Community and provider-driven social accountability intervention for family planning and contraceptive service provision: experiences from the field
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# Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>CaPSAI</td>
<td>Community and provider-driven social accountability intervention</td>
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<tr>
<td>CBO</td>
<td>Community-based organization</td>
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<tr>
<td>CHMT</td>
<td>Council health management team</td>
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<td>CHRAJ</td>
<td>Commission on Human Rights and Administrative Justice</td>
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<tr>
<td>CSO</td>
<td>Civil society organization</td>
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<td>FGD</td>
<td>Focus group discussions</td>
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<td>FP/C</td>
<td>Family planning and contraceptive</td>
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<td>GII</td>
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<td>SAM</td>
<td>Social accountability monitoring</td>
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<td>SRHR</td>
<td>Sexual and reproductive health and rights</td>
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<td>ToC</td>
<td>Theory of change</td>
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Executive summary
This document outlines the key principles used in the Community and Provider-driven Social Accountability Intervention (CaPSAI) Project study for implementing social accountability processes in the context of family planning and contraceptive (FP/C) services. The CaPSAI study builds on and contributes to a growing but limited work to better understand how social accountability and participatory processes in the context of family planning and contraceptive programmes and services contribute to the greater achievement of sexual and reproductive health and rights.

The document aims to inform practitioners or civil society organizations (CSOs) how the intervention was designed, implemented and monitored to support the integration of social accountability in the provision of contraceptive information and services. It was not intended to be a strict set of activities that were implemented exactly as outlined. Rather, it is a set of steps that were considered during the planning and implementing of the social accountability activities. Flexibility and responsiveness were encouraged during implementation given the wealth of experience CSOs had in engaging with the local communities with which they work.

The content reflects learnings from implementing this co-designed social accountability intervention and the actual experience of delivering the intervention by the CSO partners. Each of the following sections of the document focuses on one of the nine steps and is structured into two parts. The first part provides information to support the design of activities. These are adapted from the study intervention manual to reflect lessons learned through implementation. The second part provides information to support implementation: this draws on experience in implementing the intervention.
This document outlines the key principles for implementing social accountability processes in the context of family planning and contraceptive (FP/C) services for practitioners and Civil Society Organizations (CSOs). It is based on the learning and experience of implementing the Community and Provider-driven Social Accountability Intervention (CaPSAI) Project and study (1). The CaPSAI study builds on a growing body of work that aims to better understand how social accountability and participatory processes relate to FP/C programmes and services. It also examines how they can contribute to the greater achievement of sexual and reproductive health and rights (SRHR).

Ensuring that women and girls around the world have access to high-quality FP/C information, services and commodities is a fundamental component of their right to health (2). However, many potential bottlenecks can prevent these FP/C commitments from translating into real progress in FP/C access, quality and rights. Common bottlenecks include diversion of funds due to competing priorities, delays and leakages of resources, limited contraceptive choice, poor quality service provision and inadequate protection of women’s rights (3). Furthermore, limited resources and other disincentives often limit government efforts to monitor and address these problems. Inadequate FP/C services and information remain a global challenge. Often, FP/C services and reproductive health supplies remain inaccessible to many, as a result of being either unavailable or unaffordable. Many individuals are unable to access FP/C services due to challenges such as informal fees, disrespectful staff, or an insufficient variety of methods offered.

In recent years, accountability initiatives led by community members and CSOs have proliferated, particularly in the health and education sectors. These initiatives, often referred to as social accountability, are designed to empower community members and ensure that government policy, spending and services are high-quality, efficient and responsive to local needs.
There is growing evidence that when appropriately designed and implemented, these interventions produce significant positive results. Greater agency and engagement, higher-quality and more appropriate services, improved provider performance, increased service utilization, more efficient allocation and use of resources, and improved development outcomes have all been associated with social accountability initiatives (4). With appropriate support, social accountability initiatives in the FP/C sector can address bottlenecks and help programmes achieve their goal.

Social accountability is very important to health delivery, and it works best when the efforts of two sets of actors are coordinated: those with decision-making power in combination with regular members of the community. In collaboration, the two groups ensure that actions, decisions and resources for primary health care are effective and equitable. Additionally, community members and civil society can monitor and advocate for better services, given that patients engaging frontline services play a critical role in identifying local challenges in primary health care that require attention. Accountability is likely to be most effective when it brings in the voices and experiences of both actors.

This document outlines the key principles of the social accountability process examined in the CaPSAI study. It is not intended to be a prescriptive set of activities that must be precisely implemented. Rather, it is a set of steps that should be considered when planning and implementing social accountability activities. In outlining the steps, we encourage flexibility and responsiveness to the local contexts and realities, given the wealth of experience CSOs have in engaging communities with which they work.

The CaPSAI Project

The intervention described in this document has been co-designed and implemented as part of the CaPSAI Project, a study that explores the impact of a social accountability process on contraceptive uptake and use (1). The CaPSAI study tests the Theory of Change (ToC), outlined below in Figure 1, to investigate the potential for such interventions to improve SRHR.

Social accountability is best described as a process that creates social change, rather than a set of tools or activities. In this study, the social accountability process is broken into nine related steps. Together, these steps comprise the main impetus for a transformation in FP/C services, as visualized in the ToC developed for the CaPSAI study (1).
Countries have enabling legal and policy environments based on internationally recognized human rights standards in the provision of FP/C services and information.

There are basic enabling environments, including existing FP/C services with minimum method mix.

The desired social accountability intervention has been developed and implemented in country.

Community members are willing and able to participate, including women.

Health care providers and duty bearers are able and willing to make and enforce changes.
Limited uptake in use of FP/C services is often a result of poor quality services. If clients are concerned about or not satisfied with the care that they receive, they tend not to return. A social accountability process brings about a series of interrelated changes that can gradually change the attitudes and behaviours of stakeholders and improve the quality of services. The CaPSAI ToC is based on the idea that change is dynamic, interconnected and nonlinear. The CaPSAI intervention involves numerous actors, multiple components and a highly influential local context. Given the complex nature of the intervention, the pathways to the goal of increasing the uptake and use of modern contraceptive methods are dependent on a combination of mutually reinforcing and sometimes overlapping intermediate outcomes. These are outlined on the center of Figure 1. The steps outlined at the top of Figure 1 contribute to changes in the attitudes and behaviours between and among stakeholders (service users, social groups and service providers). These changes, in turn, contribute to service-level reforms.

The changes between and among stakeholders relate to:

- **Supporting service users:** Social accountability is a process that is seen to increase an individual’s knowledge about their rights and entitlements to quality health care. The importance of collaboration in demanding change is emphasized. Change at the individual level is anticipated to increase self-efficacy when engaging with health care providers, as well as with other duty bearers in both clinical and public forums. By participating in social accountability, service users strengthen their personal capabilities and assume greater confidence when talking about family planning. They also become more confident when asking questions and addressing power dynamics with health care providers, their partners and their parents.

- **Supporting social networks:** These personal changes enhance networks and relationships between community members. This builds reliance, trust and social capital that can lead to the rise of countervailing power from the community, urging decision-makers to take action and enact reforms.
Supporting service providers: Concurrently, interventions with health care providers result in increased knowledge about the needs of service users, along with greater awareness of their personal and institutional performance. It is anticipated that this will lead health providers to value community engagement in decision making around local health service, resulting in an improved responsiveness of duty bearers.

These changes in both self-perception and in the relationship between the communities and health workers lead to greater mutual understanding and local prioritization, along with changes in service delivery. There are three levels in which increased accountability could potentially have an impact on FP/C services: (i) Individual level (Personal behaviours within the community, such as increased knowledge and improved health-seeking behaviour. Also health care provider behaviours such as improved attitudes and good customer relations); (ii) Service provision level (Ensuring quality of counselling and overall services); and (iii) Health systems and policy level (Ensuring that FP/C policies and programmes respond to community needs). These three elements will result in service reforms including improved-quality counselling and interpersonal care, improved staff capacity and commodities, improved infrastructure and decreased inefficiencies related to staffing and costs. The three levels of change are interconnected, and contribute to outcome-level changes in various permutations.

The ToC guided the development of the key CaPSAI evaluation questions, key indicators for monitoring and provided a structure for data analysis and reporting. Given the complex nature of the intervention, the nested outcomes make it possible to track degrees of progress in achieving the overarching goal. This level of detail can help to highlight cases in which the causal chain is not leading to the anticipated outcomes.

The CaPSAI study was a 24-month, mixed-methods, quasi-experimental study across 16 sites in Ghana and the United Republic of Tanzania. Using an interrupted time series analysis with a control group and a cohort study, it evaluated the role of social accountability interventions on contraceptive uptake and use in settings with low modern contraceptive uptake (Steyn, 2020). It also examined how social accountability processes are implemented and operationalized, focusing on behaviours, decision-making processes, and the barriers and facilitators of change. To reflect a real world setting, the intervention was co-designed and implemented by local CSOs which had prior experience in delivering health-related social accountability programmes. It was, therefore, necessary to recognize
the expertise, experience and established routines of these CSOs. In order to achieve this, the intervention was co-designed by the study implementation leads and the two CSOs implementing the project: Ghana Integrity Initiative (GII) in Ghana and Sikika in the United Republic of Tanzania.

The intervention design

The intervention was co-designed in four stages (5). In the first stage, existing literature and programmes related to social accountability and health were reviewed. The following elements were gathered to define the key steps in social accountability processes: programme descriptions, evidence and programme reports for health-related social accountability interventions such as CSCs, report cards, citizen voice, and accountability and citizen hearings. Based on this review, a composite of eight steps typical of social accountability processes were distilled.

In the second stage, questions were developed for each step to elicit the routine practices, knowledge, experiences and concerns of the local CSOs implementing the intervention. Understanding local routine practices in advance allowed for an intervention design that better reflected what may occur in practice (5). Findings from the first and second design stages were synthesized into a guide for design stages three and four.

In the third stage, multiple meetings were held with local CSOs where the identified steps were discussed, including the explanation of previous experiences in delivering social accountability processes. The intervention manual was then developed and written in a workbook style. The manual sets out the aims and objectives of the study, along with essential information for study conduct and implementation as part of a research project (which was new for local CSOs). For each of the eight social accountability steps, the manual describes how the step is conceptualized within the ToC and lists key questions and considerations for implementers, with examples that had emerged from the co-design process. The manual has workbook pages to capture the pre and post-implementation reporting (see Annex 4). The pre-implementation plan is where implementers set out how their plans adhere to the core tenets of the intervention step and respond to key criteria and concerns. The post-implementation report allows implementers to account for implementation on the day and note any deviations from the plan or to remark on exceptional events. In the final stages, feedback on the draft manual was gathered and the workbook was refined.
In Ghana, CaPSAI was implemented by GII. GII was established in 1999 as a nonpartisan, nonprofit CSO, focused on addressing corruption and promoting good governance. It aims to achieve its goals by forging strong, trusting and effective partnership with government, business and civil society. GII is the Ghana Chapter of Transparency International (TI), the global, nongovernmental, nonprofit CSO. TI works in more than 100 countries worldwide, leading the fight against corruption. For more information on GII, go to: https://www.tighana.org.

Figure 2 outlines how GII implemented the CaPSAI social accountability intervention.

Figure 2: GII project model
The staffing structure for the project is outlined below in Figure 3:

In the United Republic of Tanzania, CaPSAI was implemented by Sikika. Sikika is an NGO that works to improve access to quality health services by advocating for strengthened health governance and financial management systems. Sikika uses evidence from policy and budget analyses, analytical studies and social accountability approaches for advocacy. For more information on Sikika, go to: https://sikika.or.tz/index.php/en/

Figure 4 outlines how Sikika has implemented the CaPSAI social accountability intervention.
This document details the learnings gained from implementing this co-designed social accountability intervention, and is based on the embedded routines of local CSOs. The content has been adapted to reflect the actual experience of the CSOs in delivering the intervention. Hence, there are now nine steps instead of eight steps. The steps have been regrouped to better reflect the implementation experience. Table 1 details the key steps for a social accountability process. While each of these is considered distinct, it should be acknowledged that some overlap may occur. The steps give a broad outline of what should happen at different stages of the CaPSAI social accountability process. Each step is a collection of goal-oriented activities that are expressed as tangible aims, detailing what the step hopes to achieve.
Table 1: Steps for a social accountability process

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<thead>
<tr>
<th>STEP</th>
<th>DESCRIPTION</th>
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<td>PREPARATORY WORK</td>
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<tr>
<td><strong>STEP TWO</strong></td>
<td>INTRODUCTION TO LOCAL AUTHORITIES AND GATEKEEPERS</td>
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<tr>
<td><strong>STEP THREE</strong></td>
<td>MOBILIZATION AND INTRODUCTION OF THE PROJECT TO THE COMMUNITY MEMBERS</td>
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<tr>
<td><strong>STEP FOUR</strong></td>
<td>HEALTH, RIGHTS AND CIVIC EDUCATION WITH COMMUNITY MEMBERS</td>
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<tr>
<td><strong>STEP FIVE</strong></td>
<td>HEALTH, RIGHTS AND STANDARDS OF CARE SENSITIZATION WITH HEALTH ACTORS</td>
</tr>
<tr>
<td><strong>STEP SIX</strong></td>
<td>PRIORITIZATION MEETING WITH THE COMMUNITY</td>
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<tr>
<td><strong>STEP SEVEN</strong></td>
<td>PRIORITIZATION WITH HEALTH ACTORS</td>
</tr>
<tr>
<td><strong>STEP EIGHT</strong></td>
<td>INTERFACE MEETING AND JOINT ACTION PLANNING</td>
</tr>
<tr>
<td><strong>STEP NINE</strong></td>
<td>REGULAR ONGOING MONITORING AND FOLLOW-UP</td>
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To prepare the necessary institutional and social permissions and approvals required to implement the social accountability process.

To ensure that local authorities and gatekeepers are both aware and supportive of the process.

To spread awareness of the project among the local community, ensuring participation from a wide range of community members.

To share information about SRHR and entitlements with community members. To work together to explore any perceived gaps or shortcomings in the services they receive. To generate discussion on the local issues that faced by the population.

To share information about SRHR and entitlements with health providers. To work together to explore any perceived gaps or shortcomings in the services they receive. To generate discussion on key issues faced by local people.

To ensure that a diverse range of community members identify and rank the most pressing issues related to FP/C information and services in their community.

To ensure that health care providers identify and rank the most pressing issues related to FP/C information and services in their community.

To share the assessments separately generated by community and health actors and then to jointly identify areas for improvement. To develop an action plan to ensure concrete measures are taken to improve services and/or maintain good practices.

To track if progress has been made in the jointly-agreed action plan, by regularly following up with both the community and health authorities. To present an opportunity to involve high-level duty bearers or third parties in addressing unresolved issues.
Each of the following sections of the document is dedicated to one of the nine steps. Each section is divided into two parts: design support and implementation support.

The first part provides information to support design. This part is adapted from the study intervention manual, with additions or changes that reflect lessons learned through implementation.

- **Step:** Each step is a collection of goal-oriented activities that are expressed as aims.

- **Description:** This subsection describes what is included in the step.

- **Questions considered at the time of designing this step:** This subsection outlines the guiding questions considered when designing the step. These questions can inform and encourage appropriate local answers.

The second part provides information to support implementation. This part was added following completion of the intervention, once more information had been obtained on how to best support the implementation.

- **What kind of resources are required?** This subsection outlines the resources required to carry out the step. This can include people, equipment, facilities or funding.

- **Key learnings from implementation:** This subsection summarizes the practical learnings based on the CaPSAI implementation experience.

- **In practice:** This subsection provides a practical account of implementing the step based on the CaPSAI implementation experience.
Step 1: Preparatory work

- To set the stage before starting the implementation of a social accountability process.
Description

In this step, it is important to ensure all project infrastructure (stakeholder mappings, staffing, training materials and partnerships) is in place. We intend this document to be used as a guide for the design and development of activities, workplans and facilitation guides. All suggested activities and actions should be adapted to the local context.

Several key activities are anticipated as part of the preparatory work:

- **Workplans**: map all project requirements, including activities and associated required resources. For example, decide what staff will be required and what their training needs will be. Also consider what materials will be needed. This mapping process can take time, but is necessary when developing a thoughtful workplan.

- **Project coordinator**: once staffing requirements have been provisionally outlined in the workplan, the recruitment process for certain roles can begin. Clear Terms of Reference (TOR) can help to clarify each person’s role. The team structures may include an overall project coordinator or Manager, who will supervise local project staff at each site and oversee the implementation of all project activities. This individual could be a facilitator, volunteer or community member. Recruiting a project coordinator early on can be advantageous during the preparatory work stage.

- **Staffing and training**: at a later stage, having completed the workplan and become familiar with local contextual factors (language, local dynamics and customs, upcoming elections, popular meeting areas), local project staff may be recruited. In selecting local project staff, consider the following criteria: trustworthiness, integrity, commitment to the cause, availability and residence in the community. They should not be active members of a political party. This phase may include
training the recruited local project staff and engaging them in onboarding activities. Training topics may include: family planning, political decision-making processes, gender and health rights, facilitation skills for education, issue prioritization, interfacing and data collection.

- **Formal approvals**: it is key to seek engagement from local decision-makers, even at this early stage. This may involve organizing meetings and sending introductory letters to those in power at a national and regional level.

- **Preliminary research**: once staffing is in place, it is essential to undertake mapping activities and preliminary research on a number of key topics. These include: local entitlements, comparative analysis of relevant facilities, and issues around family planning and sexual reproductive health. At this stage, most of the mapping work involves desk review of the local and national reports on sexual and reproductive health, many of which may be available online.

- **Partnerships**: during this step, you can also start mapping potential local collaborators and stakeholders who work with family planning or social accountability in the community, district and region. This might also be the best time to identify licensed and qualified trainers in family planning from the Ministry of Health and start working on their premises.

**Questions to consider in designing this step**

- How will you operationalize the steps into a work plan that responds to local experience and realities?

- What kind of staffing structure do you need to support the project implementation in the local context, in terms of local structures, stakeholders and community groups?

- How will you choose the local project staff who will support the process? What qualifications and experience will you require them to have?
What different kinds of training do local project staff need? Take into account, for example, gender issues, FP/C services and facilitation skills.

What kind of facilitation skills do you need to guide the conversation, address any hostility and ensure balanced participation? How will you ensure that the community facilitators are familiar with the local standards in sexual and reproductive rights and with available health services (including FP/C services)?

How do you ensure that the essential formalities and approvals are in place from the start?

How will you map key stakeholders, local collaborators and the community? Who is working on FP in the area? What are the relevant local systems and structures?

What kind of monitoring plans do you need to assess implementation and whether or not a change has occurred?

What kind of resources are required (e.g., time, people, materials, etc.)?

The preparatory work can take a minimum of one to three months to complete.

Mapping all project requirements can take a considerable amount of time. You must consider the activities, the staffing and their roles, the training requirements and materials to be developed, as well as the preliminary research needed.

Other resources may be needed for conducting certain activities. For example, fuel and transportation may be needed to dispatch letters or attend meetings with stakeholders. Materials for letter writing may also be required.
Key learnings from implementation

The key learnings based on the CaPSAI implementation experience are:

- The project coordinator can start identifying local community-based organizations (CBOs) as potential collaborators. This can help with the local recruitment of facilitators, who will oversee implementation activities. These local facilitators may have information on how best to introduce the project to the community.

- Other local officials can also be approached, such as district leads, medical officers, health officers, health management teams and local chiefs. Quite often, this list of officials is compiled with the help of local leads, either already affiliated with the Organization or with identified CBOs.

- Activities and written documentation related to implementation approval should be thoroughly documented and carefully stored.

- Given the nature of the topic, always consider the gender of the local project staff.

Preparation work in practice

Ghana

In accordance with research ethics requirements, the research team led the initial meetings with health authorities to inform them about the project. The project coordinator participated in a high-level consultative meeting held with the Director-General of Ghana Health Service to introduce the project and the study. Following the meeting, both the implementation and the research activities were approved to commence at
the selected health facilities\(^1\). The approval was accompanied by an introductory letter to the Regional Director of Health Services for the Central Region. The project team then met with the Regional Director to introduce the project, who then informed the relevant District Directors. Meetings were then held with the district authorities to secure their commitment and support for the project. In addition, the police, the social welfare offices and the Commission on Human Rights and Administrative Justice (CHRAJ) at the regional and district level were also informed.

As part of the process, the project team started to identify, recruit and train facilitators and volunteers from the local communities at selected project sites. Several criteria were considered in selecting recruits: membership of local NGOs or CBOs, prior experience in sensitization and advocacy in the area of FP/C, and existing visibility in the targeted areas. Individuals with a specific political affiliation were avoided. The Ghana Coalition of NGOs in Health (GCNH)\(^2\) was consulted to identify active member NGOs operating within the project area, who could assist in the identification of local project staff within the targeted communities. Eight facilitators were selected (seven males and one female) based on the following criteria: knowledge in family planning programmes, experience working in the relevant districts, and experience with health system actors. Additionally, volunteers familiar with local community dynamics and social norms were recruited to support the facilitators. Eight volunteers (four males and four females) were selected by the community members in conjunction with the health providers. The volunteers were then trained alongside the facilitators.

Following the recruitment process, GII designed and implemented a training programme, designed to inform the staff on the objectives and expected outcomes of CaPSAI. This process was led by GII and a representative from the Ghana Health Service (the Regional Public Health Nurse).

\(^1\) In Ghana, the Ministry of Health differs from Ghana Health Service in terms of operation and jurisdiction. The Ministry of Health directly supervises all the Teaching and major referral hospitals. The Ghana Health Service oversees the other hospitals, Health Centres, Clinics, community-based health planning and services compounds among others. In short, Ghana Health Service controls the public and private health facilities at the middle and lower levels.

\(^2\) The Ghana Coalition of NGOs in Health (GCNH) is the umbrella body for all CSO/NGOs & CBOs who focus on the health sector is a body of NGOs who undertake health related programmes. Every region in Ghana has a branch to be abreast with the health situation on the ground apart from the Ghana Health Service.
Training topics included: family planning, gender issues, mobilization, facilitation, monitoring and reporting. The training also covered the social accountability process and the standard operating procedure for dealing with and reporting social harms.

The United Republic of Tanzania

The first step was to introduce the CaPSAI Project to the relevant authorities. This began at the Ministry of Health and Community Development, Gender, Elderly and Children (MOHCDGEC) and continued down to the district level. This was done to ensure that formal procedures were followed and the correct paperwork was in place before any activities began. This also ensured that the correct stakeholders were on board. Prior to visiting the selected districts, the project and research team held joint high-level consultative meetings with the Ministry of Health and also with the President’s Office – Regional Administration and Local Government (PO-RALG). Following these meetings, the project team was provided with an introductory letter to meet with Regional Administrative Secretary, which had been issued after submitting an ethical approval certificate. The RAS, in turn, provided letters of introduction for the project team to meet with the Local Government Authorities (LGAs) and the relevant district authorities. Sikika Consultative meetings were held between the research team and district executive directors, district medical officers and the city directors, all of whom committed to a high level of cooperation.

Six facilitators were then recruited. The recruitment process was an important milestone, as it equipped the project with personnel capable of delivering quality output. The recruitment followed several steps. First, TOR was developed and advertised. Candidates were then shortlisted and interviewed. Finally, the successful candidates were selected by a staff committee. All facilitators were local residents with university degrees and pre-existing facilitation and research skills. The facilitators were expected to conduct community meetings to introduce the project. They worked with community mobilizers to ensure project participants attended scheduled meetings. They also conducted health, rights and civic education for project participants, conducted prioritization and agenda setting, and prepared field reports to track progress.
The project team drew on their previous experience and developed a training toolkit for field coordinators in the Community Score Card (CSC) process, as a means to ensure social accountability in service delivery. In addition, given the importance family planning in the project, the City Executive Director’s (CED) office was approached to provide a qualified trainer in family planning to sensitize the field coordinators in the subject. This covered family planning methods, gender issues in family planning and an overview of family planning policy, provision and standards of care in the United Republic of Tanzania. This training was evaluated with pre and post-assessments.
Step 2: Introduction to authorities and gatekeepers

- To ensure that community authorities and gatekeepers are both aware and supportive of the process.
Introduction meetings with community gatekeepers are important for both practical and ethical reasons, and can be an important step towards gaining the support of the wider community. Local authorities and gatekeepers need to understand what the process will involve, and what they are agreeing to participate in and support. Introductory meetings are also an opportunity to collect important practical information about where it will be possible to hold meetings and how best to mobilize local people. They also provide an opportunity to learn about local sociocultural dynamics and political circumstances that might affect the process. For example, if a part of the local population is pastoralist and regularly leaves the site, you will need to know how best to engage with them and include them in the process. Introductory meetings are also critical in setting the tone for how the facilities and community members come together. Several introductory meetings with local gatekeepers and local personalities may be required.

Questions to consider in designing this step

- How will you introduce the activities to the local leaders? For example, would an introductory letter or a face-to-face meeting be more appropriate?
- Which stakeholders will need to be informed and supportive to ensure success?
- How can you communicate the benefits of social accountability to them?
How can you reassure stakeholders that the process intends to be collaborative and not critical?

How will you manage expectations about what social accountability can achieve?

How will you ensure transparency and wide-ranging participation in all stages of the process?

What kind of resources are required (e.g., time, people, materials, etc.)?

Approximately one to two months are needed to introduce the project to the community members. This includes the process of recruiting local project staff, identifying and inviting participants, and mobilizing the community members for the programme.

The local project staff (facilitators and field coordinators) need to be in place to identify the relevant stakeholders and gatekeepers to approach.

Transport costs such as vehicles and fuel are needed.

Stationery costs and a communication allowance is needed to cover telephone usage and letter writing.

Key learnings from implementation

The key learnings based on the CaPSAI implementation experience are:

It is important to set the tone of the activities early on and allay any fears and anxieties surrounding social accountability. Local concerns, specific requirements or past experiences may impact how the activities are rolled out. For example, it could help to address concerns that the process may reveal unpleasant information about the community.
Many organizations working in accountability are known to community stakeholders and members. It is important to understand the potential implications of any existing perceptions and how best to build on and/or address them.

Allow ample time and be flexible, to allow for the schedules of the gatekeepers and local authorities. They are likely to have limited availability and may have to reschedule appointments if an urgent matter arises.

Preparation work in practice

Ghana

Building on the introductions from the previous step, an introductory letter from the district directors of health services was shared with the facility leaders, who then connected the project team with community opinion leaders. The community leaders shared key information about their community, such as times of local holidays, farming schedules and the best days to organize community durbars. It is important to note that the project team also met with the staff at the health facilities during this stage to discuss the partnership and the roles expected of them. Other sectors and institutions who play a critical role in promoting and securing human rights (as stipulated by the 1992 constitution of Ghana) such as Social Welfare Department, CHRAJ and the political administrations were also contacted and informed about the CaPSAI Project.

The United Republic of Tanzania

In the previous step, the district officials prepared project introduction permits for ward and facility levels. This official approval helped in garnering local support to proceed with the activities. Ward and facility authorities then helped to identify and engage local gatekeepers such as CBOs for young people, faith-based organizations and people

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3 Durbars are large community gatherings attended by more than 100 people. They are commonly used as a platform to engage in dialogue with fellow community members. When a durbar is organized in a community, every member of that community is welcome to participate, including the traditional leaders (such as chiefs, elders and Queen Mothers).
living with HIV (PLHIV). Introductory activities also enabled the project team to understand the local procedures and protocols for community organization. Conversation with the Community Development Officer (CDO) allowed the project team to develop locally-appropriate processes for selecting community representatives (see step 3).
Step 3: Mobilization and introduction of the project to the community

- To introduce and drum up community participation from diverse segments of the community.
Community mobilization aims to engage communities as partners in the social accountability process. Specifically, the communities are engaged to collaborate with health care providers to identify challenges, high priority issues and solutions to improve FP/C service provision and uptake in their localities. Mobilization can take different forms, depending on the local context. Some settings require a more personal approach and target small groups. In other settings, mobilizing hundreds of people for a community meeting is the preferred option.

Once more formal introductions have been made, the process can be introduced to the community more extensively. This may include meeting people at the ward or village level to discover who may be influential in engaging the community. It is important that everyone who needs to be engaged to participate is identified at this stage in the process. It is also critical to effectively communicate to everyone what is involved and what exactly they are agreeing to participate in and support. Efforts should be made to actively find ways to respond to or navigate local social norms and to ensure the broadest range of participants.

During this stage, community mobilizers are identified and trained in the project activities. This training should include: an explanation of the activities, training in accountability and government decision-making, communication, facilitating, report writing, ethical considerations and cultural sensitivities.

Community mobilizers then encourage the members of the community to participate in the activities using different approaches that are dependant on community dynamics and cultural sensitivities. Outreach to the community should be inclusive and aim to reach marginalized groups. Community opinion leaders (for example, Queen Mothers in Ghana) are contacted in an appropriate manner. Logistical arrangements should respond to local community needs and preferences.
The project team could write letters of invitation, identify key individuals to handle the topics to be discussed, and make contact with the regional and district directorates of health and the district assemblies. At the community level, the volunteer can reach out to the chiefs and other opinion leaders, as well as representatives from community groups, with letters of invitation to participate in the programme.

Questions to consider in designing this step

- What characteristics do mobilizers need to possess and how will they be selected (nominated, elected, appointed, delegated)? What will their training consist of?

- What information will be shared with the community? What steps will be taken to explain the process of participation, and discuss any possible risks or benefits?

- What strategies will be used to reach out to community members to inform them and garner their participation?

- How will you ensure outreach includes all groups within the community, including those who might in danger of being excluded? Are there any ethical concerns to take into account? How will you ensure that the logistical arrangements meet the needs of the broadest range of community members?

- How can you ensure that the process will not be taken over by other people or interest groups?

What kind of resources are required (e.g., time, people, materials, etc.)?

- Staff time should be allocated to prepare and conduct mobilization of participants.
The cost for conducting mobilization activities of the facilitators and the volunteers (such as transportation) should be covered.

Any costs associated with communications and announcements should be included in the budget.

Key learnings from implementation

The key learnings based on the CaPSAI implementation experience are:

- At this stage, it may be helpful to develop a description of and rationale for the social accountability process that can be used in promotional materials and messages for mobilizing participants.

- Understanding the community and how to reach them is important. Various strategies may be employed to reach out to groups in danger of being excluded or groups with a specific interest in family planning. Working with local CBOs, formal and informal groups (such as women’s and youth groups), and leaders to understand who the vulnerable people or groups are in the community is integral to ensuring meaningful engagement. It can be useful to understand which segments of the community are participating in your activities and which are not, and the underlying reasons for these patterns.

- Consider leveraging community radio, public announcement systems and media announcements in your outreach efforts. It can also be useful to ask local chiefs to share information in local meetings, or to visit the homes of CBO leaders and ask them to spread the news. See if any already-established community meetings (for example, a women’s group meeting) might be suitable for spreading information about the programme.
Community mobilization in practice

Ghana

To ensure effective mobilization, eight CBOs known to the local community were contacted to provide facilitators and to support GII in undertaking the mobilization exercises. Additionally, eight volunteers who were abreast with current community dynamics were engaged to support the mobilization process. The facilitators dealt with correspondences from the GII and oversaw the volunteers at a community level. The project coordinator organized orientations for the local project staff (both facilitators and volunteers) in communication, mobilization, gender issues and report-writing skills.

Mobilization was a multistage process, with some overlap between the stages. The project team first mobilized the opinion leaders. These included: traditional leaders, assembly members, local religious leaders, interest groups and professional associations. Other social protection bodies, such as CHRAJ and Social Welfare, were also invited to attend these durbars. They discussed their role with the community members and gave information on how they could be contacted for support. The high levels of participation at these meetings did come with a certain level of risk, so the project team engaged the police to provide protect for participants.

Following this, a durbar was held to introduce the project to the wider community. PAs were used to reach people from across the entire community and invite all to attend the inaugural meetings at each site. The project team conducted community durbars. To ensure wide participation, gatekeepers also promoted the activities, including the local chief, the Queen Mothers and other traditional leaders. Letters of invitation were also written to invite people from the regional, district and local levels to inform them about the durbar and request their participation in the meetings. The letters were given to the local project staff for further distribution. Local information centres were used to generate further publicity regarding upcoming activities and the associated preparations.
The United Republic of Tanzania

The project team worked with local leaders, including sub-ward executive officers and elected community leaders to organize meetings in the communities in the areas near to the health facilities. A day before the community meeting, a member of the project staff and community leader drove around the community with a PA system, inviting communities to attend the meeting at a specific time and place. The time and place chosen for the meeting was tailored to local needs.

The purpose of the meetings was to select members of the Social Accountability Monitoring (SAM) team for each facility. Though the selection procedures of members differed, all of the SAM members were elected representatives of different local interest groups (such as women’s groups, youth groups and marginalized communities). Each SAM team had 15 members and acted as the focal point for the social accountability process, working with the groups they represented to identify and prioritize issues and propose solutions. In addition, the SAM teams were responsible for tracking the implementation of the action plan agreed upon by the service providers, community representatives, and district officials. They also were tasked with providing feedback and updates about the action plan to the wider community.

Multiple mobilization meetings were held around each facility. During these meetings, community leaders and facilitators introduced themselves, the implementation team introduced the project and the SAM members were elected.

The SAM team organized ward and street-level meetings to introduce the project and the social accountability process to the community. A PA system was used to promote these meetings. During these meetings, community members were given the opportunity to express their concerns about the FP/C services. There were some challenges raised to mobilization. These included: the lack of representatives for certain community groups, some settlements being hard to reach, and migrant labor lifestyles making it difficult for some to attend. Local disputes within the community also occasionally boiled over during the meetings.
Step 4: Health, rights and civic education with community members

- To share SRHR and entitlements with community members. To work together to explore any gaps in the standard of care currently being received by service users. To generate discussion on the local issues that people face.
During the educational sessions, the community and/or their representatives are talked through health rights and civic education by trained facilitators. These sessions can include information on SRHR, civic and patient rights, policy and funding entitlements, and decision-making processes. Local sensitivities around sex, reproduction and political engagement should be taken into account in the development of the training. Once there is a shared understanding of the standard of care people are legally entitled to, the group can critically assess the standard of care they are currently receiving.

This step comprises three elements. Firstly, all available information and resources need to be consolidated, including local-level service standards for family planning, patient rights and local policies. All shared documentation and other materials should reflect this local information. Secondly, those leading the community education activities may need additional training on some or all aspects of the civic education component. Thirdly, educational activities take place in the community. These may take the form of large public activities or smaller, more targeted sessions. The sessions might cover topics such as local health rights legislation, FP/C service standards, human rights principles and advocacy techniques.

Questions to consider in designing this step

- What content and materials do you need to deliver the educational activities? What already-available materials can be used?
STEP FOUR

How will you ensure the educational activities are delivered in a way that is accessible to a diverse group of community members, who may speak different languages or have differing understandings of local structures?

Who can provide the educational activities? What expertise is required to provide the training?

How will community facilitators ensure all community members have an equal voice during the activities? Many factors, such as where and when the activities take place may affect this.

How and by whom will the education activities be assessed?

What kind of resources are required (e.g., time, people, materials, etc.)?

- Project staff time for developing the training materials and for coordinating the educational session.
- Training logistics such as transport costs and allowances.
- Food and refreshments for participants.
- Meeting costs such as stationery, a PA system and generators for raising community awareness.
- Letters of permission from the previous step to share with local-level authorities.

Key learnings from implementation

The key learnings based on the CaPSAI implementation experience are:

- Find the right person to deliver the training. You may need to bring external experts on board for
specific parts of the training. For example, to deliver information on family planning, an expert may be engaged from the health service or a reproductive health NGO that is active in the area.

Health, rights and civic education in practice

Ghana

Eight durbars were organized across the participating communities. Approximately 200 people attended each dbar, two thirds of whom were women. During the durbars, the project teams introduced the project and the social accountability activities, emphasizing that it was a process intended to bring the community and the health providers together to increase accessibility, availability and affordability of FP/C services. Technical resource persons were engaged from the respective district levels to lead the presentations in the durbars. The district public health nurses in charge FP/C were tasked to facilitate a discussion about family planning. They described the methods and benefits of family planning for the mother, father, child and the wider community.

The District Directors for CHRAJ and the District Social Welfare Officers were also requested to talk about civic rights. Together, they gave a presentation on fundamental human rights and how they related to the 1992 Constitution of Ghana. It was at this stage that the team designed and printed the various IE&C materials promoting citizens’ health rights.

The United Republic of Tanzania

Following their recruitment in the previous step, the SAM members were trained in health rights and civic education by the project team. Their first activity was to vote for the SAM Chairperson, Vice-Chairperson and Secretary, which involved selecting members who would be capable of coordinating the team and writing reports.

4 Chapter 5, Article 14, Clause 1 of the Constitution enumerates the rights each individual or any citizen must enjoy including the right to access FP/C services.
The SAM members were provided with three days of training. The goal of this training was to familiarize the members with key topics in sexual and reproductive health, so that they could pass this information on to their respective groups. Topics covered included SRHR and FP methods and their benefits (covered by the FP coordinator from the District Health Management). As part of the training, the SAM members visited their local health facility to meet the facility manager. The aim of this meeting was to learn about the status of FP/C service provision. At each facility, the SAM members asked questions about the health facility plan, such as whether it provided contraception, what methods were offered, whether trained providers were available, and whether the services provided were at a good standard.

This training in FP/C was then scaled-up to the community level, with the aid of a local PA system. The SAM members and the FP coordinator worked together to raise community awareness of modern contraceptives and social accountability. After the promotion campaign, the SAM members collected opinions and reactions from the community, to map the issues they face in accessing and using modern contraceptives. Opinions were collected by consulting community groups, visiting market areas, as well as door-to-door discussions, conducted with the help of street leaders.
Step 5: Health, rights and standards of care sensitization with health actors

- To share information about SRHR and standards of care with health actors. To work together to explore any gaps in what they receive and provide. To generate discussion on the local issues of the community that they serve.
Health actors (from health providers to local health authorities) are not necessarily aware of what people’s entitlements are to sexual and reproductive health services. They may be unsure what role they play in ensuring that these services are delivered in a timely and equitable manner. Therefore, the health actors involved in the social accountability process will also require training or orientation. Training health actors may require a different curriculum than that used for community members. This training must be responsive to their needs and responsibilities. There must be a focus on strengthening health systems and on addressing how best to support systems of internal accountability. Health actors are not immune to the social and cultural norms surrounding sexual and reproductive health. Ensuring they are aware of potential misconceptions and biases should be included in the training.

Questions to consider in designing this step

- How will the training take into account supervision hierarchies and different service delivery units?
- How can you ensure that the training does not conflict with working hours?
- What requirements are needed to conduct the training? For example, are there any approval requirements? Do you need to work with the health system? Are there any existing official training programmes that could be adapted?
What kind of resources are required (e.g., time, people, materials, etc.)?

- Project staff time for organizing and coordinating activities.
- Logistical costs for conducting the training, such as vehicle, venue, projector, canopy and chair, the cost of providing stationary and refreshments.
- Mobilization costs for bringing the health actors together also needs to be taken into account.

Key learnings from implementation

The key learnings based on the CaPSAI implementation experience are:

- It may be necessary to bring external experts on board to help provide the training. For example, someone from the health service or local CSO may be engaged to deliver information on family planning.

- It is important to mobilize the health providers to participate. The local health authorities may need to write a letter to the facility manager to clarify that the training is an officially-approved activity.

- This step is a good opportunity to generate engagement from health actors by framing the social accountability process as collaborative and nonconfrontational. If providers and duty bearers see the prioritization and interface meetings as an opportunity to share their concerns with the community, they may feel more open.
Ghana

The project team organized a session with the health actors at the local health facilities. The district public health nurses, functioning as the technical resource persons, provided training for the health facility staff in the standards for delivering high-quality FP/C services, the cost standardization of FP/C services and individual rights to access family planning. The Commission on Human Rights and Administrative Justice also briefed the health facility staff on civic rights and urged them not to deny any FP/C services to anyone who approached them. Participants were asked to demonstrate how they would counsel a client on contraceptive options through role-playing, following which participants provided feedback to each other.

The United Republic of Tanzania

In the United Republic of Tanzania the health actors were not trained, as this would have required approval from the Ministry of Health, potentially disrupting the project timeline. However, the project team provided orientation on a rights-based approach to service delivery, standards of care and client service charter to each facility. The project team used the same materials from the previous step, to guide discussions with the staff at the health facilities.
Step 6: Prioritization meeting with the community

To ensure that diverse community members identify and rank the most pressing issues related to FP/C information and service provision in their community, distill priorities and then collectively rank them for action.
Description

The prioritization meeting with the community members assesses the local reality of FP/C services against what is promised by national standards. Experiences of FP/C services may vary significantly, and various issues may be identified in the meeting. These will need to be prioritized in order to determine which issues can be most fruitfully addressed, considering the resources available (such as time, funding, and staff availability and capacity).

In step four, community members learned about their entitlements and compared them to their actual experiences, noting the issues that arose. In step five, they prioritize which of these issues to address and track. Different methodologies can be used by the group to determine which issues are most pressing. Once the issues have been established, the group develops indicators or measures that can be used to evaluate the facility and services. These indicators can be ranked, and the group can later present them to relevant decision-makers (see Annex 1 and Annex 2). Low and high scores may be used to justify decisions and be accompanied by suggested improvements to the service. At the end of this activity, the community members will have a combined list of priorities that will be presented during the interface meetings in the next step.
Questions to consider in designing this step

- Given the busy schedules of the participants, how will you ensure good attendance for the prioritization meeting (consider announcements, timing and location)?
- How will you ensure participation across the community, particularly from marginalized groups?
- How will the prioritization meeting be effectively facilitated (for example, avoid biasing views, maintain balanced participation)?
- How will you ensure participants understand the process of the meeting and its benefits?
- How will you get honest and frank input from the community in a safe and confidential way?
- How can you ensure that focus remains on FP/C?
- How will the views and experiences of the different groups be fairly incorporated into a single list of issues?
- How will you prepare the community for the interface meeting with health actors and select a spokesperson?

What kind of resources are required (e.g., time, people, materials, etc.)?

- Project staff and facilitator’s time for organizing and coordinating activities.
- Logistical costs for conducting the training, such as vehicle, venue, projector, canopy and chair hire, and the cost of providing stationary and refreshments.
- Mobilization costs.
The key learnings based on the CaPSAI implementation experience are:

- If prioritization is taking place at large community meetings, it may be worthwhile subdividing the participants into smaller groups, based on factors such as age and gender. These smaller groups can first identify their own issues, before joining together for a larger group discussion. Another approach is for selected community members to collect issues from the wider community. These selected members then to rate the issues and validate the list of priorities with the community.

- Manage the prioritization. Each small group will prioritize the issues they have raised, yet the larger group must also prioritize the issues of all the groups. It is important to ensure the process is democratic. You could, for example, use a democratic scoring process to ensure that the majority is represented. Using voting, rating, or other ranking systems where each participant gets an equal say makes the process more democratic.

- For larger group methodologies:
  - Encourage small group discussions. To encourage participation, particularly from marginalized groups, it can be useful to divide people into smaller groups. For example, groups of young people, people living with and affected by HIV or new mothers might each have different issues accessing services and have different priorities to raise. Some groups may not want to be separated from the larger group, so other arrangements may be necessary.
  - Ensure everyone has an equal voice. Strong facilitation skills are critical for ensuring everyone is encouraged to participate. A good facilitator can manage people who are dominating.
conversations and gently encourage those who may be shyer.

- It may be important to provide a degree of confidentiality in the voting process.

- Prepare for the interface meetings. At the end of this step, the community will have a combined list of priorities, which will be presented during the upcoming interface meetings. Prepare community members for the next step by explaining the function of the interface meetings, while managing expectations and helping the groups and subgroups agree on members to speak on their behalf.

Prioritization in practice

Ghana

In Ghana, prioritization was conducted in large public meetings. A durbar was called at each site, which were attended by more than 200 participants. Participants were divided into peer groups, such as male youth, female youth, male adults, female adults and opinion leaders. Where peer groups were more than 20 people, making group interaction impractical for a single facilitator, they were further subdivided.

In each peer group, a facilitator and rapporteur were selected to lead the discussions and document the issues. All the listed issues raised were ranked in a voting process. Each issue was called out to the attendants and those who thought the issue was important raised their hands. Finally, the issues with the most votes were collectively ranked for action by that specific subgroup. The prioritized issues were then written on a flip chart to be presented to the larger group by the rapporteurs. The priorities from all the groups were collated and collectively ranked by the larger group through a similar voting process to arrive at the overall priority issues. Issues with highest votes were documented as prioritized.
The United Republic of Tanzania

In the United Republic of Tanzania, Sikika used a smaller group format where SAM members and selected community representatives took part in the prioritization, before verifying their choices with wider community groups. After identifying the issues that hinder community members from accessing FP/C services and using modern contraceptives in the previous step, the SAM members reviewed and then participated in Focus Group Discussions (FGDs). The purpose of the FGDs were to discuss the identified issues and prioritize them for endorsement by the community groups they represent. These would be then be presented at the upcoming interface meeting. This session was important for SAM members to generate a shared understanding of the current state of local FP/C provision. The identified issues were then charted on a flipchart and prioritized by voting with coloured cards. Each issue was ranked as either GOOD (1), AVERAGE (2) or BAD (3). The issues with the worst ranking (the greatest number of BAD votes) were prioritized. The FGD also developed draft indicators that could be used to evaluate the facility and services in the joint meeting with health actors. Finally, a CSC matrix that listed the priority issues, their causes, and suggested improvements was developed.

After prioritizing the issues, the SAM members shared the drafted CSC matrix with their respective communities in small group meetings for endorsement. Endorsement entailed the community providing feedback on the whole prioritization process and confirming agreement with the listed priority issues.
Step 7: Prioritization with health actors

- To ensure that health care providers identify and rank the most pressing issues related to FP/C information and services in their community, distill priorities and then collectively rank them for action.
In the prioritization meeting with health actors, service providers, local health providers and facilities managers come together and assess FP/C services in their area. They discuss the different kinds of constraints they face and identify areas that need improvement. After agreeing on the key issues, they rate the most pressing issues. In prioritizing, health actors determine relative importance, taking available resources into account (time, finances and human resources). The group then discusses the high-scoring issues and suggests possible improvements. Depending on the group size and dynamic, the group may brainstorm how these concerns will be presented at the interface meeting. At the end of this step, the health actors will have a combined list of priorities to present during the upcoming interface meeting.

Questions to consider in designing this step

- How will you ensure successful participation in the prioritization meeting (timing and location)?
- How will you ensure appropriate facilitation of the prioritization meeting?
- How will you ensure participants understand the process of the meeting, as well any potential risks and benefits?
- Given the supervision hierarchies for health care providers, how will you make health actors feel comfortable and safe enough to participate without fear of judgment and consequences?
How will you ensure the confidentiality of the participants and their contributions?

How will you facilitate the discussion to generate issues on the challenges in the provision of FP/C?

How will you get the group to agree on the main issues?

How will you work with health actors, while remaining open to feedback and willing to make improvements?

How will you prepare the health actors for the interface meeting, given the possibility of negative reactions from the community?

What kind of resources are required (e.g., time, people, materials, etc.)?

- Project staff and facilitator’s time for organizing and coordinating activities.

- Logistical costs for conducting the training, such as vehicle, venue, projector, canopy and chair hire, and the cost of providing stationary and refreshments.

Key learnings from implementation

The key learnings based on the CaPSAI implementation experience are:

- Requirements around working with health actors vary from country to country. It is important to obtain the necessary permissions, observe the protocols and have all the required documentation.

- You should consider meeting outside working hours, to avoid impacting the provision of services.
As with the community members, the health actors will need to be briefed on what to expect when attending the interface meetings. They may worry about being singled out by community members or being placed in confrontational situations. To guard against this, participants should be kept well informed. Explain the next step in the process to them, while managing their expectations for the meeting and helping the group and subgroups agree on who should speak on their behalf.

Prioritization in practice

**Ghana**

The prioritization process was adapted to respond to the limited number of health actors, usually not more than seven participants from each participating facility. Due to the small numbers, interactions at the facility level were very engaging. A question and answer approach was favoured. Each health worker was asked to list their concerns about FP/C service delivery on a piece of paper. The project team then collated these concerns into an anonymized list, and health actors voted on the priority issues for the facility. After issues were collectively agreed, each health worker was given some marbles that they could privately allocate to issues they found most pressing. When one participant completed their allocation, the project team recorded the ranking and invited the next participant. Once this scoring process was complete, the project team wrote the results on the flip chart to determine the most high-priority issues according to the facility staff.

**The United Republic of Tanzania**

After the project team secured the necessary permits from district officials, they visited each health facility for the prioritization session. The sessions began with an introduction to the project, outlining the principles of social accountability and emphasizing a rights-based approach to service delivery. As part of the process, the project team informed health
actors that the prioritization would be achieved through a confidential questionnaire completed by all participants. The questionnaire assessed the current status of FP/C service provision at the health facility. The project team then collated questionnaire responses for the health actors to review in the upcoming FGD.

The FGD lasted one hour and the health actors discussed the issues raised by the moderator regarding the key constraints of providing services to the community. The identified issues were noted on a flipchart and prioritized through a group vote. Health actors used coloured cards ranked as either GOOD (1), AVERAGE (2) or BAD (3) to vote on the issues raised. The issue with the most BAD votes were considered the highest priority. The project team then guided the health actors to draft indicators for the prioritized issues. At the end of each FGD session, a CSC matrix with a list of priority issues and indicators, as well as suggestions on how to address them, was developed. The project team then discussed the upcoming interface meeting.
Step 8: Interface meeting and joint action planning

- To share the priorities separately generated by community and health actors and then to jointly identify areas for improvement and develop an action plan to ensure concrete measures are taken to improve services and/or maintain good practices.
Description

The interface meeting is a joint meeting where the community members, the health providers, health authorities, and other duty bearers all share and discuss their priorities and seek to agree on ways to address them through a joint action plan. This interface meeting requires careful facilitation to help the group reach a consensus on which issues they could jointly tackle and the actions required to resolve them. Some issues can only be tackled by higher health authorities, and therefore accountability efforts should be aimed at that level. Once the common goals are agreed upon, the group develops an action plan covering the following six to 12 month period. The structure of the action plan should include sections on prioritized issues, the actions agreed upon, timelines, the person or persons responsible and who should be held accountable. A monitoring plan with assigned roles and responsibilities is also required.

It is important for the group to nominate individuals who will monitor the action plan and give a progress report at future interface meetings. This team could include representatives from the community, service providers, duty bearers (local administrators, health officials) and local project staff. At regular intervals, the monitoring group will present progress in interface meetings to the larger combined groups and re-strategize if necessary (see step nine).

Questions to consider in designing this step

- How will you explain the purpose and process of the meeting to the participants?
- What methodology will be used for both groups to share their scores and allow time for a participatory dialogue?
What participatory methodologies can you use to create common ground for agreeing on an action plan, with shared responsibilities between communities and duty bearers?

How will you ensure the group identifies the duty-bearers who have the mandate to make the changes necessary to resolve the issue?

How will you develop support among the participants to jointly prioritize which indicators and issues to work on?

How will the group monitor progress against the action plan? What kind of evidence will be needed to monitor the ranked issues, following the interface meeting? Who will collect it? How can it be verified?

How will you support the group to decide who will monitor the progress of the action plan for sharing at the follow-up meeting?

How will you ensure that the action plan’s timeline is sensible and considers other factors, like elections or budget cycles?

Who will receive a copy of the action plan, and how and when will this be shared?

How can the action plan be integrated into the community or health facility plan for issues that require significant funds and other resources?

What kind of resources are required (e.g., time, people, materials, etc.)?

- Project staff and facilitator’s time for organizing and coordinating activities.

- Logistical costs for conducting the training, such as vehicle, venue, projector, canopy and chair hire, and the cost of providing stationary and refreshments.
The key learnings based on the CaPSAI implementation experience are:

- Consider organizing pre-interface meetings. Following the community and the health actors’ prioritization activities, significant preparations are required in advance of the interface meetings. This preparatory work aims to build the duty bearers’ trust and ensure the meeting does not appear confrontational. This is critical to ensure a productive and collaborative tone during the interface meeting. These pre-interface meetings can allay fears, reduce the chance of unpleasant surprises, provide a chance to prepare responses and suggested actions in advance, and encourage meaningful and positive participation in the main interface meeting. This work may include a number of additional meetings with key individuals.

- Aggregate and anonymize contributions. As there are only a small number of health actors in each facility, the presentation of their priorities can be sensitive and needs to be handled with care. It is critical to consider how to present their priorities while anticipating potential repercussions, both from other employees and community members. Aggregating and anonymizing the issues may somewhat effective, but may be insufficient in itself to protect the privacy of participants.

- Manage tone and expectations. The project team can help to ensure that interface meetings do not become confrontational, that particular individuals or interests do not dominate, and that the meeting progresses and meets its objectives. Facilitation techniques can include: the aforementioned preparations, setting clear expectations and ground rules at the beginning of the meeting, and asking community leaders to help manage expectations within the community in advance of the meeting. Choosing the right facilitators to lead the meeting is critical.
Develop an action plan. The main result of the interface meeting should be a joint action plan agreed upon by the community, service providers and duty bearers, which can be monitored and followed up on. The facilitators can help this group to articulate and formalize the action plan and engage the community to lead the monitoring. It is important to consider the role of other existing stakeholders (for example, other NGOs working in the area) who may directly or indirectly impact action plan outputs.

Agree on a monitoring team. The monitoring team should consist of community members, health actors and community leaders. The group could brainstorm on how to give feedback on the action plan’s progress to the different stakeholders such as the community, service providers and health authorities.

Interface in practice

Ghana

Interface meetings were held at each site between community members, health actors from the local health facility and local policymakers. More than 200 people participated in each meeting. A representative for the community and the health actors was selected to act as facilitator. Subsequent to each group presenting, the forum was opened to allow discussion of each issue and determine actions to be taken. The community members first raised their prioritized issues, then the health actors respond to the issues and provided solutions proposed by their superiors at the district or regional offices. Having responded to the community priorities, the health actors shared their own prioritized issues. Finally, all participants jointly agreed on areas for improvement.

Some of the shared issues were successfully resolved at the meeting. Unresolved issues were put into an action plan which detailed steps for possible resolutions. The action plan was developed to assign responsibilities for easy supervision and monitoring of the agreed issues. An independent group of selected community and health workers, referred to as volunteers, were selected to monitor the inputs in the action plan and give feedback.
The United Republic of Tanzania

There were two steps to the interface meeting. Prior to the interface meeting with the health authorities, the project team arranged a pre-interface meeting that brought together SAM members and the health actors to share their prioritized issues and scores. This meeting was intended to help avoid potential confrontations during the interface meeting. The meeting provided a space for dialogue, with a view to consolidating priority issues, actions and responsibilities.

Following this, the project team organized an interface meeting between the SAM members, health actors and local policymakers, including Council Health Management Team (CHMT) and other government officials. The aim was to bring together the duty-bearers who have the authority to influence decisions related to the action plan to improve FP/C services. At this meeting, approximately 30 people came together to review the combined priority list and the proposed action plan. On behalf of the community, the SAM team presented the community’s issues and suggested solutions, while the health actors presented their own issues to the health authorities. This meeting also provided space for the health authorities to respond directly to proposed suggestions to refine the action plan and suggested improvement measures. The final action plan agreed with health authorities also assigned roles and responsibilities. Finally, the SAM members provided feedback on the interface meeting outcomes with the community groups that they represent.
Step 9: Regular ongoing monitoring and follow-Up

- To track if progress has been made in the jointly agreed action plan. To ensure priority actions are regularly followed up on with both the community and health authorities. These follow-ups present an opportunity to involve high-level duty bearers or third parties, including the media, to address unresolved issues.
Description

Regular joint follow-ups are required to ensure the successful implementation of the action plan and to monitor outcomes collectively. Following the interface meeting, those tasked with monitoring will evaluate progress made on the prioritized issues. The progress on agreed actions should be presented to the larger group at regular intervals at follow-up meetings. The action plan will then be regularly updated to re-strategize, where needed, and advocate for further changes to improve services. Often, following social accountability interventions, it is common for the community to continue with some form of related activities or mobilizations. This building of political capability, empowerment and resourcefulness are considered key aspects of the ToC for social accountability interventions.

Questions to consider in designing this step

- What kind of evidence will be needed to monitor the ranked issues after the interface meeting?
- How will you support those monitoring the action plan to present their findings during the interface meetings?
- How will you support the group to jointly address areas where there has been little improvement?
- How will you help the group formulate additional indicators to address, monitor and modify the action plan?
- What is the appropriate interval between monitoring meetings and for how long will they be necessary?
- How will the results of the monitoring be shared with stakeholders?
What kind of resources are required (e.g., time, people, materials, etc.)?

- Project staff and facilitator’s time for organizing and coordinating activities.
- Logistical costs for conducting the training, such as vehicle, venue, projector, canopy and chair hire, and the cost of providing stationary and refreshments.

Key learnings from implementation

The key learnings based on the CaPSAI implementation experience are:

- If continued monitoring and interfacing activities are not yielding results, other advocacy levers may be used to increase the pressure on duty bearers to enact change. This may include engaging with the media and higher-level authorities or organizing community actions.
- The monitoring period could last more than a year, so activities need to be coordinated with other planning and decision-making processes.
Ghana

A four-member monitoring team was jointly-selected at each site by the community members and the health actors. This team was tasked with following up on the action plans, to ensure they were implemented. The project team designed a monitoring template for the monitoring team to use to track progress. Regular feedback was given back to the project team, who passed on status reports in a larger debriefing session every three months. The selected volunteers were given training on how to monitor and gather data from respondents to complete the template. In the case of unresolved issues, this follow-up process has provided opportunities to involve high-level duty bearers, the media or other third parties.

The United Republic of Tanzania

The follow-up process had four stages that occurred over a three-month period. Firstly, a small taskforce was set up to track the progress of the action plan in each site. The taskforce was composed of three SAM members, the facility manager and the project team. The taskforce met regularly to discuss the implementation of the action plan, to ensure progress and to identify any challenges that arose. Secondly, the taskforce met with senior facility staff to discuss the action plan in detail. The entire SAM team was then debriefed on these discussions. Thirdly, the SAM team met with health authorities, CHMT and facility staff to discuss the action plan and re-strategize in areas where there had been little progress. Finally, the SAM team gave feedback to the community they represent.
Conclusion
This document has detailed the key principles for implementing social accountability processes in the context of FP/C services, based on the learning and experience of implementing the CaPSAI Project. Central to this approach has been:

- Learning from and adapting to the local context. This includes the capacity of civil society and health system responsiveness, which are often influenced by wider state-society relationships. It also comprises the norms, values and attitudes that surround sex, reproduction, gender and contraception.

- Following up on progress made on agreed action is central to implementing social accountability, as it can sustain pressure on decision-makers long after project funding has run out. Hence, the emphasis should be on supporting local capacity.

- Equally important is the need to manage expectations about what can be achieved within a given time frame. Quick wins should not be expected, particularly in the case of potentially sensitive areas such as FP/C services and SRHR.

- The use and provision of FP/C services is influenced by local values and attitudes, which can either constrain or facilitate change. Therefore, sensitization around FP/C issues is central to the implementation of social accountability.


Annexes
Annex 1:
Sikika prioritization tool

**ILLUSTRATION 1**
Shows issues identified by participants (community/service providers), as well as agreed-on and ranked scores and priorities.

<table>
<thead>
<tr>
<th>N</th>
<th>ISSUES</th>
<th>SCORES</th>
<th>PRIORITY</th>
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<td>GOOD</td>
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**ILLUSTRATION 2**
Shows indicators, priority scores, causes and suggestions, as agreed by participants (community/service providers)

<table>
<thead>
<tr>
<th>INDICATOR CLUSTER</th>
<th>CAUSE</th>
<th>SCORES</th>
<th>PRIORITY</th>
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Annex 2:  
GII prioritization tool

<table>
<thead>
<tr>
<th>CLUSTER OF INDICATORS</th>
<th>SPECIFIC INDICATORS</th>
<th>COMMUNITY SCORE</th>
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Annex 3: GII monitoring tool

MONITORING TEMPLATE TO TRACK PRIORITIZED ISSUES AFTER THE INTERFACE FOR THE CAPSAI STUDY

<table>
<thead>
<tr>
<th>NO.</th>
<th>DATE (The day the monitoring took place)</th>
<th>PRIORITIZED ISSUES (Prioritized issues in the action plan)</th>
<th>MEANS OF VERIFICATION (eg. Observation, interviews, participant observation etc.)</th>
<th>STATUS/LEVEL OF CHANGE/OUTCOME (Here we need the change that has occurred)</th>
<th>PERSON(S) RESPONSIBLE (Team members who participated)</th>
<th>REMARKS (Any additional information or comments)</th>
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Annex 4: CaPSAI reporting templates

### PRE-IMPLEMENTATION PLAN

<table>
<thead>
<tr>
<th>DATE</th>
<th>IMPLEMENTATION SITE</th>
<th>COMPLETED BY</th>
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Please list the planned activities for this step and the timeline. If there are aspects of the planning which are not covered by the questions, please add them as needed.

[insert text here]

Who will be implementing the activities? (not covered by the questions, please add them as needed).

[insert text here]

When will the activities be taking place?

[insert text here]

Who will be involved in the activities? (list all the different groups and people you anticipate interacting with)

[insert text here]

What steps you taken leading up to the activity that have made this part of the step possible?

[insert text here]

What are the ethical and safeguarding preparations needed?

[insert text here]

Please append any materials related to this step, including any further thoughts or considerations. See the listing below for key materials to include. This list is not exhaustive, please add any other relevant documentation.

- Stakeholder list (name and role)
- Invitations to meetings or implementation related events
- Itinerary for visits
- Meeting agendas
- Promotional materials
- A copy of all and any relevant approvals
**D. POST-IMPLEMENTATION REPORT**

What happened on the day? How did it compare to what you planned? (i.e. changes to the agenda, personnel etc.)

[insert text here]

Why did you make these changes to what was planned?

[insert text here]

What do you think the impact of these changes has been, if any?

[insert text here]

Please append any materials related to this step, including any further thoughts or considerations. See the listing below for key materials to include. This list is not exhaustive, please add any other relevant documentation.

- Any additional field notes describing the outcomes of the meetings and any other details of note
- Any letter sent to introduce the study
- Listing of meetings attended and attendance lists
- Summary of inclusion activities
Guide for completing the post-implementation report

Following each implementation step, and prior to moving to the next one, a post-implementation report should be completed, appending any related documentation. Changes to the original implementation plan are expected and do not mean there has been a problem. What is key is tracking these changes so that we are later able to understand the implementation process. It is also entirely possible that there was no change to the implementation as initially planned. In this case, the team should focus on precisely describing how the implementation proceeded.

The main objective of the post-implementation report is to capture the actual implementation process and compare this with what had been planned. Therefore, the report should frequently reference the pre-implementation plan and highlight any deviations from it. Common questions that this report should answer include:

► Was the agenda for the implementation step followed?
  ● How did the implementation process proceed?
  ● Did the process proceed as initially anticipated?
  ● If it wasn’t, what was changed on the day of implementation? Venue? Date? Participants? Personnel?

► What necessitated the changes to the implementation as initially planned?
  ● Was it something that could have been anticipated by the team? If so, what plans were made?
  ● Was it something that could not be anticipated? Why?
How was the decision to adapt the implementation plan made?

- Did consultations take place? With whom? Why? When?

- Was it an emergency decision? Could no consultation be done? Why was it an emergency decision?

What was the impact of the adaptation in implementation as initially planned?

- None? Minor impact on the implementation? Major impact on implementation? Please describe the nature of the impact.

It is critical to be very specific – this means mentioning names, numbers and cadres of individuals involved in the step, mentioning the time and place where specific activities happened and mentioning who in the team was involved. Any descriptions of issues that emerged or your observations about group dynamics would be appreciated. From experience, this level of detail is best captured by those who are delivering the activities and steps. However, it is suggested a more senior member of staff monitors the reports for completion, accuracy and quality.
Use this space for notes.