parliament during the 2013-14 budget discussions, resulting in more than 1,800 midwives being recruited and posted in various health units since 2013.

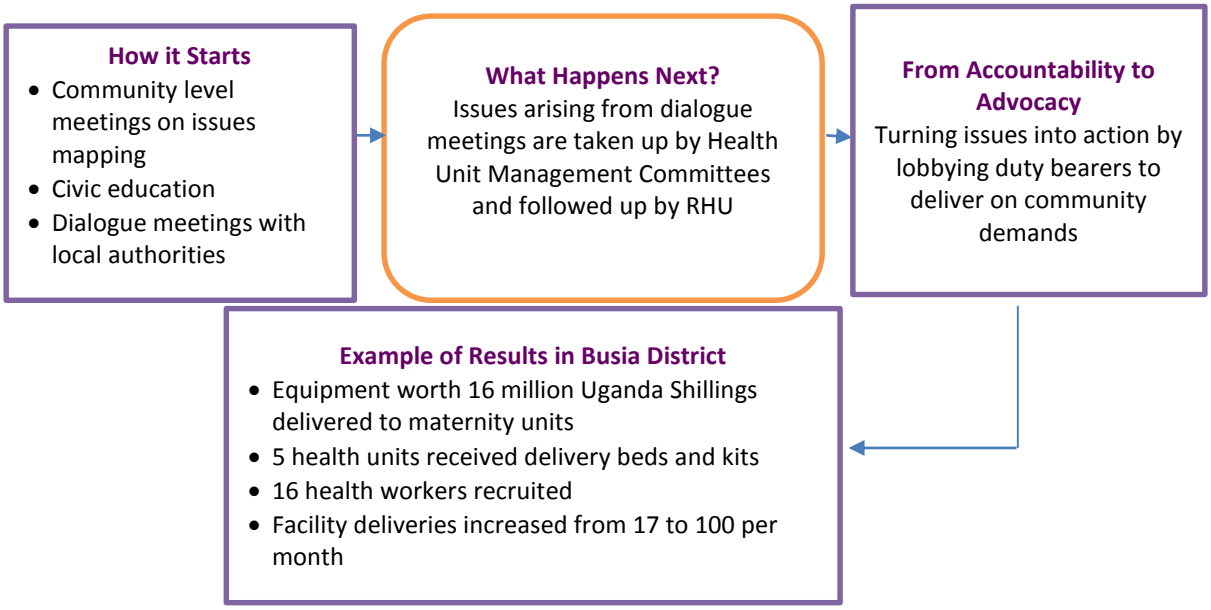
Reproductive Health Uganda

Emerging out of their vision, **Reproductive Health Uganda (RHU)** envisions a future where every Ugandan has access to sexual and reproductive health and rights (SRHR) information and services. Their commitment focuses on reaching the vulnerable and most at-risk population of young people (15-30 years) through specialized service delivery and issue-specific advocacy. RHU is using educative entertainment as a strategy to reach young people and empower them within their communities to engage their political and traditional leaders on the provision of SRHR information and services. This approach is being funded in part by USAID. Another aspect of this approach is focused on revitalizing the roles of Health Unit Management Committees at health centers at all levels for their members to know and appreciate their roles as watchdogs for health service provision, especially in the provision of youth-friendly services at public health centers.

How the Model Works

Working in collaboration with DSW (Deutsche Stiftung Weltbevoelkerung, a German development and advocacy organization), RHU extends the health action project to the communities in selected districts.

They focus on policy analysis, civic education, and the facilitation of dialogue meetings between citizens and local authorities, as well as on reviving and strengthening Health Unit Management Committees. Below is an illustrative flow chart[xii] of how it works and achievements so far:



STRENGTHS

1. **Fosters Collaboration, Partnership, and Shared Learning.** The model allows collaborative action and partnerships since it is evident that many CSOs at community levels are indeed interested in arriving at the same outcomes. The model allows for sharing among partners of their ideas, strategies, progress, challenges, and lessons learned – helping leaders to plan wisely. The model saw an expansion of and joint participation in community and district level events.

WEAKNESSES

1. **Difficult to Get Commitment from Organizations.** Due to competing priorities it is often difficult to get the commitment of many local CSOs and NGOs.
2. **Resource Constraints Hinder Follow-up.** District authorities often times are aware of the causes of poor health outcomes but are under-resourced to respond. So inasmuch as there is pressure from the accountability efforts at the grassroots, only what the district budget can finance is what can be provided.

Tools and Tactics

Organizations across Uganda are utilizing a variety of tools to help implement advocacy and accountability campaigns. From public hearings and scorecards to government-led evaluations and maternal health audits, a variety of state and civil society-led activities help guide RMNCH accountability efforts. In addition, accountability is made more efficient if supported by new forms of **information and communication technologies (ICT).** ICT tools have the power to enable the government and CSOs to obtain information and reach many people (especially the youth) with key messages on RMNCH. This section presents selected key ICT tools supporting RMNCH accountability in Uganda.

Barazas[1]

In 2009 the Government of Uganda piloted **Barazas**, sub-county-level meetings where **Residential District Commissioners (RDCs)** – who represent the President at the district level – meet with local citizens to dialogue on aspects of service delivery. The main objectives of the Barazas are to: (1) provide a community-level platform for public dialogue where citizens can engage their local leaders and hold them accountable for the resources the community received to provide health and other services; (2) act as a public information-sharing mechanism where district leaders can provide updates to citizens about what is planned and what resources are available to implement government programs in their localities; and (3) build a culture of constructive feedback and dialogue that helps improve the government's responsiveness to citizens development demands and public service delivery concerns.[xiii]

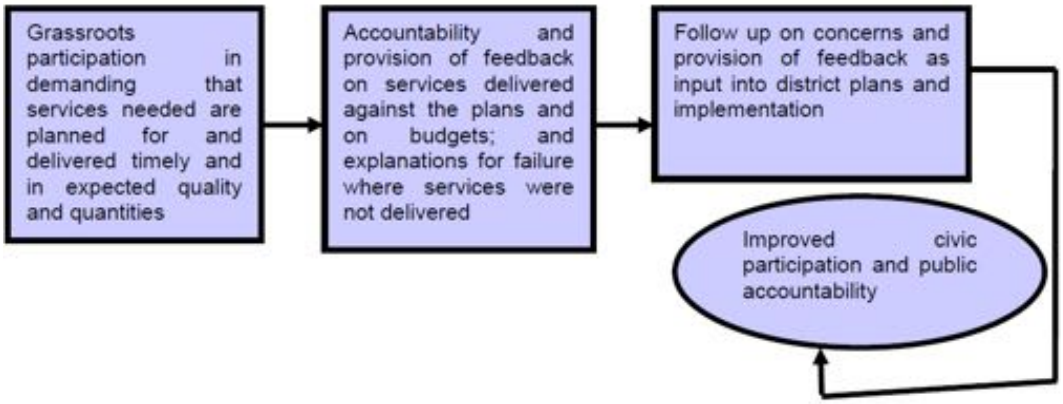
Every district in Uganda has had an opportunity to be part of the Baraza pilot program either in one sub-county, urban council, or both. At a Baraza meeting, district and political leaders make a presentation about what services were planned and what resources were received. They provide an update on current program implementation and then solicit feedback from community members. The issues discussed are recorded and sent to respective departments at the district or national level for action, depending on who is best positioned to respond. At subsequent Barazas, district leaders report on action taken to address prior items that were identified.

Records from Barazas are sent to the Office of the Prime Minister (OPM, which oversees implementation of this program) for overall monitoring of results, while RDCs are obliged to ensure follow-up by responsible parties and communication back to the communities on action to be taken. For instance, if a Baraza meeting identifies poor workmanship in the construction of a health unit and a water source, the complaints are recorded for action by the district health office and the works departments, respectively. If an issue like drug stock-outs is recorded and districts are unable to respond, the complaint is forwarded to the National Medical Stores at the ministerial level. In addition, Baraza reports are aggregated and sent to the OPM, which then disseminates findings to the respective districts. However, there is concern from CSOs that their dissemination remains very limited. The figure below illustrates the Baraza methodology and process.

As shown on the left of the diagram, communities are organized to prepare for a Baraza event (with resources from the OPM). In the middle section, district leaders (both politicians and technocrats) are then provided an opportunity to explain health service provision trends and projects, both ongoing and planned. The exchange then occurs with community members to receive feedback on their concerns. Together this exchange and dialogue creates a spirit of mutual accountability and civic participation.

[1] Barazas are public meetings held at the community level where citizens interface with local leaders to discuss issues related to public service delivery and issues arising from implementation of related local projects.

Issues that arise are taken up by various district departments and escalated to the respective line ministries for either their information or action.



Source: Office of the Prime Minister. 2012. *Baseline Survey for Barazas.* Kampala, Uganda.

> *"It was so inspiring to see a day when leaders are openly criticized without going political, tribal or religious and taking the criticism with humility. One man that got applause for instance was from the district infrastructure committee. As the district engineer shared progress on roads and bridges in this sub-county, the crowd nodded in unison with some standing to affirm the developments."*
> – U-Reporter after a Baraza day November 2011

The Baraza program has concluded its pilot phase and was scheduled for full implementation across all districts beginning in the 2014/15 financial year. Due to resource constraints, however, the OPM has not been able to hold Barazas in all sub-counties of Uganda's 111 districts. Despite this, the OPM plans to support districts in eventually carrying out Barazas as a component of their annual planning, monitoring, and evaluation processes under the supervision of the RDCs.

STRENGTHS

1. **Civil Society and Government Partnership.** CSOs, if well established at the community level, are able to participate with local and district authorities in organization and implementation of the Baraza event and benefit from the discussion without having to incur substantive financial costs.

2. **Barazas Can Support Ongoing Advocacy Efforts.** Information from Barazas can feed into a CSO's own work by validating existing knowledge about trends in health service delivery, especially information on financing for health projects, contracted work, and progress thereof.

3. **Aggregated Information Can Inform National Planning.** All Baraza events can provide a national picture of the status of health service provision, which can critically inform CSO-led accountability efforts at the national level while informing government officials of key gaps and challenges.

WEAKNESSES

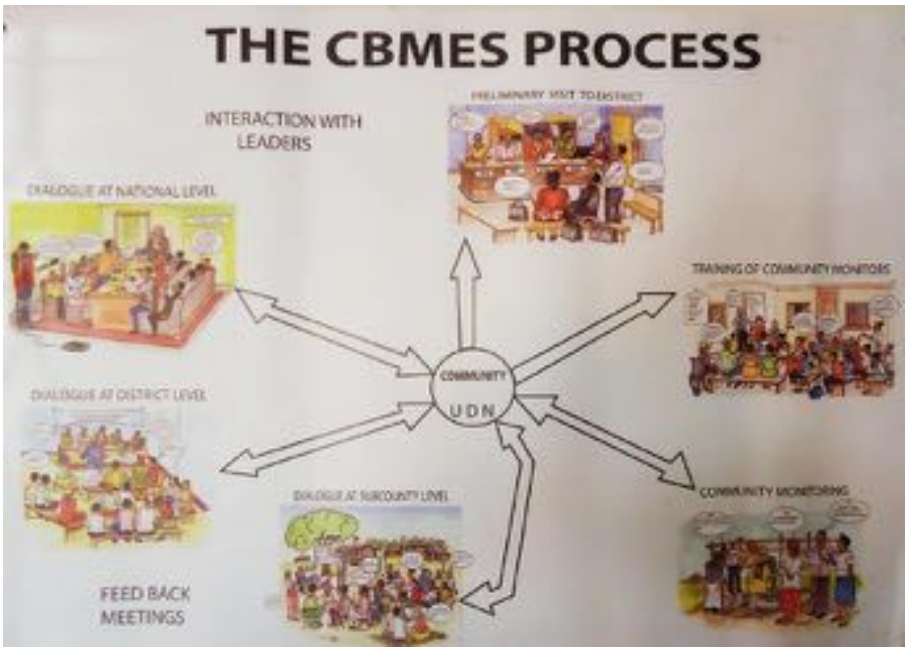
1. **Government Programs Show Conflict of Interest.** Barazas are organized by the government and the focus of their reporting is on government programs. As a result, some grassroots CSOs feel that there is a conflict of interest, particularly when feedback from citizens is not in sync with the political landscape and hence may be ignored. Similarly, there is concern from CSOs that the dissemination of Barazas' findings remains on a very limited scale.

2. **Government Systems are Not Required to Respond to Issues Raised During Barazas.** A system for implementing government responses to issues raised at Barazas has not been created. Therefore, there is no guarantee that citizen priorities are influencing planning, budgeting, and program implementation. Follow-up by the OPM is constrained by time, technical, financial, and human resource handicaps.

3. **Government Acceptance of Civil Society Voice is Unclear.** It remains to be seen if government-led Barazas can continue to appreciate the role of civil society in helping to identify needs within communities.

Community Based Monitoring and Evaluation Systemsxiv

Uganda Debt Network (UDN) is implementing a **Community Based Monitoring and Evaluation System (CBMES)**. CBMES was created to encourage citizens in their localities to know their rights and create a level of ownership of local service delivery through the use of locally identified, CBMED trained community monitors at the sub-country level. The system has four major phases as shown in the graphic display inserted from the sourcebook for CBMES (UDN).



First, communities identify CBMES monitors who are organized in groups of approximately eight. These groups then undergo training in community monitoring and evaluation (M&E) by UDN officials. This training covers four main areas: (1) how to use checklists to assess health services provision at health centers in the community; (2) understanding how **Health Unit Management Committees (HUMCs)** work and what they do; (3) appraising the work of contractors, including assessing the quality of their services and workmanship; and (4) writing reports and communicating results. Once CBMES monitors have completed health unit visits, they document their findings via written reports and request for a meeting with local leaders. Dialogues are then facilitated between monitors and officials, where they provide feedback on progress and challenges in implementation of service delivery projects. An example of success comes from the Catholic organization SOCADIDO in the Obalanga sub-county in eastern Uganda's Amuria district, where CBMES monitors were successful in demanding that the local community HC III construct a placenta pit that had not been completed as originally expected. Results of CBMES analytic and accountability work are shared at district and national level dialogues that convene when the sub-county council meets. Once the information is submitted to sub-county leaders,

CBMES monitors follow-up to ensure that actions are made on recommendations, and that finances are allocated to implement the actions. In many instances, however, resource constraints have not permitted follow-up on the part of government officials.

STRENGTHS

1. **Early Evaluation Shows Promise.** In Eastern Uganda, where this model has been implemented, there have been some good results. For example, the CBMES has developed contingency plans and submitted them to the district for approval on areas such as disaster preparedness. In this case, one district responded with provision of about 1,000 tree seedlings for community members to plant as windbreakers.

2. **Monitors Feel Empowered to Voice Concerns.** CBMES monitors have become vocal in reporting irregularities in health service provision to district health teams and those in charge of health units.

3. **CBMES Paves the Way For a New Generation of Leaders.** Some of CBMES monitors have gone on to become local leaders in their communities and, in turn, these communities now have more faith in the work of their monitors..

WEAKNESSES

1. **Local Political Leaders Feel Threatened.** When CBMES was implemented, the political elite saw community monitors as duplicating or attempting to replace their constitutional mandate. In response, CSOs are reaching out to district and sub-district officials on how this system can complement rather than overlap existing government administrative structures.

2. **Most of the Selected Community Members are Elders.** These representatives may not have the necessary skills to provide technical and analytic assessment and, as a result, significant investments are needed during training before CBMES monitors begin their work.

Village Budget Clubs[xv]

For more than 10 years, the **Forum for Women in Democracy (FOWODE)** has been at the forefront of empowering women and men to demand accountability from their leaders on public service delivery and equal opportunity. They have challenged decision makers to create gender equitable budgets that favor vulnerable groups and have continually sought to give voice to the voiceless, particularly where opinions of the disadvantaged should matter most yet are not well represented. FOWODE empowers communities to achieve equitable budgets and service delivery by:

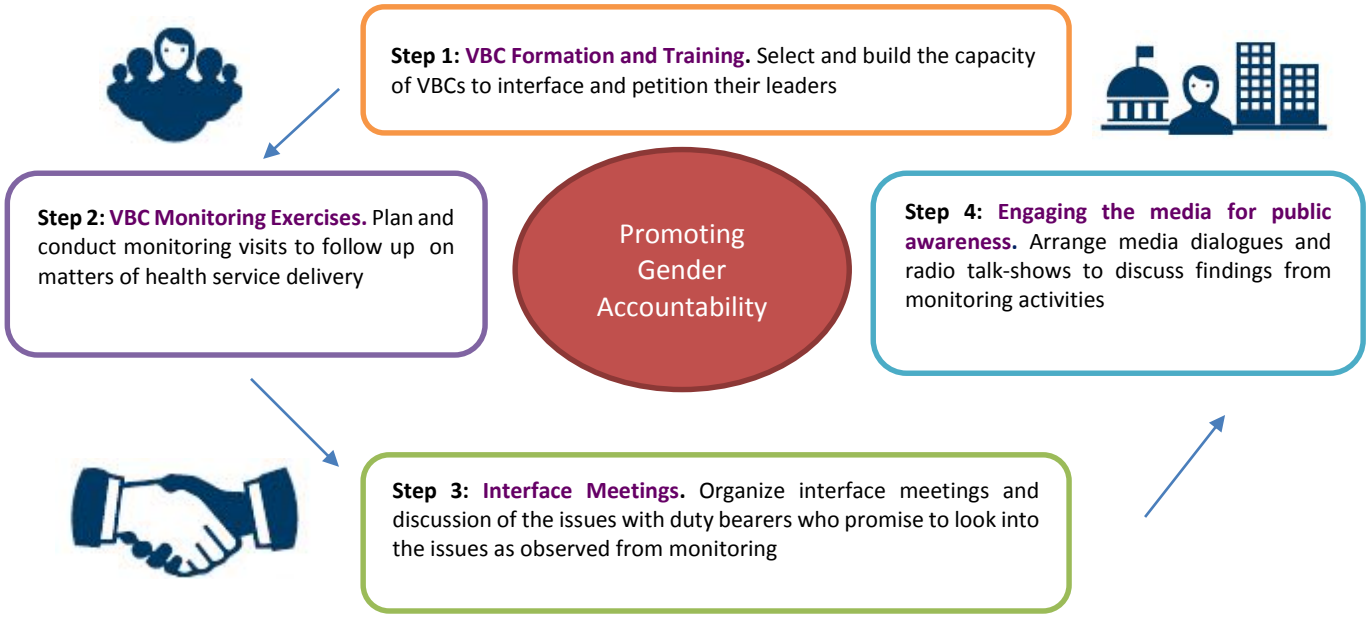
- **Demystifying budgeting** so citizens and local leaders can understand the practical factors behind the numbers and thereby contribute to the process from the bottom up;
- **Strengthening the capacity** of communities to track budgets and resource allocation so local councilors make budgetary decisions with the most vulnerable in mind;
- **Engaging policy and political processes** to influence leaders in creating gender equitable budgeting and legislation;
- **Creating opportunities for the vulnerable** (especially women) to influence leaders and be part of the process of creating equitable budgets; and
- **Establishing gender responsive budget groups** as advocacy partners with local and national legislators.

To achieve these goals, FOWODE created **Village Budget Clubs (VBC)** to lead advocacy efforts that address the needs of poor women, men, children, people with disabilities, and others. The VBCs were developed after a realization that budget literacy was low at the grassroots level. The clubs work to ensure that their issues are included in local government plans and budgets.

In addition, VBCs monitor the expenditure of public resources to identify potential corruption among public officials and ensure the delivery of quality services. VBCs are non-partisan groups composed of 20 members: 12 women and 8 men. Some of the VBC members are community opinion leaders and others hold positions of responsibility (e.g. leaders of faith based organizations). The graphic below depicts the VBC monitoring model[xvi]

Due to resource constraints, FOWODE has not been able to implement this model in all districts. In areas where the VBCs are being implemented, however, there are indications that this approach will go a long way to ensuring funding for critical interventions that support RMNCH at the lowest level of service provision. Examples of results of VBC action in communities include: (1) members who have petitioned district leadership to repair broken water sources in the Kasaala parish of Luweero District; (2) local authorities that responded to a petition by VBC and financed construction of a bathroom for female patients at a health facility in the Amuria District's Obalanga sub-county; and (3) latrine facilities were constructed at the Isuunga HCIII in Kibaale District after a VBC petition.

Figure Showing How the VBC Model Works
(re-drawn by author with information from FOWODE)



STRENGTHS

1. **Diverse Membership Enhances Legitimacy.** The structure of VBCs increases the quality of their functioning while also enhancing the acceptability and legitimacy of FOWODE's work in the public domain.

2. **Trainings Equip Club Members for Action.** Through the VBC training program, club members are equipped with the knowledge and skills to understand budgets and question how resources are mobilized and allocated.

WEAKNESSES

1. **Local Leaders Can Only Do So Much.** Officials who are working to respond to VBC needs are only able to do so much with the resources they have been provided by the government. Budget allocations have to be matched with what can realistically be provided.

2. **Policy Engagement Remains Low.** Most policy makers are not well informed of key service delivery expectations. For instance, in one of the districts, an ambulance was provided to a Health Centre IV despite the fact that there were insufficient resources for its maintenance, fuelling, driver welfare, and licensing. VBCs and policymakers alike need to think beyond the budget to ensure holistic service care packages.

Citizens' Manifesto

During the 2011 elections, the **Uganda National NGO Forum** developed the **Citizen's Manifesto (CM)**, a political statement that articulated the demands of Ugandans to the next generation of government leaders.[xvii] The CM was created with the intent of putting Ugandan citizens at the forefront of electoral politics, with the goal of encouraging civic participation to better articulate citizen demands and enable more effective political response. The idea was to capture the aspirations of citizens in a way that would demand responsiveness, respect, and commitment from leaders in pursuing and working towards them. It provides a framework for CSOs to foster a culture of civic responsibility and encourage political accountability throughout Uganda.

Based on the CM, a Citizen's Manifesto Charter for Parliament was created, which included 11 standards that citizens thought should be addressed by parliament and ultimately assessed. In addition, civic education about the roles and responsibilities of leaders and citizens was conducted. The manifesto countrywide consultative process reached over 160,000 Ugandans directly and about 6 million Ugandans indirectly. The indirect tools included media; information, education, and communications (IEC) materials; forum theatre; public launches; and a Citizen's Manifesto caravan that crossed the country disseminating information to citizens.

With another election pending in 2016, the NGO Forum will update the manifesto after reflecting on new issues that have emerged over the last five years. The CM is intended to create impact at three levels: (1) leadership/governance; (2) civil society; and (3) among citizens. At the leadership/governance level, the approach has been used to evaluate whether or not political leaders are meeting citizen demands, as well as if campaign commitments have been realized. At the CSO level, the NGO Forum has rallied civil society to ensure they demand that political leaders at all levels be held accountable to their citizens. Lastly, at the citizens' level, the goal has been to raise civic awareness among Ugandans that service delivery is 'not a gift but a right.'

ICT Tools

This section presents some of the key **Information and Communication Technology (ICT)** tools used in advocacy for RMNCH in Uganda. Some of these tools are also used for wider reporting on health sector performance by health institutions and CSOs. Cognizant of the high cost associated with grassroots accountability mechanisms, the use of such tools is on the rise to reduce reporting costs.

mTRAC[xviii]

mTrac is a text-message-based (SMS) platform that enables health care workers to submit mobile reports and data on disease surveillance. It is fully integrated into the government's **Health Management Information System (HMIS).** At the health unit, a health worker records information by using either a mobile phone with mTRAC software, an unstructured supplementary service delivery (USSD) interface, or an online computer-based dashboard. The information and data gathered is then uploaded and stored in a central repository, where it can be analyzed and used to inform decisions in real time. Using a toll-free number, patients and health service users can also send out messages as text, voice, or video uploads into the system through a compliant hotline availed by mTRAC.

STRENGTHS

1. **Data is Real-time and Actionable.** mTRAC is able to generate real-time data from lower level health facilities that can quickly inform duty bearers of problems – both alerts that require immediate attention or those that can be followed up on later.
2. **High Mobile Phone Use Makes mTRAC Feasible.** Mobile phone penetration is very high in Uganda, with over 20 million subscribers out of a population of nearly 35 million people. This makes the use of phones to generate data through mTRAC much more feasible in reaching the grassroots with health messages as well as soliciting and receiving feedback.

WEAKNESSES

1. **Platform Requires Significant Data Capacity.** mTRAC still requires substantial capacity to analyze data that surges through the SMS platform, as well as information verification. To do this verification it may require reference paper work to affirm cases of death or threat in monitored diseases, which creates a time lag from when alerts or complaints are received and when a response is delivered. However, this varies from case to case.
2. **Users Need Education on How to Use.** ICT literacy levels are low in Uganda and uploading of information by users is sometimes technically cumbersome.

Health Management Information System (HMIS)

In 2000, the Ministry of Health enhanced the **Health Management Information System (HMIS)** to improve the availability of health sector data and inform better decision-making. Before then the ministry was analyzing and reporting using both Microsoft Access (1997-2001) and EpiInfo Software (2002 to date). HMIS has enabled data management and analysis to be conducted at central, district, and health sub-district levels, with a medium-term plan of setting up a district electronic reporting network to ease the work at the national level. The HMIS has made it possible for MoH to obtain and generate quick and accurate reports, allowing dissemination of prompt feedback from the center to the districts. In 2010, a review of the HMIS conducted by the MoH demonstrated a significant improvement in data analysis and performance reporting from districts. According to the Annual Health Sector's 2013 Performance Report, MoH has obtained financial support from government and development partners

to upgrade district computers, purchase new ones where needed, and train health workers on electronic data management, analysis, and reporting.

MobileVRSxix

Since 2010 UNICEF has supported the rollout of the **Mobile Vital Registration System (MobileVRS)**. This technology is used by personnel in the district planning, population, and statistics departments to record birth and death registrations in districts, which is then fed into the HMIS. Information on death registration is critical to informing accountability efforts, especially when it comes to analyzing the cause of death among women and children.

UReportxx

UReport is a free SMS-based system that enables young Ugandans to speak out on what is happening in communities across the country and engage in dialogue with other community leaders to affect positive change. At the time of writing, UReport had 290,062 members in Uganda, whom it engages in advocacy and accountability processes by leveraging technology. Through the use of mobile phones, information is being collected from thousands of young people – contributing to an environment of accountability and helping to aggregate voices across communities. The system distributes weekly SMS polls to which members can respond on their mobile phones. The results of the polls are made available to UReporters via mobile, as well as more broadly through radio and TV features, print articles, and community events.

UReport has a track record of functioning as an accountability tool. Parliamentarians reportedly monitor UReport closely to keep up-to-date on the experiences and priorities of young people – a political necessity in a country with a very large youth population. At least one parliamentarian was reportedly motivated to start an awareness campaign to improve child vaccination levels in her district after she learned through UReport that her district had extremely low immunization rates. Despite its clear benefits, UReporters overwhelmingly are students and government employees, and it is not clear that UReport is a viable platform for giving voice to Ugandans with less education and fewer resources.[xxi]

> *"UReporters are 25% government employees; 75% students. It is good at one-way dissemination, but not two-way."*

Similar to U-report, the **Uganda-Watch** initiative has generated more than 10,000 reports via SMS sent by more than 3,000 unique users. The crowd-sourced reports were manually verified and geo-tagged by a team of trained volunteers before being published online.

Findings and Recommendations

Based on further analysis of the information gathered from the landscaping survey for RMNCH in Uganda, below is a summary of key findings and recommendations that emerged.

KEY FINDING #1: **Resource Constraints Hinder Accountability Efforts.** It was evident from the survey that many CSOs are under-resourced in terms of human capacity and financing, while also lacking the technical capacity to undertake accountability. There is a need for CSOs to gradually build their technical capacity to effectively undertake and sustain grassroots accountability efforts. As demonstrated by WRAU, successful accountability approaches ensure that CSOs and local leaders are equipped to leverage community support to improve service delivery, and supported through capacity building

initiatives that emphasize good governance practices and social accountability efforts within a rights-based approach. Community based accountability remains a new phenomenon and inasmuch as many organizations may want to undertake this work, they lack the skills within their staff to undertake key accountability aspects like service delivery audits, public expenditure tracking, monitoring and evaluation, use of ICT for local accountability, and documentation and communication of results.

KEY FINDING #2: **Accountability and Advocacy Should Go Hand-in-hand**. They must be sustainably implemented (not just 'one-off') and this takes a lot of human and financial investment. Secondly, demand-led accountability activities should be met with the supply-side initiatives for accountability to be a fruitful undertaking (at the end of the day there should be value for money). At the district and community levels it is important that district and local authorities are engaged and their capacity built to understand their role on the 'supply side.' While decentralization has improved the environment for public participation in social services administration and oversight, the capacity of district officials to take on this new role and proactively initiate with higher levels of government or respond to citizen requested remains limited.

KEY FINDING #3: **Lack of Donor Accountability Hinders Country Accountability.** This is especially true for those mechanisms that attempt to track the level of resourcing in country. Priority setting by donors, reflected in the high levels of funding in areas such as malaria and HIV, often replace more systemic issues within the health system. CSOs often reinforce this, particularly when they 'follow the funds.' Although these areas might have higher visibility both among donors and within domestic politics, they do not always align with evidence. More recently, districts have been able to solicit funds directly from donors or through INGOs. This information is not always reported to the central government, which hinders domestic accountability actors (such as parliamentarians) from acting with full information.

KEY FINDING #4: **The Timing of Accountability Events is Critical**. Work done by the Uganda NGO forum has demonstrated that citizen voices are central to successful engagement with government officials. However, this engagement is heightened at the time of elections. The role that general elections can play in enhancing accountability needs to be leveraged. This is the time when governments are most sensitive to CSO input. However, it is important to be strategic as to how the information is packaged. For instance, in the run-up to the 2011 elections, some civil society representatives indicated that health was an increasingly politicized issue and that any position seen as critical of the government was at risk of being labeled anti-government (which may prove counterproductive in the sense of enlisting government support).

KEY FINDING #5: **International Obligations Must Be Leveraged to Pressure Government Action.** Uganda is a signatory to many international conventions and the government will respond if pushed to meet its international commitments, an opportunity for accountability that has not yet been fully leveraged. Social accountability processes once timed around the key global events (like World Population Day, Women's Day, Day of the African Child, and Day of the Midwives, among others) present good opportunities to demand accountability on these issues. Global commitments were used provide additional 'push' for the government to act on their previously articulated commitments and health policies. This, along with parliamentary action, high-level champions, and citizen engagement, were pivotal factors in contributing to success.

***Recommendation 1*: Develop sustainable systems – keep costs low to help sustain and maintain accountability programs.** *For instance, the use of ICT and the media has proved critical in advancing community level accountability.*

- **Accountability programs should maximize the use of ICT tools and processes already in place.** It is important for an organization engaged in accountability work to have an established plan that is context-specific and that draws on the right tools at the right time, such as the fact that Uganda has one of the highest mobile phone per capita rates in the world (1 in every 2 Ugandans has a phone). There is a lot that can be done with use of phones and social media, especially to reach young people with information on SRHR.

- **The media has become increasingly active in spotlighting key health concerns and pushing for government response.** For example, a number of national newspapers in Uganda have given high levels of coverage to the topic of 'ghost health centers,' which exist in government records but not in reality. Other cases have included drug stocks, and cases of poor health care service provision in public health centers. At the same time where positive events have unfolded the media has been a critical transmitter of this information to the public through radio talk shows and print media.

***Recommendation 2*: Focus on the context, not a model – there is no one-size-fits-all approach.**

- **It is important that a national coordination effort be initiated** (maybe under the Uganda NGO Forum) so that these accountability models are mapped out. At the moment it remains difficult to see how these various models can synergize or combine attributes. There is a caution from one of the CSOs interviewed for this study that as CSOs pilot their different models, there are possibilities of overlaps or duplication.

- **While accountability at sub-district levels is helping to shape advocacy for CSOs at the national level, it should also feed into the government accountability mechanisms under Parliament, IGG, and BMAU.** This report shows that there is diversity in approaches and fields being covered under the broader 'banner' of accountability (e.g. HEPS-Uganda on medicines, VBCs on budgeting, and WRAU on health facilities for MCH)

***Recommendation 3*: Collaborate and partner to go beyond pilot projects and develop comprehensive accountability strategies that link to government accountability mechanisms.**

- **There is need for a cohesive approach** that brings together the different categories of players engaged in the maternal health advocacy and grassroots accountability in a manner that ensures effectiveness in strategy.

- **Government is keen on carrying on with Barazas and should request that CSOs support this effort** (as government cannot evaluate itself or hold itself accountable). CSOs are not always aware of the activities of other organizations within the country (both within health and other sectors), so raising this awareness will be important to empowering CSOs to partner with one another and increase effectiveness.

***Recommendation 4*: Communication and feedback loops from the government to the local level have to be strengthened.** *CSOs can help close the loop.*

- **Implementing citizen-level accountability mechanisms is a very costly undertaking.** It requires a lot of technical and mobilization resources to get citizens sustainably engaged. It is recommended that CSOs work through district structures already in place and identify activities that citizens can be engaged in that do not need a lot of financial investment (e.g. distributing information notices ahead of health outreaches in hard-to-reach areas).

- **Community empowerment and social accountability mechanisms take time deliver results.** Most CSOs have covered only a few districts due to the high cost associated with organizing communities to embrace local accountability and test out various models. In instances of CBMES and VBCs, volunteerism has proved both cost effective and sustainable. Awareness that creates empowerment has made community monitors view themselves as not just beneficiaries but rights-holders with a right to proper RMNCH health services – unleashing a spirit of volunteerism.

***Recommendation 5*: Include the private sector more in accountability efforts,** *as they constitute 50% of all health service provision and could contribute to accountability systems – especially in underserved areas like neo-natal health, child nutrition, and early childhood development.*

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