Use of Community Health Data for Shared Accountability

Guidance

February 2018

USAID
FROM THE AMERICAN PEOPLE

MEASURE Evaluation

Use of Community Health Data for Shared Accountability

Guidance

Tariq Azim, MBBS, DCM, MEASURE Evaluation, John Snow, Inc.
Binyam Tilahun, PhD, University of Gondar
Stephanie Mullen, DrPH, MEASURE Evaluation, John Snow, Inc

February 2018

MEASURE Evaluation
University of North Carolina at Chapel Hill
123 West Franklin Street, Suite 330
Chapel Hill, NC 27516 USA
Phone: +1 919-445-9350
measure@unc.edu
www.measureevaluation.org

This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of the MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government.
TR-18-238

ISBN: 978-1-64232-009-1

USAID
FROM THE AMERICAN PEOPLE

MEASURE
Evaluation

ACKNOWLEDGMENTS

We thank the United States Agency for International Development for its support of this work.

We thank Theo Lippeveld and Derek Kunaka, MEASURE Evaluation, John Snow Inc.; Dawne Walker, MEASURE Evaluation, ICF International; and Tanvi Monga, Maternal and Child Survival Program, ICF, for reviewing this document and contributing valuable insights. We are grateful to Zeleke Abebaw and Kassahun Dessie—both of the University of Gondar, Ethiopia—for sharing their preliminary findings from an assessment of data use at the community level and for organizing a test run of the guidance provided in this document. For that, we also thank Begashaw Abat (the Kosoye Kebele administrator, in Amba Giorgis woreda, Amhara Region, Ethiopia) and all the other participants in the community forum in Amba Giorgis woreda for supporting the guidance's application at the community level. Lessons learned from this practical application improved this guidance.

We thank MEASURE Evaluation's knowledge management team for editorial and production services.

Cover: Community meeting at a village health post in Ethiopia. Photo: Binyam Chakilu Tilahun, University of Gondor, Ethiopia

FOREWORD

In my mind, it is a strange thing that while most humans live in local communities that provide context and meaning for their lives, these same communities are often ignored or otherwise disconnected from the health systems that serve them. There are many perfectly understandable reasons for this disconnect. The sheer number of communities can be daunting. The notion of who speaks for a community can sometimes be unclear. Lack of formal training, lack of certain communication skills, or a missing sense that community opinions are important and should be heard may all at least partially sustain this kind of disconnect. But the disconnect is dysfunctional in at least two ways. First, it deprives the health system of important "expert" knowledge that can only come from the lived experiences of community members. Second, it keeps the community and its members from having a say about what happens to them in the health system—from at least some measure of determining their own destinies.

MEASURE Evaluation is pleased to make this guidance document—*Use of Community Health Data for Shared Accountability*—available to those working to improve health at the community level. The guide is grounded in the notion that people support what they help to create and that the health system can be made better by honest, purposeful, and respectful inclusion of all affected parties. As with many if not most MEASURE Evaluation products, this guide is intended to help factual evidence illuminate a health problem and to let truth light our path to solutions.

I cannot credibly name all the people who had some part, large or small, in the creation of this work, but I would like to highlight a few. First, I would like to acknowledge the leadership, insight, and perseverance of Tariq Azim (MEASURE Evaluation) in the origination and realization of this work. I would also like to acknowledge other significant global-level contributors: Stephanie Mullen, Derek Kunaka, and Dawne Walker (all of MEASURE Evaluation), Theo Lippeveld (John Snow, Inc.), and Tanvi Monga (of the ICF/Maternal Child Survival Program). Importantly, I would like to acknowledge the contributions of our country-level collaborators: Kassahun Dessie, Binyam Chakilu Tilahun, and Zeleke Abebaw (all of the University of Gondor, Ethiopia), and Begashaw Abat (the Kosoye Kebele administrator, in Amba Giorgis *woreda*, Amhara Region, Ethiopia), who gave generously of themselves and contributed practical field-level experience to this guidance document.

Jason B. Smith PhD, MPH

Director of Health Information System Strengthening

MEASURE Evaluation

CONTENTS

FIGURES

TABLES

ABBREVIATIONS

CB-DOTS	community-based directly observed treatment, short course
CHW	community health worker
CSO	civil society organization
DOTS	directly observed treatment, short course
HC	health center
HCCMC	health center co-management committee
HDA	Health Development Army
HEW	health extension worker
MCH	maternal and child health
MOH	Ministry of Health
NGO	nongovernmental organization
RHIS	routine health information system
SOW	scope of work
TB	tuberculosis
UOG	University of Gondar
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

The dissemination and use of data generated by a routine health information system (RHIS) have traditionally been limited to the health system. The community is not typically viewed as part of the health system and is not seen as a consumer or user of health data. As a result, the community is disengaged and does not play an active role in improving its own health status, the health system, and the data the system generates; and the health system is not held accountable to the community it serves. Because the community is considered to be outside the health system, interventions to promote community involvement are seen as externally driven, and do not succeed in establishing community leadership and ownership. Ownership requires taking responsibility and with that comes accountability: i.e., committing to decisions and/or actions and holding oneself answerable for those actions and their consequences (Brinkerhoff, 2003). In the case of health, both the health system and the community have important roles to play and, therefore, both have shared accountability for ensuring or contributing to the improvement and/or maintenance of the health of the community. As such, the emphasis of shared accountability has the following targets:

1. Accountability for information sharing
2. Performance accountability (Corrigan, 2015)

Conceptual framework for a health system's shared accountability for data use at the community level

Two-way sharing and use of health data for decisions and actions are the vital ingredients for joint accountability for health at the community level. A framework of shared accountability is proposed (pictured above) for (1) making good-quality health data available and accessible; and (2) committing to and taking actions to improve the quality of health services and the achievement of performance goals.

Purpose

MEASURE Evaluation, funded by the United States Agency for International Development (USAID), developed this guidance document for use by country ministries of health (MOHs), local government, nongovernmental organizations (NGOs), civil society, and community leaders to foster community engagement and shared accountability for monitoring and responding to significant health events and concerns (e.g., pregnancies, maternal and neonatal deaths, and epidemics). It takes a community-centric approach, whereby the community determines its own higher-priority health concerns and actions, in line with the principles of achieving the United Nations Sustainable Development Goals for health (United Nations, 2015). This document draws from a variety of experiences and examples of community-level data collection, presentation, and use for taking action.

The document offers a matrix (Table 1) to display the degree of shared accountability. It also offers a scorecard for shared community–health system accountability for data use and actions, which can be used to help monitor the level of engagement of the health system (including the private health sector) and the community in sharing information and taking relevant actions (see Table 2 on page 25).

Table 1. Matrix for qualitative monitoring of a community forum for shared accountability for health data

Green = desired performance Yellow = acceptable performance Pink = unfavorable situation		**Health System**	
		Shared Information	**Took Actions**
Community	**Shared Information**	Both the health system and the community shared information.	The community provided information; the health system acted on it *(health system's engagement)*.
	Took Actions	The health system shared information; the community acted on it *(community engagement in taking action)*.	No information was shared, but both the health system and the community acted on their own.

To establish a culture of shared accountability, the use of an existing forum at the community level that has wide membership from the community and the health system is proposed. Through mutual understanding and consensus, the mandate of the existing community-level forum is expanded to take on the role of "shared accountability for health at the community level." The basic principles driving the process of shared accountability are the community takes the leadership role; the community and the health system mutually decide on the health priorities and voluntarily assign themselves responsibilities for addressing those priorities; and the community and the health system practice transparency and open sharing of data while ensuring privacy and security.

There are many cases of communities and the health system coming together to respond to specific challenges. They serve as examples to build on the culture of shared accountability through information sharing and commitments. Some of the cases relating to specific health needs are:

- **Disease epidemics:** The Ebola crisis in Liberia showed how sharing responsibilities and working in collaboration with the community helped frame and implement guidelines on safe yet dignified burials of Ebola victims, which became government policy at the end of 2014.

- **Community-based maternal death surveillance** in Ghana and Malawi are examples of how communities and health facility staff worked together to investigate and respond to maternal deaths occurring in communities and at health facilities.

- **Community-based tuberculosis (TB)/directly observed treatment, short course (DOTS)** in Mozambique and Uganda uses community volunteers chosen by the TB patients themselves to supervise the daily intake of medicines. The health system provides support (supply of medicine, follow-up, and adherence support).

To promote a culture of shared accountability through the shared use of health data, support from the MOH, local government, NGOs, and civil society is required, as is building capacity in data use by community members and health system staff.

INTRODUCTION

Purpose of These Guidelines

This is a guidance for practice document on how to use health data to be more responsible and accountable to communities for their health status. This document is designed for community leaders (informal and formal, including religious leaders, ethnic group leaders, civic leaders, and civil administration leaders in the community), community activists, and community residents, in general. This document will guide them through the process of using health data for shared accountability for improving their own health. The guidelines may also be used by MOHs to provide support to communities in developing tools, procedures, and processes to foster community engagement and shared accountability between the health system and the community for the monitoring of and responsiveness to significant health events (e.g., pregnancies, child health, maternal and neonatal deaths, chronic diseases, epidemics). By using these guidelines, health ministries, district health authorities, and NGOs can promote a culture of health information use at the community level.

For Whom Are These Guidelines?

The main users of this document are:

- The residents of a community
- MOH policymakers and managers responsible for the health of the population, and for organizing the provision of quality and equitable healthcare services for the community
- NGOs working in health in the community
- Health facility staff and community-level health workers

Community

A community, either urban or rural, is a unit or group usually identified and recognized by both the people comprising that unit or group and by some geopolitical/administrative hierarchy.

In this document, we consider any community unit/group that already exists in the country at the level of the most peripheral structures of the healthcare system. For example:

- Countries may have political organizations at the lowest administrative level that consist of community representatives, local community leaders, and stakeholders.
- Governmental and nongovernmental health organizations may have set up a community of people that have special/common interests, e.g., mothers' groups, health post oversight committees, health committee at the lowest administrative level of the country.

This document is designed to help the community set up a forum for shared accountability, in collaboration with the public (and private) health systems; manage the forum; and assess the performance of the forum in a way that nurtures mutual respect and understanding and promotes self-motivated commitment. The forum

for shared accountability may be a new entity or, preferably, an expansion of an existing forum at the community level to include shared accountability as one of its functions.

MOH

The MOH provides policy guidance and programming leadership. As a policy decision, the MOH can promote the implementation of these guidelines to establish or make use of existing mechanisms to use health data at the community level for shared accountability. The MOH can also support its local administrative units and seek the collaboration of NGOs and other civil society organizations (CSOs) to facilitate capacity building of the community in the use of health data and the implementation of these guidelines.

NGOs and CSOs

NGOs and CSOs are targeted in this document because of their role as catalyst**s**. NGOs and CSOs can serve as advocates for communities to set up or use existing forums or otherwise incorporate support for health system accountability in their scopes of work (SOWs) with existing community-level forums. They can also play a role in building the capacity of the community-level forums to use these guidelines and establish mechanisms for the use of health data for shared accountability.

Health Facility Staff

Health facility staff, including staff of community-level health units (e.g., health posts) are the face of the health system for the community. They are the ones who are in direct contact with the community and are well positioned to interact with the community. They can play a mentorship role, promoting community ownership and encouraging the community to take on responsibilities. This document provides the tools for them to do so.

Who Drives This Initiative?

The main drivers are members of the community itself. The assigned, elected, or de-facto leader of the community is the person who plays the lead role in keeping the process moving. Overall ownership is with the community. The community decides on its priorities, its roles, and how it would like to interact with the health system. To make this initiative as effective as possible, the community should liaise closely with the MOH and NGO authorities/service delivery units to work together for shared accountability to improve and protect the health of the community.

The MOH and other health service delivery organizations (NGOs, CSOs, private organizations) are clearly important players. They facilitate and encourage the establishment of institutionalized channels for communication, information sharing, shared decision making, and oversight with the community. For the system of shared accountability to take root in the culture of the health system and the community it serves, the MOH and NGOs should provide initial support and mentorship to the community. Mentoring is geared to empowering the community to become the driver of joint accountability for health at the community level, through the use of good-quality information.

SHARED ACCOUNTABILITY FOR HEALTH AT THE COMMUNITY LEVEL

Accountability means taking responsibility and holding oneself answerable for actions and/or their consequences. It is a process of owning and taking responsibility for commitments and their consequences and obligating oneself to publicly report on and answer questions about decisions and/or actions to which an individual, a group, a unit, or an entity has committed.

Shared accountability is defined as a process by which partners hold each other responsible for the commitments that they have voluntarily made to each other (Institute of Medicine, 2011). The partners collectively own their decisions and actions to society or to one another; within a broader framework of commitments, they voluntarily take responsibility for their decisions and actions; are transparent in publicly reporting their decisions and actions, and the results of those actions; and agree to bear the consequences of nonperformance.

For the purposes of these guidelines, shared accountability for health at the community level is the mechanism whereby the community and public (and private) healthcare providers and managers at the community level mutually set healthcare objectives and standards for the community; take ownership and responsibility for improving the health of the community through the means available to them; and voluntarily commit to being held accountable for agreed upon actions to achieve their healthcare objectives and standards.

What Is the Purpose of Shared Accountability for Health at the Community Level?

The purpose of shared accountability for health at the community level is to create an enabling socio/political environment of mutual trust and transparency between the community and the health system that supports the taking of collective responsibility for and commitment to shared accountability for the improvement of health service delivery and contributing to the overall health of the community. In the context of the use of health and related information at the community level for shared accountability, health data use is defined as the process whereby the community, along with representatives of the health system at the community level, analyze health and related data; interpret and elaborate the data for a better understanding of the

Shared Accountability Versus Social Accountability for Health

The concept of shared accountability at the community level is about bringing the community and healthcare providers (public, private, NGO) together to voluntarily share information and commit to agreed-upon actions.

By contrast, social accountability and the tools used for that purpose primarily focus on health budget formation; its review, resource tracking, and audits; and community participation in monitoring health service delivery (Aslam & Moore, 2016).

situation; synthesize the data to form alternative explanations for the cause(s) of problems, leading to appropriate solutions; and weigh alternatives to come to a consensus on actions for which the health system and/or the community will take responsibility and be held accountable.

In the context of shared accountability for health at the community level, data use does not mean reporting, aggregating/adding up numbers, and sending the data to someone.

Accountability for What?

In broad terms, accountability can be categorized as:

1. Performance accountability—i.e., accountability for agreed upon performance targets or objectives

2. Political accountability—i.e., accountability for responding to the collective needs of the community and acting in accordance with agreed-upon values and norms of ethics, integrity, and professional responsibility

3. Financial accountability

In these guidelines, the emphasis of shared accountability is on (1) accountability for sharing quality information and using that information to decide on appropriate and relevant actions, and (2) performance accountability.

Who Are the Accountable Entities at the Community Level?

The entities that commit to shared accountability for health at the community level can generally be classified as:

1. The public and private health systems, which are primarily responsible for providing health services to the community

   At the community level, there are service providers who are directly involved in the provision of health services, and there are health managers/leaders who are responsible for planning, managing, mobilizing resources, monitoring, and governing health service delivery to the community, with the overall objective of improving/maintaining the health of the community.

   a. The public health system is usually well organized and is accepted as the authority responsible for organizing and providing health services to the community

   b. The private health system consists of organized not-for-profit entities, for-profit entities, and informal/individual healthcare providers

2. The community itself

In the community, there is the general population; people who play the role of community leaders and activists; and formal and informal community entities. The formal community entities can be the political authority (elected or otherwise) and community forums/groups formed by public or private health sector players for specific purposes.

ESTABLISHING COMMUNITY-LEVEL SHARED ACCOUNTABILITY MECHANISMS FOR HEALTH

Basic Principles

1. The community takes the leadership role.

2. The community and the health system take advantage of an existing forum at the community level and agree on revising the forum's scope of work (SOW) to make it relevant to the use of health data for shared accountability. If no community forum exists, the community and the health system mutually decide to adopt one of the examples from other countries that are provided in this guidance.

3. All entities privy to shared accountability for health at the community level mutually decide on the health priorities and assign responsibilities to themselves to address those priorities.

4. Transparency and open sharing of data are practiced, while also ensuring privacy and security.

5. The entities make a voluntary commitment to achieving the agreed-upon performance goals.

Shared Accountability versus Community-based Monitoring

Shared accountability is a process by which the partners collectively own their decisions and actions to society or to one another; voluntarily take responsibility for their decisions and actions; are transparent in publicly reporting their decisions, actions, and the results of those actions; and agree to bear the consequences of nonperformance (Institute of Medicine, 2011).

Within the framework of community-based monitoring (implemented in Uganda), both the disadvantaged and the elite discussed the status of their health services and the means for identifying the steps that providers should take to improve health service provision. Second, a provider staff meeting was held to contrast the citizen's views of service provision with that of the health worker. Third, a meeting allowed community members and health workers to discuss patient rights and provider responsibilities. The meeting outcome was a shared action plan, or a contract, outlining the community's and the service provider's agreement on what needed to be done, how, when, and by whom (Björkman, 2009).

The Setting

Ideally, the community setting should be an open forum, which all stakeholders in the community can join. In this case, the stakeholders are the community, and the healthcare providers and their manager who are directly involved in providing and managing health services for the community.

The community is represented by all members of the community, but essentially by formal and informal community leaders, and representatives of women, adolescents, poor and marginalized segments of the community, and ethnic groups in the community.

An informal leader in the community is someone who does not hold a formal post or have formal authority, but rather has influence on community members by dint of his/her own virtues, and as a result, the community has confidence and trust in that person, and aligns with his/her leadership role, particularly in situations where the formal leadership is unable to respond to the local situation (e.g., emergency, disease outbreak). Informal leaders are more acceptable to the community because of their role in galvanizing the community to address situations that require the community to come together to respond. For the purposes of shared accountability for health at the community level, informal leaders can play important roles. Informal leaders may emerge out of necessity or may already play a role in the community. It is up to the community itself to identify these leaders and include them in the community forum.

To establish the forum for shared accountability for health at the community level, the community may decide to set up a new forum with wide representation, or it may simply review and adjust the constitution and scope of an existing forum. In many, if not most, countries, community forums or structures bringing together the community and the health sector do exist. A few examples are highlighted below, which can be adapted, as appropriate.

Examples of Community Forums

Ethiopia

Community forums in Ethiopia (Adamasu, 2013; Interviews with kebele officials 2013) include:

- Kebele council (general council), in which all influential representatives from the kebele (village) are members

- Kebele cabinet: consists of the kebele chairman and nine other members, including the kebele health extension worker (HEW). The cabinet has several committees, including a health committee

- Health Development Army (HDA): This is a way to organize the community for participatory learning and actions to improve community health. The HDA is a health development team composed of 30 households from the same neighborhood. Team members are usually mothers/women because most health packages require women's involvement. Each HDA team at the kebele level is comprised of a network of six households. One of the household is the team lead and takes responsibility of the other five households. This arrangement is also called a one-to-five network. The team leaders of the network are selected by the network members. Leadership selection criteria are that the person is from a model family; has the trust of the team/network members; a better educational background; and the ability to mobilize the community.

The process of establishing the teams and network is facilitated by the HEW and the kebele administrator, with close follow up from their local health center (HC). The implementation of the activities of the health development teams/HDA are monitored by a coordination body called the command post, which is set up at every level of the health system. At the community level, it is called the kebele command post. The kebele administrator is the chairman and the HEW is the secretary of the kebele command post. It holds meetings every week.

Rwanda

There are several official forums that encourage community participation, as follows:

- Community assemblies (*inteko z'abaturage*) that convene monthly to discuss government policies and programs
- Community work (*umuganda*) that convene on the last Saturday of each month, during which citizens participate in community work to develop their communities
- Community assemblies (commonly known as *inteko z'abaturage*)
- Representation of people with disabilities on every local decision-making body

Tanzania

- Village assembly and village council: all adult member residents in the village are members of the village assembly and elect the members and the chairperson of the village council
- Village council health committee: This is a political body in the village council that oversees the work of the administrative departments, e.g., health sector
- Health committee for every health facility, which guides the provision of services to users and determines priorities

Cambodia

- The health center co-management committee (HCCMC) and the feedback committee
  The HCCMC consists of three HC staff and one elected community representative from each community covered by the HC. The feedback committee consists of all HCCMC members, and one male and one female elected representative from each village covered by the HC.

Zambia

- Health facility committee, which has a role in monitoring, planning, managing, and implementing health-related activities. The health facility committees are formed through initiatives of NGOs that are specific to their areas of interventions.

Bangladesh

- The Women's Health and Rights Advocacy Partnership—a consortium of 16 NGOs—operates in five districts and 14 subdistricts of southern Bangladesh. It works to strengthen the accountability mechanisms of health systems through a three-pronged approach. Women from marginalized sections are organized into groups at the village level (*nari dal*) and monitor the community health clinics and the upazilla health complexes. Second, the partner organizations conduct monitoring visits to the local district and subdistrict hospitals. The third strategy is working with members of Parliament, local elected representatives, and other members of the hospital management committees to create a participatory and relevant review and planning mechanism (Mahmud, n.d.)

Other Examples

- Mothers' groups, women's group, youth groups, pagoda volunteers (Cambodia)

The Content

The primary objective of the use of health data for shared accountability at the community level is to improve healthcare services in the community through joint efforts, whereby both the health system and the community contribute to improving the health of the community. The focus of shared accountability is twofold:

1. Accountability for information sharing: both the health system and the community commit to and ensure that health and related data are made available and accessible to each other. They also take responsibility for ensuring the quality of the data that are shared.

2. Performance accountability: accountability for agreed upon performance targets or objectives, and thereby, for responding to the community's health needs in a manner that upholds the principles of respectful care and the delivery of quality care.

Both the health system and the community are explicit in demonstrating their commitment to agreed-upon actions that are jointly decided. This can be in the form of resource mobilization; initiating and completing the tasks that each are assigned voluntarily; and making efforts to improve and/or maintain the quality of care.

The conceptual framework for the use of health data for shared accountability at the community level is shown in Figure 1. Under this framework, both the community and the healthcare system have responsibilities for sharing information and taking action.

Information Sharing

The community is accountable for providing the health system with information that would prompt the system to take action. Such information can be:

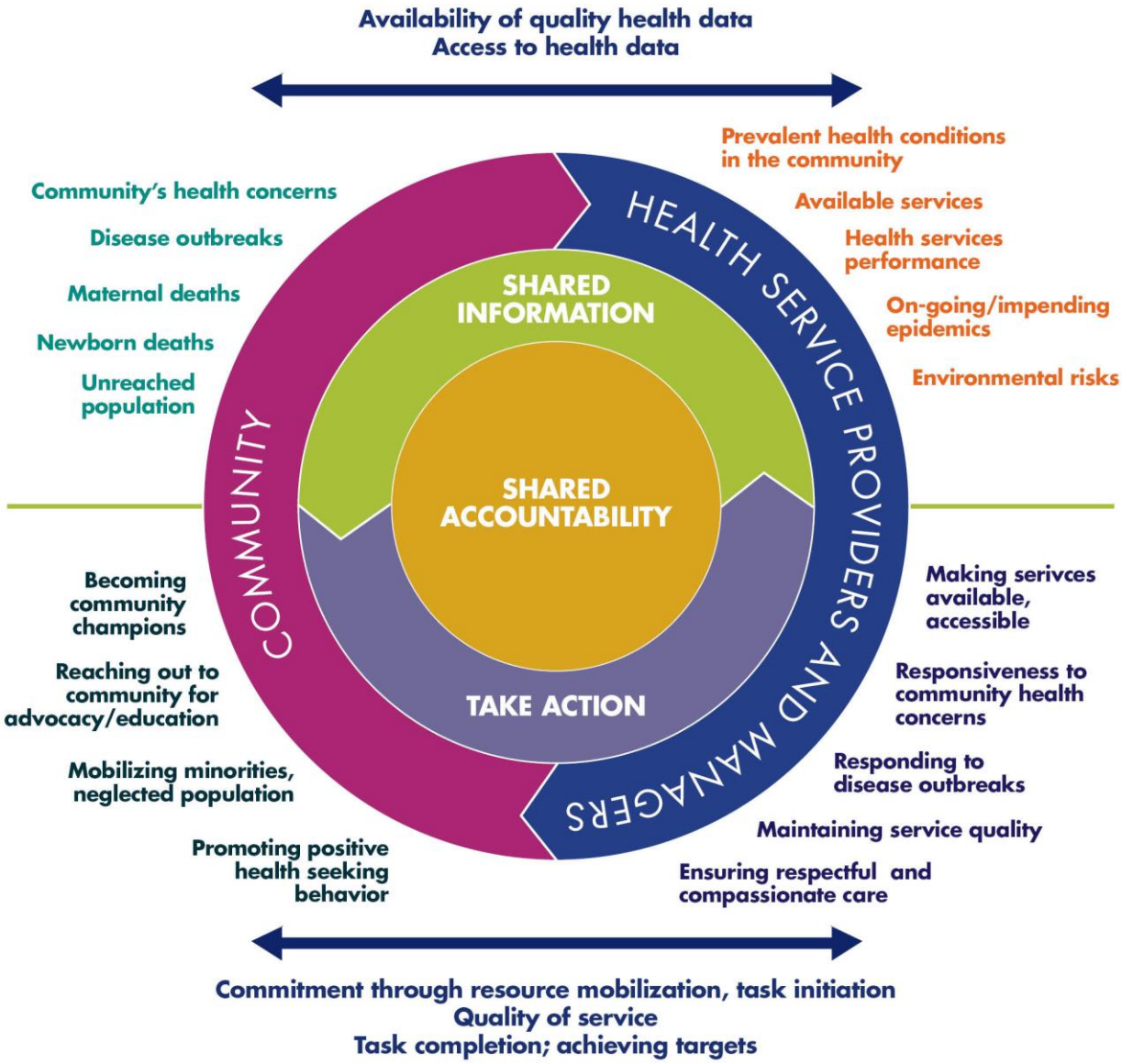
- Information about the health concerns of the community: This can range from concerns about the unavailability of certain services or medicines, to the increasing number of children with malnutrition, the inappropriate behavior of the healthcare providers, and inappropriate health behaviors in the community (lifestyle).

- Reporting disease outbreaks: Community members are best placed to be the first informers of outbreaks of any unusual disease or cases of deaths, even before the health system can detect unusual patterns. The community has a responsibility to inform the health system of such occurrences so that it can respond promptly. The community can point to the locations of high concentrations of unusual occurrences of disease. Timely information provided by the community can also create demand on the health system to act quickly and, thereby, save lives and prevent the disease from spreading.

- Reporting deaths of mothers and newborns: Such reporting can greatly improve the accounting of every maternal and newborn death in the community. Discussions on factors leading to the death can help inform appropriate measures by the community and the health system to avoid preventable deaths.

Information on the health status of or access to healthcare among neglected populations, such as the poor segments of the community, ethnic minorities, women, and people with HIV: Information provided by the community can help ensure service equity among all segments of the community.

Figure 1. Conceptual framework for a health system's shared accountability for data use at the community level



Similarly, the health system is accountable for providing information to the community. The information can be:

- Information on prevalent health conditions in the community, by sharing the community's general health statistics and information on specific health conditions or diseases that are prevalent in the community: The health system can also inform the community of ongoing or impending epidemics, worsening nutritional status of the population, or the environmental risks that the population is facing, and alert the community about public health emergencies. Sharing such information helps build awareness of the community's health conditions.

- Information on lifestyle-related issues prevalent in the community, such as nutrition, sanitation habits, sharing dwellings with domestic animals, and unprotected sex: These all affect the population's health

- Information on available services, where they are located, and how they can be accessed by the community: For example, information on basic and comprehensive obstetric care facilities can greatly help the community direct patients to the appropriate facility.

- Health systems performance: This is an essential ingredient for the accountability of the health system. Sharing information on health system performance and possible root causes of high/low performance can help build new partnerships, focus on areas of weakness, and address such issues as equity and quality of care.

Taking Action

When it comes to taking action, the health system is primarily responsible for acting and making services available and accessible to the community, including to sections of the community that are traditionally or otherwise neglected, such as ethnic minorities, women, and poor populations. Health system accountability also lies in making sure that the services provided are of good quality and are delivered in a compassionate and respectable manner. Overall, the health system should be responsive to the health concerns of the community.

Similarly, the community is accountable for taking certain actions that contribute to maintaining and/or promoting health. An example is for people to become community champions in promoting health and preventing diseases. Community champions actively reach out to and engage the community, especially those whose healthcare is neglected, such as ethnic groups and socioeconomically deprived sections of the community. These champions are committed to building awareness of and educating the community about its health responsibilities, and for catalyzing positive health-seeking behavior by community members. The leaders of the one-to-five networks in Ethiopia are examples of formally recognized community champions.

The Process

The following are suggested steps to operationalize and institutionalize the use of health data for shared accountability at the community level.

Establishment of Shared Health System Accountability Mechanisms in the Community-Level Forum

The preferred way to establish processes for shared accountability for health is to expand the role (and possibly membership) of an existing community forum. This requires that members of the existing forum agree on and revise the community forum's SOW. This may necessitate engaging new members of the community to participate on the committee. Especially important are the informal and formal community leaders, including religious leaders, ethnic group leaders, civic leaders, mothers/youth leaders, and civil administration leaders. In addition to the participation of the community-level healthcare providers (both public and private), representation by the health facility manager can enhance the effectiveness of the forum.

If there is no existing forum at the community level, community leaders and health staff can sit together to establish a new forum on shared accountability for health, bringing together the health system staff, community leaders, and a mix of community members who represent heterogeneous groups in the community. Examples from other countries and the principles described in these guidelines (below) can be used to establish such a forum.

Scope of Work

The forum can determine the SOW that suits its context and is appropriate for identifying and taking joint actions on the community's priority health problems. A sample SOW follows, which the forum can adapt, as appropriate.

The forum for shared accountability for health is composed of leaders, other representatives of the community, and representatives of the health system (public and private). It is responsible for:

- Sharing good-quality health data in an open and transparent manner, as appropriate and feasible for each party. This means that health system staff share health data on the health service's performance; disease occurrences; overall health status statistics; health programs and interventions in the community; and existing service delivery points and plans for providing health services/interventions. The community shares information on disease outbreaks; maternal deaths; newborn deaths; healthcare needs of the community; resources that the community can mobilize to improve health service delivery; information on people needing significant/long-term care; cases of childhood diseases, including malnutrition; and actions taken by the community to promote health.

- Information-sharing is done in a way that protects the confidentiality and privacy of affected individuals in the community, but also provides sufficiently specific information to direct relevant interventions to the affected segment or geographic area of the community.

- Identify and/or prioritize health issues in the community. The prioritization may be done based on the gravity of the situation and the capability of the community and the health system to respond to the needs. Issues that the community and the local health system are unable to handle can be referred to higher-level authorities for required action.

- Develop joint action plans that have clear objectives, outputs, assigned responsibilities, and timelines.

- Decide on a small number of relevant and specific indicators to monitor progress.

- Monitor the forum's performance, in terms of the sharing of health information, the implementation of joint action plans, and the health status of the community using a limited number of agreed upon indicators.

- Call regular and needs-based meetings of the forum and keep records of forum meetings and the data shared in the forum. To manage the forum, the community may select/elect a member secretary for a specified time. The forum members can also develop a roster whereby the forum's community representatives are assigned the responsibilities of the member secretary for specified periods.

- Employ easy-to-use and comprehensive tools to display the data shared in the forum. The forum may use scorecards for this purpose, as described below.

- The forum may refrain from any direct involvement in financial transactions. However, if needed, the forum can request and involve higher-level authorities to handle voluntary financial contributions. Alternatively, the forum may decide to form a separate and short-lived committee to handle financial matters, as the need arises. This committee can report to the forum about all financial transactions.

Shared Accountability for Community Health Data Use and Actions Scorecard

The forum can use a simple scorecard to monitor its performance. The scorecard below is used to measure the status of the shared accountability for information sharing and actions taken by the community and the health system. The performance of the community and of the health system are scored separately, and then the scores are aggregated to give an overall performance score. The scorecard is used on an annual or semi-annual basis for self-evaluation of the overall performance of the forum. Community participants and health staff jointly select the most appropriate statements that reflects the performance of the forum in terms of leadership, participation, information sharing, and taking action. Completing the scorecard jointly encourages discussion among forum participants and helps build a sense of mutual respect and collaboration for common goals.

For the information sharing domain, the community scores range from 0 to 3, whereas the health system scores range from 0 to 4. The additional point for the health system is to rate the participation of the private/NGO sector in the process of using health data for shared accountability. Similarly, for the taking action domain, the community scores range from 0 to 2 and the health system scores range from 0 to 3.

The highest total score is 20. Forum participants can set their own performance targets. Nevertheless, a score from 0 to 9 means that the forum is ineffective, whereas scores from 10 to 14 are acceptable, and scores from 15 to 20 are the desirable levels of performance.

Table 2. Scorecard for shared community-health system accountability for data use and actions

Community domains							
Leadership		**Participation**		**Information sharing**		**Taking action**	
	Score		**Score**		**Score**		**Score**
External facilitators called the meeting.	**0**	The meeting was attended only by community leaders.	**0**	No information was shared.	**0**	No action	**0**
The community leadership organized the meeting. The community leader called the meeting and presided over it.	**1**	The meeting was attended by only one homogenous group of people from the community (e.g., women's group only; youth group only).	**1**	The community shared information about its health needs, and/or complaints about the services provided at the local/district health facilities.	**1**	Community actions were limited to behavior change communi-cation.	**1**
		The meeting was attended by a mixed group of people from the community, such as community leaders, respected elders, women representatives, youth, and representatives of ethnic groups.	**2**	The community shared information about: • Its health needs • Maternal deaths and newborn deaths • Disease outbreaks, and service needs of specific target groups • Information about the health issues of ethnic/ deprived sections of the community • Complaints about the services provided at the local/district health facilities	**2**	Community took affirmative actions that required resource mobilization by the community.	**2**
		The meeting was attended by the public and by community leaders, respected elders, women representatives, youth, and representatives of ethnic groups.	**3**	The community shared information about: • Its health needs • Maternal deaths and newborn deaths • Disease outbreaks and the service needs of specific target groups • Information about the health issues of ethnic/deprived sections of the community • Complaints about the services provided at the local/district health facilities • Assisting in data quality checks at the community level (i.e., the community verifies reports on the provision of health services to households, especially services for target groups and ethnic/disadvantaged groups)	**3**	In addition to taking affirmative actions for the general population, the community focused actions to support vulnerable or deprived populations.	**3**
Domain score							
Subtotal score for community							

Health system domains							
Leadership		**Participation**		**Information sharing**		**Taking action**	
	Score		**Score**		**Score**		**Score**
The meeting was organized by the health staff (public health system or NGO).	**0**	Health staff from the local health facility (public or NGO) did not attend the meeting.	**0**	No information shared	**0**	No action	**0**
The health staff actively promoted community leadership through mentoring and capacity building.	**1**	Staff from the local public health facility and/or NGO facility attended the meeting.	**1**	Health system (public) shared information on service availability and/or health education messages, health system performance, and health interventions.	**1**	Actions by health staff were limited to behavior change communications.	**1**
		Health staff from the local public (or NGO) health facility and representative(s) from the district health office attended the meeting.	**2**	Health system (public) shared information on: • Service availability • Disease outbreak • Health system performance • Health interventions • Health education messages • Data quality check findings	**2**	Health system took affirmative actions that required resource mobilization by the health system (public health sector only) for implementing the decisions that were mutually agreed upon during the meeting.	**2**
		The head of the local public (or NGO) health facility and representative(s) of the district health office attended the meeting.	**3**	• Health system (both public and private/NGO) shared information on: o Service availability o Disease outbreak o Health system performance o Health interventions o Data quality-check findings	**3**	The health system (both public and private/NGO sectors) took affirmative actions that required resource mobilization by both public and private health sectors for implementing the decisions that were mutually agreed upon during the meeting.	**3**
Domain score							
Sub-total score for Health System							
Total Score (Community + Health System)							

Matrix for Qualitative Monitoring of Forum Performance

The matrix below can be used to get a sense of how the forum is performing, in terms of the sharing of information and taking actions. At the end of each meeting, forum participants can conduct a qualitative assessment of their performance, using this matrix.

Table 3. Reprise of the matrix for qualitative monitoring of a community forum for shared accountability for health data

Green = desired performance Yellow = acceptable performance Pink = unfavorable situation		Health System	
		Shared Information	**Took Actions**
Community	**Shared Information**	**BOX 1:** Both the health system and the community shared information.	**BOX 2:** The community provided information; the health system acted on it. *(health system's engagement)*
	Took Actions	**BOX 3:** Health system shared information; community acted on it *(community engagement in taking action.)*	**BOX 4:** No information was shared, but both the health system and community acted on their own.

- Box 1: Tick this box if, during the current meeting, participants from both the health system and the community shared relevant information, but no one accepted an assignment for any action.

Although this is not the most desirable performance, even minimal sharing of information between the health system and the community during a forum meeting is acceptable. This can be the outcome of some meetings but should not be a consistent scenario.

- Box 2: Tick this box if the community provided information and the health system staff accepted specific assignments to take necessary actions that were mutually decided based on the information that was shared. Also, if the health staff implemented specific actions based on the information shared during a previous meeting, put a tick in this box.

This is desirable performance and together with the status in Box 3, the two form the most desirable scenario that the community and the health system together should strive to achieve.

- Box 3: Tick this box if the health staff shared information and the community accepted responsibility to implement relevant actions that were decided based on the information shared by the health staff.

This is desirable performance and together with the status in Box 2, the two form the most desirable scenario that the community and the health system together should strive to achieve.

- Box 4: Tick this box if neither the community nor the health staff shared any meaningful information and did not take any actions/decisions.

This represents an unfavorable situation, where mutual trust and collaboration are lacking.

Sharing Information

Both the community and the health system are accountable for sharing relevant information and being responsive to each other, in terms of taking appropriate and agreed upon actions based on the information shared.

Both the community and the health system participants in the forum discuss and agree on the health priorities for the community and the information needed to understand and monitor the priority health issue. To ensure meaningful sharing of actionable information, the forum can implement the following steps:

1. Develop a community health profile, in the form of both a map and a table. Information in the health profile can include:

    - Demographic data on the community
    - Number and placement/distribution of health facilities (by type) in the community and within 10 kilometers of the community
    - Health status of the community
    - Risk factors in the community
    - Service coverage
    - Important contact information for health staff, ambulance, and/or toll-free lines for contacting the HCs or hospitals (if available)

A suggested list of indicators for each of these major categories is given in Table 1. The same list is used for monitoring progress. The data for each indicator are updated on regular basis, usually quarterly.

2. Identify the health and healthcare issues and concerns of the community.
3. Prioritize the health and healthcare issues and concerns of the community in a consensus manner.
4. Choose community-level indicators that are:

- Relevant for the concerned community
- Specific to the prioritized health and healthcare issues and concerns
- Easily comprehensible
- Easy to collect data using available sources, e.g., health facility reports and communications by the community

The indicators can be a subset of the indicators used to describe the community's health profile. The forum can decide to prioritize and focus on a select number of indicators. New indicators may be added and/or others deleted from the list of prioritized indicators, as deemed necessary, based on the evolving health and healthcare status of the community.

5. Decide on the data sources; collect, report, analyze, and interpret the data; and draw conclusions.
6. Decide on solutions and take actions.
7. Monitor progress/changes in the indicators.
8. Provide feedback, both positive and negative, in a transparent manner; encourage open discussion to explore the root causes of problems; and mutually agree on the way forward. The aim is to allow transparency in providing negative feedback, without sugarcoating it or avoiding the "sandwich approach," whereby negative feedback is hidden between two positive feedback points (Schwarz, 2013). A direct, open approach to providing and listening to negative feedback helps build trust, and channels the focus on solving the issue, rather than burying it in self-defensive explanations. The Ethiopia experience (Appendix 3) is a good example of directly providing and discussing negative feedback while maintaining the social etiquette.

Table 4. Potential community-level indicators

Category	Potential indicator	Data source	
		As reported by the health staff (public and private/NGO)	As reported by the community
Community health status	Number of under-5 deaths in the last quarter	✓	✓
	Number of newborn deaths (deaths within 4 weeks of birth) in the last quarter	✓	✓
	Number of deaths of pregnant women during pregnancy, childbirth, or within six weeks of childbirth in the last quarter	✓	✓
	Stillbirths in the last quarter	✓	
	Deaths due to malaria in the last quarter	✓	
	Deaths due to TB in the last quarter	✓	
	New cases of measles in the last quarter	✓	✓
	Number of HIV cases in the community	✓	
	Number of TB cases in the community	✓	✓
Risk factors in the community	Number of low birth weight newborns in the community	✓	
	Number of stunted under-5 children in the community	✓	
	Number of wasted under-5 children in the community	✓	
	Number of people using safely managed drinking water services	✓	✓
	Number of people using safely managed sanitation services	✓	✓

Category	Potential indicator	Data source	
		As reported by the health staff (public and private/NGO)	As reported by the community
Health service coverage	Number of pregnant women who received four antenatal care services in the community	✓	✓
	Number of births attended by skilled health personnel in the last quarter	✓	✓
	Number of under-5 children with pneumonia who received services	✓	
	Number of under 5 children with diarrhea who received oral rehydration solution	✓	
	Number of children who received Penta3/DPT3 vaccination (or are fully immunized) in the last quarter	✓	✓
	Number of people on antiretroviral therapy	✓	
Health system	Number of maternal deaths taking place in health facilities (mothers residing in the community, but may use services at health facilities outside the community)	✓	✓
	TB treatment success rate	✓	
	Number of people using the health facilities in the community in the last quarter		✓
	Number of people from the community who received essential medicines and commodities from the health facilities		✓
	Number of births in the community registered in the last quarter		✓

Category	Potential indicator	Data source	
		As reported by the health staff (public and private/NGO)	As reported by the community
	Number of deaths in the community registered in the last quarter		✓
	Number of people who visited the health facility and perceive that they received respectful and Compassionate care (elements of care, such as carefully listening to complaints, respectfully examined physically, treatment options explained, and took part in deciding the treatment regimen)		✓
	Number of disease outbreaks reported in the community	✓	✓

Being Responsive

Based on the prioritized health and healthcare issues/concerns, forum members determine possible solutions and choose from those options. A root cause analysis of the issues/concerns identified, with the help of the selected indicators, can help in deciding on appropriate solutions. The root causes may be categorized as those related to the health system (subcategorized into health personnel skills and behavior; availability of medicine, equipment, and other commodities; availability of and access to health services; overall management of the health system); those related to the community (community behavior; health seeking behavior; affordability; health-related knowledge); and other external factors or determinants.

The forum mutually agrees on the specific actions to be taken and the responsibilities assigned to the health staff and/or community members, as appropriate. Nevertheless, the health system is collectively responsible and accountable for the actions assigned to one or more health staff. Similarly, the community is accountable to support the assigned community member and, therefore, for the accomplishment of the assigned tasks.

Subsequent monitoring includes reviewing the priority health indicators and progress in the implementation of the agreed upon tasks.

Examples of Collaboration and Shared Accountability of the Community and Health System for Specific Health Issues

Several cases from a few countries provide examples of how to establish mechanisms for mutual sharing of health data and taking responsibility for appropriate actions for specific health issues/priorities.

Case 1. Disease Epidemics: Sharing Responsibilities and Working in Tandem

Two-way communication between health professionals and communities was one of the key elements of the response to the Ebola crisis. Both the health system and the community were accountable for taking action. The sharing of data between the health system and the community was essential to Ebola case detection and arresting its spread. For example, in Liberia (Protection Partners Forum, 2016), it was only when health professionals and community leaders came together that reciprocal learning and the establishment of trust and respect between the health system and the community led to changes in behavior of the health staff and people in the community. Behavior change was a necessary component of the Ebola response, to not only prevent the spread of the disease, but also to address stigmatization of and discrimination against Ebola patients and their contacts. Traditional and religious leaders in the communities rose to the occasion, giving personal examples of changed traditional/religious practices, and also guiding the communities to adopt their own solutions and establish support mechanisms for those affected. There was widespread non-compliance with government-imposed cremation to prevent the spread of the virus. In this situation, traditional and religious leaders influenced the development of World Health Organization (WHO) guidelines on safe burials with dignity, which later became government policy at the end of 2014.

The Ebola crisis underscored the importance of early, active, and sustained engagement of affected communities and their trusted leaders and networks to implement a successful epidemic control response. Such engagement requires: cultural humility; involvement of local respected male and female community leaders; organized and regular exchange of information, reciprocal learning and establishment of mutual trust and respect; joint development of response protocols that are culturally relevant yet maintain the scientific rigor essential for containment of the spread of disease and management of affected persons; regular monitoring of the process, progress, and outcomes; and evolution of a sustainable response system in the community.

Lessons from the Ebola crisis can be used to establish mutual responsibility and accountability for sharing information and taking actions in any disease outbreak situation. The type of information shared can be determined by the needs of the specific epidemic. Nevertheless, active community reporting of cases or relevant events related to the disease remain an essential ingredient of the community's responsibility for the response to an epidemic.

Case 2. Community-Based Maternal Death Surveillance

In Ghana, a community-based maternal death surveillance system was piloted in Sene district, in 2010 (Adomako 2015). In 2013, based on the lessons from the pilot and other research, a modified survey system of community-based reproductive-age mortality was implemented in the Bosomtwa district. The survey asked the following six questions:

Question 1: Was she pregnant when she died?

Question 2: Did she have a child younger than one year when she died?

Question 3: Was she pregnant in the year before she died?

Question 4: Did she have a miscarriage or abortion?

Question 5: Did she die at home or in a healthcare facility?

Question 5a: If she died in a healthcare facility, which facility was it?

Question 5b: Did she die at her own home? If not her own home, where?

Question 6: What do you think was the cause of her death?

Volunteers from the community, supervised by community nurses, conducted the survey. The system yielded twice the number of maternal deaths reported than the number reported by the facility-based reporting system. The findings indicated that the community-based survey of deaths among women of reproductive age is feasible; can help identify cases of maternal deaths in rural communities, many of which remain unreported; and can serve as a reasonable, real-time alternative, pending the establishment of a robust vital registration system of births and deaths.

In Malawi, an NGO (MaiMwana) piloted a community-linked maternal deaths review process in Mchinji District in the central region of the country. The process was implemented from 2011 to 2012. In 2013, the Reproductive Health Directorate of Malawi's MOH adopted the process for nationwide implementation. Communities and health facility staff worked in partnership to investigate and respond to maternal deaths occurring in communities and at health facilities. With the help of the community-linked maternal deaths review, the community identified twice as many maternal deaths as did the existing facility review process; the process yielded richer data and led to more actions being taken after the review.

A team is formed consisting of health staff and community volunteers. The review process is triggered in the event of any maternal death; with the woman's family consent, data are collected using a simple questionnaire. A meeting is held in the woman's local area, with the community team, at which the team and the community inform about the death and discuss and record factors the community believes contributed to the woman's death, and together, suggest strategies to prevent future deaths. Under this process, the information is further shared and discussed at the district level, involving health facility staff, and later, with a broader audience, including community leaders and district health managers. Because of this process, the health workers develop and present their planned action points; and the community agrees on community factors that may have contributed to the death and plan their own strategies, assigning action points for individuals to implement.

Lessons from these two cases on maternal death reporting can be used to establish a community-led reporting of maternal and newborn deaths using simple tools to provide essential data on the maternal or newborn death. Health staff can share data on maternal and newborn deaths occurring in a health facility. Such information sharing leads to relevant actions by both the community and health staff.

Case 3. Community-Based TB-DOTS: Accountability on Both Sides

Community-based DOTS (CB-DOTS) is where trusted and motivated volunteers from the community directly supervise the taking of anti-TB medicines by the TB patients during the continuation-phase of the TB

treatment. Patients do not have to travel far from their homes to a health facility for their daily dose of medicine. CB-DOTS is a well-practiced strategy in many countries to make the implementation of DOTS practicable and accessible, particularly in places where access to health facilities is limited and/or difficult. In many settings, TB patients choose the CB-DOTS observer from among community volunteers. For example, in Mozambique, they are the local godparents, or *padrinhos,* that the patients choose to be their DOTS supervisor (Eggens 2014). In Uganda, the parish development committee, which is a small group chosen by the community to make decisions on social, health, and economic development issues, in liaison with the sub-county public health worker, asks the community to nominate a volunteer who is willing and is acceptable to the patient to deliver DOTS, under the overall supervision of the sub-county public health worker. In this setting, the TB patients select a DOTS supporter from their social support network system. Such an arrangement helps build trust and rapport between the patient and the DOTS observer. CB-DOTS has been found to be equally effective, if not better, than facility-based DOTS. It has the advantage of creating an atmosphere that enhances the understanding of TB in the community as a disease, the possibility of its effective care and reduces stigmatization of TB patients. In Mozambique, in one intervention area, CB-DOTS contributed to the identification and referral of many new cases over the years.

The outcome of CB-DOTS is not always what is intended. Treatment failure is still seen as a problem, but many other factors are also at play and influence the outcome of CB-DOTS. The community network of volunteers must be coupled with a strengthened health system, and good record keeping practices by health facility staff. Training and mentoring of volunteers also affect the outcome. Similarly, without effective referral structures and good service delivery performance by the health system, the effectiveness of CB-DOTS is limited.

A community forum can therefore be a place where the health system and community come together to commit to improving the TB case notification and treatment success rates. The health system and the community can share data on cases referred, diagnosed, and put on DOTS; the status of patients on CB-DOTS; and their treatment completion/success.

MAKING EFFECTIVE USE OF DATA

Building the Data Use Capacity of the Community and Health System Staff

In addition to access to data, another important prerequisite for institutionalizing the use of data for shared accountability at the community level is to build the capacity of the community and the health system to understand the importance and relevance of data, and to analyze and interpret the data that are being shared. This requires building capacity of the community members and health staff who participate in the community forum. The community should also be oriented on the basics of the health issues, interventions to address those issues, and how to monitor progress in addressing the health concerns. For example, in Ethiopia, households are provided training on a package of 16 high-priority health interventions, and relevant knowledge and skills are transferred to households so that they can take responsibility for producing and maintaining their own health and encouraging their neighbors to do the same. Using lessons from such initiatives, training packages for the community forum can be developed or adapted to train the community and health staff. The forum participants also need to be oriented on the shared accountability for community health data use and actions scorecard, the matrix for qualitative monitoring of forum performance, and the indicators that can be used for monitoring progress in addressing the health needs of the community.

Support from the MOH and NGOs

The MOH and NGOs can provide the initial leadership in propagating the concept of the use of health data for accountability at the community level. The support of such entities is necessary to provide policy guidelines, develop/adapt training packages, build community and health staff skills, and implement an initial phase of mentoring.

In these guidelines, the community is encouraged to take the initiative to establish, own, and run the forum for shared accountability for health. Nevertheless, there is an increasing amount of evidence that accountability is most effective when there is coalition building across the different levels of society (Hoope-Bendera, et al., 2016; Aslam & Moore, 2016). This can promote collective actions that can leverage wider support from various entities, including the government, civil society, etc. With this perspective, the MOH, CSOs, NGOs, or community-based organizations can take proactive roles in promoting a community-based forum, building capacity of the community and health staff, and establishing networks among community-based forums for shared accountability across the country. Such national- or regional-level entities can play a catalyst role in ensuring that the ownership and management of the forums always remain with the respective communities.

KEY MESSAGES

- A consultation process for orientation and preparation of community leaders is necessary to initiate the implementation of these guidelines. (Appendix 1 provides guidelines on how to initiate the process of establishing the forum for shared accountability for health at the community level; and the slides provided in Appendix 2 can be used for the orientation purpose during this consultative process,)

- For the startup, community leaders and local health personnel should be engaged to form a nucleus of activists who will promote the environment of mutual understanding, respect, empathy, and collaboration between the community and the health system.

- Encouraging community leaders, other community members, and the health staff to use available tools and methods for presenting and using health information empowers participants.

- Initially, fault finding and finger pointing may be the main discussion items. However, community leaders should guide participants to create an environment of constructive criticism in an amicable manner and establish a sense of working together.

- Maintaining meeting minutes is a necessary element for making the forum effective.

- Use of qualitative and quantitative scorecards for self-assessment helps strengthen self-efficacy, which can lead to higher levels of proactive engagement in the sharing of health information and taking actions.

REFERENCES

Admasu, K. (2013). The implementation of the Health Development Army: Challenges, perspectives and lessons learned with a focus on Tigray's experience. *Federal Democratic Republic of Ethiopia Ministry of Health Quarterly Health Bulletin*, 5(1).

Adomako, J., Asare, G.Q., Ofosu, A., Iott, B.E., Anthony, T., Momoh, A.S., … Anderson, F.W.J. (2015). Community-based surveillance of maternal deaths in rural Ghana. *Bulletin of the World Health Organization,* 94:86–91. Retrieved from http://www.who.int/bulletin/volumes/94/2/15-154849/en/

Aslam, G. & Moore, O. (Eds). (2016). *Compilation of case studies presented at the GPSA Forum 2015, Social accountability for citizen-centric governance: A changing paradigm*. Washington, DC: Global Partnership for Social Accountability, The World Bank. Retrieved from http://www.thegpsa.org/sa/Data/gpsa/files/field/documents/compilation_of_case_studies.pdf

Björkman, M., & Svensson, J. (2009). Power to the people: Evidence from a randomized field experiment on community-based monitoring in Uganda. *The Quarterly Journal of Economics*, 124 (2):735–769. Retrieved from https://academic.oup.com/qje/article-abstract/124/2/735/1905094?redirectedFrom=fulltext

Brinkerhoff, D. (2003). *Accountability and health systems: Overview, framework, and strategies*. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc. Retrieved from http://www.who.int/management/partnerships/accountability/AccountabilityHealthSystemsOverview.pdf

Corrigan, J.M., & Fisher, E.S. (2015). *Accountable health communities: Insights from state health reform initiatives*. Lebanon, New Hampshire: Dartmouth Institute for Health Policy & Clinical Practice. http://tdi.dartmouth.edu/images/uploads/AccountHealthComm-WhPaperFinal.pdf

Eggens, H. (2014). *Final evaluation of the Vurhonga community-based TB DOTS project, Mozambique*. Retrieved from https://www.mcsprogram.org/wp-content/uploads/2015/08/World-Relief-Mozambique-FE-Report.pdf

Hoope-Bendera, P., Hilber, A.M., Nove, A., Bandali, S., Nam, S., Armstrong, C., … Hulton, L. (2016). Using advocacy and data to strengthen political accountability in maternal and newborn health in Africa. *International Journal of Gynecology & Obstetrics*, 135(3): 358–364. Retrieved from www.sciencedirect.com/science/article/pii/S0020729216304404

Institute of Medicine. (2011). *For the public's health: The role of measurement in action and accountability*. Washington, DC: The National Academies Press. Retrieved from https://www.nap.edu/catalog/13005/for-the-publics-health-the-role-of-measurement-in-action

Interviews with kebele officials in Kormagefia kebele, Basona Werena wereda, North Shewa, Oromiya—Stage 3 questions. (2013). Retrieved from http://ethiopiawide.net/wp-content/uploads/S3KormargefiaKebele.docx

Mahmud, S. (n.d.) In Bangladesh citizens leave a legacy in health. Citizenship DRC Case Study Series. Retrieved from https://assets.publishing.service.gov.uk/media/57a08b53e5274a27b2000aab/CDRC-Bangladesh.pdf

Protection Partners Forum, Liberia. (2016). Community Responses to Ebola in Liberia. A Report Drawing on a Wide Range of Community Engagement and Empowerment Dialogues (CEED) and Key Informant Interviews across Liberia 2016. Retrieved from http://acts-consultancy.com/docs/Liberia%20CEED%20Ebola%20Report%20FINAL.pdf

Schwarz, R. (2013, April 19). The "sandwich approach" undermines your feedback. Retrieved from https://hbr.org/2013/04/the-sandwich-approach-undermin

United Nations. (2015). Sustainable development goals: 17 goals to transform our world. New York, NY: United Nations. Retrieved from http://www.un.org/sustainabledevelopment/sustainable-development-goals/

SUGGESTED READING

Bayley, O., Chapota, H., Kainja, E., Phiri, T., Gondwe, C., King, C.,… Colbourn, T. (2015). Community-linked maternal death review (CLMDR) to measure and prevent maternal mortality: a pilot study in rural Malawi. *BMJ Open*, 5(4):1–11. Retrieved from http://bmjopen.bmj.com/content/bmjopen/5/4/e007753.full.pdf

Bhuiya, A., Yasmin, F. Begum, F., & Rob, U. (1996). *Community participation in health, family planning and development activities: A review of international experiences*. Dhaka, Bangladesh: International Centre for Diarrhoeal Diseases Research, Bangladesh and The Population Council. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.507.7035&rep=rep1&type=pdf

Campbell, C., Nhamo, M., Scott, K., Madanhire, C., Nyamukapa, C., Skovdal, M., & Gregson, S. (2013). The role of community conversations in facilitating local HIV competence: case study from rural Zimbabwe. *BMC Public Health*, 13:354. Retrieved from https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-354

CARE Malawi. (2013). *The community score card (CSC): A generic guide for implementing CARE's CSC process to improve quality of services*. Atlanta, GA: Cooperative for Assistance and Relief Everywhere, Inc. Retrieved from http://www.care.org/sites/default/files/documents/FP-2013-CARE_CommunityScoreCardToolkit.pdf

Commonwealth Local Government Forum. n.d. The local government system in Rwanda. Retrieved from http://www.clgf.org.uk/default/assets/File/Country_profiles/Rwanda.pdf

Dube, O., Haushofer, J., & Siddiqi, B. n.d. Study summary: Improving health service delivery through community monitoring and non-financial awards in Sierra Leone. Retrieved from https://www.poverty-action.org/printpdf/6691

Edward, A., Osei-Bonsu, K., Branchini, C., Yarghal, T.S., Arwal, S.H., & Naeem, A.J. (2015). Enhancing governance and health system accountability for people centered healthcare: an exploratory study of community scorecards in Afghanistan. *BMC Health Services Research*, 15:299. Retrieved from https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-015-0946-5

FHI 360 and JSI. (2016). *Strengthening health services as part of the post-Ebola transition in Sierra Leone: Community engagement implementation toolkit*. Washington, DC: FHI 360. Retrieved from https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/2017.4.20_apc-ce-toolkitmhformat_tagged.pdf

Flores, W. (2017, March). *Using audiovisual evidence for citizen-led accountability*. PowerPoint presentation presented at Institutionalizing Community Health Conference, Johannesburg, South Africa. Retrieved from http://www.ichc2017.org/sites/default/files/images/Session%2024/Walter%20Flores-Using%20Audiovisual%20Evidence%20for%20Citizen-Led%20Accountability.pdf

Gabriel, A.P., & Mercado, C.P. (2011). Evaluation of task shifting in community-based DOTS program as an effective control strategy for tuberculosis. *The Scientific World Journal*, 11:2178–2186. Retrieved from https://www.hindawi.com/journals/tswj/2011/984321/

Gaudrault, M., LeBan, K., Crigler, L., & Freeman, P. (2015). *Community Health Management Committee Assessment and Improvement Matrix (CHMC AIM)*. Monrovia, CA: World Vision. Retrieved from www.wvi.org/sites/default/files/CHMC-AIM_Final_Draft.pdf

Governance and Accountability Programme: Tanzania. n.d. Retrieved from http://governance.care2share.wikispaces.net/file/view/GAP+Tanzania+Factsheet.pdf

Hoffmann, K.D. (2014). *The role of social accountability in improving health outcomes: Overview and analysis of selected international NGO experiences to advance the field*. Washington, DC: CORE Group. Retrieved from http://coregroup.secure.nonprofitsoapbox.com/storage/documents/Resources/Tools/Social_Accountability_Final_online.pdf

Institute of Medicine. (1997). *Improving health in the community: A role for performance monitoring*. Washington, DC: The National Academies Press. Retrieved from https://www.nap.edu/catalog/5298/improving-health-in-the-community-a-role-for-performance-monitoring

IntraHealth International. (2008). Role of village health committees in improving health and nutrition outcomes: A review of evidence from India. Retrieved from https://www.intrahealth.org/sites/ihweb/files/attachment-files/ER_Brief_VHC%25204.pdf

Jaramillo, E., (2002). *Community contribution to TB care: A Latin American perspective*. Geneva, Switzerland: WHO. Retrieved from http://apps.who.int/iris/bitstream/10665/67432/1/WHO_CDS_TB_2002.304.pdf

Joint United Nations Programme on HIV/AIDS (UNAIDS). (2012). *Promising practices in community engagement for elimination of new HIV infections among children by 2015 and keeping their mothers alive*. Geneva, Switzerland: UNAIDS. Retrieved from http://www.unaids.org/sites/default/files/media_asset/20120628_JC2281_PromisingPracticesCommunityEngagements_en_0.pdf

John Snow, Inc. (JSI). (2012). *Engaging your community: A toolkit for partnership, collaboration, and action*. Boston, MA: JSI. Retrieved from http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=14333&lid=3

JSI. (n.d.) Timor-Leste Health Improvement Project: Engaging communities to improve health. Retrieved from http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=16076&lid=3

Kironde, S., & Kahirimbanyi, M. (2002). Community participation in primary health care (PHC) programmes: Lessons from tuberculosis treatment delivery in South Africa. *African Health Sciences*, 2(1):16–23. Retrieved from www.ncbi.nlm.nih.gov/pmc/articles/PMC2141563/pdf/AFHS0201-0016.pdf

Lynch, U., McGrellis, S., Dutschke, M., Anderson, M., Arnsberger, P. & Macdonald, G. (2013). Systematic review: What is the evidence that the establishment or use of community accountability mechanisms and processes improves inclusive service delivery by governments, donors and NGOs to communities? London, UK: Social Science Research Unit, Institute of Education, University of London. Retrieved from http://eppi.ioe.ac.uk/cms/Portals/0/PDF%20reviews%20and%20summaries/Community%20accountability%202013%20Lynch%20report.pdf?ver=2013-10-08-145129-450

Marais, F., Minkler, M., Gibson, N., Mwau, B., Mehtar, S., Ogunsola, F.,… Corburn, J. (2015). A community-engaged infection prevention and control approach to Ebola. *Health Promotion International*, 31(2):440–449. Retrieved from https://academic.oup.com/heapro/article/31/2/440/1750493

Ministry of Health and Social Welfare, National Tuberculosis and Leprosy Programme, United Republic of Tanzania. (2010). *Community based TB care: Experience from Temeke, Tanzania.* Dar es Salaam: Ministry of Health and Social Welfare. Retrieved from http://ihi.eprints.org/3359/1/community_based_tb_care_experience_from_temeke_-tanzania.pdf

Molyneux, S., Atela, M., Angwenyi, V., & Goodman, C. (2012). Community accountability at peripheral health facilities: a review of the empirical literature and development of a conceptual framework. *Health Policy and Planning,* 27:541–554. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3465752/pdf/czr083.pdf

Nepal, A.K., Shiyalap, K., Sermsri, S., & Keiwkarnka, B. (2012). Compliance with DOTS among tuberculosis patients under community based DOTS strategy in Palpa District, Nepal. *International Journal of Infection and Microbiology,* 1(1):14–19. Retrieved from https://www.nepjol.info/index.php/IJIM/article/view/6717

Ohio Family and Children First. (2008). Effective practice model for county FCFC core function: Shared accountability. Retrieved from http://www.fcf.ohio.gov/Portals/0/Home/Resources/FCFC%20Effective%20Practice%20Models/Shared%20Accountability%20Local%20Model.pdf

Research on Poverty Alleviation. (2008). *The oversight processes of local councils in Tanzania: Final report*. Retrieved from http://siteresources.worldbank.org/EXTSOCIALDEVELOPMENT/Resources/244362-1170428243464/3408356-1170428261889/3408359-1242412320366/tanzania_stageI.pdf

Rifkin, S.B. (1986). Lessons from community participation in health programmes. *Health Policy and Planning*, 1(3): 240–249. Retrieved from www.researchgate.net/publication/260336920_Lessons_from_community_participation_in_health_programmes

Santarelli, C. (2010). *Working with individuals, families and communities to improve maternal and newborn health*. Geneva, Switzerland: WHO. Retrieved from http://apps.who.int/iris/bitstream/10665/84547/3/WHO_MPS_09.04_eng.pdf?ua=1

Shifo Foundation. (2017). Leaving no child behind – closing equity gaps and strengthening outreach performance with My Child Outreach. Retrieved from https://shifo.org/doc/MyChildOutreach.pdf/

Somanje, H., & Barry, S.P. Health systems strengthening: Improving district health service delivery and community ownership and participation. Retrieved from http://apps.who.int/iris/bitstream/10665/1683/1/AFR-RC60-7.pdf

The Global Fund. (2014). Community systems strengthening framework. Retrieved from www.theglobalfund.org/media/6428/core_css_framework_en.pdf

UNICEF. (2016). *UNICEF approach to health systems strengthening: A resource paper for the UNICEF Strategy for Health 2016 – 2030, draft 22 April 2016*. New York, NY: UNICEF. Retrieved from www.unicef.org/videoaudio/PDFs/UNICEF_HSS_Approach_-_22Apr16.pdf

World Health Organization, The Partnership for Maternal, Newborn and Child Health, Countdown to 2030, Health Data Collaborative, UNICEF, UNFPA, The World Bank, UN Women, UNAIDS. (2016). *Monitoring priorities for the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)*. Geneva, Switzerland: WHO. Retrieved from http://www.who.int/life-course/partners/global-strategy/gs-monitoring-readiness-report.pdf?ua=1

Zhang, H.Y., Ehiri, J., Yang, H., Tang, S., & Li, Y. (2016). Impact of community-based DOT on tuberculosis treatment outcomes: A systematic review and meta-analysis. *PLOS ONE*, 11(2): e0147744. Retrieved from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0147744

APPENDIX 1. INITIATION OF A FORUM FOR SHARED ACCOUNTABILITY FOR HEALTH AT THE COMMUNITY LEVEL

The community is the main driver of the use of health data for shared accountability at the community level. Community leaders, whether formal or informal, take the lead role in keeping the process moving. They are the ones who facilitate the establishment of a liaison with the MOH and NGO service delivery units to improve and protect the health of the community, and encourage the community to decide on its priorities, its roles, and its interaction with the health system.

To play this role, community leaders, whether formal or informal, require capacity building to use health data and to facilitate effective meetings. The MOH or local NGO(s) can help set up the processes for using health data at the community level and the mechanisms for shared accountability. The health facility or health unit staff at the community level can play an important role in mentoring and supporting the community to acquire the needed capabilities. This may require capacity building of health staff by the MOH or the NGO/CSOs active in the community. Once the process has been initiated, the community assumes responsibility for running the forum and facilitating meetings. However, if community leaders or any other champion(s) from the community feel confident in using these guidelines on their own, they are encouraged to do so.

The initiation process that follows is based on experience in Ethiopia. It can be customized to the context of a specific community.

Objective

The objectives of this initiation process are to:

1. Contextualize these guidelines in the realities of a specific community. This means identifying an existing forum in which the health data use and shared accountability framework can be embedded; expanding the forum membership to include other members from vulnerable and/or neglected segments of the population; selecting a meeting facilitator from the community; and understanding the nuts and bolts of how to organize an effective meeting on shared accountability at the community level.

2. Orient community leader(s) on the guidelines for establishing and facilitating health data use at the community level for shared accountability.

Initiation Activities

1. Orientation of the community leader, e.g. the village/kebele administrator, elected council member.

2. Organization of the community meeting with health staff.

3. Documentation of the process (how the meeting was organized; who facilitated the meeting; the meeting agenda; what was discussed; meeting decisions/outputs; observations on how well the

community and health staff participated in the meeting; assessment of the meeting using the scorecard).

4. Focus group discussion

5. Adjustment and fine-tuning of the guidelines based on the initiation activities.

Orientation of the Community Leader (e.g., Kebele Administrator, Village Council Member/Leader)

The community leader is provided an orientation on the overall objective of the activity, which explains the following:

- The purpose of the meeting
- What is shared accountability and why is it important; the overall framework for community use of health data for shared accountability; and the matrix for qualitative monitoring of forum performance
- How information sharing and use are central to shared accountability
- Expectations from the activity, i.e., learning to fine tune the guidelines
- How to organize the meeting: who should be invited; where the meeting should be held; who should facilitate the meeting; the role of the observers; use of flip charts as a tool to assist in discussion and decision making; importance of active participation of all meeting attendees, i.e., from the community and from the health system; invitation of a NGO representative to participate in the meeting; expected outputs of the meeting in terms of decisions on health priorities, sharing of information on those priority areas, selecting indicators for monitoring; and deciding on actions and assigning responsibilities to the community and to health staff

The Meeting of Community and Health Staff on the Use of Health Data for Shared Accountability

1. Invitation to the community members and the health staff by the community leader

A. Community members can include:

   i. Village council members

   ii. Religious leaders

   iii. Elderly/respected persons (male and female) in the community

iv. Youth (male and female); members of youth associations in the community

v. NGO (non-health) local representative

vi. Representative from ethnic minorities

vii. Women's groups

viii. Volunteers

B. Health system staff

i. Health extension workers; community health workers (CHWs)

ii. HC head

iii. CHW supervisors from the HC

iv. NGO (health-related) representative

2. Holding the meeting (3+ hours); Facilitator: Community leader or anyone selected from the community (but in no case by the health system or NGO staff)

C. Agenda

i. Welcome and opening

ii. Orientation on:

a) What is shared accountability and why is it important?; the framework for community use of health data for shared accountability; how information sharing and use are central to shared accountability

iii. Matrix for qualitative monitoring of the performance of a community forum for shared accountability for health data: Presentation on the health status of the community (CHW/HEW and supervisor from the HC)

a) Current service coverage at the kebele level (or HC catchment area, if community-specific data are not available)

b) Number of cases of top five diseases (male/female) in the village (or HC catchment area); number of maternal and newborn deaths in the past six months in the village/community; status of malnutrition, sanitation, bed nets distribution, deliveries at the HC

c) Services available at the community/health post and HC; other programmatic activities conducted by the health system (public and NGO)

d) Community reporting (informal reporting/sharing information known to the community) on disease occurrences, maternal deaths, newborn deaths, use of health services, pockets of neglected populations

e) Brainstorming on the health issues prevailing in the community (use flip chart to record all the points/ideas expressed by the community)

f) Prioritization of the health issues (using simple scoring/voting by each participant)

g) Discussion and decision on possible activities to address the priority issue(s)

h) Assigning roles and responsibilities to health staff and the community

i) Selecting/deciding on indicators to monitor progress

j) Next meeting time and agenda (if the community is eager to continue with such meetings).

iv. Self-assessment of the meeting (facilitated by the community leader or other community member)

a) Participants self-assess the performance of the meeting using the matrix for qualitative monitoring of a community forum for shared accountability for health data; open discussion of these questions:

- Did the participants find the meeting useful?
- Do they want to continue with such meetings; if yes, how can they ensure continuity?
- What could have been improved or discussed to make the meeting fruitful/effective?
- Based on the qualitative assessment, did community and health staff commit to taking responsibilities and holding themselves accountable for the actions that they voluntarily decide to implement? What can be done to improve the forum performance in terms of data sharing and taking responsibilities for actions?

D. Documentation of the process (done by the organization assisting with the initiation of activities or the champion from the community)

a. Who attended the meeting?

b. Who facilitated the meeting?

c. What was the venue?

d. What was presented; discussed?

e. What questions were asked during the meeting?

f. What tools were used to facilitate discussions?

g. General observations on the participation of the community and health staff; data presented.

E. Focus group discussion with participants (done by the organization assisting with the initiation of activities or the champion from the community)

a. Discussion points

- Utility/necessity of such meetings?
- How to improve the meeting (e.g., who else should participate; how the community can take ownership to regularly organize such meetings)?
- How to ensure that the health staff from the HC or even from the district can participate in these meetings?
- Is there any need for training the community?
- If they are to continue such meetings, how can they cover the expenses; who will be responsible for calling the meetings in future?
- How to make the presentations of health data more understandable and informative for the community?

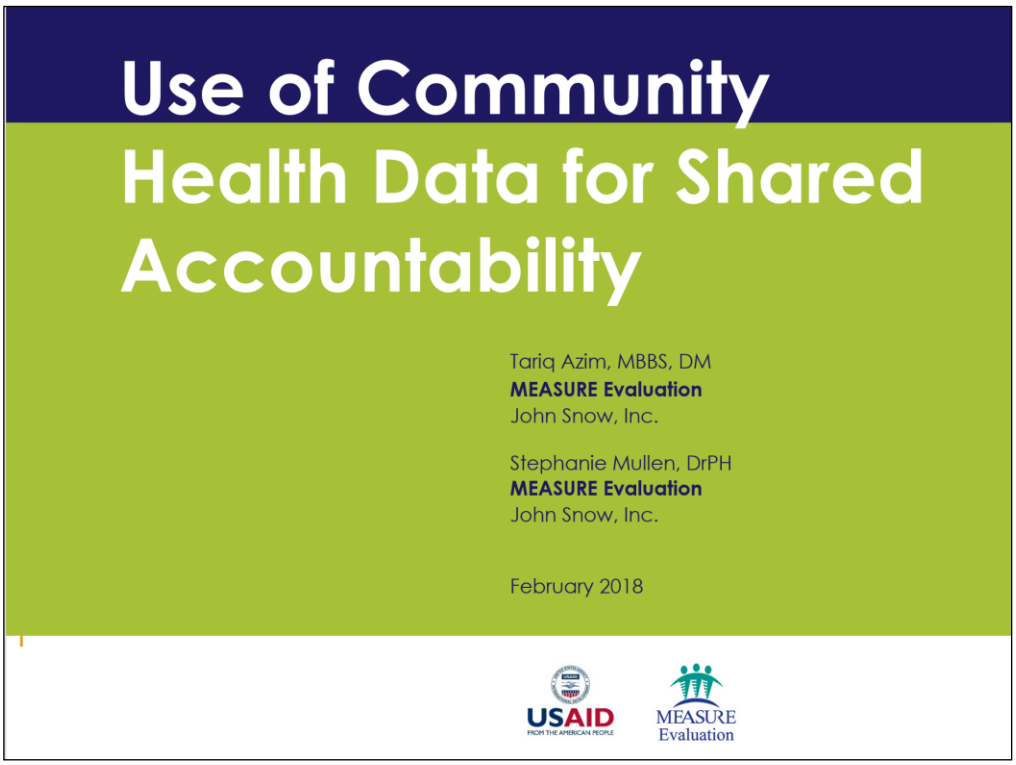
F. Adjustment and fine-tuning of the guidelines based on the initiation activities (done by the organization assisting with the initiation of activities or the champion from the community)

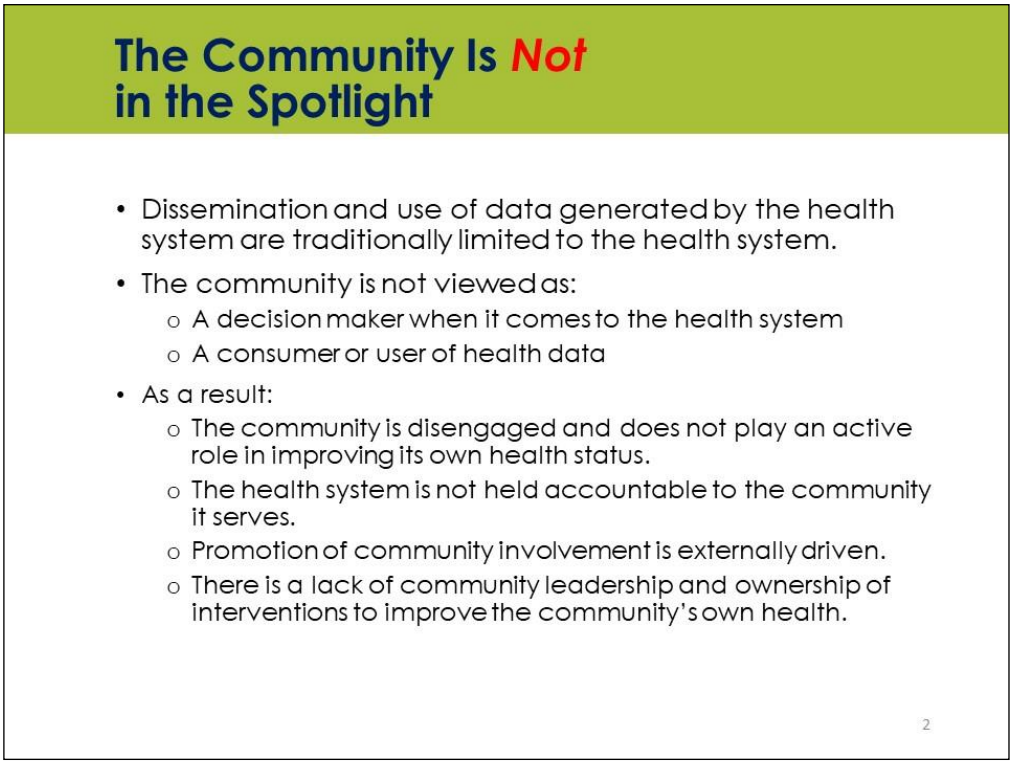
b. Report the findings to the community leader(s) and the forum.

c. Decide on adjustments/customization of the guidelines.

d. Circulate/share the revised standard operating procedures for the forum/meeting.

APPENDIX 2. SLIDES FOR COMMUNITY ORIENTATION FOR THE INITIATION





Community Ownership & Accountability

- Ownership requires:
  - Taking responsibility
  - With that comes accountability
- Accountability:
  - Committing to decisions and/or actions and holding oneself answerable for those actions and their consequences

3

Shared Accountability to Ensure Health

- Shared accountability is defined as a process by which partners hold one another responsible for the commitments that they have voluntarily made to each other (Institute of Medicine, 2011).

- Both the community & the health system (public and/or private) are accountable for:
  - Sharing health and related information
  - Taking actions to improve/maintain health
  - Publicly reporting and answering questions about those decisions and/or actions

4

Shared Accountability for Health at the Community Level

Purpose:

- Create an enabling socio/political environment of mutual trust and transparency between the community and the health system
- Support the taking of collective responsibility and commitment to shared accountability to improve health service delivery
- Contribute to the overall health of the community

5

Basic Principles: Community Health Data Use for Shared Accountability

- The community takes the leadership role in running the forum/meeting
- Use an existing forum at the community level
- The community and the health system both share health and related data/information
  - Health status, service coverage, disease occurrences, service availability, maternal & infant deaths
- Mutually decide on the health priorities and voluntarily commit to taking responsibility for addressing health priorities
- Promote transparency and open sharing of data while ensuring privacy and security

6

Qualitative Monitoring of Forum Performance

Legend: Green = desired performance Yellow = acceptable performance Red = unfavorable situation		Health System	
		Shared Information	**Took Actions**
Community	**Shared Information**	Box 1: Both the health system and the community shared information	Box 2: Community provided information; health system acted on it *(health system's responsiveness)*
	Took Actions	Box 3: Health system shared information; community acted on it *(community engagement in taking action)*	Box 4: No information was shared, but both the health system and community acted on their own

Quantitative Monitoring of Forum Performance

Table 2. Scorecard for shared accountability for community health data use and actions

Community domains							
Leadership		**Participation**		**Information sharing**		**Taking action**	
	Score		**Score**		**Score**		**Score**
External facilitators called the meeting.	0	The meeting was attended only by community leaders.	0	No information was shared.	0	No action	0
The community leadership organized the meeting. The community leader called the meeting and presided over it.	1	The meeting was attended by only one homogenous group of people from the community (e.g., women's group only; youth group only).	1	The community shared information about its health needs, and/or complaints about the services provided at the local/district health facilities.	1	Community actions were limited to behavior change communication.	1
		The meeting was attended by a mixed group of people from the community, such as community leaders, respected elders, women representatives, youth, and representatives of ethnic groups.	2	The community shared information about: • Its health needs • Maternal deaths and newborn deaths, and • Disease outbreaks, and service needs of specific target groups, and • Information about the health issues of ethnic/ deprived sections of the community • Complaints about the services provided at the local/district health facilities	2	Community took affirmative actions that required resource mobilization by the community.	2
		The meeting was attended by the public and by community leaders, respected elders, women representatives, youth, and representatives of ethnic groups.	3	The community shared information about: • Its health needs • Maternal deaths and newborn deaths, and • Disease outbreaks, and service needs of specific target groups • Information about the health issues of ethnic/ deprived sections of the community, • Complaints about the services provided at the local/district health facilities • Assisted in data quality checks at the community level (i.e., the community verifies reports on the provision of health services to households, especially services for target groups and ethnic/disadvantaged groups)	3	In addition to taking affirmative actions for the general population, the community focused actions to support vulnerable or deprived populations.	3
Domain score							
Subtotal score for community							

Shared Accountability: Cases

- **Disease epidemics: sharing responsibilities and working in tandem**
  - Liberia Ebola crisis
    - There was widespread noncompliance with government-imposed cremation to prevent viral spread.
    - Traditional and religious leaders influenced the development of World Health Organization guidelines on safe burials with dignity, which became government policy at the end of 2014.

Shared Accountability: Cases

- **Community-based maternal death surveillance**
  - Accra, Ghana
    - A modified survey system of community-based reproductive age mortality using six questions was implemented in the Bosomtwa district of Accra
  - Malawi
    - Community-linked maternal death review: Communities and health facility staff worked in partnership to investigate and respond to maternal deaths occurring in communities and at health facilities

Shared Accountability: Cases

- **Community-based tuberculosis directly observed treatment, short course (TB-DOTS): accountability on both sides**
  - Mozambique
    - Clients choose their DOTS with support from the local volunteers, known as *padrinhos*
      - Example of community taking responsibility for supervising TB-DOTS
      - Padrinhos make themselves accountable to the larger community regarding adherence to DOTS by the clients of TB services.

This presentation was produced with the support of the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. The views expressed in this presentation do not necessarily reflect the views of USAID or the United States government.

APPPENDIX 3. LESSONS FROM THE PILOT IN ETHIOPIA

Background

A pilot test of these guidelines was carried out in Ethiopia. It was conducted in a rural kebele located in Amba Giorgis woreda (district) north of Gondar city, in northwest Ethiopia. A kebele is the smallest administrative unit in Ethiopia; it can have two to three villages. The kebele has a council; the head of the council is the kebele administrator.

Three consultants from the University of Gondar (UOG) in Ethiopia facilitated the pilot. However, the meeting of the community and health staff was led by the kebele administrator.

The Setting

In the test kebele, there are three different types of community meetings that are held regularly. They are:

- Meeting of the kebele council, which consists of 236 members from the community
- The kebele command post meetings
- The HDA meetings, which bring together HDA members (mostly female) and HEWs every two weeks

The first two forums are more political; health is not a prominent topic of discussion during the meetings. In contrast, health is the main agenda item of the HDA meetings. The kebele administrator decided to use the HDA forum for the meeting on the use of health data for shared accountability. He also agreed to invite elderly and religious leaders and youth from the community and HC staff serving the kebele.

Organizing the Meeting

The organization of the community meeting in the kebele to share health data and talk about accountability required three steps:

- **Step 1:** Communication with and orientation of the community leader, in this case the Kebele administrator. This was carried out by the facilitators from the UOG.
- **Step 2:** Preparation for the meeting
  The kebele administrator arranged a meeting with the HEW, the HDA leader, and a maternal and child health (MCH) expert from the local HC to prepare for the meeting. The facilitators from the UOG assisted them in preparing the agenda and the presentations by the HDA leader, the HEW, and the MCH expert. Flip charts were used to record the data that would be presented by each person.
  The HDA leader was responsible for informing all HDA members to participate in the meeting. The kebele administrator invited two religious leaders, two respected elderly persons, and two youth leaders from the community.

- **Step 3:** The actual meeting

  The meeting was held in the open area adjacent to the health post in the kebele. Forty-eight female members of the HDA, two religious leaders, two respected elderly persons, and two youth leaders from the community, three HEWs, and an MCH expert and a midwife from the local HC attended the meeting. The kebele administrator led the meeting. The facilitators from UOG were also present, but only as observers.

The meeting was conducted in the local language. It was preceded by a coffee ceremony, which is a usual cultural practice in Ethiopia, arranged by volunteers from the HDA.

The HDA leader reported that in her area, there are two infants, and both are receiving immunization doses, and about two-thirds of the women eligible for family planning are using contraceptives. She also reported that in recent days, there were three women who gave birth. Two delivered at home, and the third delivered at the health facility. Unfortunately, that mother died at the health facility, but her child lived. She also advised that one of the women who delivered at home initially went to the district hospital but was sent back because the health staff told her that her delivery time was not due. However, that woman delivered at home on her return from the hospital. The HDA leader raised the issue of the availability of an ambulance for accessing delivery services at the HC or hospital.

Next, one of the HEWs, who was the head of the health post in the kebele, presented on the types of health services offered at her facility; the top five health problems/diseases in the community; and, in an interactive manner, provided health education on acute watery diarrhea, which at that time was the top health problem in the community.

The MCH expert reported that the overall immunization coverage in the community was good and, unlike other kebeles, there has been no reporting of vaccine preventable diseases in the kebele. He also listed the achievements made by the community in the implementation of the model household strategy. For example, almost all households have private latrines, but the community is still not accepting the installation of smoke outlets in their kitchens. He also pointed out that the unavailability of an ambulance is due to the shortage of ambulance drivers. The MCH expert advised that a team from the Woreda Health Office and HC would stay in the kebele for about a month to provide technical and logistic support to the HEW.

These presentations were followed by open discussion. Several issues were raised, ranging from the difficulty of constructing latrines and smoke-free ovens without the help of others, to resistance by the male members of the community to separate the cattle house from the main house, and negligence and uncompassionate behavior by some HC/hospital staff toward women who come for delivery services. The religious leader emphasized the use of family planning methods, while the village elder advised of the donation of *teff* (local grain) to the local HC for its maternity ward so that women coming for delivery can receive their traditional cereal during their stay at the HC.

The health experts from the HC explained the efforts made to improve delivery services and provided the phone number to call the ambulance service. He also committed to assessing the behavior of HC health staff and to discuss the issue with the staff and provided the "Family Health Card" to participants for their health education.

The village elderly persons also committed to disseminating health education messages during their public gatherings. The kebele administrator took responsibility for following up on the decisions taken and issues raised in the meeting.

Review of the Test Meeting Based on the Basic Principles of Community Health Data Use for Shared Accountability

Principle 1. The community takes the leadership role.

Finding

In this case, the kebele administrator took the lead. This helped to quickly organize the meeting, facilitated the participation of health staff from the health post and the woreda health office, and added value to the discussions that took place between the community and the health staff. He also acted as a moderator. Although there was some finger-pointing, the presence of the kebele administrator helped to keep the tone of the meeting to one of collaboration and taking responsibility for solutions.

Principle 2. The community and the health system take advantage of an existing forum at the community level and agree on revising the SOW of the community forum to make it relevant to the use of health data for shared responsibility.

Finding

The kebele administrator and the HDA members and the health staff were already well-oriented on holding community meetings. The process just required adding a few members from the community and thorough preparation on presenting the health data to make the meeting effective.

At the end of the meeting, the participants supported the idea of involving the religious leaders, respected elderly persons, and youth leaders from the community.

Principle 3. All entities privy to shared accountability for health at the community level mutually decide on the health priorities and assign responsibilities for addressing those priorities.

Finding

There was a of realization that everyone should take responsibility within their own areas to improve the health of the community. The community was able to voice its concerns about the nonresponsiveness of the health system, while the health staff were able to direct attention to the community's roles. At the end, the kebele administrator, the religious leaders, the HDA team leader/members, and the health staff voluntarily took assignments.

Principle 4. Transparency and open sharing of data are practiced while ensuring privacy and security.

Finding

Simple visual presentations of the health data by the HEW, MCH expert from the HC, and the HDA team leader helped to give a better view of the health status of the community and contributed to the focused discussions on the health issues prevailing in the community. The open discussion also brought forth several concrete instances of health and health service-related issues in the community.

There were a few instances where the community members mentioned the name of the health staff in relation to a behavior, but that was done when they were specifically asked for a name. Nevertheless, when reporting on family planning method users and delivery cases, confidentiality of the persons was maintained.

Principle 5. All entities make a voluntary commitment to achieving the agreed-upon performance goals.

Finding

The assignments taken by meeting participants were done on voluntary basis. There was no pressure on anyone to commit to taking any action. This helped keep the meeting atmosphere congenial and respectful.

Comments by Observers from the University of Gondar

- These kinds of meetings are important because they include all possible stakeholders at the community level. Community members were very excited about the meeting and they urged that it continue. Even the male participants (other than religious leaders and community elders) insisted on being part of the meeting even though the HDA teams are women-only networks.

- Involving health managers from the woreda (district) health office at each HDA meeting is useful, but this is not feasible for actual implementation because there are lots of HDAs in a given community.

- There was finger-pointing among participants, but it was beneficial in terms of identifying the root causes of problems and taking specific responsibility for future actions.

- To increase the effectiveness of the meeting, detailed training on how to conduct the forum meetings, orientation on important /relevant health indicators, and training on how to do simple analysis of the health data (e.g., making comparisons between the number of past and present disease occurrences) is very important for the Kebele administrator, HEWs, and HDA leaders.

MEASURE Evaluation
University of North Carolina at Chapel Hill
123 West Franklin Street, Suite 330
Chapel Hill, NC 27516 USA
Phone: +1 919-445-9350
measure@unc.edu
www.measureevaluation.org

This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of the MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government.
TR-18-238

ISBN: 978-1-64232-009-1

USAID
FROM THE AMERICAN PEOPLE

MEASURE
Evaluation