Impact Evaluation: Accountability Can Transform Health

ACT Health is a **governance programme for the health sector** that runs from 2014 to 2018. The programme itself was modelled on a pivotal study[1] which suggests that when local communities are actively engaged in monitoring and assessing health services, those services will improve, leakages will diminish, and utilisation will increase. With funding from UKAID, ACT Health works with communities and local health service providers in 18 (formerly 16) districts to develop strategies that address gaps and quality issues in service delivery.

ACT Health has **two phases**. The **first phase focused on community dialogues** that used citizen report cards to share information on the status of service delivery in government health facilities and surrounding communities. The citizen report cards were shared in dialogues with health workers and community members, and served as a foundation for participatory discussions and action planning. The **second phase focuses on people-centred advocacy** at the district level (and also includes a national-level advocacy pilot to address policy issues that require responses from national-level duty-bearers).

Randomised Controlled Trial on Community Dialogues

The first phase of ACT Health was designed to scale up a celebrated social accountability study conducted in Uganda in the mid-2000s that showed promising improvements in service utilisation and reductions in under-five mortality.[2] While the original study was implemented in a small number of health facilities (25 intervention / 25 control), ACT Health designed different variations of the programme across 376 randomly assigned health facilities in 16 target districts.[3] (GOAL and partners implemented programme activities in 281 health centres; the remaining 91 health facilities comprised the control.) The random assignment of health centres (and surrounding communities) to four different programme procedures established a counterfactual to better understand the effectiveness of different programme components. With this design, we intend to isolate the effectiveness of sharing information (citizen

1 Bjorkman M. and Svensson J. (2009). Power to the People: Evidence from a Randomized Field Experiment on Community-based Monitoring in Uganda. *Quarterly Journal of Economics* 124 (2): 735-69.

2 Bjorkman et al 2009.

3 Districts were selected to ensure geographical representation. Efforts were also made to avoid districts that were supporting other large-scale health accountability programmes. Programme districts include the following: Agago, Apac, Bukedea, Bundibugyo, Gulu, Kabarole, Kibaale, Katakwi, Kitgum, Lamwo, Lira, Manafwa, Mubende, Nakaseke, Pader, and Tororo.

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report cards) with communities and health workers, and conducting interface dialogues between health facility staff and community members. Data was collected at baseline (in 2014), at midline (in 2015, after 12 months of implementation), and at endline (in 2016, after 24 months of implementation).

To implement the RCT, GOAL partnered with Innovations for Poverty Action (IPA) and three principal investigators: Daniel Posner at UCLA, Pia Raffler at Harvard University, and Doug Parkerson at IPA. Results from the full study are expected in early 2018. We intend the evaluation to contribute to larger debates about social accountability–where it works, and where government leaders may need to be engaged in more direct ways than many social accountability approaches have traditionally allowed.

Responsiveness

Health centre staff use resources effectively and provide care in line with Ministry of Health standards in the Uganda Minimum Health Care Package.

Responsibility

Individuals have good care-seeking behavior. They seek preventive care (pre-natal, immunisation, testing, etc.) and go early for treatment of illness.

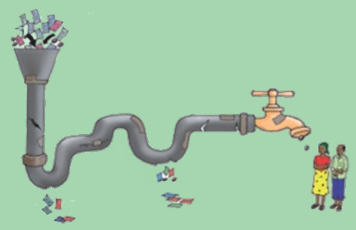
Relationships

Mutual understanding and trust between community members and health centre staff is strong. Includes understanding each other's constraints.

Effects of Weak Accountability

$10 million

Health staff/facilities have limited resources, but even these limited funds can be wasted through loss of drugs and absent staff. A conservative World Bank assessment from 2010 estimated that health worker absenteeism may cost the country's health sector as much as 10 million USD per year. [4]



The Two Models of Accountability

Through its two phases of programming, ACT Health explores the viability of two models of accountability: **social accountability**, which relies on community dialogues and the provision of information to strengthen the performance of health facilities; and **political accountability**, which involves training members of affected communities in how to develop and execute advocacy campaigns to compel duty-bearers within the government to properly monitor and enforce their own policies.

4 Okwero P. et al. (2010). Fiscal Space for Health in Uganda. World Bank Working Paper No. 186, Washington, DC. See also: Government of Uganda (2010). National Health Sector Strategic Plan III 2010-2015, p 21 (http://www.health.go.ug/docs/HSSP_III_2010.pdf)

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GOAL is an international non-governmental development and humanitarian organisation responding to the needs of people at the bottom of the pyramid and those in and recovering from crisis. Since inception in 1977, GOAL has spent over $1billion on humanitarian and development programmes in more than 50 countries across Africa, Asia, the Middle East and Latin America.

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