HEALTH SYSTEMS STRENGTHENING ACCELERATOR

Improving Linkages between Social Accountability and Social and Behavior Change:

A Preliminary Report of Country Data Collection for Côte d'Ivoire, Ghana, and Guinea

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About the Accelerator

The Health Systems Strengthening Accelerator (Accelerator) is a global health system strengthening initiative, funded by the United States Agency for International Development (USAID), with co-funding from the Bill & Melinda Gates Foundation that supports local partners as they find their own pathways to meaningful and lasting health systems change.

The Accelerator is led by Results for Development (R4D), with support from Health Strategy and Delivery Foundation (HSDF), headquartered in Nigeria, and ICF. Additional global, regional, and local partners will be selected in partnership with USAID/Office of Health Systems and USAID Missions based on demand.

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Disclaimer

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Abbreviations and Acronyms

CBO	community-based organization
CCP	Johns Hopkins Center for Communication Programs
CHPS	Community-based Health Planning and Services
CSO	civil society organization
FY	fiscal year
GDP	gross domestic product
GHS	Ghana Health Service
HSS	health systems strengthening
MHPH	Ministry of Health and Public Hygiene
NGO	nongovernmental organization
NHIS	National Health Insurance Scheme
OHS	Office of Health Systems
OGP	Open Government Partnership
PMTCT	prevention of mother-to-child transmission
RANAS	Risks, Attitudes, Norms, Abilities, and Self-Regulation
SA	social accountability
SBC	social and behavior change
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Background

The Health Systems Strengthening Accelerator (Accelerator) is a 5-year program funded by the United States Agency for International Development's (USAID) Office of Health Systems and the Bill & Melinda Gates Foundation. The Accelerator works with local, regional, and global partners to identify pathways to self-sustaining, strong health systems. The Accelerator is led by Results for Development with ICF, the Health Strategy and Delivery Foundation, and a growing consortium of local and regional partners including Global Challenges Corporation and RIP+ in Côte d'Ivoire and Benin-based CERRHUD in Togo.

Between May 2020 to October 2020, the Accelerator team designed and implemented a study on the linkages between social accountability (SA) and social and behavior change (SBC). The study centered on investigating examples of and strategies for social accountability activities to be more social and behavior change oriented in their design and implementation, including in relation to efforts to advance Universal Health Coverage (UHC).

Literature and international development practitioners commonly define social accountability broadly and frame the work as strategies, tools, or approaches that aim to increase the degree that government and health service providers are held accountable for their conduct, performance, and management of resources. Often social accountability activities are grounded in amplifying citizen engagement. Social and behavior change programming works to help individuals, households, and communities recognize the possible negative and positive impacts of choices and actions as well as how context influences behavior. Specific social and behavior change strategies, approaches, and interventions rely on evidence and data to communicate and foster preferred practices. USAID and other international development actors, such as the World Health Organization and the World Bank, define UHC in terms of access to essential health care, including safe, effective, quality, and affordable essential medicines and vaccines, along with protection from catastrophic financial risk.

The SA-SBC linkages study seeks to address the under-considered linkage of social accountability and behavior change within health systems strengthening (HSS) work, including work that aims to increase equity and efficiency through UHC.

Methods and Data Collection

A series of literature reviews were conducted to explore linkages between social accountability and social and behavior change. The reviews focused on the global context as well as perspectives from the three selected countries—Côte d'Ivoire, Ghana, and Guinea. In addition, an online survey and key informant interviews were conducted. Given COVID-19, data collection among HSS and UHC stakeholders was conducted virtually. A link to the survey was shared by email with 1,370 stakeholders and 179 were responses received (13.1% response rate). A total of 21 key informant interviews were conducted using Zoom among 6 broad categories of HSS and UHC stakeholders.

This executive summary provides analysis of some of the online survey data in general and in relation to each of the five research questions.

Findings

A total of 179 individuals responded to the survey, including 135 men, 43 women, and 1 respondent who did not indicate their sex. There were 76 responses for Côte d'Ivoire, 74 for Ghana and 29 for Guinea. Across the three countries, 31.8% of respondents reported that they work for a government ministry, and 28.5% reported that they work for a nongovernmental organization. In Guinea, however, respondents who reported that they worked for a nongovernmental organization were comparatively lower (6.9%), and respondents who reported that they worked for an implementing organization (27.6%) and donor agency (20.7%) were comparatively higher. When asked to characterize their work in relation to the six World Health Organization building blocks, 35.6% indicated that they work in leadership and governance.

Across this breadth of survey respondents broadly categorized as HSS and UHC stakeholders, some of the findings are noted below, organized in relation to the five research questions.

Research Question 1: To what extent do social accountability approaches explicitly pull in behavior change strategies, and what are the dynamics and nuances surrounding the ways these two prominent areas tend to operate in isolation of each other?

Literature suggests that examples in which programs, activities, or strategies make an explicit link between social accountability and social and behavior change are not common. The interview participants shed light on the ways that the term social accountability may not be universally known, and, as such, they suggested that many activities embody the intent of social accountability but are not necessarily cast as social accountability specifically. In addition, many of the responses to the open-ended questions in the survey reflected unfamiliarity with framing the work of health system institutions, such as health care facilities and the government, as sites for potential behavior change. Taken together, these two findings align with the limited examples across the literature of explicitly delineating the link between social accountability and social and behavior change.

In a 2005 working paper entitled *Social Accountability in the Public Sector: A Conceptual Discussion and Learning Module*, the World Bank Institute posited that there are six elements of social accountability by which systems and interventions can be classified:

- The spectrum of punishment versus reward
- The spectrum of rule following versus performance-based evaluation
- Level of institutionalization (i.e., ad hoc activism or institutionalization into law)
- Level of involvement of citizens versus external actors
- Inclusiveness of participation (i.e., whether elitist or more inclusive)
- Branches of government that are targeted

In the context of the social accountability literature, the results from this study suggest that it is important to consider a seventh dimension—the degree to which the social accountability system catalyzes social and behavior changes on either the side of the citizenry or state actors. This is an important question, because literature has revealed several challenges with social accountability interventions in the past, suggesting that specific social and behavior change mechanisms are needed to improve the effectiveness of social accountability activities.

Research Question 2: What might be gained through more targeted efforts to include behavior change strategies within social accountability approaches? What would this look like, particularly in relation to social accountability in support of UHC?

Across the 179 respondents, 92.7% indicated that there is an active effort to advance UHC in their country, with 53.8% reporting that the effort has been active for 1 to 5 years. Data from the key informant interviews, however, suggest that UHC efforts may not be as active and operational as the survey respondents indicate. The strong response from survey respondents around the existence of UHC efforts may have been more aspirational, whereas the key informant interviews allowed more time to reflect on the degree that a UHC effort is known to both national and sub-national stakeholders and citizens. Among all survey respondents, the most commonly selected barrier to citizen participation in UHC efforts was that there are few organizations bringing citizens together to focus on UHC.

Respondents were largely split about whether social accountability activities are being used to advance UHC. A total of 48.5% of respondents indicated that they are, and 51.5% indicated that they are not. A larger percentage of respondents in Ghana (65.3%) reported that social accountability approaches are being used, compared to 41.4% in Guinea and 34.3% in Côte d'Ivoire.

The challenges that respondents reported in relation to social accountability in support of UHC included a top-down approach in developing and rolling out UHC, few if any processes for involving citizens, a lack of a culture or of understanding of social accountability, and poor citizen organization and mobilization. Further, many respondents indicated that UHC is not a priority for the government and that there is weak mobilization for UHC and for social accountability.

Taken together, these findings potentially indicate that social accountability in support of UHC would need to both unite citizens and stakeholders and improve on strategies for disseminating policies and related information from the national level to the different levels of a decentralized government and health system.

Research Question 3: What social accountability approaches have been implemented recently, and by whom? What factors have influenced successes and challenges with these approaches, and to what extent did behavior change (or lack of behavior change) play a role?

Across the 179 respondents, 68.7% indicated that social accountability is prioritized in their country. Responses to likert scale questions suggest that more respondents in Ghana felt that social accountability activities were being implemented successfully, compared to Côte d'Ivoire and Guinea. Government support and citizen advocacy were noted as key to the success of social accountability.

Challenges with implementing social accountability activities reported centered on the need for more transparency, communication, good governance, collaboration, and community engagement. In addition, the respondents suggested social accountability activities, such as information-sharing, health care facility forums, exchange and feedback mechanisms, quality assessments, and performance monitoring tools.

Perceptions about the degree that social accountability is prioritized appear to be different, depending on the organization type of the survey respondent. Among respondents who reported that they work

for the government, 78.9% indicated that they feel social accountability is prioritized in their country. Among the eight other organization types collectively, 63.9% of respondents indicated that they feel social accountability is prioritized in their country.

The survey focused on eight common social accountability activities. In general, respondents said that these activities have been implemented in their country and have been successful in increasing social accountability. The data suggest the following:

- Partnership-defined quality, public hearings, and community radio were perceived to be the most successful social accountability activities.
- Perceptions about the use and success of citizen satisfaction surveys and citizen voice and action were mixed across the three countries.
- Participatory budgeting, community scorecards, and user-centered information dissemination were most frequently reported as social accountability activities not being used.

Research Question 4: To mobilize considerable and diverse voices to engage in social accountability approaches in support of UHC, what individual-level and institutional-level behaviors need to change and in what ways?

Government officials are thought to be UHC leaders in all three countries—78.9% of respondents in Côte d'Ivoire and 83.8% of respondents in Ghana agreed or strongly agreed that they were leaders. Although a slightly smaller percentage (58.6%) in Guinea identified government officials as leaders, more respondents selected agree or strongly agree for government officials than any other category. This is not an indication that government plans have been effective in advancing UHC, but rather that stakeholders view government as leading efforts, whether for good or bad.

Across the three countries, the percentage of respondents replying strongly agree or agree that specific groups are well represented in efforts to advance UHC are relatively low, as presented in Table ES-1. These findings suggest that UHC efforts are perceived to struggle with representativeness. Striving for greater representativeness is an important strategy that can be achieved by changing behaviors to adopt more inclusive processes with collaborative work between government, health care providers, health care institutions, and citizens.

Table ES-1: Percent of Respondents Agreeing Specific Population Groups Represented in Universal Health Coverage Efforts

	Côte d'Ivoire	Ghana	Guinea
Men	20.0	40.5	24.1
Women	17.3	31.1	37.9
Youth	16.0	18.9	27.6
Persons with disabilities	16.0	14.9	17.2
Individuals with specific health conditions	14.7	12.3	20.7
Individuals who struggle with mental illness	6.8	5.5	10.3
Urban citizens	23.0	28.4	41.4
Rural citizens	21.3	18.9	37.9

Research Question 5: What lessons have been learned around how to foster productive alliances and common goals between citizens and government, including behavior change-related lessons?

Foundational to productive alliances is a landscape in which stakeholders work together while also routinely pursuing new ways of working together or with different stakeholder groups. Across all respondents, the types of stakeholder collaboration most commonly reported included the following:

- Improve communication and coordination of activities related to HSS and UHC
- Strengthen community-level implementation and participation
- Improve population health outcomes
- Strengthen technical capabilities and results-based management for project implementation
- Strengthen use and dissemination of media and information
- Improve data collection and analysis for evidenced-based decision-making
- Help mobilize resources toward a specific health outcome
- Improve social accountability
- Improve financial management
- Increase participation of civil society organizations and the private sector
- Strengthen policies, governance, and leadership
- Enhance capabilities in geographic information systems

Only in Ghana did the majority of respondents feel that stakeholders other than government officials were actively involved in advancing UHC efforts. In Côte d'Ivoire and Guinea, health service providers, heath facility managers, and citizens were not perceived as being engaged in the process.

Respondents in all three countries agreed that citizens are engaged in demanding quality and affordable health care. However, fewer than a third of the respondents felt that facility providers or administrators were accountable to patients, and fewer than half agreed that the government was accountable to citizens for providing quality services, information about health services, and equitable allocation of financial resources.

Most respondents, particularly in Côte d'Ivoire, emphasized the need for behavior change from health care service providers and health care facilities as key for improving patient satisfaction and quality of care. Respondents appeared to view behavior change from the government and citizens as linked in often asserting that the government must change its behavior and better inform citizens of their rights, and citizens must change their behavior to exercise their rights.

Limitations and Recommendations

This study is qualitative oriented. As such, as is the case with most qualitative research, the study entails common limitations, such as the limited generalizability of the data and potential bias in responses from survey respondents and key informant interview participants.

This report will be shared with selected stakeholders in Côte d'Ivoire, Ghana, and Guinea, with the aim of facilitating discussion to delineate ideas and options for applying the findings to specific social and behavior change-oriented social accountability program design recommendations.

Background and Introduction

Accelerating Health Systems Strengthening

The Health Systems Strengthening Accelerator (Accelerator) is a 5-year program funded by the United States Agency for International Development's (USAID) Office of Health Systems (OHS) and the Bill & Melinda Gates Foundation. The aim of the program is to provide catalytic support to countries as they tackle health systems challenges and accelerate progress toward self-reliance. In working toward this aim, the Accelerator facilitates dialogue among key actors from across sectors—government officials, community leaders, and local and regional technical organizations—to advance their understanding of the most pressing systemic issues, identify their root causes, and draw from global and regional experience to co-create innovative solutions that suit the local context. The program's approach involves supporting local partners as they lead implementation and find their own pathways to meaningful and lasting health systems change. The Accelerator is currently partnering with USAID Missions, country leaders, and local and regional partners in Côte d'Ivoire, Ethiopia, Ghana, Georgia, Guinea, Liberia, Sri Lanka, and Togo, as well as USAID's Asia Bureau and Bureau for Democracy, Conflict, and Humanitarian Assistance.

Each fiscal year (FY), USAID/OHS makes funding available for core activities intended to align to programming strategies across USAID's Bureau for Global Health. The core activities focus on current, high-priority topics and potential innovations and also create space for the Accelerator to build tools and approaches that can be shared across the program and beyond. In addition, core activities help generate engagement at the country level and position the Accelerator to be responsive to Mission and country needs.

In FY 2020, USAID/OHS funded a core activity entitled Improving Linkages between Social Accountability (SA) and Social and Behavior Change (As the title suggests, the aim of the activity is to explore the linkages between these two prominent practice areas in general and in relation to health systems strengthening (HSS), including a focus on increasing equity and efficiency through Universal Health Coverage (UHC). The activity has followed these two workstreams:

- **Knowledge brief:** Based on a targeted literature review, develop a knowledge brief that assesses what might be gained through increased use of social and behavior change strategies within social accountability approaches.
- **Country data collection:** Through an online survey and virtual consultations with HSS and UHC stakeholders in Côte d'Ivoire, Ghana, and Guinea, investigate social accountability work and the successes and challenges as well as the extent that certain actions and behavior facilitate or impede success.

This report focuses on the second workstream, country data collection (hereafter, the SA-SBC linkages study). The primary goal is to present the data in organized ways, with particular attention on establishing lines of analysis and pathways for discussion. Work on the SA-SBC linkages activity overall, including the SA-SBC linkages study, will continue in FY 2021.

Problem Statement

There is significant evidence on social accountability to advance health system goals. Extensive work has also been undertaken in the area of social and behavior change. However, less common is work that explicitly acknowledges the overlap of these two areas and unites them within specific approaches or strategies to improve health, despite potentially catalytic effects. The SA-SBC linkages study is part of an activity that seeks to address this knowledge gap—the under-considered linkage of social accountability and social and behavior change within HSS work. Overall, the activity aims to identify and support promising opportunities for social accountability and social and behavior change efforts to work together to increase equity and efficiency through UHC.

Study Questions

The SA-SBC linkages study undertook data collection in three countries—Côte d'Ivoire, Ghana, and Guinea—and focused on five questions:

- To what extent do social accountability approaches explicitly pull in behavior change strategies, and what are the dynamics and nuances surrounding the ways these two prominent areas tend to operate in isolation of each other?
- What might be gained through more targeted efforts to include behavior change strategies within social accountability approaches? What would this look like, particularly in relation to social accountability in support of UHC?
- What social accountability approaches have been implemented recently, and by whom? What factors have influenced successes and challenges with these approaches, and to what extent did behavior change (or lack of behavior change) play a role?
- To mobilize considerable and diverse voices to engage in social accountability approaches in support of UHC, what individual-level and institutional-level behaviors need to change and in what ways?
- What lessons have been learned around how to foster productive alliances and common goals between citizens and government, including behavior change-related lessons?

Design, Methods, and Implementation

Overview

The SA-SBC linkages study—undertaken from May 2020 to October 2020—was designed primarily as a qualitative study, with some quantitative information collected through an online survey. Such a design aligned with the study's focus on understanding perceptions, actions, and behaviors in relation to social accountability. Multiple research methods were used, including the following:

- Literature review
- Online survey
- Key informant interviews

Literature Review

Two literature reviews were conducted. The first review was a formative and broad review. It focused on subject matter (e.g., social accountability, behavior change) and types of sources (e.g., peer-reviewed articles, technical briefs, project reports, webinars) and informed the development of the research questions. Appendix 1 presents a list of resources reviewed. Key findings from this review are as follows:

- There are few explicit examples of linking social accountability and social and behavior change. However, documenting the successes, challenges, and nuances of social accountability and social and behavior change efforts is a productive pathway for identifying options for tweaking social accountability approaches to be more behavior change oriented.
- Social accountability typically revolves around citizen engagement and government accountability, which collectively represent advocacy for institutional and systemic change. Social accountability actors often have a background in political science.
- There is considerable variation in what social and behavior change means. In the health context, the term often focuses on a specific health condition or health behavior and the drive to change a health outcome. Social and behavior change actors often have a background in public health.
- To a certain extent, social accountability approaches are behavior change interventions; however, social accountability actors tend to not explicitly refer to their work in this way.

A second country-specific literature review was conducted to further inform the study design, including the development of specific data collection approaches and tools. Key findings from the country-focused literature review are presented in the next section of this report.

Three countries were selected for data collection. Each of the countries selected–Côte d'Ivoire, Ghana, and Guinea–currently have ongoing Accelerator activities, as follows:

- **Sustainable HIV Response in Côte d'Ivoire:** The Accelerator team facilitates multi-stakeholder coordination with domestic Ivorian leadership that improves the financing, management, and coordination, and consequently the sustainability, of the HIV response within the larger UHC and sustainable health financing context.
- **Partnership to Accelerate Ghana's Vision of Health for All:** The Accelerator supports the Government of Ghana and other local health actors to address key health systems challenges and ensure adequate and efficient use of health sector resources to achieve Ghana's vision of health for all.
- **Integrated Health Systems Strengthening Support in Guinea:** Through a regional cross-bureau activity, the Accelerator provides integrated HSS support to Guinea to improve community health outcomes. The focus is on analyzing and addressing priority challenges and gaps related to the implementation and scale up of the National Community Health Strategy.

The relevant USAID Mission and country offices, as well as ministry of health officials in Côte d'Ivoire, Ghana, and Guinea, were informed of the SA-SBC linkages study and gave their consent.

Online Survey Design, Administration, and Data Analysis

Bearing in mind the research questions, different country contexts, and with a wide range of HSS and UHC stakeholders as potential respondents, the survey instrument was divided into parts, as follows:

- Part 1—Stakeholders in Your Country
- Part 2—Social Accountability in Your Country
- Part 3—Universal Health Coverage in Your Country
- Part 4—Behavior Change Efforts in Your Country

The survey instrument included yes or no, close-ended, and Likert scale questions, along with a set of open-ended questions. The survey was written in English and administered in English for stakeholders in Ghana. For stakeholders in Côte d'Ivoire and Guinea, the survey was translated into French and administered in French. The English version of the survey instrument is provided in Appendix 2, and the French version is provided in Appendix 3. The survey was administered through Google Forms, a free, web-based application. Prior to launching the survey, piloting was conducted to ensure ease of use and flow of questions.

The survey link was received by 1,370 valid email addresses, with a response rate of 13.1%. Sharing the survey to a relatively large number of stakeholders was a purposeful strategy, given that response rates to online surveys are commonly low. Table 1 presents details regarding the survey administration for each country. The survey remained open for 4 weeks for Côte d'Ivoire and Ghana and 7 weeks for Guinea. Email reminders were sent approximately each week the survey was open.

The email addresses were obtained in consultation with country-based Accelerator team members. The survey did not request personally identifying information, and the link between an individual's email address and their response was anonymized. Results from the survey were downloaded into a Microsoft Excel file and imported into Stata for analysis.

Table 1: Survey Administration and Response Rates

	Total Emails	Returned Emails	Valid Emails	Survey Responses	Response Rate
Côte d'Ivoire	**471**	**127**	**344**	**76**	**22.1%**
Source of emails	- *Rapid desk research of governmental reports, websites, etc., to identify health sector stakeholders* - *Consultations with (personally) known health sector stakeholders to solicit recommendations* - *Contacts made through other Accelerator and non-Accelerator activities*				
Ghana	**791**	**97**	**694**	**74**	**10.7%**
Source of emails	- *Attendance list from the Ministry of Health's 2019 Health Summit* - *Members of the Ghana Coalition of NGOs in Health* - *Private health sector and professional associations*				
Guinea	**362**	**30**	**332**	**29**	**8.7%**
Source of emails	- *Listserv of health sector stakeholders (known as the PTF listserv)* - *PTF listserv is administered by a health sector stakeholder who is employed by the World Health Organization, but the list is not an official World Health Organization listserv* - *The survey was announced at the PFT July 2020 monthly meeting*				

Key Informant Interview Approach and Data Analysis

Similar to the survey instrument, the key informant interview guide was divided into parts, as follows:

- Introductions—Work Responsibilities and Challenges
- Part 1—Stakeholders in Your Country
- Part 2—Social Accountability in Your Country
- Part 3—Universal Health Coverage in Your Country
- Part 4—Behavior Change Efforts in Your Country

The interview guide included open-ended questions intended to facilitate exploration of the research questions in ways not possible through the close-ended survey questions. The interview guide was written in English, and interviews with stakeholders in Ghana were conducted in English. For stakeholders in Côte d'Ivoire and Guinea, the interview guide was translated into French, and the interviews were conducted in French. The English version of the interview guide is provided in Appendix 4, and the French version is provided in Appendix 5.

A total of 21 key informant interviews were conducted. Based on a subset of the 1,370 valid email addresses used for survey administration, and with the aim of capturing a range of perspectives, key informants were grouped into 6 broad categories in relation to the different types of organizations that encompass health sector stakeholders. One key informant per category was selected for an interview. Table 2 presents details regarding the key informant interviews for each country. A detailed statement about the key informant selection criteria is provided in Appendix 6.

Key informants were selected in consultation with country-based Accelerator team members. Each interview was conducted by a lead interviewer and a note-taker and recorded with permission from each key informant. Each interview team included one colleague based locally in the capital city and one colleague from the Accelerator's headquarters team. Interview notes and summaries were developed and initially analyzed to establish themes. In this report and any future reports, key informant interview data will be presented in relation to key informant type, not by individual key informant or organization names. The note-taking procedures are presented in Appendix 7.

Table 2: Key Informant Interviews by Type and Sex

Type of Key Informant	TOTAL	Côte d'Ivoire	Ghana	Guinea
Ministry of health	4	2	1	1
Civil society organization	4	2	1	1
Implementing partner, international nongovernmental organization, or nongovernmental organization	3	1	1	1
Health care provider	4	1	1	2
Community health	3	1	1	1
Donor	3	1	1	1
TOTALS	**21**	**8**	**6**	**7**
Sex of Key Informants	**TOTAL**	**Côte d'Ivoire**	**Ghana**	**Guinea**
Male	14	5	4	5
Female	7	3	2	2

Challenges and Limitations

One aim of this report is for the data and information to be used collaboratively and iteratively in efforts to enhance the degree that social and behavior change strategies are used in social accountability activities, including in relation to efforts to advance UHC objectives. In this context, several limitations of the study are important to bear in mind:

- The overall study design is qualitative oriented, both in its approach to the online survey and key informant interviews. As such, as is the case with most qualitative research, the study entails common limitations, such as the limited generalizability of the data and potential bias in responses from survey respondents and key informant interview participants.
- Given COVID-19, all data collection was undertaken virtually. The small nuances and details that come with administering surveys and conducting interviews in person are challenging to replicate through an online survey and interviews over the phone.
- Adopting broad definitions of health sector stakeholder, HSS stakeholder, and UHC stakeholder to identify survey respondents and interview participants yields a constructive breadth of perspectives, but it is potentially limited in terms of depth of any single perspective.
- The focus of this study is large, multi-layered, and without definitive answers. The data are better seen as providing insights and ideas that can be further investigated and applied as part of program design and implementation.

Findings: Literature Review

Introduction

Social accountability is widely understood to be a way for citizens to hold state actors accountable for their actions. In a 2005 working paper, the World Bank Institute defined social accountability as "an approach toward building accountability that relies on civic engagement, that is, in which ordinary citizens and/or civil society organizations participate directly or indirectly in exacting accountability from government" (World Bank Institute 2005). Since then, much has been written about social accountability as a tool to improve health systems and health outcomes. Because many elements of health systems in most countries are run by state actors, holding these actors accountable and making them more responsive to the needs of the citizens they intend to serve has significant potential to affect the health services and interventions that are delivered.

In the same paper, the World Bank Institute posited that there are six elements of social accountability by which systems and interventions can be classified:

- The spectrum of punishment versus reward
- The spectrum of rule following versus performance-based evaluation
- Level of institutionalization (i.e., ad hoc activism or institutionalization into law)
- Level of involvement of citizens versus external actors
- Inclusiveness of participation (i.e., whether elitist or more inclusive)
- Branches of government that are targeted

In context of the social accountability literature, the SA-SBC linkages study and the activity overall are advocating that a seventh dimension—the degree to which the social accountability system catalyzes behavior changes on either the side of the citizenry or state actors—should also be considered. This is an important question, because the literature has revealed several challenges with social accountability interventions in the past, suggesting that specific behavior change mechanisms are needed to improve the effectiveness of social accountability activities.

A 2018 study of social accountability mechanisms in Gujarat state in India is useful for understanding potential social accountability activities for creating behavior change related to health (Hamal et al. 2018). The study identifies several types of formal structures for social accountability in the health system, within both the government and civil society. These include (1) individual people (e.g., health workers and volunteers); (2) government structures (e.g., village councils, village health committees); and (3) community-based organizations (CBOs) that implemented specific interventions to improve social accountability, namely community monitoring and maternal death reviews. Of these, the study found that the CBO efforts had the most influence on maternal health determinants, which may be because they were the most successful at creating behavior change. On the demand side, an increase in awareness among women of maternal health services due to participation in CBO and women's group activities led to increased use of maternal health services. On the supply side, both availability and accessibility of services as well as quality of care showed improvements as a result of lobbying efforts by CBOs and women's groups. Notably, social accountability efforts were overall *not* effective at influencing policies at the district level. Other studies have suggested mechanisms to create behavior change by political leaders at higher levels by shifting the incentives for these leaders to act in the public interest and to legally enforce that they do (O'Meally 2013), and to form wider partnerships of international, national, and local bodies for monitoring behavior (Dasgupta 2011).

These studies provide a useful frame of reference for thinking about mechanisms and structures that lead to behavior change in the three countries selected (Côte d'Ivoire, Guinea, and Ghana), and they underscore the importance of looking for change and implementing activities at the community level. The SA-SBC linkages study provides an opportunity to examine the potential effect of the interaction of social accountability and behavior change on health outcomes because the majority of health services are provided by the public sector, and the study countries are in West Africa, which has received less attention on these topics. However, the three countries are at significantly different stages in terms of key health outcomes, the attainment of UHC, and the structures in place to promote social accountability. An overview of key dimensions of health, social accountability, and UHC are presented in Table 3 and in the country-specific literature review that follows.

Table 3: Summary of Key Contextual Factors in Côte d'Ivoire, Ghana, and Guinea

	Côte d'Ivoire	Ghana	Guinea
Key Health Outcomes			
Maternal mortality ratio 2017 (modeled estimate, per 100,000 live births)[1]	617	308	576
Under-5 mortality rate (per 1,000 live births) 2019[2]	79.2	46.1	98.8
Stunting prevalence (%) among children under 5 2016/2017/2018[3]	21.6	17.5	30.3
Adolescent fertility 2018 (births per 1,000 women ages 15–19)[4]	116	66	133
HIV incidence 2019 (per 1,000 uninfected population ages 15–49)	0.8	1.1	0.7

	Côte d'Ivoire	Ghana	Guinea
Social Accountability			
Corruption perceptions score 2019*[5]	35	41	29
Corruption perceptions rank 2019[6]	106 out of 198 countries	80 out of 198 countries	130 out of 198 countries
Health-related grants from the Global Partnership for Social Accountability (GPSA)	*Has not opted into GPSA*	Transparency, Participation, Feedback around Local Government Budgeting and Planning Systems (2013)	Ensuring Accountability and Transparency of the National Post-Ebola Recovery Process (2017)
Other notable social accountability interventions	▪ Open Government Partnership ▪ National Civil Service Program ▪ U-Report ▪ Prevention of mother-to-child transmission of HIV initiatives ▪ West Africa Breakthrough Action ▪ HELVETAS Intercooperation group water, sanitation, and hygiene project	▪ Health service scorecards ▪ "I Am Aware" Project ▪ Budget transparency ▪ Community engagement initiatives	
UHC			
Service coverage index 2019[7]	47	47	37
Per capita government health spending, 2017 (current US$)[8]	$19.85	$22.34	$5.79
Current status of UHC plans	UHC mandated in 2019—roll out of new insurance scheme in progress	National Health Insurance established 2003	Nascent stage
Existence of performance-based health financing schemes	Yes—national	Yes—pilots	No

**Corruption perceptions score is indicated out of a total of 100. A score of 0 indicates extremely high corruption, and a score of 100 indicates little to no corruption.*

[1] https://data.worldbank.org/indicator/SH.STA.MMRT
[2] https://childmortality.org/
[3] https://data.worldbank.org/indicator/SH.STA.STNT.ZS
[4] https://data.worldbank.org/indicator/SP.ADO.TFRT
[5] https://www.transparency.org/en/cpi/2019/results
[6] https://www.transparency.org/en/cpi/2019/results
[7] https://www.who.int/docs/default-source/documents/2019-uhc-report.pdf
[8] https://data.worldbank.org/indicator/SH.XPD.GHED.PC.CD

Côte d'Ivoire

Health Systems Strengthening

As a lower middle-income country, Côte d'Ivoire's government has made a concerted effort to ensure political and economic stability, resulting in a growing gross domestic product (GDP), with increases averaging 8% between 2011 and 2018 (Oxford Business Group 2020). Despite these efforts, the poverty rate has remained stagnant, with 46.3% of the population living below the poverty line in 2015, compared to 48.9% in 2008 (AfDB African Development Fund 2018). Health indicators reveal a similar picture; years of underinvestment in the health system due to political and military conflict (Oxford Business Group 2020) have resulted in widespread disparities between urban and rural areas and between different age groups and genders. All of this has resulted in a low Human Development Index value of 0.492 in 2017, or a rank of 170 out of 189 countries (United Nations Development Programme 2018). The maternal mortality rate was 617 per 100,000 births in 2017, and the neonatal mortality rate was 33.5 deaths per 1,000 births (Oxford Business Group 2020). Overall life expectancy at birth stands at 55 years as of 2016 (Primary Health Care Performance Initiative 2018).

The Ivorian health care system is managed by the Ministry of Health and Public Hygiene (MHPH) and is made up of 20 regional health directorates and 86 smaller health districts. Within these, there are 2,027 primary health facilities, 84 general hospitals, 17 regional hospitals, and 2 specialized hospital centers (Oxford Business Group 2020). Private sector facilities provide more than 25% of health care services, largely for urban areas (USAID 2016). There have been some recent efforts to rehabilitate public service facilities, but further and more substantial improvements are needed. To this effect, in 2019, the National Assembly passed a bill to change the structure of the health system by converting public health centers into *établissements publics hospitaliers* (public hospital establishments). The plan is for the *établissements publics hospitaliers* to run as private businesses using results-based management approaches (USAID 2016).

The Ivorian government has committed to strengthen its health sector through its commitment to UHC. Côte d'Ivoire's most recent National Development Plan reflects this sentiment, which plans greater investments in health and for the *Direction Générale de la Santé* (General Directorate for Health) to work with the MHPH and other partners to move toward UHC (Republic of Côte d'Ivoire and OGP 2016). Prioritized areas for the plan include improving public financial management, improving delivery and use of health services (through strengthened supply chains, high-quality services, and access to care), and strengthening health sector governance (Dagnan 2018).

Improving Public Financial Management

The MHPH has adopted a three-pronged approach to move toward sustainable financing for health services. First, in 2017, increased coordination between the MHPH and the Ministry of Budget and the Ministry of Economy and Finance through the establishment of an inter-ministerial committee (Joint United Nations Programme on HIV/AIDS 2017). Second, development of the National Health Insurance Fund by the Ministry of Social Affairs to pool government and household resources and expand financial protections for health services (Konan et al. 2014). Third, expand a performance-based financing strategy to improve management of health facilities and motivate service providers (Dagnan 2018).

Improving Delivery and Use of Health Services

Côte d'Ivoire has focused on improving delivery of maternal and child health services through guidelines for services in facilities that receive performance-based financing and increasing the number of service providers trained at primary and secondary levels of care. Centers for focused care for mothers and children were created at 25 hospitals as an effort to reorganize service delivery. The government also instituted the New Public Health Pharmacy of Côte d'Ivoire to ensure that medicines and other supplies for service delivery are available through a central purchasing center for all facilities (Dagnan 2018).

Strengthening Health Sector Governance

Côte d'Ivoire undertook an assessment of health sector governance in 2014 (Ministry of Health and the Fight Against AIDS 2014), and results showed challenges related to "conflicts of interest, informal payments, and lack of transparency, monitoring, community participation, and accountability" (Dagnan 2018). The MHPH has taken actions, including auditing facility-level management risks and assessing informal payments; standardizing financial controls and audit tools at local levels; training national-level inspectors in new audit processes; building management capacity at facilities and sub-national levels; introducing leadership, management, and governance approaches at sub-national levels; and building cultures of accountability throughout the health structure (Dagnan 2014). Côte d'Ivoire recently joined the Global Financing Facility to bolster its governance reform efforts (Global Financing Facility 2017).

Universal Health Coverage

Côte d'Ivoire's expenditures in health care have been increasing (from CFA330.5bn or $568 million in 2016 to CFA446bn or $776.7 million in 2020). This currently represents about 5–6% of the GDP, and the government plans to increase this to 15% of the GDP (Oxford Business Group 2020). This is crucial, given population dynamics and trends (i.e., a growing middle class, greater rates of non-communicable diseases, and a drive toward UHC) (Oxford Business Group 2020). Côte d'Ivoire's health sector reform is very much with the understanding that a healthy population is one that supports economic growth (Bloom and Canning 2008). It is within this context that Côte d'Ivoire has committed to several global and regional health initiatives, including UHC2030, signed in 2017, which is a tool to ensure mutual accountability between different stakeholders in the health sector as the country moves toward UHC (UHC2030 2017), and the 2018 Declaration of Astana, which focuses on universal access to primary health care (Global Health Now 2018). Côte d'Ivoire is a Trailblazer country according to the Primary Health Care Performance Initiative due to ongoing initiatives to improve the availability of quality data and data-driven decision-making (Primary Health Care Performance Initiative 2020). Côte d'Ivoire is also a member of the Ouagadougou Partnership (IntraHealth International 2018) and Family Planning 2020, which are global and regional initiatives that aim to empower women and girls through rights-based family planning (Family Planning 2020).

Social Accountability

As Côte d'Ivoire moves to adopt UHC, it will need to strengthen multi-stakeholder processes at national and sub-national levels so that the government, health service providers, civil society organizations (CSOs), the media, and communities are mutually accountable to each other and can align to broader national strategic plans and global commitments (UHC2030 2018). Institutionalizing engagement with

communities and civil society through participatory governance can help ensure that vulnerable groups are not sidelined in UHC2030 efforts (UHC2030 2020). Since 2015, Côte d'Ivoire has been a member of the Open Government Partnership (OGP), a multilateral initiative to promote open government, empower citizens, fight corruption, and strengthen overall governance (OGP 2020). Under this initiative, Côte d'Ivoire developed two action plans: 2016-2018 and 2018-2020, which speak broadly of a series of commitments around increasing involvement of its citizens in public affairs management (OGP Côte d'Ivoire 2020). The 2016-2018 plan, for example, aims to (Republic of Côte d'Ivoire and OGP 2016):

- Operationalize an Open Data portal that citizens can use to check and verify data
- Set up and operationalize a national competitiveness monitoring body run by the private sector and CSOs to ensure that contracts are awarded fairly
- Promote access to public interest information as mandated by the 2013-867 Act from December 23, 2013
- Ensure freedom of press, including television, to ensure that a diversity of opinions is reflected and to ensure a commitment to democracy and freedom of expression
- Set up five municipal committees to prevent racketeering by ensuring oversight and decision-making at local levels through local monitoring and control mechanisms for all public services

The 2018-2020 plan builds on some of these commitments while also focusing on some new ones (Republic of Côte d'Ivoire and OGP 2018):

- Develop a citizens' budget that makes the contents of the state budget and decision-making behind policy decisions accessible to the public
- Build 80 community preschools through a participatory decentralized development approach that empowers the recipient communities to be responsible for development of the preschools
- Adopt and implement laws that protect whistleblowers who fight against corruption
- Promote participatory budgeting, governance, and decision-making at local levels to encourage citizen accountability
- Continue to counter racketeering in local communities
- Continue to build an Open Data portal and support participatory governance
- Continue to liberalize television and freedom of expression

Review of Côte d'Ivoire's plans and achievements from the 2016-2018 report by the OGP Independent Reporting Mechanism found that although the government committed to approaches to increase accountability, lack of measurability challenged actual outcomes (OGP Côte d'Ivoire 2020). The report also noted that civil society was not involved and recommended involvement in future OGP plans.

Civil Society Involvement

Civic participation through CSOs that represent vulnerable populations and communities has historically been minimal in Côte d'Ivoire, despite open dialogue with the government. For example, during planning as part of the Global Financing Facility process, CSOs were minimally involved in the budget planning and validation phase due to a lack of budget information (CSO Global Financing Facility 2020). This type of participatory budgeting is an important aspect of social accountability. In an Open Budget survey conducted in 2017 by the International Budget Partnership, Côte d'Ivoire achieved a 24 out of

100 transparency open budget index score, 0 out of 100 for public participation (no opportunities to engage in budget process), and 31 out of 100 for budget oversight by legislature and audit (International Budget Partnership 2017). The Partnership noted that although Côte d'Ivoire is committed to transparency, as evidenced by commitments made through the OGP (OGP Côte d'Ivoire 2016), opportunities for public participation will be crucial to truly improve social accountability (International Budget Partnership 2017).

This may speak to a larger challenge in which donor funds make up large proportions of funds for health and social programs, putting CSOs further at a disadvantage. This is seen in the case of programmatic decision-making for President's Emergency Plan for AIDS Relief or Global Fund programs in Côte d'Ivoire. CSOs are always part of groups such as the Global Fund's Country Coordinating Mechanisms, but they were rarely in leadership roles and were found to speak less frequently (Le Fonds Mondial vu d'Afrique 2019). As such, power dynamics between the different types of participants further sidelines CSO contributions. CSOs are often part of nongovernmental organizations (NGOs) that are directly funded by the President's Emergency Plan for AIDS Relief or the Global Fund, and participants are often unwilling to speak against their funders. National actors, such as the National Programme to Combat HIV/AIDS and other government stakeholders, may have limited decision-making power, further limiting the ability of CSOs to impact programmatic decision-making (Le Fonds Mondial vu d'Afrique 2019).

Community Engagement

In Côte d'Ivoire, civic participation programs are largely funded by international organizations on behalf of the government. A special focus has been on Ivoirian youth. The *Programme du Service Civique National* (National Civil Service Program) was created by the government in 2007 and funded by the European Union to complement the education system to counter youth unemployment and improve engagement (Innovations in Civic Participation 2020). The original programming focused on agropastoral approaches, handicrafts, building and public works, and new information technologies and communication, and it was also accompanied by civic education and citizenship training (AllAfrica 2008). More recently, since 2016, UNICEF Côte d'Ivoire has advocated and promoted equity and engagement of youth in decision-making processes within the country (UNICEF 2017). This has largely been accomplished by providing different multimedia platforms as forums for youth to express opinions and ideas on issues that matter to them (UNICEF Côte d'Ivoire 2020), such as U-Report (a mobile messaging tool [UNICEF Office of Innovation 2020]), *Voix des Jeunes, Jeunes reporters de Côte d'Ivoire, (Voices of Youth, Young Reports from Côte d'Ivoire)* and other digital media. In October 2019, Côte d'Ivoire reached a major milestone with 1 million youth actively participating as U-Reporters (UNICEF Côte d'Ivoire 2019).

Communities have been engaged in Côte d'Ivoire through health sector-specific working groups, also funded through international organizations. The Joint United Nations Programme on HIV/AIDS Inter-agency Task Team developed indicators to quantify community engagement in prevention of mother-to-child transmission (PMTCT) programs, and Côte d'Ivoire moved to pilot these engagement indicators at the national level and at health facilities (Radin et al. 2018). Populations directly impacted by HIV/AIDS participated in national reviews of the PMTCT programs at review meetings and by analyzing progress by communities and civil society. At the facility level, the percentage of facilities that provided PMTCT services that had accountability measures in place in the preceding 12 months were counted. These

measures included the following: citizen report cards (large-scale surveys of PMTCT client feedback, with results used for advocacy and to increase public accountability); partnership-defined quality (working with health workers and mothers living with HIV to review HIV programs and develop action plans through an externally facilitated process); and integrative supportive supervision (Radin et al. 2018).

Linkages between Social Accountability and Social Behavior Change

Strengthening social accountability implies impacting governance in two ways: (1) communities themselves become more aware or educated of the impact that their collective voices can have on influencing health policies and services through targeted behavior change, and (2) government itself changes its behavior or approach to policy making and service provision based on received preferences from its constituents (Wibbels 2014). In the latter, a strong process of social accountability provides opportunities for citizens to provide feedback or evaluate the quality of government behavior (Wibbels 2014) (i.e., feedback loops between communities and their local and national officials are strong so that polices and services are responsive and adaptive to changing contexts).

In Côte d'Ivoire, the West Africa Breakthrough ACTION family planning project has used community inputs to designate health facilities as good quality as they relate to family planning services (Johns Hopkins Center for Communication Programs [CCP] 2019). Quality is defined by community members as they enter the health facility, move through receiving services, and provide feedback during follow-up. The community definition of "quality" thus supports the development of an accreditation system, building on a similar program creating "Gold Circle" clinics from the 1990s. Johns Hopkins CCP is using findings from community focus groups that are part of this program to develop strategic messages to promote improved quality of care that communities can receive, encouraging even more community members to use available family planning services and strengthening the feedback loop between social accountability and behavior change (Johns Hopkins CCP 2019).

The HELVETAS Swiss Intercooperation group has similarly approached social accountability and behavior change through its water, sanitation, and hygiene project in Côte d'Ivoire and other countries. By using the behavior change model known as RANAS (Risks, Attitudes, Norms, Abilities, and Self-Regulation), health practitioners were able to influence program interventions based on results from the RANAS study on communities seeking to access safe water sources (Technical and Operational Performance Support Program and USAID 2017).

Ghana

Health Systems Strengthening

Under the Ministry of Health, the Ghana Health Service (GHS) operates as the executive agency that manages the implementation of national policies. The GHS is organized into three management and supervision levels: national, regional, and district; with five functional levels: national, regional, district, sub-district, and community. A priority for the GHS is to extend primary care services at the regional, district, and sub-district levels. The GHS implements strategies promoting greater equity and efficiency to create a more accessible and responsive health care system. It then manages health services at all levels either directly or indirectly by hiring sub-contractors for implementation (GHS, 2016).

The Centre for Health Information Management, in the Ministry of Health, created the Health Information Exchange, which is a heath sector reporting portal using the District Health Information Management System. The Health Information Exchange also includes Tracker modules for TB, HIV/AIDS antiretroviral therapy, and maternal and child health services, which includes antenatal care, postnatal care, delivery, and family planning. In addition to the Health Information Exchange, the Demographic Surveillance System collects community-based data, which are used to monitor health threats, track population changes, and assess policy interventions (GHS, 2016).

Ghana began making strides toward equity in health care in 1978 through participation in the Alma-Ata Conference. By 1999, Ghanaian citizens, especially those in rural areas, continued to experience barriers to health care, and, in response, the Community-based Health Planning and Services (CHPS) program was developed. The goal of CHPS is to connect community members, especially those in rural areas, with preventative and public health services, using mobile community-based care administered by a resident nurse or community health officer. The CHPS program depends on the traditional community structure to set priorities and for service delivery (World Health Organization [WHO], 2018).

In 2003, the National Health Insurance Scheme (NHIS) was introduced with the aims of providing citizens access to health services and increasing affordable health care and use of health services. This program targets poor and vulnerable populations in Ghana and was the first such program in sub-Saharan Africa. There had been previous attempts to establish a national health system, and the lessons learned from those attempts were applied to the creation of the current NHIS. The current iteration offers a more inclusive policy and officially began in 2004 with the National Health Insurance Authority (WHO, 2018).

The NHIS is funded through a National Health Insurance Levy as well as contributions from public and private sector workers to the Social Security and National Insurance trust, premium fees, donor funds, and money allocated by Parliament. The single benefit package is available to anyone who registers, regardless of employment, income, or age. This insurance plan endeavors to cover 95% of the diseases in Ghana.

There have been few attempts by sub-Saharan African countries to carry out a nationally led universal health care insurance program. Although Act 650 requires all Ghanaians to enroll in the NHIS, there is no penalty for not enrolling, and therefore, it could be considered voluntary (Blanchet et al. 2012).

A major barrier to fully implementing the CHPS is in moving from the planning phase to the implementation phase at the district level. CHPS addressed this by creating an exchange program in which mentors from successfully implemented community programs fostered adoption in districts not yet in the implementation phase (WHO 2018).

High registration fees, which must be paid in person, have been a barrier to the NHIS, especially for those who are poor or living in rural areas. This has resulted in a low percentage of the population enrolled in the NHIS, approximately 35% in 2017 (WHO 2018, Nsiah-Boateng and Aikins 2018). In addition, although the NHIS covers a majority of the health issues Ghanaians face, it fails to cover some expensive treatments and procedures, including cancer treatment and certain surgeries, which can significantly increase the cost of health care (WHO, 2018).

Social Accountability

In recent years, research has been conducted to better understand the efficacy of social accountability interventions to improve health care for Ghanaians at the community level. Examples of recent social accountability interventions include scorecards to improve maternal and newborn health services at health facilities, the availability and accessibility of information and data products to citizens, and citizen awareness of and participation in the national budget process.

In 2016, Evidence for Action used scorecards to determine the perceived quality of maternal and newborn health services and then to improve those services. This intervention employed both health and non-health stakeholders at the district level to assess the quality of emergency obstetric care in the Ashanti and Volta regions of Ghana. The scorecard gauged the ability of facilities to provide emergency obstetric care as well as client perspectives and their satisfaction with the services provided. These results were then shared at stakeholder meetings at the district/municipal, health facility, and community levels to create partnerships and accountability among these different levels. Qualitative results from the study show improved accountability at the community and district levels in areas such as community participation; increased transparency among communities, facilities, and policy makers; and improved accountability among decision-makers. For these results, researchers found that strong leadership was key in engaging stakeholders at all levels and in developing positive relationships among health facilities, district assemblies, and communities. Further, there were improvements in many areas across the assessment, including accessibility of maternity wards, availability of essential drugs and equipment, and infrastructure (Blake et al. 2016).

The “I Am Aware” social accountability project in Ghana made health facility data publicly available to citizens and promoted their use to compare service quality at facilities. Information products were created to help make data more accessible and useful to users. An evaluation of this project found that the data accessed have yet to influence national policy or budget outcomes, which could increase central government accountability. Most citizens lacked the confidence to make demands, and there were few civic groups in districts. To encourage data use, the project created social action groups, which were able to use the data to identify inadequacies and issues they faced with facilities. The project also found radio to be an effective media for sharing information and noted the importance of fostering citizen champions to make progress (Jones et al. 2019).

Another project aimed to improve access to and quality of services in the health and education sectors by improving social accountability and transparency in the budgeting process. This project also had goals of building awareness of and capacity for budgeting among citizens, growing citizen participation in the budget process, and improving the alignment between citizen priorities and economic policy. An evaluation of this project found an increase in citizen budget awareness and participation, the incorporation of citizen priorities into the national budget, and some improvements in health services. Although the evaluation showed some positive outcomes, this specific intervention may be difficult to replicate in other environments, because it requires trust in CSOs, the need for projects need to align with the policy and strategies of the government stakeholders, and the need for CSOs to appropriately and effectively promote the collaborations fostered in the intervention (Mills 2019).

Community Engagement

Community engagement is related to social accountability in that it leverages community resources and organizations to improve health care, which is crucial in countries in which resources are limited and citizens need access to quality health care. A recent study focusing on community engagement sought to remove barriers to health care in Ghana by decreasing barriers to enrollment in the NHIS and use of health services, enhancing client and community participation in health care quality assessments, diminishing communication gaps between health providers and clients through information dissemination, and empowering clients. Clients identified barriers and gaps using community scorecards to rate health facility performance. These barriers and gaps were then communicated to health facilities, which were encouraged to make improvements based on these inputs, with the promise of an incentive. Throughout the intervention, community members' view of health care quality improved, which could have been due to improvements made at the health facilities based on the scorecards (Alhassan, Nketiah-Amponsah, and Arhinful 2016).

In a study that examined the effect of community engagement on health worker motivation, researchers found that engaging clients in health service delivery can enhance knowledge levels of mothers on antenatal and postnatal care. Using a systematic community engagement approach, community groups assessed health facilities to determine whether feedback would result in better motivated staff and better client experiences at intervention health facilities. Although results might not be directly attributable to the community engagement intervention, improvement was seen at the intervention facilities. The number of adverse medical events decreased, as well as the number of defaulting clients and self-medicating clients. There is also some evidence from a sub-sample analysis that showed an association between staff motivation levels and community groups involved in the community engagement activity. Overall, the study showed that promoting community engagement in the health service sector could potentially enhance staff experiences and work relationships with clients and encourage better health-seeking behaviors from clients (Alhassan et al. 2016).

In a smaller case study, close integration in local communities helped promote community engagement and create relationships with research initiatives by focusing on traditional practices at the local level. To understand these relationships, the research group engaged community members in community mapping to describe hierarchies of authority and decision-making pathways within the community. This exercise helped identify pathways through which the researchers could appropriately and effectively enter the community. This entry using the traditional customs allows the community to have some control of the tone and initial engagements, which can help increase the success of the activity. Understanding and respecting these preexisting pathways can greatly facilitate community engagement and can also act as a buffer against some of the key ethical violations that could inhibit global health research in a community (Tindana et al. 2011).

Another community engagement intervention focused on maternal and child health services in selected primary health care facilities. This intervention used existing community groups to pinpoint service delivery gaps in facilities using a systematic community engagement process. This bottom-up approach was intended to promote community participation to improve health care quality. Community members systematically monitored the quality of maternal and child health care services using scorecards and

provided feedback to health care facilities. This resulted in several improved outcomes, including an increase in spontaneous vaginal deliveries, an increase in female condom distribution, positive impacts on HIV testing for pregnant women, an improved number of clients testing for malaria before treatment, and overall enhancement of knowledge levels of mothers on the importance of antenatal and postnatal services (Alhassan et al. 2019).

Universal Health Coverage

In 2004, Ghana launched the current iteration of the NHIS. Initially, it was a contributory model primarily limited to only those who contributed. Policy makers and practitioners have debated shifting to a one-time premium payment policy. Advantages to this system include an additional source of revenue for the NHIS, employment for premium collectors, and a sense of ownership to clients in that they feel responsible for their health. However, disadvantages are also apparent and include time-consuming and expensive premium collection, barriers for those who cannot afford the premium, and a flat rate that imposes a higher burden on the poor (Abiiro and McIntyre 2012).

In general, insurance coverage can affect the behavior of participants. Individuals may feel safer with coverage and take on more risk, or they may change the choices they make when facing health issues. These assumptions were tested in a study looking at affiliations between insurance coverage and increased use in Ghana. Overall, the study looked at health-seeking behaviors of those enrolled in the insurance scheme. It found that enrolled women were more likely to seek formal care when sick, have a large number of prescriptions, have sought care from a clinic or hospital in the year before the survey, and experience a night in a hospital. Women enrolled in the insurance scheme also tended to be older, more educated, and have poorer health. The study found that health insurance increased the use of health care. However, there are sustainability concerns regarding the NHIS, and the introduction of less healthy participants or older participants could be more costly to the system. Therefore, in the coming years, adjustments will need to be considered to continue health care coverage for the entire population in the present and future (Blanchet et al. 2012).

Several inequities have been highlighted in the current NHIS policy. Access to the health care system needs to be addressed to continue to positively impact health outcomes in Ghana. Uneven distribution of human resources impacts access, such as uneven distributions between urban and rural areas, in which urban areas and richer populations are favored. Citizens in urban areas and those in richer households are more likely to have NHIS coverage than those in rural and poorer households. Quality of care is also disparate among health facilities, which impacts outcomes (Escribano-Ferrer et al. 2016).

Researchers explored other motivational factors and barriers that contribute to Ghana's population either participating in or opting out of the NHIS in Cape Coast Metropolis (Kumi-Kyereme et al. 2017). Major motivational factors included an affordable health insurance premium; access to free drugs; social security for any unexpected health issues; and encouragement from friends, family members, and colleagues. Common barriers found in Cape Coast Metropolis included long waiting times and lines, perception of poor drug quality, and poor attitude of health service providers at health facilities and insurance offices (Kumi-Kyereme et al. 2017).

The NHIS has worked to address some of the barriers to move toward UHC. However, a major challenge that persists is ensuring quality service coverage to remote areas and to underserved populations. A 2020 study in the Volta region of Ghana explored how the barriers were addressed in NHIS policy initiatives at the community level. These initiatives mainly focus on sustaining the CHPS program to reach remote or underserved populations. Such initiatives include the following:

- Continuing CHPS policy to provide those in remote geographical areas with primary health care services at the community level
- Stationing a resident nurse in communities who is also tasked with providing outreach services to reach remote and vulnerable populations
- Continuing the CHPS program to sustain marked improvements in maternal and child health outcomes, including reductions in mortality rates, increased antenatal care coverage, and increased rates of immunizations in rural areas
- Leveraging the CHPS through primary health care to move toward UHC, emphasizing availability and accessibility of services
- Continuing with progressive policies to address financial barriers to accessing the NHIS, including user fee exemptions for specific services, such as those for pregnant women, infants, and young children (Sheff et al. 2020).

Guinea

Health Systems Strengthening

The Republic of Guinea is consistently ranked as one of the poorest countries in the world, with poor economic performance and health outcomes as well as extreme fragility and an inability to respond to external shocks (World Bank 2018). The Ebola epidemic struck Guinea in 2014 and further incapacitated government systems while exposing and exacerbating major weaknesses in the health system (Rios 2019). A 2017 assessment revealed several key challenges, including inefficient allocation of resources, fragmented and duplicative roles and responsibilities, and weak capacity at the central and regional levels (Thomas, Suresh, and Lathrop, 2017). The health system in Guinea is meant to be decentralized, in line with the 1988 policy that established local government, but district health teams face serious issues with inadequate resources. The health system is divided into three levels—primary care facilities that consist of health posts and health centers, primarily located in rural areas; secondary care that consists of district and regional hospitals; and tertiary care that consists of two teaching hospitals and a new Sino-Guinéenne hospital, which serves wealthier, urban populations (World Bank 2018).

Availability of health workers, especially outside Conakry, is a particular challenge. There is an oversupply of medical doctors and nursing assistants, and a severe undersupply of other cadres of health workers, especially skilled birth attendants (Van de Pas et al. 2019). Service utilization is another key challenge that exists due to financial barriers and low-quality care (Health Finance & Governance n.d.). Although Guinea is technically required by its Constitution to provide free health services to the entire population, in practice, user fees are charged for almost all services (Wright et al. 2017). Out-of-pocket household contributions comprise a higher proportion of health spending than in many other countries in the region; these costs deter poorer households from accessing needed services, and there

are few forms of financial risk protection present in Guinea (World Bank 2018). Under-resourcing of the health system is a major driver of weak capacity, with low per capita spending on health and low, but increasing, government contributions to health (World Bank 2018). In 2016, the Ministry of Health signed a National Health Compact and the president committed to increase health spending to 10% of the GDP and distribute additional resources to regions and districts, but significant funding gaps remain (Universal Health Coverage Partnership 2017). The majority of government resources support the salaries of health workers, leaving few resources available for public health programming, primary care facilities, or pharmaceuticals, and the salaries are low compared to other countries in the region, which drives health workers to supplement their income in the private sector in urban areas and often abandon their official rural postings (World Bank 2018).

Partner contributions make up more than a third of all health spending in Guinea (World Bank 2018). This funding helps fill key funding gaps, and in recent years, it has focused particularly on improving reproductive and maternal health care outcomes at the primary care level. However, most of this funding circumvents the Ministry of Health and is given to NGOs and other contractors (World Bank 2018), which is a key consideration for improving social accountability. The 2016 Health Compact includes a provision to harmonize the interventions of each partner by being more systematic and linking to annual district operational plans (Universal Health Coverage Partnership 2017).

The World Bank is supporting HSS in three of eight regions, but it acknowledges that much more support, including financial resources and especially long-term systemic reform, is needed to achieve the targets set forth in the 2015-2024 National Health Plan (World Bank 2018).

One project implemented by USAID's Health Finance & Governance project is of particular note. In 2016, the project worked with the Health Commission of the National Assembly to provide training on the national health budget and its implications for HSS (Abt Associates, n.d.). This helped improve relationships between Parliament and the Ministry of Health and increased engagement (Abt Associates, n.d.). A Health Sector Coordinating Committee also exists and meets at least twice annually, and efforts were underway in 2017 to decentralize this body to the sub-national level to help evaluate and plan regional programs (Yasané 2017).

Social Accountability

Recently, Guinea has been marred by political and ethnic violence that has resulted in weak government capacity to respond to the needs of its citizenry, with a weak civil society that has limited opportunities to engage state actors. The Ebola epidemic spurred a further crisis of public confidence in the government's ability to provide basic services. However, several initiatives on the demand and supply side have been taken to increase social accountability:

- A project called *Faisons Ensemble,* implemented from 2007 to 2013 in 10 high-performing communes, provided training on local government processes, support to health and education service providers, training for health and school committees, and the creation of Innovation Circles (Brinkerhoff and Wetterberg 2016). Results showed significant positive impact on citizen empowerment and interaction with local officials, and their responsiveness to concerns (Brinkerhoff and Wetterberg 2016). However, the challenging starting point, with limited

resources, weak organizational capacity, and resistance from higher levels of government, reduced the impact seen on service delivery (Brinkerhoff and Wetterberg 2016).

- The government developed a Post-Ebola Priority Action Plan in 2015 and a National Economic and Social Development Plan to restart economic growth and be more responsive to citizen needs in the post-Ebola period (Rios 2019). In this context, the World Bank-led Global Partnership for Social Accountability is working to increase citizen participation in decision-making processes in the health and education sectors through a project called "Build Back Better: Building Civil Society to engage in State Reform Programs" (Rios 2019). This approach includes developing media capacity in weak or fragile areas and implementing activities at the community level in eight prefectures that aim to increase the capacity of the government and civil society to plan, implement, and monitor budgets, expenditures, and delivery of basic services, specifically around the disbursement of Ebola recovery funds (Rios 2019). The baseline study of this project identified a cultural obstacle to social accountability in that populations do not demand accountability because government representatives are deeply respected by society. Religious leaders, private sector union representatives, and the Ministries of Decentralization and Citizenship agreed to create a platform for advancing collaboration between the state and civil society, with the World Bank serving as a broker for collaboration (Poli et al. 2020).

Health facilities in Guinea, as in many other West and Central African countries as a result of the Bamako Initiative, are meant to be run by a management committee that includes community members. These committees are intended to provide an opportunity for social accountability in two ways: first, by engaging in community outreach and co-managing resources, and second, by engaging in the integration of community concerns and preferences into service delivery. In Guinea, they play a particularly important role in the control of drug prices that are charged by health workers (Lodenstein et al. 2017). A review of these health facility committees in Guinea, the Democratic Republic of the Congo, and Benin found that the committees provided an opportunity for health care providers to engage with communities through meetings to identify service failures and improve service quality, but these processes are not systematic and are dependent on individual leaders and linkages with other community structures (Lodenstein et al. 2017).

Universal Health Coverage

Mobilizing adequate financial resources is the first goal of the country's plan for achieving UHC (Wright et al. 2017). Strengthening the health system is also a key element of this approach. Toward this end, a partnership among the European Union, Luxembourg, and the WHO has been formed to support HSS and the achievement of UHC. The National Compact for Health was signed in 2016 and serves as a framework and agreement among government, partners, and civil society regarding health sector reform (WHO 2017, Yasané 2017, Adzodo 2017). More specific plans for extending insurance coverage are outdated—in 2014, various state actors had envisioned establishing a compulsory social health insurance system to increase financial risk protection, because other forms of insurance covered only a small portion (less than 5%) of the population (Wright et al. 2017). Since then, these plans have stalled.

Linkages Between Social Accountability and Social and Behavioral Change

The World Bank Global Partnership for Social Accountability project has been successful in changing the way budgets are created by bringing government representatives together with CSOs at the time of budgeting and designing services, but more information is needed on the mechanism for bringing these actors together and its sustainability. The project also identified successes around linking social accountability efforts to broader efforts for peace consolidation, because the lack of transparency around access to resources (specifically water, land, and revenue from extractives) was found to be a significant driver of outbreaks of conflict (Poli et al. 2020). In addition, creating a "safe space" for government officials to interact with civil society without fear of being confronted was found to be a successful way to create behavior change around social accountability, as well as giving political authority to sub-national officials, establishing agreements and frameworks around the specifics of how collaboration would be carried out, and providing both government and CSOs the opportunity to practice "learning-by-doing" in collaborating with one another (Poli et al. 2020).

Lodenstein et al. found that a lack of monetary compensation for health facility committee members did not seem to hinder engagement in these social accountability processes (Lodenstein et al. 2017). They did identify several mechanisms for creating behavior change in social accountability, including making the mandate of health facility committees more explicit and linking them to formal administrative accountability mechanisms in the broader health system (Lodenstein et al. 2017).

Findings: Online Survey

Overview of the Survey Respondents

A total of 179 individuals responded to the survey, including 135 men, 43 women, and 1 respondent who did not indicate their sex. Across the three countries, 31.8% of respondents reported that they work for a government ministry, and 28.5% reported that they work for an NGO. In Guinea, however, respondents reporting that they worked for an NGO were comparatively lower (6.9%), and respondents reporting that they worked for an implementing organization (27.6%) and a donor agency (20.7%) were comparatively higher. When asked to characterize their work in relation to the six WHO building blocks, 35.6% of all respondents indicated that they work in leadership and governance. Table 4 provides an overview of the survey respondents. Appendixes 8–11 provide survey data tables.

Table 4: Overview of the Survey Respondents and Where they Work

	All		Côte d'Ivoire		Ghana		Guinea	
	%	N	%	N	%	N	%	N
Survey respondents by sex	N=178		N=75		N=74		N=29	
Male	75.8	135	76.0	57	74.3	55	79.3	23
Female	24.2	43	24.0	18	25.7	19	20.7	6
What type of organization do you work for?	N=179		N=76		N=74		N=29	
Government ministry, agency, or parastatal	31.8	57	34.2	26	29.7	22	31.0	9
Health facility, including hospital, clinic	6.7	12	9.2	7	4.1	3	6.9	2
Donor agency	10.6	19	6.6	5	10.8	8	20.7	6
International implementing organization	8.9	16	5.3	4	5.4	4	27.6	8
Local NGO	28.5	51	30.3	23	35.1	26	6.9	2
Local CSO	3.9	7	2.6	2	6.8	5	0.0	0
Private sector business	3.4	6	1.3	1	4.1	3	6.9	2
News and media	3.4	6	7.9	6	0.0	0	0.0	0
University or research institution	1.7	3	1.3	1	2.7	2	0.0	0
Other	1.1	2	1.3	1	1.4	1	0.0	0
Where does your work fall?	N=177		N=74		N=74		N=29	
Service delivery	27.1	48	27.0	20	24.3	18	34.5	10
Health workforce	6.8	12	6.8	5	8.1	6	3.4	1
Health information systems	14.1	25	9.5	7	17.6	13	17.2	5
Access to essential medicines	2.3	4	2.7	2	2.7	2	0.0	0
Financing	2.8	5	4.1	3	2.7	2	0.0	0
Leadership and governance	35.6	63	37.8	28	33.8	25	34.5	10
Other	11.3	20	12.2	9	10.8	8	10.3	3
	%	Yes	%	Yes	%	Yes	%	Yes
Do you work at these levels of the health system? (check all that apply)	N=179		N=76		N=74		N=29	
National level	73.3	132	63.2	48	81.1	60	82.8	24
Regional level	72.6	130	67.1	51	77.0	57	75.9	22
District level	76.0	136	82.9	63	71.6	53	69.0	20
Community level	65.4	117	71.1	54	60.8	45	62.1	18

The survey was divided into four parts. Following part 1, which focused on stakeholders, each of the survey's remaining three parts began with a yes or no question to gather baseline information about the perceptions of the respondents. Table 5 provides a summary of these responses.

Table 5: Survey Respondents' Perceptions of Social Accountability and Universal Health Coverage in their Countries

	All		Côte d'Ivoire		Ghana		Guinea	
	%	N	%	N	%	N	%	N
Is social accountability prioritized in your country?	N=179		N=76		N=74		N=29	
Yes	68.7	123	67.1	51	68.9	51	72.4	21
No	31.3	56	32.9	25	31.1	23	27.6	8
Is there an active effort to advance UHC in your country?	N=165		N=75		N=74		N=29	
Yes	92.7	165	96.0	72	94.6	70	79.3	23
No	7.3	13	4.0	3	5.4	4	20.7	6
How long has the effort to advance UHC been active in your country?	N=169		N=73		N=71		N=25	
Less than 1 year	4.1	7	8.2	6	0.0	0	4.0	1
1 to 5 years	53.8	91	69.9	51	38.0	27	52.0	13
6 to 9 years	11.8	20	4.1	3	21.1	15	8.0	2
10 or more years	24.3	41	16.4	12	39.4	28	4.0	1
Don't know	5.9	10	1.4	1	1.4	1	32.0	8
Does UHC include social accountability in your country?	N=171		N=70		N=72		N=29	
Yes	48.5	83	34.3	24	65.3	47	41.4	12
No	51.5	88	65.7	46	34.7	25	58.6	17
Is social accountability seen as requiring behavior change in your country?	N=179		N=76		N=74		N=29	
Yes	95.0	170	100.0	76	87.8	65	100.0	29
No	5.0	9	0.0	0	12.2	9	0	0

Organization of the Findings of the Survey

The next four sections present results by survey part. Each survey part included pre-coded, Likert-scale, and open-ended questions. Findings in relation to the first two types of questions are presented in survey tables. The findings from the open-ended questions were thematically coded and are presented in relation to specific survey tables. As is common with on-line surveys, open-ended questions have mixed success. For example, not every respondent answers each open-ended question, and in some instances, the answers from the respondents do not relate to the question posed.

In this report, the analysis focuses first on each part of the survey individually followed by analysis of the key informant interviews. Further, the survey data are presented for all three countries sequentially in alphabetical order. For clarity, the countries are color coded:

Survey Part 1: Stakeholders in Your Country

The first part of the survey focused on the diversity and degree of interconnectedness between stakeholders, seen as those that may have a vested interest in UHC or have historically been involved in HSS and health-related social accountability. These data help in understanding the nature and extent of the networks between stakeholders and build evidence for how to further strengthen interactions or facilitate the creation of new ones in support of country mandates toward UHC.

Table 6 shows the frequency with which each survey respondent indicated that they interact with other stakeholders. In general, considerable interaction across all stakeholders is seen for all three countries, in that respondents occasionally or regularly interact with all types of stakeholders.

Across all three countries, respondents frequently interacted with government ministry, agency, or parastatal and local NGO stakeholders, and they only occasionally interacted with private sector businesses and university and research institutions. Only in Guinea did more of the respondents note that they rarely interact with news and media (37.9%). Respondents from both Côte d'Ivoire and Ghana noted occasional interaction with donor agencies (44.0% in Côte d'Ivoire and 50.7% in Ghana) and international implementing organizations (50.7% in Côte d'Ivoire and 58.9% in Ghana). Interestingly, in Guinea, respondents appeared to regularly interact with each of these stakeholders, with 72.4% interacting with donor agencies regularly and 55.6% interacting with international implementing organizations. Interaction with CSOs was also different across the countries—47.3% of respondents in Côte d'Ivoire and 39.3% of respondents in Guinea interacted occasionally with CSOs, and 50.0% of respondents in Ghana interacted regularly with them.

Table 6: Frequency of Working with Other Stakeholders

Côte d'Ivoire (highest %)
Ghana (highest %)
Guinea (highest %)

	% Rarely	% Occasionally	% Regularly
Government ministry, agency, or parastatal	1.4	23.3	75.3
	1.4	20.5	78.1
	6.9	10.3	82.8
Health facility, including hospital, clinic, etc.	6.7	16.0	77.3
	6.8	38.4	54.8
	17.2	44.8	37.9
Donor agency	16.0	44.0	40.0
	9.6	50.7	39.7
	13.8	13.8	72.4
International implementing organization	18.7	50.7	30.7
	15.1	58.9	26.0
	18.5	25.9	55.6
Local NGO	1.3	26.7	72.0
	9.6	38.4	52.1
	21.4	28.6	50.0
Local CSO	8.4	47.3	44.6
	14.9	35.1	50.0
	32.1	39.3	28.6
Private sector business	35.1	39.2	25.7
	27.0	48.6	24.3
	32.1	50.0	17.9
News and media	17.3	52.0	30.7
	24.3	39.2	36.5
	37.9	27.6	34.5
University or research institution	39.2	50.0	10.8
	17.8	64.4	17.8
	10.3	58.6	31.0

The first part of the survey included two open-ended questions related to understanding the types and frequency of stakeholder interactions:

- What stakeholders would you like to work with more?
- Why would additional work with those stakeholders be beneficial? For example, what would you accomplish?

Responses for each question were coded thematically to understand which additional stakeholders the respondents felt would be beneficial to interact with more. In many instances, the respondents wrote in more than one stakeholder type. Table 7 shares the results of this coding effort.

Table 7: Number of Respondents Indicating Wanting to Work More with Specific Stakeholders

	All	Côte d'Ivoire	Ghana	Guinea
Donor agency	48	26	16	6
Government ministry, agency, or parastatal	37	19	12	6
Health facility, including hospital, clinic, etc.	35	11	20	4
Local NGO	30	21	5	4
University or research institution	30	21	7	2
International implementing organization	28	20	4	4
CSOs	26	17	8	1
Communities or CBOs	25	6	15	4
News and media	22	12	8	2
Private sector business	21	11	9	1
Sub-national government—regional or district	12	4	6	2
All stakeholders	8	6	1	1

In general, respondents who answered this question felt that increased collaboration with donor agencies, government ministries and agencies, health facilities and hospitals, local NGOs, and university or research institutions would be of interest. Respondents also brought up two categories of stakeholders in all three countries that were not listed as a type of stakeholder in the survey—communities or CBOs and sub-national government bodies (including both regional and district levels). For communities or CBOs, 25 respondents remarked on a need for additional interaction, and for sub-national government bodies, 12 respondents remarked on a need for additional interaction.

Some variations were seen between the countries. For example, in Côte d'Ivoire, respondents reported they would like to work more closely with donor agencies, university or research institutions, local NGOs, and international implementing organizations. One respondent brought up a need for increased linkages with referral hospitals in Europe.

In Ghana, respondents noted a desire to work with health facilities and hospitals, donor agencies, communities or CBOs, and government ministries and agencies. Three respondents in Ghana also noted a need to interact with pharmaceutical companies, and one mentioned an interest in working with women leaders. One respondent shared their understanding of the complexity of the work and the need for multifaceted partnerships: "*Because there are more problem[s] at the community level which need to be solved, and when these [have] been solve[d] the media will therefore bring it out for the public to know. With it, the donor agency [can] support it with funding.*" *(Ghana-17)*

In Guinea, respondents wanted to work with government ministries and agencies and donor agencies, and equally, health facilities and hospitals, international implementing organizations, and communities or CBOs. One respondent wrote:

> *The district and community levels are, in my opinion, the operational levels par excellence for the health system. Working with these levels allows me to share my experience and contribute to better implement health policy, especially community health, universal health coverage. Collaboration with NGOs and international organizations makes it possible to synergize their experience at the international level and mine to act with more chance of success. (Guinea-14)*

Respondents were also queried on their reasons for wanting to work with these additional stakeholders. Responses varied widely but were thematically coded into 12 groups, as shown in Table 8.

Table 8: Number of Respondents Indicating Benefits of Working with Additional Stakeholders

	All	Côte d'Ivoire	Ghana	Guinea
Improve communication and coordination	48	24	16	8
Strengthen community participation	42	12	23	7
Improve population health outcomes	37	18	15	4
Strengthen technical capabilities	31	16	9	6
Strengthen use of media and information	27	9	14	4
Better data for evidenced-based decision-making	22	12	8	2
Mobilize resources toward a specific health outcome	21	15	5	1
Improve social accountability	19	2	13	4
Improve financial management	12	0	12	0
Increase participation of CSOs and private sector	12	1	10	1
Strengthen policies, governance, and leadership	9	1	5	3
Enhance capabilities in geographic information systems	1	1	0	0

Across all three countries, the majority of respondents mentioned that improved linkages among stakeholders would facilitate communication and coordination of activities related to HSS and UHC and strengthen community-level implementation and participation, which were followed by improve population health outcomes, strengthen technical capabilities and results-based management for project implementation, and strengthen use of media and information. Interestingly, the focus of respondents appeared to be on coordination and implementation of service delivery and ensuring that communities participate in being stewards of their own health through increased awareness and holding leaders accountable. CSOs, generally seen as crucial for social accountability, were not brought up often, although community participation was described as essential. In addition, a few respondents mentioned the need to improve policies, governance, and leadership.

The benefits to increased linkages as shared by respondents varied from country to country. In Côte d'Ivoire, although improve communication and coordination of activities related to HSS and UHC and improve population health outcomes were the highest responses, respondents also felt that it was important to mobilize resources toward specific health outcomes, such as smoking, drug abuse, pandemics, ample supply of blood products, and routine vaccinations. Respondents also wrote the following around improving social accountability, service delivery, and overall efficiency:

> *In Côte d'Ivoire, a deficit in blood products is recorded each year. This type of support [and] collaboration would allow us to be more effective in the field because we are sorely lacking in resources. (Côte d'Ivoire-27)*

> *As a journalist, we have a weekly health page which requires that we very often meet specialists to explain certain pathologies to us. But we have to say that in recent years, communication has become very difficult with these officials because now it is mandatory to have the approval of the Director of Communication of the Ministry of Health. And generally, he is not cooperative. (Côte d'Ivoire-34)*

> *[Increased interaction would] put in place social accountability mechanisms to improve the quality of services provided at the local level. (Côte d'Ivoire-54)*

> *Regular work with stakeholders allows a better alignment of strategies and financing with the real needs of the country and would improve confidence between the different actors of the health system for more efficiency and effectiveness of the health system. (Côte d'Ivoire-75)*

Respondents in Ghana focused on different kinds of issues in their response to benefits to interactions with additional stakeholders. Twenty-three respondents noted a benefit of strengthening community-level implementation and participation. Following this, respondents were balanced across improving communication and coordination of HSS and UHC activities, improving health outcomes, strengthening use and dissemination of media and information, improving social accountability, and improving financial management. Mobilizing resources and strengthening policies, governance, and leadership did not rank highly in respondents' minds when it came to consider social accountability, HSS, and UHC. Some of the benefits brought up by respondents included the following:

Community collaboration and oversight of health practitioners' activities by community members. Hospital board members comprising community members to ensure hospital administrative system runs smoothly. Client satisfaction surveys conducted by hospital staff. (Ghana-18)

Training of citizenry on local governance process. Advocacy against corruption. (Ghana-22)

Monitoring health service standards, community health services scorecard, development and piloting of social accountability framework for social protection including the national health insurance scheme, budget tracking, etc. (Ghana-26)

Most barriers to health care services are cultural in nature and the traditional authority have influence in that. (Ghana-49)

Gain insight into current gaps in knowledge at the global or regional level that I can help to address through research. (Ghana-51)

Media: add transparency and regular communication to the population on progress and challenges from Government of Ghana. Private sector: drive sustainable coverage for HIV, TB, and malaria. (Ghana-56)

Influence policy to reflect on needs of the people. (Ghana-65)

For respondents in Guinea, improving communication and coordination of activities related to HSS and UHC was at the forefront of their minds, with strengthening community-level implementation and participation and strengthening technical capabilities to improve project implementation following closely behind. Respondents shared the following related to benefits seen through increased stakeholder linkages:

Sensitization. Involvement of the community in the development of PAOs of the various health services and facilities at the decentralized level. Community involvement in the monitoring/evaluation process at the operational level of health programs and projects across the country. (Guinea-4)

Performance contract between the central level of the Ministry of Health and the DRS. Accountability of the municipal council to its population. (Guinea-9)

For colleagues from information and medias, they will send clear messages to inform the population on how to preserve their health, on essential practices. For the universities and research institutes, they will help to have professionals according to the needs of the population. (Guinea-27)

To better understand the effective execution of planned activities, ensure the monitoring and evaluation of actions. (Guinea-29)

Survey Part 2: Social Accountability in Your Country

The second part of the survey focused on social accountability. To strive for consistent understanding, social accountability was defined as having the aim to increase the degree that government and service providers are accountable for their conduct, performance, and management of resources and noted that social accountability is a broad term that includes strategies, approaches, activities, and tools.

The survey questions aimed to assess the respondents' perspectives on the existence of social accountability activities in their country, the success of those activities, factors that make them successful, and the parties that should be held accountable and to whom.

As presented in Table 5, 68.7% of respondents reported that social accountability is prioritized in their country, with 68.9% of respondents in Côte d'Ivoire, 72.4% of respondents in Ghana, and 67.1% of respondents in Guinea reporting that social accountability is prioritized in their country.

Table 9 presents findings around perceived success among survey respondents of eight common social accountability activities identified through the literature review. In general, the survey respondents appear to be of the opinion that these social accountability activities have been implemented in their country and have been successful in increasing social accountability, given that the percentages are predominantly higher in the strongly agree and agree category in comparison to the strongly disagree and disagree category. Community radio stood out, with 57.9% of the responses in Côte d'Ivoire, 82.2% in Ghana, and 69.0% in Guinea falling in the strongly agree and agree category.

Table 9: Perceived Success of Social Accountability Activities

Côte d'Ivoire (highest %)
Ghana (highest %)
Guinea (highest %)

_____ has been successful in increasing social accountability	% Strongly Disagree and Disagree	% Neutral	% Strongly Agree and Agree	% *Not Used*
Participatory budgeting	15.8	14.5	28.9	*18.4*
	25.0	9.7	41.7	*9.7*
	34.5	13.8	37.9	*0.0*
Partnership-defined quality	14.7	17.3	41.3	*13.3*
	25.7	8.1	54.1	*6.8*
	20.7	13.8	55.2	*3.4*
Community scorecards	14.7	14.7	24.0	*21.3*
	17.6	16.2	52.7	*4.1*
	27.6	10.3	27.6	*13.8*
Citizen satisfaction surveys	17.1	19.7	32.9	*6.6*
	23.0	10.8	54.1	*4.2*
	27.6	13.8	34.5	*17.2*
Citizen voice and action	23.7	11.8	27.6	*13.2*
	16.2	12.2	60.8	*2.7*
	31.0	13.8		*17.2*
Public hearings	14.5	19.7	34.2	*15.8*
	18.9	13.5	62.2	*1.4*
	20.7	17.2	41.4	*6.9*
Community radio	6.6	19.7	57.9	*2.6*
	4.2	8.2	82.2	*2.7*
	10.3	6.9	69.0	*3.4*
User-centered information	14.5	19.7	39.5	*26.3*
	17.6	27.0	52.7	*1.4*
	17.2	20.7	44.8	*17.2*

In Guinea, there appears to be disagreement about the success of community scorecards, with the same percentage of responses (27.6%) falling in the strongly disagree and disagree category and the strongly agree and agree category. For citizen voice and action, the percentages are discordant across the three countries. In Guinea, a greater percentage of responses fall in the neutral (13.8%) and strongly disagree and disagree category (31.0%), compared to the percentage of responses in the strongly agree and agree category (27.6%). In Côte d'Ivoire and Ghana, greater percent of responses fall in the neutral and strongly agree and agree categories.

The gray column in Table 9 shows respondents indicating that these eight social accountability activities are not being used. In particular, the three highest instances are in Côte d'Ivoire and relate to user-centered information (26.3%), community scorecards (21.3%), and participatory budgeting (18.4%). The lowest instances of respondents indicating that a social accountability activity is not being used relate to community radio (2.6% for Côte d'Ivoire, 2.7% for Ghana, and 3.4% for Guinea). The following also yielded a low percentage of not used responses

- Participatory budgeting in Guinea (0.0% not used)
- Partnership-defined quality in Guinea (3.4% not used)
- Citizen voice and action in Ghana (2.7% not used)
- Public hearings in Ghana (1.4% not used)
- User-centered information in Ghana (1.4% not used)

Responses to the open-ended question "What are some of the common social accountability activities currently being used in your country?" were coded thematically. In many cases, the social accountability activities referenced are similar to those delineated in Table 9.

Across the three countries, the most common response was performance monitoring. A total of 38 respondents indicated that activity reports and monitoring activities, particularly those structured around data, are ongoing. Respondents mentioned quarterly, monthly, and annual reporting, and reviews at all levels, and emphasized the importance of sharing findings at national, decentralized, and community levels. Thirteen respondents reported supervision, performance reviews, and peer reviews as existing social accountability activities, and 10 reported feedback meetings. Another monitoring and accountability activity reported by 10 respondents was the use of participatory budgeting, including budget reports, budget meetings, investment plans, and transparent budget allocation.

Community involvement was a common theme across the cited activities. Nineteen respondents reported community engagement activities, including public hearings, community meetings, and town hall. Ten respondents reported the use of community or citizen scorecards. Fourteen cited the existence of committees, councils, and committee/council meetings, and six reported the engagement of CSOs. Five respondents highlighted the importance of the rights of communities, including the right to health and the right to participate in the health system.

The final theme that emerged was around communication and coordination. Twelve respondents cited forms of media engagement, including television, radio, and press briefings. Fourteen respondents mentioned activities focusing on increasing engagement of key stakeholders, and six mentioned engagement with civil society.

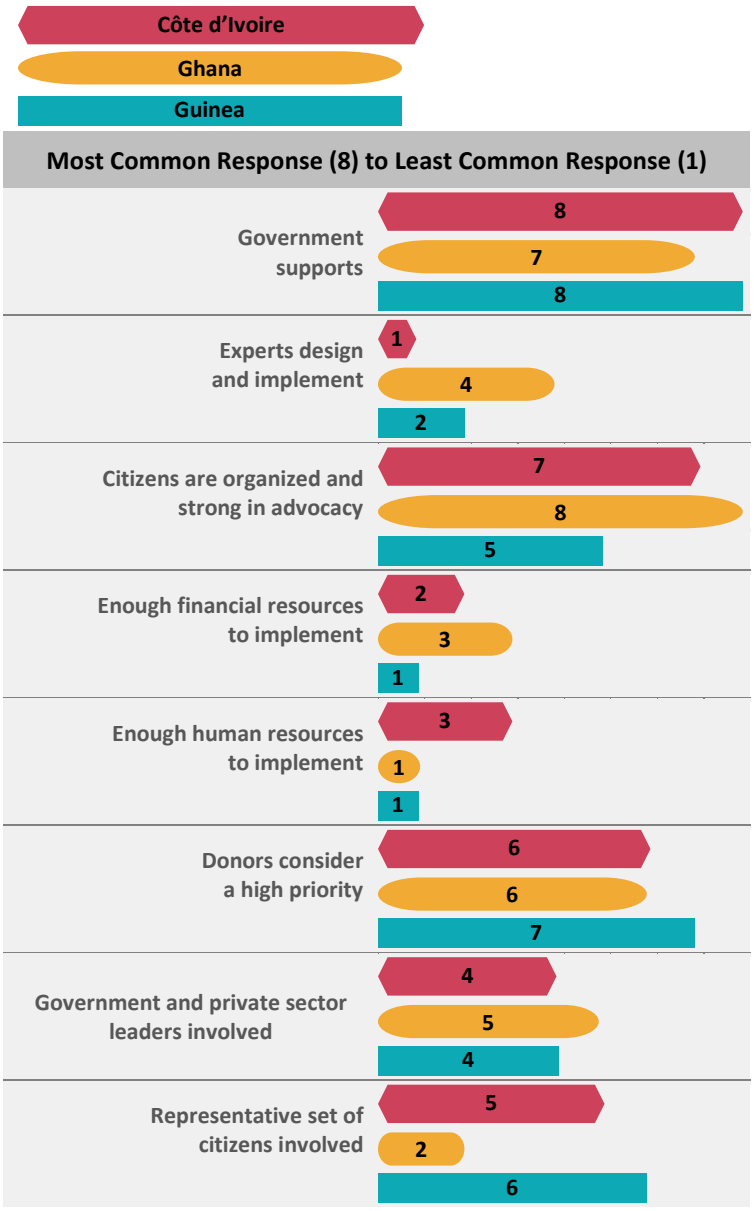
Survey respondents were asked to select factors for facilitating the success of a social accountability activity. Table 10 illustrates these findings, with the number of responses ranked from the most common response to least common response.

Across the three countries, government support of social accountability activity was one of the most important factors for facilitating success. This was the most common response in both Côte d'Ivoire and Guinea, and the second most common response in Ghana.

Citizens being organized and strong in their advocacy for social accountability was also an important factor across all three countries, and it was the most common response in Ghana, the second most common response in Côte d'Ivoire, and the fourth most common response in Guinea.

Experts designing and implementing activities, sufficient financial resources to implement, and sufficient human resources to implement ranked as the three least common responses in terms of factors that enable the success of social accountability activities.

Table 10: Social Accountability Success Factors



Other factors, including experts design and implement activities, government and private sector leaders involved, and representative set of citizens involved varied more by country.

Table 11 shows degrees of agreement with nine statements regarding accountability from whom to whom. The statements focus on health care providers, health facility managers, government, and citizens. In general, a higher percentage of responses fall in the strongly agree and agree category in comparison to the neutral or strongly disagree and disagree categories; however, often the percentage point differences across the three categories are small. One exception is the three statements regarding the extent that citizens make demands. Each of these statements falls decidedly in the strongly agree and agree category.

Table 11: Accountability from Whom to Whom Among Health System Actors

Côte d'Ivoire (highest %)
Ghana (highest %)
Guinea (highest %)

	% Strongly Disagree and Disagree	% Neutral	% Strongly Agree and Agree
Health providers feel accountable to patients regarding the quality of services provided	25.0 31.5 27.6	40.8 43.8 31.0	34.2 24.7 44.8
Health facility managers feel accountable to patients regarding the cost of services provided	39.5 35.1 37.9	32.9 43.2 31.0	27.6 21.6 31.0
Health providers and health facility managers feel accountable to government to use resources equitably for all citizens	32.9 27.0 34.5	31.6 28.4 24.1	35.5 44.6 41.4
Government feels accountable to citizens regarding providing information about health care services	22.4 27.8 24.1	34.2 26.4 24.1	43.4 45.8 51.7
Government feels accountable to citizens regarding the quality of health care services being made available	33.8 29.7 34.5	31.1 29.7 20.7	35.1 40.5 44.8
Government feels accountable to citizens regarding equitable allocation of financial resources for health services	45.3 35.6 34.5	30.7 31.5 31.0	24.0 32.9 34.5
Citizens demand quality health services	6.8 9.7 37.9	15.1 26.4 6.9	78.1 63.9 55.2
Citizens demand affordable health services	2.6 5.5 17.2	13.2 13.7 17.2	84.2 80.8 65.5
Citizens demand the government to be accountable for the health system	2.6 5.4 27.6	13.2 17.6 13.8	84.2 77.0 58.6

One statement—health providers feel accountable to patients regarding the quality of services provided—revealed notable disagreement across the three countries. The majority of respondents in Côte d'Ivoire (40.8%) felt neutral to this statement, followed by 34.2% strongly agreeing or agreeing. The majority of respondents in Ghana also felt neutral about the statement, although their second highest response was strongly disagree or disagree (31.5%). In Guinea, the majority of respondents strongly agreed or agreed (41.4%). Two statements leaned toward disagreement in all three countries—health facility managers feel accountable to patients regarding the cost of services provided and government feels accountable to citizens regarding equitable allocation of financial resources for health services. Each of these two instances concerns financing and equity.

Survey Part 3: Universal Health Coverage in Your Country

The third part of the survey posed questions about UHC. As presented in Table 5, across the three countries, 92.7% of respondents indicated that there is an active effort to advance UHC. Almost all respondents in Côte d'Ivoire (96.0%) and Ghana (94.6%) indicated that there is an active effort. In Guinea, a slightly smaller percentage, 79.3%, indicated there is an active effort. As noted in the literature review, both Ghana and Côte d'Ivoire have concrete initiatives in place to advance UHC, but Guinea's plan to achieve UHC has not been fully formulated, so it is reasonable to expect that some stakeholders would not perceive these efforts to be active.

In Côte d'Ivoire and Guinea, a majority (69.9% and 52.0%) of respondents indicated that the effort to advance UHC has been in place 1–5 years. For Côte d' Ivoire, 16.4% of respondents felt efforts have been in place for more than 10 years—the other categories were negligible. A substantial portion (32.0%) of respondents in Guinea did not know how long efforts have been in place. Respondents in Ghana were more divided. A similar percentage of respondents from Ghana felt that efforts have been in place 1–5 years (38.0%) and for 10 or more years (39.4%). A smaller percentage (21.1%) of respondents in Ghana felt that efforts to advance UHC have been in place for 6–9 years.

Table 12 summarizes the responses regarding who leads efforts to advance UHC. Government officials are thought to be leaders in all three countries—78.9% of respondents in Côte d'Ivoire and 83.8% of respondents in Ghana agreed or strongly agreed that they were leaders. A slightly smaller percentage (58.6%) in Guinea identified government officials as leaders, but more respondents selected agree or strongly agree for government officials than any other category. This is not an indication that government plans have been effective in advancing UHC, but rather that stakeholders view government as leading efforts, whether for good or bad. Respondents were more divided by country for other categories. Health care service providers and facility managers were largely not seen as leaders in Côte d'Ivoire and Guinea but were seen as leaders in Ghana. Citizens were not seen as leaders in Côte d'Ivoire but were in Ghana. In Guinea, respondents were almost evenly split as to whether they perceive UHC efforts to be citizen-led. In subsequent analysis, it may be useful to explore why stakeholders perceive UHC efforts to be led by government, and whether citizen participation has led a to a higher attainment of UHC in Ghana.

Table 12: Universal Health Coverage Leaders

Côte d'Ivoire (highest %)
Ghana (highest %)
Guinea (highest %)

_____ are leaders in the effort to advance UHC in my country	% Strongly Disagree and Disagree	% Neutral	% Strongly Agree and Agree
Health care service providers	40.8	31.6	27.2
	18.9	23.0	58.1
	44.8	24.1	31.0
Health care facility managers	38.2	27.6	34.2
	16.2	29.7	54.1
	41.4	27.6	
Government officials	6.6	14.5	78.9
	2.7	13.5	83.8
	24.1	17.2	58.6
Citizens	46.1	31.6	22.4
	28.4	33.8	37.8
	37.9	24.1	37.9

The survey asked whether certain groups of people are well represented in efforts to advance UHC. Responses are summarized in Table 13. Although results are largely mixed, the slant toward strongly disagree and disagree for many categories indicates that UHC efforts are largely not perceived to be representative. In all three countries, individuals with mental illness were most perceived to not be well represented—78.1% of respondents in Côte d'Ivoire, 76.7% of respondents in Ghana, and 75.9 % of respondents in Guinea strongly disagreed or disagreed that individuals who struggle with mental illness are well represented in efforts to advance UHC.

Table 13: Representativeness of Population Groups in Universal Health Coverage Efforts

Côte d'Ivoire (highest %)
Ghana (highest %)
Guinea (highest %)

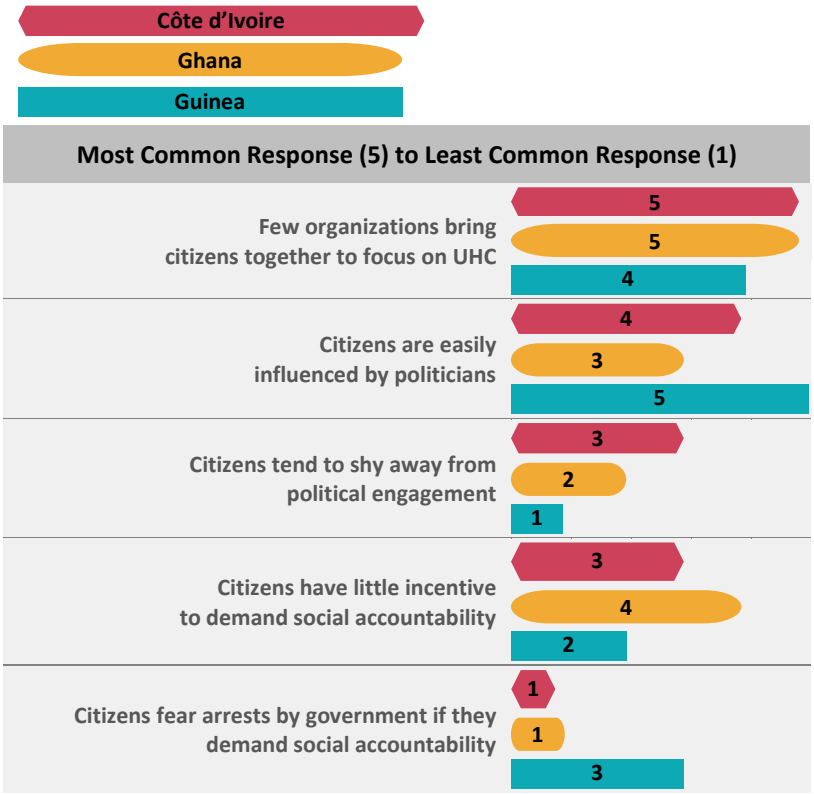
_____ are well represented in efforts to advance UHC in my country	% Strongly Disagree and Disagree	% Neutral	% Strongly Agree and Agree
Men	40.0	40.0	20.0
	18.9	40.5	40.5
	27.6	48.3	24.1
Women	42.7	40.0	17.3
	28.4	40.5	31.1
	37.9	24.1	37.9
Youth	46.7	37.3	16.0
	43.2	37.8	18.9
	34.5	37.9	27.6
Persons with disabilities	56.0	28.0	16.0
	59.5	25.7	14.9
	58.6	24.1	17.2
Individuals with specific health conditions	60.0	25.3	14.7
	68.5	19.2	12.3
	58.6	20.7	20.7
Individuals who struggle with mental illness	78.1	15.1	6.8
	76.7	17.8	5.5
	75.9	13.8	10.3
Urban citizens	33.8	43.2	23.0
	39.2	32.4	28.4
	34.5	24.1	41.4
Rural citizens	37.3	41.3	21.3
	54.2	27.0	18.9
	34.5	27.6	37.9

Persons with disabilities and individuals with specific health conditions were also not perceived to be well represented, with more than half of respondents in all three countries disagreeing or strongly disagreeing that these groups are well represented. More than one-third of respondents in all three countries strongly disagreed or disagreed that youth are well represented. Respondents were more divided regarding other groups, with a few exceptions. A substantial portion (81.0%) of respondents in Ghana strongly agreed, agreed, or were neutral that men are well represented, whereas survey

respondents in Côte d'Ivoire and Guinea tended to disagree that men are well represented. Among respondents in Ghana, 71.6% strongly agreed, agreed, or were neutral that women are well represented, compared to 62.0% in Guinea and 57.3% in Côte d'Ivoire. More than half of respondents in Ghana strongly disagreed or disagreed that rural citizens are well represented, compared to about one-third of survey respondents in the other two countries.

Table 14 ranks the responses from most common to least common in terms of barriers to citizen participation in the effort to advance UHC. Among all respondents, the most commonly selected barrier to citizen participation was that there are few organizations that bring citizens together to focus on UHC. As reflected in Appendix Table 10.5, 31.3% of respondents selected this as the most common barrier, 21.8% of respondents felt that citizens having little incentive to demand social accountability was the most common barrier, and 20.7% of respondents felt that citizens being easily influenced by politicians was the most common barrier. Smaller percentages of respondents indicated that citizens fearing arrest by government if they demand social accountability (9.5%) or citizens tending to shy away from political engagement (8.4%) were the most common barriers.

Table 14: Barriers to Citizen Participation in Universal Health Coverage Efforts



A notable exception to this pattern is in Guinea, where citizens being easily influenced by politicians was the most common response, and citizens fearing arrest was the third most common response. No survey respondents in Guinea indicated that citizens tending to shy away from political engagement was the most common barrier. Citizens having little incentive to demand social accountability was more prominent in Ghana, as the second most common response.

These results suggest that space and tangible opportunities for citizen participation in UHC efforts are more of a barrier to citizen participation than the citizen-politician relationship, at least in Côte d'Ivoire and Ghana; however, there was a fair amount of disagreement in all countries around what was the most significant barrier, with no clearly dominant barrier. In the short answer questions, a lack of a specific mechanism for citizens to participate or contribute to UHC efforts and their top-down nature emerged as a primary theme, discussed further below.

As noted in Table 5, respondents are largely split about whether social accountability activities are being used to advance UHC. A total of 48.5% of respondents indicated that they are, and 51.5% indicated that they are not. A larger percentage of respondents in Ghana (65.3%) reported that social accountability approaches are being used, compared to 41.4% in Guinea and 34.3% in Côte d'Ivoire.

The survey included follow up questions relating to the yes or no question noted above as well as an open-ended question relating to social accountability more broadly, as follows:

- Describe the types of social accountability activities being used to support UHC.
- Describe why in your opinion social accountability activities are not being used to support efforts to advance UHC.
- What types of actions do you feel could be most successful in increasing social accountability for health in your country?

These three questions were analyzed collectively. One analysis challenge is that often respondents answered both the first and second question, despite the preceding yes or no question implying they should answer only one of the two questions. This likely occurred because there was no skip pattern used. The answers, however, suggest that possibly the respondents struggled to definitively indicate whether social accountability is being used in efforts to advance UHC and instead see more nuance in the sense that there are ways that social accountability is being used and ways that it is not being used. Table 15 provides an overview of the responses to the three open-ended questions about the use of social accountability to support UHC.

Table 15: Social Accountability to Support Universal Health Coverage

Examples of Social Accountability to Support Universal Health Coverage		
Côte d'Ivoire	**Ghana**	**Guinea**
▪ New insurance system ▪ Focus groups and community radio for awareness raising ▪ Community engagement ▪ Service quality and costing monitoring	▪ Education for rights holders ▪ Community scorecards and participatory budgeting ▪ Client satisfaction survey ▪ CSO monitoring and forums for feedback	▪ CSO advocacy ▪ Declaration of law on social protection ▪ Basic health services ▪ Community mobilization
Challenges with Social Accountability to Support Universal Health Coverage		
Côte d'Ivoire	**Ghana**	**Guinea**
▪ Top-down approach from the government ▪ Cultural of accountability not present ▪ No process for involvement from the community ▪ Disinterest in UHC	▪ Lack of understating of social accountability ▪ Top-down approach from the government ▪ Community members not involved in decisions ▪ No enforcement mechanisms	▪ Weak mobilization for social accountability ▪ UHC not a priority for the government ▪ No health facility management committee ▪ Lack of political will

In Côte d'Ivoire, respondents largely seem to perceive UHC efforts to be synonymous with the rollout of the new insurance system—as a result, the most common activity described was awareness-raising with the population of how the insurance system works. Respondents did not describe these activities in detail, but focus groups and radio advertising were mentioned as examples of awareness-raising activities. Other social accountability activities frequently mentioned include involving community members in facility operations through determining needs, monitoring the quality of services, and determining which services would be offered and how much they would cost.

The top-down process used to develop and roll out the insurance system, including the high degree of perception of government officials as leaders of UHC efforts, seems to be the primary reason why social accountability approaches are not being used to advance UHC. Other actors, such as CSOs and individual citizens, have not been meaningfully engaged—survey respondents mentioned lack of funding, a lack of a culture of accountability, a lack of a mechanism for participation and consultation, and the technical and complicated nature of the insurance system as possible reasons for this. Underlying challenges in the health system, such as a lack of medicines, may have compounded new issues that have arisen with the rollout of UHC, such as the delay in registering people in the insurance system. Survey respondents indicated that taken together, much of the population is disinterested in UHC as a result.

In Ghana, the social accountability approaches being used seem less directly related to health and are more concerned with educating rights holders about social accountability in general—lack of awareness is perceived to be a significant barrier in these responses. This may serve as an underlying cause of several of the barriers identified by stakeholders in Ghana, as presented in Table 16. For example, government officials may lack political will to include social accountability in UHC efforts because citizens are not aware of their status as rights holders and do not generate demand for such activities. Community scorecards and budget tracking were most frequently mentioned as specific social accountability activities, and CSO monitoring, submission of complaints, and client satisfaction surveys were also mentioned to a lesser extent. However, overall, stakeholders feel that these activities are insufficient to actually result in meaningful social accountability. Numerous barriers were mentioned, including many of those delineated in Table 16.

In general, stakeholders seem to sense that decisions about UHC are extremely "top-down," and there are few structures in place, especially at the community level, to hold government officials accountable. NGOs, faith leaders, community leaders, and individual citizens are not involved in decision-making processes. Several respondents also mentioned a lack of enforcement mechanisms for government agencies who were not transparent as a reason why social accountability activities are not being used. Further analysis might look at the suggestion of one respondent to revitalize the community health management committee and community health volunteer program, as these may be a key mechanism for addressing the underlying cause of lack of awareness of social accountability within UHC efforts.

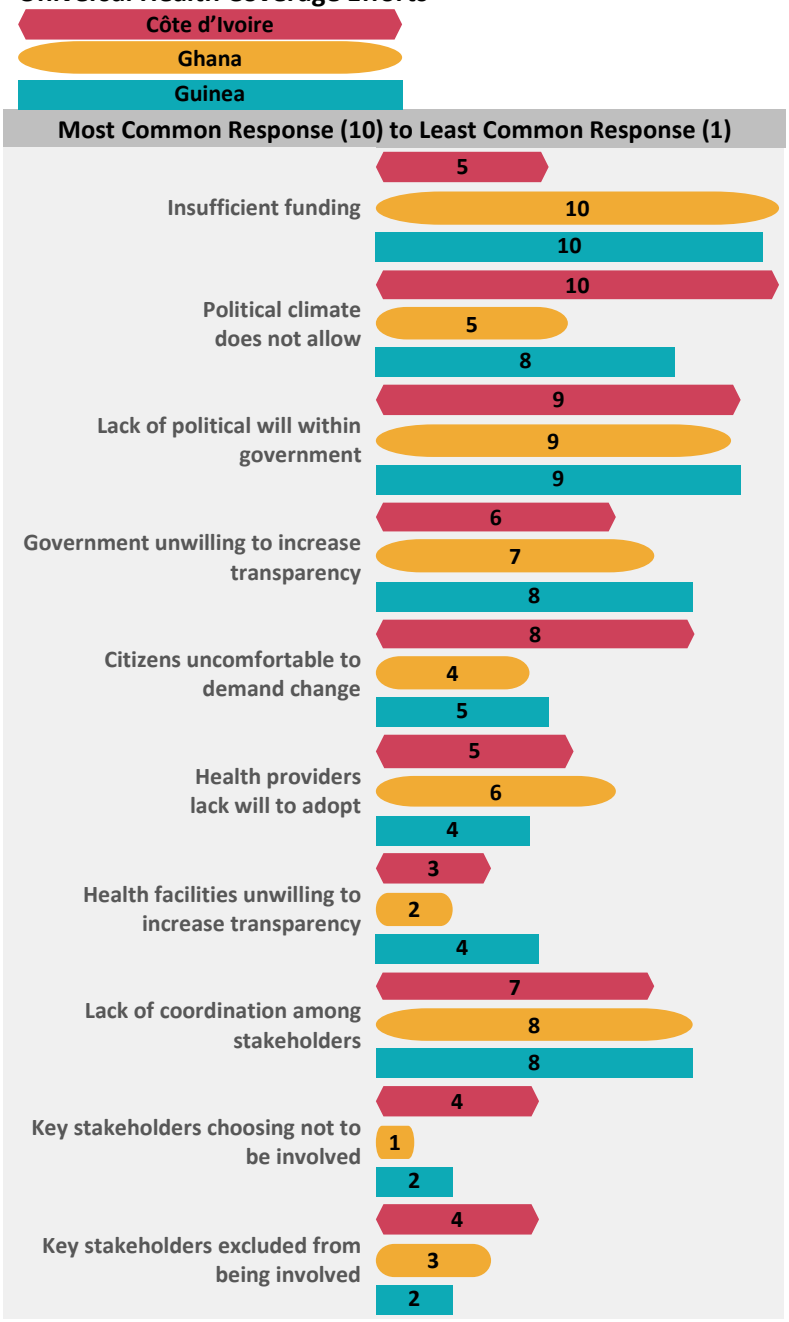
Respondents in Guinea seemed to struggle a bit more than other respondents in answering this question, possibly because it is difficult to define what constitutes efforts to advance UHC in Guinea, much less social accountability activities within UHC efforts. A few general activities, such as advocacy by CSOs, community mobilization, and the declaration of the law on social protection, were mentioned as social accountability activities already in place, but none of these emerged as salient themes, and in

fact, several respondents simply stated that the provision of basic free health services, such as HIV, TB, and malaria treatment, vaccinations, and caesarean sections, were a social accountability activity (though respondents may have misinterpreted the question). Many respondents indicated that UHC is not a priority for the government and there is weak mobilization for UHC or for social accountability, which is supported by responses shown in Table 16. Corruption results in a lack of political will to promote social accountability, as politicians have no incentive to change the citizen-politician dynamics from the status quo. The disappearance of health facility management committees was also mentioned by one respondent here as it was in Ghana, as was the top-down nature of UHC dialogue.

Table 16 ranks the responses from most common to least in terms of barriers for including social accountability activities in efforts to advance UHC. Lack of political will within government was the second-most selected response in all three countries, indicating that this is an important barrier. This is reasonable to expect, given that politicians and other government officials may be fearful of social accountability activities and may not have incentives to promote or support social accountability with the limited funds that are available.

Insufficient funding was the most selected barrier in Ghana and Guinea, and political climate was the most selected barrier in Côte d'Ivoire. This is interesting, given that Côte d'Ivoire is the only country that does not receive funding from the World Bank through the Global Partnership for Social Accountability. We might expect Côte d'Ivoire to have more substantial funding challenges than Ghana or Guinea, but perhaps these results are more reflective of a lack of funding for health and UHC in general in Ghana and Guinea, and not necessarily of a lack of funding

Table 16: Barriers to Including Social Accountability in Universal Health Coverage Efforts



for social accountability activities within UHC. A lack of coordination among stakeholders was also noted as an important barrier. This aligns with the previous finding shown in Table 14 in which the most important barrier to citizen participation in UHC efforts was lack of space or organizations that bring citizens together to focus on UHC.

To address these barriers, survey respondents suggested strategies that have direct correlation to the barriers they identified. The most commonly mentioned activities were involving citizens and CSOs in the process of establishing UHC, establishing mechanisms for citizen participation and monitoring (especially decentralized mechanisms), information-sharing and awareness-raising about UHC, funding specific social accountability efforts, and improving the availability and quality of health services. Traditional social accountability activities that are already implemented, such as community scorecards, CSO mobilization and empowerment, and budget transparency, were also mentioned fairly consistently. In Côte d'Ivoire, there was a stronger focus on improving the rollout of the insurance system as a whole, whereas in Ghana, survey respondents more frequently mentioned improving health worker attitudes and service quality. In Guinea, improving remuneration for service providers and then holding them accountable for providing quality services, was mentioned more frequently.

It is interesting that the idea of donor funding was only mentioned in two instances in the discussion on social accountability within UHC, even though insufficient funding was noted as a key barrier. The respondents, both from Ghana, noted that donor support of NGOs and better donor coordination would increase social accountability. The idea of how social accountability might intersect with donor accountability might be worth further exploring within UHC, because it is a key donor priority in many of these countries. Survey respondents did not seem to think that a lack of social accountability is related to the fact that UHC efforts receive large portions of funding from external donors rather than through taxpayer funds, over which citizens might feel a greater sense of ownership and hold political officials more accountable. The idea that governments feel more accountable to external donors rather than to citizens to produce UHC-related outcomes may be worth exploring further in subsequent analysis.

Survey Part 4: Behavior Change Efforts in Your Country

The fourth part of the survey focused on social accountability and behavior change. As noted in Table 5, across the three countries, 95.0% of the respondents indicated that social accountability is seen as requiring behavior change. All respondents in Côte d'Ivoire and Guinea indicated that social accountability requires behavior change, whereas in Ghana 12.2% indicated the opposite. Here it may be constructive to consider the set of questions in Table 5 in comparison. In particular, a higher percentage of respondents in Ghana (65.3%) indicated that social accountability is used to support UHC, compared to Guinea (41.1%) and Côte d'Ivoire (34.3 %). Potentially the Ghanaian respondents are familiar with ways to increase social accountability that do not require behavior change. In addition, given that 68.7% of respondents indicated that social accountability is prioritized and 48.5% indicated that social accountability activities are used in support of UHC, there may be a possibility for behavior change to be a tool to prioritize social accountability and employ social accountability in support of UHC. Indeed, behavior change among health system stakeholders could generate an increase in social accountability, local prioritization of social accountability, and the use of social accountability approaches for UHC and, in turn, behavior change efforts could impact HSS efforts.

As shown in Table 17, most respondents indicated that social accountability for health would require behavior change from each set of health system actors. In Ghana and Guinea, it appears that respondents feel strongly that social accountability and behavior change at health care facilities and in government institutions is needed because no respondents selected strongly disagree or disagree.

Table 17: Behavior Change to Increase Social Accountability

Côte d'Ivoire (highest %)

Ghana (highest %)

Guinea (highest %)

_____ need to change their behavior to help increase social accountability for health	% Strongly Disagree and Disagree	% Neutral	% Strongly Agree and Agree
Health care service Providers	3.9	21.1	75.0
	1.4	16.4	82.2
	3.4	10.3	86.2
Health care facility institutions	1.3	22.4	76.3
	0.0	15.1	84.9
	0.0	3.4	96.2
Government Institutions	4.0	14.7	81.3
	0.0	10.8	89.2
	0.0	10.3	89.7
Individual Citizens	7.9	17.1	75.0
	4.1	16.4	79.5
	0.0	3.4	96.8

In Côte d'Ivoire, a greater proportion of respondents agree with the statement "government institutions need to change their behavior to help increase social accountability for health" (81.3%) than the proportion of respondents who agree when the statement concerns behavior change for health care facilities (76.3%), service providers (75.0%), or citizens (75.0%). Many respondents reported holding neutral views on the need for behavior change by facilities (22.4%), service providers (21.1%), citizens (17.1%), and government institutions (14.7%).

In Ghana, most responses fell in the strongly agree or agree category. Specifically, in order of highest to lowest, the responses regarding who must change their behavior are as follows: government institutions (89.2%), health care facilities (84.9%), service providers (82.2%), and citizens (79.5%). Further, the respondents in Ghana held fewer neutral views on the need for behavior change by government institutions (10.8%) than they did on the need for behavior change by the other health system actors, which potentially suggests that they were mostly confident that behavior change by government institutions is needed to increase social accountability for health.

In Guinea, only a few of the 29 respondents reported holding neutral views on the need for behavior change by government institutions, health care facilities, service providers, and individual citizens. The majority selected strongly agree or agree that behavior change is needed, with almost all respondents (96.8%) agreeing that individual citizens must change their behaviors to increase social accountability for health. In fact, greater numbers of survey respondents in Guinea felt strongly about behavior change needed from citizens (96.8%) and facilities (96.2%) than they did about behavior change needed from government institutions (89.7%) and service providers (86.2%).

These findings suggest that respondents believe or strongly believe that the behavior of government institutions is closely linked with social accountability. Therefore, it follows that exploring ways to facilitate behavior change at government institutions will be critical to increase social accountability for

health in these settings. There is more variation in responses about the need for behavior change by health care facilities, service providers, and individual citizens. For example, most respondents in Guinea communicated a need for behavior change by citizens in relation to social accountability, and several respondents either strongly disagree or disagree that citizens need to change their behavior to increase social accountability for health in Côte d'Ivoire (7.9% strongly disagree or disagree) and in Ghana (4.1% strongly disagree or disagree). This divergence in results in the three countries could be explained by the fact that most survey respondents in Guinea reported working for a health facility (6.9%) or the government (31%), and their work is either related to service delivery (34.5%) or leadership and governance (34.5%). For these individuals, it could be harder to recognize a need for behavior change by the stakeholder group to which they belong or that is most closely related to their line of work.

As a complement to rating level of their agreement with whose behavior needs to change statements, the survey included the following parallel open-ended questions:

- What are some ways *health care service providers* in your country could change their behavior to help increase social accountability for health?
- What are some ways *health care facility institutions* in your country could change their behavior to help increase social accountability for health?
- What are some ways *government institutions* in your country could change their behavior to help increase social accountability for health?
- What are some ways *citizens* in your country could change their behavior to help increase social accountability for health?

As shown in Table 18, the response rates for these open-ended questions are high. However, the thematic coding revealed the need to view the high response rates cautiously. First, in some instances the response to each question is similar. That similarity, however, potentially points to a possible interpretation—the absence of distinguishing the behavior change needed for each health system actor reflects that because social accountability concerns change at institutional levels, it is not automatic to think in terms of behavior change, which more traditionally concerns change at individual levels. Second, on several occasions, respondents questioned the notion that facilities or institutions can change their behavior. Such a response can be seen as logical, given that facilities and institutions are not human beings, but the response can again be seen as an example of how it is not automatic to conceptualize facility-level or institutional-level change from the perspective of behavior change.

Table 18: Response Rates to Open-ended Questions on Behavior Change of Health System Actors

	All	Côte d'Ivoire	Ghana	Guinea
Health care service providers	86.6%	89.5%	81.1%	93.1%
Health care facility institutions	85.5%	92.1%	79.7%	82.8%
Government institutions	83.2%	88.2%	79.7%	79.3%
Citizens	78.8%	88.2%	66.2%	86.2%
All	83.5%	89.5%	76.7%	85.3%

In general, responses to the four open-ended questions were consistent across the three countries. Most respondents, particularly in Côte d'Ivoire, emphasized the need for behavior change from health care service providers and health care facilities as key for improving patient satisfaction and quality of care. Respondents appeared to view behavior change from the government and citizens as linked in often asserting that the government must change its behavior and better inform citizens of their rights, and citizens must change their behavior to exercise their rights. For example, a respondent in Ghana noted, *"Citizens [need] to understand the policies that support social accountability. Citizens need to know how to make effective use of the social accountability policies. Citizens need to be collectively active to demand for their rights."* (Ghana-40)

Table 19 highlights the ways the responses reference both behaviors that need to change, along with suggested social accountability activities to prioritize. Across the three countries, responses consistently centered on the need for more transparency, communication, good governance, collaboration, and community engagement. In addition, the respondents suggested social accountability activities such as information-sharing, health care facility forums, exchange and feedback mechanisms, quality assessments, and performance monitoring tools.

Table 19: Behavior Change to Inform Activities

Behaviors to change
▪ Increased transparency from the government
▪ Improved communication across governmental levels and with civil society
▪ Consistent community engagement, including collaboration with local community leaders
Social accountability activities to prioritize
▪ Hold open days at health care facilities to improve dialogue between communities and service providers
▪ Create spaces to exchange feedback among the different levels of the health system
▪ Establish systems to enable patients to provide feedback on the quality of the services
▪ Develop frameworks and tools to evaluate performance against objectives

To conclude the fourth part of the survey, respondents were asked to share any additional individuals or institutions that need to change their behavior to help increase social accountability for health. In Côte d'Ivoire, most respondents mentioned senators, the judiciary, and other government officials. Several respondents cited donors, international organizations, NGOs, development institutions, and financial or technical partners of the government. In Ghana, respondents cited civil society and grassroots organizers as well as the private sector, traditional and religious leaders, chiefs, and other community leaders. Respondents in Guinea shared that behavior change by civil society, NGOs, and international organizations is needed to increase social accountability for health. The role of the media and researchers was also mentioned.

Analysis of the Key Informant Interviews

A total of 21 key informant interviews were conducted. Interview notes and summaries were developed for each interview. One aspect of the note-taking procedures focused on post-interview reflection around three questions. The reflective questions were oriented toward consideration of the interviews collectively. In addition, the questions were summative in terms of their focus on assessing the ways the interview participants provided both similar and different perspectives and what types of findings and conclusions could be considered. This section provides a summary of the interview notes in relation to the three reflective questions.

QUESTION 1: How did the key informants give similar responses, and do they appear to share similar views on health, social accountability, and UHC?

Côte d'Ivoire

- Across the eight interviews, the participants commonly noted that community members and program beneficiaries often do not have much voice or influence in decision-making. Relatedly, the interview participants expressed that community members and program beneficiaries should be involved in important decision-making and help shape the national health system.
- The participants stressed the importance of improving communication among the different stakeholders of the health system.
- Several participants commented on the challenge to implement UHC effectively, with some describing the UHC implementation process as "complicated" or "disorganized."
- There appears to be consensus among the interview participants that social accountability can improve the implementation of UHC. Participants indicated that *comités de gestion des centres de santé* (health center management committees) represent an important pathway for encouraging social accountability.
- Participants agreed that behavior change is necessary to encourage social accountability. In particular, the participants suggested that citizens must gain a better understanding of their role, respect the resources that are made available to them, and avoid excesses. Equally, the participants noted that the health care providers must improve the quality of services, improve patient care, and better manage resources to avoid waste.

Ghana

- Across the six interviews, the participants commonly indicated that there is a need to improve health care in Ghana. There was consensus and emphasis that improvements would require collaboration among stakeholders within the health system as well as collaboration with public and private sectors external to the health system.
- Belief that social accountability activities are common and prioritized in Ghana was somewhat mixed; however, the participants consistently reported there are many activities focused on the objectives of social accountability but may not use the term social accountability.

- The participants agreed that social accountability work must focus equally and collectively on the government, health care providers, and citizens seeking health care services. It was noted that such a focus is seemingly self-evident, yet it does not necessarily consistently happen.
- Across the six interviews, the participants concurred that UHC efforts appear to be gaining strength; however, many underlying challenges continue to be unresolved, notably how to fund UHC.
- The participants agreed that there is a link between social accountability and social and behavior change. In particular, the participants noted that behavior change is needed among health care providers and citizens, including around the inter-relationship of increased adoption of health-seeking behaviors and better recognizing the right of citizens to demand equitable funding and quality health care.
- There was strong agreement among the participants that whichever set of stakeholders has the most external funding, this is the set of organizations and people who hold the most influence and decision-making power.

Guinea

- Across the seven interviews, the participants agreed that behavior change would be needed to improve social accountability and efforts to advance UHC.
- Consistently, the participants referenced challenges with improving health outcomes, including several who emphasized the lack of communication and collaboration between stakeholders, levels of government, and the public and private sector.
- Most participants indicated that there are not many ongoing social accountability activities, and several were not familiar with the concept of social accountability.
- There was some agreement that social accountability work occurs primarily at the national level, but with a decentralized government, governors, mayors, and community stakeholders are often not aware of the specific policies and strategies being pursued.
- The participants noted that the UHC movement is very minimal, if it exists at all, and several were not familiar with the concept of UHC.
- The participants described health sector challenges, such as a lack of coordination, lack of resources (human resources, financial resources, and equipment), lack of trained service providers in rural areas, and lack of general funding to cover salaries, equipment, trainings, and other needed materials to have a fully functioning health system.

QUESTION 2: How did the key informants give different answers, and do they seem to share different views on health, social accountability, and UHC?

Côte d'Ivoire

- Interview participants expressed differing views regarding which stakeholders have the most influence on shaping the health system and local efforts to promote social accountability.
- There did not appear to be consensus regarding relationships among different health system stakeholders. Some participants expressed a belief that all stakeholders work well together, and others spoke about poor communication, lack of coordination between partners, and tensions between some government institutions.
- Interview participants disagreed on the national stakeholders' capacity to influence the health system. Several participants indicated that the MHPH and health providers can influence and shape the national health system, and others were adamant that donors and financial or technical partners have the most influence and power to shape the system.
- With respect to social accountability work, some participants reported that the work is ongoing, and others appeared to be adamant that social accountability is non-existent.
- Several interview participants indicated that they believe that the government should promote social accountability; however, several others described the need for citizens to be individually accountable for their actions or decisions and that citizens must learn how to be accountable.

Ghana

- Several interview participants expressed the view that a focus on UHC has not led to improved health outcomes and that there should be more focus on improving the quality of care. Conversely, some participants indicated that they believe that UHC is ultimately the best way to improve health outcomes.
- There were differing views about the relationships among stakeholders. Notably, several participants stressed that government stakeholders and private sector stakeholders tend to disagree about how to interpret evidence related to the quality of health care. However, there were also instances in which the participants indicated that the evidence clearly shows that quality of care is poor.

Guinea

- There was some disagreement among the participants in terms of whose behavior would need to change to improve social accountability. Several participants strongly indicated that the government must change, and others noted that the government, the health sector, and citizens must all collectively change.
- Views about leadership and roles within social accountability work were varied. Some participants expressed that communication from the national level to sub-national levels is poor, and other participants highlighted the unwillingness of mayors to be involved, poor coordination between technical and financial partners, and a lack of health-seeking behavior at the community level.

- Across the seven interviews, there were a range of perspectives regarding pathways to achieve UHC. Some participants emphasized the importance of work at the national level, including policy making and political will, and others advocated that mayors are key actors who need to be a central part of a UHC movement. In addition, several participants suggested that, given the prominence of traditional medicine, community members would need to change their views and practices around health for UHC to gain traction.

QUESTION 3: What do you think are the main conclusions of this set of interviews?

Côte d'Ivoire

- Across the eight interviews, the participants commonly noted that community members and program beneficiaries often do not have much voice or influence in decision-making.
- The participants reported that citizens and the MHPH must have more influence on the health system than donors or the government's technical or financial partners. The participants suggested that it is important local stakeholders take full ownership of the health system and therefore of UHC.
- The interviews highlighted that implementing UHC is a challenging process, with some participants sharing anecdotes on the administrative and operational problems they faced while trying to enroll in the scheme or obtain their insurance card.
- Interview participants noted that UHC is not well-known by all stakeholders. As such, better communication is needed for citizens to be aware that they must enroll in the UHC scheme and for providers who do not understand the basket of services included in the UHC scheme.
- There appears to be a consensus among interview participants that civil society can help improve social accountability, but some posit that civil society is not very active or effective.
- The interview participants expressed that there is need for behavior change at individual and institutional levels to encourage social accountability and help implement UHC effectively.

Ghana

- Across the six interviews, the participants identified numerous examples of progress around health delivery and management, including increased awareness among health care providers on the role that communities play in striving for quality and equitable health care.
- The participants reported that there is increased openness in the health system. In particular, the participants noted that health care providers are more open to receive feedback from consumers, and consumers are more open to participate in the full health care delivery process. The participants suggested that some of the increased openness is the result of consumers believing now, unlike before, that their views count.
- Despite progress toward improved health delivery and management, the participants identified several underlying challenges, including the behavior change among health care providers, government, and citizens, as well as funding for UHC, low uptake of health services, and uneven representation across different groups of stakeholders.

- The participants emphasized that behavior change programming requires well thought out and nuanced sensitization and awareness raising.

Guinea

- Across the seven interviews, the participants indicated that, although there has been some work done around social accountability and UHC, largely the efforts are sporadic and not sustainable.
- The participants acknowledged that the government has made attempts to advance UHC with national health strategies and integrate social accountability activities with monitoring and evaluation systems built into the health system; however, these efforts consistently fall short.
- Advancing UHC through social accountability activities would require focus on underlying challenges, including limited resources (human and financial), lack of capacity, and poor communication across the health system and among stakeholders.
- The participants described behavior change as fundamental in the movement toward social accountability and UHC, noting that change must occur at all levels of the health system.

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Appendix 1: List of Resources from Formative Review

Social Accountability

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Food and Nutrition Technical Assistance (FANTA) https://www.fantaproject.org/

Food Security and Nutrition (FSN) Network / Implementer-Led Design, Evidence, Analysis and Learning (IDEAL) https://www.fsnnetwork.org/ideal

Health Communication Capacity Collaborative (HC3) https://healthcommcapacity.org/

Human Resources for Health (HRH) (Capacity Plus Project) https://www.hrhresourcecenter.org/index.html

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Appendix 2: Survey Instrument (English)

Stakeholder Survey: Social Accountability and Social and Behaviour Change

BACKGROUND

This survey is organized by the Health Systems Strengthening Accelerator (Accelerator), a five-year (2018-2023) global health systems strengthening (HSS) initiative funded by the US Agency for International Development (USAID) with co-funding from the Bill & Melinda Gates Foundation. The Accelerator project helps countries tackle health systems challenges to accelerate progress toward self-sustaining health systems.

This survey is being administered to stakeholders in three Accelerator focal countries - Côte d'Ivoire, Ghana, and Guinea. The goals of the survey are to better understand the following:

- Social accountability approaches being used for HSS and Universal Health Coverage (UHC)
- Actions and behaviour that facilitate or impede success for HSS and UHC

THANK YOU FOR YOUR INPUT

Completing this survey will take about 20 – 25 minutes. Please move through each section of the survey and click submit at the end.

We are very grateful for your willingness to complete this survey. Your perspectives on this important topic are crucial to the success of the activity. Our original vision was to hold stakeholder consultation meetings in person. Unfortunately, given COVID-19, we must pursue consultation in a different way. While this survey cannot replace an in-person conversation, we feel confident that the questions and your responses will productively inform this learning activity.

HOW THE FINDINGS FROM THIS SURVEY WILL BE SHARED AND USED

The findings from this survey will be consolidated into a single technical report with actionable recommendations around integrating behaviour change strategies into social accountability work. Upon completion of the report, we will hold a virtual webinar to launch the report. We will disseminate the report widely. Our hope is that the report will be beneficial to stakeholders across all levels of the health system and a wide range of organizations in identifying promising opportunities for social accountability and behaviour change approaches to work together for countries to advance toward UHC.

Please note that your responses are anonymous and will not be shared with any other third party. Please do not write your name anywhere on the questionnaire.

Best Regards.

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Part 1: Stakeholders in your Country

Q1. What type organization do you work for?

1. Government ministry, agency, or parastatal
2. Health facility, including hospital, clinic, etc.
3. Donor agency (e.g., USAID, World Bank, UN, etc.)
4. International implementing organization
5. Local non-governmental organization (NGO)
6. Local civil society organization (CSO)
7. Private sector business
8. News and media
9. University or research institution
10. Other

Q2. If your answer to Q1 is "Other," please specify the type of organization you work for

Q3. What is the name of your organization?

Q4. What is your title within the organization? Or if you do not have an exact title, briefly describe your role within the organization.

Q5. Which country are you based in?

1. Côte d'Ivoire
2. Ghana
3. Guinea
4. Other

Q6. If your answer to Q5 is "Other," please indicate which country your responses are in relation to

1. Côte d'Ivoire
2. Ghana
3. Guinea

Q7. Often the health sector and the health system align to six core components, commonly known as the WHO Building Blocks. Where does your work primarily fall within these building blocks?

1. Service delivery
2. Health workforce
3. Health information systems
4. Access to essential medicines
5. Financing
6. Leadership and governance
7. Other

Q8. If your answer to Q7 is "Other," please describe how you characterize your health sector or health system work

Q9. What is your gender?

1. Female
2. Male

Q10. What is your age?

Q11. Do you regularly work at these levels of the health system?

	Yes	No
National Level		
Regional Level		
District Level		
Community Level		

Q12. How often do you work with colleagues from a government ministry, agency, or parastatal?

1. Rarely
2. Occasionally
3. Regularly

Q13. How often do you work with colleagues from a health facility, including hospital, clinic, etc.?

1. Rarely
2. Occasionally
3. Regularly

Q14. How often do you work with colleagues from a donor agency (e.g., USAID, World Bank, UN, etc.)?

1. Rarely
2. Occasionally
3. Regularly

Q15. How often do you work with colleagues from an international implementing organization?

1. Rarely
2. Occasionally
3. Regularly

Q16. How often do you work with colleagues from a local non-governmental organization (NGO)?

1. Rarely
2. Occasionally
3. Regularly

Q17. How often do you work with colleagues from a local civil society organization (CSO)?

1. Rarely
2. Occasionally
3. Regularly

Q18. How often do you work with colleagues from a private sector business?

1. Rarely
2. Occasionally
3. Regularly

Q19. How often do you work with colleagues from news and media?

1. Rarely
2. Occasionally
3. Regularly

Q20. How often do you work with colleagues from a university or research institution?

1. Rarely
2. Occasionally
3. Regularly

Q21 What stakeholders would you like to work with more?

Q22. Why would additional work with those stakeholders be beneficial? For example, what would you accomplish?

Part 2: Social Accountability in your Country

For this survey we are focusing on health-related social accountability, defined as follows:

- Social accountability aims to increase the degree that government and service providers are accountable for their conduct, performance, and management of resources
- Social accountability is a broad term that includes strategies, approaches, activities, and tools

Q1. In the context of the health system in your country, is social accountability prioritized in your country?

1. Yes
2. No

Q2. What are some of the common social accountability activities currently being used in your country?

In Q3 - Q11, the focus is on common social accountability activities and your views on if they have been successful in your country. Please respond in relation to your level of agreement if the specific social accountability activity has been successful in your country in increasing the social accountability of government, health care service providers, and/or health care facility managers

Q3. Participatory budgeting in my country (e.g., a democratic process for communities to give input on how to spend part of a public budget) has been successful in increasing social accountability.

1. Strongly disagree
2. Disagree
3. Neutral
4. Agree
5. Strongly agree
6. Participatory budgeting has not been used in my country
7. I do not know if participatory budgeting has been used in my country

Q4. Partnership-defined quality in my country (e.g., community involvement in defining, implementing, and monitoring the heath care quality improvement process) has been successful in increasing social accountability.

1. Strongly disagree
2. Disagree
3. Neutral
4. Agree
5. Strongly agree
6. Partnership-defined quality has not been used in my country
7. I do not know if partnership-defined quality has been used in my country

Q5. Community scorecards in my country (e.g., a monitoring tool that provides citizens the opportunity to discuss and analyse government provided services such as health) have been successful in increasing social accountability.

1. Strongly disagree
2. Disagree
3. Neutral
4. Agree
5. Strongly agree
6. Community scorecards have not been used in my country
7. I do not know if community scorecards have been used in my country

Q6. Citizen satisfaction surveys in my country (e.g., having systems in place for citizens to anonymously provide feedback to government official, health care service providers, and/or health care facility managers) have been successful in increasing social accountability.

1. Strongly disagree
2. Disagree
3. Neutral
4. Agree
5. Strongly agree
6. Citizen satisfaction surveys have not been used in my country
7. I do not know if citizen satisfaction surveys have been used in my country

Q7. Citizen voice and action in my country (e.g. an approach to increase dialogue between citizens and government) has been successful in increasing social accountability.

1. Strongly disagree
2. Disagree
3. Neutral
4. Agree
5. Strongly agree
6. Citizen voice and action has not used in my country
7. I do not know if citizen voice and action has been used in my country

Q8. Public hearings in my country (including community meetings and other forums that provide a platform for citizens to publicly state their concerns) have been successful in increasing social accountability.

1. Strongly disagree
2. Disagree
3. Neutral
4. Agree
5. Strongly agree
6. Public hearings have not been used in my country
7. I do not know if public hearings have been used in my country

Q9. Community radio in my country (e.g., shows dedicated to providing health-related information to citizens) has been successful in increasing social accountability.

1. Strongly disagree
2. Disagree
3. Neutral
4. Agree
5. Strongly agree
6. Community radio has not been used in my country
7. I do not know if community radio has been used in my country

Q10. User-centered information and dissemination in my country (e.g., having systems in place that ensure citizens have understandable information about health conditions, new government policies, etc.) has been successful in increasing social accountability.

1. Strongly disagree
2. Disagree
3. Neutral
4. Agree
5. Strongly agree
6. User-centered information and dissemination has not been used in my country
7. I do not know if user-centered information and dissemination has been used in my country

Q11. Please select what you think are the three most important factors for facilitating the success of a social accountability activity in your country?

1. The government supports the social accountability activity
2. The relevant experts design and implement the social accountability activity
3. Citizens are organized and strong in their advocacy for social accountability
4. There are enough financial resources to implement social accountability activity
5. There are enough human resources to implement social accountability activity
6. Donors consider the social accountability activity a high priority
7. The needed government and private sector leaders are involved in the social accountability activity
8. A socio-demographic representative set of citizens are involved in the social accountability activity
9. Other
10. Don't know

Q12. If you answered "Other" to Q11, please specify important factors for facilitating the success of a social accountability activity in your country?

Each of the statements below provides a description of who might be accountable to whom in the context of a country's health system. Rate each statement in terms of your level of agreement.

Q13. Health care service providers in my country feel accountable to patients regarding the quality of services provided

Strongly disagree	1	2	3	4	5	Strongly agree

Q14. Health care facility managers in my country feel accountable to patients regarding the cost of services provided

Strongly disagree	1	2	3	4	5	Strongly agree

Q15. Health care service providers and health care facility managers in my country feel accountable to the government to use resources equitably for all citizens

Strongly disagree	1	2	3	4	5	Strongly agree

Q16. Government in my country feels accountable to citizens regarding providing information about health care services in the country

Strongly disagree	1	2	3	4	5	Strongly agree

Q17. Government in my country feels accountable to citizens regarding the quality of health care services being made available in the country

Strongly disagree	1	2	3	4	5	Strongly agree

Q18. Government in my country feels accountable to citizens regarding equitable allocation of financial resources for health care services in the country

Strongly disagree	1	2	3	4	5	Strongly agree

Q19. Citizens in my country demand quality health services

Strongly disagree	1	2	3	4	5	Strongly agree

Q20. Citizens in my country demand affordable health services

Strongly disagree	1	2	3	4	5	Strongly agree

Q21. Citizens in my country demand the government to be accountable for the health system

Strongly disagree	1	2	3	4	5	Strongly agree

Part 3: Universal Health Coverage in your Country

Please note that for this survey the term "Universal Health Coverage" or UHC, encompasses a concept of broad access to essential health care, including safe, effective, quality and affordable essential medicines and vaccines, along with protection from catastrophic financial risk

Q1. Is there an active effort to advance UHC in your country?

1. Yes
2. No

Q2. If yes, for how long has the effort to advance UHC been active?

1. Less than 1 year
2. 1 to 5 years
3. 6 to 9 years
4. 10 or more years
5. Don't know

Rate each statement about who is involved in efforts to advance UHC in your country

Q3. Health care service providers are leaders in the effort to advance UHC in my country

Strongly disagree	1	2	3	4	5	Strongly agree

Q4. Health care facility managers are leaders in the effort to advance UHC in my country

Strongly disagree	1	2	3	4	5	Strongly agree

Q5. Government is a leader in the effort to advance n UHC in my country

Strongly disagree	1	2	3	4	5	Strongly agree

Q6. Citizens are leaders in the effort to advance UHC in my country

Strongly disagree	1	2	3	4	5	Strongly agree

Q7. Men are well represented in efforts to advance UHC in my country

Strongly disagree	1	2	3	4	5	Strongly agree

Q8. Women are well represented in efforts to advance UHC in my country

Strongly disagree	1	2	3	4	5	Strongly agree

Q9. Youth are well represented in efforts to advance UHC in my country

Strongly disagree	1	2	3	4	5	Strongly agree

Q10. Persons with disabilities are well represented in efforts to advance UHC in my country

Strongly disagree	1	2	3	4	5	Strongly agree

Q11. Individuals with specific health conditions are well represented in efforts to advance UHC in my country

Strongly disagree	1	2	3	4	5	Strongly agree

Q12. Individuals who struggle with mental illness are well represented in efforts to advance UHC in my country

Strongly disagree	1	2	3	4	5	Strongly agree

Q13. Urban citizens are well represented in efforts to advance UHC in my country

Strongly disagree	1	2	3	4	5	Strongly agree

Q14. Rural citizens are well represented in efforts to advance UHC in my country

Strongly disagree	1	2	3	4	5	Strongly agree

Q15. What do you think is the most common barrier to citizen participation in the effort to advance UHC in your country?

1. There are few organizations that bring the citizens together to focus on UHC
2. Citizens are easily influenced by politicians
3. Citizens tend to shy away from political engagement
4. Citizens have little incentive to demand social accountability
5. Citizens fear arrests by government if they demand social accountability
6. Other
7. Don't know

Q16. If you answered "Other" to Q15, please specify what you think is the most common barrier to citizen participation in the effort to advance UHC in your country

Q17. In efforts to advance UHC in your country, are social accountability activities being used?

1. Yes
2. No

Q18. If yes, describe the types of social accountability activities being used to support efforts to advance UHC.

Q19. If no, describe why in your opinion social accountability activities are not being used to support efforts to advance UHC.

Q20. Please select the three most common barriers for including social accountability activities in efforts to advance UHC in your country

1. Insufficient funding for social accountability activities
2. Political climate does not allow for citizens to make demands for the government to change
3. Lack of political will within the government to adopt social accountability strategies
4. Unwillingness of government to increase their transparency
5. Citizens do not feel comfortable to make demands for the health system to change
6. Lack of will among health care service providers to adopt social accountability strategies
7. Unwillingness of health care facilities to increase their transparency
8. Lack of coordination among stakeholders
9. Key stakeholders are choosing to not be involved
10. Key stakeholders are being excluded from being involved
11. Other
12. Don't know

Q21. If you answered "Other" to Q20, please specify common barriers for including social accountability activities in efforts to advance UHC in your country

Q22. What types of actions do you feel could be most successful in increasing social accountability for health in your country?

Part 4: Behaviour Change Efforts in your Country

Q1. In your country, is social accountability for health seen as requiring behaviour change?

1. Yes
2. No

Q2. Rate your level of agreement with this statement: Individual health care service providers in my country need to change their behaviour to help increase social accountability for health.

Strongly disagree	1	2	3	4	5	Strongly agree

Q3. What are some ways health care service providers in your country could change their behaviour to help increase social accountability for health?

Q4. Rate your level of agreement with this statement: Health care facility institutions in my country need to change their behaviour to help increase social accountability for health

Strongly disagree	1	2	3	4	5	Strongly agree

Q5. What are some ways health care facility institutions in your country could change their behaviour to help increase social accountability for health?

Q6. Rate your level of agreement with this statement: Government institutions in my country need to change their behaviour to help increase social accountability for health

Strongly disagree	1	2	3	4	5	Strongly agree

Q7. What are some ways government institutions in your country could change their behaviour to help increase social accountability for health?

Q8. Rate your level of agreement with this statement: Individual citizens in my country need to change their behaviour to help increase social accountability for health

Strongly disagree	1	2	3	4	5	Strongly agree

Q9. What are some ways citizens in your country could change their behaviour to help increase social accountability for health?

Q10. Please describe any additional individuals or institutions in your country that need to change their behaviour to help increase social accountability for health

Part 5: Conclusion

Q1. Please share any additional thoughts you have about work focused on health system strengthening (HSS), social accountability (SA), universal health coverage (UHC) and behaviour change in your country.

Q2. If you know of colleagues in your country working in the health field who might like to complete this survey, please feel free to forward the link or share your suggestions in the reply below. Also, feel free to contact either Amanda Folsom (afolsom@r4d.org) or Susan Pietrzyk (susan.pietrzyk@icf.com) with your suggestions.

THANKS FOR COMPLETING THE SURVEY.

WE GREATLY APPRECIATE YOUR TIME AND YOUR INISGHTS. WE LOOK FORWARD TO SHARING THE RESULTS OF OUR FINDINGS.

Appendix 3: Survey Instrument (French)

Enquête auprès des parties prenantes : Redevabilité sociale et changement social et comportemental

PRÉSENTATION

Cette enquête est organisée par l'Accélérateur du Renforcement des Systèmes de Santé (Accélérateur), une Initiative d'une durée de cinq ans (2018-2023) qui vise à renforcer les systèmes de santé globaux (RSS) fondée par l'Agence des États-Unis pour le Développement International (USAID) sur financement conjoint avec la Fondation Bill & Melinda Gates. Le projet accélérateur aide les pays à relever les défis posés par les systèmes de santé pour accélérer la mise en place de systèmes de santé autonomes.

Cette enquête va être administrée à des parties prenantes dans trois pays cibles participants au projet Accélérateur - Côte d'Ivoire, Ghana, et Guinée. Les objectifs de l'enquêtes sont de mieux comprendre les éléments suivants :

- Les approches de Redevabilité Sociale qui vont être utilisées pour le Renforcement des systèmes de santé (RSS) et la mise place d'une Couverture Médicale Universelle (CMU)
- Les actions et le comportement qui facilitent ou qui entravent la réussite vers la mise place d'un RSS et d'une CMU.

MERCI POUR VOTRE PARTICIPATION

Répondre aux questions de l'enquête prendra environ 20 – 25 minutes. Veuillez parcourir chaque section de l'enquête et cliquez sur "SUBMIT" pour soumettre à la fin.

Nous vous remercions de bien vouloir participer à cette enquête. Votre opinion et point de vue sur ces sujets importants sont essentiels pour la réussite de cette activité. Initialement, nous avions envisagé d'organiser des réunions dans lesquelles nous aurions consulté en personne les parties prenantes. Malheureusement, la survenue de l'épidémie de COVID-19 nous a obligé à organiser les consultations de manière différente. Bien que cette enquête ne puisse remplacer des entretiens en personne, nous sommes convaincus que les questions et vos réponses contribueront de manière productive au succès de cette activité d'apprentissage.

COMMENT LES RÉSULTATS DE CETTE ENQUÊTE SERONT-ILS PARTAGÉS ET UTILISÉS

Les résultats de cette enquête seront regroupés dans un seul rapport technique assorti de recommandations concrètes pour l'intégration de stratégies de changement de comportement dans le travail de redevabilité sociale. Une fois le rapport terminé, nous tiendrons un séminaire virtuel pour lancer le rapport. Le rapport sera largement diffusé. Notre espoir est que toutes les parties prenantes, à tous les niveaux du système de santé, ainsi qu'un large éventail d'organisations puissent profiter de ce rapport pour identifier les pistes prometteuses en termes d'approches de la redevabilité sociale et le changement de comportement afin de travailler ensemble pour que les pays s'acheminent vers la mise en place de la CMU.

Veuillez noter que les réponses sont anonymes et qu'elles ne seront pas partagées avec des tiers. N'écrivez pas votre nom sur le questionnaire, à aucun endroit.

Meilleures salutations

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Susan Pietrzyk
International Health and Development Team, ICF
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Partie 1 : Parties prenantes dans votre pays

Q1. Pour quel type d'organisation travaillez-vous ?

1. Ministère, Agence du gouvernement ou organisme paraétatique
2. Établissement de santé, comprenant les hôpitaux, cliniques, etc.
3. Agence de donateurs (tels que USAID, Banque Mondiale, ONU, etc.)
1. Agence Internationale d'exécution
2. Organisation locale non gouvernementale (ONG)
3. Organisation locale de la société civile (CSO)
4. Secteur privé lucratif
5. Information et médias
6. Université ou institut de recherche
7. Autre

Q2. Si votre réponse à Q1 est "Autre," précisez, s'il vous plait, le type d'organisation pour laquelle vous travaillez

Q3. Quel est le nom de votre organisation ?

Q4. Quelle est votre position dans l'organisation ? ou si vous n'avez pas de position bien définie, décrivez brièvement votre rôle dans l'organisation

Q5. Dans quel pays êtes-vous basé ?

1. Côte d'Ivoire
2. Ghana
3. Guinée
4. Autre

Q6. Si votre réponse à Q5 est "Autre," indiquez s'il vous plait à quel pays se rapporte vos réponses dans cette enquête

1. Côte d'Ivoire
2. Ghana
3. Guinée

Q7. Le secteur de la santé et le système de santé doivent comporter six composantes standard, communément appelé Piliers de l'OMS. À quel pilier se rattache principalement votre travail ?

1. Prestation des services
2. Personnel de santé
3. Systèmes d'Information Sanitaire
4. Accès aux médicaments essentiels
5. Financement
6. Direction et gouvernance
7. Autre

Q8. Si votre réponse à Q7 est "Autre," décrivez s'il vous plait comment vous caractérisez votre travail dans le secteur de la santé ou le système de santé

Q9. Quel est votre genre ?

1. Féminin
2. Masculin

Q10. Quel âge avez-vous ?

Q11. Travaillez-vous de manière régulière à ces niveaux du système de santé ?

	Oui	Non
Niveau National		
Niveau Régional		
Niveau du District		
Niveau de la communauté		

Q12. À quelle fréquence travaillez-vous avec des collègues d'un ministère, d'une agence du gouvernement ou d'un organisme paraétatique ?

1. Rarement
2. Occasionnellement
3. Régulièrement

Q13. À quelle fréquence travaillez-vous avec des collègues d'un établissement de santé, comme un hôpital, une clinique, etc. ?

1. Rarement
2. Occasionnellement
3. Régulièrement

Q14. À quelle fréquence travaillez-vous avec des collègues d'une agence de donateurs (comme l'USAID, la Banque Mondiale, l'ONU, etc.) ?

1. Rarement
2. Occasionnellement
3. Régulièrement

Q15. À quelle fréquence travaillez-vous avec des collègues d'une agence internationale d'exécution ?

1. Rarement
2. Occasionnellement
3. Régulièrement

Q16. À quelle fréquence travaillez-vous avec des collègues d'une organisation locale non gouvernementale (ONG) ?

1. Rarement
2. Occasionnellement
3. Régulièrement

Q17. À quelle fréquence travaillez-vous avec des collègues d'une organisation de la société civile (CSO) ?

1. Rarement
2. Occasionnellement
3. Régulièrement

Q18. À quelle fréquence travaillez-vous avec des collègues du secteur privé lucratif ?

1. Rarement
2. Occasionnellement
3. Régulièrement

Q19. À quelle fréquence travaillez-vous avec des collègues de l'information et des médias ?

1. Rarement
2. Occasionnellement
3. Régulièrement

Q20. À quelle fréquence travaillez-vous avec des collègues d'une université ou d'un institut de recherche?

1. Rarement
2. Occasionnellement
3. Régulièrement

Q21 Avec quelles parties prenantes voudriez-vous travailler plus ?

Q22. Pourquoi un travail supplémentaire avec ces parties prenantes serait-il bénéfique ? Par exemple, qu'est-ce que vous accompliriez ?

Partie 2 : Redevabilité Sociale dans votre pays

Dans cette enquête, nous nous intéressons à la redevabilité sociale liée à la santé que nous définissons comme suit

- La redevabilité sociale a pour but le renforcement des mécanismes par lesquels le gouvernement et les prestataires des services doivent répondre de leur conduite, de leur performance et de leur gestion des ressources vis-à-vis des citoyens
- La redevabilité sociale est un terme global qui comprend des stratégies, des approches, des activités et des outils

Q1. Dans le contexte du système de santé de votre pays, est-ce que la Redevabilité Sociale est une priorité dans votre pays ?

1. Oui
2. Non

Q2. Quelles sont certaines des activités courantes de redevabilité sociale qui sont actuellement utilisées dans votre pays ?

Les questions Q3 - Q11portent sur les activités courantes de redevabilité sociale et cherchent à savoir si, selon vous, ces activités ont été un succès dans votre pays. Répondez, s'il vous plait, en donnant votre niveau d'appréciation pour juger de la réussite de l'activité de redevabilité sociale spécifique à augmenter la responsabilité sociale du gouvernement, des prestataires des services de soins de santé et/ou des gestionnaires d'établissements de santé dans votre pays.

Q3. La budgétisation participative dans mon pays (par ex. un processus démocratique par lequel les communautés donnent leur avis sur la façon de dépenser une partie d'un budget public) a réussi à augmenter la redevabilité sociale.

1. Fortement en désaccord
2. En désaccord
3. Neutre
4. D'accord
5. Fortement d'accord
6. La participation budgétaire n'a pas été utilisée dans mon pays
7. Je ne sais pas si la participation budgétaire a été utilisée dans mon pays

Q4. L'approche de qualité définie par le partenariat- dans mon pays (par ex : la participation de la communauté à définir, mettre en œuvre, et à faire le suivi du processus d'amélioration de la qualité des services sanitaires) a réussi à augmenter la redevabilité sociale.

1. Fortement en désaccord
2. En désaccord
3. Neutre
4. D'accord
5. Fortement d'accord
6. L'approche de qualité définie par le Partenariat n'a pas été utilisée dans mon pays
7. Je ne sais pas si l'approche de qualité définie par le partenariat a été utilisée dans mon pays

Q5. La carte communautaire de performance dans mon pays (par ex. un outil d'd'évaluation qui donne aux citoyens l'opportunité de discuter et de donner leur avis sur la qualité des services fournis par le gouvernement, comme la santé) a réussi à augmenter la redevabilité sociale.

1. Fortement en désaccord
2. En désaccord
3. Neutre
4. D'accord
5. Fortement d'accord
6. La Carte Communautaire de Performance n'a pas été utilisée dans mon pays
7. Je ne sais pas si la Carte Communautaire de Performance a été utilisée dans mon pays

Q6. Les enquêtes de satisfaction des citoyens dans mon pays (par ex. Avoir des systèmes en place pour permettre, de façon anonyme, aux citoyens de faire connaître leur avis aux responsables officiels du gouvernement, aux prestataires des services de soins de santé et/ou aux gestionnaires des établissements de santé) ont réussi à augmenter la redevabilité sociale.

1. Fortement en désaccord
2. En désaccord
3. Neutre
4. D'accord
5. Fortement d'accord
6. Les Enquêtes de Satisfaction des Citoyens n'ont pas été utilisées dans mon pays
7. Je ne sais pas si les Enquêtes de Satisfaction des Citoyens ont été utilisées dans mon pays

Q7. Voix et action des citoyens dans mon pays (par ex une approche pour augmenter le dialogue entre les citoyens et le gouvernement) a réussi à augmenter la redevabilité sociale.

1. Fortement en désaccord
2. En désaccord
3. Neutre
4. D'accord
5. Fortement d'accord
6. Voix et Action des Citoyens n'a pas été utilisée dans mon pays
7. Je ne sais pas si Voix et Action des Citoyens a été utilisée dans mon pays

Q8. Des audiences publiques dans mon pays (comprenant des réunions communautaires et autres forum qui constituent des plateformes à partir desquelles les citoyens peuvent publiquement déclarer leurs problèmes) ont réussi à augmenter la redevabilité sociale.

1. Fortement en désaccord
2. En désaccord
3. Neutre
4. D'accord
5. Fortement d'accord
6. Des audiences publiques n'ont pas été utilisées dans mon pays
7. Je ne sais pas si des audiences publiques ont été utilisées dans mon pays

Q9. Une radio communautaire dans mon pays (par ex. des émissions consacrées à la diffusion d'informations sur la santé pour les citoyens) a réussi à augmenter la redevabilité sociale.

1. Fortement en désaccord
2. En désaccord
3. Neutre
4. D'accord
5. Fortement d'accord
6. Une radio Communautaire n'a pas été utilisée dans mon pays
7. Je ne sais pas si une radio Communautaire a été utilisée dans mon pays

Q10. Information et divulgation centrée sur l'utilisateur dans mon pays (par ex. avoir des systèmes en place qui garantissent aux citoyens l'accès à des informations compréhensibles sur leur état de santé, aux nouvelles directives gouvernementales, etc.) a réussi à augmenter la redevabilité sociale

1. Fortement en désaccord
2. En désaccord
3. Neutre
4. D'accord
5. Fortement d'accord
6. Information et Divulgation centrée sur l'utilisateur n'a pas été utilisée dans mon pays
7. Je ne sais pas si Information et Divulgation centrée sur l'utilisateur a été utilisée dans mon pays

Q11. Sélectionnez parmi les facteurs suivants, les trois plus importants qui, selon vous, facilitent la réussite de la redevabilité sociale dans votre pays

1. Le gouvernement soutient les activités en matière de redevabilité sociale
2. Les spécialistes dans le domaine conçoivent et mettent en œuvre les activités de redevabilité sociale
3. Les citoyens sont organisés et mènent des plaidoyers vigoureux pour la redevabilité sociale
4. Les ressources financières sont suffisantes pour mettre en place des activités de redevabilité sociale
5. Les ressources humaines sont suffisantes pour mettre en place des activités de redevabilité sociale
6. Les donateurs considèrent les activités en matière de redevabilité sociale somme une priorité élevée
7. Les dirigeants nécessaires du gouvernement et du secteur privé sont impliqués dans les activités de redevabilité sociale
8. Un groupe de citoyens représentatifs au plan socio-démographique est impliqué dans les activités de redevabilité sociale
9. Autre

Q12.Si vous avez répondu "Autre" à Q11, précisez les facteurs qui, selon vous, sont importants pour faciliter la réussite des activités de redevabilité sociale dans votre pays

Chacune des déclarations ci-dessous fournit une description de qui doit être redevable à qui dans le contexte du système de santé d'un pays. Évaluez chacune des déclarations en fonction de votre niveau d'approbation.

Q13. Les prestataires des services de santé dans mon pays se sentent responsables envers les patients de la qualité des services de santé fournis

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q14.Les gestionnaires des établissements de santé dans mon pays se sentent responsables envers les patients du coût des services de santé fournis

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q15. Les prestataires des services de soins de santé et les gestionnaires des établissements de santé dans mon pays se sentent responsables vis-à-vis du gouvernement de l'utilisation équitable des ressources pour tous les citoyens

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q16. Le gouvernement dans mon pays se sent responsable envers les citoyens de fournir des informations sur les services de santé dans le pays

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q17. Le gouvernement dans mon pays se sent responsable envers les citoyens de la qualité des services de santé qui sont disponibles dans le pays

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q18. Le gouvernement dans mon pays se sent responsable envers les citoyens de l'allocation équitable des ressources financières pour les services de santé dans le pays

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q19. Les citoyens dans mon pays exigent des services de santé de qualité

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q20. Les citoyens dans mon pays exigent des services de santé à un coût abordable

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q21. Les citoyens dans mon pays exigent que le gouvernement soit redevable de la qualité du système de santé

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Partie 3 : Couverture Médicale Universelle dans votre pays

Veuillez noter que dans cette enquête, le terme de “Couverture Médicale Universelle” ou CMU, recouvre un large concept englobant l’accès à des soins de santé essentiels, comprenant les médicaments et vaccins essentiels, sans risques, efficaces et à un coût abordable, ainsi qu’une protection contre des risques financiers catastrophiques

Q1. Dans votre pays, est-ce qu’il y a un effort actif pour s’acheminer vers la mise en place d’une CMU ?

1. Oui
2. Non

Q2. Si oui, depuis combien de temps cet effort pour arriver à une CMU est-il actif ?

1. Moins d’1 an
2. 1 à 5 ans
3. 6 à 9 ans
4. 10 ans ou plus

Évaluez chaque déclaration concernant les personnes impliquées dans les efforts pour faire avancer la mise en place d’une CMU dans votre pays

Q3. Les prestataires des services de santé sont des chefs de file dans l’effort pour faire avancer la mise en place de la CMU dans mon pays

Fortement en désaccord	1	2	3	4	5	Fortement d’accord

Q4. Les gestionnaires des établissements de santé sont des chefs de file dans l’effort pour faire avancer la mise en place de la CMU dans mon pay

Fortement en désaccord	1	2	3	4	5	Fortement d’accord

Q5. Le gouvernement est un leader dans l’effort pour faire avancer la mise en place de la CMU dans mon pays

Fortement en désaccord	1	2	3	4	5	Fortement d’accord

Q6. Les citoyens sont des chefs de file dans l’effort pour faire avancer la mise en place de la CMU dans mon pays

Fortement en désaccord	1	2	3	4	5	Fortement d’accord

Q7. Les hommes sont bien représentés dans l’effort pour faire avancer la mise en place de la CMU dans mon pays

Fortement en désaccord	1	2	3	4	5	Fortement d’accord

Q8. Les femmes sont bien représentées dans l’effort pour faire avancer la mise en place de la CMU dans mon pays

Fortement en désaccord	1	2	3	4	5	Fortement d’accord

Q9. Les jeunes sont bien représentés dans l’effort pour faire avancer la mise en place de la CMU dans mon pays

Fortement en désaccord	1	2	3	4	5	Fortement d’accord

Q10. Les personnes avec des handicaps sont bien représentées dans l'effort pour faire avancer la mise en place de la CMU dans mon pays

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q11. Les personnes ayant des problèmes spécifiques de santé sont bien représentées dans l'effort pour faire avancer la mise en place de la CMU dans mon pays

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q12. Les personnes souffrant de troubles mentaux sont bien représentées dans l'effort pour faire avancer la mise en place de la CMU dans mon pays

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q13. Les citoyens urbains sont bien représentés dans l'effort pour faire avancer la mise en place de la CMU dans mon pays

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q14. Les citoyens urbains sont bien représentés dans l'effort pour faire avancer la mise en place de la CMU dans mon pays

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q15. Quelle est, selon vous, la barrière la plus courante à la participation des citoyens dans l'effort pour faire avancer la mise en place de la CMU ?

1. Il y a peu d'organisations qui rassemblent les citoyens pour se concentrer sur la CMU
2. Les citoyens sont facilement influencés par les politiciens
3. Les citoyens ont tendance à se tenir à l'écart de l'engagement politique
4. Les citoyens sont peu incités à exiger la redevabilité sociale
5. Les citoyens craignent d'être arrêtés par le gouvernement s'ils exigent la redevabilité sociale
6. Autre

Q16. Si vous avez répondu "Autre" à Q15, précisez spécifiquement quelle est, selon vous, la barrière la plus courante à la participation des citoyens dans l'effort pour faire avancer la mise en place de la CMU

Q17. Dans votre pays, est-ce que les activités de redevabilité sociale ont été utilisées pour faire avancer la mise en place de la CMU ?

1. Oui
2. Non

Q18.Si oui, décrivez les types d'activités de redevabilité sociale qui ont été utilisées pour soutenir l'effort pour faire avancer la mise en place de la CMU.

Q19. Si non, décrivez pourquoi, selon vous, les activités de redevabilité sociale n'ont pas été utilisées pour soutenir l'effort pour faire avancer la mise en place de la CMU.

Q20. Sélectionnez les trois barrières les plus courantes qui empêchent d'inclure les activités de redevabilité sociale dans l'effort pour faire avancer la mise en place de la CMU dans votre pays.

1. Financement insuffisant pour les activités de redevabilité sociale
2. Climat politique ne permet pas aux citoyens de formuler des exigences pour que le gouvernement change
3. Manque de volonté politique au sein du gouvernement pour adopter des stratégies de redevabilité sociale
4. Réticence du gouvernement à augmenter sa transparence
5. Les citoyens ne se sentent pas à l'aise pour exiger que le système de santé change
6. Manque de volonté parmi les prestataires des services de soins de santé pour adopter des stratégies de redevabilité sociale
7. Réticence des établissements de santé à augmenter leur transparence
8. Manque de coordination parmi les parties prenantes
9. Les principales parties prenantes font le choix de ne pas être impliquées
10. Les principales parties prenantes sont exclues de la participation
11. Autre

Q21. Si vous avez répondu "Autre" à Q20, précisez spécifiquement quelle est, selon vous, la barrière la plus courante à l'insertion des activités de redevabilité sociale dans l'effort pour faire avancer la mise en place de la CMU dans votre pays

Q22. Quels types d'actions seraient, selon vous, les plus susceptibles de réussir pour augmenter la redevabilité sociale pour la santé dans votre pays ?

Partie 4 : Effort pour le changement de comportement dans votre pays

Q1. Dans votre pays, est-ce que la redevabilité sociale pour la doit passer par un changement de comportement?

1. Oui
2. Non

Q2. Évaluez cette déclaration en fonction de votre niveau d'approbation : Dans mon pays, les prestataires des services de soins de santé individuels doivent changer leur comportement pour permettre une augmentation de la redevabilité sociale pour la santé.

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q3. Dans votre pays, de quelles manières les prestataires des services de soins de santé pourraient-ils changer leur comportement pour permettre une augmentation de la redevabilité sociale pour la santé ?

Q4. Évaluez cette déclaration en fonction de votre niveau d'approbation : Dans mon pays, les institutions de soins de santé doivent changer leur comportement pour permettre une augmentation de la redevabilité sociale pour la santé.

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q5. Dans votre pays, de quelles manières les institutions de soins de santé pourraient-elles changer leur comportement pour permettre une augmentation de la redevabilité sociale pour la santé ?

Q6. Évaluez cette déclaration en fonction de votre niveau d'approbation : Dans mon pays, les institutions gouvernementales doivent changer leur comportement pour permettre une augmentation de la redevabilité sociale pour la santé.

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q7. Dans votre pays, de quelles manières les institutions gouvernementales pourraient-elles changer leur comportement pour permettre une augmentation de la redevabilité sociale pour la santé ?

Q8. Évaluez cette déclaration en fonction de votre niveau d'approbation : Dans mon pays, les citoyens doivent changer leur comportement pour permettre une augmentation de la redevabilité sociale pour la santé.

Fortement en désaccord	1	2	3	4	5	Fortement d'accord

Q9. Dans votre pays, de quelles manières les citoyens pourraient-ils changer leur comportement pour permettre une augmentation de la redevabilité sociale pour la santé ?

Q10. Citez d'autres individus ou institutions dans votre pays qui doivent changer leur comportement pour permettre une augmentation de la redevabilité sociale pour la santé

Partie 5 : Conclusion

Q1. Partagez, s'il vous plait, des questions supplémentaires que vous vous posez sur le travail concernant le Renforcement des Systèmes de santé (RSS), la Redevabilité Sociale (RS), la couverture médicale Universelle (CMU) et le changement de comportement dans votre pays.

Q2. Si vous connaissez des collègues dans votre pays qui travaillent dans le domaine de la santé qui pourraient être intéressés à participer à cette enquête, n'hésitez pas à leur transmettre le lien ou à nous contacter pour nous faire parvenir vos suggestions. Vous pouvez contacter Amanda Folsom (afolsom@r4d.org) ou Susan Pietrzyk (susan.pietrzyk@icf.com) avec vos suggestions.

MERCI DE VOTRE PARTICIPATION À L'ENQUÊTE.

NOUS VOUS SOMMES RECONNAISSANT POUR LE TEMPS QUE VOUS AVEZ BIEN VOULU NOUS ACCORDER ET NOUS VOUS REMERCIONS POUR VOTRE CONTRIBUTION. NOUS ATTENDONS AVEC INTÉRET DE PARTAGER LES RÉSULTATS DE NOTRE ENQUÊTE.

Appendix 4: Key Informant Interview Guide (English)

RECORD KEEPING

Date of interview	
Interview conducted by	
Note-taker	
Country	
Key informant name	
Male (1) or female (2)	
Organizational affiliation	
Job title	
Organization type (use survey codes)	
Works primarily at what health system level (e.g., urban, rural, community, national, sub-national, etc.)	
Was a survey administered? (yes/no)	
Why was this key informant was selected?	
Other notes	

INTRODUCTION

The introduction should be in your own words. The introduction must keep in mind any past communication you had with the key informant to set up the interview as well as if you have previously met the key informant in a professional or personal context.

The key points to highlight in an introduction include:

- Hello, my name is_____.
- Thank you for taking the time to talk with me today.
- I will be conducting this interview with my colleague_____.
- I am part of a team of people working on a USAID funded project called the Health Systems Strengthening Accelerator
- We are interested in the relationship between work focused on health and health system strengthening, social accountability, universal health coverage (UHC), and behaviour change.
- To gather information and understand this relationship we are administering an online survey and conducting interviews in Côte d'Ivoire, Ghana, and Guinea
- Your perspectives on this important topic are crucial to the success of our work. We want to hear your insights on how behaviour change can help increase social accountability for Universal Health Coverage (UHC).
- Our original vision was to hold stakeholder consultation meetings in person. Unfortunately, given COVID-19, we must pursue consultation in a different way. While this phone conversation cannot replace an in-person conversation, we feel confident that the questions and your responses will productively inform this activity.
- I would just note that the findings from this interview as well as the results from the survey will be consolidated into a single report with recommendations around integrating behaviour change strategies into social accountability work.
- When we complete the report, we will hold a webinar, and disseminate the report widely.
- Our hope is that the report will be beneficial to stakeholders across all levels of the health system and a wide range of organizations in identifying promising opportunities for social accountability and behaviour change approaches to work together for countries to advance toward UHC.
- It is also important to emphasize that your responses are anonymous. We will not use your name in the report.
- During this interview both myself and _____ will be taking notes. In addition, if you have no objections, we will record the interview. The recording is for reference only. We will not share the recording with anyone, and it will be deleted once the report is drafted.
- Before we proceed with the interview, do you have any questions for me?

INTERVIEWER NOTE: If the key informant asks questions and is interested in further details, feel free to share the activity description with them.

ICE BREAKER / CONFIRMATIONS

INTERVIEWER NOTE: Remember to turn the recorder on.

1. I understand you work for [insert name of organization]. Can you tell me about your work? What do you do, what challenges do you face in your work?

2. What levels of the health system do you work at (e.g., national, regional, district, community)? And have you found that there are tensions between these levels? If yes or no, explain why.

Part 1: Stakeholders in your Country

To begin, I would like to ask you some questions about health sector stakeholders in [insert name of country].

3. When you think about the health sector and the range of stakeholders, where are there strong connections? What enables these strong connections? Also, where are the connections weaker, and why is this the case?

4. What set of health sector stakeholders do you think have the most influence? What set of people and institutions plays the biggest role in shaping the health system in your country? Do you think the right stakeholders have the most influence?

5. What set of people and/or institutions do you think don't have enough voice and influence in the health sector?

Part 2: Social Accountability in your Country

Next, I would like to ask you about the social accountability work in [insert name of country].
In particular, we have seen over the years a lot of focus on social accountability projects where the aim is to increase the degree that government and health service providers are accountable for their conduct, performance, and management of resources. Often specific social accountability strategies, approaches, activities, and tools are grounded in amplifying citizen engagement

6. In [insert name of country], is this type of work common? Can you describe the work? And specifically, what accountability is being demanded and by whom?

7. Do you think social accountability work is making a difference? How? Are these activities targeting the right issues? Can you give specific examples? When you think about these examples, do you think part of what is changing includes institutions and individuals being held more accountable? And does that involve behaviours changing?

8. What are some of the challenges that come with social accountability work? Challenges for the government? For citizens? For health care providers? Who needs to change and in what ways to address these challenges?

Part 3: Universal Health Coverage (UHC) in your Country

9. Do you think social accountability approaches can help to advance UHC in [insert name of country].? How?

10. When you think about the roadblocks to achieving UHC, which ones do you feel are about institutions and processes that need to change? Which ones are more about the need for individuals to change the way they think and what actions they do and do not take?

11. I'd like to ask a few more questions about UHC in [insert name of country]. Who are the main actors and stakeholders working on UHC? Do you think these sets of people work well together, or are there tensions? Are the tensions specific to UHC, or are they more longstanding tensions? Are they political in nature?

12. Do you think the right sets of stakeholders are pushing for UHC? Are there people and specific ideas or approaches being excluded from UHC work? Why is this happening?

Part 4: Behaviour Change Efforts in your Country

INTERVIEWER NOTE: Consider and pull in what has been discussed so far as part of bringing the interview to a close. The concluding set of questions should be tailored to the key informant and focus on behaviour change.

I just have one more set of questions. I would like to focus on the behaviour change aspects.

13. Do you think institutions and individuals need to change how they work, including their behaviour for social accountability projects to be successful? And what about to achieve UHC? Why is behaviour change needed, can you give some examples? Have institutions and individuals been able to change their behaviours as they work toward UHC? What has facilitated behaviour change? What has impeded behaviour change?

14. If you could design a social accountability project, what would it look like?
INTERVIEWER NOTE: Be mindful that the key informant might be leading a social accountability project, so adjust your wording accordingly

15. If you were in charge of working towards UHC, what would your approach be?
INTERVIEWER NOTE: Be mindful that the key informant might be in charge of UHC, so adjust your wording accordingly

Part 5: Conclusion

Last question.

Is there anything that you wanted to ask me? Or anything else that you would like to share and talk about?

THANK YOU FOR YOUR TIME AND YOUR INSIGHTS.

I HAVE REALLY ENJOYED CHATTING WITH YOU AND I APPRECIATE THE TIME YOU HAVE TAKEN OUT FO YOUR BUSY DAY.

Appendix 5: Key Informant Interview Guide (French)

ENREGISTREMENT DES DONNÉES

Date de l'interview	
Interview conduite par	
Preneur de notes	
Pays	
Nom de l'informateur-clé	
Homme (1) ou femme (2)	
Affiliation organisationnelle	
Profession	
Type d'organisation (utilisez les codes de l'enquête)	
Travaille essentiellement à quel niveau du système de santé (par exemple, urbain, rural, communautaire, national, sous-national, etc.)	
Une enquête a-t-elle été menée ? (oui/non) ?	
Pourquoi cet informateur-clé a-t-il été sélectionné ?	
Autres notes	

INTRODUCTION

Vous devez rédiger l'introduction avec vos propres mots. Cependant, vous devez mentionner dans votre introduction toute communication passée que vous avez eue avec l'informateur-clé pour organiser l'interview et également si vous avez précédemment rencontré cette personne dans un contexte professionnel ou sur le plan personnel.

Ci-dessous, figurent des points-clés à souligner dans une introduction :

- Bonjour, je m'appelle _____.
- Merci d'avoir bien voulu prendre de votre temps pour parler avec moi aujourd'hui.
- Je vais conduire cette interview avec mon/ma collègue _____.
- Je fais partie d'une équipe de personnes travaillant sur un projet financé par l'USAID appelé Accélérateur du Renforcement des Systèmes de Santé
- Nous nous intéressons à la relation entre le travail axé sur la santé et sur le renforcement du système de santé, la redevabilité sociale, la couverture médicale universelle (CMU) et le changement de comportement.
- Pour réunir les informations et comprendre cette relation, nous administrons une enquête en ligne et nous menons des interviews en Côte d'Ivoire, au Ghana, et en Guinée
- Vos points de vue concernant ce sujet important sont essentiels à la réussite de notre travail. Nous souhaitons connaître votre opinion sur la manière dont le changement de comportement peut contribuer à augmenter la redevabilité sociale en vue de l'instauration de la Couverture Médicale Universelle (CMU).
- À l'origine, nous avions pensé à organiser des réunions au cours desquelles nous aurions consulté des parties prenantes en personne. Malheureusement, la survenue de l'épidémie de COVID-19 nous a obligé à poursuivre nos consultations d'une autre manière. Bien que cette conversation téléphonique ne puisse pas remplacer une conversation en personne, nous pensons que les questions et vos réponses apporteront des éléments productifs pour cette activité.
- Je voudrais simplement ajouter que les résultats de cette interview comme les résultats de l'enquête seront fusionnés dans un seul rapport assorti de recommandations sur l'intégration des stratégies de changement de comportement dans le travail de redevabilité sociale.
- Lorsque nous aurons terminé le rapport, nous organiserons un webinaire et nous divulguerons largement le rapport.
- Nous espérons que ce rapport apportera un bénéfice aux parties prenantes à tous les niveaux du système de santé et à un large éventail d'organisations en identifiant les opportunités prometteuses de prise en compte des approches de redevabilité sociale et de changement de comportement pour travailler ensemble à faire avancer les pays vers la mise en place d'une CMU.
- Il est également important d'insister sur le caractère anonyme de vos réponses. Nous n'utiliserons pas votre nom dans le rapport.
- Au cours de cette interview, _____et moi-même prendrons des notes. De plus, si vous n'y voyez pas d'objections, nous enregistrerons l'interview. L'enregistrement servira seulement de référence. Nous ne partagerons cet enregistrement avec personne et il sera détruit une fois le rapport rédigé.
- Avant de commencer l'interview, avez-vous des questions à me poser ?

NOTE POUR L'ENQUÊTEUR : Si l'informateur-clé pose des questions et souhaite avoir plus de détails, n'hésitez pas à lui fournir une description de l'activité.

BRISE-GLACE / CONFIRMATIONS

NOTE POUR L'ENQUÊTEUR : Pensez à mettre l'enregistreur en marche.

1. Je comprends que vous travaillez pour [insérez nom de l'organisation]. Pouvez-vous me parler de votre travail ? Que faites-vous, à quels problèmes devez-vous faire face dans votre travail ?

2. À quels niveaux du système de santé travaillez-vous (par exemple., national, régional, niveau du district, communautaire) ? Et avez-vous constaté qu'il y avait des tensions entre ces niveaux ? Si oui ou non, expliquez pourquoi.

Partie 1 : Parties prenantes dans votre pays

Pour commencer, je voudrais vous poser quelques questions sur les parties prenantes du secteur de la santé en/au [insérez le nom du pays].

3. Quand vous pensez au secteur de la santé et aux diverses parties prenantes, où y a-t-il de fortes connections ? Qu'est-ce qui rend ces connections si fortes ? Et où ces connections sont-elles les plus faibles et pourquoi est-ce le cas ?

4. D'après vous, quel est le groupe de parties prenantes dans le domaine de la santé qui possède le plus d'influence ? Quel groupe de personnes et d'institutions joue le rôle le plus important dans la façon dont le système de santé est façonné dans votre pays ? Pensez-vous que ce sont les bonnes parties prenantes qui ont le plus d'influence ?

5. Selon vous, quel groupe de personnes et/ou d'institutions ne dispose pas de suffisamment de voix et d'influence dans le secteur de la santé ?

Partie 2 : Redevabilité sociale dans votre pays

Je voudrais ensuite vous poser des questions sur le travail sur la redevabilité sociale en/au [insérez nom du pays]. En particulier, nous assistons au fil des années à un intérêt grandissant pour des projets de redevabilité sociale dont le but est d'augmenter le niveau de responsabilisation du gouvernement et des prestataires des services de soins de santé concernant leur conduite, leur performance, et leur gestion des ressources. De manière plus spécifique, les approches, les stratégies, les activités et les outils sont fondés souvent sur le développement de l'engagement citoyen.

6. En/au [insérez le nom du pays], ce type de travail est-il courant ? Pouvez-vous décrire le travail ? et plus précisément, quelle part de redevabilité est exigée et par qui ?

7. Pensez-vous que le travail de redevabilité sociale crée une différence ? Comment ? Ces activités ciblent-elles les vrais problèmes ? Pouvez-vous donner des exemples précis ? Quand vous pensez à ces exemples, pensez-vous qu'une partie de ce qui change est dû au fait que les institutions et les individus soient tenus plus responsables de leurs actions ? Et cela implique-t-il un changement des comportements ?

8. Quels sont certains des défis associés au travail de redevabilité sociale ? Les défis pour le gouvernement ? Pour les citoyens ? pour les prestataires des services de soins de santé ? Qui a besoin de changer et de quelle manière doit-on s'attaquer à ces défis ?

Partie 3 : Couverture Médicale Universelle (CMU) dans votre pays

9. Pensez-vous que les approches de redevabilité sociale peuvent contribuer à faire progresser la mise en place de la CMU en/au [insérez le nom du pays] ? comment ?

10. Quand vous pensez aux obstacles à l'instauration de la CMU, lesquels, selon vous, sont liés aux institutions et aux processus qui doivent changer ? Lesquels sont davantage liés au fait que les individus doivent changer leur manière de penser et aux actions qu'ils font et ne font pas ?

11. Je voudrais vous poser quelques questions de plus sur la CMU en/au [insérez nom du pays]. Que la sont les principaux acteurs et parties prenantes qui travaillent sur la CMU ? Pensez-vous que ces groupes de personnes travaillent bien ensemble ou y-a-t-il des tensions ? Ces tensions sont-elles spécifiques à la CMU ou existent-elles depuis longtemps ? Ces tenions sont-elles de nature politique ?

12. Pensez-vous que les bons groupes de parties prenantes font tout leur possible pour mettre en place une CMU ? Y a-t-il des personnes et des idées ou des approches particulières qui sont exclues des travaux pour la mise en place d'une CMU ? Pourquoi cela se passe-t-il ainsi ?

Partie 4 : Efforts de Changement de comportement dans votre pays

NOTE POUR L'ENQUÊTEUR : : Prenez en compte et considérez ce qui a été discuté jusque- là pour amener l'interview vers la fin. La série de questions finales doit être adaptée à l'informateur-clé et les questions doivent porter sur le changement de comportement.

J'ai juste une autre série de questions. Je voudrais qu'on se concentre sur les aspects du changement de comportement.

13. Pensez-vous que les institutions et les individus doivent changer leur façon de travailler, y compris leurs comportements pour que les projets pour la redevabilité sociale réussissent ? Et pour arriver à la mise en place de la CMU ? Pourquoi un changement de comportements est-il nécessaire, pouvez-vous donner quelques exemples ? Les institutions et les individus ont-ils été en mesure de changer leurs comportements tout en travaillant pour la mise en place de la CMU ? Qu'est ce qui a facilité leur changement de comportement ? Qu'est ce qui a empêché le changement de comportement ?

14. Si vous pouviez concevoir un projet de redevabilité sociale, à quoi ressemblerait-il ?
NOTE POUR L'ENQUÊTEUR : Il se peut que l'informateur dirige un projet de redevabilité sociale, pensez-donc à adapter la formulation de vos questions ?

15. Si vous étiez chargé de travailler à la mise en place de la CMU, en quoi consisterait votre approche ?
NOTE POUR L'ENQUÊTEUR : Il se peut que l'informateur travaille à la mise place de la CMU, pensez-donc à adapter la formulation de vos questions

Partie 5 : Conclusion

Une dernière question.

Y a-t-il quelque chose que vous souhaiteriez me demander ? Ou quelque chose dont vous voudriez me faire part ou que vous aimeriez discuter ?

MERCI POUR NOUS AVOIR ACCORDÉ VOTRE TEMPS ET POUR NOUS AVOIR DONNÉ VOTRE POINT DE VUE.

J'AI BEAUCOUP APPRÉCIÉ D'AVOIR BAVARDÉ AVEC VOUS ET JE VOUS REMERCIE DE NOUS AVOIR CONSACRÉ DU TEMPS À CETTE ENQUÊTE ALORS QUE VOS JOURNÉES SONT TRÈS OCCUPÉES.

Appendix 6: Key Informant Profile and Selection Criteria

Overall Criteria

The key informant profile is an individual who through paid work, volunteer work, or personal experience is a health sector stakeholder. They would be involved in or highly aware of UHC and social accountability efforts. The overall criteria are noted below. These criteria are applicable for each of the 6 key informants.

- National of the country, or long-term resident
- Mid- to senior-level in terms of work experience and expertise
- Practitioner (e.g., someone involved in hands-on, day-to-day work as opposed to a high-level individual in an executive level leadership position)
- Willingness to spend one-hour on the phone
- Access to reliable internet
- Gender balance (e.g. ideally 3 women and 3 men)

Different Types of Key Informants

In conducting 6 Interviews, one goal is different types of key informants. We want a balanced set of individuals who work in various parts of the health sector. The 6 types are listed below in order of priority. We want to interview one of each.

1. Ministry of health employee who is Involved in or aware of UHC efforts
2. Manager or Program Officer level staff member from an advocacy oriented civil society organization (CSO) involved in UHC and social accountability work
3. Manager or Program Officer level staff member from an implementing partner (IP), international non-governmental organization (INGO) or local non-government organization (NGO) who works in health-related social accountability, governance, or citizen engagement
4. Health care provider based in a government hospital or clinic (e.g., a doctor, nurse, or direct service provider)
5. Manager or Program Officer level professional with in-depth expertise on community outreach and community-based health from a CSO, IP, INGO, NGO, or facility-based
6. Staff from a donor organization (e.g., World Bank, USAID, Global Fund) that is supporting UHC efforts.

Process to Set-up Interviews

In recognition that setting up interviews takes time, the points below highlight the process we would like to follow.

- We want to approach the selection process as a strategic, yet random process. For example, we must avoid selecting 6 people simply because they are known to us professionally or personally
- Sometimes people back out of an interview; therefore, we want to develop a list of interview candidates for each type.
- Confirm if the survey was administered to each potential key informant interview option, plan accordingly, and consider the following:
  - The survey data will not be available before the interview
  - Interview people who have not completed the survey with recognition that by agreeing to the interview they likely will not complete the survey

- Avoid the key informant interview being unproductive because the person keeps saying, I wrote about that in my survey response
- The survey is anonymous, so we cannot use the key informant interview to discuss what the key informant said in the survey
- If after completing the interview, the person wants to complete the survey that is fine, but do not push for this

Purpose of the Key Informant Interviews

Keep in mind the purpose of the key informant interviews, notably:

- We are interested in an inter-related set of topics; specifically:
  - The country's health system, how can it be improved
  - Social accountability approaches and tools, are they effective
  - UHC efforts, who Is leading the work and what is the progress, and what are the key challenges
  - Collectively then, what behavior needs to change to improve the health system, to increase social accountability, to advance UHC
  - Behavior refers to institutional level behavior and individual level behavior
- The key informant interviews are meant to complement the survey; however, each key informant interview should investigate the topics in more depth
- At the end of each interview, you should know the opinions of the key informant, and what their ideas are around improving the health system, improving accountability, advancing UHC, and whose behavior needs to change to realize these improvements
- To the extent possible, please encourage the key informant to cite specific initiatives or promising entry points for strengthening accountability for UHC

Interviewing Approach and Tips

The overall approach is to facilitate a conversation. The interview guide is organized as individual sets of questions. Ask questions clearly, listen well, and ask follow ups.

When asking questions (with the interview guide in hand) and in your in-the-moment follow up questions, remember these points:

- Use encouraging and warm words
- Phrase questions in open-ended ways
- Don't pose leading questions
- Allow an answer, don’t answer for them
- Don't let clarifying their answer become disagreeing with their answer
- Be polite and non-judgmental, yet inquisitive

Make small interjections to maintain conversation, such as:

- Why
- Please explain
- Can you give an example
- That’s interesting, can we talk about that more
- Thank you for that, can you elaborate
- I understand what you are saying, I’d like to ask a follow up question
- The next topic I’d like to discuss is X, what I am interested to know is….
- I really appreciate what you said, can I also ask…

Appendix 7: Key Informant Interview Note-taking Procedures

GENERAL

For this activity we are conducting virtual interviews with stakeholders in Côte d'Ivoire, Ghana, and Guinea. We have a team of two for each country. It is important that we establish note taking procedures that can be used consistently by each team

NOTES QUESTION BY QUESTION

- Use the interview guide document, one for each key informant
- Fill out the record keeping information before the interview
- Write out as close to verbatim as possible answers the key informant gives for each question
- Write out any additional questions that were asked, and how the key informant answered
- After the interview, review and clean up the notes to create a final version of the interview notes
- If you took notes in French, the final version of the notes must be English
- As needed, review the recording; however, be careful that the timeline and budget do not allow for listening to the recording and transcribing the interview

PRELIMINARY ANALYIS FOR EACH INTERVIEW

Think about the interview, review the notes, and write up answers to these questions. Write summatively and concisely, use bullet points. The final version of this analysis is to be written in English.

1. What about the conversation and what the key informant had to say surprised you?
2. Summarize and assess the key informant's perspective on social accountability
3. Summarize and assess the key informant's perspective on UHC
4. Summarize and assess the key informant's perspective on behaviour change in relation to social accountability and UHC
5. What questions did the key informant struggle with? Why do you think this was the case?
6. What do you see as the key findings from this interview?

PRELIMINARY ANALYIS FOR THE SET OF INTERVIEWS

Review the preliminary analysis for each of the six interviews collectively and write up answers to these questions. Write summatively and concisely, use bullet points. The final version of this analysis is to be written in English.

1. In what ways did the six key informants give similar answers and seem to share similar perspectives about health, social accountability, and UHC?
2. In what ways did the six key informants give different answers and seem to share different perspectives about health, social accountability, and UHC?
3. What do you see as the key findings from this set of six interviews? That is, based on what you learned in conducting the interviews, what conclusions and recommendations can be drawn about lessons learned and ideas for designing social accountability activities in support of UHC that integrate behaviour change strategies?

Appendix 8: Survey Part 1 Data Tables

Appendix Table 8.1: Organization Type

	All		Côte d'Ivoire		Ghana		Guinea	
	N = 179		N = 76		N = 74		N = 29	
	F	%	F	%	F	%	F	%
Government ministry, agency, or parastatal	57	31.8	26	34.2	22	29.7	9	31.0
Health facility, including hospital, clinic, etc.	12	6.7	7	9.2	3	4.1	2	6.9
Donor agency (e.g., USAID, World Bank, UN, etc.)	19	10.6	5	6.6	8	10.8	6	20.7
International implementing organization	16	8.9	4	5.3	4	5.4	8	27.6
Local non-governmental organization (NGO)	51	28.5	23	30.3	26	35.1	2	6.9
Local civil society organization (CSO)	7	3.9	2	2.6	5	6.8	0	0.0
Private sector business	6	3.4	1	1.3	3	4.1	2	6.9
News and media	6	3.4	6	7.9	0	0.0	0	0.0
University or research institution	3	1.7	1	1.3	2	2.7	0	0.0
Other	2	1.1	1	1.3	1	1.4	0	0.0

Appendix Table 8.2: Work in Relation to World Health Organization Building Blocks

	All		Côte d'Ivoire		Ghana		Guinea	
	N = 177		N = 74		N = 74		N = 29	
	F	%	F	%	F	%	F	%
Service delivery	48	27.1	20	27.0	18	24.3	10	34.5
Health workforce	12	6.8	5	6.8	6	8.1	1	3.4
Health information systems	25	14.1	7	9.5	13	17.6	5	17.2
Access to essential medicines	4	2.3	2	2.7	2	2.7	0	0.0
Financing	5	2.8	3	4.1	2	2.7	0	0.0
Leadership and governance	63	35.6	28	37.8	25	33.8	10	34.5
Other	20	11.3	9	12.2	8	10.8	3	10.3

Appendix Table 8.3: Sex of Survey Respondents

	All		Côte d'Ivoire		Ghana		Guinea	
	N = 178		N = 75		N = 74		N = 29	
	F	%	F	%	F	%	F	%
Female	43	24.2	18	24.0	19	25.7	6	20.7
Male	135	75.8	57	76.0	55	74.3	23	79.3

Appendix Table 8.4: Mean Age of Survey Respondents

	All	Côte d'Ivoire	Ghana	Guinea
	N = 172	N = 74	N = 71	N = 27
Mean age -all respondents	47	48	45	51
Mean age - female respondents	49	49	47	54
Mean age - male respondents	46	48	44	51

Appendix Table 8.5: Work at Different Levels of the Health System

All	N =	Yes	No	% Yes
National Level	179	132	47	73.7
Regional Level	179	130	49	72.6
District Level	179	136	43	76.0
Community Level	179	117	62	65.4
Côte d'Ivoire	**N =**	**Yes**	**No**	**% Yes**
National Level	76	48	28	63.2
Regional Level	76	51	25	67.1
District Level	76	63	13	82.9
Community Level	76	54	22	71.1
Ghana	**N =**	**Yes**	**No**	**% Yes**
National Level	74	60	14	81.1
Regional Level	74	57	17	77.0
District Level	74	53	21	71.6
Community Level	74	45	29	60.8
Guinea	**N =**	**Yes**	**No**	**% Yes**
National Level	29	24	5	82.8
Regional Level	29	22	7	75.9
District Level	29	20	9	69.0
Community Level	29	18	11	62.1

Appendix Table 8.6: Frequency of Work with Other Stakeholders

All	N =	Rarely		Occasionally		Regularly	
		F	%	F	%	F	%
Government ministry, agency, or parastatal	175	4	2.3	35	20.0	136	77.7
Health facility, including hospital, clinic, etc.	177	15	8.5	53	29.9	109	61.6
Donor agency	177	23	13.0	74	41.8	80	45.2
International implementing organization	175	30	17.1	88	50.3	57	32.6
Local non-governmental organization (NGO)	176	14	8.0	56	31.8	106	60.2
Local civil society organization (CSO)	176	26	14.8	72	40.9	78	44.3
Private sector business	176	55	31.3	79	44.9	42	23.9
News and media	178	42	23.6	76	42.7	60	33.7
University or research institution	176	45	25.6	101	57.4	30	17.0
Other	0	0		0		0	
Côte d'Ivoire	**N =**	**Rarely**		**Occasionally**		**Regularly**	
		F	**%**	**F**	**%**	**F**	**%**
Government ministry, agency, or parastatal	73	1	1.4	17	23.3	55	75.3
Health facility, including hospital, clinic, etc.	75	5	6.7	12	16.0	58	77.3
Donor agency	75	12	16.0	33	44.0	30	40.0
International implementing organization	75	14	18.7	38	50.7	23	30.7
Local non-governmental organization (NGO)	75	1	1.3	20	26.7	54	72.0
Local civil society organization (CSO)	74	6	8.1	35	47.3	33	44.6
Private sector business	74	26	35.1	29	39.2	19	25.7
News and media	75	13	17.3	39	52.0	23	30.7
University or research institution	74	29	39.2	37	50.0	8	10.8
Other	0	0		0		0	
Ghana	**N =**	**Rarely**		**Occasionally**		**Regularly**	
		F	**%**	**F**	**%**	**F**	**%**
Government ministry, agency, or parastatal	73	1	1.4	15	20.5	57	78.1
Health facility, including hospital, clinic, etc.	73	5	6.8	28	38.4	40	54.8
Donor agency	73	7	9.6	37	50.7	29	39.7
International implementing organization	73	11	15.1	43	58.9	19	26.0
Local non-governmental organization (NGO)	73	7	9.6	28	38.4	38	52.1
Local civil society organization (CSO)	74	11	14.9	26	35.1	37	50.0
Private sector business	74	20	27.0	36	48.6	18	24.3
News and media	74	18	24.3	29	39.2	27	36.5
University or research institution	73	13	17.8	47	64.4	13	17.8
Other	0	0		0		0	
Guinea	**N =**	**Rarely**		**Occasionally**		**Regularly**	
		F	**%**	**F**	**%**	**F**	**%**
Government ministry, agency, or parastatal	29	2	6.9	3	10.3	24	82.8
Health facility, including hospital, clinic, etc.	29	5	17.2	13	44.8	11	37.9
Donor agency	29	4	13.8	4	13.8	21	72.4
International implementing organization	27	5	18.5	7	25.9	15	55.6
Local non-governmental organization (NGO)	28	6	21.4	8	28.6	14	50.0
Local civil society organization (CSO)	28	9	32.1	11	39.3	8	28.6
Private sector business	28	9	32.1	14	50.0	5	17.9
News and media	29	11	37.9	8	27.6	10	34.5
University or research institution	29	3	10.3	17	58.6	9	31.0
Other	0	0		0		0	

Appendix 9: Survey Part 2 Data Tables

Appendix Table 9.1: Is Social Accountability Prioritized in Your Country?

	All N = 179		Côte d'Ivoire N = 76		Ghana N = 74		Guinea N = 29	
	F	%	F	%	F	%	F	%
Yes	123	68.7	51	67.1	51	68.9	21	72.4
No	56	31.3	25	32.9	23	31.1	8	27.6

Appendix Table 9.2: Perceived Success of Social Accountability Activities

All	AVG	N =	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree		6 Not Used		7 Don't Know	
			F	%	F	%	F	%	F	%	F	%	F	%	F	%
Participatory budgeting	3.2	177	10	5.6	30	16.9	22	12.4	46	26.0	17	9.6	21	11.9	31	17.5
Partnership-defined quality	3.4	178	8	4.5	28	15.7	23	12.9	72	40.4	15	8.4	16	9.0	16	9.0
Community score cards	3.3	178	7	3.9	25	14.0	26	14.6	50	28.1	15	8.4	23	12.9	32	18.0
Citizen satisfaction surveys	3.3	179	10	5.6	28	15.6	27	15.1	62	34.6	13	7.3	13	7.3	26	14.5
Citizen voice and action	3.3	179	10	5.6	29	16.2	22	12.3	54	30.2	20	11.2	17	9.5	27	15.1
Public hearings	3.5	179	6	3.4	25	14.0	30	16.8	63	35.2	21	11.7	15	8.4	19	10.6
Community radio	3.9	178	6	3.4	5	2.8	23	12.9	88	49.4	36	20.2	5	2.8	15	8.4
User-centered info	3.4	179	9	5.0	20	11.2	41	22.9	70	39.1	12	6.7	26	14.5	1	0.6
Côte d'Ivoire	**AVG**	**N =**	**1 Strongly Disagree**		**2 Disagree**		**3 Neutral**		**4 Agree**		**5 Strongly Agree**		**6 Not Used**		**7 Don't Know**	
			F	**%**	**F**	**%**	**F**	**%**	**F**	**%**	**F**	**%**	**F**	**%**	**F**	**%**
Participatory budgeting	3.3	76	2	2.6	10	13.2	11	14.5	17	22.4	5	6.6	14	18.4	17	22.4
Partnership-defined quality	3.4	75	1	1.3	10	13.3	13	17.3	26	34.7	5	6.7	10	13.3	10	13.3
Community score cards	3.2	75	3	4.0	8	10.7	11	14.7	16	21.3	2	2.7	16	21.3	19	25.3
Citizen satisfaction surveys	3.3	76	3	3.9	10	13.2	15	19.7	20	26.3	5	6.6	5	6.6	18	23.7
Citizen voice and action	3.0	76	5	6.6	13	17.1	9	11.8	17	22.4	4	5.3	10	13.2	18	23.7
Public hearings	3.4	76	1	1.3	10	13.2	15	19.7	20	26.3	6	7.9	12	15.8	12	15.8
Community radio	3.7	76	3	3.9	2	2.6	15	19.7	33	43.4	11	14.5	2	2.6	10	13.2
User-centered info	3.4	76	3	3.9	8	10.5	15	19.7	25	32.9	5	6.6	20	26.3	0	0.0

Appendix Table 9.2: Perceived Success of Social Accountability Activities (continued)

Ghana	AVG	N =	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree		6 Not Used		7 Don't Know	
			F	%	F	%	F	%	F	%	F	%	F	%	F	%
Participatory budgeting	3.3	72	3	4.2	15	20.8	7	9.7	21	29.2	9	12.5	7	9.7	10	13.9
Partnership-defined quality	3.4	74	4	5.4	15	20.3	6	8.1	33	44.6	7	9.5	5	6.8	4	5.4
Community score cards	3.5	74	2	2.7	11	14.9	12	16.2	28	37.8	11	14.9	3	4.1	7	9.5
Citizen satisfaction surveys	3.4	74	3	4.1	14	18.9	8	10.8	35	47.3	5	6.8	3	4.1	6	8.1
Citizen voice and action	3.7	74	1	1.4	11	14.9	9	12.2	33	44.6	12	16.2	2	2.7	6	8.1
Public hearings	3.6	74	3	4.1	11	14.9	10	13.5	33	44.6	13	17.6	1	1.4	3	4.1
Community radio	4.1	73	1	1.4	2	2.7	6	8.2	39	53.4	21	28.8	2	2.7	2	2.7
User-centered info.	3.4	74	3	4.1	10	13.5	20	27.0	36	48.6	3	4.1	1	1.4	1	1.4

Guinea	AVG	N =	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree		6 Not Used		7 Don't Know	
			F	%	F	%	F	%	F	%	F	%	F	%	F	%
Participatory budgeting	3.0	29	5	17.2	5	17.2	4	13.8	8	27.6	3	10.3	0	0.0	4	13.8
Partnership-defined quality	3.4	29	3	10.3	3	10.3	4	13.8	13	44.8	3	10.3	1	3.4	2	6.9
Community score cards	3.0	29	2	6.9	6	20.7	3	10.3	6	20.7	2	6.9	4	13.8	6	20.7
Citizen satisfaction surveys	3.0	29	4	13.8	4	13.8	4	13.8	7	24.1	3	10.3	5	17.2	2	6.9
Citizen voice and action	3.0	29	4	13.8	5	17.2	4	13.8	4	13.8	4	13.8	5	17.2	3	10.3
Public hearings	3.3	29	2	6.9	4	13.8	5	17.2	10	34.5	2	6.9	2	6.9	4	13.8
Community radio	3.8	29	2	6.9	1	3.4	2	6.9	16	55.2	4	13.8	1	3.4	3	10.3
User-centered info.	3.4	29	3	10.3	2	6.9	6	20.7	9	31.0	4	13.8	5	17.2	0	0.0

Appendix Table 9.3: Social Accountability Success Factors

All	N =	Yes	No	% Yes
The government supports the social accountability activity	173	61	112	35.3
The relevant experts design and implement the social accountability activity	173	23	150	13.3
Citizens are organized and strong in their advocacy for social accountability	173	64	109	37.0
There are enough financial resources to implement social accountability activity	173	18	155	10.4
There are enough human resources to implement social accountability activity	173	16	157	9.2
Donors consider the social accountability activity a high priority	173	48	125	27.7
The needed government and private sector leaders involved in social accountability activity	173	30	143	17.3
A socio-demographic representative set of citizens involved in social accountability activity	173	24	149	13.9
Other	173	16	157	9.2
Don't know	173	9	164	5.2
Côte d'Ivoire	**N =**	**Yes**	**No**	**% Yes**
The government supports the social accountability activity	75	16	59	21.3
The relevant experts design and implement the social accountability activity	75	5	70	6.7
Citizens are organized and strong in their advocacy for social accountability	75	12	63	16.0
There are enough financial resources to implement social accountability activity	75	5	70	6.7
There are enough human resources to implement social accountability activity	75	5	70	6.7
Donors consider the social accountability activity a high priority	75	10	65	13.3
The needed government and private sector leaders involved in social accountability activity	75	5	70	6.7
A socio-demographic representative set of citizens involved in social accountability activity	75	7	68	9.3
Other	75	4	71	5.3
Don't know	75	6	69	8.0
Ghana	**N =**	**Yes**	**No**	**% Yes**
The government supports the social accountability activity	69	36	33	52.2
The relevant experts design and implement the social accountability activity	69	17	52	24.6
Citizens are organized and strong in their advocacy for social accountability	69	48	21	69.6
There are enough financial resources to implement social accountability activity	69	13	56	18.8
There are enough human resources to implement social accountability activity	69	11	58	15.9
Donors consider the social accountability activity a high priority	69	32	37	46.4
The needed government and private sector leaders involved in social accountability activity	69	22	47	31.9
A socio-demographic representative set of citizens involved in social accountability activity	69	12	57	17.4
Other	69	12	57	17.4
Don't know	69	2	67	2.9
Guinea	**N =**	**Yes**	**No**	**% Yes**
The government supports the social accountability activity	29	9	20	31.0
The relevant experts design and implement the social accountability activity	29	1	28	3.4
Citizens are organized and strong in their advocacy for social accountability	29	4	25	13.8
There are enough financial resources to implement social accountability activity	29	0	29	0.0
There are enough human resources to implement social accountability activity	29	0	29	0.0
Donors consider the social accountability activity a high priority	29	6	23	20.7
The needed government and private sector leaders involved in social accountability activity	29	3	26	10.3
A socio-demographic representative set of citizens involved in social accountability activity	29	5	24	17.2
Other	29	0	29	0.0
Don't know	29	1	28	3.4

Appendiix Table 9.4: Accountability from Whom to Whom Among Health System Actors

All	AVG	N =	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree	
			F	%	F	%	F	%	F	%	F	%
Health care service providers in my country feel accountable to patients regarding the quality of services provided	3.0	178	17	9.6	33	18.5	72	40.4	37	20.8	19	10.7
Health care facility managers in my country feel accountable to patients regarding the cost of services provided	2.9	179	18	10.1	49	27.4	66	36.9	33	18.4	13	7.3
Health care service providers and health care facility managers in my country feel accountable to the government to use resources equitably for all citizens	3.1	179	10	5.6	45	25.1	52	29.1	55	30.7	17	9.5
Government in my country feels accountable to citizens regarding providing information about health care services in the country	3.3	177	9	5.1	35	19.8	52	29.4	60	33.9	21	11.9
Government in my country feels accountable to citizens regarding the quality of health care services being made available in the country	3.1	177	14	7.9	43	24.3	51	28.8	50	28.2	19	10.7
Government in my country feels accountable to citizens regarding equitable allocation of financial resources for health care services in the country	2.9	177	20	11.3	50	28.2	55	31.1	37	20.9	15	8.5
Citizens in my country demand quality health services	3.9	174	8	4.6	15	8.6	32	18.4	50	28.7	69	39.7
Citizens in my country demand affordable health services	4.2	178	3	1.7	8	4.5	25	14.0	50	28.1	92	51.7
Citizens in my country demand the government to be accountable for the health system	4.1	179	6	3.4	8	4.5	27	15.1	59	33.0	79	44.1

Appendix Table 9.4: Accountability from Whom to Whom Among Health System Actors (continued)

Côte d'Ivoire	AVG	N =	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree	
			F	%	F	%	F	%	F	%	F	%
Health care service providers in my country feel accountable to patients regarding the quality of services provided	3.2	76	7	9.2	12	15.8	31	40.8	14	18.4	12	15.8
Health care facility managers in my country feel accountable to patients regarding the cost of services provided	2.9	76	8	10.5	22	28.9	25	32.9	14	18.4	7	9.2
Health care service providers and health care facility managers in my country feel accountable to the government to use resources equitably for all citizens	3.1	76	3	3.9	22	28.9	24	31.6	20	26.3	7	9.2
Government in my country feels accountable to citizens regarding providing information about health care services in the country	3.3	76	4	5.3	13	17.1	26	34.2	20	26.3	13	17.1
Government in my country feels accountable to citizens regarding the quality of health care services being made available in the country	3.0	74	7	9.5	18	24.3	23	31.1	18	24.3	8	10.8
Government in my country feels accountable to citizens regarding equitable allocation of financial resources for health care services in the country	2.7	75	12	16.0	22	29.3	23	30.7	14	18.7	4	5.3
Citizens in my country demand quality health services	4.3	73	1	1.4	4	5.5	11	15.1	16	21.9	41	56.2
Citizens in my country demand affordable health services	4.5	76	0	0.0	2	2.6	10	13.2	10	13.2	54	71.1
Citizens in my country demand the government to be accountable for the health system	4.4	76	1	1.3	1	1.3	10	13.2	20	26.3	44	57.9

Appendix Table 9.4: Accountability from Whom to Whom Among Health System Actors (continued)

Ghana	AVG	N =	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree	
			F	%	F	%	F	%	F	%	F	%
Health care service providers in my country feel accountable to patients regarding the quality of services provided	2.8	73	9	12.3	14	19.2	32	43.8	15	20.5	3	4.1
Health care facility managers in my country feel accountable to patients regarding the cost of services provided	2.8	74	7	9.5	19	25.7	32	43.2	13	17.6	3	4.1
Health care service providers and health care facility managers in my country feel accountable to the government to use resources equitably for all citizens	3.2	74	6	8.1	14	18.9	21	28.4	27	36.5	6	8.1
Government in my country feels accountable to citizens regarding providing information about health care services in the country	3.2	72	3	4.2	17	23.6	19	26.4	28	38.9	5	6.9
Government in my country feels accountable to citizens regarding the quality of health care services being made available in the country	3.1	74	5	6.8	17	23.0	22	29.7	24	32.4	6	8.1
Government in my country feels accountable to citizens regarding equitable allocation of financial resources for health care services in the country	3.0	73	7	9.6	19	26.0	23	31.5	17	23.3	7	9.6
Citizens in my country demand quality health services	3.8	72	3	4.2	4	5.6	19	26.4	25	34.7	21	29.2
Citizens in my country demand affordable health services	4.1	73	1	1.4	3	4.1	10	13.7	31	42.5	28	38.4
Citizens in my country demand the government to be accountable for the health system	4.0	74	3	4.1	1	1.4	13	17.6	30	40.5	27	36.5

Appendix Table 9.4: Accountability from Whom to Whom Among Health System Actors (continued)

Guinea	AVG	N =	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree	
			F	%	F	%	F	%	F	%	F	%
Health care service providers in my country feel accountable to patients regarding the quality of services provided	3.2	29	1	3.4	7	24.1	9	31.0	8	27.6	4	13.8
Health care facility managers in my country feel accountable to patients regarding the cost of services provided	2.9	29	3	10.3	8	27.6	9	31.0	6	20.7	3	10.3
Health care service providers and health care facility managers in my country feel accountable to the government to use resources equitably for all citizens	3.2	29	1	3.4	9	31.0	7	24.1	8	27.6	4	13.8
Government in my country feels accountable to citizens regarding providing information about health care services in the country	3.3	29	2	6.9	5	17.2	7	24.1	12	41.4	3	10.3
Government in my country feels accountable to citizens regarding the quality of health care services being made available in the country	3.2	29	2	6.9	8	27.6	6	20.7	8	27.6	5	17.2
Government in my country feels accountable to citizens regarding equitable allocation of financial resources for health care services in the country	3.1	29	1	3.4	9	31.0	9	31.0	6	20.7	4	13.8
Citizens in my country demand quality health services	3.3	29	4	13.8	7	24.1	2	6.9	9	31.0	7	24.1
Citizens in my country demand affordable health services	3.8	29	2	6.9	3	10.3	5	17.2	9	31.0	10	34.5
Citizens in my country demand the government to be accountable for the health system	3.5	29	2	6.9	6	20.7	4	13.8	9	31.0	8	27.6

Appendix 10: Survey Part 3 Data Tables

Appendix Table 10.1: Is There an Active Effort to Advance Universal Health Coverage?

	All N = 171		Côte d' Ivoire N = 70		Ghana N = 72		Guinea N = 29	
	F	%	F	%	F	%	F	%
Yes	83	48.5	24	34.3	47	65.3	12	41.4
No	88	51.5	46	65.7	25	34.7	17	58.6

Appendix Table 10.2: For How Long has the Effort to Universal Health Coverage Been Active?

	All N = 169		Côte d' Ivoire N = 73		Ghana N = 71		Guinea N = 25	
	F	%	F	%	F	%	F	%
Less than 1 year	7	4.1	6	8.2	0	0.0	1	4.0
1 to 5 years	91	53.8	51	69.9	27	38.0	13	52.0
6 to 9 years	20	11.8	3	4.1	15	21.1	2	8.0
10 or more years	41	24.3	12	16.4	28	39.4	1	4.0
Don’t know	10	5.9	1	1.4	1	1.4	8	32.0

Appendix Table 10.3: Universal Health Coverage Leaders

All	AVG	N =	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree	
			F	%	F	%	F	%	F	%	F	%
Health care service providers are leaders in the effort to advance UHC in my country	3.1	179	21	11.7	37	20.7	48	26.8	51	28.5	22	12.3
Health care facility managers are leaders in the effort to advance UHC in my country	3.1	179	18	10.1	35	19.6	51	28.5	58	32.4	17	9.5
Government is a leader in the effort to advance n UHC in my country	4.1	179	4	2.2	10	5.6	26	14.5	66	36.9	73	40.8
Citizens are leaders in the effort to advance UHC in my country	2.9	179	31	17.3	36	20.1	56	31.3	33	18.4	23	12.8
Côte d'Ivoire	**AVG**	**N =**	**1 Strongly Disagree**		**2 Disagree**		**3 Neutral**		**4 Agree**		**5 Strongly Agree**	
			F	%	F	%	F	%	F	%	F	%
Health care service providers are leaders in the effort to advance UHC in my country	2.8	76	14	18.4	17	22.4	24	31.6	14	18.4	7	9.2
Health care facility managers are leaders in the effort to advance UHC in my country	2.9	76	12	15.8	17	22.4	21	27.6	20	26.3	6	7.9
Government is a leader in the effort to advance in UHC in my country	4.1	76	2	2.6	3	3.9	11	14.5	29	38.2	31	40.8
Citizens are leaders in the effort to advance UHC in my country	2.6	76	20	26.3	15	19.7	24	31.6	12	15.8	5	6.6

Appendix Table 10.3: Universal Health Coverage Leaders (continued)

Ghana	AVG	N =	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree	
			F	%	F	%	F	%	F	%	F	%
Health care service providers are leaders in the effort to advance UHC in my country	3.5	74	3	4.1	11	14.9	17	23.0	32	43.2	11	14.9
Health care facility managers are leaders in the effort to advance UHC in my country	3.4	74	4	5.4	8	10.8	22	29.7	33	44.6	7	9.5
Government is a leader in the effort to advance n UHC in my country	4.3	74	0	0.0	2	2.7	10	13.5	29	39.2	33	44.6
Citizens are leaders in the effort to advance UHC in my country	3.2	74	8	10.8	13	17.6	25	33.8	14	18.9	14	18.9
Guinea	**AVG**	**N =**	**1 Strongly Disagree**		**2 Disagree**		**3 Neutral**		**4 Agree**		**5 Strongly Agree**	
			F	**%**	**F**	**%**	**F**	**%**	**F**	**%**	**F**	**%**
Health care service providers are leaders in the effort to advance UHC in my country	2.9	29	4	13.8	9	31.0	7	24.1	5	17.2	4	13.8
Health care facility managers are leaders in the effort to advance UHC in my country	3.0	29	2	6.9	10	34.5	8	27.6	5	17.2	4	13.8
Government is a leader in the effort to advance n UHC in my country	3.6	29	2	6.9	5	17.2	5	17.2	8	27.6	9	31.0
Citizens are leaders in the effort to advance UHC in my country	3.0	29	3	10.3	8	27.6	7	24.1	7	24.1	4	13.8

Appendix Table 10.4: Representativeness of Population Groups in Universal Health Coverage Efforts

All	AVG	N =	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree	
			F	%	F	%	F	%	F	%	F	%
Men are well represented in efforts to advance UHC in my country	3.0	178	14	7.9	38	21.3	74	41.6	40	22.5	12	6.7
Women are well represented in efforts to advance UHC in my country	2.9	178	18	10.1	46	25.8	67	37.6	33	18.5	14	7.9
Youth are well represented in efforts to advance UHC in my country	2.7	178	27	15.2	50	28.1	67	37.6	25	14.0	9	5.1
Persons with disabilities are well represented in efforts to advance UHC in my country	2.3	178	47	26.4	56	31.5	47	26.4	22	12.4	6	3.4
Individuals with specific health conditions are well represented in efforts to advance UHC in my country	2.3	177	46	26.0	66	37.3	39	22.0	20	11.3	6	3.4
Individuals who struggle with mental illness are well represented in efforts to advance UHC in my country	1.9	175	78	44.6	57	32.6	28	16.0	9	5.1	3	1.7
Urban citizens are well represented in efforts to advance UHC in my country	2.8	177	22	12.4	42	23.7	63	35.6	41	23.2	9	5.1
Rural citizens are well represented in efforts to advance UHC in my country	2.7	178	30	16.9	48	27.0	59	33.1	33	18.5	8	4.5

Appendix Table 10.4: Representativeness of Population Groups in Universal Health Coverage Efforts (continued)

Côte d'Ivoire	AVG	N =	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree	
			F	%	F	%	F	%	F	%	F	%
Men are well represented in efforts to advance UHC in my country	2.7	75	10	13.3	20	26.7	30	40.0	11	14.7	4	5.3
Women are well represented in efforts to advance UHC in my country	2.7	75	11	14.7	21	28.0	30	40.0	8	10.7	5	6.7
Youth are well represented in efforts to advance UHC in my country	2.5	75	14	18.7	21	28.0	28	37.3	9	12.0	3	4.0
Persons with disabilities are well represented in efforts to advance UHC in my country	2.4	75	20	26.7	22	29.3	21	28.0	9	12.0	3	4.0
Individuals with specific health conditions are well represented in efforts to advance UHC in my country	2.3	75	22	29.3	23	30.7	19	25.3	8	10.7	3	4.0
Individuals who struggle with mental illness are well represented in efforts to advance UHC in my country	1.8	73	35	47.9	22	30.1	11	15.1	4	5.5	1	1.4
Urban citizens are well represented in efforts to advance UHC in my country	2.8	74	10	13.5	15	20.3	32	43.2	14	18.9	3	4.1
Rural citizens are well represented in efforts to advance UHC in my country	2.7	75	12	16.0	16	21.3	31	41.3	13	17.3	3	4.0

Appendix Table 10.4: Representativeness of Population Groups in Universal Health Coverage Efforts (continued)

Ghana	AVG	N =	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree	
			F	%	F	%	F	%	F	%	F	%
Men are well represented in efforts to advance UHC in my country	3.3	74	3	4.1	11	14.9	30	40.5	23	31.1	7	9.5
Women are well represented in efforts to advance UHC in my country	3.0	74	5	6.8	16	21.6	30	40.5	17	23.0	6	8.1
Youth are well represented in efforts to advance UHC in my country	2.7	74	10	13.5	22	29.7	28	37.8	10	13.5	4	5.4
Persons with disabilities are well represented in efforts to advance UHC in my country	2.3	74	19	25.7	25	33.8	19	25.7	10	13.5	1	1.4
Individuals with specific health conditions are well represented in efforts to advance UHC in my country	2.2	73	16	21.9	34	46.6	14	19.2	8	11.0	1	1.4
Individuals who struggle with mental illness are well represented in efforts to advance UHC in my country	1.9	73	29	39.7	27	37.0	13	17.8	3	4.1	1	1.4
Urban citizens are well represented in efforts to advance UHC in my country	2.8	74	8	10.8	21	28.4	24	32.4	17	23.0	4	5.4
Rural citizens are well represented in efforts to advance UHC in my country	2.5	74	13	17.6	27	36.5	20	27.0	11	14.9	3	4.1

Appendix Table 10.4: Representativeness of Population Groups in Universal Health Coverage Efforts (continued)

Guinea	AVG	N =	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree	
			F	%	F	%	F	%	F	%	F	%
Men are well represented in efforts to advance UHC in my country	3.0	29	1	3.4	7	24.1	14	48.3	6	20.7	1	3.4
Women are well represented in efforts to advance UHC in my country	3.0	29	2	6.9	9	31.0	7	24.1	8	27.6	3	10.3
Youth are well represented in efforts to advance UHC in my country	2.9	29	3	10.3	7	24.1	11	37.9	6	20.7	2	6.9
Persons with disabilities are well represented in efforts to advance UHC in my country	2.4	29	8	27.6	9	31.0	7	24.1	3	10.3	2	6.9
Individuals with specific health conditions are well represented in efforts to advance UHC in my country	2.4	29	8	27.6	9	31.0	6	20.7	4	13.8	2	6.9
Individuals who struggle with mental illness are well represented in efforts to advance UHC in my country	1.9	29	14	48.3	8	27.6	4	13.8	2	6.9	1	3.4
Urban citizens are well represented in efforts to advance UHC in my country	3.0	29	4	13.8	6	20.7	7	24.1	10	34.5	2	6.9
Rural citizens are well represented in efforts to advance UHC in my country	2.9	29	5	17.2	5	17.2	8	27.6	9	31.0	2	6.9

Appendix Table 10.5: Barriers to Citizen Participation in Universal Health Coverage Efforts

All	**N =**	**179**
	F	**%**
There are few organizations that bring the citizens together to focus on UHC	56	31.3
Citizens are easily influenced by politicians	37	20.7
Citizens tend to shy away from political engagement	15	8.4
Citizens have little incentive to demand social accountability	39	21.8
Citizens fear arrests by government if they demand social accountability	17	9.5
Other	7	3.9
Don't know	8	4.5
Côte d'Ivoire	**N =**	**76**
	F	**%**
There are few organizations that bring the citizens together to focus on UHC	23	12.8
Citizens are easily influenced by politicians	13	7.3
Citizens tend to shy away from political engagement	12	6.7
Citizens have little incentive to demand social accountability	12	6.7
Citizens fear arrests by government if they demand social accountability	9	5.0
Other	4	2.2
Don't know	3	1.7
Ghana	**N =**	**74**
	F	**%**
There are few organizations that bring the citizens together to focus on UHC	26	14.5
Citizens are easily influenced by politicians	15	8.4
Citizens tend to shy away from political engagement	3	1.7
Citizens have little incentive to demand social accountability	23	12.8
Citizens fear arrests by government if they demand social accountability	2	1.1
Other	2	1.1
Don't know	3	1.7
Guinea	**N =**	**29**
	F	**%**
There are few organizations that bring the citizens together to focus on UHC	7	3.9
Citizens are easily influenced by politicians	9	5.0
Citizens tend to shy away from political engagement	0	0.0
Citizens have little incentive to demand social accountability	4	2.2
Citizens fear arrests by government if they demand social accountability	6	3.4
Other	1	0.6
Don't know	2	1.1

Appendix Table 10.6: In Efforts to Advance Universal Health Coverage are Social Accountability Activities Being Used?

	All N = 171		Côte d'Ivoire N = 70		Ghana N = 72		Guinea N = 29	
	F	%	F	%	F	%	F	%
Yes	83	48.5	24	34.3	47	65.3	12	41.4
No	88	51.5	46	65.7	25	34.7	17	58.6

Appendix Table 10.7: Barriers to Including Social Accountability in Universal Health Coverage Efforts

All	N =	Yes	No	% Yes
Insufficient funding for social accountability activities	173	57	116	32.9
Political climate does not allow for citizens to make demands for the government to change	173	38	135	22.0
Lack of political will within the government to adopt social accountability strategies	173	54	119	31.2
Unwillingness of government to increase their transparency	173	33	140	19.1
Citizens do not feel comfortable to make demands for the health system to change	173	21	152	12.1
Lack of will among health care service providers to adopt social accountability strategies	173	23	150	13.3
Unwillingness of health care facilities to increase their transparency	173	8	165	4.6
Lack of coordination among stakeholders	173	38	135	22.0
Key stakeholders are choosing to not be involved	173	5	168	2.9
Key stakeholders are being excluded from being involved	173	12	161	6.9
Other	173	7	166	4.0
Don't know	173	8	165	4.6
Côte d'Ivoire	**N =**	**Yes**	**No**	**% Yes**
Insufficient funding for social accountability activities	74	5	69	6.8
Political climate does not allow for citizens to make demands for the government to change	74	20	54	27.0
Lack of political will within the government to adopt social accountability strategies	74	12	62	16.2
Unwillingness of government to increase their transparency	74	6	68	8.1
Citizens do not feel comfortable to make demands for the health system to change	74	8	66	10.8
Lack of will among health care service providers to adopt social accountability strategies	74	5	69	6.8
Unwillingness of health care facilities to increase their transparency	74	1	73	1.4
Lack of coordination among stakeholders	74	7	67	9.5
Key stakeholders are choosing to not be involved	74	2	72	2.7
Key stakeholders are being excluded from being involved	74	2	72	2.7
Other	74	3	71	4.1
Don't know	74	3	71	4.1
Ghana	**N =**	**Yes**	**No**	**% Yes**
Insufficient funding for social accountability activities	71	47	24	66.2
Political climate does not allow for citizens to make demands for the government to change	71	15	56	21.1
Lack of political will within the government to adopt social accountability strategies	71	38	33	53.5
Unwillingness of government to increase their transparency	71	24	47	33.8
Citizens do not feel comfortable to make demands for the health system to change	71	11	60	15.5
Lack of will among health care service providers to adopt social accountability strategies	71	17	54	23.9
Unwillingness of health care facilities to increase their transparency	71	6	65	8.5
Lack of coordination among stakeholders	71	28	43	39.4
Key stakeholders are choosing to not be involved	71	3	68	4.2
Key stakeholders are being excluded from being involved	71	10	61	14.1
Other	71	0	71	0.0
Don't know	71	3	68	4.2
Guinea	**N =**	**Yes**	**No**	**% Yes**
Insufficient funding for social accountability activities	28	5	23	17.9
Political climate does not allow for citizens to make demands for the government to change	28	3	25	10.7
Lack of political will within the government to adopt social accountability strategies	28	4	24	14.3
Unwillingness of government to increase their transparency	28	3	25	10.7
Citizens do not feel comfortable to make demands for the health system to change	28	2	26	7.1
Lack of will among health care service providers to adopt social accountability strategies	28	1	27	3.6
Unwillingness of health care facilities to increase their transparency	28	1	27	3.6
Lack of coordination among stakeholders	28	3	25	10.7
Key stakeholders are choosing to not be involved	28	0	28	0.0
Key stakeholders are being excluded from being involved	28	0	28	0.0
Other	28	4	24	14.3
Don't know	28	2	26	7.1

Appendix 11: Survey Part 4 Data Tables

Appendix Table 11.1: Is Social Accountability for Health Seen as Requiring Behavior Change?

	All N = 179		Côte d'Ivoire N = 76		Ghana N = 74		Guinea N = 29	
	F	%	F	%	F	%	F	%
Yes	170	95.0	76	100.0	65	87.8	29	100.0
No	9	5.0	0	0.0	9	12.2	0	0.0

Appendix Table 11.2: Behavior Change to Increase Social Accountability

All	AVG	N =	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree	
			F	%	F	%	F	%	F	%	F	%
Individual health care service providers in my country need to change their behavior to help increase social accountability for health.	4.3	178	1	0.6	4	2.2	31	17.4	50	28.1	92	51.7
Health care facility institutions in my country need to change their behavior to help increase social accountability for health	4.3	178	0	0.0	1	0.6	29	16.3	58	32.6	90	50.6
Government institutions in my country need to change their behavior to help increase social accountability for health	4.4	178	0	0.0	3	1.7	22	12.4	55	30.9	98	55.1
Individual citizens in my country need to change their behavior to help increase social accountability for health	4.2	178	2	1.1	7	3.9	26	14.6	62	34.8	81	45.5
Côte d'Ivoire	**AVG**	**N =**	**1 Strongly Disagree**		**2 Disagree**		**3 Neutral**		**4 Agree**		**5 Strongly Agree**	
			F	%	F	%	F	%	F	%	F	%
Individual health care service providers in my country need to change their behavior to help increase social accountability for health.	4.1	76	1	1.3	2	2.6	16	21.1	26	34.2	31	40.8
Health care facility institutions in my country need to change their behavior to help increase social accountability for health	4.1	76	0	0.0	1	1.3	17	22.4	29	38.2	29	38.2
Government institutions in my country need to change their behavior to help increase social accountability for health	4.2	75	0	0.0	3	4.0	11	14.7	26	34.7	35	46.7
Individual citizens in my country need to change their behavior to help increase social accountability for health	4.0	76	1	1.3	5	6.6	13	17.1	32	42.1	25	32.9

Appendix Table 11.2: Behavior Change to Increase Social Accountability (continued)

Ghana	AVG	N =	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree	
			F	%	F	%	F	%	F	%	F	%
Individual health care service providers in my country need to change their behavior to help increase social accountability for health.	4.4	73	0	0.0	1	1.4	12	16.4	18	24.7	42	57.5
Health care facility institutions in my country need to change their behavior to help increase social accountability for health	4.4	73	0	0.0	0	0.0	11	15.1	20	27.4	42	57.5
Government institutions in my country need to change their behavior to help increase social accountability for health	4.5	74	0	0.0	0	0.0	8	10.8	22	29.7	44	59.5
Individual citizens in my country need to change their behavior to help increase social accountability for health	4.2	73	1	1.4	2	2.7	12	16.4	21	28.8	37	50.7

Guinea	AVG	N =	1 Strongly Disagree		2 Disagree		3 Neutral		4 Agree		5 Strongly Agree	
			F	%	F	%	F	%	F	%	F	%
Individual health care service providers in my country need to change their behavior to help increase social accountability for health.	4.5	29	0	0.0	1	3.4	3	10.3	6	20.7	19	65.5
Health care facility institutions in my country need to change their behavior to help increase social accountability for health	4.6	29	0	0.0	0	0.0	1	3.4	9	31.0	19	65.5
Government institutions in my country need to change their behavior to help increase social accountability for health	4.6	29	0	0.0	0	0.0	3	10.3	7	24.1	19	65.5
Individual citizens in my country need to change their behavior to help increase social accountability for health	4.6	29	0	0.0	0	0.0	1	3.4	9	31.0	19	65.5