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Moving on Up: Multilevel Monitoring and Advocacy for Health Rights

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Caption: Parents, health care providers, teachers, religious leaders and local politicians gathered at a Citizen Voice in Action meeting in Chunkuri Village, Dakope, Bangladesh - part of the USAID Bureau of Humanitarian Assistance funded Nobo Jatra program.

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Abbreviations List

ACT-Health	Accountability Can Transform Health
AIDS	acquired immunodeficiency syndrome
CBMP/CAH	Community-based Monitoring and Planning/Community Action for Health
CEGSS	Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud (Center for the Study of Equity and Governance in Health Systems)
COPASAH	Community of Practitioners on Accountability and Social Action in Health
CSO	Civil society organization
CVA	Citizen Voice and Action
DFID	UK Department for International Development (now Foreign, Commonwealth and Development Office)
EVA	Empowerment, Voice, and Accountability for Better Health and Nutrition
GPSA	World Bank's Global Partnership for Social Accountability
MBW	Making the Budget Work
MCH	maternal and child health
MNCHN	maternal, newborn, and child health and nutrition
NGO	nongovernmental organization
NHM	National Health Mission (Uganda)
RCT	randomized control trial
SATHI	Support for Training and Advocacy to Health Initiatives
USAID	United States Agency for International Development

Summary

Multilevel approaches to monitoring and advocacy are often used by international development practitioners, particularly in civil society, in efforts to hold governments—from the national to the local—to account for policy implementation. However, such approaches are not yet well understood or identified by many scholars in the social accountability field.

This evidence review addresses this gap through a cross-case comparison of multilevel approaches in ten health rights programs across Africa, Asia, and Latin America. It draws on published evaluations, working papers, and peer-reviewed journal articles, as well as insights shared by implementers and researchers. Cases were selected to illustrate health rights initiatives that included monitoring or advocacy activity at a minimum of two different levels: local health facility, district, regional, provincial or national.

Comparison renders visible recurring patterns that allow an exploration of how vertical integration—a type of multilevel monitoring and advocacy that emphasizes the *linkages* between levels—takes place.

Four significant findings emerge from this review of evidence:

1. Vertical integration is a relatively common feature of multilevel monitoring and advocacy in these ten cases and is most likely to take place at the lower ends of the health system. However, it is largely implicit, and often not articulated in project design or theories of change.

2. Horizontal organizing—the coordination of civil society action across districts or geographies—is a less visible feature of multilevel approaches to health rights programming than vertical integration.

3. Despite the multilevel nature of health monitoring and advocacy in these ten cases, less than half reported working at the regional or provincial level, indicating a 'missing middle' between local and national activity.

4. Escalation—the process by which citizens' unaddressed claims move upwards to those with greater decision-making powers—is an important mechanism for accountability and one way in which vertical integration can happen. However, escalation is not clearly articulated in much of the gray literature, and therefore merits further research.

The findings from this evidence review have implications for strategy, including: the importance of explicitly identifying multilevel tactics for monitoring and advocacy; theorizing the process by which unaddressed claims can be addressed, particularly moving up beyond the local level; emphasizing the importance of the 'middle' and ensuring regional and provincial decision-making is leveraged; and looking to link vertical integration with opportunities for horizontal organizing.

1. Introduction

Pro-participation and social accountability programs often employ tactics and undertake activities at different levels of government. Numerous studies depict social accountability taking place at all levels—from multilateral citizen engagement forums such as those of the World Bank (Donaldson, Gallagher, and Nadelman 2022) to organizing by grassroots activists (Fischer-Mackey et al. 2020). What has not yet been systematically explored, however, is the extent to which accountability initiatives have been *multilevel* or the potential implications of such an approach.

To practitioners and activists working with communities, multilevel approaches may seem common sense. Yet much of the academic and gray literature on monitoring, advocacy, and power-shifting tactics still treats multilevel integration and scale as an afterthought—if it is acknowledged at all. There has not yet been a review of the existing evidence base nor a consolidated meta-analysis of best practices or enabling (or hindering) conditions or contexts from which to draw high-level lessons about what works and what does not.

This cross-national evidence review synthesizes publicly documented cases of vertically integrated monitoring and/or advocacy within the health sector. By providing a stock-take of multilevel dynamics in different types of social accountability programs and initiatives, across diverse geopolitical contexts, the review aims to address the current knowledge gap. It does not seek to evaluate the conditions that support multilevel health programs, nor address causal claims for what may have enabled a multilevel approach, but rather looks across the health sector to identify patterns in how multilevel strategies are used.

1.1 Case selection

This review looks at cases within the health sector specifically. In the development field, health systems are widely recognized as a sector that requires activity at multiple levels to ensure service delivery (particularly in comparison to other development sectors). However, the role of civil society in health systems is not sufficiently addressed in either academic or policy literatures.

To be included in this meta-analysis, a health systems program or initiative had to include monitoring and/or advocacy activity at a minimum of two different levels, including but not restricted to: local health care facility level, district level, municipal level, provincial level, and national level. All programs reviewed in this paper include at least two levels of activity.

The analysis only reviews programs and initiatives for which there was a sufficient quantity of readily available evidence (e.g. published evaluations, working papers, and peer-reviewed journal articles) for the author to determine what happened in each case and to identify patterns across cases. This criterion has resulted in the inclusion of a high number of donor-funded projects implemented by international or local nongovernmental organizations (NGOs), which were more likely to have conducted evaluations for donor accountability purposes. The exceptions are SATHI in India, CEGSS in Guatemala, and Naripokkho in Bangladesh. In total, ten cases were selected (Table 1).

1.2 Analytical approach

The author reviewed the documentation for each case in an inductive process, looking at both multilevel approaches and outcomes. Initial themes were identified and iteratively compared to identify emerging lessons or patterns regarding multilevel monitoring and advocacy. Case summaries and early analysis were then reviewed by key stakeholders in each case (e.g. implementers, evaluators, and researchers). The written inputs from stakeholders enabled the meta-analysis to triangulate information and validate certain findings. Their inputs also provided a level of nuance that may not have been readily visible in public documentation or evaluations.

Table 1. Multilevel Monitoring and Advocacy Health Cases

Case	Primary actor	Country	Sources
Naripokkho's reactivation of health committees	National CSO (Naripokkho)	Bangladesh	Azim 2001; Huq 2003; ARROW 2013
Nobo Jatra–New Beginning	International NGO (World Vision Bangladesh)	Bangladesh	Long and Panday 2020
National AIDS policy creation and implementation	Grassroots activists and federal government reformers	Brazil	Rich 2022a; 2022b; 2013
Making the Budget Work	National CSO (SEND-Ghana)	Ghana	Mills 2019; Agyemang 2018
CEGSS's efforts to build citizen capacities	National CSO (Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud, CEGSS)	Guatemala	Hernández et al. 2019; Flores and Hernández 2018; Hernández et al. 2017; Flores, Sánchez, and Delgado 2014
SATHI's community-based monitoring and planning	State-level CSO (Support for Training and Advocacy to Health Initiatives, SATHI)	India	Shukla et al. forthcoming; Gaitonde et al. 2017; Shukla, Khanna, and Jadhav 2018; Shukla and Sinha 2014
Government Accountability and Improved Services	International NGO (World Vision Indonesia)	Indonesia	Westhorp and Ball 2018
Empowerment, Voice, and Accountability for Better Health and Nutrition (EVA Pakistan)	Development project management company (Palladium) and national CSO (Center for Communication Programs)	Pakistan	Kirk 2017
Participatory Voices Project	National CSO (ForoSalud) and international NGO (CARE Peru)	Peru	Samuel and Frisancho 2022; Frisancho 2021; Samuel and Frisancho 2015; Aston 2015
Accountability Can Transform Health	National CSO (GOAL)	Uganda	Bailey and Mujune 2021

This working paper begins with a discussion of key concepts, including multilevel monitoring and advocacy, escalation, and vertical integration. Section 3 sets out brief summaries of the ten health system cases, to enable cross-case comparison; findings are presented in Section 4. The paper concludes by pointing to future opportunities for research regarding escalation and enabling conditions for multilevel monitoring and advocacy.

2. Clarifying Concepts

Multilevel monitoring and advocacy refer to policy and implementation monitoring and advocacy at diverse levels of civil society. Similarly, 'vertical integration' is a strategic approach to policy monitoring and public interest advocacy that aims to make individual efforts greater than the sum of their parts. It specifically refers to the "coordinated civil society monitoring and advocacy across more than one level of public sector decision–making (local, subnational, national, and/or international)" (Fox 2022, 78). This coordination happens "between diverse levels of civil society" (Fox 2001, 617).

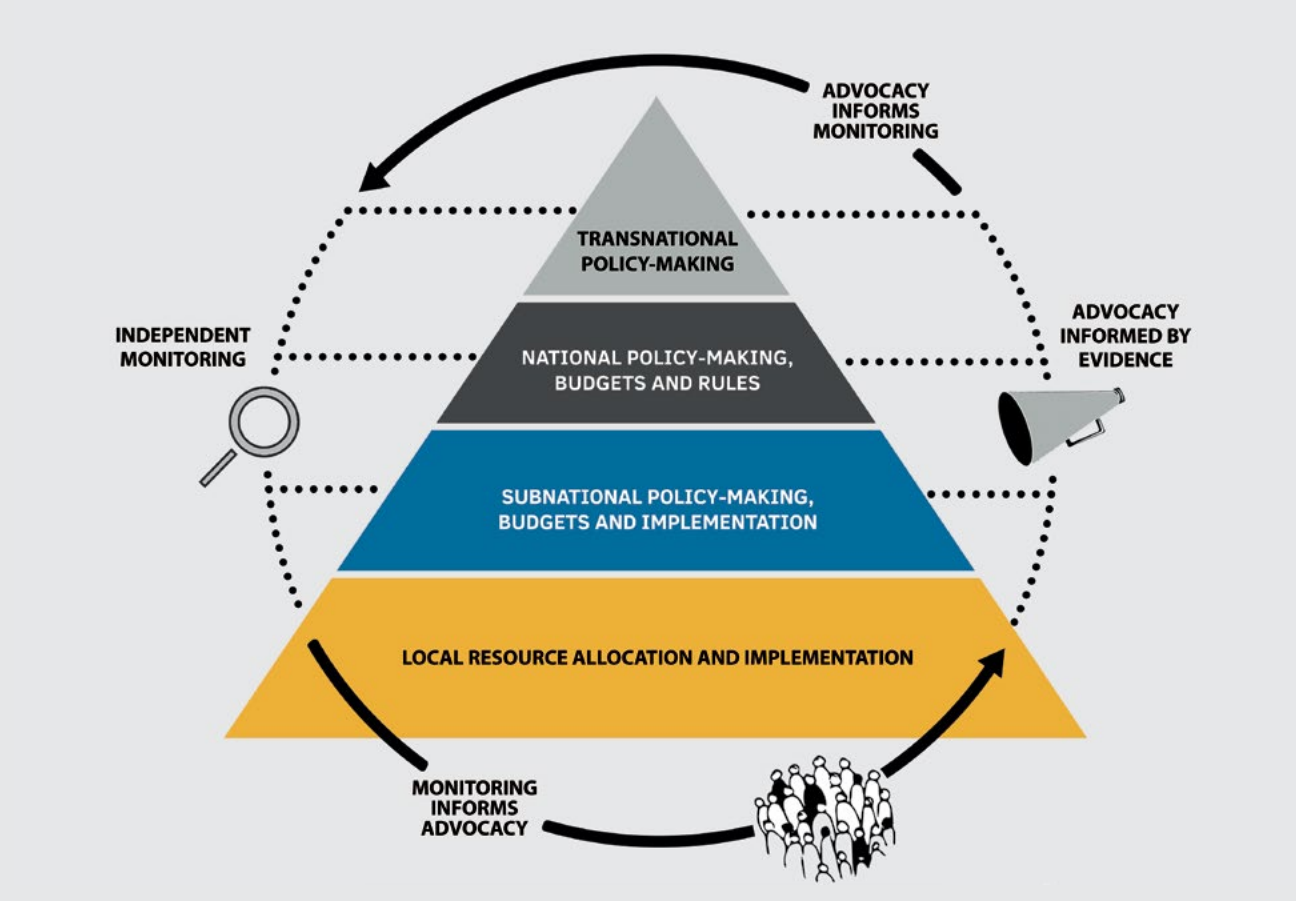
Vertical integration is a type, *not a synonym*, of multilevel monitoring and advocacy. Policy monitoring or advocacy can take place at multiple levels—yet without coordination between the different levels. Vertical integration emphasizes the *linkages* between multiple levels of monitoring and advocacy as well as the extent to which the efforts are greater than the sum of their parts. Fox (2016), for instance, discusses how "vertically integrated accountability initiatives attempt to take scale into account by linking citizen action at the grassroots with action at the national level" (13). Oversight of the public sector is often multilevel, but activities are less often in coordination with one other. Oftentimes, the expectation that there would be linkages between levels may be unrealistic. Additionally, monitoring and advocacy are not always conducted in tandem. There may be instances of multilevel monitoring without advocacy and vice versa.

Vertical integration—coordination of civil society action at different levels of public sector decision-making—is distinct from **horizontal integration**—coordination of civil society action *across regions or geographies* (ibid.). As discussed by Fox (2016) and Fox et al. (2016), the distinction between these two approaches to "projecting voice… raises the question of what kinds of messages and targeting manage to be heard by those in power" (Fox 2016). A visual depiction of the process of multilevel monitoring and advocacy is presented in Figure 1 below.

Multilevel approaches to monitoring and advocacy, including but not limited to vertical integration, have been discussed with regard to accountability initiatives in international development (Fox 2001; 2016; Fox, Aceron, and Guillán Montero 2016; Aceron and Isaac 2016; Aceron 2018). Aceron, the Convenor-Director of G-Watch and a Research Fellow at the Accountability Research Center, and the co-authors discuss instances of multilevel citizen action for accountability.

Scholars and practitioners such as Aceron have begun to identify instances of vertical integration—whether intentional or unintentional—in development programs. For instance, vertical integration has been explored in detail regarding citizen-led reform campaigns in the Philippines (Aceron 2018). Aceron and Isaac (2016, 12) characterize vertical integration as an analytical framework that seeks to capture: the *combination* of actors and actions at a given level of governance; the *intensity* of the use of different kinds of actions at each level; and the *extent* of civil society's use of different actions or strategies at each level. They explore seven cases in the Philippines of how vertical integration supported improved accountability and project results.

Figure 1. Multilevel Monitoring and Advocacy



Source: Jonathan Fox and Waad Tamaa in Fox and Halloran (2016)

One way in which vertical integration takes place is through **escalation**. The term escalation, referring to multilevel advocacy in particular, can be understood as the process by which citizens or civil society organizations (CSOs) take unaddressed claims and demands from one level of a system upwards towards a higher level in the system where there may be greater power or decision making. Escalation relates specifically to the linkages between levels. It is closely associated, but not synonymous with vertical integration; multilevel initiatives may involve monitoring and advocacy at multiple levels without a process of escalation—or linkages—between them. Multilevel monitoring *without* escalation may be more likely when the articulation of voice only takes place from the facility to the local level, thereby limiting opportunities for escalation upwards to levels where there is greater decision-making and financial power (i.e. district, regional, or national levels). Instances of escalation are discussed in greater detail in Chapter 4.

3. Case Summaries

3.1 Bangladesh: Naripokkho's reactivation of health advisory committees

Period: 1983 to present
Activity type: Collective action through a membership organization

Founded in 1983, Naripokkho is a membership-based activist organization that undertakes advocacy, research, and training on women's rights and justice issues in Bangladesh. In 1996, Naripokkho began to investigate women's health concerns by monitoring the government's commitment to the Programme of Action of the International Conference on Population and Development. The organization's efforts centered on reactivating moribund government committees at the grassroots level, including the Upazila health advisory committees (Azim 2001; Asian-Pacific Resource & Research Centre for Women 2013).

As an example of membership-driven monitoring and advocacy, there are no publicly available evaluations of Naripokkho's efforts. However, Naripokkho staff and partners—such as the Women's Health and Rights Advocacy Partnership and the Community of Practitioners on Accountability and Social Action in Health (COPASAH) learning network—have published peer-reviewed journal articles and gray literature on their work. Most notably, this includes Shireen Huq's article, "Bodies as Sites of Struggle: Naripokkho and the Movement for Women's Rights in Bangladesh" (Huq 2003). She discusses how Naripokkho positioned health services monitoring as a fundamentally feminist political concern:

> Health constitutes a key arena of women's suffering, and represents the end results of discrimination, violence and inequality. Naripokkho sought to activate the Upazila Health Advisory Committee, set up by the government to monitor and improve health services at local level. This committee, composed of a cross-section of society, public representatives and government functionaries, proved to be effective in bringing about improvements, once activated. (ibid, 61)

3.2 Bangladesh: Nobo Jatra–New Beginning

Period: 2015–2022
Activity or initiative type: Donor-funded, NGO-led program
Primary actors: World Vision Bangladesh, the World Food Programme of the United Nations, and Winrock International
Funding: United States Agency for International Development (USAID)

Nobo Jatra–New Beginning is a USAID Food for Peace (Title II) Development Food Security Activity that aimed to improve gender-equitable food security, nutrition, and resilience in southwest Bangladesh.

The program's activities were multi-sector, spanning maternal and child health (MCH); water, sanitation, and hygiene (WASH); agriculture and alternative livelihoods; disaster risk reduction; good governance and social accountability; and gender. Nobo Jatra employed World Vision's Citizen Voice and Action (CVA) approach (Box 1), working with 119 community clinics, 40 union agricultural services units, and 40 union WASH committees across the southwest region. However, it is notable that there was a lag in the implementation of many CVA components. Most CVA working

groups in the project area were not constituted until 2018, and many initial CVA activities were not launched until 2018 or 2019 (Long and Panday 2020).

Box 1. World Vision International's Citizen Voice and Action Model

The CVA approach emphasizes community leadership and ownership. It works by (1) informing citizens about their rights, (2) facilitating dialogue between communities, service providers, and local officials through which participants assess services against both government- and community-determined standards, and (3) equipping communities with a basic set of advocacy tools so that they can work with other stakeholders to influence decision-makers to make improvements.

Source: Adapted from World Vision International (2017) and Reynolds (2020)

The program was originally slated for five years but received a two-year extension in 2019 (2020–2022); a second two-year program—Nobo Jatra II—had just been approved at the time of writing and is set to run from October 2022 to September 2024. An independent evaluation of the CVA component of the Nobo Jatra program was conducted at the end of the initial funding period (Long and Panday 2020). This meta-review draws from the findings of this evaluation, as well as other secondary sources on the program and its results.

Nobo Jatra built on the 2009 Bangladesh Local Government Act, which devolved much of the administrative and financial responsibility for service provision to local government groups. The program was intentionally multilevel in its approach and emphasized within both its inception report and its evaluation framework the importance of investigating "vertical hierarchy" (Long and Panday 2020, 13).

> Inherent within [Nobo Jatra]'s "theory of change" is the recognition that addressing pervasive challenges related to food security, nutrition, and resilience require broader coordination and long-term solutions *that can only be achieved by strengthening linkages with relevant state and non-state actors at the national and regional ("meso") levels* in Bangladesh. (ibid, 11) [emphasis added]

Nobo Jatra's multilevel approach was most evident in its Purpose Four, which aimed to improve social accountability and national policy engagement for service provision. Under this stream of work, the program undertook "advocacy at the national level, along with civic engagement and good governance initiatives at the local level" (ibid). According to Long and Panday (2020, 13), "vertical hierarchies allow things to 'trickle down' and 'trickle up" . The program also engaged district government officials in sub-district dialogues. The unaddressed issues at the local level were raised to the district, division, and national levels, respectively, through periodic meetings and dialogues in which district stakeholders were present. This also included instances of division- and national-level dialogues, and the subsequent incorporation of Nobo Jatra working areas into the National Multi-Purpose Health Volunteer Program (ibid.). Nobo Jatra's escalation and vertical integration processes were also coupled with 'horizontal' dimensions. They intended to link citizens directly with public service providers for an intended 'trickle across' approach.

3.3 Brazil: National AIDS policy creation and implementation

Period: 1980s
Activity or initiative type: Local community activism and government policy
Funding: Brazilian government, World Bank, UNESCO

In the 1980s, local community activists and grassroots movements began responding to the AIDS epidemic in Brazil (Rich 2022a; 2022b; 2013). These movements took place in an era of democratic transition in the country, as local civil society organizations gained traction and influence. As a result of the grassroots movement, the country's National AIDS Program was established in the early 1990s, and targeting AIDS was considered a priority for national policy-makers including Presidents Cardoso and Lula da Silva. The national policy was instituted in a decentralized context, however, as social policy in Brazil is highly decentralized and subnational governors hold a significant amount of power (Samuels 2003).

Brazil's National AIDS Program was renewed in the early 1990s to better reflect the concerns of grassroots civil society organizations regarding existing policies. The semi-independence of the bureaucracy was established through foreign aid from the World Bank and independent management provided by UNESCO. Despite these achievements at the national level of a "health care system gone right" (Rich 2013, 7), significant challenges remained at the subnational level due to decentralized governance.

Local civil society actors monitored the National AIDS Program's policy failures and its implementation by subnational governments across 26 states and over 5,500 municipalities. From there, local CSOs escalated concerns upwards to federal bureaucrats, primarily via the Unit for Engagement with Civil Society and Human Rights as well as the National Commission of Engagement with Social Movements established by the federal AIDS bureaucracy. As Rich (2022a) discusses in detail, the case of Brazil is an example of a 'sandwich strategy,'—the mutually reinforcing interaction of pro-reform actors in both state and society. Here, federally established monitoring mechanisms enabled local CSOs and activists to monitor subnational and local implementation of national policy and "pressure [local politicians] to conform" (ibid, 13).

3.4 Ghana: Making the Budget Work

Period: 2014–2018
Primary actor: SEND-Ghana
Funding: World Bank Global Partnership for Social Accountability (GPSA)

The Making the Budget Work (MBW) program sought to strengthen accountability and transparency in national and subnational budget processes for Ghana's health and education sectors. The activities within the program included improving citizens' knowledge through budget-sensitization campaigns in the community and on the radio, monitoring budget implementation, and producing advocacy research materials informed by citizen monitoring. At the local level, the program conducted participatory budget monitoring exercises in liaison with local government officials and implemented a communications strategy to disseminate findings and build pressure for government action.

MBW also established a network of District Citizen Monitoring Committees, made up of community volunteers, in 30 districts across four regions of Ghana. These volunteers completed citizen and community scorecards to monitor access to and quality of services and the extent to which they met user needs. Local monitoring was supplemented by local advocacy efforts, such as the development of citizen budgets, in which citizens participate (at national, regional, and district levels) during budget planning and execution. At the district and national levels, SEND-Ghana

also sought to facilitate the participation of the District Citizen Monitoring Committee Network so that network members could use consolidated district-level citizen budgets in advocacy efforts at the national level.

The evidence base for the MBW program is an independent final evaluation (Mills 2019) and a reflection note by SEND-Ghana's internal programs (Agyemang 2018). In relation to multilevel advocacy specifically, Agyemang (2018) finds that the SEND-Ghana team's decision to include key government actors in the Project Steering Committee from the outset resulted in greater ownership by higher-level government stakeholders, opened up more spaces for constructive engagement, and formalized relationships between the program and government at multiple levels.

3.5 Guatemala: CEGSS's efforts to build citizen capacities for monitoring

Period: Since 2006
Primary actor: Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud (CEGSS)
Activity or initiative type: CSO participatory action-research
Funding: Multiple international sources including IDRC

The Center for the Study of Equity and Governance in Health Systems (CEGSS) undertakes advocacy, research, and capacity building in support of marginalized and indigenous peoples' right to health.

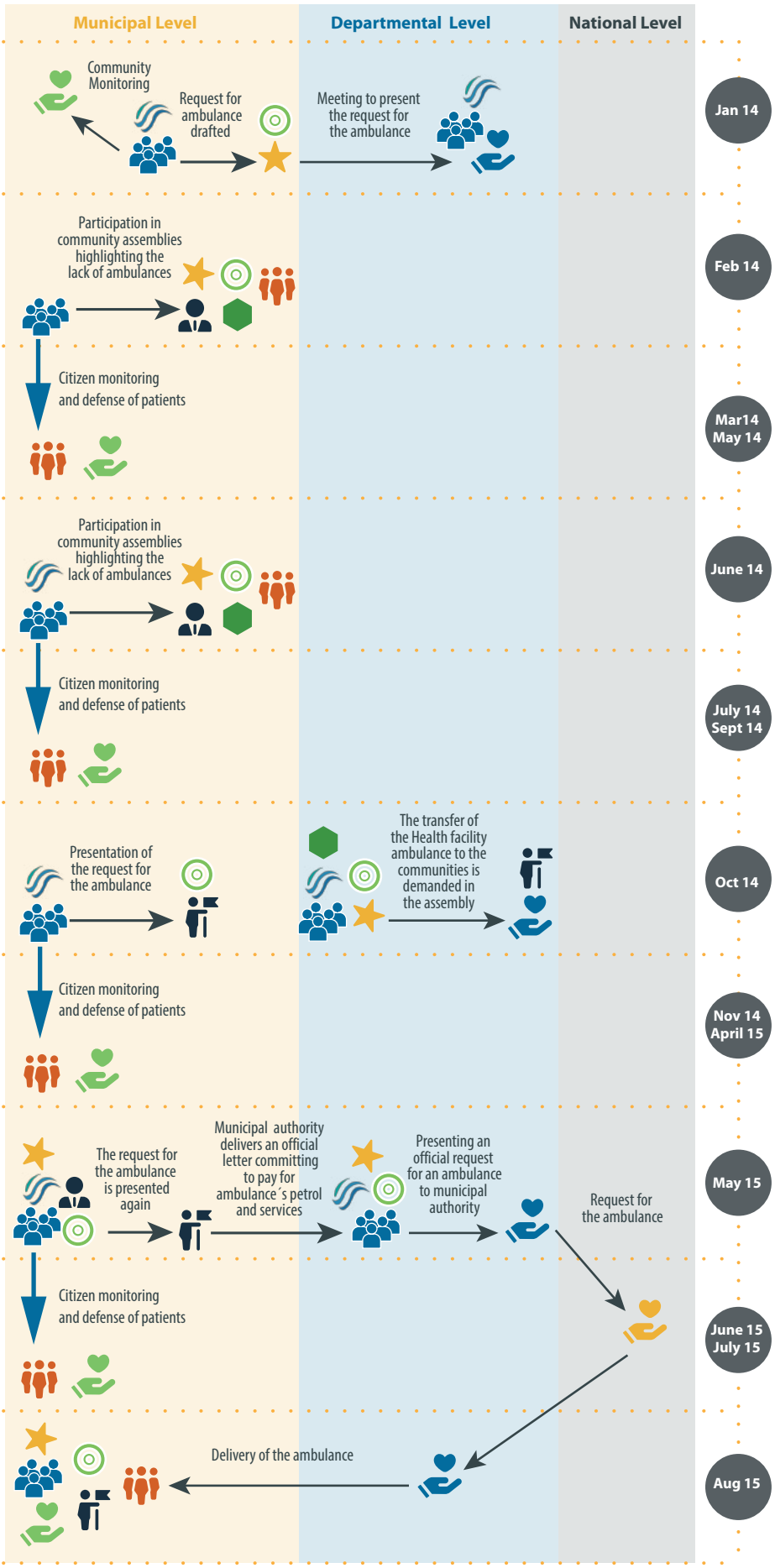
Most relevant to this meta-analysis is CEGSS's participatory action-research program, which develops the capacities of indigenous citizens to use audio-visual tools in community monitoring of public health policies and services. These citizens—known as "right-to-health community defenders"—present the data they collect to authorities at municipal and provincial levels, and sometimes even at the national level. For instance, community defenders have organized provincial-level public exhibits to present audiovisual evidence of the right to health violations gathered in their municipalities (Flores and Hernández 2018). Monitoring data is also communicated through local cable, community radio, and community assemblies. To date, there are more than 150 CEGSS-trained community defenders (at least 40 percent of whom are women) in the 37 municipalities across five regions in which the program operates (ibid).

The publicly available evidence-base for CEGSS includes training materials, journal articles, and policy reports on generating evidence for social mobilization through community ethnographers. The most notable is Hernández et al. (2019), which discusses how citizen groups bolster their negotiating power to advocate for improved health outcomes. The authors find that, due to asymmetries of power, simply engaging with authorities may not be sufficient. Instead, much of CEGSS's success in Guatemala depended on wider community mobilization, *as well as* multilevel vertical engagement (i.e. above and beyond the local) and horizontal engagement (i.e. building networks with other community advocates across different regions of the country).

For example, Batzin, Culum, and Fischer-Mackey (2020) describe how citizens organized horizontally, across communities, and engaged vertically, with multiple actors at municipal, departmental, and national levels to address the lack of ambulances in rural areas. Figure 2 illustrates the time and effort that this required from different stakeholders. The use of both vertical and horizontal organizing across some cases such as CEGSS is discussed in the following section.

Figure 2. The Multilevel efforts Required by CEGSS and Other Stakeholders to Procure an Ambulance

Lack of Ambulance Services in the Municipality of Concepción, in the Department of Sololá.



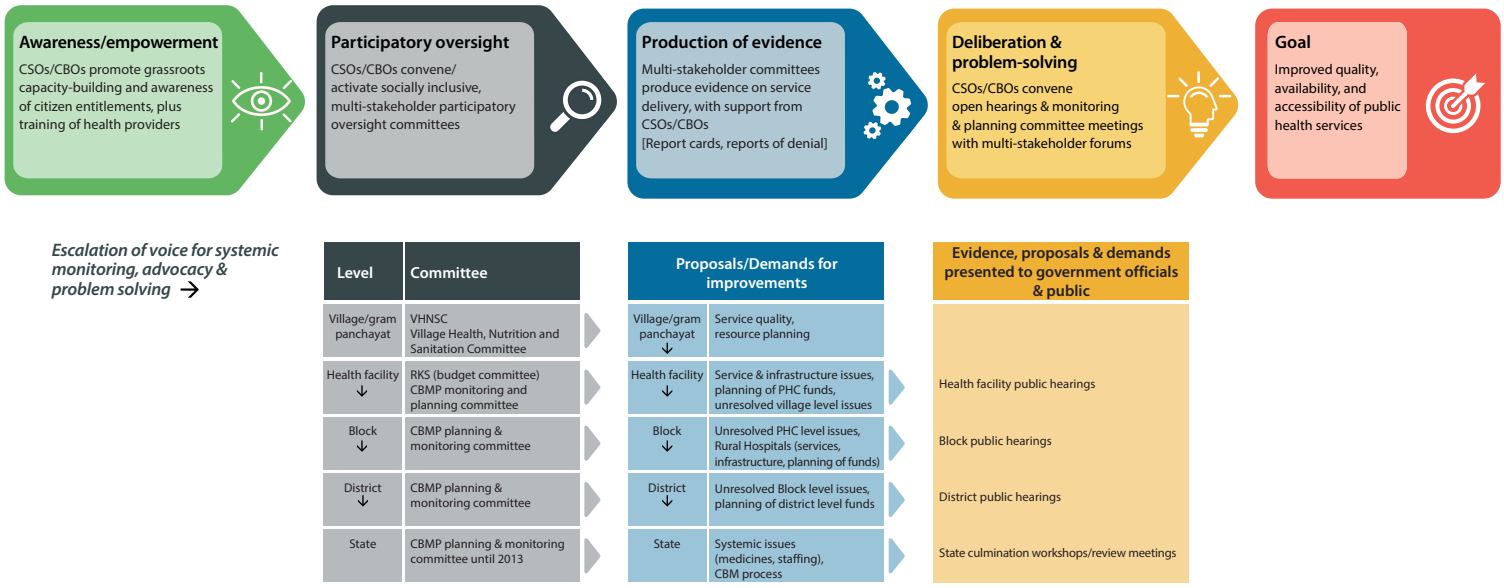
Source: Batzin, Culum, and Fischer-Mackey (2020, 22).

3.6 India: SATHI's community-based health monitoring and planning

Period: Since 2007
Activity or initiative type: Regional health monitoring and planning by CSOs
Primary funder: Indian government National Health Mission

In 2005, the Indian government launched the National Rural Health Mission (known later as the National Health Mission, NHM), which aimed to provide accessible, affordable, and quality health care to the country's rural population. A significant component of the NHM was Community-based Monitoring and Planning (CBMP), currently referred to as Community Action for Health (CAH). CBMP/CAH processes sought to encourage greater synergy between reformers inside and outside the government (Figure 3).

Figure 3. Escalation in SATHI's Community-based Monitoring and Planning Strategy



Source: Shukla et al. forthcoming

The civil society organization SATHI has been implementing CBMP/CAH processes in Maharashtra State since 2007. Despite national de-prioritization of the NHM in 2014, CBMP/CAH has remained influential in Maharashtra, India's second most populous state. SATHI in Maharashtra has continued to be significant, as CSOs in the state attempt to maintain a certain level of independence for citizen demands while balancing their collaborations with the government.

SATHI's strategy is based on a multilevel approach to engaging with the public health system; the organization has sought to coordinate its decision-making influence at all levels—village, block, district, and state. At each level, committees and public forums monitor and transmit information for advocacy and often escalate unaddressed concerns. For instance, "when CBMP activities identify problems that do not get addressed at local levels, the CSO network escalates problem-solving efforts putting the issues on the agenda of discussions with more senior health system authorities" (Shukla et al. forthcoming).

The most prominent piece of evidence regarding the continued legacy of SATHI's CBMP/CAH processes in Maharashtra is the forthcoming Accountability Research Center working paper by Shukla et al., which examines large-scale participatory processes to promote social accountability in public health services. There has also been scholarly research on the origins and dynamics of the NHM in India more broadly (Gaitonde et al. 2017), as well as a discussion of NHM in Maharashtra specifically (Shukla, Khanna, and Jadhav 2018). SATHI has also published reports on the role of citizen monitoring and accountability within CBMP. This meta-analysis draws primarily from the most recent forthcoming working paper, which specifically identifies and uplifts the multilevel and escalation aspects of SATHI's work in the state (Shukla et al. forthcoming).

3.7 Indonesia: Government Accountability and Improved Services

Period: 2014–2018
Activity or initiative type: Donor-funded, NGO-led program
Primary actor: Yayasan Wahana Visi Indonesia (World Vision Indonesia)
Funding: World Bank Global Partnership for Social Accountability (GPSA)

The Citizen Voice and Action for Government Accountability and Improved Services program aimed to improve the provision of maternal, newborn, and child health and nutrition (MNCHN)—specifically the *quality and quantity* of services provided by midwives and District Health Offices—by strengthening the full system of health policy, delivery, and feedback.

The program applied World Vision International's CVA approach (Box 1, Section 3.2) in 60 villages across three districts of Indonesia's East Nusa Tenggara province. The program trained and supported village-level facilitators who ran a series of processes at village, sub-district, and district levels. Through these processes, villagers and local staff were able to assess MNCHN services against both official standards and villager-determined standards, develop local plans for service improvement, and advocate for these at higher levels of the service delivery system.

The project's focus on system strengthening demonstrates an understanding of the need to 'take scale into account' when seeking to address the underlying causes of failures embedded within and across the health system. This meant employing a strategic approach that expanded the boundaries of policy advocacy beyond the local level to include decision-makers and officials at the community, district, and national levels as well.

The MNCHN program's multilevel approach was facilitated by an enabling political environment. Independent evaluations found that national provisions for maternal and child health, as well as greater support for democratization and accountability in the national legislative and regulatory sphere, contributed to the effectiveness of the CVA model (Westhorp and Ball 2018, 13). The enabling national context may have also led to higher rates of achievements at higher levels of the service system (*Puskesmas* (sub-district) and *Polindes* (village) level) than at *Posyandu* (sub-village) level. While only a small instance, this demonstrates at the local level how 'taking scale into account' should be considered when planning vertically integrated strategies. The extent to which this takes place remains an open question for further research. There was also significant activity at the national level. For instance, World Vision, with partners, produced policy briefs and national action plans on social accountability and worked with the Indonesian Ministry of Villages to scale up and institutionalize their CVA social accountability approach.

3.8 Pakistan: Empowerment, Voice, and Accountability for Better Health and Nutrition

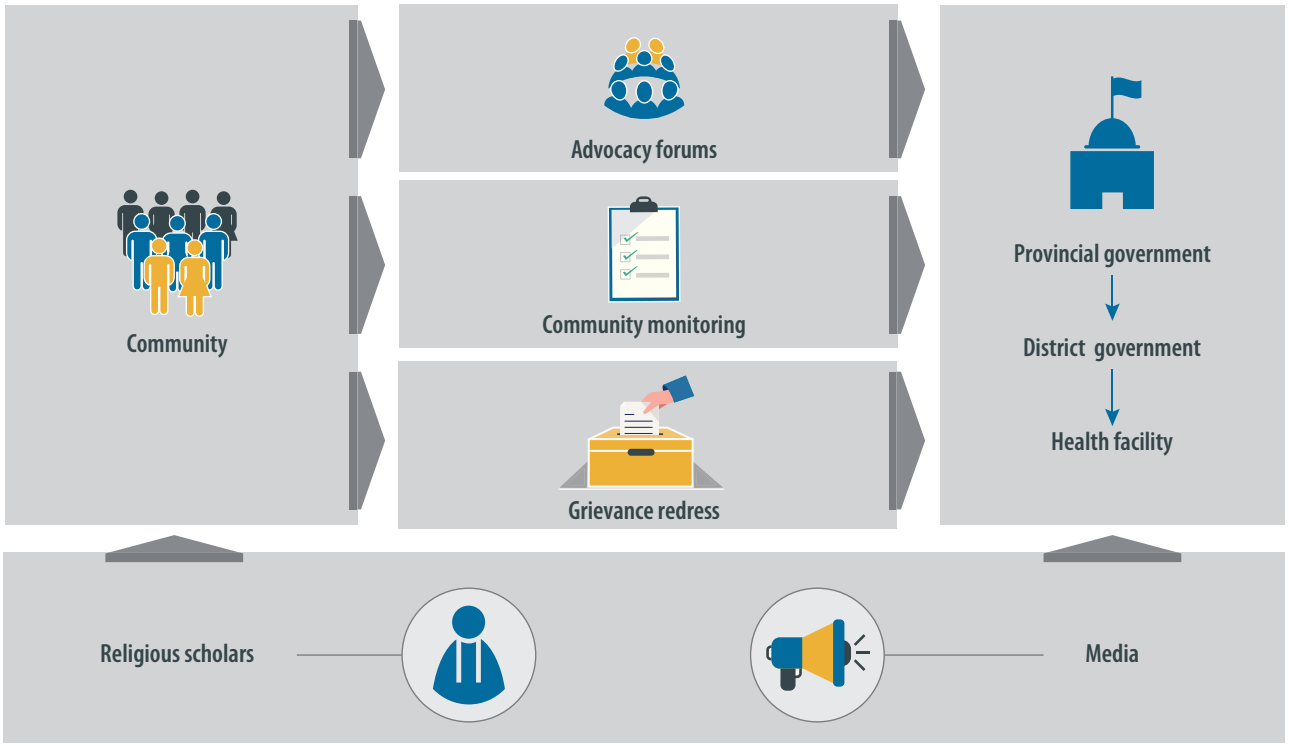
Period: 2014–2019
Activity or initiative type: Donor-funded, NGO-led program
Primary actors: Palladium and the Center for Communications Programs Pakistan
Funding: UK Department for International Development (DFID, now Foreign, Commonwealth and Development Office)

Empowerment, Voice, and Accountability for Better Health and Nutrition (EVA Pakistan) was a component of DFID Pakistan's flagship maternal and child health and nutrition program.

EVA Pakistan sought to empower and equip citizens in Punjab and Khyber Pakhtunkhwa provinces to hold government stakeholders accountable for better quality MNCH services and outcomes. Initial challenges and early successes (namely, securing service improvements through the application of bottom-up pressure) prompted the EVA Pakistan team to rethink the program's assumptions, reconcile internal differences, and consider how to leverage local knowledge more effectively (Kirk 2017).

After a substantial redesign, EVA Pakistan instituted a multilevel approach to monitoring and advocacy, wherein community concerns were escalated to the district and provincial levels via mechanisms such as advocacy forums, community monitoring, and grievance redress (Figure 4).

Figure 4. EVA Pakistan's Different Avenues for Raising Voice for Quality MCNHN Services



Source: Palladium EVA-BHN Program Theories of Change (December 2015)

This shift towards multilevel monitoring and advocacy, which saw the EVA Pakistan team link community groups to representatives working at the district level, enabled the program to:

> Demonstrate to senior powerholders that the demands it raise[d] come from active communities; as opposed to a well-meaning but ultimately irrelevant donor organization. It also allows issues that require managerial or policy changes to be debated at higher levels. (Kirk 2017, 22)

As the EVA Pakistan program continued, this multilevel approach became more central to its theory of change. Therefore, a key lesson that emerged from EVA was how the introduction of vertically integrated monitoring and advocacy efforts can be important to supporting social accountability in difficult contexts.

3.9 Peru: Participatory Voices

Period: 2008–2011
Activity or initiative type: Donor-funded project led by civil society network
Primary actors: ForoSalud,[1] CARE Perú, and the regional Ombuds Office
Funding: UK Department for International Development (DFID, now Foreign, Commonwealth and Development Office)

The Participatory Voices project trained indigenous women in Peru's Azángaro and Melgar provinces to monitor health services and facilities—specifically the right to good quality, appropriate, and culturally respectful maternal health services (Aston 2015).[2] The project had four central components: (1) tailored capacity building; (2) paired citizen monitoring of health facilities; (3) service user interviews in indigenous languages; and (4) regular documentation and production of monitoring reports with the regional Ombudsman's Office, the Departmental Office for Integrated Health Insurance, and project staff. Regular check-ins generated a 'dialogue agenda' for meetings with local government health officials, provincial hospital directors, and their staff.

The evidence regarding CARE and ForoSalud's defense of maternal health rights in Peru has been discussed extensively in the literature (Aston 2015; Samuel and Frisancho 2015; Frisancho 2021; Samuel and Frisancho 2022). Aston (2015) discusses how the program's citizen monitoring model improved service delivery quality and health facility transparency, reduced corruption, and increased demand for health services. Frisancho, a former president and directorate member of ForoSalud, also discusses the model of "*vigilancia ciudadana*" ("citizen oversight") and the speed with which it was embraced by local leaders in Quechua (Frisancho 2021; Samuel and Frisancho 2022). According to one local leader, transparency and monitoring at all levels—from the top to the bottom—are valued: "This is what we want. We want to see the bottom. For everything to be clear, like the water in this glass" (Frisancho 2021).

3.10 Uganda: Accountability Can Transform Health

Period: 2012–2018
Activity or initiative type: Donor-funded NGO program
Primary actors: GOAL Uganda, the Coalition for Health Promotion and Social Development, Kabarole Research & Resource Centre, and Multi-community Based Development Initiative
Funding: Irish Aid (2012–2015); UK Department for International Development (DFID, now Foreign, Commonwealth and Development Office) (2016–2018)

Accountability Can Transform Health (ACT Health) was a three-phase program that aimed to promote direct engagement between citizens and public servants in the Ugandan health system (Bailey and Mujune 2022). The initial pilot (2012–2015), took place in one district and 33 government health facilities; with funding from UK Aid, this was expanded to 16 districts and 282 government health facilities for the first phase of full implementation (2014–2016). Phase 1 included establishing community-level dialogues with elected government health officials to surface community concerns. This first phase was evaluated via a randomized control trial (RCT), after which the second phase of full implementation (2016–2018) added a new approach wherein program staff accompanied volunteer community advocates. Phase 2 was implemented across 18 districts and 98 government health facilities, with a total of 396 community advocates.

Bailey and Mujune (2021) provide an in-depth analysis of how ACT Health approaches evolved across the phases, the weaknesses of the RCT, and the extent to which both vertical and horizontal efforts took place in Phase 2 of the program. For instance, beginning in 2016, community-level advocates collected health facility monitoring data and were supported by local civil society staff to aggregate that data across communities and take it upward to engage directly with government officials at the regional and national levels. This was expanded in Phase 2, as advocacy campaigns strategically identified and targeted government officials across five levels of government (ibid, 26).

Table 2. **Patterns of Multilevel Monitoring and Advocacy in Health Systems Programs**

KEY

- Evidence of high intensity of action
- Evidence of medium intensity of action
- Evidence of low intensity of action
- No evidence of action present in documentation

Program by country	Sub-district and facility			District			Regional/provincial			National		
	Monitoring	Advocacy	Outcomes	Monitoring	Advocacy	Outcomes	Monitoring	Advocacy	Outcomes	Monitoring	Advocacy	Outcomes
Bangladesh: Naripokkho												
Bangladesh: Nobo Jatra												
Brazil: AIDS policy												
Ghana: Making the Budget Work												
Guatemala: CEGSS												
India: SATHI												
Indonesia: Government Accountability												
Pakistan: EVA Pakistan												
Peru: Participatory Voices												
Uganda: ACT Health												

4. Emerging Findings from the Meta-analysis

4.1 Most multilevel activity takes place at the 'retail-end' of the health system

All the cases reviewed 'take scale into account' (Fox 2016, 12). However, most of the cases and the intensity of monitoring and advocacy activity are focused at the lower levels of the system, closest to the end-user, as depicted in Table 2. For all but three cases (Brazil AIDS, EVA Pakistan, and SEND Ghana), there is evidence of at least some degree of multilevel monitoring and advocacy taking place at both the health facility/village and district levels.

For instance, World Vision Indonesia's MNCHN program supported health care assessments with the use of community scorecards at two levels of primary and secondary care. At the district level, monitoring was also expanded to include district health budget monitoring. This is an example of how multilevel monitoring reveals "more precisely not only where the main causes of accountability failures are located, but also their interconnected nature" (Fox 2016, 13). However, the findings from this meta-analysis of program documentation raise the question of whether the heavy focus on monitoring at the more 'retail-end' of service delivery health system could have a greater impact if paired with monitoring at higher levels (e.g. national and regional/provincial).

Although all programs but one conducted both monitoring *and* advocacy at village/facility level, where most service delivery takes place, it is unclear to what extent the former informed the latter. For example, all programs conducted some sort of monitoring—predominately through community scorecards, citizen monitoring, and service-user interviews. All programs also included advocacy efforts, including meetings with local health officials, presentations at public forums, leveraging public grievance redress mechanisms (as in the case of EVA Pakistan), and reviving previously moribund committees (discussed in greater detail below). However, not all programs described expressing *how* data evidence was transformed into advocacy.

One clear example of monitoring data being successfully transformed into advocacy is provided in the case of CEGSS. A peer-reviewed journal article on the program describes how:

> Regular monitoring of health facilities, communication channels with community authorities and health authorities provide a base for engagement with authorities at multiple governance levels… Building on this base of sustained collective action, leaders engaged with authorities at diverse governance levels to bring more attention to the problems documented and seek solutions… (Hernández et al. 2019, 398)

Examples of the power-shifting—towards those seeking to demand and enforce public accountability (Halloran 2021)—tactics used by the health programs are presented below in Table 3.

Table 3. **Examples of Power-shifting Tactics Utilized in Multilevel Health Programs**

Program	Key power-shifting tactics
Naripokkho	Community reactivation of moribund oversight institutions Strengthening of women-activist-led CBOs
Nobo Jatra	Use of World Vision's Citizen Voice and Action approach and evidence Intentional 'trickle-up' approach
National AIDS policy	Partnership between federal bureaucrats and local activists Horizontal coalition building
Making the Budget Work	Program-led budget sensitization campaign Creation of district committees and networks
CEGSS	Horizontal organizing and publishing evidence in the media Escalation of district-level concerns
CBMP/CAH	Escalation at all levels Flexible, community-oriented problem-solving approach to discourse and action
Government Accountability and Improved Services	Use of World Vision's Citizen Voice and Action approach Health budget monitoring
EVA Pakistan	Escalation of concerns upwards Program-led initiation of public oversight institutions
Participatory Voices	Partnerships between citizen monitors and oversight institutions Capacity building of women leaders
ACT Health	Horizontal organizing Escalation at multiple levels

Table 4. Summary Table of the Extent of Multilevel Power Shifting Tactics in Health Cases

KEY

	Evidence of high intensity of action
	Evidence of medium intensity of action
	Evidence of low intensity of action
	No evidence of action present in documentation

Program (location)	Sub-district and facility			District			Regional/provincial			National	
	Horizontal organizing	Oversight institutions	Escalation to next level	Horizontal organizing	Oversight institutions	Escalation to next level	Horizontal organizing	Oversight institutions	Escalation to next level	Horizontal organizing	Oversight institutions
Naripokkho (Bangladesh)											
Nobo Jatra Program (Bangladesh)											
National AIDS policy (Brazil)											
Making the Budget Work (Ghana)											
CEGSS (Guatemala)											
SATHI (India)											
MNCHN CVA (Indonesia)											
EVA (Pakistan)											
Participatory Voices (Peru)											
ACT Health (Uganda)											

4.2 Patterns of activity at the regional level are less clear than those at lower (local) and higher (national) levels

All programs discuss monitoring and advocacy at the most localized levels (health facility and village levels). Most programs (six out of the ten cases) also reported positive outcomes as a result of citizen oversight at both the local and national levels. However, only four programs—SATHI in India, SEND-Ghana, Brazilian AIDS policy, and EVA Pakistan—reported any monitoring taking place at regional or provincial levels, illustrating a 'missing middle' (Gaventa and McGee 2010).

Despite this lack of reported *activity*, many programs identified *outcomes* at both the regional and national levels. The most notable example is the case of Brazilian AIDS policy implementation. Due to the highly decentralized nature of social policy implementation in the country, federal bureaucrats (i.e. at the national level) partnered with established activists at the local level—in an example of a 'sandwich strategy'—to monitor implementation by sub-national and regional governors.

In another case from Latin America, citizen monitors worked *in collaboration* with regional actors, rather than monitoring them. The Participatory Voice program in Peru enabled citizen monitors and regional-level officials to work together to request that the National Health Minister officially recognize citizen monitoring committees at the local level (though this policy was never carried out). In this case, it was unclear what monitoring activities took place at the regional level or how they affected national decision-making; citizen monitors reported the need to strengthen regional presence in vertical integration through "a renewed, joint effort in which the Ministry of Health, the regional and local governments, and civil society networks converge and ensure implementation of mechanisms of citizen participation and citizen monitoring" (Frisancho 2013, 15).

The use of escalation varies, as does its articulation in program plans and theories of change. Only half of the cases reviewed—EVA Pakistan, CEGSS, Nobo Jatra, MNCHN Indonesia, and ACT Uganda—made use of escalation pathways to enable unaddressed citizen claims at one level to be moved upwards. Among the initiatives that *did* use escalation, the extent to which pathways were explicit in their initial planning and theories of change varied. For example, Nobo Jatra in Bangladesh intentionally implemented a 'trickle-up' approach to advocacy, which aimed to spur decision-making at the regional and national levels (Long and Panday 2020, 13). The program evaluation found that the CVA approach resulted in greater clarity, delegation, and escalation of accountability across levels. One example of the CVA approach in action was the creation of a globally unique citizen feedback cloud database that aggregated data to help track government response to citizen demands and support national lobbying. Therefore, while the database was not originally conceptualized as 'escalation,' its use was purposively driven and not reactive. In the MNCHN CVA program in Indonesia, escalation pathways were not evident in project documentation and evaluation; however, the program did strategically escalate unaddressed issues (identified by monitoring and advocacy at the grassroots level) to the district (and to a lesser extent, provincial) level, where budget and planning authority is concentrated.

The SATHI program in India also utilized escalation pathways for problem-solving at multiple levels in the state of Maharashtra but did not refer to such processes as 'escalation' until later reflection (Shukla et al. forthcoming). Such escalation pathways were not intentionally defined or developed during design but became evident after the program began. See Figure 3 above in Section 3.6 for a visual presentation of the escalation strategy.

Horizontal organizing is another important strategy, but less present than vertical integration. The available evidence reveals examples of horizontal organization in six of the ten reviewed cases, predominately at the district level. For instance, ACT Uganda enabled horizontal organizing by convening citizens from multiple health centers across multiple villages. This included intra-district and inter-district organizing. Within each district, "a minimum of five health centers had active community advocates collaborating on a joint advocacy campaign" (Bailey and

Mujune 2021, 23). This enabled community advocates to coordinate monitoring strategically and support collective voice. Similarly in SATHI, grassroots activists from different villages came together during regularly organized block- and district-level public hearings to present their common health system concerns to officials in what SATHI staff considered a low-intensity form of horizontal integration. Rich (2022) also finds evidence of "horizontal/bottom-up efforts" to support civic coalition-building among AIDS NGOs in Brazil. This was encouraged by national stakeholders to increase grassroots coordination among activists.

The importance of horizontal organizing was also prominent from the start of Nobo Jatra in Bangladesh. In addition to their 'trickle up' strategy of vertical integration, the program used a 'trickle across' strategy of horizontal linkages (Long and Panday 2020, 13). Interestingly, Nobo Jatra expanded the concept, organizing not only citizens across communities but also duty bearers and service providers at the union and Upazila levels (most local levels). In Guatemala, with CEGSS, leaders from different communities similarly mobilized—in one instance to advocate for an ambulance in remote rural areas. The demand for an ambulance was granted, but the extent of horizontal organizing in that region was not subsequently maintained (Hernández et al. 2019, 397).

Who is a 'citizen' and who is in the 'community'? The extent to which programs provide clarity on exactly *who* in the community is engaging in and leading monitoring and advocacy efforts varies. Some programs are explicit: for example, EVA Pakistan trained citizen journalists; CEGSS in Guatemala worked with community health defenders conducting health service user interviews and facility monitoring. Most of the other programs reviewed, however, apply more general terms— such as community 'groups' or 'members'—without identifying who this does or does not include. For instance, both CVA-based programs (MNCHN in Indonesia and Nobo Jatra in Bangladesh), often refer to 'community members' and 'citizens' interchangeably. The implications of these somewhat flat definitions need further exploration; while World Vision International's organizational conception of 'community' may be intentionally broad to include non-citizens such as migrants and refugees in certain contexts, its use could have unintended complications. Without a specific focus on social inclusion under the generic banner of 'community,' there may be a greater risk of elite capture, for instance. Additionally, if we don't distinguish between different community stakeholders or look at which actors are most effective or successful (or unsuccessful) in different contexts, we may limit the extent to which lessons can be learned to inform future social accountability initiatives.

Many of the health accountability programs reviewed attempted to activate (or reactivate) official committees for citizen monitoring and advocacy at the village and district levels to provide public forums and voice citizen demands. Some of these committees were developed by the implementing NGO—that is, created by and for the program. In other instances, the program supported the reactivation of moribund official government-convened committees. But how sustainable are these committees *once the program has ended*? In looking at the example of SATHI in India, Shukla et al. (forthcoming) found that official government-established committees were substantially more active in intervention areas than non-intervention areas, even years after the program had ended. This points to a potential 'afterglow' effect of accountability programs. The reviewed cases also reveal differences in who leads the activation of oversight committees, which raises questions regarding agency. For example, in the case of Nobo Jatra, it was program staff who activated previously dormant committees; while in the Naripokkho case, it was coalition-supported, women-activist-led community members.

The nature of the available documentation affects the evaluability of multilevel health programs and limits analysis of "who did what." This meta-review chose to focus primarily on donor-funded and NGO-implemented health programs, based on the assumption that such programs are more likely to have rigorous and publicly available evaluations and reports. However, this comes with its own challenges. Because evaluations are typically conducted for donor-driven accountability purposes, some NGOs are inclined to emphasize the outputs and results of program-funded staff and activities. While this is not always the case (CEGSS and ForoSalud describe the role of community health defenders and monitors in detail), most other programs refer broadly to community members and attribute most activities to program staff. This may mean that certain efforts are minimized or omitted.

5. Conclusion

This meta-analysis has looked across empirical examples of the undertheorized question of multilevel approaches to citizen oversight of government health delivery. It has also explored the extent to which such approaches to multilevel monitoring and advocacy take place. All ten cases demonstrate just how often vertical integration *does* take place—even if it is not always intentional or expansive.

The cross-case comparison also highlights the strength of citizen-led monitoring at the 'retail-end' of health service delivery. However, many concerns identified at the local and community level are a result of political and financial decision-making at much higher levels of the state. This points to a potential 'missing middle' as less advocacy and monitoring takes place at regional and provincial levels of government, despite the greater potential efficacy of such efforts (Gaventa and McGee 2010). Similarly, this review has also highlighted the importance of escalation, identifying it as a distinct process within multilevel monitoring and advocacy that is not often clearly theorized in programming.

These insights pose questions as to how citizens can escalate concerns to decision-makers with power over budgetary and human resources decisions and how to build a broad constituency of support for shared goals. Moving forward, further research is also needed on the enabling conditions and effectiveness of multilevel approaches to monitoring and advocacy and the extent to which citizens can organize collectively both vertically (across levels) and horizontally (across communities).

Notes

1 ForoSalud is the largest civil society network in the Peruvian health sector.

2 Training was conducted in Quechua or Aymara, though most participants also spoke Spanish (Aston 2015).

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