Social accountability
to improve family planning information and services

Social accountability to improve family planning

Enabling Environment

Appendix. Evidence-informed interventions

Table 1. Effects of social accountability initiatives that included family planning and intervention/control groups on HIP and intermediate outcomes from the theory of change

Intervention	HIP Outcomes (Reported by Providers)	HIP Outcomes (Reported by Clients/Communities)	Intermediate Outcomes/Benefits
Malawi (Gullo et al., 2017[1]; Gullo et al., 2018[2]; Gullo et al., 2020[3])			
CARE Community Score Card (CSC) using cyclical process, every 6 months over 2 years with community members (men, women, youth, vulnerable groups, power holders), health providers and power holders (including District Health Management Team): (1) meetings (community and providers separately) to identify barriers/ facilitators to service use and delivery, and develop measurable indicators (i.e., score card); (2) interface meetings to develop plans; and (3) monitoring. **Evaluation Design:** Cluster randomized control trial with women[1] Analysis of provider and community developed and rated Score Card indicators[1] Survey of all health workers in intervention and comparison sites at endline[3]	From Gullo et al. 2020[3] Health resources and services more equitably distributed, leading to improved access and use among vulnerable populations • Average age of clients counseled (younger) √, + Health sector actors' capacity to deliver quality and equitable family planning care is strengthened • Higher reported responsibility for comprehensive antenatal care counseling (including family planning) √, + • # women counseled about family planning in past month Ø • Client's partner present during last family planning consultation Ø • Details of last family planning consultation (e.g., private, asked about having a child) Ø	From Gullo et al. 2017[1] Client experienced improved quality of care that is responsive to their needs • Satisfaction with services (family planning included) √, + (DID analysis ±) • Felt respected, increased confidentiality, decision respected Ø • Information provided (e.g., explain method use, side effects) Ø From Gullo et al. 2018[2] Improved trust in the health system among community, providers, and health authorities • Trust in health workers √, -	From Gullo et al. 2018[2] Community members have increased ability to express needs and participate in dialogue with health actors* • Received help from community group √, + • Participated in community groups √, + • Equity (inclusion of marginalized) and quality of CSC meetings and processes √, + • There is a Community Action Group or Safe Motherhood Committee √, + • Power sharing for decision-making between health service and community Ø • Community and community & health actors can work together to achieve outcomes Ø *continued next page*

Intervention	HIP Outcomes (Reported by Providers)	HIP Outcomes (Reported by Clients/Communities)	Intermediate Outcomes/Benefits
Malawi (Gullo et al., 2017[1]; Gullo et al., 2018[2]; Gullo et al., 2020[3])			
			continued from previous page Solutions are implemented and collectively monitored, with adaptations as needed • Joint monitoring and transparency between community and health system √, + • Service changes made √, + • Perceived positive changes in health services √, + Community and health system actors have increased mutual understanding of their respective needs and constraints • Mutual responsibility for meeting needs of women/marginalized groups √, -
Uganda (Björkman and Svensson, 2009[4]; Donato et al., 2019[5])			
Community report card approach with community member meetings to discuss report card and rights, and to develop and prioritize a plan to improve services; a meeting with the health facility to discuss report card; an interface meeting to discuss and develop a shared action plan (including monitoring), and follow-up meetings over 6 months. **Evaluation[4]:** Cluster randomized controlled trial, with data collected pre- and post (1 year) from providers and community members **Replication[5]:** Used data from Björkman and Svensson (2009) to replicate and extend analyses (e.g., include process measures, assess and address balance in treatment and comparison communities). Analyses yielded similar results.	Clients experience improved quality of care that is responsive to their need • Reduced time spent at the facility (less waiting time) √, + • Equipment used during examinations √, + Health sector actors' capacity to deliver quality and equitable family planning care is strengthened • Suggestion box √, + • Numbered waiting cards √, + • Posters informing clients of free services √, + • Ratio of workers not physically present at time of survey √, + • Management of clinic (condition of floors, walls, furniture) √, + • Reduced share of months in which facility indicated no availability of drugs √, +	Clients experience improved quality of care that is responsive to their needs • Health information received • Received information on importance of family planning	Community members have increased ability to express needs and participate in dialogue with health actors • Discuss the functioning of the health facility at a local council meeting in the last year √, + • Receive information on the Health Unit Management Committees roles and responsibilities √, +

Intervention	HIP Outcomes (Reported by Providers)	HIP Outcomes (Reported by Clients/Communities)	Intermediate Outcomes/Benefits
Uganda (Boydell, V. et al, 2020[6])			
Intervention: Brought together service providers and users to assess service delivery problems and find a way to address them using a community scorecard approach. In addition to scorecard activities, activities to strengthen accountability were also implemented (e.g., training to health providers, officials, CBOs, and communities on health rights, accountability, and family planning). **Evaluation:** Descriptive case studies with document review and qualitative data collection.		Improved trust in the health system among community, providers, and health authorities • Increased confidence in health system More supportive community/social and gender norms around family planning • More positive attitude towards family planning, which has become a legitimate public concern	Community members have increased ability to express needs and participate in dialogue with health sector actors • Increased awareness of health issues (community scorecard approach) • Increased empowerment, to raise voices (community scorecard approach) • Increased diffusion of information (community scorecard approach) Community and health system actors have increased mutual understanding of their respective needs and constraints • Increased knowledge about entitlements and expected standards of care • Mutual understanding between community and health system, e.g., health system actors saw community inputs as useful
Uganda (Boydell, V. et al, 2020[6])			
Intervention: Community dialogue approach bringing together groups of village members to identify the issues they faced when accessing family planning. Used village-level women-only Pressure Groups (PG), Female Champions, Male Role Models (MRM), and women's groups. These specially trained groups interacted with local health authorities to advocate for change and reported back to the village groups. This cycle was repeated on a quarterly basis. In addition, the village participants engaged in health promotion for family planning work and set up self-help groups. **Evaluation:** Descriptive case studies with document review and qualitative data collection.		More supportive community/social and gender norms around family planning • More positive attitude towards family planning • Some myths and misconceptions about family planning dispelled • Increased male engagement in family planning	Community members have increased ability to express needs and participate in dialogue with health sector actors • Many self-sustaining women's groups were formed and were so successful that they registered with the local authorities as independent organizations so they could access additional funds. Community and health system actors have increased mutual understanding of their respective needs and constraints • Family planning became a legitimate public concern Barriers/issues and their solutions are jointly agreed upon • A district-wide platform to coordinate family planning was established Solutions are implemented and collectively monitored, with adaptations as needed • Budget lines for family planning were secured

Key

√ statistically significant

Ø not statistically significant

\+ Positive association

\- Negative association

* Among 284 women in intervention communities aware of CSC (around one-quarter of the sample in the treatment area), assessed association between participation (yes/no) and intermediate governance outcomes.

±DID = difference in difference analysis

Qualitative = no tests for statistical significance

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The *Social accountability to improve family planning information and services* brief is available from: http://www.fphighimpactpractices.org/briefs/social-accountability/