

Community score cards and citizen report cards in Uganda; What facilitates and constrains implementation?

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Abstract

Background; While there is some evidence about the effectiveness of social accountability initiatives using citizen or community reporting through report cards or scorecards, respectively, much less has been published about the facilitators and barriers to their implementation in low income countries. This paper aimed at identifying the facilitating factors and barriers to the implementation of community score cards (CSCs) and citizen report cards (CRCs) within the health sector in Uganda.

Methods; We carried out a qualitative study between November 2017 and February 2018 among nine respondents from implementing partner organizations who had worked on CSC or CRC projects. Data collection was guided by a key informant interview guide and analysed using a thematic approach.

Results; The key factors that enhanced implementation of CSCs and CRCs included the implementing partners' provision of capacity building and continuous support to implementing teams, broad stakeholder ownership and engagement at the district and community level, problem solving mind-set across actors, advocacy and linkage with high level networks such as ministry of health Technical working groups. The factors that hindered successful implementation included community fear of reprisal by health workers and on the other hand, health worker fear of reprisal by supervisors and enlightened empowered communities, political compromise with a reduction in community voice because of the monetary incentives given to citizens by politicians, as well as a strong dependency culture among citizens, and fragmented implementation.

Conclusions; Local implementation factors such as wide scale involvement of local stakeholders, community empowerment and capacity building are essential for successful implementation of social accountability initiatives. Their wide scale implementation requires

national guidance and leadership. This would allow the development of a guiding framework for the implementation of CSCs and CRCS, subsequently enhancing integration of implementation into planning structures, work plans and budgets of relevant sectors including public agencies, civil society organizations and political actors who play a key role in accountability. Brokering partnerships between communities and stakeholders at subnational and national levels is also important for the tackling of more upstream issues identified during CSC and CRC processes.

Keywords; community scorecards, Citizen report cards, accountability, facilitators, barriers

Background

Improving the responsiveness of the health system to ensure efficient and effective delivery of health services has been an on-going challenge especially in low-and middle income countries (1, 2). It calls for the involvement of all stakeholders including health workers, political leaders, donors, and most importantly the citizens (2, 3). When empowered, citizens can influence policy, strategies and expenditure priorities at different levels of the health care system(4). Indeed individual citizens and groups can ensure that beneficiaries receive timely and quality services that address their needs and respond to their expectations by using systematic tracking of processes and activities (5). By doing this, citizens are able to hold providers accountable.

Accountability comprises of two main aspects; answerability “*the obligation of an individual or agency to provide information and make justification for their actions to other actors*” and enforcement “*the imposition of sanctions in response to the failure of power-holders to uphold their duties*”(6). From a health care standpoint, accountability is critical for reducing inappropriate use of public funds and authority, ensuring that duty bearers respect societal and professional values and standards, and augmenting service delivery and management through enhanced feedback and learning processes (7). Brinkerhoff (8) further categorizes

accountability mechanisms in the health sector as external, regulating answerability between the community and the health system and internal, focusing on bureaucratic mechanisms that regulate answerability within different levels of the health system.

Whereas these internal bureaucratic structures for accountability exist in developing countries, they are often non-functional and therefore unable to effectively hold providers accountable. Informal spaces for lodging complaints and dialogue are also similarly limited (9, 10). These weaknesses have contributed to the heightened interest in social accountability (11). Social accountability has often been defined as a type of accountability in which citizens play an active role in holding health providers and other duty bearers accountable. Social accountability tools that have been commonly used in the health sector include: citizen report cards (CRCs), participatory monitoring, budget analysis, expenditure budget tracking, social audit, public hearings, as well as CSCs (9). The CRC is a demand- side oriented tool used to solicit user feedback on service provider performance (12). The CSC is a hybrid of social accountability tools such as social audit, the citizen report card, participant defined quality and the balanced scorecard (13, 14). It is a participatory tool that has been employed to monitor and evaluate the performance of services, projects and government administrative units by the community (15).

The accountability landscape in Uganda features several mechanisms, including facility management boards, district councils, and cross-sectoral community dialogues at the sub-county level, also called “barazas”. However, these structures are not consistently functional (16-18). Several organizations in the health domain have previously employed the CSC and the CRCs. These organizations have used CSCs as a tool for advocacy and to engage the community in assessing the quality of services being provided by government and non-governmental organizations. The CSC and CRC have generally been implemented in all the

four main regions of the country including; Northern, Eastern, Western and central Uganda. The Ministry of Health (MoH) has also developed several national score cards, that are used to measure achievements in addressing Reproductive, Maternal Child and Adolescent Health (RMNCAH) targets, as well as progress against the health sector development plan. The RMNCAH is a facility scorecard which mainly captures supply side issues such as number of institutional deliveries, maternal mortality rates among others (19). Unfortunately Uganda's RMNCAH score card does not capture demand side issues (such as affordability of transport to maternal health clinics, support by male partners during pregnancy and at the time of birth).

While there is some evidence about the effectiveness of the use of CSCs and CRCs, much less has been published about the facilitators and barriers to the implementation of CSCs and CRCs in low income countries (20). The existing studies do not provide a detailed account of local contextual factors and how they influence the implementation of the community score card process. Existing studies report that effective implementation of CSCs require an understanding of the local socio- political context, skilled facilitators, strong public awareness campaigns, active participation and buy-in from service providers and public agencies, implementation of locally relevant and feasible solutions, as well as coordinated and strategic follow up actions (21, 22). The barriers that were highlighted included securing and maintaining participation from different groups of stakeholders, inadequate national level advocacy and engagement(22). On the other hand, a recent systematic review on social accountability tools that included CSCs, CRCs, health facility committees and patient charters (23) identified engaging different stakeholders, use of local contextually based tools, increasing trust between citizens and leaders, increased clarity of roles, standards and responsibilities, financial and technical support from experienced groups and meaningful citizen and community involvement as the key facilitators for promoting social accountability. In addition, the review highlighted the lack of external financial and technical inputs, weak community

leadership and lack of community commitment to sustain the initiatives as factors that hindered implementation of social accountability interventions (23).

For interventions to be sustained or institutionalized, the financial, political, organizational and social environment need to be supportive and their designs need to be in synchrony with existing structures(14). The paper aims to identify barriers and facilitators to the implementation of CSCs and CRCs within the Ugandan health sector, focusing on how different CRC and CSC implementation models engage communities. These facilitators and barriers will be useful for guiding the design and implementation of initiatives aimed at promoting wide scale use of CRC and CSC initiatives that are aimed at promoting wide scale use of CSCs and CRCs in resource constrained settings.

Methods

Study design and aim,

We carried out a qualitative study between November 2017 and February 2018 with an aim of identifying facilitating factors and barriers to the implementation of community score cards (CSCs) and citizen report cards (CRCs) within the health sector in Uganda.

Study setting and participants

The study was carried out among respondents from implementing partner organizations who had implemented CSC or CRC projects in Uganda within the previous 10 years. We used a ten year period because we felt this would allow us to include respondents who had sufficient institutional memory to provide the answers required. Through an initial landscaping exercise on the use of CSCs we identified key institutions that had been involved in implementing CSCs and citizen report cards in Uganda, and then we identified at least one to two individuals who had been actively involved in implementing CSCs from each of these institutions. The

institutions included UNHCO-1 interview, UNASO-1 interviews, AGHA-1, ACODE-1 interviews and UNICEF (CODES)-2 interviews, and CFI-3 interviews.

Data collection

Data collection was guided by a semi - structured interview guide that aimed to identify the experience that implementers had in implementing CSCs and CRCs, achievements obtained in the projects that they had participated in as well as facilitators and barriers to the implementation of CSCs and CRCs. Senior researchers with experience in conducting qualitative research carried out and audio-recorded all key informant interviews in English.

Data management and analysis

Research assistants transcribed the interviews verbatim. We analysed the data using a thematic approach. The explored themes related to barriers and facilitators of CSC and CRC implementation and institutionalization. The transcripts were read several times by the researchers to allow them to familiarize themselves with the findings. A team of researchers that included EEK, SK, and RRA identified the codes that they expected to find in the data in terms of specific barriers and facilitators of CSC and CRC implementation and institutionalization and used this to develop the initial codebook. These included codes such as high cost of implementation, consultation of stakeholders, capacity of the facilitators. NN and EEK manually coded the transcripts and added additional codes during the coding process, as they emerged from the data. The themes emerging from the data were then identified and summarised. The list of themes was later reviewed to ensure that it covered all key issues contained in the data. Quotes illustrating meanings or key messages from the analysis were selected and some of them were presented during analysis.

Results

The principal themes that formed during the analysis included capacity building and continuous support to implementing teams, broad stakeholder ownership and engagement, problem solving mind set, advocacy and linkage with high level networks while the factors that hindered implementation included fear of reprisal, political compromise coupled with a dependency syndrome as well as fragmented implementation.

Description of the projects represented by KI's

Table 1 summarizes the characteristics of the projects from which the key informants were selected. The key informants interviewed had been involved in the implementation of projects that employed CRCs and/or community score card projects. Several of them were involved in the CODES project. This project used the lot quality assurance survey (LQAS) methodology to collect data that was presented to the community through the CRCs. The community dialogues were held to identify community problems and solutions and CODES committees, that comprised of a team of volunteers selected by the team, were given the responsibility of ensuring that agreed upon actions were implemented. Changes in the indicators selected were captured using the CRCs and reported in subsequent dialogues. Further details about the codes project is described in the paper by Katahoire et al (24). The other key informants were involved in community score card projects which worked with local communities to identify local problems and to identify solutions to these problems. This effort was often led by a project team which worked in collaboration with community and district leaders to implement the project. Their implementation mode often followed the commonly used procedure for implementing CSCs (22).

Capacity building and continuous support to implementing teams

Almost all key informants said that building capacity of implementing teams and local technical and political stakeholders, including community members, is important for equipping

the local stakeholders with the skills required to participate in the implementation process. This would enable them to select and collect locally-relevant indicators and communicate relevant messages, hence enhancing the implementation of CSCs and CRCs. This is even more critical for the CRCs where data collection and analysis is more complicated.

Capacity building was also noted to be important for continued implementation after the end of a project. Some respondents mentioned that CSC and CRC models that rely on NGO's that are not based within the district, often do not build the capacity of local implementers adequately enough for them to continue implementing the score card activities after the exit of the project. One of the key informants pointed out that;

"I think what I can say is that you see it is (capacity) at organization level especially among the NGOs because they are the ones that have been largely involved in this and it is hard for us to really say with certainty that there is capacity at community level because otherwise if capacity was there why are these community initiatives not continuing where these projects have been if there was capacity then these initiatives would continue..... So the projects have rolled back with their capacity in my view back to the headquarters. (KI Respondent 2)

It was noted that sometimes NGO's who conduct CSCs are based in the capital city and do not have offices in the districts. Such NGO's that are external to the district could still play a key role in supporting districts to sustain implement the scorecard if they work with local NGO's that are based within the districts they are supporting to implement the score card processes or if they set up a system that is embedded within the existing structures and that can be used for continued support and monitoring of the local NGO's after the project ends.

“, if some project stops, there should be a system that can continue for some time not to stop once and leave, when you leave it also stops..... like now for us we stopped in

December 31st the project is over staff who were at [...] dispersed, so as I talk now I don't think there is anybody, who is mindful of what is happening in the district..... so there should be some leg, if it is a 5-year project, at least leave a skeleton or leave like few people to continue helping the district until it is fully institutionalized” (KI Respondent 3)

One of the key informants reported that in areas where they had built capacity among the local stakeholders and local NGOs, community dialogues were being conducted even after the project had ended.

Capacity building was particularly important to ensure skilled facilitation for community meetings. Skilled facilitators who can build rapport with the community and create a safe environment for dialogue and negotiation were identified as a key ingredient for implementing CSCs and CRC's by the majority of key informants interviewed.

“Aaah starting the whole process of getting between the communities and the duty bearers this in most cases can be hard, hard in terms of creating that constructive dialogue such that people have an open discussion, there is an initial friction that happens normally between health workers and the communities. So you need to help them overcome that process otherwise it can abort before it becomes successful so you must have a mechanism to take them through this until they reach a point where they begin to sit on the table and discuss these matters” (KI Respondent 3)

Human, financial and non-financial resources

Human, financial and non-financial resources were also noted to be essential for a successful engagement process. The CSC processes needed to attract the involvement of influential people who had the power and authority to demand for specific action from role bearers. For example,

217 in one of the projects, a newly built health centre did not have lighting and one of the leaders
218 was tasked with the responsibility of ensuring there was lighting in the health facility.

219 *“a very big, beautiful maternity ward lacked lighting, so when she went in the evening*
220 *..... she got a midwife actually conducting a delivery using the torch in her small*
221 *phone..... she told the sub county chief that I want electricity (in this health centre),*
222 *because the electricity pole was actually inside the compound of the facility....., the*
223 *sub county chief was like no no this must be a top priority for the next financial year*
224 *and they now have electricity” (KI Respondent 4)*

225 Inadequate financial resources were one of the major barriers that was mentioned by almost all
226 the key informants. It was reported that implementing a scorecard is very expensive due to
227 costs such as facilitation of meetings, paying human resources and following up on agreed
228 actions. Following up of actions is further constrained by the poor functionality of some of the
229 structures that could be used to follow up CSCs. This poor functionality limits their usefulness
230 in monitoring and tracking implementation of scorecard activities.

231 Indeed, continuous support through additional funding was pointed out as a key requirement
232 for continued implementation by some of the respondents. It was suggested that this funding
233 could be provided through existing budget lines, if the score card process is considered one of
234 the normal accountability processes.

235 *I think they should be institutionalised in the district plan, and investment put, because if*
236 *they are institutionalised then they are budgeted for, in a way they will sort of like be*
237 *sustainable, instead of getting this one NGO which pops in and the other goes and another*
238 *comes in if they are institutionalised in district plans and people are taken through, how to*
239 *do them it becomes part of the performance review approaches (KI Respondent 5)*

Furthermore, many projects in Uganda provide monetary facilitation for people who facilitate programs even when these programs are included in their job descriptions. This has made it difficult to sustain CSC processes in the absence of money to pay the facilitators. The community is also often facilitated for attending meetings through transport refunds and provision of drinks at the meeting. In the absence of this facilitation they also sometimes refuse to come to the dialogue meetings. Lastly half of the key informants said that implementing a scorecard is time consuming and comes along with fatigue of stakeholders. They also reported limited decision space and conditional transfer of funds as a constraint, which made it difficult to implement CSCs, since the priorities identified could not be addressed.

“the decision space; that is the ability of a leader to make decisions based on the local situation without much hindrance and the fiscal space; the amount of money they have to reallocate things is so thin and limited that people can’t do anything about it so I think the score card is being introduced in a context in which resources are tied, so limited and tied up” (KI Respondent 1)

Stakeholder ownership and engagement

The majority of the key informants emphasized the importance of broad stakeholder engagement and community ownership as a facilitating factor for successful implementation. Inclusion of all key stakeholders and their early involvement in the planning and implementation phases of the scorecards were reported to be essential for enhancing local ownership. Furthermore, appreciation of outputs of the scorecard process among the different stakeholders facilitates stakeholder buy in and consequently contributes to successful implementation as this arouses and maintains interest among stakeholders.

It was further stressed that making the scoring process responsive and tailored to community needs increases the participation of stakeholders in the community scorecard and citizen report

264 card implementation. With regard to the CRCs, it was reported that if agreed actions are not
265 implemented, stakeholders may lose interest in continuing to analyse data for the development
266 of the CRC and “burn out”

267 *“Actually for burnout I need to even qualify it, the burnout usually happens when*
268 *analysis is done on some activities and nothing is done so it kills the motivation and the*
269 *next time you will not be asking people to do an analysis on the same thing”*

270 Constructive engagement enabled different stakeholders such as politicians, health workers,
271 and community members to express their views freely, to identify local service delivery
272 problems and to identify what each party can do to solve the service delivery problems as
273 explained in this quotation.

274 *... So beyond people asking questions they also ask themselves questions; on our part*
275 *what have we done and on the part of those who should be providing services what*
276 *have they done and they are able to reach a consensus on what needs to be done to*
277 *improve service delivery so overall you will see uptake of services improving when*
278 *these score cards are well implemented. By the way the other thing that I think people*
279 *don't know with these scorecards is the fact that there is constructive engagement that*
280 *occurs.” (KI Respondent 1)*

281 It was reported that for constructive stakeholder engagement to occur, the community must be
282 empowered. Half of the key informants mentioned that in order for the community to hold the
283 duty bearers responsible, it is important to sensitize the community so that they know their
284 rights, responsibilities, roles and the services that they are entitled to as well as the rights and
285 roles of the service providers.

286 *“The real empowerment that we talked about in this score card process must be to*
287 *equip the citizens- not you as the project staff to go and ask on their behalf, it must*
288 *equip them to be able to identify these problems, it must equip them to be able to engage*
289 *directly with the district leadership and management on these matters...”* (KI
290 Respondent 2)

291 Furthermore, good leaders were considered essential for ensuring that suggestions that are
292 identified during the dialogue meetings are actually carried out. Leadership was noted to be
293 important for both technical and political leaders, since they are all instrumental in leading
294 different initiatives. The importance of allowing the local stakeholders to lead the process, was
295 explained by one of the key informants while clarifying the role that he felt implementing
296 partners should play in the implementation process by saying;

297 *“...And you play more of a monitoring role, you let the district take lead otherwise*
298 *when you build parallel systems you will end up suffocating the district. When you leave*
299 *they will go back to their normal operations so you need to let them work within their*
300 *normal operations but then twist them a bit, tap them a bit to see that.....”* (KI
301 Respondent 6)

302 **Advocacy and linkage with influential networks**

303 Respondents across projects emphasized that it is critical to identify platforms and partners
304 who can advocate for the actions agreed upon especially when these actions are beyond the
305 control of the community. At the lower level, these platforms included for example district
306 councils. At the ministry level it included for example technical working groups or discussions
307 with the ministry of finance as described below.

308 *“Our presence within the technical working groups somehow has pushed most of the*
309 *health sector issues progressively towards addressing them, so in the technical working*

310 *group meetings, we usually present and say okay from our ground presence these are*
311 *the issues that are at the health facility and we think these are the recommendations to*
312 *address them, so issues of staffing, funding, but overall also issues of accountability”*

313 (KI -Respondent 5)

314 Coalitions with other CSOs were also used to put pressure and advocate for required actions.
315 Having a common coordinated voice and relevant evidence was important for convincing the
316 stakeholders with power that specific action was required.

317 The other themes that emerged were highlighted by a minority of the key informants and
318 included lack of a problem solving mindset, fear of reprisal; political compromise coupled
319 with a dependency syndrome as well as fragmented implementation.

320 **Problem Solving Mind set**

321 A few respondents also noted that successful stakeholder engagement thrives in a community
322 that has a problem-solving mind-set so that they come to the meeting not to look for faults and
323 blame duty bearers but rather to look for a solution. This was emphasized by one of the
324 respondents:

325 *“I have been telling people that come with your brains don’t leave them behind*
326 *because the moment you don’t come with your brain this work is cumbersome it calls*
327 *for you to think it calls for you to move out from the norm..... most of our people*
328 *don’t want to think like that they want to think like this is how we do our thing, we have*
329 *always done it like this even so and so was here and we did it like this” (Respondent 9)*

330 In the Ugandan context, some politicians have made people believe that government will
331 provide all the requirements needed for service delivery free of charge. Communities that hold
332 this view strongly may therefore not be willing to contribute any resources towards their health

333 service delivery. This dependency syndrome can therefore hinder self-help initiatives that are
334 initiated through CSCs or CRs.

335 *“I would say one thing is for sure they (the community) need to stop this mentality*
336 *of thinking [that government is the one to solve all their problems] “government*
337 *etuyambe” they need to move from that to more of what can we do for ourselves and*
338 *that one does not come with a snap of a finger it requires first of all to work with them*
339 *so then they have the other thing I was saying the mindset, you need to have their mind-*
340 *set change from them saying government help us to I think we can do this for ourselves*
341 *we can do this because you need to encourage them to contribute a certain level before*
342 *they come to government”* (Respondent 8)

343 **Fear of Reprisal**

344 In addition to the issues listed thus far, one of the other barriers mentioned by a minority of
345 the key informants was fear of reprisal both among duty bearers and the community members.
346 Some of the health workers feared that they may lose their jobs if they provide the community
347 and other role bearers with too much information, which may then encourage the community
348 and other leaders to hold them accountable and subsequently find them at fault if they are not
349 carrying out their expected duties. Similarly, some of the community members also feared that
350 if they complain about the health service providers, they may be denied services.

351 *“.....now here a person is empowered and he feels that there is a problem, and he feels*
352 *like taking the initiative to push for change but now here is a poor lady who gets*
353 *services from this very health facility, which is a public health facility where they expect*
354 *relatively free services, and now when she goes there and reports, to either sub county*
355 *or to any other official, there was that fear that once am identified, that once, a person*

356 *comes to realize it's me, I will be denied services and I don't have another alternative,*
357 *because I can't afford a private health facility, that was one.” (KI Respondent 6)*

358 **Political Compromise**

359 Political compromise was also highlighted by one key informant as a barrier. In the Ugandan
360 context politicians often give citizens money and other basic requirements such as sugar, hoes
361 etc. in exchange for their votes. Subsequently, some community members find it hard to hold
362 accountable the same person who gave them these gifts.

363 *“[...] there was also another issue of political compromise during elections, these are*
364 *the people who give out, material things during elections like soap, salt, he is a leader,*
365 *he is a chairperson LC2, LC3, LC5, now at the end of the day, you realize that actually*
366 *most of the issues that are happening at the health facility, for example at the lower*
367 *level health facilities, HC2, HC3, is because there is inadequate monitoring and*
368 *supervision and who monitors? It's the politicians, so which means it is the politician,*
369 *who is accountable and who should be accountable, but how will the person, who*
370 *received some material gifts from the person he is trying to hold accountable [take*
371 *action], will he or she really hold her/him accountable?....” (KI-Respondent 7)*

372 **Fragmented Implementation**

373 Two of the key informants who are affiliated with academic institutions held the view that the
374 role of CSCs within the health sector has not been clearly stipulated or communicated to key
375 implementers and the public. Secondly, they felt that there is no standard way of implementing
376 CSCs hence different implementers have used different models and different methods to
377 implement CSCs. This has therefore led to fragmented implementation of the CSCs in the
378 country with a multiplicity of scorecards that are not harmonized.

379 **Discussion**

380 Social accountability initiatives such as CSCs and CRCs have been present in Uganda for a
381 long time, yet usually remained local and at a small-scale. Our exploration seeks to understand
382 the factors that could enhance the implementation of such social accountability interventions,
383 in hopes that these could inform future initiatives. Our work identified the following key factors
384 that could enhance implementation of CSCs capacity building and continuous support to
385 implementing teams, broad stakeholder ownership and engagement, problem solving mind-set,
386 advocacy and linkage with high level networks. On the other hand, the factors that hindered
387 implementation included fear of reprisal, political compromise coupled with a dependency
388 syndrome as well as fragmented implementation.

389 National leadership in guiding implementation of CSCs and CRCs is critical for their
390 successful implementation and for implementation at scale. Although CSCs and CRCs have
391 been implemented in Uganda over the past two decades, there is still no wide scale application
392 of these tools within the health sector. Most of the community score card projects in Uganda,
393 have been implemented by NGOs. Whereas implementation that is largely led by NGOs was
394 successful in achieving the desired objectives (24), often the NGOs did not leave in place a
395 system that could support continued implementation. This has subsequently led to a situation
396 where there is a plethora of fragmented implementation efforts by different NGOs
397 implementing different types of score cards using different methods, inadequate capacity
398 building of local stakeholders to implement the score cards and subsequently lack of
399 continuity of implementation of the score cards after the project exits.

400 Firstly, the national leadership needs to provide a guiding framework for the implementation
401 of CSCs and CRCs. This would include identifying key features of the scorecard or citizen
402 report card that should be implemented nationally by districts and partners who can further
403 adopt it. Secondly it needs to provide a guiding framework for the implementation process.

404 This would include identifying key structures that are to get involved in the implementation of
405 CSCs. The capacity of the local stakeholders and other non-state actors to implement CSCs
406 should inform the implementation model employed as well as selection of structures that are
407 to be used. Inclusion of government structures can give the CSCs and CRC's the stability and
408 legitimacy that is required for its continued implementation, while inclusion of non-state actors
409 provides the objectivity that is essential in social accountability. Work by Wild showed that in
410 some contexts it would be futile to insist on working outside or against the public agencies,
411 and some degree of alliance often yielded more positive results compared to none at all (21).
412 Furthermore, if wide scale implementation is desired predictability of donor funding on which
413 many non-state agencies depend and nationwide presence of these agencies especially in more
414 rural areas needs to be carefully considered.

415 Thirdly it needs to guide allocation of resources that can be used for wide scale implementation
416 and for investment in building the capacity of these institutions. This could also allow
417 government to coordinate resources from NGOs involved in implementing CSCs allowing for
418 their equitable distribution throughout the country and systematic long term investment in
419 capacity building initiatives meant to strengthen and support implementation at local level.
420 This kind of capacity building should eventually equip the community and its leaders with the
421 skills necessary to support and to push for inclusive service delivery in their communities on
422 their own.

423 Fourthly, government can provide a framework for its integration into planning structures,
424 work plans and budgets of relevant sectors including government agencies, NGO oversight
425 structures and political actors who play a role in accountability. This would make it easier to
426 feed issues identified during the score card implementation into management and decision-
427 making platforms at subnational and national level. Such decision-making platforms would

428 then have the responsibility of addressing the problems identified. This would create a
429 conducive environment for wide scale implementation of the community and citizen report
430 cards.

431 While government needs to play a central role in guiding implementation, the importance of
432 local stakeholder ownership and engagement during implementation of community scorecard
433 and citizen report card processes cannot be over emphasized. It aids active participation of
434 community, political and technical stakeholders which is critical in facilitating implementation
435 of the score card and achieving the desired objectives (9, 22-24). This also allows communities
436 to participate more actively in improving their health as co producers of their health(9) . Lastly
437 stakeholder ownership and engagement also promotes the formation of partnerships and
438 coalitions that have been noted to increase achievement of agreed outputs (25). A deliberate
439 effort therefore needs to be made to involve key local technical and non-technical leaders who
440 have the power to initiate the actions required to bring about desired changes. In Ghana,
441 involvement of local chiefs led to more successful implementation of a maternal and new-born
442 CSC project (26). There is evidence that the effectiveness of local leaders in holding providers
443 accountable is sometimes hindered by their limited knowledge about the rights and
444 responsibilities of communities, providers and different role bearers or by lack of clarity about
445 their roles(5, 22, 23). Community score card processes have been shown to be instrumental in
446 empowering local leaders with the information that they need, as well as clarity about their
447 roles with regard to accountability(9, 23, 26). Additionally, in some cases the problems
448 identified during the community engagement process can not be solved locally. They need the
449 involvement of highly placed officials who belong to networks that can influence upstream
450 issues or highly politicized issues. Brokering of partnerships and linkage with networks that
451 are influential enough to bring about desired changes at the local or national level come to play
452 in such situations (21).

453 Social accountability approaches are hinged around the active involvement of citizens, their
454 adequate preparation before implementation starts is therefore of paramount importance. This
455 preparation should include both sensitization about the CSC and CRC implementation process
456 and community empowerment. In the absence of this, they may have expectations of providers
457 that are not aligned with the roles and rights of the providers (22, 23). Such misunderstandings
458 can lead to conflicts between the community and the health workers. On the other hand, some
459 of the communities may not be aware that they are supposed to provide oversight and can
460 therefore hold providers accountable(10, 24) especially in an “*environment where providers*
461 *are seen as demi gods who hold the keys to good health*” Furthermore, they may fear to voice
462 their complaints, thinking that they will be denied services or will be mistreated if they
463 complain about the services provided to them (22). Additionally, implementers need to be
464 aware of the power dynamics that often manifests through fear of reprisal, political compromise
465 and a dependency syndrome that can dampen efforts to get communities actively involved in
466 solving health service delivery and utilization problems (10). Skilled facilitators and buy in and
467 active participation of influential local leaders becomes very important in neutralizing such
468 negative influences. Engagement of political leaders and community leaders early is important
469 for getting them on board so that they can support such initiatives that encourage the
470 community to take charge of their health and local problems. Their early involvement in the
471 CSCs and presentation of community score card objectives in a manner that allows them to
472 appreciate the usefulness of the score card can be instrumental in getting their support. Lastly,
473 our work brought to light the importance of the community having a problem-solving mind-
474 set. This kind of mind-set creates an enabling environment for constructive engagement and
475 for the generation of local initiatives that could solve local problems identified through the
476 CSC and CRC process.

Study limitations and strengths; Since this is a purely qualitative study it was not possible to accurately quantify the extent to which the different factors facilitate or constrain implementation. Recall bias may also have influenced the findings since some respondents had implemented the projects some years back. However the kind of information we collected is unlikely to have been heavily influenced by recall. Furthermore we interviewed several key informants to allow us to get a wide variety of experience and so we are confident that we captured the key issues. Although all the experiences reported are from work done in Uganda we believe that the findings are generalizable to other low and middle income countries.

Conclusions

Although CSCs and CRCs have been piloted in many countries few countries have scaled them up nationwide. According to our findings some of the key positive influencers of implementation included capacity building and continuous support to implementing teams, broad stakeholder ownership and engagement, having a problem-solving mind-set, advocacy and linkage with high level networks. On the other hand, negative influencers included fear of reprisal, political compromise coupled with a dependency syndrome as well as fragmented implementation. Additionally, our work highlights the key role that national governments can play in guiding wide scale implementation through developing a guiding framework for the implementation of CSCs and CRS and ensuring integration of implementation into planning structures, work plans and budgets of relevant sectors including public agencies, NGO oversight structures and political actors who play a key role in accountability. This is likely to promote coordinated implementation and leveraging of resources that exist among non-state actors so as to allow long term systematic funding and investment of the funds into building local capacity and support for continued implementation of community and CRCs. Brokering partnerships at subnational and national level is also important for the tackling of more upstream issues. This calls for deliberate efforts to engage and link with influential people

from the onset of the process. Lastly power dynamics that manifest through fear of reprisal, political compromise and a dependency syndrome need to be countered through community empowerment and early engagement of influential actors who can counteract such influences and instead promote the development of a problem-solving mind-set in the community that can heighten community efforts to improve health.

List of Abbreviations

CSC	Community Scorecard
CRC	Citizen Report card
ACODE	Advocates Coalition for Development and Environment
NGO	Non-Governmental Organization
LC	Local council
HC	Health centre
AGHA	Action Group for Health, Human Rights and HIV/AIDS
CSOs	Civil society organizations
UNHCO	Uganda National Health consumers Organization
UNASO	Uganda Network AIDS Service Organisations
UNICEF	United Nations Children's Fund
CFI Child	Fund International
RMNCAH	Reproductive maternal Newborn child and Adolescent Health

Declarations

Ethical approval and consent to participate

Ethical clearance for the study was obtained from the Makerere University School of Public Health Higher Degrees, Research and Ethics Committee (MakSPH HDREC) and the Uganda National Council of Science and Technology (UNCST) (study number SS 4323). The

526 objectives, benefits and risks of the study were explained to the study participants and written
527 informed consent obtained from all the study participants. All data obtained during the study
528 were treated as confidential and anonymous identifiers were used. We restricted data access to
529 only the investigators and the research assistants.

530 **Consent for publication**

531 Consent to publish the findings of the study was obtained at the point of seeking consent to
532 participate. The participants' confidentiality and anonymity while reporting was assured.

533 **Availability of data and materials**

534 The data used to undertake this study is safely stored by the monitoring and evaluation team of
535 the FHS study at Makerere University School of Public Health.

536 **Competing interests**

537 We declare no conflict of interest

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541 **Authors' contributions**

542 All authors contributed towards the conceptualization of the paper. EKK and NN and RRA led
543 the drafting of the manuscript. NN did the data coding and EEK conducted the analysis for the
544 study. All authors reviewed the drafts, provided significant intellectual input and approved the
545 final manuscript.

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