

Can Multi-stakeholder Committees Create Accountability?

Lessons from Community Scorecards in Local Health Services

The Non-State Actors Component (NSAC) of the DFGG project resulted in citizen or community monitoring of over 300 schools, 100 health centers and 100 communes. This provided a sample to compare approaches to the design and implementation of a well-known social accountability tool. In the early stages of agreeing the scope and content of grants, it was noted that many Cambodian NGOs were opting to implement community scorecards – a feedback and dialogue mechanism – through committees comprised of Councilors, service providers and citizens. This Learning Note considers the experience of multi-stakeholder committees in facilitating citizen feedback processes. It sets out what worked, what didn't work and why and presents some simple lessons.

Introduction

Community scorecards (CSCs) provide a mechanism to monitor the services that are provided by, inter alia, schools, health centers, communes and districts. A variety of approaches were developed through the grants to non-state actors. Being able to compare and contrast this experience has been very useful for lesson learning and moving forward with those lessons in mind.

One of the commonalities found in the implementation of the CSCs developed in DFGG was that the committees established to carry out the scorecard were mixed. Research¹ conducted over the same period in baseline communities was illustrating the limitations of these groups (e.g. the school support committee, and health center management committee) in enhancing citizen voice. During DFGG implementation, a key concern of technical specialists² was that the vehicles that were being selected in some sub-projects to execute activities focused on enhanced accountability, included some of the service providers that were to be held accountable. To better understand implications of multi-stakeholder committees, often appointed by government to conduct citizen outreach, an effort was made to better understand the experience and lessons learned during implementation.

Multi-stakeholder Committees. In the early 2000s, Cambodia began experimenting with local management committees. With the aim of promoting cooperation between state and non-state actors, these committees are a hybrid of participatory citizen bodies and sectoral government committees. Membership includes both government staff and citizens, and a local government representative usually appoints the citizen volunteers (though in some cases NGOs will select specific citizens to

assist on projects) – an issue that shapes the potential for these actors to play a social accountability role. In the health sector, committees include the health center management committee (HCMC) and its affiliate at the village level, the village health support group (VHSG).

The HCMC is a multi-stakeholder group including sub-national officials and service providers. The HCMC prepares and monitors implementation of the HC annual operational plan; manages the HC budget, including fees; maintains buildings and equipment; and refers patients to referral hospitals. The HCMC is also designed to build a horizontal bridge between the health center and the commune, as the commune council (CC) chief heads the committee and the health center chief plays the role of his deputy.



The VHSG is comprised of village volunteers and state actors often including the village chief and deputies. The VHSG supports the HCMC with official duties including: ensuring a regular flow of information between the community and the HC; distributing health education materials to villagers; assisting the HC in outreach and health campaigns to raise health related awareness; helping detect cases of tuberculosis; identifying poor households in their villages (to be exempt from payment for health services); and, organize transport for referred patients to the HC or referral hospitals.

In three of the NSAC grants, NGOs worked closely with these multi-stakeholder committees to assist in the facilitation of the community scorecard (CSC) on health services.³ The three NGOs had a long history of working in the health sector, and used a combination of members from HCMCs, VHSGs, and other local sub-national

¹ *Voice Choice and Decision 2: A Study of Local Basic Service Delivery in Cambodia (2013)*, The World Bank and The Asia Foundation.

² From The Asia Foundation and the World Bank

³ The three organizations working on promoting accountability in the health center included: Buddhism for Health (BFH), Reproductive and Child Health Alliance (RACHA), Reproductive Health Association of Cambodia (RHAC). BFH utilized commune councilors and VHSG volunteers; RACHA, a range of HCMC, VHSG, and commune officials; RHAC, commune councilors from HCMCs.



authorities to facilitate the CSC. The committees played three key roles in this project, assisting NGOs to: identify and convene citizens to participate in the CSC process; facilitate citizens to identify common concerns and undertake scoring of health services; and facilitate interface meetings to create action plans or joint list of priorities to improve health services.

Contributions

Mobilization. It is important to note that there were synergies between the mandate of multi-stakeholder committees and the benefits of the CSC. Given their role in outreach and promoting transparency, in some respects, the committees were a natural partner in raising awareness about the CSC process and how it can improve service delivery. As they were already involved in disseminating material and organizing meetings, they played a role in convening and organizing community meetings.

Outreach and follow-up. While there were concerns about the suitability of these quasi-state actors as independent facilitators, in some cases they played an important role in outreach and follow-up after the CSC exercise. First, by providing clear outreach on the roles/responsibilities for health care professionals at the various tiers, members of the VHSg were also able to ensure that expectations of the citizens were aligned with the services that were available. To this point, based on the findings of a brief survey, RACHA reported improved transparency in 20 out of 21 and improved outreach in 15 health centers in Prey Veng, suggesting that incorporating VHSgs into CSC activities partly led to improved outreach and access to information.

Challenges. Based on this initial evidence, grantee NGOs agreed that using HCMC and VHSgs for demand-side activity can be problematic and undermine CSC goals.

HCMC and VHSg members as facilitators. Three problems emerged when HCMC and VHSg members were used to facilitate the CSC process. First, they affected citizen/user engagement and honesty as they were seen to be appointed by, and representing the health center staff; second, they lacked facilitation experience; and third, as they were volunteers, their level of participation was not always reliable. Most NGO grantees suggest that given the close ties between these quasi-state actors and health staff, and the fact that they are usually appointed, not selected, they would struggle to provide neutral and independent facilitation. This often led to CSC sessions with weak participation – citizens being guarded in their critique, facilitators dominating and determining responses (as they felt more knowledgeable about health care than ordinary citizens). It should be noted that this finding was not shared by all the implementing NGOs however, some saw benefit in knowledgeable resource people. RACHA for instance, reports that although the VHSgs had limited knowledge of the overall aim of the CSC, their role was helpful in facilitating participation of the community.

Strengthening Capacity of Committees

HCMC oversight. Feedback from grantees (and evidence from the VCD2 research) indicates that Commune Chiefs, in their role as Head of the HCMC, lack confidence to address issues due to concern with their technical knowledge. Incorporating the HCMC into the CSC and action planning process helped to: develop understanding of issues affecting service delivery; and provide Commune Councilors with a clear mandate from service users for actions to be achieved to improve services.

Information flows through the VHSg. Evidence from fieldwork suggests that VHSg members are effective at disseminating information to citizens, but most lack confidence to convey candid citizen feedback to health centers. The CSC process addresses this weakness by facilitating citizen feedback directly to the service. VHSg members then become an effective tool to assist ongoing monitoring of agreed action items for the HCMC. As the Commune Chief heads the HCMC, which coordinates closely with VHSg, this feedback has helped to improve the Commune's awareness of ongoing challenges and enabled them to better respond to citizen concerns. Thus incorporating VHSg into the CSC processes compensates for low capacity acting as feedback mechanism whilst capitalizing on strengths for monitoring of action plans.

Recommendations. Moving forward it is important to continue gathering empirical evidence as to the impact on the disaggregated objectives of the social accountability process: improved service delivery, improved accountability and improved social capital and empowerment. Second, state and non-state actors implementing the community scorecard should make sure that the roles of facilitation, monitoring and follow up can be separated so that safe space is created for communities to provide candid feedback, but that the benefits of quasi-state actors is also incorporated. Utilizing these actors in outreach, monitoring, and through quasi-technical roles contributions can be productive. Moreover, they can uniquely report on progress to both citizens and health center actors, underscoring their potential to play a coordinating role in the future.

This note outlines the benefits and pitfalls of involving quasi-state actors in social accountability activities. It suggests that further work is needed to evaluate impact, but that it is desirable to disaggregate the roles of local actors in the implementation of community scorecards, especially to enhance citizen voice while also optimizing the benefits of both linked-in village volunteers and independent facilitators.

The DFGG Learning Note Series provides quick summaries of the lessons learned in the field. This note reflects on lessons learned in the Non-State Actor Component. It is based on experiences reported in grantee reporting, consolidated monitoring reports, and an earlier World Bank field visit.

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