

## N'WETI'S COMMUNITY SCORECARD EXPERIENCE IN NAMPULA: A CASE STUDY



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Maputo | 2015



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## Abstract

This case study was commissioned by N'weti *Comunicação para a Saúde* to explore the changes emerging from the implementation of an adapted version of the Community Scorecard (CSC) tool in 11 health facilities catchment areas in Nampula. This case study discusses how N'weti has adapted the Community Scorecard (CSC) tool to better improve the quality of the participation and prospects of accountability for citizens. The case study presents evidence that the adapted CSC tool has resulted in an increased awareness of rights, an improved relationship with the service providers, a revitalisation of the health unit Co-management Committees, citizens feeling that their voice is being heard, and N'weti is recognised by people and authorities as catalyser and legitimate mediator of this voice. However, challenges also surfaced which N'weti must reflect and learn from. The first relates to the meaningful control from regular citizens (rather than NGO staff members) of the institutionalisation, follow-up of commitments and advocacy actions derived from the implementation of a CSC process. Other challenges refer to social exclusion, the lack of a deeper understanding of power dynamics, and the fact that ignoring previous histories of citizen engagement and other contextual factors can be misleading as not all change can be directly attributed to the implementation of the CSC.

The case study presents evidence that the adapted CSC tool has resulted in an increased awareness of rights, an improved relationship with the service providers, a revitalisation of the health unit Co-management Committees, citizens feeling that their voice is being heard, and N'weti is recognised by people and authorities as catalyser and legitimate mediator of this voice. However, challenges also surfaced which N'weti must reflect and learn from.

## Introduction

This case study was commissioned by N'weti Comunicação para a Saúde (here onwards N'weti). N'weti is a Mozambican non-profit organization whose mission is to contribute to the improvement of the health status of Mozambicans through health promotion and social accountability in health approaches interventions that aim at guaranteeing quality health services and promoting social and behavioural changes at individual, community and structural levels. N'weti is a pioneer in communication for health and consistently uses research-based approaches and consultation to design and implement programs and activities.<sup>1</sup>

Initially, N'weti's work was centred on behaviour change of citizens in relation to their health service provision (i.e. demand side). In recent years, N'weti has started to engage and develop programmes aimed at monitoring and holding accountable health service providers in order to improve the quality of the service provision (i.e. supply side). For this purpose, N'weti has joined national consortia such as Cidadania e Participação (CEP)<sup>2</sup> and led in the creation of others such as Mais Vida<sup>3</sup>; as well as undertaking individual actions. One of these has been the integration of the Community Scorecard (CSC) mechanism into their programme Tua Cena, facilitating the participation and engagement of citizens in monitoring the quality of health services through the collection of information and evidence in order to inform the dialogue with direct providers, their managers, and decision makers.

Learning from the CSC process within the Tua Cena programme is the focus of this case study. In 2014, a pilot programme of using CSC was carried out in health units in Gaza and Maputo province; the pilots in the South surfaced a number of challenges. Through a process of action-reflection-planning-action N'weti's team adapted the general CSC cycle (Figure 1) in order to improve some aspects of the cycle. These innovations are seen in Box 1.

The renewed CSC cycle (Figure 1) was implemented in 2015 across eleven health units in Nampula province showing positive changes.



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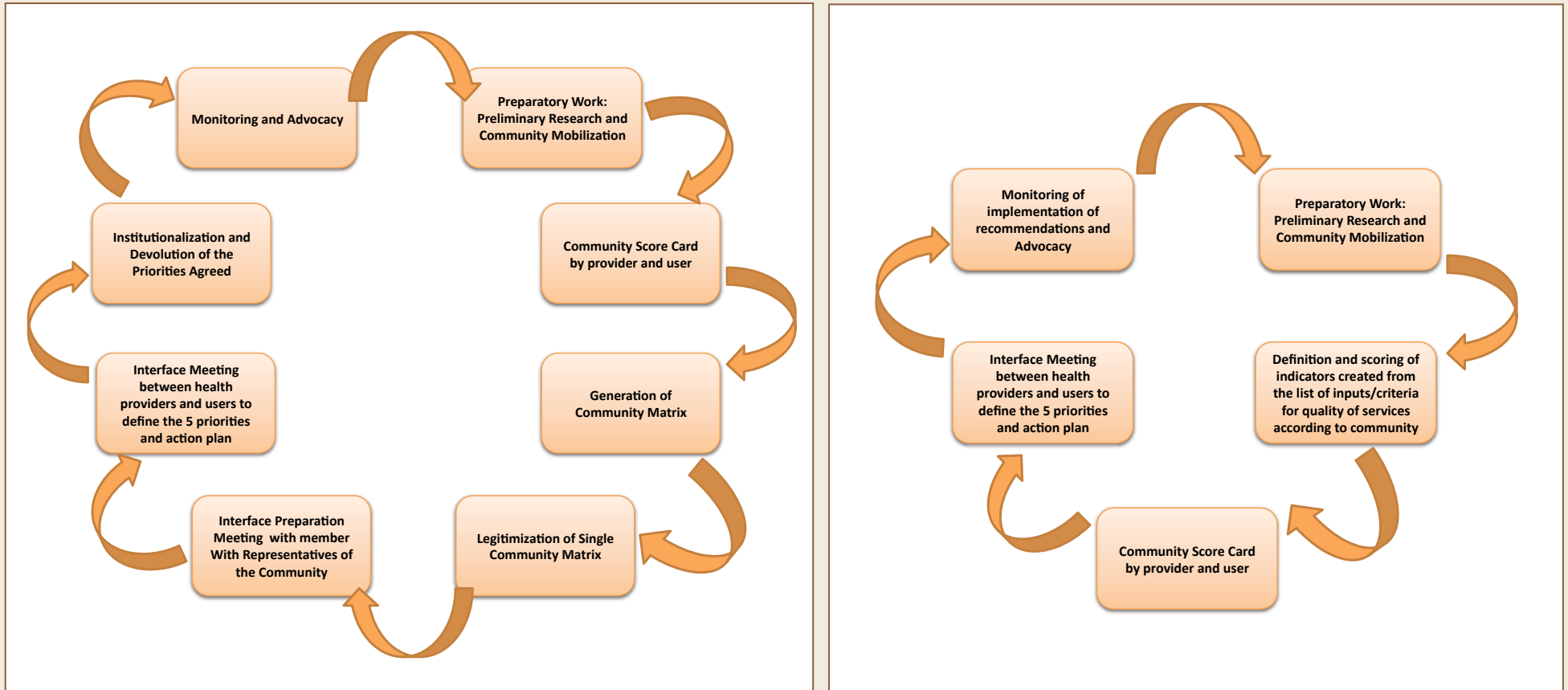


1. Information from the website: [www.nweti.org](http://www.nweti.org)

2. CEP is an innovative program working across 4 provinces in Mozambique which is fostering citizen participation and engagement in monitoring health and education services at the unit level through Community Scorecards and Citizen Report Cards. N'weti has been part of the CEP consortium since its inception in 2013, and has contributed its expertise to the programme as well as learnt insights on SAcc processes.

3. Mais Vida is a citizen engagement programme to demand improved maternal and child health services in Cabo Delgado and Niassa provinces. Nweti is part of the implementing Consortium.

Figure 1. CSC cycle stages versus N'weti's revised model of 8 stages



## Box 1. Innovations introduced to the Community Scorecard cycle

After implementing the CSC pilot phase in localities of Gaza and Maputo provinces, N'weti integrated a series of steps to the cycle as a way to address some of the challenges faced. These are:

**Step 3. Generation of the single community matrix:** based on the outcomes of different community groups' scoring, we systematise them in a single matrix that is going to be the main instrument containing the community assessment of the public health service quality;

**Step 4. Legitimation of the single community matrix:** the groups involved in scoring have access to the outcomes of their assessment, through the single community matrix which is validated in a meeting, and it is the responsibility of the community to confirm that this reflects their concerns and it is a result of their assessment. In such meetings, community representatives for the interface are selected.

**Step 5. Preparation of the interface:** in this meeting, and under the leadership of the district supervisor, the members elected by the community to represent them in the interface get prepared for this crucial moment. They improve their understanding on the issues and concerns raised by the community in their service quality assessment comprised in the single community matrix, and they strengthen their assertive negotiations skills. The community is provided with information on the different interface stages.

**Step 7. Institutionalisation and outcomes feedback:** Finally, N'weti incorporated a public event where service providers and other relevant authorities sign a 'social contract' with the commitments derived from the interface meeting.



N'weti commissioned this case study in order to better understand what are the main outcomes derived from the innovations they have incorporated to the design of the CSC mechanism in the province of Nampula. Of particular interest was for the organisation to discern if these changes were contributing to attaining the two objectives set out through the implementation of the CSC:

- (1) Addressing problems related to quality of health service provision at the local level
- (2) Accountability of service providers and local health authorities

After conducting the fieldwork, it was clear that analysing results against each of the stages would result in a very descriptive piece of work. As such, we decided to ask: How is N'weti's approach to citizen participation within the CSC cycle resulting in a more comprehensive Social Accountability (SAcc) pathway? The main argument of this case study is that N'weti has adapted the CSC cycle in a way that is improving the quality of the participation and prospects of accountability. This is evidenced by the fact that people's rights awareness has increased, the relationship with the service providers has improved, there is a revitalisation of the health unit Co-management committees (CCGs), citizens feel that their voice is now heard, and N'weti has been a catalyser and legitimate mediator of this voice. However, limitations also surfaced; one key to SAcc initiatives relates to the direct leadership of common citizens, rather than NGO staff members, on the institutionalisation, monitoring and advocacy stages of the CSC process. Others, in relation to dynamics of social exclusion, power dynamics which remain veiled, and the fact that previous histories of engagement and context are determinant for achieving the intended changes of mechanisms of SAcc.

This speaks to the fact that external actors, such as NGOs and other development actors, do have a crucial role to play in fostering, nurturing and designing spaces and environments for citizen engagement in raising demands and holding authorities to account. However, in order to take a more strategic rather than a tactical approach to SAcc, continued reflection on practices and in-depth analysis of the contextual factors shaping the prospects of citizen action should be at the core of the implementation of any SAcc mechanism (see Box 2). Above all, in order to achieve transformative participation, an agreed vision has to be in place amongst these mediating elites about the real power that direct citizen action can have in changing the structures (Fung 2015) which limit the right to participation of those most marginalised.

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## Box 2. Different approaches under the SAcc umbrella

- |   |  |
|---|--|
| <ul style="list-style-type: none"><li>• Tactical</li><li>• Bounded interventions (also known as tools)</li><li>• Limited to “society-side” efforts to project voice</li><li>• TOC assumes that access to information alone will motivate localized collective action. This collective action will in turn generate sufficient power to influence public sector performance</li><li>• Evidence shows limited results on achieving accountability</li></ul> | <ul style="list-style-type: none"><li>• Strategic</li><li>• Deploy multiple tactics</li><li>• Encourage enabling environments for collective action for accountability</li><li>• Coordinate citizen voice initiatives with governmental reforms that bolster public sector responsiveness</li><li>• Are much more promising for achieving accountability</li></ul> |
|---|--|

Fox 2007: 8

The methodology designed to conduct this case study is detailed in the following section. A background to SAcc and the CSC mechanism within the Mozambican context will be provided. Section 1 will describe N'weti's CSC cycle and how citizen participation varies across the 8 stages. Section 2 describes the positive outcomes expressed by citizens and authorities engaged in the CSC process in 3 districts in Nampula. Section 3 speaks about those limitations encountered in the implementation of the CSC. The report then ends with final considerations to be considered in future thinking around the CSC process and wider SAcc initiatives.



## Methodology of this study

We adopted a qualitative approach with a general background document analysis. Different data collection techniques were combined: a desk study, focus group discussions (FGDs) and individual interviews with key informants were used. It is important to mention that this study was designed as an inquiry, and not an evaluation or an impact study; as such, there was no intention of controlling for certain variables.

## Data Collection

### Literature Review

The literature review used in the first stage of data collection allowed for a review of a wide range of N'weti project documents, legal frameworks, studies and papers conducted in Mozambique and other contexts across the region and at international level. This initial review allowed for deepening the research questions, better understanding the project, as well as understanding the latest debates on Social Accountability.

### Focus Group Discussions

Data collection in the three districts of Nampula (Moma, Rapale and Meconta) was conducted across 6 days. Over this period, the Administrative Posts of Namitório (Moma), Corrane (Meconta) and Anchilo (Rapale) were visited. In these districts, 12 Focus Group Discussions (FGD) took place: 3 with adolescents, 3 with the Co-management Committee members, 3 with young people and 3 with adults. The selection of the FGD participants obeyed the following criteria: (a) people of both sexes who participated in the first CSC cycle that was implemented in Nampula in 2014; (b) people of both sexes within the 15 - 49 age group; (c) adult members of the co-management and health committee.

The selection of people who participated in the first cycle of CSC was based on the fact that these were regarded as informants with knowledge of the process, thus allowing for capturing perceptions on the CSC process and stages, as well as possible positive changes as a result of the CSC process.

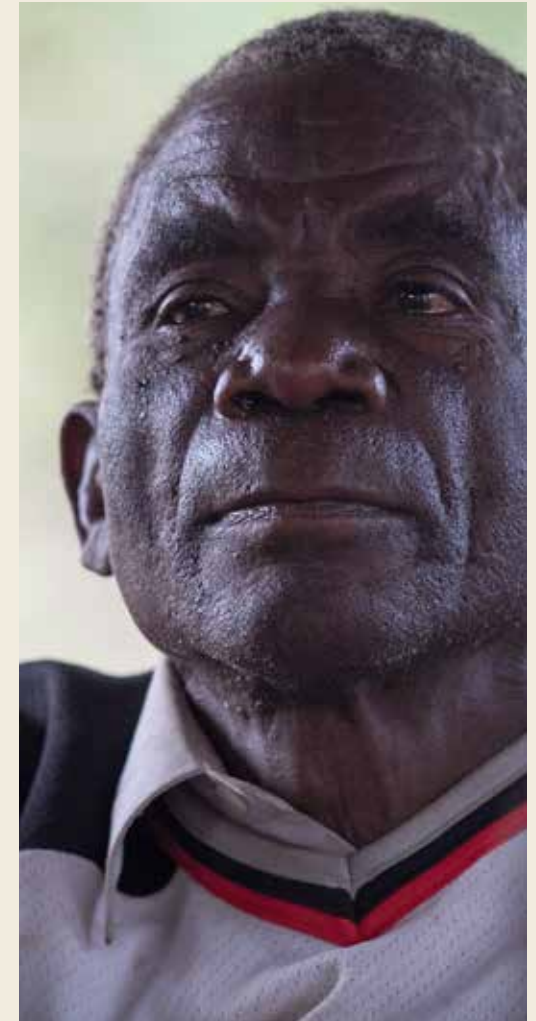


## Interviews with Key Informants

In addition, interviews were conducted with key informants. Four of these informants are members of N'weti who take strategic decisions related to planning, programming and implementation of programmes. Two field supervisors were interviewed through a questionnaire to gather the views of those directly coordinating activities in the ground. Finally, six interviews were done with the heads of the assessed Health Units and heads of Administrative Posts. These last interviews allowed us to better understand the level of openness of the local government and health providers to collaborate with N'weti. On the other hand, they allowed us to capture the perceptions of the authorities and providers around the relevance of CSC with a focus on the different moments/stages, perceptions on the main attained outcomes, as well as receiving inputs for process improvement.

## Data Analysis

The data analysis process began with an analysis on key topics from the collected data; through deliberation amongst the two researchers involved, key categories for classifying and coding the data were created. Afterwards, data was codified manually (data classification and organisation) and, based on continuous analysis, it was possible to understand the relevance of each of the CSC stages, and the perceptions around positive changes that were behind the achievement of the quality of services as a result of the CSC implementation.



## Background of CSC as a tool for social accountability

In the democratic realm, promotion and regard of the accountability principle is critical. It has a number of ingredients, including access to information, existence of SAcc mechanisms, capacity to use these mechanisms, and willingness of duty bearers to respond. In the field of development, SAcc has been in line with the discussions and reflections on the realisation of 'good governance' principles, heavily promoted by the World Bank since the mid-1990s; however, in the last decade, it has been evident how difficult it is to reach a common understanding of this broad concept. For the World Bank (2014), SAcc strategies try to improve institutional performance by bolstering both citizen engagement and the public responsiveness of states and corporations. In practice, the concept includes a wide range of institutional innovations that both encourage and project voice. Insofar as SAcc builds citizen power vis-à-vis the state, it is a political process – yet it is distinct from political accountability, which focuses specifically on elected officials and where citizen voice is often delegated to representatives (i.e. parliamentarians) in between elections. This distinction makes SAcc mechanisms an especially relevant approach for societies in which representative government is weak, un-responsive or non-existent.

For Houtzager and Joshi (2012) SAcc is an evolving umbrella category that includes: citizen monitoring and oversight of public and/or private sector performance, user-centred public information access and/or dissemination systems, public complaint and grievance redress mechanisms, as well as citizen participation in actual resource allocation decision-making, such as participatory budgeting. According to a review from Rhodes University (Sipondo 2015), SAcc goes beyond the traditional accountability efforts by citizen or civil society to hold government accountable. The practice of so-called traditional public accountability in most democracies has always emphasised the citizens or the public as final agent to whom all public servants (both elected and appointed) were to be held accountable. A distinctive characteristic of SAcc is that the state must undertake efforts to enhance citizen knowledge of the existence and use of conventional mechanisms of accountability; as well as continuing efforts to improve the effectiveness of internal accountability mechanisms through greater transparency and civic engagement.

Depending on its vision and underlying theories of change, SAcc mechanisms can be categorised around two ideological streams, each of which has a different perception of the role of the individual, and most importantly the vision of impact it is supposed to achieve (see table 1).



Table 1. Ideological background and vision of impact of SAcc initiatives

Ideological stream	Description	Perception of the individual	Vision of Impact
New Public Management	Has its origins in the economic theory of rational choice and methodological individualism	Form of accountability to 'service users as individual consumers who could choose to use these mechanisms or, alternatively, exit in favour of other providers'. Empower people as consumers through better information	Developmental outcomes case
Rights-based and direct democracy approaches	Emphasise collective demands for accountability and its 'public good' qualities, as well as the importance of coherence between the aim of promoting rights and democratic values, and the methods and approaches used for doing so	The person is a citizen who has a right to claim rights, able to seek redress in case of inaction from the government or violation of rights. This claim can be on an individual or collective level.	The Democratic outcomes case  The Empowerment case (when it is particularly targeted to changing the balance of power between citizens and the state but also within citizen groups)

Table made by author with information from Joshi (2011, 2012, 2013) in McGee and Kelbert (2012)



Due to the growing difficulty and complexity of the Social Accountability concept, a number of mechanisms and tools have been adopted with a view to achieve SAcc; some of these are: Community Scorecards; Citizen Report Cards; Social Audits; Public Expenditure and Budget Tracking. This report focuses on the Community Scorecards (CSC). The World Bank (2005) understands the CSC process as a community based monitoring tool that is a hybrid of the techniques of social audit and citizen report cards (CRC). These combine participatory tracking of service performance (i.e. 'input tracking'), service providers' self-evaluation, and community interface meetings, in which performance assessments are discussed and remedial action plans developed. In contrast to CRC, the CSC process uses the collective as its unit of analysis, and is focused on monitoring at the local/facility levels. It facilitates community monitoring and performance evaluation of services, projects and even government administrative units (like district assemblies). CSCs rely on the information generated by scoring and focus group discussions, while information for citizen report cards is gathered through surveys. CSCs rely heavily on the participation of community members in the assessment of service quality and performance and negotiating the findings with service providers (Babajanian 2014).

## The Mozambican context

In Mozambique, associational movements date from the colonial period with the incorporation of Organizações Democráticas de Massa (ODMs). However, the discussion on engagement and participation of civil society in development processes begins in the early 1990s during the political transition process, characterised by the adoption of the multiparty system and approval of the 1990 Multiparty Constitution and the legislation thereof, such as the Law on Associations (law 8/91 of 18 of July). It is important to consider that solidarity, mutual assistance and country reconstruction principles, (in the civil war and natural disasters context) are some values and principles that guide the actions of associations that emerged in Mozambique from the 1990s.

The emergence of civil society players in a political transition context triggered the need to establish and institutionalise public spaces with a view to promote discussion on structuring civil society, as well as discussion on themes that were excluded from the government agenda, such as those that are regarded as spaces of democratisation of public administration. From this time onwards, the focus on participation has been a matter of discussion and review due to the social dynamics and the need to move towards a governing process that is even more democratic, inclusive and that goes beyond electoral participation. In contrast to other neighbouring countries, it has been recognised that one of the most critical factors that leverages the participation of civil society in Mozambique is undoubtedly the existence of legal openness to the freedom of association, freedom of expression as well as freedom

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of participation of citizens and civil society in governance processes. The 1990 Constitution states the freedom of speech and association as the citizens' right, and it was defined as fundamental principles in the 2004 Constitution (COWI&ITAD 2012; SDC 2013).

In the context of political transition, in particular during the launch and implementation of the Public Sector Reform, civil society participation in governance processes gained momentum and relevance. It is at that point when a set of legal instruments were adopted; establishing the means and spaces for citizens' participation in the governing processes, from the central to the sub-national levels, in conformity with the principles of accountability and transparency in the management of public affairs and accountability. For instance, nr. 3 of article 3 of Law 08/2003, of May 19, advocates that under the operation of the State Local Bodies (OLEs), amongst other issues, these bodies, "... conform the principles of respect for the subjective rights and for the legitimate interests of those being administered; they ensure active participation of citizens, and encourage local initiative in addressing community issues...". No 1 of Article 100 of Decree 11/2005, of June 10, a legal instrument that regulates the Law 8/2003, states the following in relation to participation: "The State Local Bodies shall ensure the participation of citizens, local communities, associations and other forms of organisation whose objective is to advocate for their interests in making their own decisions." (MAP Consultoria 2011)

It is with the instruments above and within that environment that a scoping study of the Citizen Engagement Programme (CEP 2013) considers that a new means of participation of civil society emerges in Mozambique. This is characterised by the widening of the realm of action and intervention of civil society from a merely social sphere to a political sphere whereby participation in electoral processes, protests campaigns and complaints of bad public governance and management practices, and use of information technology to denounce corruption, production and dissemination of position documents are indicated as signs of this participation on governance processes. On the one hand, these examples reveal the interest of citizens to contribute towards the construction of the democratic system of the country. On the other, they indicate that civil society has started to use evidence to advocate and influence governance processes at the national and local levels. It is in the context of the civil society's growing interest and awareness of the importance of developing evidence-based mechanisms that Civil Society Organisations (CSOs) in Mozambique adopt the aforementioned mechanisms for SAcc. These have been mostly focused on the improvement of public services, in particular in the fields of health and education.

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The use of these tools for evidence collection has gained importance among the Mozambican CSOs with interventions in the field of SAcc. For CEP (2013), these kind of initiatives are promoted at large by international agencies within the scope of development aid, where strengthening the capacity of the CSOs to demand accountability, transparency and promotion of democratic values constitute the argument used by agencies for funding such programs. Hence, the availability of international cooperation funds, over the past five years, in addition to the changes in laws and regulations on citizen participation have laid the ground for a “boom” of SAcc interventions across the country. However, in Mozambique, a substantive body of literature or studies that show these interventions’ outcomes or longer term impact is still a work in progress.





## Learning from the implementation of the Community Scorecard by N'weti

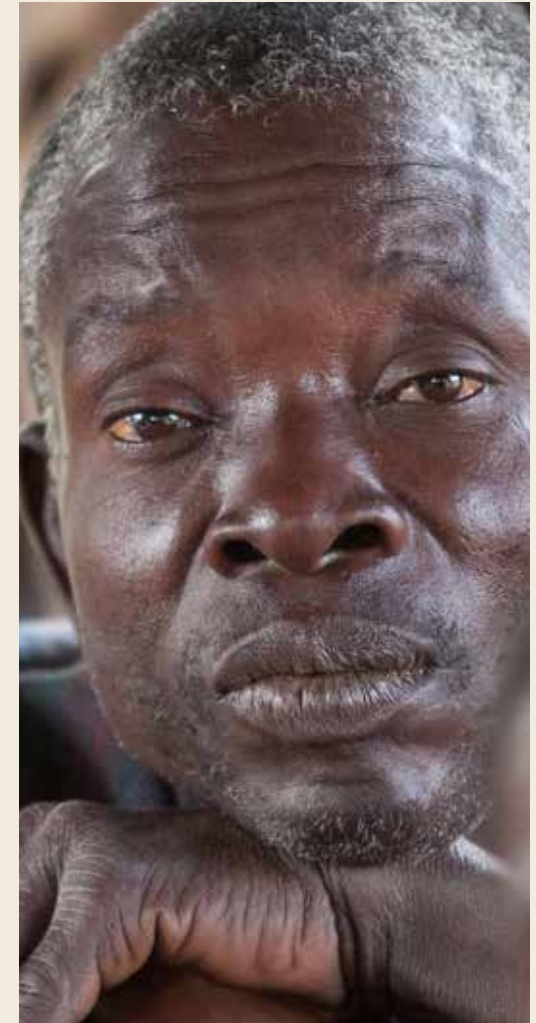
*We think this N'weti project is good because it helps the communities to voice their problems as well as improve the health care services in the health centre, which is good (Head Administrative Post, Namitoria)*

As stated in the section above, initiatives aimed at establishing social accountability in Mozambique have increased considerably in the past five years. The use of a mechanism such as the Community Scorecard (CSC) by N'weti lies in the fact that:

*N'weti believes that the desired change in services provision can also be achieved with increased demand for better services by citizens as a relevant contribution towards improved quality of services provided. It is acknowledged that citizen demand for better health services will not alone improve quality of services, but can contribute to this improvement (TOC N'weti 2014).*

Moreover, when interviewed, the Executive Director of the organisation recognised that CSCs are a mechanism used to generate changes in service provision at the unit-level but also have the potential to promote changes in the wider health structures through the aggregation of data:

*N'weti decided to specifically use scorecards to monitor the quality of the services provided by health units, to put upfront the priorities of the users, to monitor implementation of health policies at the local level, to influence the planning at the district level, and more recently we have also decided to use it as a tool to collect evidence for advocacy*



The following sections will explore how N'weti has approached citizen participation through adapting or adding stages to the CSC cycle, and how this has resulted in, on the one hand, remarkable results in relation to the improvement of health service delivery and citizen-authorities relationships. On the other hand, it has highlighted limitations to the autonomy of citizens to act to seek redress from inaction or wrongdoing from the service providers. The first section will describe N'weti's participation approach across the stages of the CSC cycle, while the following section will speak to the most relevant outcomes of the implementation in the districts of Nampula where the research took place. The last section will describe some issues which N'weti must remain cautious about at this moment in expanding the CSC to more health units and programmes.

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## Section 1. N'weti's CSC Cycle: shaping participation for making it more meaningful

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Generally speaking, mechanisms for SAcc have three broad components: information, citizen action (i.e. participation), and state response, which interact to derive in particular outcomes ranging from improved service delivery to citizen empowerment. Despite assumptions about the linear relationship of these three components, it has been proven that the way they relate is not straightforward (Joshi 2013: 27). The case of the CSC as a SAcc process is particular in the sense that citizen participation is not only one of the avenues for change nor an outcome, but a central component to the whole cycle. From the design of the indicators to be measured by the scorecard to developing the solutions (i.e. action plan) and making sure that authorities take action; the CSC model anticipates citizens to participate in all stages.

In this sense, whilst analysing the CSC process designed by N'weti, it was relevant to think about the way the organisation is approaching citizen participation throughout each of the eight stages. This approach determines the degree to which local citizens actively engage to attain better health service provision and the avenues opened up to them for holding local health authorities accountable in case of inaction or violation of citizens' rights. The CSC process designed by N'weti starts from a very broad participation base, which is reduced constantly (except at Stage 6 when it is broadened again) to minimum local citizen participation in the last stages of the cycle (Monitoring and Advocacy). Figure 2 represents how citizen participation increases or decreases across the 8 stages of the cycle and provides a description of each of these stages.

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In settings where there are many participatory initiatives, organisations need to be very strategic about whom they put forward as representatives and how much energy they are demanding from citizens (Cornwall 2008). N'weti sees the last stages of the CSC expanding beyond the local level, proving the need to use their political leverage as a national CSO in order to advocate for wider structural changes in order to address some of the most pressing problems. The ToC document states:

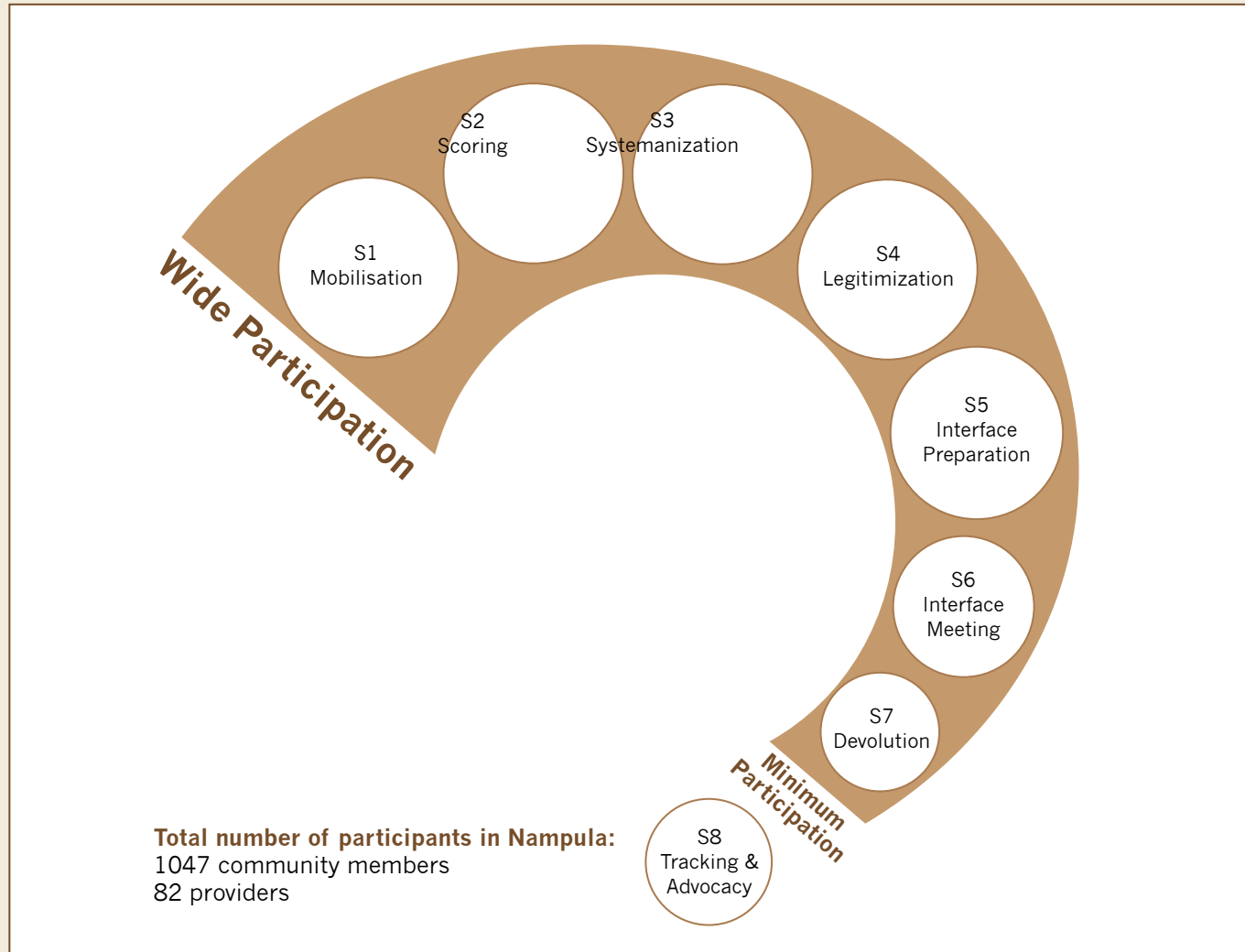
N'weti acknowledges that in the Mozambican context, the planning and policy making as well as implementation systems are highly centralized and top-down while the service delivery takes place at local level (health units). Therefore, N'weti plans to focus its activities on two levels of change:

1. Local level – empower women, men and youth, and civil society organisations to influence service provision in their respective districts and health facilities. This rests on the assumption that improvement of the capacity of the demand-side stakeholders, including civil society organisations and ordinary citizens in 5 districts of Nampula to demand and influence service delivery practices and district level planning, will stimulate the capacity of service providers and local authorities to provide justifications and improve their performance.
2. Provincial and National - influence health policies by systematising the evidence gathered at district level and bring it to the macro-level policy discussion. This rests on the assumption that bringing evidence from the field can reduce the disconnection between the development of policies and political discourse at national level and reality and practices at local level.



In settings where there are so many participatory initiatives, organisations need to be very strategic about whom they put forward as representatives and how much energy they are demanding from citizens (Cornwall 2008).

Figure 2: N'weti Community Scorecard 8 stage cycle and levels of citizen participation



Step of CSC Cycle	Description	Level of citizen participation
1. Mobilisation	Preliminary research and community mobilisation. Data collection on the health unit to be assessed is collected. Community groups that will voluntarily engage in the CSC are selected and trained.	Community-wide
2. Scoring	Based on a set of indicators defined by the community and other previously selected indicators, community and providers, in separate groups, assess the quality of the public health services.	Limited to voluntary citizen groups
3. Systematisation	The scores of different community groups are systematised in a single matrix. This is the main instrument containing the community assessment of the health service.	Minimum: carried out by N'weti staff
4. Legitimization of the single community matrix	The groups involved in scoring have access to the outcomes of their assessment, through the single community matrix which is validated in a meeting. In such meeting, community representatives for the interface are selected.	Limited to voluntary citizen groups
5. Interface preparation	Elected community members elected get prepared for this crucial moment in order to improve their understanding on the issues and concerns raised by the community, and strengthen their negotiations skills.	Elected representatives from the citizen groups
6. Interface meeting	Elected community members and the providers come together to revisit their scores, concerns and propose solutions. Consensus is reached on priority actions with local solution to be undertaken.	Elected representatives from the citizen groups
7. Institutionalisation and Devolution	In addition to pushing a health units to integrate the agreed actions into their annual plans, N'weti incorporated a public event where service providers and other relevant authorities sign a 'social contract' with the commitments derived from the interface meeting.	Community-wide
8. Tracking and Advocacy	The priority issues with local solution, comprised in the health unit annual plan, are monitored regularly by both the community and providers based on existing mechanisms of community participation in the management of the health unit. Priorities whose solution requires action beyond the scope of the health unit are scaled-up.	Minimum: carried out by N'weti staff and a few members of CCGs

Through analysing N'weti's most recent reports, reflections and interviews with relevant management staff, it is evident that the organisation strives towards a transformative approach to participation. The idea of *participation as empowerment* where the practical experience of being involved in considering options, making decisions, and taking collective action to fight injustice is in itself transformative. It leads on to greater consciousness of what makes and keeps people poor, and instills greater confidence in their ability to make a difference. If achieved, participation as empowerment alters the structures and institutions that lead to marginalisation and exclusion (White 1996). At the core of achieving transformative participation rests the recognition of people living in poverty and marginalisation that the construction and expression of their citizen identity starts by acknowledging that they *have the right to have rights* (Gaventa and Benequista 2011). The significance of working with marginalised citizens in rights awareness is recognised by N'weti:

Citizens, especially those infected and affected by HIV/AIDS, need to understand their rights and entitlements to continuously participate in such processes. They also need to be empowered by simple tools that allow them to establish evidence of whether these processes are improving over time in order to realise their needs and rights (TOC document)

Having that in mind, the organisation's strategy for fostering participation through the CSC process puts a strong emphasis on mobilising and raising awareness on citizens' rights and responsibilities at the community-level. As further explored on the following section, for citizens this is one of the most positive outcomes of the process; expressing that increased awareness of their rights has made a change in the personal and community dynamics.

*The majority of us did not know that we had rights and responsibilities. We learned about such rights during the implementation of CSC. We did not know how to solve problems, all we knew was to refer issues to the government. Today, we participate in identifying problems (Old man - Corrane)*

*We know some health rights and responsibilities, namely: when someone is sick, he/she has the right to go to hospital, be assisted as a person and receive medicine. As a citizen, I have the right to have a diagnosis; to receive medication and get an explanation on how to administer it (Young man - Namitoria)*

However, in practice, even the most open-ended of participatory exercises will involve only a fraction of potential participants. Once the Mobilisation stage is completed, the following stages of the CSC process see a decrease on the numbers of community members participating. This fact is not necessarily wrong, citizen participation cannot only mean large numbers attending meetings, responding to consultations or ticking boxes. Much depends on who participates, what they participate in and what effect their engagement actually has on the outcomes of decisions, policies or programmes (Cornwall 2008).

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As seen through the FGD, having a smaller group of people in some of the stages actually improves the quality of participation because those involved are more confident and prepared to speak to their service providers.

For the data collection, volunteers interested on joining the CSC exercise were selected across the different localities<sup>2</sup> following parameters of inclusion and representation of the diverse sectors of the population. Unfortunately, vulnerable groups participated in a limited way, either because they were not intentionally considered at the time of Mobilisation (for example, children) or due to limitations in their identification and reach (people with disabilities or suffering chronic illnesses).

Approximately 12-14 people divided across 8 citizen groups and 1 group of service providers per health centre participate in Stage 2 - Scoring. Once this is done, the facilitators then systematise the data coming from each of these groups into a unique matrix of results (Stage 3) which summarises the most important problems for that health unit and the groups' ideas on how to solve them. During the first round of implementation, this stage was carried out only by N'weti staff and facilitators coming from Community Based Organisations (CBOs). Upon reflection, it has been acknowledged that, in the future, at least one member of the community must participate in synthesising this matrix - despite the fact that the facilitators and supervisors come from the communities. Stage 4: Legitimation: This process sees all the people involved in the data collection approving the unique matrix of results. Interestingly, the research showed that overall people are pleased with the priorities identified and only two persons expressed reservations about the process:

*It's a good practice because we now see that communities share the same type of problems, and this helps in legitimising them (Old man Corrane)*

Once the priorities are agreed on, 8 community members from each of the 8 groups are selected to represent the community in the interface meeting with the health service providers (Stage 6), alongside the local leadership and members of the health unit co-management committees (CCGs). Overall, participants in this research felt that this selection process was transparent, that it was good that community members - and not only the local leaders - came to the interface meeting, and some suggested that more people should join. Moreover, those who participated in this dialogue with authorities felt that the preparatory session (Stage 5) gave them an opportunity to develop skills for negotiation with those more powerful, and becoming more confident to speak.

*This early preparation is crucial because as community members we can now lobby for processes, and there's a need to build our capacity for these meetings (Old man Corrane)*

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2. For this study, the term 'locality' is used as an overarching term to encompass the smaller unit of organisation in Mozambique: bairros and localidades

*Training is both indispensable and good because it helps breaking the ice and people become more firm (Member CCG-Corrane)*

Despite the numbers of participants decreasing, the quality of the interaction between citizens and service providers becomes more meaningful because time was taken for developing skills for negotiation. Moreover, after the pilots in the South, N'weti recognised the need for bringing not only health sector authorities, but also other stakeholders into the process. The participation of other powerholders from different sectors is key, as solutions to most problems have various underlying causes and cannot be solved solely by health authorities. This decision was an outcome of the action-reflection-planning-action approach which N'weti has taken to the implementation of the CSC:

*Some of the problems go beyond the users and service providers. For example, if there is an issue with lack of water it is not on the health authority domain to address it but on the Obras Publicas side (Nampula manager-Nweti)*

As will be explored in more detail in Section 2, having a well facilitated space for dialogue was identified by citizens as crucial for raising the identified problems with the relevant authorities; a space to be heard:

*In the meeting where both the providers and the community come together, the community brought its concerns, and there was a discussion aiming at finding a joint solution for the poor service delivery issues. Although I did not participate, I find it a good moment where both the community and the providers meet to resolve the community problems (Young man - Anchilo)*

*Because during the scoring I was not sure that I would be able to talk to the providers. It is a moment in which I understood and felt that we have the right to complain and discuss problems with the providers (Adult – Namitoria)*

Bringing citizens and service providers into a dialogue for reaching an action plan is central to the CSC process; as it will be seen in section 2.2 below, participants showed substantial appreciation for this space. Hence, preparing people to participate meaningfully is crucial as in many cases it has been seen that citizen participation can lead to frustration, and occasionally reprisal (Gaventa and Barret 2010). Despite initial reservations, authorities valued the possibility of listening to citizens' demands:



*In the first phase, when the CSC began, we were even afraid because it was the first time that the community would say something about our services, and as you are well aware, nobody likes to be assessed by the users of their services. But after implementing the CSC, we understood that this is a positive exercise because it helps us identify some community issues, since as health providers, sometimes we do not reach out all the communities to listen to their concerns (Director of health unit – Namitoria)*

As explored in more detail on Section 3.4, histories of citizen-state engagement in Nampula province have been determinant for this relatively open attitude from authorities. Moreover, N'weti's relationship with service providers and other authorities, over the past six years, has allowed for opening avenues for better understanding and minimise risks of defensive attitudes or reprisal:

*(...) people were not sure that coming to the meeting would make a change and they also thought that they could be later on mistreated by the providers. Looking for a solution, we realised that we hadn't conveyed the importance of the process. So, we clarified the importance of the process for the community and for the providers because they also had to understand that this was going to be on their benefit (Nweti manager - Nampula)*

In Nampula, N'weti innovated by adding a stage 7 in which results of the interface meeting are communicated to the wider community through a public event where key authorities signed a 'social contract' committing to undertake the actions agreed. People in the FGD all agree that this event is a good idea and that it allows service providers to come face to face with communities to acknowledge the problems faced at the health unit. Under Arnstein's (1969) categorization, participation at this stage is merely informative<sup>3</sup>, but key for surfacing the issues and sharing the action plan with those community members not involved in the CSC process:

*(...) it is important and beautiful, because as a community, we are sure that this is now a commitment; now, when there is no signature, and the communities do not know, they will be in doubt. Between secret and public issues, we prefer the public ones (Adult participant - Anchilo)*

The FGDs showed that once the devolution of results happens, people disengage from the CSC process. It was unclear for all the participants what were the next steps and who had the responsibility of making sure that the authorities acted upon their commitments. Moreover, none of the participants had knowledge about advocacy processes, nor the avenues for citizen participation in the health planning processes. An interesting finding is that people do not mind being left out of the monitoring process; changes are visible and happened quickly, as this participant recognised:

N'weti innovated by adding a stage 7 in which results of the interface meeting are communicated to the wider community through a public event where key authorities signed a 'social contract' committing to undertake the actions agreed.

3. According to the Ladder of Citizen Participation (Arnstein 1969) rung 3 corresponds to participation as being 'informative'. As such, citizens are able to hear (and in some cases of being heard) but they lack power to ensure that their views will be translated in to actions by the powerful.

*No, we do not know what happens afterwards... but we can see change now (Old man Namitoria)*

Moreover, another participant recognised that it was N'weti's supervisors' perseverance on following through the agreed actions with authorities, which brought on change:

*(...) the providers are afraid of the Lion who is "roaring". So when the project ends, could you kindly bring another person? It is going to be difficult to choose someone from the community, because the community are not used to exposing problems. If N'weti's supervisor is around, the community gains confidence. (Adult - Corrane)*

Analysing the way that participation happens across N'weti's CSC cycle, allows us to see that the dynamics generated within these communities in Nampula have allowed for the achievement of significant outcomes across the two broad objectives of the process. On the one hand, problems related to quality of health service provision at the local level are being addressed and the communities are pleased to see that these speak to their priorities; a degree of accountability from the local service providers is happening. On the other, there are limitations to the CSC mechanism which surface as N'weti takes the responsibility of ensuring change happens. It has proved challenging to foster direct leadership of common citizens, rather than NGO staff members, on the institutionalisation, tracking of commitments and advocacy stages. This, amongst other limitations, is explored on Section 3.

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## Section 2. Outcomes of CSC implementation

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During the last few years, there have been several attempts to assess the impact of social accountability initiatives in the context of various outcomes including service delivery, aid transparency, governance and extractive industries, budgets and freedom of information (O'Neil et al. 2007; Rocha Menocal and Sharma 2008; Gaventa and Barrett 2010; McGee and Gaventa 2010; Joshi 2013; Fox 2014). However, Joshi notes that most studies have looked at immediate outcomes such as visible improvements in public services. Yet implicit expectations of long-term outcomes are many and range from those focused on social actors (empowerment, social cohesion, transforming social norms), to those focused on state operations (reduced corruption, responsive officials, better policy design, good governance) to those that improve the spaces and channels where social groups interact with the state (councils, public hearings, etc.). N'weti set two key objectives when starting the implementation of the CSC:



**Objective 1:** Addressing problems related to quality of health service provision at the local level

**Objective 2:** Accountability of service providers and local health authorities

This case study is not by any means an impact study. However, the research shows that N'weti is advancing in both objectives in Anchilo, Namitoria and Corrane. Moreover, N'weti has kept a record of these changes in each of the health units across the five districts in Nampula where the process was undertaken and, through the research, citizens and service providers recognised the improvements achieved in health service provision at their units after this first round of implementation of the CSC. The most significant changes have happened on issues related to: quality of the treatment received, the disappearance of illicit costs related to maternal health services and medicine provision, improved attendance and punctuality of staff from health units, availability of medicines, and sexual and reproductive health facilities.

*From the mobilisation, it was explained that this activity aimed at improving health work, so I participated and I can now see change (Young person Corrane)*

*And we can see change in how we are being treated; there are always medicines at the pharmacy, and we have heard that some people got arrested by the police due to selling medicines illegally (Head of Adm. Post Namitoria)*

In the particular case of these districts, change has happened swiftly, a situation that has translated into people being motivated and grateful to the process and to N'weti as catalyser. Changes in health units are so visible and tangible, that there are calls for extending the CSC mechanism to a tool for monitoring other aspects and widen the meaning of 'accountability':

*We have now been asked to use CSC to hold community leaders accountable for taking care of orphaned and vulnerable children (...) use the mechanism to monitor community actions and not only public servants; this might aide to effect more profound changes, such as social norms that perpetuate discrimination (Director N'weti)*

Most studies on mechanisms for SAcc do not examine a longer trajectory of citizen–state relationships or civil society networks that underpin those specific initiatives, neither do they examine the influence of activities outside the narrow scope of the initiative (whether citizen or state-led) that can influence outcomes. Partly, the reason for this is that a large proportion of social accountability experience that is reported in the literature has been externally driven and is circumscribed by specific project cycles (Joshi and Houtzager 2012: 154). Hence, across this section, changes beyond those happening



at the operational level of the health unit will be analysed as an attempt to elicit some light into those dynamics that could be capitalised on in order to achieve longer-term outcomes. These refer to: awareness of health as a right rather than a service; improved relationship between citizens and health providers; citizens' voices heard by the authorities; revitalisation of CCGs; and N'weti as a catalyser and mediator of the CSC process.

## 2.1 Awareness of health provision as a right and not only a service

*(...) when I participated in the scoring process,  
I became aware of our rights and responsibilities.  
We already know that the moon shed light (CCG-Corrane)*

Looking at a variety of examples of SAcc initiatives during the last five to ten years, experts have found numerous cases of so-called 'widgets' (Joshi and Houtzager 2012), referring to those initiatives that have a structured, institutional form – often driven by external actors. These can also be seen as 'tactical' SAcc approaches as they are bounded interventions (also referred to as tools), frequently limited to efforts to project citizen voice (Fox 2014). These type of mechanisms would be categorised under the New Public Management ideological stream (see Table 1, p. 3) and pose limitations for reaching the transformational objectives of the rights-based and direct democracy approaches to SAcc (Avritzer 2002; Fox 2007; Fung and Wright 2003; Gaventa 2006).

The CSC can run the risk of remaining only as a widget, as a tactical way of searching SAcc (Fox 2014). An example of this is CARE's four-country study on the use of the CSC, in which none of the key findings relate to people's recognition of their rights and responsibilities as citizens. It was only in Rwanda, out of four countries, where women credited the CSC process and the training surrounding it with empowering them to successfully bring these issues into the open, to challenge their husbands and to assert the rights they were previously unaware of (Wild et.al. 2015). However, the transformational potential of CSCs and other widgets can be achieved by setting objectives which emphasise collective demands for accountability as a 'public good' in itself and designing coherent processes (i.e. methods and approaches) for promoting rights and democratic values (Ackerman 2004).

This study in Nampula showed that one of the most relevant outcomes that people expressed through the FGD and interviews is the realisation of every citizen's right to access quality health services. Both, young and adult participants in this research acknowledge how the CSC process allowed them to better understand and act upon their rights and responsibilities. The diverse stages of the CSC can foster rights to be not only 'understood' but also exercised by citizens speaking up:



*Before CSC, we did not know that we had rights and responsibilities around our health. And we didn't even know that we had the right to demand certain things. Before CSC, we were asked about health issues and we could not say anything, but now we no longer are afraid of going to the health centre and talk about our rights and responsibilities. Before CSC we would not speak for fear of reprisals (Young man - Anchilo)*

Moreover, most of the participants, were very specific on providing meaning to what these rights look like in practical terms regarding good quality health provision:

*My rights are to go to hospital and be given the results and the analysis/to go to the pharmacy and receive drugs and be told how to administer them; and I have the responsibility to comply with the prescribed medication... (Man-Anchilo)*

*I must be assisted, and if I have to be admitted into hospital, I have the right to have a bed, and the responsibility to keep the hospital clean (Woman - Anchilo)*

The comments below from participants across the three research sites show that a change was also reached regarding the position of the people towards the health provision. They recognised their responsibilities as co-owners of the health unit; the need for them to undertake reasonable tasks:

*(...) with the CSC process, the community became aware that a Health Unit belongs to the community and not the technicians (Member CCG-Namitoria)*

*The practices shared by N'weti team helped us to understand our rights and responsibilities in relation to health services because we were not aware of them, but we are now (Young man - Corrane)*

*We have the responsibility to respect the technicians and comply with all the norms in the health centre. We have the right to be well assisted, to have technical medical assistance. One of the responsibilities of a patient is when he/she takes somebody to hospital, the companion has the responsibility to help the technicians with the cleaning, as well as to inform the technician on the health status of the patient/relative (Boy - Anchilo)*

Amidst these positive remarks, two elements could be further explored by N'weti. The first one relates to sexual and reproductive rights (SRH) awareness amongst young people; several participants in the FGD were confused around the accessibility of these services. When asked if they knew about SRH, this was the answer:

Moreover, most of the participants, were very specific on providing meaning to what these rights look like in practical terms regarding good quality health provision...

*More or less: because we no longer pay now. A number of people have left and now no one pays for delivering a baby. But for you to have access to the baby's monitoring card, the service agents/midwives charge 50 meticaís. When you give birth outside the maternity, there are technicians who do not believe that we were on the way to hospital when the delivery took place, and end up charging us 50 meticaís for the baby's card (Anchilo)*

*(...) because they were not aware of that before, but after the implementation of the CSC, it was brought to our knowledge that sexual and reproductive health services must be provided in all the health centres free of charge (Young person-Namitoria)*

*(...) we don't know. We feel ourselves young, but we want to do it. They say it is for free now, but we are still reluctant. That's why we say "no" because we do not know (Young person-Anchilo)*

The second one relates to the fact that not all the population across these localities seem to have the same level of rights awareness as those who have engaged in the whole CSC process:

*Only a few community members participate in community meetings, therefore, they know little about their rights and responsibilities (Young man-Namitoria)*

*Some do know, but others don't because we can see that from the users' attitudes and behaviours at health units (Young man-Corrane)*

Further explored in Section 3, as one of the limitations of the CSC process, there is the fact that rights awareness is a process that requires time investment and strategies for sustaining it over time to reach the vast majority of the population:

*However, we must increase the dissemination of information on CSC process, because it takes long for people to engage in mobilisation, as well as to participate in local development processes and engagement with providers (CCG-Corrane)*

If rights-awareness is an on-going, long-term endeavour, perhaps attributing this outcome only to the CSC process is not precise as these communities were previously engaged with Community Dialogues implemented by N'weti. In these 9 community dialogue sessions, community members were exposed to 18 hours of learning and discussion of issues related to health rights, entitlements and responsibilities, concepts of participation, engagement and accountability and their applicability. It was from these wider groups that community representatives and volunteers went later on to form the groups involved in the CSC process. Hence, it could be the case that the participants viewed the dialogues as part of the



CSC cycle. This is something to capitalise on: in contrast to tactical approaches, strategic approaches to SAcc take the sum of actions and context to generate synergy (Fox 2014, see Box 2), a result beyond the sum of the parts (this is further explored in section 3.4).

## 2.2 Improved relationship between citizens and health providers

*And before CSC, the health centre problems were resolved unilaterally by the Health Unit (CCG-Namitoria)*

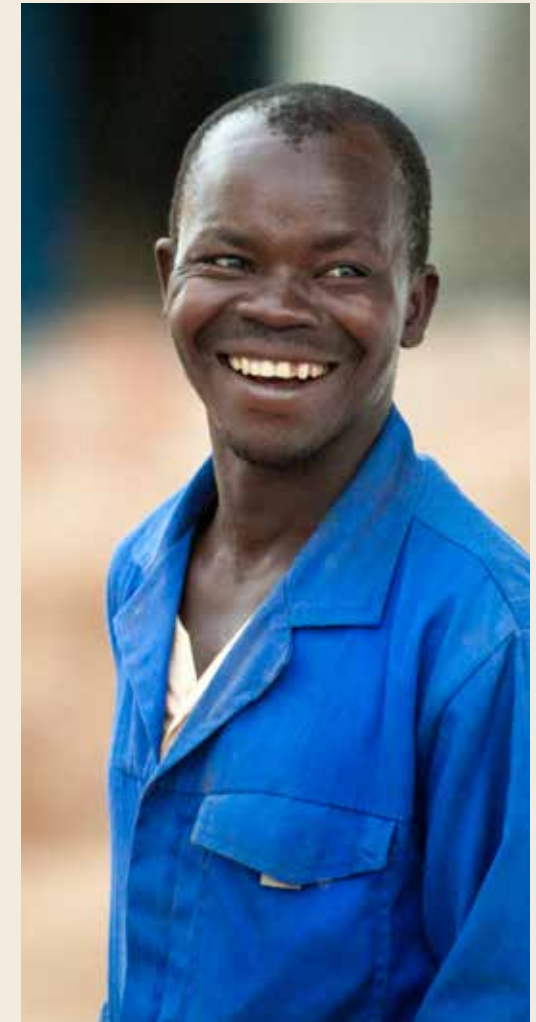
Guaranteeing the universal availability of health services is one of the least contested development objectives for governments. However, availability does not mean quality and often not even access. Research from eighteen organisations working with poor and marginalised groups across 29 countries showed deep concerns about the quality of services available to the poorest. Even where there is access to services, if the quality is poor or inappropriate, it does not constitute real access (Burns et.al. 2013). For example, participants in Ghana regretted the decline in training of traditional birth assistants. People's perception was that good quality traditional practices had been taken away and replaced with services that were of poor quality and inappropriate.

Particularly, in delivering on rights to health and health care, health systems need to overcome the many ways communities are marginalised from care. This is due to various barriers of availability, relevance, accessibility and acceptability as well as the way people *experience the system* when they use it (Loweden et.al. 2014). Hence, quality of the service provision has become as important as the availability of the service. Participants in the research acknowledge how common harsh treatment was in the health units monitored:

*Indeed there were so many changes. In the past, when going to the health centre, we were disregarded. But after participating in the CSC, we see many changes starting from respect (Old man-Corrane)*

*When people got sick, they were seen as strange, the technicians would not show politeness. They would get very angry, rather than helping. The technicians would come early, but consultation would begin late. There was a severe lack of hygiene, but today that is no longer an issue. The community take part in the cleaning (Young man-Namitoria)*

*(...) Technician Mazive is now a different person. Despite the fact that he does not speak Macua, he now says "if you cannot speak Portuguese, you may speak Macua". (Old man-Anchilo)*



Programmes set in place for accountability of the health sector must highlight the importance of achieving changes in the *quality* of the service provision. Through the different moments of engagement and dialogue across the implementation of the CSC, it was possible to see a positive change in the treatment received by citizens from the service providers at their health units. Participants said:

*They now take notes of us because they have realised that, as a community, we are now able to talk about our problems. (Young woman - Anchilo)*

*There's change of behaviour when it comes to the technicians. Before, they were not polite, but today they now assist us with love and kindness, and they listen to our problems (Young man - Corrane)*

*These changes have come as an unexpected positive surprise for the people; as it was a situation they had not experienced before: When we talk, they understand our concerns. Before, the nurse Mazive used to mistreat people. No one ever thought that the head nurse would change (Man - Anchilo)*

The relationship between citizens and those providing the service is a determinant factor for people to decide if they will be attending the health centre rather than visiting a local healer who is a member of the community who has gained their trust. Achieving a meaningful change in the relationship between citizens and authorities is key for SAcc initiatives to have a more transformative potential (Fox 2014); where the latter are recognised by citizens as providing a service to the population, rather than having total power over the resources and decision making. A male participant eloquently said:

*The CSC opens up our vision, many of the things we were not aware of, we now know them. We used to believe that the Hospital belonged to the government and that the staff were from the government. With CSC we got to realise that hospital belonged to us and that the technicians were people to serve us (Old man - Corrane)*

*Moreover, the common sense of fear, apathy or unfamiliarity between citizens and authorities is changing to one of better understanding and empathy generated through facilitated dialogue, which fosters understanding: I am very grateful because this project has led us to find answers to our concerns. Now there is understanding between the community and providers. And we now know who is a doctor and who is a head nurse (Old man - Anchilo)*

The CSC process has been described as taking a more trusting, collaborative, and dialogic approach to resolving issues of poor services provision through collective deliberation and joint problem solving; the result is a promotion of new channels that attempt to fill the democratic deficit which characterises traditional party politics / electoral processes, by linking citizens directly with authorities (Fung and



Wright 2003). This was evidenced through the FGD in Nampula where research participants expressed a better understanding of the challenges that service providers have in delivering adequate health services. Citizens recognised that often there are issues out of the control of the health unit to solve:

*As a community, they understood that the technicians were few. Even if the community attends the health unit for the service, the technicians able to provide such services are few (...) after the CSC, technicians became more considerate, but not at the desired level because there are not enough of them. Even if they want to be good, it is difficult (Young man-Namitoria)*

*Despite the previous behaviour, CSC made us understand that the technicians are faced with problems (...) sometimes they do not have water (Old man-Corrane)*

*(...) in fact, the technicians have been facing problems, but after CSC we now see technicians assisting patients with serious illness, and we see that they put a lot of effort (...) from the time we denounced illegal charges, we understand that they have been aiming to assist the community (Young man-Anchilo)*

Joshi (2014) acknowledges that this is an important element of social accountability: to give governments opportunities to remedy the situation when suitably informed or provide credible explanations of why the standards cannot be met. The interview with the Director of the health centre in Corrane (Box 1) showed how this direct contact and deliberation about the problems confronted allowed him to better understand citizens' concerns and take action to address them.

The interface meeting is the space where this dialogue takes place across the CSC cycle; both citizens and authorities expressed this as a crucial moment for generating this shift on the way they had been relating to each other previously as expressed by the Chief of Admin Post in Corrane:

*I also participated in the meeting where the community and the technicians came together to discuss the problems (interface). This was a very good moment because it was there where everything began to change, and the technicians started assisting the patients accordingly. In particular, for local authorities it was a space for explaining the reasons behind some of their actions/ inaction: (...) the communities were not aware that before the work begins, the technicians have to meet and talk about the previous day's occurrences as well as make plan for the following day. But we do acknowledge that we did not inform the community (Director of health unit – Corrane)*

After the first implementation of the CSC process, some service providers even mentioned that it was a good idea to also involve more people during the signature of the social contract. Moreover, the interface meeting made visible the fact that service providers' concerns and requests for improving the health provision frequently are similar to those expressed by citizens:

Joshi (2014) acknowledges that this is an important element of social accountability: to give governments opportunities to remedy the situation when suitably informed or provide credible explanations of why the standards cannot be met.

*In the first phase, when the CSC began, we were even afraid because it was the first time that the community would say something about our services, and as you are well aware, nobody likes to be assessed by the users of their services. But after implementing the CSC, we understood that this is a positive exercise because it helps us identify problems, since as health providers we are not able to reach out to all communities to listen to their concerns (Director of a health unit - Namitoria)*

*In the first CSC, the community said that it would be useful to have a laboratory technician at the health unit. An issue that we, as health centre, had already requested from the district last year. We have already received a laboratory technician, but he is not operating yet because they are still finalising assembling the laboratory equipment (Head of Post - Corrane)*

### **Director of Health Unit in Corrane: Example of behaviour change from a service provider**

Through the interviews with key staff from the health units and other authorities, some insights were noted regarding behaviour change. Of particular relevance were the statements provided by the Director of the Health Unit in Corrane whose words show an understanding of his responsibility and the duty of care he has towards the citizens he serves:

*I believe that the CSC helped us a lot, and now I find myself a manager who not only solve people's diseases, but also those of the health unit in order to improve the services*

He took action to address the issue of illegal drug sales surfaced by the CSC process: Personally, as the head of the health unit, what I did to now was to talk to my colleagues, telling them that if someone is involved in drug sales they'd better stop doing so because it may prejudice them. Once again, I did not accuse anyone. I simply convened a meeting with my colleagues to encourage them to leave this practice, because whoever will be find doing it is going to have a disciplinary process.

Also, made sure that the free availability of health care was known to all the patients: In addition to talking to all the colleagues, I also put a list of those services that are free of charge on all the health centre doors.

As well, he has bridged links with other relevant health authorities in his route to problem solving: What I did as the head of the health centre was to refer the issue to the district, but we still await solution (DIR-CRN)

And has recognised that sustained changes in health provision are dependent on all staff in the health unit and cannot be dependent on him: In this second CSC, everyone do take part. Also it was my colleagues who talked in the interface, I was just a listener.



Accountability is about creating a culture of responsibility, in which citizens and duty holders are aware of their rights and responsibilities, and seek to respond accordingly. If one views social accountability as part of a longer political process of citizen engagement with the state, it is worth looking at the challenges of conducting truly inclusive and meaningful deliberative processes where citizens who live in poverty and marginalisation are able to raise their voices and not only select choices available to them (Burns et.al. 2015). It is also crucial to take into account the histories of prior engagement which will shape expectations of stakeholders; expectations that will be constantly changing over time (Joshi 2014).

### 2.3 Citizens' voices heard by the authorities

'Voice' is commonly understood as a mechanism through which people or groups express their preferences or opinions (Goetz and Gaventa 2001). Many endeavours of citizen engagement start from the premise of providing people (often marginalised groups) a real or symbolic space to raise their 'voice'. This understanding harbours two problematic assumptions: first, that there is an actor (often the State) that is able to hear, listen to and respond to those preferences and opinions; and 2) that people or groups are willing and able to articulate their preferences and opinions in a way that can be heard (Oswald 2014). There is also an issue that participation programmes can generate pressure for building collective aims and positions through consensus, a process which can favour the priorities of those more outspoken groups and leave behind the ones of minorities (Orone and Pottier 1995).

Interestingly, the research in Nampula showed that, at least amongst those people involved in the CSC process, 'collectivising' demands was not a problem. A participant in Corrane, said that despite the communal *ethos* of the CSC process there was space for raising individual concerns through the different spaces for dialogue: *The program came in a community fashion, but it enabled people to express themselves individually (the right to participation). And the program shall not stop now because if that happens, all our problems will come back. And the health unit will bring back its problems.*

As mentioned in Section 1, N'weti innovated in the CSC cycle and set up a concrete stage for the different groups participating in the collection of data to discuss and reach a unique set of priorities. During the validation of this matrix, citizens realised that problems are common across different localities and as such they understood how it makes sense for them to unite as a common voice for addressing them; youth expressed:

As mentioned in Section 1, N'weti innovated in the CSC cycle and set up a concrete stage for the different groups participating in the collection of data to discuss and reach a unique set of priorities. During the validation of this matrix, citizens realised that problems are common across different localities and as such they understood how it makes sense for them to unite as a common voice for addressing them...

*(...) what encouraged us the most is the fact that the majority of the community identified the same problems, and we had the opportunity to verify the scored matrixes per group/the majority of the community problems were the same when it came to health services (Young man - Anchilo)*

*There was a lot of interaction with other groups from other communities/townships, and this ended up improving the participants' level of knowledge and for all jointly (Youth - Corrane)*

The generation of a united 'voice' was perceived as more powerful than making individual claims:

*(...) a single matrix is good because it will facilitate bringing in all the community problems. If every community group presented its own matrix, it would create confusion and we would fail to explain the issue to the health centre service providers (Young man-Corrane)*

Furthermore, the public signature of a social contract in Stage 7, seems to be generating the perception, perhaps still symbolic, that authorities are making a public commitment towards the citizens they serve. It seems, that this social contract is addressing the concern about collective 'voice' often not being heard by authorities or being heard only in a tokenistic manner:

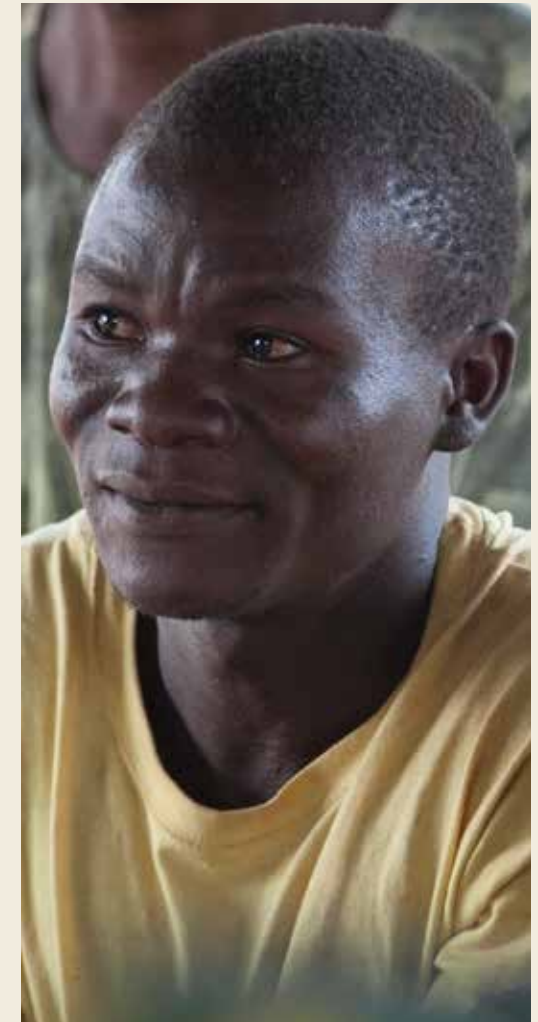
*It is important because it does not make sense if we do not sign it, and in the absence of a signature, it becomes a simple paper. We must sign it because it shows commitment/the community per se feels more honoured when seeing a signature (Old man-Anchilo)*

*During the signature of the social contract... because both the Anchilo community as well as the technicians would undertake to abide by the agreed issues. Thus, everyone would know what was agreed during the Interface meeting (Young man - Anchilo)*

It might be a symbolic action, but the reality is that authorities have responded and, as previously mentioned, small but significant behaviour change has taken place by responding to citizens' demands and 'people's voice'. The director of the health centre in Namitoria mentioned:

*People also claim that it takes long for them to be assisted. What we did was to bring down the time of meetings in the morning, and the technicians, whenever they are absent in their room, inform their colleague about where they are going, and whether or not they will take long, so that the latter may inform the patients who are in the queue to receive some service.*

Whilst citizens express:



*(...) They are thankful because the health centre directorate welcomed the community request, and at some point, they requested that the technician who was impolite to them be transferred, and the health unit directorate granted this community request (Old man-Namitoria)*

*(Regarding) the impolite technician... The Co-management Members contributed to his transfer. The program contributed a great deal towards behaviour and attitude change, as well as openness in listening to the people's voice (CCG-Namitoria)*

After this first round of implementation, there seems to be a good number of citizens' voices being heard. Going forwards, it is important to be vigilant about those voices which are being left out of that 'collective voice' generated to the scorecard process. It is important to reach out to those groups who have not been participating. These and other dynamics of exclusion are further explored in section 3.2.

## 2.4 Improved relationship with Co-management committees (CCG)

The Mozambique law has developed a comprehensive model for citizen participation across different sectors. In particular, through the Health Promotion Strategy (*Estratégia de Promoção de Saúde*); the Community Involvement Strategy (*a Estratégia de Envolvimento Comunitário*); the National Strategy for Health Quality Improvement and Humanization (*a Estratégia Nacional para a Melhoria da Qualidade e Humanização dos Cuidados de Saúde (2011-2014)*); and the Family Planning and Contraception Strategy (*Estratégia de Planeamento Familiar e Contraceção (2010-2015/2020) (CEP 2013)*), the Ministry of Health welcomes people and civil society organizations to participate in improving the health service provision. The Co-management Committees (CCGs), created in 2012, are the spaces set up by the Mozambican government to open spaces for citizen participation at the health unit level. The CCGs are an *invited space*; a meeting place where those who deliver services can interact with those who represent the users of those services, or actual users.

Relatively similar institutional structures exist in vastly different socio-cultural and political contexts. So, the same institutional design can have very different effects in different parts (Cornwall 2008). In Mozambique, it has been recognised that these institutionalised participation structures have not worked effectively, despite their appropriate design:



The existing participation forums (co-management committee meetings, school councils) allow for consultation and communication on the government activities, but they do not yet serve as accountability mechanisms. In many contexts, it is understood that there is lack of tolerance in relation to opposite opinion, and the perception that disagreement may be regarded as being “political opposition”, with implications in a potential retaliation (DFID 2012)

However, one of the characteristics of these invited spaces is that opportunities exist for changing the rules, introducing new procedures, strengthening capacity through training, coordination with other actors, etc. In that regard, invited spaces can be not only spaces for change but *spaces that can be changed* (Cornwall 2008). Speaking with members of these groups through this research showed certain changes related to the implementation of the CSC process:

*The Committee was already in place, but before CSC there was no link with the members and the Co-management Committee. But today, they feel that there is a link. And the CSC project helped revitalise the committees as a link between communities and health unit (CCG Member - Namitoria)*

Participating in the CSC brought dynamism to the CCGs. The initial training provided by N'weti refreshed the knowledge around the roles and responsibilities that these committees should have towards the citizens they represent with authorities, but also with other formal citizen participation structures: *“The Co-management Committee was regarded as the one that was responsible for cleaning outside. Having influence inside was impossible: But they do so nowadays” (CCG-Corrane)*

Moreover, the fact that members of the CCG were integrated from the Mobilisation to the Devolution stage, has restored the validity of these groups as entities which have the mandate of jointly managing the health units with the health providers and directors. As such, there seems to be a shift in the recognition from both the authorities and citizens of the role that the committees should have and exercise within the health service provision

*Before N'weti's CSC, the Co-management Committee only had power at community level, but today they are now heard by the providers, because when they report their issues to the health unit they are solved, and now they have legitimacy because they give good feedback to the community (CCG - Namitoria)*

*In fact, before the CSC the technicians would not mingle with the Co-management Committees, but today problems and solutions are discussed jointly. All this linking and openness is thanks to the interface meetings (CCG - Namitoria)*

However, one of the characteristics of these invited spaces is that opportunities exist for changing the rules, introducing new procedures, strengthening capacity via training, coordination with other actors, etc. In that regard, invited spaces can be not only spaces for change but spaces that can be changed (Cornwall 2008).

An illustrative situation of this was the participation of the CCG in Corrane and Namitoria regarding the verification of medicine kits. During the interviews, this was said:

Because of the report on lack of drugs and their sale on the streets, we have now involved the co-management committee in the opening of drugs kits when we receive them. This joint opening helps us make the community understand which drugs we have and which we do not have, because if a technician prescribes drugs that we do not have at the pharmacy, the community then knows that they do not exist. (Director of health unit - Namitoria)

Members of the CCG in Corrane recognised that it is already evident how they are resuming their responsibilities, ranging from problem identification to involvement in the budget planning process for the health unit: (...) *"the health unit started acknowledging the CCG group, and we identify the problems now; we report what is not good; we participate in the opening of drugs kits, and for the first time this year, the health invited us to participate in the health unit planning and budgeting process"*.

The dynamism brought to the CCGs in Anchilo, Namitoria and Corrane is a positive outcome of the CSC process. But, the fact that a significant body of critical literature on the nature of participation in health systems clarifies that participation without redistribution of power, while often practised, is a hollow and ritualistic process (Loewenson et al. 2014) must not be overlooked. Hence, it is important for organisations working across invited spaces to think what combination of design characteristics, legislation and other factors, lend such institutions the possibility of realising their democratic potential (Cornwall 2008).

## 2.5 N'weti as an effective catalyser and mediator of the CSC process

The question of who participates – and in whose name – has been a growing preoccupation of participatory governance and development. As new spaces of participation have opened up, new representatives have entered the scene; bringing with them particular practices of participation. The research showed that, through the CSC process N'weti has facilitated increased direct citizen-state interaction in their role as catalyser and mediator. Citizens and authorities participating in the research, without being directly asked about N'weti, referred to the organisation and its local staff members as having undertaken all of these roles and more throughout the CSC process:

*We feel Nweti's support because it has improved our skills to act as judges in order for us to monitor problems and find solutions (A - Namitoria)*

The research showed that, through the CSC process N'weti has facilitated increased direct citizen-state interaction in their role as catalyser and mediator

*(...) the group was not functioning; it had not been well designed. A few days ago, Nweti acted towards training us on the citizens' rights and responsibilities and the role of Co-management Committee, and how to link the health unit with the Community. (CCG - Corrane)*

*But after supervisor's explanation, we got to know what it is all about, and we now collaborate with the CSC because we find it to be a beautiful and relevant activity for the health sector (Director health unit-Corrane)*

In Nampula, N'weti has a trajectory of six years of work in the province. For the majority of this time they have supported behaviour change programmes and referral to health units, but sometimes they have even supported health authorities to get their job done, by providing relevant data but also with support on practical tasks. For example, in one case, a health unit director had resources in his health unit but did not know how to allocate them. Normally in the districts the resources stay in one health unit and they are not distributed to the others. So, it is not that they don't have the money but they do not know what the needs are of those more isolated health units are, so, data coming from the diverse organisations working in development becomes very useful for authorities:

*For example, in Rapale, N'weti has helped local health authorities with the distribution of medicines because sometimes these arrive and are stored at the district capital but they never reach far away health centres. Often, authorities lack proper transportation and the road is very hard to pass. However, N'weti does have an appropriate vehicle and it is simple to give them 'a ride' (Nampula staff)*

These actions have gained N'weti trust within communities and authorities. In Namitoria, the CCG acknowledged the role of the team in mobilising the general population to open up and share their problems:

*For this major link to exist, Nweti team encouraged them to report their problems. For so long, the Co-management Committee members started reporting problems, for instance, the issue related to birth deliveries outside the facilities, because the supervisor helped them to raise the issue at the health unit directorate; the fact that mothers did not feel comfortable to have an institutional birth deliveries in the presence of a man. (CCG - Namitoria)*

The director of the health unit saw how due to the support of N'weti the CCG is having 'new life':

**In Nampula, N'weti has a trajectory of six years of work in the province; for the majority of this time they have supported behaviour change programmes and referral to health units, but sometimes they have even supported health authorities to get their job done, by providing relevant data but also with support on practical tasks.**

*There's a health unit Co-management Committee but it is not operational, but soon after the first CSC, the committee members realised its relevance, and with N'weti assistance we are now revitalising the Co-management Committee (...) (Director of health unit-Namitoria)*

Overall, N'weti is seen by the citizens in the research as a legitimate organisation that is working in partnership with local citizens to improve their life conditions. It seems they are in a position of interlocutors who recognise that for the voiceless to exercise voice effectively require support –as well as cross-cultural translation and bridge building (Fox 2014):

*The process gave credit and legitimacy to other N'weti's activities because from the time Nweti promoted the interface, we felt that Nweti's activities are serious (Old man-Namitoria)*

*We as the health unit have always collaborated with N'weti. N'weti's supervisor is from here in Namitoria, and has always helped us whenever there are health campaigns. Thus, when he presented the CSC activities, we bought in, because he is our partner (Director of health unit-Namitoria)*

Despite the high regard of N'weti's role, the research showed that there are certain signals of both citizens and authorities realising that it is their voice and action that is influencing the authorities to make changes, a situation N'weti must capitalise on.

*Our discussions help us achieve improvements at the Health Unit level (Young man-Corrane)*

*Nowadays, when the community goes to the health centre, they can place a complaint when they receive poor service (Head of Post-Corrane)*

CSOs working in SAcc with poor and marginalised groups truly need to focus efforts on supporting citizens at ground level to raise their voices; this includes working in longer-term partnerships to build the sustainability of citizens mobilising for change (Lopez Franco and Shahrokh 2015). N'weti has to keep thinking and innovating on a vast array of activities such as training in public speaking, sustained awareness raising on entitlements and rights, consciousness-raising work that enables people from marginalised groups to recognise their own issues in their own ways and find the inner and collective power to act in the public arena, and the provision of environments and other logistical and financial support where citizens can drive their agenda and grow their confidence (Cornwall 2008).

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## Section 3. Limitations to achieving social accountability

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In 2003, looking at general mechanisms for citizen participation, Houtzager, Lavallo and Acharya recognised that: *citizen participation is not simply an exercise of political involvement by ordinary citizens, it rather includes a set of collective actors*. At that time, the question was: what forms of representation are civil society actors constructing in the new participatory institutions and how do these new forms of representation involve ordinary citizens in policy-making? Today, with the growth of SAcc initiatives the question needs to go further: How can formal civil society actors (CSOs) engage ordinary citizens in holding accountable policymakers for the implementation of those policies (i.e. not just participating/ having voice) so citizens have the capacities and avenues for doing so?

As previously mentioned, the SAcc widgets created to achieve tactical outcomes have proven limited in their transformative potential. One of the major criticisms of mechanisms such as CSCs, social audits, budget tracking, etc. is that they are commonly promoted by an external actor, most likely a well-established national or international NGO, who drives the initiative. Looking beyond SAcc, a recent, comprehensive study from the World Bank (Mansuri and Rao 2013) has clearly outlined the risks of induced participation. However, sustaining meaningful participation from ordinary citizens across the years is still yet a challenge which NGO practitioners, development workers, policymakers, service providers and citizens are far from overcoming.

In this piece, it has been noted that in Nampula N'weti has engaged in the role of catalyser effectively, as a national NGO, which has credibility amongst the community members they work with as well as with local and provincial authorities. They have been working with community facilitators and supervisors from the districts where they have been implementing the CSC and other programmes in order to minimise the 'external actor' effect. Increasingly they have strengthened links with other civil society platforms in Nampula.

Despite these efforts, there are still limitations derived from the research that should be taken into account as an organisation increasingly active in the social accountability field. These are: the challenge of building citizen leadership on monitoring and advocacy; exclusion dynamics, power dynamics within the community, and the risk of overlooking the importance of previous work and context. The following sections will give a brief account of them. On the final considerations, some elements will be outlined for N'weti to consider at this crucial point in its organisational development, when strategic plans and theories of change for years to come are being created.

Despite these efforts, there are still limitations derived from the research that should be taken into account as an organisation increasingly active in the social accountability field. These are: the challenge of building citizen leadership on monitoring and advocacy; exclusion dynamics surfaced; power dynamics within the community; and the risk of overlooking the importance of previous work and context.

### 3.1 The challenge of citizen leadership in the institutionalisation, tracking commitments and advocacy stages

The majority of the participants in the FGD spoke of the fact that they did not know what the next steps once the devolution of results to the wider community happens; there is no citizen leadership across the following stages. However, people did not raise this as a problem. The fact that changes are evident in the health units monitored has maintained a sense of motivation and enthusiasm on joining the CSC activity:

*We do not know what then follows... but we can see changes (Young man - Corrane).*

*We do not have clear information on the next steps, but we can see changes (Old man - Anchilo)*

Looking back to Figure 1, p. 10, it is evident that the levels of citizen participation in the CSC process decreases substantially in the stages of institutionalisation, tracking commitments, and advocacy. Regarding the institutionalisation of the action plan agreed during the interface meeting into the health unit planning process, it is the local staff from N'weti, and rarely the citizens themselves, who have persuaded health units to do so. Tracking the implementation of commitments has been a double act between N'weti and particularly the CCGs:

*N'weti sees its role as strengthening the committees in order for them to become the vehicle for following-up and making sure that the health authorities are implementing the agreed actions. These CCGs are composed of representatives from the community and community leaders. We have decided to use the invited spaces for dialogue as the main architecture of the invited spaces for participation in the health sector (Director N'weti)*

Finally, the Advocacy stage at national level has been led by N'weti, mostly in regard to those problems which are impossible to solve at the health unit level; often, driving demands all the way from the health unit up to national level. These two final stages of the CSC process are fundamental for developing what Fox (2007, 2014) has named as 'teeth', i.e. institutional capacity for accountability. The emphasis of SAacc experts on response capacity from the authorities is that when governments do respond to voice, they create incentives for more voice, and vice versa. As such, N'weti has played a key role in guaranteeing that response. Members of the CCG in Corrane spoke clearly about N'weti's role in tracking the progress of the commitments and having oversight over authorities:

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*N'weti's supervisor has been monitoring the nurses. All health departments are working because there is a perception that there is someone watching them. (CCG - Corrane)*

*Matters were getting worse and worse before the supervisor (i.e. from N'weti) came in, and after the project came into force, the supervisor started monitoring all the departments (...)*

*(...) we would like to thank N'weti because it is an added value to see changes in health. In the past, there was no good coordination, but today N'weti's actions are bearing fruits.*

This sense of reliance on N'weti's actions is certainly perceived as a success and fulfils internal as well as external expectations:

*I understand those changes because I see them everyday. I feel proud of these changes brought by N'weti (Supervisor N'weti) :*

*Fear has gone because the CSC has eliminated it, and the providers are afraid of N'weti's supervisor who is there making noise to them. When the project comes to an end, please give us another person; and it is going to be difficult to choose someone from the community, because the community is not used to expose problems. Now with Nweti's supervisor around, they have confidence to do so (Old man-Corrane)*

The research has shown that N'weti is confronting the challenge of developing citizen leadership in institutionalising, tracking and advocating for the changes sought through the CSC process. So far, N'weti staff at local level (district supervisors) has taken the responsibility of making the authorities respond; and in their latest reflection meeting, the team has already identified further actions to advance the institutionalisation and advocacy of the action plans. Out of 16 actions proposed, only four speak directly about integrating local citizens into these stages more meaningfully (N'weti, June 2015):

- Involve the provincial and district citizen platforms to assist in the institutionalisation monitoring process;
- Use the co-management committees for better follow-up of the interface priorities;
- Design and share the monitoring formats with field teams;
- Ensure the participation of the partner CBOs in the district coordination council and the planning meetings that takes place before the provincial coordination council;



The research process shed light on the potential of continuing the growth on capacity, skills and knowledge of the CCGs as the formal channel of accountability within health units; some members have become aware that all the responsibility cannot be left to N'weti:

*We feel that we should take part because Nweti is not from here. Thus, since we are from here, we must participate in the identification of our problems, and this will have more impact in working with the health unit, and the community will feel that their concerns are being heard by their representatives (...)  
We are the ones who should work with the health unit because Mr. -{Name of supervisor} will leave us, and we must carry on... (CCG-Corrane)*

As seen in section 2.4 the CSC process has revitalised these committees. They have already attained a more direct relationship with service providers in the day to day planning of the health centre:

*They had access to the CSC plan, and the committee has a weekly plan with the health unit, and the plan is monitored through these meetings. The committee plan goes beyond the health centre and covers other areas (CCG-Namitoria).*

However, not all actions can rely on the CCGs; power dynamics within these invited spaces for participation must also be taken into account as further seen in section 3.3.

Another avenue to explore in order to increase citizen leadership at the local level relates to building more on young people's energy, drive and awareness. N'weti could think more on how to 'capitalise' on the knowledge and skills that have been sowed amongst young people through their programmes. How to grow local leaders since young age for these people to provide continuity after N'weti's programmes finish and hence improve sustainability? Across the three localities participating in the research, not one single young person joined the interface meeting. From the information collected is not possible to know the reasons behind this lack of youth participation in direct dialogue with service providers.

Developing leadership and knowledge around the technical components of the district-level planning process, as well as meaningfully connecting youth to district and provincial citizen platforms and networks is a long-term endeavour. Hence, if youths are able to get skills for negotiating with authorities and engaging in these processes sooner rather than later, it is possible that they grow-up to become more confident citizens, able to hold powerful actors accountable and become champions for change. Certainly, this is an area of opportunity for N'weti to look into. Due to its trajectory and the trust built among citizens, the organization is in a good position to challenge potential discriminatory social norms around young people's participation in order to attain this.

The research process shed light on the potential of continuing the growth on capacity, skills and knowledge of the CCGs as the formal channel of accountability within health units;

Finally, a question core to the SAcc debates centres on the role of national NGOs and other mass membership organisations in their role as representatives in central-level decision making spheres. Looking at this, Fox (2007) asks: How can the scaling up of voice transition from aggregation to representation? This process involves not only large numbers of people speaking at once, but the consolidation of organisations that can effectively scale up deliberation and representation as well; organisations which are able to put first the voices from the ground, rather than their own agendas. N'weti has proven to be able to catalyse, broker, monitor, and push for duty bearers to respond, even linking to national level health advocacy. But as an organization, it must remain asking if their programmes are looking at ways to become sustainable to a point where change is driven by regular citizens.

### 3.2 Dynamics of exclusion surfaced

As stated by Cornwall (2008) the dilemma of inclusion/exclusion is inherent to participation as in practice, even the most open-ended of participatory exercises will involve only a fraction of potential participants. Through their wide-ranging mobilisation and awareness raising endeavour in Nampula, N'weti had the intention to reach the majority of the population; aiming to foster knowledge on rights and responsibilities; however, this was not fully attained as already mentioned in Section 2.1

Thinking about those frequently excluded groups, such as children and youth, the elderly, people with disabilities and chronically ill, N'weti outlined certain measures to minimise the risks of exclusion during the group formation process. For a start, N'weti has taken the decision of not involving young children in the CSC cycle due to personal security reasons. However, they did intend to engage the elderly, people with disabilities and those suffering from chronic illnesses such as HIV AIDS in the monitoring process. However, the participants of the FGD reported minimum (if at all) participation of the latter groups. It is true that this requires substantial efforts and developing more inclusive communication tools as well as enabling spaces for interaction for people with mobility challenges. Nevertheless, for an organisation such as N'weti it must be of particular relevance to enable the inclusion of the perspectives and protect the rights of those people who are most vulnerable and dependent on the good performance of the health services for their survival.

Another issue that resurfaced regards the gender dynamics within the research. Women were the majority of those participating in the focus groups discussions (35 Women to 23 Men). In the context of Mozambique, health centres at the local level have a strong emphasis on maternal and child healthcare. In the pilot process carried out in the South, it was seen that as a consequence, most participants were women and it has remained a challenge to mobilise men, thereby running the risk of side-lining men's

for an organisation such as N'weti it must be of particular relevance to enable the inclusion of the perspectives and protect the rights of those people who are most vulnerable and dependent on the good performance of the health services for their survival.

interests, deriving from a women-focused rather than a balanced gender perspective (Bell 2001:8). However, the situation in Nampula is different. During the years of work in the province, N'weti has fostered men's participation and now in the CSC process the gender distribution remains well balanced.

Finally, another dynamic of exclusion which any participatory process must be aware of relates to the risk of elite capture where resources transferred for the benefit of the masses are usurped by a few, usually politically and/or economically powerful groups, at the expense of the less economically and/or politically influential groups (Dutta 2009). The devolution of results to the wider community can indeed minimise this risk; however, it is only by speaking with citizens remaining at the margins of the CSC process that further, less obvious exclusion issues will surface. Unfortunately, the scope of this research did not allow for that to happen; so, it is highly recommended to include this component in the *Tua Cena* programme future evaluations.

### 3.3 Power dynamics insufficiently explored

Dynamics of inclusion and exclusion have both implications for the practices of participation within a group of citizens as well as towards the wider community. Also, they have implications for accountability; often those groups aware of formal accountability processes and mechanisms exclude certain types of people due to their powerless position (Lopez Franco 2014). It is often those most powerful who, due to their titles or advanced starting point, automatically have a seat on the table of 'citizen participation' initiatives and often, set the agenda. Moreover, studies in Mozambique have shown that invited spaces for participation have been co-opted by partisan politics and that local participation structures are still characterised by a paternalistic relationship, rather than that of an active citizenship demanding its right to benefit from the public funds as well as to hold government accountable for its management (DFID 2008; Kula 2014).

Aware of this situation, N'weti made the strategic decision to involve the CCGs and other traditional leadership structures from the beginning of the CSC implementation. In some ways this has paved the way for a process including both, citizens and duty bearers. The research participants in the FGD did not overtly complain about specific actions or inactions of the members of the CCGs. Unfortunately, gleaning the power dynamics is not achievable through a half a day meeting; an in-depth, well facilitated process is required for that purpose. Across the three sites, only one comment in a FGD referred to the links between the CCGs and the ruling party:

*(...)During speeches (i.e. political), after exhausting their agenda, the Head of Post encourages the community to use the Management Committees as a focal point and for collecting issues. (Youth-Namitoria)*

The devolution of results to the wider community can indeed minimise this risk; however, it is only by speaking with citizens remaining at the margins of the CSC process that further, less obvious exclusion issues will surface.

Moreover, all FGD participants agreed that traditional leaders should not be the only ones representing the community in the interactions with local authorities. A comment around this was that, on occasion, leaders kept the knowledge to themselves:

*The presence of leaders together with the community is crucial, because together they will collect data and be aware. Because when the leader goes alone, the knowledge acquired will just remain with him (Young man-Namitoria)*

Furthermore, one of the young participants in Anchilo made an interesting remark in relation to the lack of knowledge of health rights and responsibilities amongst traditional leaders:

*During the interface, we agreed that the leaders must help lecturing on rights and responsibilities, but few leaders do so; therefore, we believe that they are not yet aware of the health rights and responsibilities (Young man-Anchilo).*

*In spite of this, using local leadership is considered by N'weti as an avenue for communicating the outcomes of the CSC process to the wider population, as stated in an interview: The local leaders would become a channel to disseminate information because there are still localities without community radio signal so they miss the progress (staff from N'weti)*

As any other group, 'traditional leadership' is not a homogenous concept. These leaders do not act in the same way across all localities; in some places they can be an inclusive and a driving force for citizen participation, in others they can be obstacles. As such, these nuances must be considered when thinking about the role foreseen for them and the role they are actually playing. On making further decisions about the work with CCGs and local leadership structures a much more thorough understanding of the power dynamics within and from those groups to fellow citizens must be attained. It is important that N'weti keeps this in mind on further interactions to better understand how political dynamics are shaping the CSC process across the different localities.

### 3.4 Legacies of previous work and context conditions must not be ignored

One of the most fervent debates in the SAcc field for these last 2-3 years has been around the fundamental need for adequately understanding the context under which any initiative is put in place. Joshi (2014: 23) outlines this clearly: *At the micro level, local factors can clearly drive the way certain SAcc initiatives unfold and the extent to which they are successful even within otherwise broadly similar contexts.* As previously mentioned, treating the CSC process as a widget only aimed to improve services is



problematic for several reasons. One of them particularly links to de-contextualising the mechanism from the broader socio-political dynamics in which it is being implemented. Dynamics related to the history of the long-term processes of political bargaining, public–social movement alliances, previous experiences of citizen engagement and the networks within which collective actors are embedded (Joshi and Houtzager 2012).

In this research two fundamental contextual characteristics surfaced as highly influential to attaining the positive outcomes described in section 2. The first one refers to the existence of 'community dialogues', which preceded the implementation of the CSC process in Nampula under the broader *Tua Cena* programme. These were seen as key for generating trust and interest from people to join this new endeavour and overall make the Mobilisation stage more effective: *Mobilisation for participation was facilitated by community dialogue activities and N'weti and its local partners' credibility in different administrative posts (N'weti, June 2015)*

N'weti staff, supervisors and citizens have recognised that capitalising on these dialogues is essential and awareness raising cannot be a one-off activity, but a constant endeavour; hence the need for complementing them with community radio campaigns and other site specific activities, such as promotion visits to schools community or stage theatre. In this regard a member of the CCG in Corrane said: *"However, we must increase the dissemination of information on CSC process, because it takes long for people to engage in mobilisation, as well as to participate in local development processes and engagement with providers"*.

Despite acknowledging the value of these dialogues, N'weti has made the decision to expand the second phase of implementation at sites where these have not been used. The aim is to look at this particular characteristic of the context in order to have more concrete/systematic evidence on the difference (if any) community dialogues bring to the CSC process:

*We assume, right from the onset, the enormous challenge of this scaling-up precisely due to the fact that the new sites do not have the community dialogues component that is critical in building an enabling environment. This presents an opportunity for comparing sites with or without community dialogues, and for generating an opportunity for learning and collecting evidence of what works best (N'weti June 2015).*

The second contextual characteristic shown to be relevant in achieving positive outcomes of this first round of CSC implementation is the particular characteristics of engagement and relationship-building in Nampula province.

N'weti staff, supervisors and citizens have recognised that capitalising on these dialogues is essential and awareness raising cannot be a one off activity, but a constant endeavour;

*(i) the level of Nweti and its partners' integration and credibility at different sites (about 6 years), (ii) field teams experience in community mobilisation activities, (iii) the excellent relationships with provincial and district government entities (Nweti June 2015)*

As seen in section 2.5, N'weti's work is not only recognised and respected by people on the ground but also by the authorities from the health unit to the provincial levels:

*Because of the type of activities and information disseminated in the CSC process, the Administrative Post asked N'weti's supervisor to assist in the dissemination of rights and responsibilities for some public services technicians here in the Administrative Post (Head of Post-Corrane)*

N'weti staff in Nampula have developed, across 6 years of work in the province, a network of supporters within the different government levels who are frequently invited and informed about the organisation's activities. For example, they have organised monthly meetings with staff from the health centres in addition to signing formal MOUs at the administrative post and at district levels, as well as hosting a wider meeting where statistics useful for the health authorities are disseminated. Moreover, N'weti organises an annual meeting which brings together its partner CBOs and local government actors across all districts and the second day is dedicated to building relationships with local authorities (Interview, N'weti manager). In addition to these informal mechanisms, other structural characteristics present in Nampula, and not yet seen in other provinces, were identified as relevant:

1<sup>st</sup> The province benefits from NGOs since the 1990s, there is a sense of 'associativismo' – communities are already aware of the importance of working with others; of collective action.

2<sup>nd</sup> The majority of the districts have associations created 10 years ago and people understand they are not for profit; hence, there is no expectation of a monetary remuneration

3<sup>rd</sup> A legal framework is in place across the province – the government has put laws in place that are incentivising the creation of these local, small, community-based groups

Nampula's particular context and the pre-conditions generated by N'weti's work over the past years must not be overlooked as determinant factors for the success attained through the CSC process. Hence, when thinking about 'scaling-up' the CSC mechanism particular attention must be put into these contextual factors.





## Final Considerations

This document presented an analysis of the CSC process implemented by N'weti in the province of Nampula; with information gathered with citizens from Anchilo, Corrane and Namitoria districts. The CSC is one of the many existing mechanisms designed to achieve SAcc; some common lessons in this field include: (1) that information and transparency is necessary but not sufficient for accountability actions to be undertaken; (2) that accountability action without a corresponding capacity for state response can be counterproductive; (3) that effective sanctions play an important role in sustaining accountability demands; (4) that collective action is important for accountability to the poor; and (5) that existing cases of successful social accountability are underpinned by cross-boundary alliances between social actors and state reformists that create accountability coalitions (Joshi 2014:24).

Despite the fact that the scope of this research was not to make an assessment across all of these elements, some reflections can be drawn out from the implementation of the CSC process in Nampula, in relation to the previous four lessons learnt on SAcc:

- Citizen-led: The data generated through the CSC process is relevant for citizens; particularly, if citizens define the indicators to be monitored. It speaks to their realities and priorities, fostering their continued interest in the process
- Rights-based: The component of rights-awareness and skills development for negotiating is key for two purposes. Firstly, to generate confidence in people who have been historically marginalised from decision-making processes and a sense of the power of being able to work collectively. Secondly, for being able to speak the language of those who are taking decisions
- Context: In Nampula, six years of work with local staff and actors have translated in a very clear understanding of the context – a determinant factor to make any programme relevant to the local people. In addition, this time has allowed for the development of personal relationships, which have been determinant on navigating the obstacles along the way.
- Role of an intermediary NGO: N'weti has been able to foster authorities' response through positive incentives as well as seeking formal sanctions such as dismissal.

Furthermore, from this study it can be concluded that when the right preparatory work is in place and with the correct facilitation process; the scorecard method has a lot of potential for transforming service provision at the local level; mostly in relation to those small changes which can be triggered by staff in the health units with collaboration from citizens and NGOs. The biggest challenge lies in thinking about what will happen when there are no more 'small gains' to be achieved; when the line of accountability has to be directed towards other more powerful actors (for example, the pharmaceutical industry)



and levels of governance far beyond the understanding of people on the ground. It is likely that after three rounds of implementation, citizens realise that changes are not as tangible and motivation for participating decreases: How to give continuity to that which was fostered by the CSC process?

N'weti has already embarked on designing an advocacy process from the district to the national level in order to tackle those structural problems. It is important to keep actions grounded, as extensive research on citizen participation has shown that gains are quickly followed by reversals. In some cases, the loss of key reformers or champions inside the state can affect the sustainability of outcomes (Gaventa and Benequista 2011). It is then crucial to remember that citizen participation is not just about policy; it is also deeply political. After all, substantial citizen engagement will be sustained over time only if citizens come to support the institutions and practices of participation – that is, if they grow into a constituency that will not only engage but also defend against efforts to reduce participation (Fung 2015).



It is then crucial to remember that citizen participation is not just about policy; it is also deeply political. After all, substantial citizen engagement will be sustained over time only if citizens come to support the institutions and practices of participation – that is, if they grow into a constituency that will not only engage but also defend against efforts to reduce participation (Fung 2015).

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