

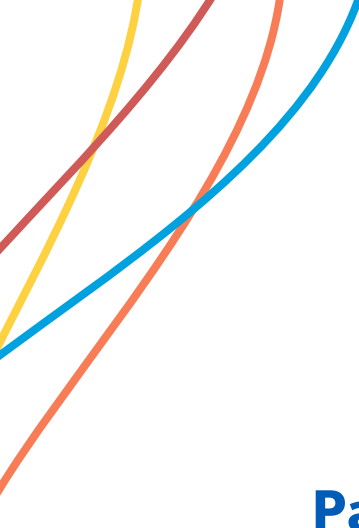


SOCIAL ACCOUNTABILITY

Evidence on pro-equity interventions to
improve immunization coverage for zero-
dose children and missed communities



EVIDENCE BRIEF



Part of a series, this evidence brief presents results from a **rapid review** of the literature to understand the effectiveness and implementation considerations for selected interventions, including social accountability, that could help achieve more equitable immunization coverage, specifically helping to increase coverage and reach zero-dose children and missed communities.

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Evidence summary

<p>What is social accountability?</p>	<p>Social accountability involves strategies rooted in citizen engagement and collective action used to hold governments and service providers accountable for their actions. This review focuses on social accountability within the context of public health and health care delivery systems. Community-led, evidence-informed advocacy that elicits a response from service providers, governments, or other relevant actors can play a critical role in social accountability. The purpose of this rapid review was to understand how social accountability can be used to advocate for essential health services, especially among zero-dose children and missed communities.</p>	
<p>How effective are social accountability interventions to advocate for zero-dose children and missed communities?</p>	<p>Despite a proliferation of descriptive reports on social accountability, few empirical studies have been conducted to assess its effectiveness in improving aspects of health service provision. This limitation is likely due to the highly context-dependent, dynamic, and complex nature of these approaches. Nonetheless, this rapid review identified several existing reviews and more recent primary research studies suggesting that social accountability can positively impact health care service delivery across a range of contexts and populations, in part through advocacy efforts. It can also impact intermediate outcomes such as community empowerment and self-efficacy, which may contribute to communities' ability to advocate for better health services.</p> <p>Social accountability approaches, specifically community score card approaches, have most frequently occurred in rural settings aimed to effect change within local health care facilities. At more macro-levels, social accountability approaches have been used in contexts where governments have mandated or formalized mechanisms to increase citizen participation in health care. Rights-based approaches have frequently involved marginalized groups. Few social accountability approaches have occurred in fragile/conflict-affected settings or have sought to address gender-related barriers through taking gender-responsive or gender-transformative approaches.</p>	<div style="text-align: center;">  <p>PROMISING INTERVENTION</p> </div>
<p>What are the main facilitators and barriers to implementation?</p>	<ul style="list-style-type: none"> • Facilitators include mobilizing communities to foster cohesion, purpose, and collective action; building coalitions and leveraging partnerships; having responsive governments and enabling policy and legislative environments; and creating effective forums for communities and decision-makers to share information and engage in bi-directional dialogue. • Barriers include lack of resources and funding, weak citizen participation, potential for excluding the most marginalized groups, difficulties scaling-up or sustaining without external support, and existing health system barriers. 	

What are the key gaps?

Key gaps include **lack of a clear theoretical understanding of the relationship between advocacy and social accountability**, and **lack of evidence** to support the mechanisms through which social accountability is hypothesized to effect change. More distinction is also needed on the **types of social accountability approaches** and when, where, and how they are most effectively deployed.

Introduction

What is social accountability?

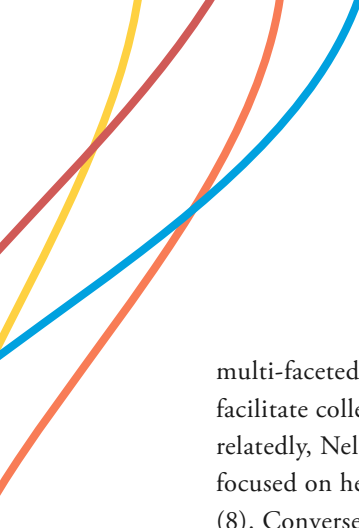
Social accountability has been defined as “citizens’ efforts at ongoing meaningful collective engagement with public institutions for accountability in the provision of public goods” (1). Social accountability is often grounded within human rights discourse through focusing on the relationship between “rights holders” (citizens or non-citizens—anyone who holds rights) and “duty bearers” (governments and those providing public services) (2). Social accountability can involve a multitude of different processes and activities that potentially impact various outcomes, including but not limited to community empowerment, community participation, responsiveness of duty-bearers, quality and accessibility of health services, and health outcomes, such as morbidity and mortality (3, 4). At its core, social accountability involves collective action on the part of rights holders to elicit a response from duty bearers. Often this involves citizen-led advocacy to influence decision-makers and impact the delivery of health services and health outcomes among particular groups, such as zero-dose children and missed communities.

Main actions involved in social accountability include information gathering, engaging in negotiation, and follow-up/enforcement (4). Community-based information collection, such as through community-based monitoring (CBM), often plays a critical role (5). Monitoring of interventions and activities through CBM have been discussed in a separate evidence brief. This brief focuses on how social accountability can be used specifically for the “advocate” component of the IRMMA framework (Identify – Reach – Monitor – Measure – Advocate), which focuses on activities that engender political commitment to mobilize and prioritize zero-dose children and missed communities (6).

Of note, social accountability approaches are typically complex and dynamic, often working to mobilize communities with diverse priorities, to shift unequal power dynamics across various groups, and ultimately seek to impact how citizens and the state interact. Recent conceptualizations of social accountability have sought to make important distinctions and categorizations. Fox et al. (2016) differentiates between “tactical” and “strategic” social accountability in which “tactical” approaches focus on micro-level changes, using bounded, well-defined tools that mainly work through utilizing communities’ increased access to information to push for changes from governments and/or service providers. “Strategic” responses are more

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multi-faceted and work to elicit change across levels, in part through fostering enabling environments that facilitate collective coordination and provide motivation for public-sector responsiveness (7). Separately but relatedly, Nelson et al. (2022) categorize “activist” versus “technician” led approaches, where the former is focused on health equity, often framed using rights-based language and prioritizes shifting power dynamics (8). Conversely the “technician” approach is typically focused on building consensus and on achieving short, more program-focused goals and objectives related to service delivery (8). Lodenstein et al. (2013) did not categorize social accountability approaches but posits that to be successful, initiatives must provide avenues for both citizen engagement *and* citizen oversight (i.e., monitoring and enforcement) and must take place within the context of a responsive government (9). Another seminal work in the field by Joshi et al. (2017) compares legal empowerment and social accountability approaches, viewing the two as complementary and noting legal empowerment’s focus on rights and the law—typically focused on marginalized individuals/groups whose rights have been violated—and social accountability’s focus on whole communities (1). These definitions and distinctions are relevant to issues discussed in this brief.

Why is social accountability relevant for advocating for zero-dose children and missed communities?

Social accountability approaches are relevant to advocacy efforts to prioritize zero-dose children and missed communities for several reasons. **Social accountability approaches can help empower disadvantaged or marginalized populations, including members of missed communities and those with a high prevalence of zero-dose children, through increasing awareness of health-related rights, building capacity, and providing tools and information to help these groups negotiate with providers, governments, and other relevant actors through advocacy efforts.** Social accountability approaches can shift power and alter relationship dynamics between rights holders and duty bearers, thus potentially allowing citizens in missed communities to exercise more agency. Mobilizing communities and fostering collective action is an important component of social accountability and could be especially relevant for disadvantaged communities. Social accountability provides an avenue for advocacy where community members can be directly involved and hold health systems accountable. Of note, due to an anticipated lack of social accountability studies specific to zero-dose children and missed communities, this review covered social accountability interventions relevant to the delivery of any essential health service(s) among disadvantaged or marginalized groups.

Why was this rapid evidence synthesis on social accountability undertaken?

The overall goal of this activity was to rapidly synthesize existing evidence on the effectiveness and implementation of social accountability interventions for advocating for essential health services, including immunization activities, within communities in vulnerable contexts. Through a rapid review of peer-reviewed and gray literature, this work aimed to evaluate the following questions:

1. Are social accountability interventions effective in advocating for essential health services, particularly immunization services, for communities in vulnerable contexts, including those who are marginalized or underserved?
2. What types of social accountability activities are occurring among communities in vulnerable contexts regarding health, and which models and/or key components work better than others to advocate for health services, particularly immunization services?
3. What are the implementation considerations for social accountability activities among communities in vulnerable contexts, including those who are marginalized or underserved?

To conduct the rapid review, multiple electronic databases and gray literature sources were searched from 2010-2022. Due to the focus on equity, only articles and reports were included that focused on communities facing vulnerabilities or those that took place in settings prioritized by the Equity Reference Group (ERG) due to the high prevalence of zero-dose children and missed communities found within them, which include settings involving remote rural populations, urban poor, conflict-affected areas, and settings in which gender-related barriers drive inequities (10). Studies from low-, middle-, and high-income countries were included, provided the social accountability intervention involved members of marginalized or otherwise disadvantaged groups. Studies were included if they presented relevant results from an existing systematic or scoping review, reported on primary research or programs that compared health-related outcomes using a pre/post or multi-arm study design to understand the effectiveness of social accountability, or described the implementation of a health-related social accountability intervention. More information on the review methods is included in Appendix A.

Results: What is known about social accountability?

Effectiveness: What is known about whether social accountability “works”?

The review identified 11 reviews published from 2010-2022 that covered both effectiveness and implementation, 7 studies that presented results on effectiveness, and 21 studies that discussed implementation. **Based on results, social accountability was categorized as a “promising” approach to address inequities in immunization approaches; results are summarized in the table below.**

Overall categorization of effectiveness

To help program planners assess whether an intervention, such as social accountability, should be considered for advocacy activities for zero-dose children and missed communities, a categorization scheme was used to

rate interventions as potentially ineffective, inconclusive, promising, or proven. A more detailed description of this categorization can be found in the general methodology for reviews in this series [linked on the evidence map website].

CATEGORIZATION	RATIONALE
<p>PROMISING</p>	<p>Despite a proliferation of descriptive reports on social accountability, few empirical studies have been conducted to assess its effectiveness. This limitation is likely due to the highly context-dependent, dynamic, and complex nature of these approaches. Nonetheless, this rapid review identified several existing reviews and more recent primary research studies suggesting that social accountability can positively impact health care service delivery across a range of contexts and populations, in part through advocacy efforts. Although evidence on effectiveness regarding health outcomes is mixed, evidence on the impact of social accountability on intermediate outcomes, such as improved community empowerment, trust, and communication between communities and health care systems, is mostly positive. Several studies provided qualitative evidence suggesting that social accountability initiatives had led to successful advocacy efforts, which in turn led to improved health services through avenues such as policy changes, increased funding, and increased accessibility of health care services.</p> <p>Types of social accountability initiatives identified include rights-based approaches, often focused on legal empowerment or generation of demand for rights and services among marginalized groups, initiatives involving community groups or committees (often through health facility committees), community score card (CSC) initiatives, and multi-sectoral/multi-level approaches. Most evidence exists for CSC initiatives in general community settings whereas rights-based approaches were often more geared to addressing specific needs of marginalized or stigmatized groups.</p> <p>Social accountability approaches have most frequently occurred in rural settings aimed to effect change within local health care facilities. At more macro-levels, social accountability approaches have been used in contexts where governments have mandated or formalized mechanisms to increase citizen participation in health care. Few social accountability approaches have occurred in fragile/conflict-affected settings or have sought to address gender-related barriers through taking a gender-responsive or gender-transformative approach.</p>

Further details of included studies are provided below to illustrate why social accountability is a promising approach for advocacy within communities in vulnerable contexts.

What evidence exists on the effectiveness of social accountability?

To synthesize results from the relevant reviews and primary research studies, studies were categorized into type of approach, including: 1) rights-based approaches, 2) committees/community groups, 3) non-governmental facilitated models (including community score card initiatives), and 4) multi-sectoral/multi-level interventions. Although these categories are overlapping, not mutually exclusive, and are in many ways an oversimplification of the complex interventions described, they provide a heuristic for discussing and comparing the effectiveness of different approaches.

Rights-based approaches

Approaches in this category typically relied on legal empowerment or focused on the generation of demand for rights and services among specific marginalized groups. **Although this type of approach mostly lacked empirical quantitative evidence of effectiveness in terms of government responsiveness or changes to health-related outcomes, there was robust qualitative evidence of how this type of approach impacted various outcomes, including participant/community empowerment, improved health services, and better communication between citizens and providers.** One study presenting some pre/post results indicating effectiveness (i.e., improvements to service delivery) was a community treatment observatory (CTO) in West Africa that deployed over 150 community treatment advocates—members of support groups for people living with HIV—to engage in systematic, routine data collection at health care facilities across 11 countries. The CTO model is based on using community-driven data to engage in multi-level advocacy efforts. Results from the CTO demonstrate successful advocacy experiences with national, subnational, and facility actors, and data suggest improvements such as reduced time of drug stock-outs, more tests performed at clinics, and improved health outcomes for clients (11). Other examples presenting qualitative results suggesting effectiveness include the Namati Program in Mozambique that trains health advocates in legal empowerment to help clients resolve cases of health-related rights-violations. Qualitative results suggest the program empowered clients, improved the quality of health care service delivery, and improved relationships between clients and the health system, although it is unclear what advocacy activities occurred (12). Other examples include an initiative in Gujarat, India to improve awareness of rights for sexual and reproductive health among gender diverse youth and youth with health conditions or impairments. The study reports that youth who participated in the program engaged in advocacy efforts by helping set an advocacy agenda at the national level and participated in webinars and meetings (13). Additionally, a rights-based approach utilizing a community complaints mechanism for refugees in northern Uganda receiving sexual and reproductive health services was successfully undertaken. Although no quantitative results from the pilot were presented, qualitative results suggest the intervention empowered users, strengthened trust between communities and the health system, and led to changes in health care delivery brought about through advocacy efforts undertaken as part of the intervention (14).

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Committees and community group-based approaches

Two relevant reviews included social accountability approaches delivered through committees or other community-based groups (15, 16) and both found promising results but noted a general lack of evidence overall. The review by McCoy et al. (2016) focused on the effectiveness of health facility committees (HFCs) as an accountability mechanism. Four effectiveness studies were identified, all which showed promising effects in terms of improving quality, coverage, and health outcomes. Authors noted that these committees serve multiple functions, including roles in governance, which encompasses social accountability, and roles in advocacy, which can encompass serving as the community voice during advocacy efforts with health authorities (15). A review by Molyneaux assessed community accountability interventions among peripheral health centers in sub-Saharan Africa and found that most interventions focused on committees or groups (n=19), whereas one focused on public report cards and another on patients' rights charters. The review noted a lack of empirical data on effectiveness but included details on implementation noted further below (16).

Non-governmental organization (NGO) facilitated models

A review by Hoffman et al. (17), described three different social accountability models that have been developed by international NGOs and applied in many contexts, including the Citizen Voice and Action approach (developed by World Vision), the Partnership Defined Quality approach (developed by Save the Children), and the Community Score Card approach (developed by CARE International). Main summaries of the intervention types and evidence of effectiveness are presented below.

Citizen Voice and Action (CVA)

This intervention aims to improve relationships between communities and government through “catalyzing alliances” (17). The intervention utilizes community score cards and social audits as part of fostering “evidence-based dialogues” between communities and government service providers, focusing on one health facility at a time. This intervention has been applied in many sectors, including health, and has been implemented in 42 countries (17). Two identified studies report on CVA approaches implemented in Zambia (18) and Kenya (19). The qualitative analysis from Zambia found that CVA improved state-society communication, trust, and “co-production” of local priorities and service delivery (18). The qualitative assessment from Kenya focused more on advocacy and found that the CVA initiative was effective for local-level advocacy, resulting in health care worker recruitment and direct increases to the annual budgets of facilities (19).

Partnership Defined Quality (PDQ)

Like CVA, PDQ emphasizes relationship building between communities and service providers, recognizing that both perspectives are needed to improve service quality (17). The approach involves four phases, including support building, exploring quality, bridging the gap between perspectives, and working together to enact change (17). Notably, the approach emphasizes inclusivity and specifies that 30% of community participants should be from marginalized groups to ensure adequate representation (17). Quality Improvement Teams form

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a key part of implementation. Despite several examples of PDQ reported as case studies and references in the Hoffman et al. review, no studies pertaining to effectiveness were identified.

Community Score Card (CSC)


The CSC approach was by far the most common approach to social accountability identified. **Results from reviews and from primary research studies mostly show promising results, especially for intermediate outcomes including increased community participation and awareness, increased trust between communities and facilities, but also in terms of improvements to quality of care, care utilization, and health outcomes** (20). Two reviews (20, 21), six primary research studies presenting quantitative findings (22-27), and two studies presenting qualitative findings related to social accountability outcomes (18, 28) focused on CSC. One review synthesized evidence from eight studies that utilized the CARE CSC approach, a phased approach where community members and providers identify issues, develop priority indicators to track and a scoring system; and engage in collective action planning and monitoring. Dialogues between community members and providers encompass the main avenue through which change is created, although one evaluation included in the review mentioned that providers were successfully able to advocate for additional resources because of the CSC activities (20). Notably, a randomized controlled trial (RCT) evaluating a CSC intervention in Malawi found improvements in maternal health outcomes (23). However, two multi-country quasi-experimental studies—one in Ghana and Tanzania and one in Cambodia, Guatemala, Kenya, and Zambia—found no overall improvements in health-related outcomes across CSC interventions, although some results varied by country (22, 27). Both highlighted important contextual factors that might have limited interventions effectiveness (22, 27). Neither study elaborated on the role of advocacy.

Multi-sectoral or multi-level approaches

Three studies described interventions involving multi-sectoral actors or took a multi-level approach (29-31) and all demonstrate positive results. An intervention in Maharashtra, India discussed having support from the government, through policy mandates, to engage in social accountability and described a multi-level process. The process included the completion of health report cards by village committees and community members (tools were adapted to enable use by semi-literate community members); discussing results of the report cards at *jan sunwais* (public hearings), including using testimonials from community members to highlight issues and advocate for change; networking and mobilizing among civil society organizations (CSOs) at the state, district, and village levels; enabling dialogue between CSOs and state-level health authorities; and involvement of media to increase public awareness and intensify demands. Results from this initiative demonstrate improvements in quality ratings of facilities, including increases in ratings of immunization services by 21 percentage points from round 1 to round 3 (31). Another social accountability initiative in Malawi, called the “Social Accountability for Every Woman Every Child” aimed to improve reproductive, maternal, newborn, child, and adolescent health outcomes by implementing a “strategic” approach with activities designed for the community, district, and national levels, including through the use of *bwalo* (meetings based on traditional dialogue methods). Although no quantitative results on effectiveness were presented, qualitative results suggest the strategy was effective in addressing issues at the local level, or if

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unresolved, elevating issues to higher levels (29). Finally, a combination of approaches in Zambia, although not explicitly described as social accountability, sought to create “bottom-up” feedback by meaningfully engaging community leaders and community members in immunization programming, including building community trust and ownership and providing forums for discussion among community representatives and district and provincial health management teams. Communities participated in program planning and evaluation and provided suggestions for improvement; community feedback was incorporated into future policies, which were tailored to the local context. Although the study presented only qualitative results from key informant interviews, results suggest the multi-level program is effective in improving immunization programming and coverage (30). Notably, the program does not mention advocacy specifically.

What evidence exists on the effectiveness of social accountability to advocate for immunization services directed toward zero-dose children or missed communities?

No social accountability initiatives were specific to zero-dose children and missed communities. The multi-level, community-feedback approach that took place in Zambia was the only assessment identified that implemented social accountability approaches within immunization. This approach is described above and involved a series of participatory approaches across multiple levels to engage communities, incorporate feedback, tailor interventions, and build trust.

Effectiveness by type of social accountability initiative

As outlined above, social accountability approaches generally fell into one of four categories: rights-based approaches, community groups or committees, community score card initiatives, or multi-sectoral/multi-level approaches. Most evidence of effectiveness exists for CSC initiatives, including CVA approaches. These interventions typically involved community mobilization and advocacy for whole communities as defined by geography; few mentioned the explicit inclusion of marginalized groups within communities. Results pertaining to health facility committees and other community groups also typically involved serving geographically defined communities. Conversely, rights-based approaches typically focused on marginalized groups, although these interventions mostly lacked quantitative findings relevant to effectiveness but had promising qualitative results. Although few examples were identified, and results were mostly qualitative, multi-sectoral/multi-level SA approaches presented the most thorough conceptual models on how SA initiatives were hypothesized to effect change and demonstrated how initiatives could be embedded within existing systems and forums.



Effectiveness within ERG settings

Most reviews and many effectiveness studies did not mention or highlight the specific ERG setting in which they occurred. Among primary studies, most CSC approaches were implemented in rural areas, with efforts mostly confined to the local health facility levels. Several studies also occurred in urban areas, such as within urban area of India (31), and several of the multi-sectoral approaches encompassed both urban and rural areas. Notably two interventions occurred in fragile and/or humanitarian settings, including a social accountability initiative in Burundi (32) and one within refugee populations in northern Uganda (14). Neither intervention presented quantitative results related to effectiveness, but the intervention in Burundi experienced challenges based on issues of mistrust that hampered accountability efforts (32), while the initiative in Uganda showed promise in empowering marginalized groups, improving trust between communities and providers, and improving service provision (33).

Implementation: What is known about “how” social accountability works?

Barriers and facilitators across ERG settings

Twenty-one studies and reports, as well as several reviews, presented information relevant to the implementation of social accountability interventions across ERG settings. Major barriers and facilitators to implementation are summarized below in Table 1. Because most studies and reviews were not specific to a particular ERG setting, general barriers and facilitators that are likely relevant across settings are included. Also included are barriers external to the intervention but relevant to the context in which social accountability is implemented.

TABLE 1. Barriers and facilitators to implementation

FACILITATORS	BARRIERS
<ul style="list-style-type: none"> • Use SA initiatives to form coalitions, leverage partnerships, and embrace multi-sectoral/multi-stakeholder approaches (3, 34) • Engage in extensive community mobilization and garner support from communities, health systems, and politicians for SA efforts (18, 35, 36) • Generate community-based demand for rights and better services (13, 37) • Implement SA among cohesive, centralized community-based networks (38) and in contexts where community groups are recognized and accepted by health authorities (28) • Implement SA in contexts where health systems are responsive and open to participation in SA (4, 34) • Promote intentional inclusivity by creating distinct roles and groups for marginalized populations within SA initiatives (13, 36) • Tailor accountability interventions to sociopolitical context (3, 34) • Sensitize leaders to the health needs of marginalized groups at the start of SA activities (37, 39) • During SA, identify and engage “intermediaries” (i.e., champions) who can amplify and legitimize the needs of marginalized groups seeking change (37) • Work to strengthen enforcement of changes facilitated by SA through linking with legal accountability and budgetary spending (36) 	<ul style="list-style-type: none"> • Presence of health system barriers, such as poor governance, limited capacity, resource constraints, and insufficient funding (3, 40) • Inappropriate SA leadership (i.e., having accountability mechanisms led by those being held accountable) (41) • Lack of meaningful community engagement (42) or insufficient capacity to mobilize (28) • Weak citizen participation (41); failure to leverage existing participant mechanisms and ongoing initiatives (20); lack of networking among existing community groups (28) • Absence of mandate/lack of enabling policies and legislation (21, 36, 40) • Exclusion of marginalized groups (14, 21, 28, 34, 36) • Structures to support SA might exist but might be non-functional, thus hampering efforts (21, 28, 40) • SA efforts might be resisted by stakeholders (21), lack of commitment from leaders (26), or efforts by authorities to block community groups from mobilizing and advocating for community interests (28) • Risk of physical or social harm to community members or health system actors who participate in SA (36) • Inability to address issues perceived to exceed the authority of SA participants (28, 36) • Lack of clear guidance, authority, and knowledge of sensitive health topics at local levels and cultural norms that make it challenging to prioritize and mobilize around certain issues (34, 36) • Failure to emphasize national advocacy and engagement within SA, thus limiting responsiveness and impact (20) • Lack of trust among community members and mistrust between community members and providers, which might be especially relevant in fragile/post-conflict settings (32) • Existing gender norms which prevent participation and contribute to marginalization (13, 28, 32, 40)

Social accountability has been abbreviated as “SA” in the table above.

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Implementation outcomes

Expanding on the facilitators and barriers listed above, below is a summary of specific implementation considerations related to acceptability, feasibility, appropriateness, cost, and sustainability.

Acceptability

Studies found that social accountability initiatives were generally accepted by community members, providers, and other health system actors, but there were also many instances where acceptability was sub-optimal. For example, studies mentioned resistance from stakeholders (21), lack of commitment from leaders (26), and even efforts by health authorities to dismantle community groups actively working to promote community interests (28). Several studies emphasized the need to educate community members about their rights and about health issues to generate acceptance of, participation in, and engagement with social accountability initiatives (13, 37). This was especially relevant for rights-based approaches, where increased understanding of and claiming rights was an important outcome in and of itself (18, 33). However, notably few studies described the motivation for community members and groups to participate in social accountability initiatives, such as describing how participants were chosen, whether they were compensated, and what community members felt they gained from the experience. Additionally, the acceptability of advocacy as a specific component of social accountability was not discussed.

Feasibility

Many studies noted several key elements necessary for feasibility of social accountability, including having mobilized, engaged citizens who participate in the initiative; a system in place for gathering information and sharing information and facilitating dialogue between communities and health system authorities; and having health systems that are responsive to community needs. Studies that noted breakdowns in any of these areas reported challenges with feasibility. For example, several studies noted weak community participation or issues with isolated community groups leading to limitations in mobilization and collective action (20, 28, 41, 42). Another study on social accountability approaches in Odisha, India found that community participation was weak, in part because committees developed to support the accountability efforts were not community-led and were controlled by the health care workers being held accountable (41). Regarding information gathering and sharing, some studies noted that structures to support social accountability were in place, but issues with functionality, selection of committee members, and existing social hierarchies and information flows within communities made implementation challenging and potentially ineffectual (21, 28, 43). Concerning responsive health systems, studies noted the critical importance of having health systems that supported social accountability initiatives and were capable/willing to be responsive to issues raised. In some cases, such as in India and Guatemala, governments mandated community-led engagement in health, which created an enabling environment for implementing social accountability (31, 35, 37, 38). In other cases, social accountability initiatives focused on the local level and noted the lack of national advocacy and engagement most likely hampered impact (20). Tailoring interventions to the relevant sociopolitical context was seen as critical by many studies and reviews (3, 4, 34).

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Appropriateness

Several studies commented on the appropriateness, or perceived fit of the intervention, noting potential issues when implementing initiatives in conflict-affected settings, or when trying to reach marginalized sub-populations. Of relevance to ERG settings, one study described implementation of social accountability initiatives in Burundi, a fragile/post-conflict affected area. Investigators in this study found that while the government made efforts to foster social accountability to improve maternal health care through developing health committees and suggestion boxes, community members did not use them, in part due to mistrust, fear, and existing gender norms that constrained women's participation (32). In this context, community members preferred relying on community health workers as intermediaries to report on service delivery issues (32). Of relevance for marginalized and stigmatized communities, one study noted that social accountability initiatives focused on geographically defined "communities," as is generally the case in CSC or CVA initiatives, often miss priorities of certain disadvantaged groups within communities such as adolescents (14). The possibility of ignoring needs of special groups might make geographically based social accountability approaches inappropriate for impacting change among marginalized subpopulations. Reviews noted similarly that marginalized populations are often excluded from social accountability, unless specific efforts are made to include these groups, such as by organizing special groups or roles for members of these communities (36, 44).

Costs

Little information on costs of social accountability initiatives were identified. One study described the cost of implementing a CSC initiative in rural Uganda (45), one described the general costs of operating a CTO (39), and one briefly mentions the cost of implementing a CVA intervention in Kenya (28). The CSC initiative in rural Uganda found that the average cost of implementing the CSC within each district subcounty was 1,998 USD per scoring round. Two scenarios were assessed to estimate potential costs of scale-up: one involved inputs from the research team implementing the CSC pilot and the second involved cost inputs from subcounty coordinators and District Health Teams implementing the CSC pilot. The estimated total annual costs of scaling-up to the entire district for the two scenarios was 76,021 USD and 28,465 USD, respectively (36). Main drivers of cost were transportation, technical support to local implementers, and coordination/supervision costs (36).

Sustainability

Sustainability was a common concern across studies. Two studies describe social accountability activities that are still occurring several years after external funding has ended, including one CSC intervention in Bangladesh (21) and one CSC intervention in Malawi (46). Activities that have been sustained include regular communication between the facilities and community groups in Bangladesh and the continuation of functioning health facility committees in Malawi. Authors note that sustainability without sufficient resources and commitment on the part of rights holders and duty bearers is challenging. Reviews and studies also noted the inherent challenges of scale-up.

Existing evidence gaps and areas for future research

This rapid review of social accountability interventions for health-related programs among vulnerable and marginalized populations found evidence that social accountability interventions were used successfully to advocate for improved quality, accessibility, and acceptability of service provision. Further, they typically fostered improvements in communication and trust between communities and health authorities. Having informed, engaged, and mobilized communities was critical to success, as was gathering information on citizen experiences and relaying this information back to relevant health system actors to advocate for change. The third critical element was having governments that were responsive to community priorities and meeting community needs. However, this review found that social accountability approaches varied widely in terms of approach and outcomes, and contextual tailoring made it challenging to draw overarching conclusions. More specific gaps identified include:

- 1. Lack of clarity regarding the relationship between advocacy and social accountability.** Although advocacy and social accountability are clearly related, a theoretical understanding of how these concepts are related was lacking from studies identified in this review. For example, in this review, few interventions explicitly discussed the role of advocacy in social accountability, including few descriptions of what advocacy activities took place, how they were informed by information gathered through social accountability, and results of the advocacy efforts. Those that did explicitly mention advocacy suggest positive results and have been summarized earlier. Additionally, several studies note positive outcomes related to intermediate outcomes, such as empowerment and self-efficacy, which could be important antecedents to advocacy. More research and theory development on advocacy and social accountability, particularly surrounding advocacy for immunization services, would be beneficial.
- 2. Lack of characterization of mechanisms through which social accountability works.** Social accountability interventions are complex, dynamic, and context dependent. These characteristics make it challenging for studies to describe the mechanisms through which social accountability works. Many studies describe the importance of intermediary outcomes in social accountability approaches, such as building empowerment, self-efficacy, and the capacity for collective action within communities, yet none were able to link changes in intermediary outcomes to positive changes in health outcomes. More understanding of the mechanisms through which change is expected would be beneficial albeit challenging to define and measure.
- 3. Lack of understanding of when and where to deploy different types of social accountability.** As described in the introduction, several attempts have been made to categorize social accountability approaches, including “tactical” versus “strategic” approaches and endeavors led by “activists” versus “technicians” (7, 8). While this brief categorized social accountability approaches using yet another typology, it remains unclear when certain types of social accountability should be used and in what contexts they show the most promise.

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4. **Lack of quantitative and qualitative data related to effectiveness.** Overall, this review identified few rigorously designed studies to evaluate social accountability initiatives. More research is needed to understand their effectiveness and mechanisms through which impact is achieved, including how these interventions use advocacy to achieve results. Notably, a measurement tool has recently been developed to help programs and countries plan, monitor, and/or evaluate social accountability approaches (47). Use and application of more standardized measures and tools could be helpful in building the evidence base and providing clear understanding as to whether an approach is “working.”
5. **Lack of direct application to immunization and prioritizing zero-dose children and missed communities.** While many studies used social accountability to improve service provision for marginalized groups, none focused on zero-dose children and missed communities. To understand how social accountability can be used as a pro-equity strategy within the field of immunization, more research is clearly needed.

Limitations

Despite undertaking a comprehensive search strategy, this synthesis involved a rapid literature review; relevant citations could have been missed. Additionally, this review included only relevant peer-reviewed publications and available gray literature sources. It is possible that more evidence exists, especially programmatic data unavailable through the sources searched. Publication bias, although not formally assessed, might be of relevance, especially if successful social accountability interventions are more likely to be published than unsuccessful ones. Also, despite the use of standardized forms and trained staff members, data interpretation is somewhat subjective, especially given that formal, quantitative synthesis of outcomes was infeasible. Additionally, social accountability approaches often provided little detail of how efforts were used specifically for advocacy, although implicitly advocacy was a key part of many approaches. This made it challenging to understand whether social accountability “works” as an advocacy strategy.

Conclusions

How to potentially shift pro-equity programming based on findings?

Based on findings from this review, there are several steps programs can take to tailor social accountability interventions to help achieve equity.

- Identify characteristics of zero-dose children and missed communities, such as understanding whether geographic areas are most affected (e.g., remote rural areas), or whether certain groups that share similar characteristics are most affected (e.g., those of lower socio-economic status, ethnic or religious minorities) as the most effective social accountability approach might differ depending on who is affected. CSC approaches have been used most frequently when entire geographically defined communities are

targeted whereas rights-based approaches have been used more frequently to address challenges faced by marginalized or disadvantaged sub-populations.

- When social accountability approaches involve marginalized groups, designate specific roles for members of these groups within social accountability initiatives to ensure their voices are heard, and sensitize leaders and health system actors regarding their needs.
- Ensure that critical ingredients for a successful social accountability approach are in place, including confirming community members are willing to participate and whether health systems are motivated to be responsive to issues raised. Understanding the policy and legislative environment and developing a platform for information gathering, such as through CBM, are also critical.
- Understand what current partnerships exist and how coalitions could be formed and leveraged to develop an effective social accountability approach. Also understand if there are existing forums for community stakeholder dialogue and whether these could be enhanced for social accountability purposes (e.g., enhanced networking, building social capital). Developing a theory of change and considering involvement of multi-level activities and/or multi-sectoral actors are also important.

Based on the findings, should social accountability interventions with an equity perspective be brought to scale?

This review found that social accountability interventions are promising for use in advocating for the prioritization of the health needs of communities in vulnerable contexts. However, because no interventions were found that were specific to social accountability used for advocacy among zero-dose children and missed communities, more research is needed for consideration of scale-up. Additionally, this review identified little on the cost of social accountability, which is an important scale-up consideration. To address these gaps, countries should consider developing learning agendas and conducting implementation research to better understand social accountability development and implementation specific to addressing inequities in immunization.

Appendix A.

How was this evidence synthesis conducted?

SEARCHING, DATA EXTRACTION, AND ANALYSIS: The review followed a general methodology for all topics in this series. In brief, the methodology involved comprehensively searching electronic databases from January 2010 through November 2022, conducting a gray literature search, screening through all citations, and developing topic-specific inclusion criteria. Data were extracted into standardized forms, and results were synthesized narratively.

INCLUSION CRITERIA: We included studies that involved social accountability among a community, population, or geographic area described as vulnerable, marginalized, underserved, or otherwise disadvantaged. Social accountability interventions could take place in either high-, middle-, or low-income countries (as defined by the World Bank) as long as the social accountability intervention involves and is set-up to benefit members of communities facing vulnerabilities, including marginalization and being otherwise disadvantaged, in some health-related aspect. Interventions had to include an outcome of interest, including measurement and/or monitoring results of health outcomes or service delivery. We included both effectiveness studies (defined as using a multi-arm design or using pre/post or time series data to evaluate an intervention involving social accountability) and implementation studies (defined as any study containing descriptive or comparative data relevant to implementation outcomes). Notably, due to the identification of several studies that discussed effectiveness qualitatively but did not include quantitative pre/post or multi-arm results, these studies were discussed in the “effectiveness” section of the brief to provide a comprehensive assessment; however, their inclusion of only qualitative data was noted.

SEARCH RESULTS:

- 1,437 articles were identified in the published literature search.
 - 1,294 articles were excluded during the title and abstract screening.
 - Of the remaining 143 retained for the full text screening, 112 were excluded, leaving 37 eligible studies, including:
 - » 10 existing relevant reviews
 - » 6 effectiveness studies (covered in 7 articles)
 - » 20 articles related to implementation, including articles that discussed qualitative results related to effectiveness.
- 4 potential reports were identified in the gray literature or through contacting experts in the field to identify relevant grey literature:
 - 4 reports were eligible and included 2 related to the same effectiveness study, 1 review, and 1 implementation report
- In total, 41 studies were included:
 - 11 existing reviews
 - 7 effectiveness studies (covered in 9 articles with quantitative results)
 - 21 implementation studies

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