DISCUSSION PAPER / 2022.03

Social accountability initiatives in the delivery of public services in Sub-Saharan Africa

A systematic literature review

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June 2022

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Abstract

Poor public service delivery is pervasive in Sub-Saharan Africa. Weak institutions, ineffective monitoring systems, and weak accountability relationships between actors involved in the service delivery chain have exacerbated the problem. Social accountability has emerged as an innovative strategy that aims to improve public sector performance by engaging ordinary citizens in exacting accountability as well as bolstering state/providers' responsiveness. How do information interventions social accountability initiatives impact public service delivery? This study conducts a systematic literature review of the impact of these interventions and identifies common facilitating or limiting factors that mediate the impact. Relevant articles published between 2000 and 2021 were searched from the Web of Science and Scopus database and, the final list covered in this review included articles published between 2005 and 2021. A total of twenty-two (22) peer-reviewed articles, published in the English language, gauging social accountability interventions in twelve (12) countries of Sub-Saharan Africa were eligible for inclusion. Both quantitative and qualitative study designs were included. The findings from twenty-seven (27) social accountability interventions identified in twenty-two (22) studies provide mixed evidence of impact on access to and quality of public services delivery, particularly in health and education service. The results further suggest that provision of actionable information, overcoming elite capture and collective action problems, collaborative engagement of multi-stakeholders, the existence of structures promoting state-society interactions, the institutionalization of social accountability within state structures, the history of citizen-state engagement, the willingness of political and traditional leaders, and sandwiching of bottom-up and top-down accountability approaches are crucial for factors for success. Contrarily, inappropriately designed social accountability mechanisms, conflicts between actors, cultural heterogeneity, exclusion of supply-side actors, and poor program implementation undermined the success of social accountability initiatives in improving service delivery. Hence, in the presence of weak institutions in Sub-Saharan Africa, social accountability initiatives can potentially improve public service delivery when contextual, intervention design, and implementation factors mediating its effectiveness and impact are carefully considered along the causal chain. More research that builds a more rigorous theory of change studying the impact of social accountability in various sectors and contexts while using diverse mechanisms is essential to allow a strong and generalizable conclusion of the findings. Also, to enable unpacking the black box of impact, more research examining impact while adopting the mixed-methods approach is crucial.

1. Introduction

Effective public service delivery is crucial for human development and poverty reduction (World Bank, 2003). Yet, poor public service delivery is pervasive in developing countries-Sub- Saharan Africa included (Chaudhury et al., 2006; Molina et al., 2017; Reinikka & Svensson, 2011). Teacher and health worker absenteeism, corruption, inefficient allocation of resources, leakages of funds and subsidies are widespread in the public sector and have adversely affected access and quality of public service delivery (Aker & Ksoll, 2019; Bjorkman & Svensson, 2009; Chaudhury et al., 2006; Duflo et al., 2015; Pan & Christiaensen, 2012; Reinikka & Svensson, 2011).

The World Bank's 2004, *World Development Report* on public service delivery directly identified a failure in public service delivery as a failure in accountability relationships between actors involved in the service delivery chain. This report further argued that the weakness embedded in the long route to accountability- through elected politicians and policymakers via providers- often failed the citizens especially, the poor. Moreover, Bjorkman & Svensson (2009), Chaudhury et al. (2006) & Devarajan et al. (2011) urged that the ineffective systems of monitoring and weak accountability of actors involved in service delivery and implementation of public sector policies have resulted in poor public service delivery. Furthermore, other scholars such as Bardhan (2002), Bjorkman & Svensson (2009), and Fox (2015) asserted that poor public service delivery is more prevalent in developing countries (Sub-Saharan Africa included) because the institutions assigned for monitoring and exacting accountability[1] are often weak, non-responsive, or non-existent.

[1] Exacting both horizontal and vertical accountability. Fox (2015, p.347) defined horizontal accountability as "the mutual oversight embedded in the state institutions of check and balances" and vertical accountability as "the political accountability relationships between citizens and their elected representatives".

Considering the above arguments, Stiglitz (2002) claimed that direct involvement of ordinary citizens is crucial for better service delivery as ordinary citizens have more incentives to monitor and hold service providers accountable. In addition, the 2004 *World Development* Report on public service delivery argues that strengthening the short route to accountability- by directly involving citizens especially, the poor, in exacting accountability (i.e., through client power)-can potentially improve service delivery for the poor citizens too. However, Fox (2015) asserted that the short route metaphor proposed by the World Development Report(2004) is not direct as initially postulated[2] , and its success may depend on making long route actors more responsive. Thus, strengthening the short route while enhancing the responsiveness of supply-side actors in the long route is critical for success.

While Malena et al.(2004) defined the direct involvement of citizens in exacting accountability for improved service delivery as social accountability, Fox (2015) described social accountability as strategies/initiatives that try to improve public sector performance (i.e., service delivery included) by engaging ordinary citizens in exacting accountability and bolstering public responsiveness of the state. He further argued that the initiatives that create an enabling environment for collective action combined with bolstered state capacity to respond to citizens' voices are more promising. Thus, in the context where institutions responsible for exacting accountability are weak or irresponsive, scholars and practitioners believe that social accountability initiatives can enhance accountability for improved service delivery.

The potentiality of social accountability initiatives in improving public service delivery has captured the interest of many scholars; however, there is still fragmented evidence on its impact. For instance, (Andrabi et al.,2017; Argaw et al., 2021; Bjorkman & Svensson, 2009; Duflo et al.,2015; Keefer & Khemani, 2014; Gullo et al.,2017; Molina 2015; Pandey et al.,2009; Pradhan et al.,2014 and Reinikka & Svensson, 2011) have documented positive impact in service delivery outcomes while, others (Arkedis et al.2021; Banerjee et al.,2010; Falisse & Ntakarutimana 2020; Olken,2007 and Ravallion et al.,2013) found no impact of social accountability intervention in service delivery outcome. Development practitioners and researchers argue that the fragmented evidence of impact is not entirely surprising because the evidence covers a broader range of interventions implemented in diverse contexts with various study designs. (Fox, 2015; Joshi, 2013; Ringold et al., 2011; Grandvoinnet et al., 2015)

Although systematic and non-systematic evidence of its impact covering various countries in Asia, Latin America, and Sub-Saharan Africa has been documented by Fox (2015), Gaventa & Barrett (2010), Gaventa & Mcgee (2013), Joshi (2013), Molina et al. (2017), Ringold et al. (2011), Westhorp et al. (2014) and Waddington et al. (2019) still, there is insufficient systematic evidence of impact and common factors facilitating or limiting its success, particularly in Sub-Saharan Africa. In addition, O'Meally (2013) and Brinkerhoff & Azfar (2006) also argue that limited systematic evidence of impact limits the ability of major donors' and practitioners' to make a precise claim on the impact of these initiatives in service delivery. Moreover, the World Bank Country Policy and Institution Assessment (CPIA) index for the public sector shows that Sub-Saharan African (SSA) countries scored low in terms of public administration, accountability, transparency, and corruption in public sectors, as such these have weakened the public sector performance and poverty reduction in large (World Bank, 2020). Therefore, strengthening social accountability practices in this region is among the way to solve governance failures and improve public sector performance.

Thus, gathering new evidence on the impact of social accountability interventions in public service delivery, mainly in Sub-Saharan Africa, is useful to inform practitioners, policymakers, and researchers and contribute to the literature. It is on this account that this review intends to fill the gap by systematically assessing and synthesizing the evidence of the impact of social accountability initiatives in Sub-Saharan Africa for the past two decades and further identifying common facilitating and limiting factors that mediate its impact.

This paper is structured as follows: section **two** briefly presents the social accountability concept, social accountability interventions, and hypothesized theory of change, sections **three** and **four** present study objectives and methods, sections **five** and **six** present and discuss findings and limitations of the

[2] Fox (2015) urged that the short route metaphor is not direct as initially postulated because institutions' failure is not primary local (i.e., not attributed to providers only); instead, it is distributed to the whole governance supply chain.

review. Finally, section **seven** provides the conclusion and recommendations of the study.

2. UNDERSTANDING SOCIAL ACCOUNTABILITY

Accountability is "the obligation of power-holders to account for or take responsibility for their actions" (Malena et al., 2004, p.2). Power holders "refer to those who hold political, financial, administrative or other forms of power and include officials in government, private corporations, international financial institutions and, civil society organizations" (Malena et al., 2004, p.2).

The term accountability entails two concepts which are answerability and enforceability (Schedler,1999). Answerability is "the obligation of public officials to inform about and to explain what they are doing," while enforceability is "the capacity of accounting agencies to impose sanctions on power holders who have violated their public duties" (Schedler, 1999, p.14). Accountability is further classified as horizontal, vertical, or diagonal. Horizontal accountability refers "to the mutual oversight embedded in the state institutions of check and balances" (Fox, 2015, p.347). This type of accountability is also referred as state-centered or internal (Brinkerhoff & Wetterberg, 2016; Lindberg, 2013; Malena et al., 2004; Schedler, 1999). Vertical accountability refers "to political accountability relationships between citizens and their elected representatives" (Fox, 2015, p.347), while diagonal accountability "refers to the hybrid combinations of horizontal and vertical oversight, involving direct citizen engagement within state institutions" (Fox, 2015, p. 347).

Social accountability is defined as "an approach towards building accountability that relies on civic engagement, i.e., in which ordinary citizens and/or civil society organizations participate directly or indirectly in exacting accountability" (Malena et al., 2004, p.2). Similarly, Grandvoinnet et al. (2015, p.3) defined social accountability as "the extent and capacity of citizens to hold the state and service providers accountable and make them responsive to needs of citizens and beneficiaries." Social accountability is also referred to as vertical accountability; however, in this case, the accountability is between citizen and state and is beyond election (Grandvoinnet et al., 2015; Malena et al., 2004; Peruzzotti &Smulovitz, 2006). In social accountability, ordinary citizens, civil society organizations, or both can demand accountability either directly through affecting elected politicians and/or appointed state officials or indirectly by triggering horizontal accountability mechanisms (Grandvoinnet et al., 2015; Malena et al., 2004). Social accountability encompasses a diverse array of actions such as citizen monitoring and oversight on public sector performance, user-centered public information access and dissemination, citizen participation in actual resource allocation decision making such as participatory budgeting, participatory public policymaking, complaints, and grievance redress mechanism (Fox, 2015; Malena et al., 2004). These actions can be initiated by citizens, government, or both but are often demand-driven and operate from the bottom-up (Malena et al., 2004).

Social accountability actions are urged relevant specifically in the context where conventional accountability mechanisms-horizontal and vertical- are weak or ineffective. Therefore, these actions are intended to complement and trigger conventional accountability mechanisms (Fox, 2015; Grandvoinnet et al., 2015; Malena et al., 2004). Scholars and practitioners have widely propagated the social accountability actions because of their capacity to increase the effectiveness of public service delivery, improve governance and democracy, empower citizens (i.e., the poor, disadvantaged, and marginalized), reduce corruption, improve state-society synergy[3], contribute to better policy design and responsive public officials (Brinkerhoff & Wetterberg, 2016; Grandvoinnet et al., 2015; Joshi, 2014; Malena et al., 2004). Given the broad expected aims or impacts of social accountability actions presented, this review mainly focuses on the influence or impact of social accountability actions on improving public service delivery in Sub-Saharan Africa.

[3] State society synergy such as institutional channels for interaction, trust, legitimacy, democratic deepening and state building (Grandvoinnet et al., 2015; Joshi, 2014).

2.1. Social accountability interventions

Social accountability interventions, often referred to as social accountability mechanisms are "efforts to provide information to the citizen and channels to enable them to use the information to hold service providers accountable. These efforts intend to increase citizen agency both individually and collectively" (Ringold et al., 2011, p.8). Social accountability interventions create opportunities for the citizens to monitor service providers and state for improvement in service delivery outcomes (Molina et al., 2017; Waddington et al., 2019). In the context of this study, monitoring means a process of measuring, recording, collecting, analyzing information, communicating, and acting on that information to improve performance by holding service providers and politicians accountable (Grandvoinnet et al., 2015; Molina et al., 2017).

Stiglitz (2002) pointed out that community members have more incentives to monitor service delivery than providers as they draw more benefits from improved service delivery (Molina et al., 2017). This idea has led to more scholarly work introducing social accountability interventions (e.g., experiments, action research, etc.) to study their potential to improve service delivery in Sub-Saharan Africa. For instance, Alhassan et al. (2019), Bjorkman & Svensson (2009), Gullo et al. (2017), and Ho et al. (2015) used community scorecards to improve health outcomes in Ghana, Uganda, Malawi, and Congo, while Keefer & Khemani (2014) and Reinikka & Svensson (2011) adopted information campaigns to improve education outcomes in Benin and Uganda respectively.

Social accountability interventions are usually grouped into two sets which are information interventions and grievance redress mechanisms (Ringold et al., 2011). Information interventions include all efforts that aim to provide information to community members to enable them to use this information to hold service providers accountable for improvement in service delivery. These include the right to information by legislation, information campaigns, community scorecards, citizen report cards, and social audits (Ringold et al., 2011). Grievance redress mechanisms (GRMs) are formal sets of arrangements that give opportunities to citizens to demand their rights, raise their complaints, and provide service delivery feedback to providers and policymakers (Ringold et al., 2011). **Table 1** summarizes the social accountability interventions that aim to influence service delivery outcomes by allowing the community to monitor services as the central intervention.

Access to information is a legal right that enhances citizens to demand information from public authorities. Allowing citizens to access information from public authorities provides opportunities for them to monitor and hold providers accountable for improvement in service delivery (Ringold et al., 2011).

Information Campaigns (IC) are interventions that usually provide information about citizens' right to access services and information about the performance and quality of service delivered or performance of providers or politicians. Such campaigns mainly aim to encourage participation and accountability for improvement in service delivery (Molina et al., 2017; Ringold et al., 2011; Waddington et al., 2019). Information could be offered through various means such as radio, televisions, public gatherings, door to door, and newspapers. For example, Keefer & Khemani (2014) and Reinikka & Svensson (2011) used radio and newspapers campaigns in Benin and Uganda to influence education outcomes.

Table 1. Social accountability interventions.

Information Interventions	
Right to information legislation	A legal framework that enables the citizens to demand information from public authorities.
Information campaigns	These are efforts to inform citizens about their entitlements to service, standards, quality, and service performance.
Community Scorecards (CSC)	A quantitative survey of community satisfaction with public service delivery includes an interface meeting between service providers and the community to agree upon joint action plans.

Report cards (RC)	A report which provides information about the performance of service delivery and/or service providers can involve ranking or comparison of services or service providers
Social audits	A participatory inspection in which community members compare stated service delivery output by providers and actual service delivery output collected from users. The audit is usually conducted at the public hearing
Grievance redress mechanisms (GRM)	
Courts	These are legal redress mechanisms through courts systems. The courts can redress service failure by providers by enforcing them to adhere to statutory and contractual obligations
Government redress agencies	These are redress mechanisms that operate within government institutions. It involves various avenues for grievances and complains
Independent redress institutions	These are redress mechanisms that operate outside the government agencies. It includes ombudspersons, tribunals, Civil society organizations (CSO's), and labor unions

Source: Grandvoinnet et al. (2015), Molina et al. (2017), and Ringold et al. (2011)

Report cards (RC) are forms of information campaigns that provide information about the performance of either service delivery and/or service providers to the citizens. They often involve ranking or comparing services offered by different service providers (Ringold et al., 2011). Report cards usually provide passive information and do not involve interface meetings between providers and users (Ringold et al., 2011). Andrabi et al. (2017) adopted reports cards in Pakistan to influence education quality.

Community scorecards (CSC), often referred to as Citizen report cards (CRC), are information interventions that directly involve the community/ citizens in assessing the service delivery performance (Ringold et al.,2012). They also provide feedback on the providers' performance and conduct interface meetings between users and providers for discussing the results and documenting joint action plans (Grandvoinnet et al., 2015; Ringold et al., 2011). CSC's are also regarded as active information campaigns (Ringold et al., 2011). Bjorkman & Svensson (2009) and Gullo et al. (2017) reveal that community scorecards positively impacted health outcomes in Uganda and Malawi.

Social audits are a form of community inspection that allows the community to monitor service delivered by inspecting the information reported by service providers against the information collected from services users. This form of audit usually crosschecks the information on providers' attendance, eligibility of service users to receive subsidies and transfer payments, and proper allocation of funds (Ringold et al., 2011). Social audits involve interface meetings between politicians, service providers, and users (Molina et al., 2017; Ringold et al., 2011). Social audits have been a prominent accountability tool in India, Indonesia, and Columbia (Afridi & Iversen, 2014; Molina, 2015; Olken, 2007; Singh & Vutukuru, 2010).

Grievance redress mechanisms (GRMs) are formal accountability mechanisms of last resort that give citizens opportunities to voice their demands and provide feedback to the government regarding service delivery and/or government programs. The feedback is usually in terms of complaints or grievances through various institutions/ agencies within or outside the government (Ringold et al., 2011). Grievance redress mechanisms(GRMs) are categorized into three types: within government agencies, redress through independent institutions and redress through the court system (Ringold et al., 2011). Redress within government agencies is a type of GRMs where government agencies establish various avenues within service delivery points (such as schools, hospitals, local government offices, or ministries) to receive complaints and/ or grievances on the performance of service delivery or government programs. The avenues for filing complaints or grievances can be through mailboxes, text messages systems, websites, telephones hotlines, and complaints-handling officers (Ringold et al., 2011). Independent redress institutions are institutions established outside the government systems; they include Ombudsmen, trade unions, Civil Society Organizations (CSOs), and tribunals (Ringold et al., 2011). Courts are legal redress mechanisms through court systems. The

primary role of the court systems when grievances or complaints have been filled regarding service failures or poor handling of government programs is to enforce the agencies or providers to comply with set rules, standards, and contractual obligations (Ringold et al., 2011).

2.2. Theory of change for social accountability interventions

This part presents the hypothesized Theory of Change (ToC) as visualized in **Figure 1**. The ToC explains how these social accountability interventions are expected to impact service delivery outcomes; specifically, on the processes and mechanisms through which these social accountability interventions are expected to work (Joshi, 2014; Molina et al., 2017; Ringold et al., 2011). The presented theory of change is grounded from the conventional theory of change presented by the World Bank's 2004 *World Development Report*. The report articulated the cruciality of actively involving citizens/clients as principles and providers, politicians, and policymakers as agents for improved service delivery outcomes. The assumptions along the causal chain are drawn from Bjorkman & Svensson(2009), Dewachter & Holvoet (2017), Fox (2015), Gaventa & Mcgee (2013), Joshi (2014), Joshi & Houtzager (2012), Lieberman et al.(2014) and Molina et al. (2017) to mention the few.

The theory of change (ToC) in **Figure1** assumes that social accountability interventions that provide passive or active information or avenue for grievances and/or complaints will trigger community participation in monitoring service delivery and providers (Joshi, 2014; Molina et al., 2017; Waddington et al., 2019). As the result of community participation, service providers, politicians, and policymakers will respond by dedicating more efforts to their performance which will ultimately improve service delivery outcomes in terms of access, use, and quality of service delivered (Joshi, 2014; Molina et al., 2017; Ringold et al., 2011; Waddington et al., 2019).

Information or communication campaigns (building block 1) usually accompany many social accountability interventions prior to any citizen action (Joshi, 2014; Joshi & Houtzager, 2012; Molina et al., 2017). Information on rights/ entitlements of services, standards, and performance of government or service delivery are not widely known by the community; thus, providing the community with information will increase their knowledge and establish the basis for citizens action (Joshi, 2014; Joshi & Houtzager, 2012; Molina et al., 2017; Ringold et al., 2011). With the information provided in building block1, the citizens are expected to act collectively (building block 2) by participating in monitoring activities (building block 3) (Bjorkman & Svensson, 2009; Joshi, 2014; Molina, 2015; Molina et al., 2017; Ringold et al., 2011).

Participation in monitoring activities (building block 3) is pivotal for any form of social accountability intervention that intends to influence service delivery outcomes. Participation by a few members may reduce their ability and capacity to voice out their demands and put pressure on providers and politicians to respond (Molina et al., 2017). Participation in monitoring activities can take various forms. For instance, in community scorecards, interface meetings between providers and service users (citizens) are conducted, and joint action plans are set. (Ringold et al., 2011). In social audits, public hearings with politicians, providers and, users(citizens) are carried out, and in grievance/redress mechanism complaints and/or grievances are filled to particular institutions/agencies (Grandvoinnet et al., 2015; Molina et al., 2017; Ringold et al., 2011).

As a result of participation in monitoring activities (building block 3), it is expected that citizens will inform other citizens (building block 5) who did not participate in monitoring activities, and at the same time, citizens will voice out their demands about service delivery failures to elected official-politicians (building block 4) and service providers (building block 6) (Molina, 2015; Molina et al., 2017). Citizens' participation in monitoring activities is assumed to reduce the cost of monitoring frontline providers, increase visibility, and citizens' ability to understand whether politicians are making efforts to improve service delivery (Molina, 2015; Molina et al., 2017). Consequently, politicians will be incentivized to put more pressure on service providers to improve service delivery (building block 8). Moreover, politicians' and citizens' use of formal and informal sanctions is believed to trigger service providers' responses (Molina et al., 2017).

The theory of change in **Figure1** presents processes and mechanisms through which social accountability interventions are expected to impact service delivery. However, these processes and mechanisms

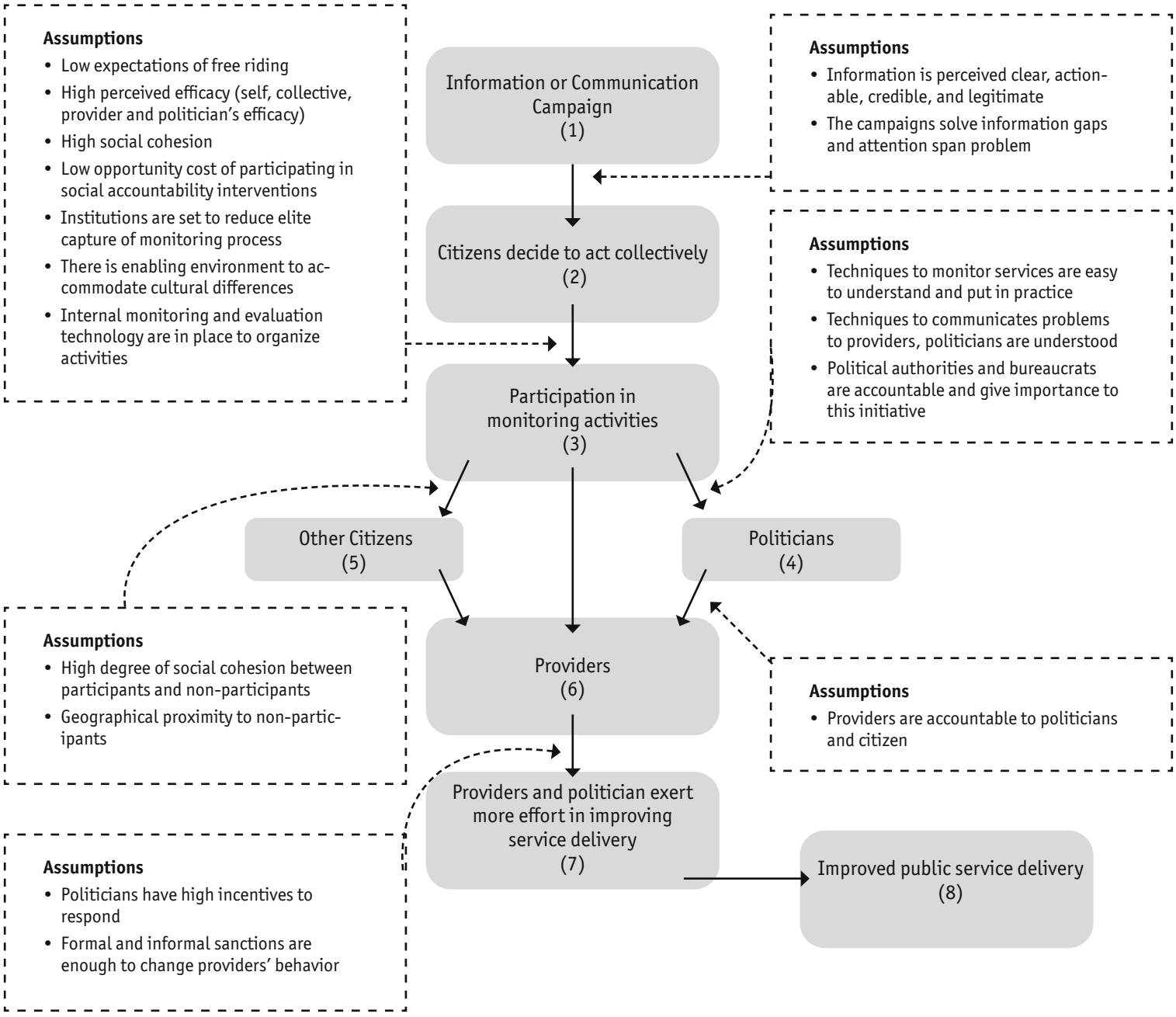
do not happen automatically; they are dynamic and often mediated by several assumptions (Grandvoinnet et al., 2015; Joshi, 2014; Molina et al., 2017). For instance, the information provided by (building block 1) will only trigger collective action (building block 2) when the information is perceived as clear, actionable, credible, and legitimate (Fox, 2007; Fox, 2015; Joshi, 2014). Moreover, Fox (2015) urges that for citizens(i.e., poor) to be able to act on the information provided(i.e., Building block 1), an enabling environment[4] for reducing fear of reprisals should be heightened.

Community participation in monitoring activities (building block 3) is regularly assumed to be automatic; however, this building block is not self-evident (Banerjee et al., 2010; Barr et al., 2012; Björkman & Svensson, 2010; Dewachter & Holvoet, 2017; Lieberman et al., 2014; Molina, 2015; Olken, 2007). Scholars argued that factors such as free-riding problems, low perceived efficacy (i.e., self, collective, providers and politicians efficacy), elite capture, high opportunity cost, lack of attention plan or rational inattention, degree of social cohesion, information gap problems[5], income inequality, and cultural fractionalization tend to hinder community participation in monitoring activities (Barr et al., 2012; Björkman & Svensson, 2010; Dewachter & Holvoet, 2017; Lieberman et al., 2014; Molina, 2015; Molina et al., 2017; Olken, 2007; Ringold et al., 2011). Thus, careful consideration of such factors while designing the theory of change is crucial for enhancing effective community participation.

Furthermore, after citizen participation in monitoring activities (building block 3), it is expected that they inform other citizens (building block 5); however, this can only happen if social cohesion between participants and non-participants is high and there is close geographical proximity of participants and non-participants (Molina et al., 2017). Simultaneously, citizens will voice their complaints, grievances, and feedback on specific service failures to politicians (building block 4) and providers (building block 6) if they understand the modalities of communicating their problems and the politicians and providers are accountable to citizens (Molina et al., 2017). Politicians' and providers' (building blocks 4 and 6) accountability to citizens is crucial for social accountability interventions to impact service delivery (Joshi, 2014; Molina, 2015; Molina et al., 2017). The politicians' will not respond to citizens demands when they have weak incentives to respond (i.e., little or no space for citizens to make them win elections or stay in power), secondly when the degree of political competition[6] is low, and lastly when the degree of social polarization is high[7] (Molina et al., 2017; World Bank, 2003). Likewise, providers (building block 6) will fail to respond to citizens if the informal sanctions or rewards are not enough to change providers' behaviours and citizens do not have the power to choose providers (Molina et al., 2017).

[4] Joshi (2014 p.28) defines credible and legitimate information "as the information created through the process that involve both citizens (i.e.,users) and providers." As discussed in Fox (2015, p. 357), enabling environment "refers to actions by external allies that have two characteristics. First, they reduce actual and perceived risks inherent in collective action. Secondly, they bolster actual and perceived efficacy of collective action by increasing likelihood and/or degree of positive institutional response".
[5] Fox (2015) and Joshi (2014) pointed out that, information gaps happens when information disseminated is regarded opaque or unclear, not actionable, not credible, and legitimate.
[6] Baraldi (2019) defined political competition as a competition for political power- political parties compete for the ability to shape and control the content and direction of the public policy
[7] World Bank (2003, p.81) defined social polarization as "voting based on social, ethnic, or religious identity rather than policy or service delivery performance".

Figure 1. A hypothesized theory of change for social accountability interventions.



Source: Adopted and modified from Molina et al. (2017) and Holvoet (2019)

3. Objectives

The main objective of this review is to assess and synthesize the evidence of the impact of social accountability interventions in the delivery of public services in Sub-Saharan Africa (SSA). Specifically, the review intends to respond to the following questions:

1. What are the impacts/effects of social accountability interventions in public service delivery outcomes? (intermediate and final outcomes)
2. What factors facilitate or limit the impacts of social accountability interventions in public service delivery?

4. Methodology

This article presents a systematic review of the evidence of impacts of social accountability interventions in public service delivery. A systematic review "aims to bring evidence together to answer a pre-defined research question. This involves the identification of all primary research relevant to the defined question, the critical appraisal of this research, and the synthesis of the findings" (Pollock & Berge, 2018, p.138).

Definition of concepts around the subject matter is crucial for any review (Renmans et al., 2016). Social accountability interventions are "efforts to provide information to the citizens and channels to enable them to use the information to hold service providers accountable" (Ringold et al., 2011, p.8). Moreover, Joshi (2013, p.31) further urges that accountability for service delivery can be demanded from various stakeholders such as politicians (i.e., over adopting inappropriate policies), public officials(failing to deliver according to rules or entitlements or to monitor providers for appropriate service levels) and providers (not maintaining service levels in terms of access and quality).

Thus, to make the synthesis of evidence of impacts of social accountability more manageable, this review makes several restrictions. First, it includes all social accountability interventions that primarily provide information and opportunities for citizens to monitor public service delivery and their main actors[8]. Secondly, it entails social accountability interventions that are explicitly[9] and largely citizen-led; lastly, it incorporates all social accountability interventions intended to improve the performance of services that are regarded as rights either through legislation or government rules.

4.1. Search strategy

This paper systematically reviewed published articles from two online databases: Web of Science Core Collection (WoS) and Scopus. This review used a combination of three groups of search words and filters, as presented in **Table 2.** The Booleans operators such as (**AND, OR** and, **QUOTATION MARKS** "") were used within and between groups of search words to enable the combination of these keywords. Additionally, the searches were carried out between March 2020 to June 2021. The combination of three groups of search words was adopted to allow a comprehensive search of primary studies on social accountability interventions in Sub- Saharan Africa as per the selected filters.

[8] Joshi (2013) and World Bank (2003) highlighted that, politicians, policy makers, service providers and public officials are the key actors involved in service delivery chain.
[9] Lodenstein et al. (2013, p.6) defined explicit social accountability interventions as "interventions that aim to empower citizens to articulate, voice and express their concerns regarding service delivery with the aim of transforming provider organizations or policymaking institutions. They most probably are initiated or driven by citizens and they are most likely to involve collective actions by associations or groups of citizens (and not by individuals)".

Table 2. Used search words and filters

Database	Search words	Filters
Web of Science	Group 1: Social accountability interventions/tools/mechanisms "Social audits" OR "Citizen audits" OR "Community-based monitoring" OR "Community monitoring" OR "Information campaigns" OR "Citizen report cards" OR "Report Cards" OR "Scorecards" OR "Community Scorecards" OR "Grievance redress mechanisms." OR Group 2: Social accountability synonyms "Social accountability" OR "Societal accountability" OR Bottom-up accountability" OR Citizen-led accountability" OR Group 3: Social accountability process/ activity "Community participation" OR "Citizen participation" OR "Citizen engagement" AND "Service delivery" OR "Public services"	• Time Span:2000-2021 • Document type: Articles • Field: All fields • Language: English • In abstract title or keywords
Scopus	Group 1: Social accountability interventions/tools/mechanisms "Social audits" OR "Citizen audits" OR "Community-based monitoring" OR "Community monitoring" OR "Information campaigns" OR "Citizen report cards" OR "Report Cards" OR "Scorecards" OR "Community Scorecards" OR "Grievance redress mechanism." OR Group 2: Social accountability synonyms "Social accountability" OR "Societal accountability" OR Bottom-up accountability" OR Citizen-led accountability" OR Group 3: Social accountability process/ activity "Community participation" OR "Citizen participation" OR "Citizen engagement" AND "Service delivery" OR "Public services"	

4.2. Selection criteria

This paper included primary studies on social accountability from Sub-Saharan Africa. Social accountability interventions that provide citizens with information and encourage them to use the information to monitor public service providers and/or politicians were included. Studies that adopted qualitative, quantitative, or mixed design while reporting intermediate and final outcomes as per our definition were eligible. Moreover, studies exclusively examining social accountability as their main intervention or part of the larger study were included. Lastly, both studies were included with or without control groups (e.g., the population that received the usual public services without social accountability interventions).

In this study, immediate outcomes refer "to the changes that are expected to occur once one or more outputs have been provided or delivered by the implementer. These are short-term outcomes and are usually changes in the capacity, such as an increase in knowledge, awareness, skills or abilities among intermediaries and/or beneficiaries" (Global Affairs Canada, 2016 p.17). Thus, in this review, immediate outcomes include increased knowledge or awareness of the rights, standards, or performance of public service delivery, participation in monitoring or meetings, and increased ability or skills of providers to deliver service. Intermediate outcomes refer "to the changes that are expected to logically occur once one or more immediate outcomes have been achieved. These are medium-term outcomes and are usually changes in behaviour, practice or performance among intermediaries and/or beneficiaries" (Global Affairs Canada, 2016, p.16). Therefore, in this study, intermediate outcomes include increased service access and use (i.e., increased attendance, enrollment, number of the patient using healthcare service, increased immunization, decreased dropout, etc.) and improved quality of service (i.e., Increased test scores, increased health centers performance, reduced waiting time, service satisfaction, etc.). Final outcomes "are the highest-level change to which an organization, policy, program, or project contributes through the achievement of one or more intermediate outcomes. These are long-term outcomes and are usually changes in state or condition or wellbeing among intermediaries and/or beneficiaries" (Global Affairs Canada, 2016, p.17). In this review, final outcomes include improved well-being such as decreased illness or death, increased birth, anthropometry, literacy, etc. The criteria for inclusion and exclusion are presented in **Table 3.**

Table3. Summary of criteria for inclusion and exclusion

Criteria	Inclusion definition
Population	These are participants from Sub-Saharan Africa (SSA) region were included, other regions were excluded
Intervention	Social accountability interventions that provide information and opportunities for citizens to monitor service providers, politicians, and /or policymakers and hold them accountable for improvement in service delivery were included. Social accountability interventions that involve citizens in public policy and resource allocation decision-making were excluded.
Comparison	The populations that receive "usual public service" without social accountability interventions were served as control or comparison.
Outcomes	Intermediate and final outcomes such as increased service access, use, quality, and well-being of individuals were included. The interventions reporting only immediate outcomes were not included.
Study design	Quantitative, qualitative, and mixed study designs were used to answer both review questions.

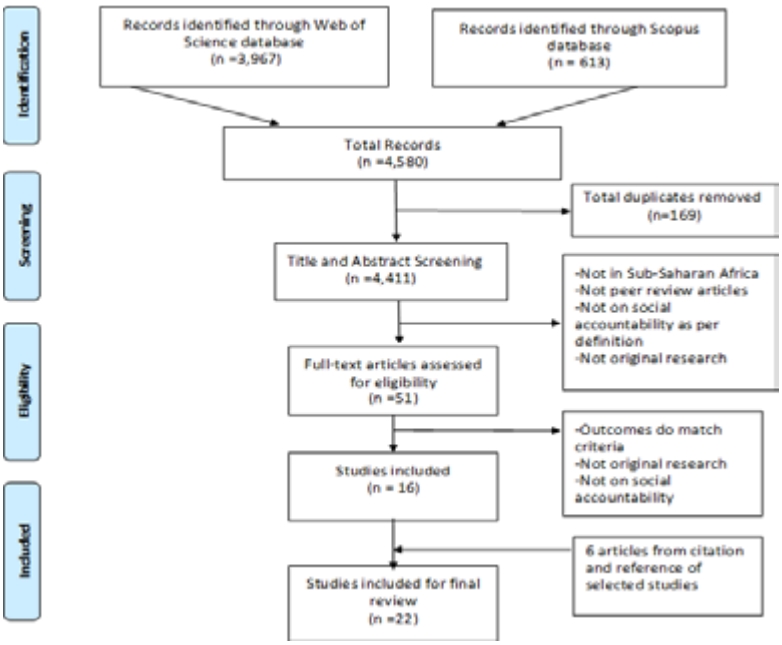
5. RESULTS

This section presents the results of this systematic review. Specifically, the study intended to assess and synthesize evidence of the impact of social accountability interventions in public service delivery and identify facilitating or limiting factors that hinder its success. Section 5.1 presents the identification, screening, eligibility, and inclusion process of primary and peer-reviewed studies of social accountability interventions in Sub-Saharan Africa between 2000-2021. Section 5.2 presents the impact of different types of social accountability interventions in public service delivery. Finally, section 5.3 highlights the mediating factors that facilitate or limit social accountability interventions' impact on public service delivery.

5.1. Search results

As shown in ***Figure 2,*** the initial search from the Web of Science and Scopus database retrieved 4,580 potentially relevant articles. Out of them, 169 articles were deleted because of duplication leaving 4,411 articles that were subjected to title and abstract screening. Based on the title and abstract, 4,391 articles were further excluded. The main reasons for exclusion were studies not from Sub-Saharan Africa, not peer-reviewed articles, not original/ primary research, not on social accountability as of our definition, outcomes do not match our criteria. Thus, 51 articles remained and were subjected to full-text screening, of which 16 studies were eligible for this review. Afterwards, six (6) peer-reviewed articles were also added from citations and references of the selected studies. Hence, a total of 22 studies were included in the final review to address research questions 1 and 2.

Figure 2. Flow diagram for search results.



A descriptive summary of the included studies for this review is presented in the **Appendix table**. Studies evaluated the impact of 27 social accountability interventions identified in 22 studies. These include Community scorecards/ Citizen reports cards (14), Information Campaigns (4), combinations of community scorecards and information campaigns (2), Community-based monitoring (3), and combined community scorecards and social audits (1). Most studies have been conducted in Uganda (7), followed by Malawi (3), Ghana (2), Tanzania (2), and one each in Kenya, Niger, Congo, Benin, Zambia, Sierra-Leone, Burundi, and Ethiopia. The included studies mostly focused on the health sector (16), followed by the education sector (5) and local government (1). Thirteen (13) studies adopted quantitative design, five (5) qualitative design, and four (4) mixed design. The implementation time of the interventions ranged from 1 year to 5 years, while most of the interventions were facilitated by local or international Non-Governmental organizations (NGOs).

Based on the specific sector, different outcome measures were used. For instance, access and use to service were measured as utilization or immunization in the health sector, while enrollment or attendance was used to measure access in the education sector. Concurrently, test scores were used to measure the quality of service in the education sector. In contrast, mortality rate, waiting time, weight to age or spontaneous vaginal delivery, etc., were used to measure the quality of service in the health sector.

5.2. Impact/ effect of social accountability interventions

Table 4a & 4b summarize evidence of social accountability interventions' impact on public service delivery outcomes- both intermediates and final outcomes.

Table 4a. Evidence of social accountability interventions in the health sector.

Sector	Country	Social Accountability Intervention	Study design	Impact	Source
Health	Ghana	CSC	RCT	Improved access and quality of health service	Alhassan et al. (2019)
Health	Tanzania	CSC	Mixed design	No improvement in utilization, quality and, health outcomes	Arkedis et al. (2021)
Health	Ethiopia	CSC	Pre-post longitudinal design	Improved access, utilization, and quality of health services	Argaw et al. (2021)
Health	Uganda	CSC+IC	RCT	Improved access, quality, and health outcomes	Bjorkman & Svensson (2009)
Health	Ghana	CSC	Mixed design	Improved access and quality of health service	Blake et al.(2016)
Health	Burundi	IC	Mixed design	No improvement in access and quality of health service delivery	Falisse & Ntakarutimana (2020)
Health	Tanzania	CBM	DID & FE	-Improved quality by reducing essential drug stockout -No improvement in quality of other domains of health facility performance	Francetic et al. (2021)
Health	Malawi	CSC	RCT	Improved access, quality health service	Gullo et al. (2017)
Health	Malawi	CSC	RCT	Improved access, quality health service	Gullo et al. (2018)
Health	Malawi	CSC	RCT	Improved quality of some health service	Gullo et al. (2020)
Health	Congo	CSC	Qualitative case study	Improved access and quality of service	Ho et al. (2015)
Health	Uganda	CSC	Qualitative case study	Improved health service utilization in some selected districts	Katahoire et al. (2015)
Health	Uganda	CSC	Mixed design	-Improved in quality of Maternal and Newborn Health (MNH) services -No improvement in utilization of Antenatal care (ANC) -No improvement in the availability of drugs	Kiracho et al. (2020)
Health	Uganda	CSC+1C	RCT	Improved access, quality, and health outcomes	Nyqvist et al. (2017)
		CSC		No significant improvement in access and quality of service	

Health	Sierra-Leone	CSC	Qualitative case study	No improvement in access and quality of service	Pieterse (2019)
Health	Zambia	CSC+SA	Qualitative case study	Improved quality of service	Schaaf et al.(2017)

CSC: Community Scorecards; CBM: Community-based Monitoring: Information Campaign; SA: Social Audit; RCT: Randomized Control Trial; IV: Instrumental variables; DID: Difference in Difference; FE: Fixed Effect

Table 4b. Evidence of social accountability interventions in the Education and Local government sector

Sector	Country	Social Accountability Intervention	Study design	Impact	Source
Education	Niger	CBM	RCT	Improved learning outcomes	Aker & Ksoll (2019)
Education	Uganda	Standard CSC	RCT	No changes in test score	Barr et al. (2012)
		Participatory CSC		Improved test score	
Education	Kenya	CBM	RCT	Improved test score	Duflo et al. (2015)
Education	Benin	IC	Quasi-experimental	Improved test scores	Keefer & Kheman(2014)
Education	Uganda	IC	IV, DID	Improved enrollment and learning outcomes	Reinikka & Svensson (2005; 2011)
Local government	Uganda	IC	Qualitative case study	Improved quality of public service delivered in some selected sites	Van Campenhout et al. (2018)

CSC: Community Scorecards; CBM: Community-based Monitoring: Information Campaign; SA: Social Audit; RCT: Randomized Control Trial; IV: Instrumental variables; DID: Difference in Difference; FE: Fixed Effect

5.2.1. Information campaigns

This review identified four studies that disseminated various kinds of information to citizens and provided the opportunity to citizens to monitor service providers for improvements in service delivery. Reinikka & Svensson (2005; 2011) studied the intervention in Uganda, which disseminated information on the monthly transfer of capitation education grants to districts, school entitlements and responsibilities, and misuse of capitation grants funds. The information was disseminated via the national newspapers- The New Vision and The Monitor. As a result of this intervention, enrollment and average test scores of standard seven (7) students increased. In addition, Keefer & Khemani (2014) conducted a natural experiment in Benin. They circulated information on education programs via community radio, and the communities that had access to radio programs showed a significant improvement in literacy scores for grade two pupils.

Moreover, Van Campenhout et al.(2018) studied the citizens through a citizen advocacy forum known as "*Baraza.*" which disseminated information on the local government planned activities and achievements in the selected district of Uganda. The intervention resulted in the operationalization of plans for the construction of seed secondary school in Mulungu Parish by initiating a land survey and hiring 21 new teachers, reducing absenteeism of health workers, repairing and constructing roads and bridges, and distributing motorcycles destined for rural health centres. Lastly, Falisse & Ntakarutimana (2020) studied a randomized control trial implemented in 251 Burundian public-funded Health Facilities(HFs) where Health Facility committees (HFC) were provided with localized information on health facility performance and finances. With the information provided, the HFCs were expected to monitor HFs' performance, help HF providers make effective decisions, and hold them accountable for improved service delivery. As a result, the information intervention did not impact the use, perceived quality, and health services access.

5.2.2. Community Scorecards/ Citizen reports cards

A total of fourteen (14) studies that adopted community scorecards as their primary social accountability intervention were identified. All community scorecards provide an avenue for interface meetings between users(community) and service providers, a joint set of action plans, and community monitoring of

agreed actions plans. For instance, Barr et al. (2012) conducted field and lab experiments in Uganda, whereas standard scorecards[10] and participatory scorecards[11] were two arms used to monitor the performance of 100 rural primary schools. Participatory scorecards significantly improved student math and literacy test scores and student attendance. In contrast, the standard scorecard shows no significant improvement in test scores and students' attendance. Additionally, Using community scorecards administered in 64 randomly selected primary health care centres in Ghana, Alhassan et al. (2019) documented a significant improvement in access to and quality of health care services(i.e., child immunization, vaginal deliveries, distribution of female condoms, and an increase in the average number of test for Human Immunodeficiency Virus (HIV) and Malaria to pregnant and non-pregnant women). Gullo et al. (2017, 2018, 2020) studied the intervention which administered scorecards in 20 health facilities in Malawi and found significant improvements in postnatal visits, use of modern family planning contraceptives, service satisfaction, proportional of women receiving a home visit during pregnancy, and comprehensive provision of antenatal care. Argaw et al.(2021) studied the effect of CSC implementation in 31 districts in 159 Primary Health Care Units (PHCU's) in Ethiopia, and they found a significant improvement in access and utilization and quality of Maternal, Neonatal, and Child services (MNCs).

Moreover, Ho et al. (2015) conducted a study in two selected districts in Congo using community scorecards. The study found that the intervention reduced stockout of drugs and equipment, improved maintenance of physical infrastructure, and increased access to service due to changes in user fees and/or reduction in bribes. Pieterse (2019), who studied the intervention implemented by World Bank in Sierra-Leone, found that community scorecards had no impact on quality of service because patients who were entitled to receive free care and medicine continued to be charged, and there was no change in health care practices such as reduced absenteeism, etc. Katahoire et al. (2015) studied the intervention conducted in five selected districts in Uganda. The study found that citizen report cards followed by community dialogue positively impacted service utilization(i.e., child immunization coverage, child OPD attendance, and parasitological test for children under four(4) years) in some selected districts. Blake et al. (2016) studied the intervention implemented in eight(8) districts of Volta and Ashanti in Ghana, and they found that the intervention led to increased access to maternity wards, availability of drugs and essential equipment, improvement in water, sanitation, hygiene and improvement in the client-provider relationship. Kiracho et al.(2020) studied the CSC intervention in five sub-counties and one town council in the Kibuku district in Uganda. The study found that the CSC implementation led to improvement in the availability of midwives and deliveries beds as well as a decrease in Traditional Birth attendants (TBA) deliveries. However, the CSC did not affect the attendance of mothers in Antenatal care and the availability of drugs in health facilities. Lastly, Arkedis et al. (2021) studied the T4D program, which implemented CSC in 200 villages of Dodoma and the Tanga region in Tanzania. The study found that CSC has no significant impact on the utilization and quality of Maternal and Newborn Health (MNH) as well as children's health outcomes (i.e., infant height and weight for age).

5.2.3. Community Scorecards and Information Campaigns

Two studies were identified under this category. These studies used a combination of community/ citizen report cards and information campaigns to influence service delivery outcomes. Bjorkman & Svensson (2009) conducted a field experiment in 50 health facilities in Uganda where local NGOs disseminated information on the provider performance and patients' entitlements and encouraged the community to participate in monitoring activities. Community, provider, and interface (providers & community) meetings were held at different times to solicit stakeholders' ideas and set joint action plans to improve service delivery. As a result, the intervention led to increased immunization of children under five years, increased utilization of services such as general outpatient care, antenatal care, and family planning, reduced the waiting time and providers absenteeism, improved management of facilities, increased use of medical equipment (thermometer) increased child weight for age and reduced under-5 mortality rate. Nyqvist et al. (2017) evaluated the long-run impact of the field experiment by Bjorkman & Svensson (2009) and the short-run impact of an intervention that encourages participation but does not disseminate information on provider

[10] Standard scorecard was a scorecard developed in consultation with Ministry of Education, District Education Offices, and NGO partners.
[11] Participatory scorecard was a scorecard developed by school management committee members during a dialogue.

performance. They found that improvement in access and quality of health care and wellbeing remained the same in the long run despite the minimal follow-up. In contrast, there was no record of improvement in access or quality of health care for the intervention that encouraged participation only.

5.2.4. Community Scorecards and Social Audit

Only one(1) study that adopted intervention was identified. Schaaf et al. (2017) studied the intervention conducted by World Vision in three rural districts in Zambia within five health facilities purposively selected. The intervention positively impacted access and quality of service, such as availability of essential drugs, repairing clinic boreholes, construction of a new clinic, and clinic wings for maternity, antenatal, and mother shelter.

5.2.5. Community monitoring

Three studies from Niger, Kenya, Tanzania were identified in this category. These studies mainly aim to monitor ongoing programs introduced to improve service delivery outcomes. Duflo et al. (2015) conducted a study in Kenya where Extra Teacher Program (ETP) was introduced in 140 rural schools. The parents were trained to monitor the program's implementation after attending the training. As a result of the intervention, tests scores in math and literacy and student attendance were recorded significantly higher in the intervention group than in the control group. Aker & Ksoll (2019) conducted a study in Niger where the adult education program was introduced in 114 villages, and 20 served as control. Among the 114 adult education program villages, villages were then assigned to either the mobile or no mobile phone intervention. The mobile phone intervention performed weekly phone calls to the teachers, two randomly selected students, and the village chief, while in the intervention with no mobile phone, no phone calls were made; instead, the villages were monitored by NGO and Ministry staff. As a result, test scores in math and literacy improved in both interventions; however, more increases in test scores and decreased likelihood of dropout were recorded in the mobile phone intervention villages compared to villages with no mobile phone intervention. Likewise, Francetic et al. (2021) studied the intervention, namely Social Accountability Monitoring (SAM). The SAM intervention was implemented in two districts of the Dodoma region, while the other five districts served as control. The SAM intervention formed and trained community-based supervision teams and conducted meetings with district stakeholders while embracing the feedback systems and continuous monitoring of health facilities by community-based supervision teams. The intervention resulted in a significant reduction in essential drug stockout with a larger effect on antibiotics. In contrast, no effect has been found on other health facility performance indicators, such as improving facilities' infrastructures.

5.3. Mediating factors facilitating or limiting the impact of social accountability interventions

The findings presented in **Table 4a&4b** show mixed evidence of the impact of social accountability interventions in public service delivery. Therefore, understanding the mediating factors that facilitate or hinder the success of these interventions along the casual chain is crucial. Brinkerhoff & Wetterberg (2016), Grandvoinnet et al. (2015), Joshi(2013,2014), Tembo (2013), and Waddington et al. (2019) claimed that these mediating factors could range from context, implementation of the intervention, intervention design, or mechanism adopted. Thus, drawing from this, the review presents evidence of mediating factors that facilitated or limited the success of twenty-seven (27) social accountability interventions in public service delivery in Sub-Saharan Africa.

5.3.1. Facilitating factors

The capacity to reduce the risk of elite capture has been revealed as a crucial enabler for the success of social accountability intervention on public service delivery. Bjorkman & Svensson (2009), Gullo et al. (2017, 2018), and Nyqvist et al.(2017) have minimized elite capture of social accountability interventions by involving representatives from different spectra of society such as youth, elderly, disabled, women, leaders, and mothers during various meetings. Such involvement has enabled effective capturing of their

views on monitoring providers and improving service delivery. Such a process has contributed to the success of community scorecards in improving health outcomes in Uganda and Malawi. Scholars such as (Bardhan, 2002; Dasgupta & Beard, 2007; Molina et al.,2017) urged that community monitoring is often vulnerable to elite capture[12]. Therefore, reducing the risk of domination by elites is crucial because often elite capture in community-based monitoring interventions tends to limit the participation and decision-making power by non-elites and ultimately hinders effectiveness and the intended outcome (Bardhan 2002; Dasgupta & Beard, 2007; Molina et al., 2017; Musgrave & Wong 2016; Olken, 2007).

The capacity to overcome collective action problems has proved to be a critical factor in facilitating the effectiveness and impact of community scorecards in improving education outcomes in Uganda. Barr et al. (2012) tested two social accountability interventions: standard scorecards and participatory scorecards. The standard and participatory scorecards differed in how School Management Committee (SMC) members were involved in the intervention. In standard intervention, SMC members were trained to use a best-practice monitoring instrument, whereas, in the participatory intervention, SMC members were invited to design their own monitoring instrument in a participatory manner that encouraged a dialogue about aims for the school. The participatory intervention significantly improved pupils' test scores and attendance, while the standard scorecard had an insignificant impact. The differential impact between the two interventions is explained by the capacity of the intervention to overcome the collective action problem by giving SMC ownership of the monitoring process, which instigated their willingness to act collectively. Social accountability interventions are conceptualized as collective action, and often, these interventions are prone to collective action problems such as free-riding and perceived efficacy problems (Dewachter & Holvoet, 2017; Molina, 2015; Olken, 2007). When community members expect other individuals to free-ride on their effort (i.e., monitoring service delivery) or believe service providers/ politicians would not respond, they will choose not to participate in the monitoring activities (Dewachter & Holvoet, 2017; Molina, 2015; Molina et al., 2017). Thus, overcoming collective action problems in social accountability intervention is essential for attaining outcomes.

The collaborative approach of engaging multi-stakeholders from both demand and supply sides has proved to be a significant facilitating factor for improving health outcomes and the facility's performance. For instance, Alhassan et al.(2019), Bjorkman & Svensson (2009), Blake et al.(2016), Gullo et al.(2017, 2018, 2020), Nyqvist et al.(2017), Argaw et al. (2021), and Kiracho et al., (2020) conducted series of feedback and interface meetings. The interface meetings between community members, health providers, and administrative officials enabled collective and collaborative identification of the health service delivery challenges, setting the joint action plans, and providing a forum for feedback. Such engagement of demand and supply-side actors tends to strengthen relationships and trust between service providers, users, and administrative officials, increase the sense of self-efficacy and intrinsic motivation of service providers to exert more effort, improve attitudes and behaviour of actors. All these mechanisms embedded in the collaborative approach have proven critical for the success of social accountability initiatives in service delivery (Alhassan et al., 2016; Gullo et al., 2017; Waddington et al., 2019).

Provision of information on providers' performance or comparative providers' performance has shown to mediate the impact of social accountability intervention in terms of improving health outcomes both in the short run and long run (Bjorkman & Svensson, 2009; Nyqvist et al., 2017). Nyqvist et al. (2017) tested social accountability interventions in two folds: information & participation intervention and participation intervention. The information & participation intervention disseminated health facility and providers' performance information while the participation intervention did not provide such information. The latter significantly impacted access and health service quality, while the former recorded no impact. The difference between the two interventions is resonated around the content of the agreed action plan. The participation & information intervention led to the setting of actionable action plans that are within the implementation capacity of either users or health providers (i.e., absenteeism, patient-health worker interaction, opening hours, and waiting hours). In contrast, the participation intervention documented the

[12] Dasgupta & Beard (2007, p.230) define elites "as individuals with disproportionate access to social, political or economic power" and elite capture "as to the process by which these individuals with disproportionate access to social, political or economic power dominate and corrupt community-level planning and governance."

action plans that required third-party actions (i.e., more financial and in-kind support from upper-level authorities and NGOs, timely deliveries of medicines from the center, etc.). Thus, beneficiaries empowered with understandable or actionable information are more likely to boost collective action, which is pivotal for the success of any social accountability intervention (Fox 2007; Fox 2015; Joshi 2014).

Improved provider-user relationships and establishment of trust have been revealed to be an enabling factor for the success of social accountability interventions in improving access to and use of health care services such as modern family planning. The community scorecards intervention (CSC) conducted by Bjorkman & Svensson (2009), Gullo et al. (2017), and Ho et al.(2015) provided the avenue (e.g., interface meetings) for the patients and providers to discuss local health care challenges impeding the use, access, and quality as well as setting the agreed action plans for improvement. Such processes embedded in the CSC have helped build and strengthen the relationship and trust between patients and providers, which has led to improved uptake of modern family planning in Uganda and Malawi. Care Malawi (2013), Gullo et al.(2017, 2018), and Mbiti & Serra (2021) further urged that improved relationships and trust between patients and providers tend to create spaces for communication and dialogue, increased sense of shared responsibilities, and motivation to act which are crucial for patient satisfaction, health utilization, health service seeking behaviour and ultimately improved health outcomes.

Behavioural change of providers, politicians, and community members has also been articulated as enabling factors for success. The community scorecards implemented by (Bjorkman & Svensson, 2009) in Uganda attested that improved access and quality of health care services such as increased outpatient services utilization, lower death of children under five years, improved weight of infants and, improvement in other treatments practices (i.e., immunization, examination procedures, and absenteeism) were attributed to behaviour change of health facility staff. Aker & Ksoll (2019) also linked teachers' and students' behaviour change and increased math and literacy performance among students randomly assigned to the adult education program with mobile phone monitoring. Keefer & Khemani (2014) urged that the improvement in literacy scores for students in the villages with access to community radios was significantly influenced by behaviour change of parents than government responsiveness. The behavioural change includes financial investment in their children's education, such as buying books and paying informal or private tuition to schools. Van Campenhout et al. (2018) reported that politicians' behavioural change, especially that of councillors after the "Baraza" initiative, has facilitated improvements in public service delivery in Uganda. Ho et al. (2015) showed that changes in the behaviour of healthcare providers had mediated the success of community scorecards in improving health service delivery in Katanga and the South-Kivu district of the Eastern Republic of Congo. Lastly, Francetic et al.(2021) also urged increased pressure on providers by community monitors, motivated the providers to exert more effort on forecasting the needs of medicines, and filing timely and complete drugs orders. Such behavioural change of providers has mediated the success of the social accountability intervention in Tanzania. This evidence align with the argument by Molina et al. (2017), who pointed out that social accountability interventions will only be effective if they can influence behaviour change of actors involved in the service delivery chain. Thus, behaviour change of providers, politicians, and community members is the crucial mechanism for calibrating change and realizing the impact.

The history of citizen-state engagement has been identified as a crucial factor that facilitated information campaign success in improving Uganda's student enrollment and learning outcomes Reinikka & Svensson (2011). Parents have been long involved and played a role in managing and controlling public primary schools in Uganda. As such, the history of engagement of parents in the public school's management has influenced their participation in the information campaign intervention, which mediated the impact (Reinikka & Svensson, 2011). This aligns with the studies by Brinkerhoff & Wetterberg (2016), Gaventa & Mcgee (2013), and O'Meally (2013), who urged that the history of state-citizen engagement tends to influence citizens' expectations, their willingness to engage in the social accountability intervention as well as the extent to which they trust state actors. All these components emanated from the prior engagement of citizens and state are essential for achieving the impacts of social accountability.

The opportunity cost of participation has been shown to mediate the impact of social accountability interventions in public service delivery. This is evidenced by Reinikka & Svensson (2011), who urged that based on survey results, most households in Uganda have high salience on education (i.e., they

prioritize education over other social services). Such high salience towards education lowered their opportunity cost of monitoring local administrators resulting in increased participation of the households in the information campaign intervention that reduced the capture of funds and ultimately improvement in enrollment and learning outcomes. This coincides with Molina et al.(2017) 's argument that if the opportunity cost of participation in social accountability intervention is higher, the probability of participation will be lower(i.e., only a few citizens will participate), resulting in reduced capacity of citizens to uncover problems and put pressure on the politicians and/ or providers for improved service delivery.

Sandwiching of top-down and bottom-up monitoring has proved to be an enabling factor for the success of social accountability interventions in improving public service delivery. Kiracho et al. (2020), who studied the effect of CSC in the Kibuku district in Uganda, pointed out that the implementation of scorecards empowered the community to voice their demands which triggered the top-down monitoring of health providers and facilities' performance. Similarly, Van Campenhout et al. (2018) revealed that "Baraza" interventions where citizens voiced their demands about quality of public service delivery prompted politicians' and administrators' consciousness towards improving quality of service by increasing monitoring of service providers and resource allocation. This aligns with Fox (2015), who urged that the bottom-up monitoring (i.e., voice) often lacks bite and citizen voice coordinated with government reforms (i.e., increased top-down monitoring) is more promising. Similarly, Malena et al. (2014) urged that social accountability initiatives (i.e., bottom-up accountability) that intend to complement and trigger the convectional accountability (top-down) have more potential in realizing the outcomes. Thus, the social accountability initiatives that are capable of embracing accountability sandwich strategies are more promising.

Structures promoting state-society interaction have been shown to mediate the impact of social accountability interventions in public service delivery. Schaaf et al. (2017) studied the social accountability intervention in Zambia revealed that the existence of government-created groups and committees (i.e., Safe Motherhood Action Groups and Area Development Coordination Committees) have enabled the effective implementation of the social accountability intervention (The CVA program). Such groups and committees provided an avenue for community and/or health centre managers to complain, offered support for conducting and realization of CVA activities and goals, and reflected stated government commitment to community participation. Thus, these structures' existence is crucial for the effectiveness and impact of social accountability intervention in service delivery.

The willingness of political and traditional leaders to support social accountability interventions has been demonstrated to be the critical condition for success. Blake et al. (2016) and Schaaf et al. (2017) revealed that political leaders' readiness to participate in the interface and other meetings had been an essential building block for the success of the community scorecards in improving health service in Ghana and Zambia. Their readiness to participate in the intervention not only provided room for interaction with the community (constituents) but also allowed them (i.e., political leaders) to learn of their constituents' wants and enabled them to contribute to drafting action plans and participating in monitoring the implementation of the agreed action plans priorities. Thus, the power of shared decision-making in planning and implementing social accountability interventions has contributed to the improved access and quality of health services in Ghana and Zambia. In addition, Kiracho et al.(2020) attested that the support provided by local political leaders during the implementation of CSC in Uganda influenced mobilization and advocacy for increased health budget allocation, which contributed to improved health service delivery. Moreover, Schaaf et al. (2017, p.856) also showed that traditional leaders[13] were important interlocutors or intermediaries who used community trust and legitimacy to boost the attendance of citizens during interface meetings and promote accountability coalition. Thus, this confirms the argument by Gaventa & Mcgee (2013), O'Meally (2013)& Tembo (2013), who highlighted that the readiness of political and traditional leaders as well as strong and committed political leadership are crucial for the success of social accountability interventions.

Institutionalization of social accountability within the local structure has been found to be crucial for the success of social accountability interventions. Argaw et al. (2021) studied the effect of

[13] Honig (2019, p.1) defined traditional leaders as "local elites who derives legitimacy from custom, tradition and spirituality".

CSC in access, utilization, and quality of MNCs service in Ethiopia and showed that CSC implementation was preceded by training the supply and demand-side actors[14] on theory and practicability of CSC as well as on the institutionalization of CSC within health systems in Amhara and SNNP regions in Ethiopia. Such training enabled a clear understanding of CSC composition and the roles and responsibilities of each actor in the implementation of CSC. Thus, the institutionalization of CSC in the structure of PHCU in Ethiopia has mediated the success of social accountability in MNC's services.

5.3.2. Limiting factors

Conflicts between actors have been shown to hinder the success of social accountability interventions in improving service delivery**.** Van Campenhout et al. (2018) studied the impacts of the information campaign on the quality of public service delivery in two sub-counties of Uganda. The study revealed that conflicts between Administrative Officers (i.e., Chief Administrative Officer) and Politicians (i.e., District Local Council Chairperson) hindered the success of the "Baraza" intervention (information campaign) in improving the quality of public service in one of the sub-counties of Uganda. Likewise, Falisse & Ntakarutimana (2020) asserted that clashes between Health Facility Committees (HFC) and Chief Nurses created tensions between them that prevented further improvement in health service delivery as intended by the intervention. Therefore, conflicts between actors directly involved in the service delivery chain are toxic to the effective implementation and realization of the impact of social accountability intervention in service delivery.

The exclusion of supply-side actors in social accountability interventions has proved to constrain its success in attaining the intended outcome. A study by Pieterse (2019) in Sierra Leone showed that the exclusion of local authorities in the implementation of scorecards reduced the incentives of health providers to respond to health users' demands and hence affected its outcome. Fox (2015) asserts that even when demand-side actors are empowered with information and strengthened to demand accountability through voice, they may not achieve the desired outcomes without bolstering the capacity of the supply-side actors to respond to their demands. Thus, both "voice" and "teeth"[15] are crucial for the success of social accountability interventions.

Poor implementation of the social accountability program has proved to undermine the success of social accountability interventions. Pieterse (2019) studied a community scorecard intervention implemented in Tonkolili district, Sierra- Leone. The intervention aimed at improving health service delivery outcomes by implementing a range of activities such as administering interface meetings between community and health service providers, presenting community scores for health services, discussing health service delivery challenges, and setting action plans for behavioural change for both community and health providers jointly. However, the NGO contracted to implement the community scorecards process only documented agreed behavioural change for the community and none for the health workers. Thus, such poor implementation of the CSC program contributed to health workers' poor responsiveness and accountability towards improving service delivery. Moreover, Arkedis et al. (2021) also attested CSC in Tanzania had many planned activities such as education, socialization campaign, and others. However, the household survey data indicated that many recent pregnant women in the treatment areas were unaware of the other activities apart from education-related activities.

Inappropriately designed social accountability tools have been shown to hinder success. Francetic et al. (2021) studied an intervention implemented by SIKIKA NGO in two districts of the Dodoma region, Tanzania, revealed that the Social Accountability Monitoring (SAM) intervention was not successful in improving health facility infrastructure. The study urges that the designed SAM intervention could not influence the implementation of activities that are beyond the control of the health facility workers. As such, this yielded no impact in improving health facility infrastructures as intended by the program. The study further pointed out that the investment in health facilities infrastructures requires the involvement of higher governance levels, and the SAM intervention did not foresee the inclusion or involvement of higher governance levels during the designing of the intervention, which ultimately hindered the outcome. Katahoire et al.

[14] Supply side actors were 632 district officials and Primary Health Care Units personnel while demand side actors include the 4053 client councils in the selected Primary Health Care Units.
[15] Fox (2015, p.353) define teeth "as the state's capacity to respond to citizen voice- a process that includes both negative sanctions and proactive reforms."

(2015) also documented that Citizen Report Cards (CRC) and SMS-based monitoring tool (U-report) designed to improve child survival in five districts of Uganda were unclear to mothers/caretakers with the lower level of education and limited access to mobile phones. Most of them were not able to understand and interpret CRC as well as send the monitoring message through the U-report. Such bottlenecks affected their participation in the interface meeting and oversight function, which ultimately affected the intended intermediate outcome in some cases selected.

Moreover, Gullo et al.(2020) showed that the CSC implemented in Malawi was not successful in improving some health services' quality because of the inability of the designed CSC to bolster central health systems' responsiveness. Lastly, Arkedis et al.(2021) also urged that most planned activities along the casual chain were vague, not context-appropriate, and had a weak/indirect link to health outcomes. Thus, the inappropriateness of social accountability initiatives to fit a particular group and context tend to hinder its effectiveness and impact(Waddington et al., 2019).

Cultural heterogeneity has been documented to hinder effective participation in social accountability intervention and ultimately intended outcome. Kiracho et al.(2020) studied the effect of CSC on access and quality of Maternal and Newborn Health (MNH) services and found no significant improvement in access to MNH service by mothers. Through the focus group discussion and key informants' interview, it was revealed that some communities, based on their cultural beliefs, were not allowed to seek health care, including MNH care. Such beliefs hindered their participation and eventually collective action for improved uptake of MHN services. This finding aligns with Bjorkman & Svensson (2010), who urged that social-cultural heterogeneity adversely impacts the collective action for improved service delivery. Thus, the social accountability interventions designed to improve service delivery should find the mechanism to enhance collective action in social-cultural heterogeneous communities.

6. Discussion

6.1. Discussion of results

This review identified twenty-two (22) studies with twenty-seven (27) social accountability interventions in the education, health, and local government sectors. Specifically, the study identified five (5) studies with six (6) social accountability interventions evaluating the impact on tests scores, enrollment, and/or attendance in the education sector. Five (5) social accountability interventions suggest the overall positive impact on test scores and enrollment or attendance, while one (1) intervention found no impact on test scores. Likewise, the review found sixteen (16) studies with twenty (20) interventions in the health sector. Fourteen (14) interventions reported an overall positive impact on access to and quality of health service delivery as well as the well-being of the community, and six (6) recorded no impact on either access to or quality of health service delivery. In addition, only one (1) study adopting information campaigns was identified in the local government sector. The information dissemination on local government planned activities and achievements reported a positive impact on access and quality of public service delivery, specifically education, health, and infrastructure roads in some selected areas sub-counties in Uganda. Therefore, of the twenty-seven (27) social accountability interventions identified, 20(74.1%) documented the overall positive impact of social accountability initiatives in service delivery. In contrast, 7(25.9%) reported no effect on either access to or quality of service delivery. Lastly, the results also indicate that most of the social accountability interventions have been implemented in the sectors where public service is delivered directly to citizens by front-line providers (i.e., health and education sector) than in the sectors where citizens access the service independent of providers (i.e., water and sanitation, infrastructure, etc.).

Further, Information Campaigns (IC) have been more widely used in the education sector than in the health sector. At the same time, community scorecards (CRC) have been more prevalent in the health sector than in the education sector. Positive experiences documented by influential studies such as Reinikka & Svensson (2005) and Bjorkman & Svensson (2009) on information campaign and community scorecards in education and health, respectively, might have proliferated the adoption of these mechanisms in the selected countries within Sub-Saharan Africa. Thirteen (13) studies adopted quantitative design such as randomized control trials and quasi-experimental design etc., five (5) studies adopted qualitative study design, and four (4) adopted mixed study design. The evidence suggests no substantial difference between quan-

titative, qualitative, or mixed research design results. However, variability of outcome measures, the use of self-reported outcomes, and the absence of matched control groups in some of the studies make it difficult to comment on the overall differential impact of these designs.

In Addition, out of twenty-two (22) identified studies, only three (3) reported intermediate and final outcomes, while the other nineteen (19) reported only intermediate outcomes. This may be caused by the fact that the intermediate outcomes are usually expected to occur by the end of the intervention, whereas the final outcomes typically happen after the end of the intervention (Global Affairs Canada, 2016). Bjorkman & Svensson (2009) and Nyqvist et al. (2017) documented a significantly large increase in the intermediate outcome-utilization (i.e., immunization, outpatient, delivery, antenatal, and family planning) as compared to the final outcome-improvement in health outcomes such as under-5 mortality and child weight. The notable difference is due to the fact that intermediate outcomes are closer to the intervention than final outcomes.

Moreover, the evidence shows that most social accountability interventions have been initiated and/or facilitated by local or international non-governmental organizations. This is resonated around the argument by Devarajan et al. (2011) and Waddington et al. (2019), who pointed out that interventions initiated and/or facilitated by non-governmental organizations tend to be effective because of their capacity to strengthen and enhance community voice and participation as well as shifting the balance of power between citizen and providers. The implementation period of most of the interventions was between 1 to 2 years. However, Fox (2015), Grandvoinnet et al. (2015), Joshi (2014), and Joshi & Houtzager (2012) conceptualized social accountability as a political, non-linear, complex, and iterative process, which implies that change takes time and it is often incremental with steps building on each other. Thus, a longer time implementation of social accountability interventions is critical for the realization of impact as well as its sustainability.

Furthermore, the findings of this review suggest "mixed evidence" of the impact of social accountability interventions in access and quality of public service delivery in Sub-Saharan Africa. Some studies (Bjorkman & Svensson, 2009; Alhassan et al., 2019; Gullo et al. 2017; Argaw et al., 2021; Reinikka & Svensson, 2011) documented positive evidence of social accountability intervention in access and quality of health and education service. Others such as (Arkedis et al., 2021; Falisse & Ntakarutimana, 2020; Pieterse, 2019) have documented no impact of interventions on access, utilization, and quality of service delivery. The fragmented evidence of impact in this review is not entirely surprising as other reviews covering various countries in Asia, Latin America, and Sub-Saharan Africa as documented by (Fox, 2015; Gaventa & Mcgee, 2013; Joshi, 2013; Waddington et al., 2019; Ringold et al.,2011) have also revealed the same. These studies argued that the "mixed evidence" of impact is because the empirical studies identified in these reviews adopted a wide range of social accountability interventions implemented in diverse contexts with different study designs, intervention designs, and implementation quality and periods.

Lastly, given the mixed evidence of the impact of the social accountability interventions identified, ascertaining facilitating and limiting factors to success is essential. The review suggests the capacity to overcome elite capture and collective action problems, provision of perceived actionable information, collaborative engagement of multi-stakeholders from demand and supply sides, the existence of structures promoting state-society interaction, improved trust and provider-users relationship, behavioural change of actors, the history of citizen-state engagement, the willingness of political and traditional leaders, the institutionalization of social accountability, and the synergy of bottom-up and top-down monitoring approach have shown to facilitate the success of social accountability in access and quality of public service delivery. Whereas, the exclusion of supply-side actors, the conflict between actors, cultural heterogeneity, poor implementation of the social accountability initiatives, and inappropriate designed social accountability mechanisms to fit given context have been reported to hinder the success of social accountability interventions in improving public service delivery in the identified countries of Sub-Saharan Africa. These findings align with the previous research by Brinkerhoff & Wetterberg (2016), Gaventa & Barrett (2010), Fox(2015), Gaventa & Mcgee (2013), Grandvoinnet et al. (2015), Joshi (2013, 2014), O'Meally (2013), Tembo(2013), Waddington et al.(2019), and, Westhorp et al. (2014). These scholars attested that contextual, intervention design and implementation factors are critical for the success of any social accountability intervention.

6.2. Limitation of the study

The limited number of studies with diverse social accountability intervention in various contexts and largely implemented in the education and health sector has limited generalization of the results to Sub- Saharan Africa (SSA) countries. Thus, careful interpretation of results is crucial. Further, some studies that did not include a matched control group make it difficult to conclude whether the reported outcome is due to social accountability intervention or other factors. Additionally, exclusive self-reported outcomes in some studies doubt its reliability. Moreover, the review was limited to peer-reviewed articles in scientific journals. The peer-reviewed articles are believed to be credible, high-quality, and provide a trusted form of scientific communication (Kelly et al.,2014). While reports from local and international NGOs incorporated social accountability interventions that might provide additional findings, these were not considered due to the absence of peer review. Furthermore, even though there are non- English-speaking countries in Sub-Saharan Africa that might have conducted studies on social accountability, the review considered studies published in the English language due to resource constraints such as time and funds for translation. Finally, most of the studies identified reported positive outcomes. Renmans et al. (2016) argue that publication bias towards more positive results is not unlikely. More critical studies may need more time to develop theoretically and methodologically.

7. Conclusion and Recommendations

7.1. Conclusion

Teacher and health worker absenteeism, corruption, inefficient allocation of resources, leakages of funds and subsidies, service provider informal charges, and malpractices are widespread in the public sector in Sub-Saharan Africa. Such practices have adversely affected access to and quality of public service delivery and the citizens' well-being, especially the poor. Among other factors, many scholars have attributed the poor public service delivery in Sub-Saharan Africa to failure in accountability relationships between actors involved in the public service delivery chain. Thus, strengthening the accountability relationship between actors is deemed crucial for improved public service delivery. Such a proposition has triggered the rise of social accountability initiatives that aimed at providing information to the citizen (specifically the poor) and channels to enable them to use the information to monitor and hold service providers/politicians accountable for improved service delivery.

Despite the recent popularity of social accountability interventions in public service delivery, still, there is insufficient systematic evidence of impact, particularly in Sub-Saharan Africa, and little oversight of common factors facilitating or limiting the success of these interventions in the delivery of public service. Thus, this study mainly aims to fill the void by synthesizing the evidence of the impact of social accountability interventions in delivering public service and further ascertaining facilitating or limiting factors mediating its success or failure, particularly in Sub-Saharan Africa.

The overall results provide "mixed evidence" of the impact on access to and quality of public services delivery in Sub-Saharan Africa. While 20(74.1%) social accountability interventions indicate a positive impact on access and quality of public service delivery, others 7(25.9%) show no impact on either access or quality of service delivery. The studies documenting positive impact suggest that social accountability interventions were more likely to be successful when 1)the intervention could overcome elite capture and collective action problems, 2) when the interventions included multi-stakeholders from the demand side and supply side, 3) when the intervention embraced a collaborative rather than the confrontational approach in exacting accountability, 4) when the intervention improved provider-user interaction and trust, 5) when the intervention is implemented in the context where there is a solid history of state-citizen engagement, committed political leaders and existing structures that promote state-society interactions, 6)when the intervention had the capacity to change the behavior of providers or politicians or citizens, 7) when the intervention is institutionalized within state structures, 8) when the intervention triggered the top-down monitoring and 9) when interventions provide information that is perceived actionable, credible and legitimate. Likewise, the studies reported no impact, indicate that the social accountability interventions were not successful in improving service delivery when 1) the intervention design was context-inappropriate 2)

the intervention was poorly implemented, 3) there were conflicts between actors 4) the intervention excluded the supply-side actors and 5) when the intervention failed to enhance collective action in social-cultural heterogeneous communities.

Therefore, in the existence of weak institutions and weak accountability of service providers/ politicians in Sub-Saharan Africa, social accountability interventions can potentially improve public service delivery when contextual (both demand and supply side), intervention design, and implementation factors are carefully considered along the casual chain.

7.2. Recommendations

This part highlights the recommendations for policymakers and researchers based on the systematic review findings. These include -

7.2.1. Recommendations for policymakers

Social accountability interventions that embrace a collaborative approach rather than a confrontational approach are more likely to be successful. This is evidenced by (Alhassan et al., 2019; Barr et al., 2012; Bjorkman & Svensson, 2009; Blake et al., 2016; Gullo et al., 2017; Nyqvist et al., 2017; Schaaf et al., 2017; Van Campenhout et al., 2018) who showed that stakeholders from demand and supply-side (i.e., community, frontline service providers, managers, politicians, and traditional leaders) were jointly engaged in identifying challenges impeding service delivery, developing action and follow-up plans for implementation. Such collaborative engagement of multi-stakeholders has enabled effective capturing of views and concerns, strengthened relationships and trust, increased self-efficacy and intrinsic motivation, which were pivotal for success.

Secondly, contextual and program implementation factors are crucial for the success of any social accountability intervention. The studies by (Barr et al. 2012; Bjorkman & Svensson 2009; Blake et al., 2016; Ho et al., 2015; Reinikka & Svensson 2011; Schaaf et al.,2017) attested that the overcoming elite capture and collective action problems, the provision of actionable information, the willingness of political leaders, the history of citizen-state engagement, and the presence of structures promoting state-society interaction mediated the impact of social accountability intervention in public service delivery. Thus, program implementation and contextual factors should not be neglected when executing social accountability interventions.

Thirdly, well-designed social accountability interventions that fit the given context are pivotal for success. This is evidenced by Arkedis et al.(2021), Francetic et al. (2021), Gullo et al. (2020), and Katahoire et al. (2015), who claimed that the poor designing of social accountability interventions had hindered the effectiveness and impact of such interventions in health and education service delivery. Thus, context-specific designed social accountability interventions are considered significant for success.

Fourthly, to enhance effective community participation in social accountability interventions, working with interlocutors such as local or international non-governmental organizations, community-based organizations, traditional leaders, and media is essential. Aker & Ksoll (2019), Bjorkman & Svensson (2009), Duflo et al. (2015), Katahoire et al. (2015), Reinikka & Svensson (2011), and Schaaf et al. (2017) attested that facilitation by these interlocutors has contributed to citizen participation in the monitoring activities.

Lastly, long-term implementation and follow-up of social accountability intervention are critical for realizing sustainability. Fox (2015), Grandvoinnet et al. (2015), and Joshi (2014) conceptualized social accountability as a political, non-linear, complex, and iterative process, which implies that longer time implementation is pivotal for earning sustainability. Furthermore, Alhassan et al. (2016) and Danhoundo et al. (2018) attest that many social accountability interventions lack sustainability because they frame social accountability as just a mere intervention and not a process, which influenced their short term nature of implementation and follow-up.

7.2.2. Recommendation for researchers

Further systematic reviews assessing impact and identifying common facilitating or limiting factors mediating success in other contexts and specific sectors are needed to update existing reviews and enable strong conclusions. Secondly, more primary research adopting mixed methods designs is crucial for opening the black box of impacts by unpacking the underlying causal mechanisms that link interventions to outcomes. Thirdly, more research studying the effect of social accountability interventions in the sectors where service is delivered indirectly of service providers such as water supply and sanitation, physical infrastructures such as roads, railways, and electricity are needed. Lastly, considering the unquantifiable nature of other costs, more research studies incorporating intervention costs are required to allow cost-benefit comparison across various interventions. For instance, Aker & Ksoll (2019) and Bjorkman & Svensson (2009) set good examples on the way forward.

References

Afridi, F., & Iversen, V. (2014). Social Audits and MGNREGA Delivery: Lessons from Andhra Pradesh. *India Policy Forum*, *10*(1), 297–341.

Aker, J. C., & Ksoll, C. (2019). Call me educated: Evidence from a mobile phone experiment in Niger . *Economics of Education Review*, *72*(May), 239–257. https://doi.org/10.1016/j.econedurev.2019.05.001

Alhassan, R. K. A., Nketiah-Amponsah, E., Spieker, N., Arhinful, D. K., & De Rinke Wit, T. F. (2016). Assessing the impact of community engagement interventions on health worker motivation and experiences with clients in primary health facilities in Ghana: A randomized cluster trial. *PLoS ONE*, *11*(7), 1–19. https://doi.org/10.1371/journal.pone.0158541

Alhassan, R. K., Nketiah-Amponsah, E., Ayanore, M. A., Afaya, A., Salia, S. M., Milipaak, J., Ansah, E. K., & Owusu-Agyei, S. (2019). Impact of a bottom-up community engagement intervention on maternal and child health services utilization in Ghana: A cluster randomised trial. *BMC Public Health*, *19*(1), 1–11. https://doi.org/10.1186/s12889-019-7180-8

Andrabi, T., Das, J., & Khwaja, A. I. (2017). Report cards: The impact of providing school and child test scores on educational markets. *American Economic Review*, *107*(6), 1535–1563. https://doi.org/10.1257/aer.20140774

Argaw, M. D., Fekadu, B. D., Mamo, E., Abebe, M. G., Rogers, D., Demelash, A., Ayele, A. A., Reda, Z., Tareke, A. S., Erfo, A. M., Wonjalo, W. W., Bele, T. A., Ayede, A., & Abebe, L. G. (2021). Implementing a social accountability approach for maternal, neonatal, and child health service performances in Ethiopia: A pre-post study design. *Global Health Science and Practice*, *9*(1), 123–135. https://doi.org/10.9745/GHSP-D-20-00114

Arkedis, J., Creighton, J., Dixit, A., Fung, A., Kosack, S., Levy, D., & Tolmie, C. (2021). Can transparency and accountability programs improve health? Experimental evidence from Indonesia and Tanzania. *World Development*, *142*, 105369. https://doi.org/10.1016/j.worlddev.2020.105369

Banerjee, A. V., Banerji, R., Duflo, E., Glennerster, R., & Khemani, S. (2010). Pitfalls of participatory programs: Evidence from a randomized evaluation in education in India. *American Economic Journal: Economic Policy*, *2*(1), 1–30. https://doi.org/10.1257/pol.2.1.1

Baraldi A.L. (2019) Political Competition. In: Marciano A., Ramello G.B. (eds) Encyclopedia of Law and Economics. Springer, New York, NY. https://doi.org/10.1007/978-1-4614-7753-2_365

Bardhan, P. (2002). Decentralization of governance and development. *Journal of Economic Perspectives*, *16*(4), 185–205. https://doi.org/10.1257/089533002320951037

Barr, A., Mugisha, F., Serneels, P., & Zeitlin, A. (2012). Information and collective action in community-based monitoring of schools: Field and lab experimental evidence from Uganda. *Working Paper*, 1–37. http://cega.berkeley.edu/assets/cega_events/3/doc7Zeitlin-et-al_Information-and-Collective-Action-in-Community-based-mMonitoring-of-Schools.pdf

Bjorkman, M., & Svensson, J. (2009). Power to the People : Evidence from a Randomized Field Experiment on Community-Based Monitoring in Uganda Author (s): Martina Björkman and Jakob Svensson Published by : Oxford University Press Stable URL : http://www.jstor.org/stable/40506242. *The Quarterly Journal of Economics*, *124*(2), 735–769.

Björkman, M., & Svensson, J. (2010). When is community-based monitoring effective? Evidence from a randomized experiment in primary health in Uganda. *Journal of the European Economic Association*, *8*(2–3), 571–581. https://doi.org/10.1111/j.1542-4774.2010.tb00527.x

Blake, C., Annorbah-Sarpei, N. A., Bailey, C., Ismaila, Y., Deganus, S., Bosomprah, S., Galli, F., & Clark, S. (2016). Scorecards and social accountability for improved maternal and newborn health services: A pilot in the Ashanti and Volta regions of Ghana. *International Journal of Gynecology and Obstetrics*, *135*(3), 372–379. https://doi.org/10.1016/j.ijgo.2016.10.004

Brinkerhoff, D. W., & Azfar, O. (2006). Decentralization and community empowerment: does community empowerment deepen democracy and improve service delivery? *U.S. Agency for International Development*, *October*, 1–43.

Brinkerhoff, D. W., & Wetterberg, A. (2016). Gauging the Effects of Social Accountability on Services, Governance, and Citizen Empowerment.

Public Administration Review, *76*(2), 274–286. https://doi.org/10.1111/puar.12399

Care Malawi. (2013). *The Community Score Card (CSC): a generic guide for implementing CARE's CSC process to improve quality of services*. Cooperative for Assistance and Relief Everywhere, Inc. CARE Technical Guidance.

Chaudhury, N., Hammer, J., Kremer, M., Muralidharan, K., & Rogers, F. H. (2006). Missing in action: Teacher and health worker absence in developing countries. *Journal of Economic Perspectives*, *20*(1), 91–116. https://doi.org/10.1257/089533006776526058

Danhoundo, G., Nasiri, K., & Wiktorowicz, M. E. (2018). Improving social accountability processes in the health sector in sub-Saharan Africa: A systematic review. *BMC Public Health*, *18*(1), 1–8. https://doi.org/10.1186/s12889-018-5407-8

Dasgupta, A., & Beard, V. A. (2007). Community driven development, collective action and elite capture in Indonesia. *Development and Change*, *38*(2), 229–249. https://doi.org/10.1111/j.1467-7660.2007.00410.x

Devarajan, S., Khemani, S., & Walton, M. (2011). Civil Society, Public Action and Accountability in Africa. *World Bank Policy Research Working Paper*, *5733*, 68.

Dewachter, S., & Holvoet, N. (2017). Intersecting social-capital and perceived-efficacy perspectives to explain underperformance in community-based monitoring. *Evaluation*, *23*(3), 339–357. https://doi.org/10.1177/1356389017716740

Duflo, E., Dupas, P., & Kremer, M. (2015). School governance, teacher incentives, and pupil-teacher ratios: Experimental evidence from Kenyan primary schools. *Journal of Public Economics*, *123*, 92–110. https://doi.org/10.1016/j.jpubeco.2014.11.008

Falisse, J. B., & Ntakarutimana, L. (2020). When information is not power: Community-elected health facility committees and health facility performance indicators. *Social Science and Medicine*, *265*(August). https://doi.org/10.1016/j.socscimed.2020.113331

Fox, J. (2007). The uncertain relationship between transparency and accountability. *Development in Practice*, *17*(4–5), 663–671. https://doi.org/10.1080/09614520701469955

Fox, J. A. (2015). Social Accountability: What Does the Evidence Really Say? *World Development*, *72*, 346–361. https://doi.org/10.1016/j.worlddev.2015.03.011

Francetic, I., Fink, G., & Tediosi, F. (2021). Impact of social accountability monitoring on health facility performance: Evidence from Tanzania. *Health Economics (United Kingdom)*, *30*(4), 766–785. https://doi.org/10.1002/hec.4219

Gaventa, J., & Barrett, G. (2010). So What Difference Does it Make? Mapping the Outcomes of Citizen Engagement. *IDS Working Papers*, *2010*(347), 01–72. https://doi.org/10.1111/j.2040-0209.2010.00347_2.x

Gaventa, J., & Mcgee, R. (2013). The impact of transparency and accountability initiatives. *Development Policy Review*, *31*(S1). https://doi.org/10.1111/dpr.12017

Global Affairs Canada. (2016). *Results-based management for international assistance programming at Global Affairs Canada: A how-to guide*. *2016*. http://www.international.gc.ca/world-monde/assets/pdfs/funding-financement/results_based_management-gestion_axee_resultats-guide-en.pdf

Grandvoinnet, H., Aslam, G., & Raha, S. (2015). Opening the Black Box: The Contextual Drivers of Social Accountability. In *Opening the Black Box: The Contextual Drivers of Social Accountability*. https://doi.org/10.1596/978-1-4648-0481-6

Gullo, S., Galavotti, C., Kuhlmann, A. S., Msiska, T., Hastings, P., & Marti, C. N. (2017). Effects of a social accountability approach, CARE's Community Score Card, on reproductive health-related outcomes in Malawi: A cluster-randomized controlled evaluation. *PLoS ONE*, *12*(2), 1–20. https://doi.org/10.1371/journal.pone.0171316

Gullo, S., Galavotti, C., Kuhlmann, A. S., Msiska, T., Hastings, P., & Marti, C. N. (2020). Effects of the community scorecard approach on reproductive health service -related outcomes in Malawi. *PLoS ONE*, *15*(5), 1–21. https://doi.org/10.1371/journal.pone.0232868

Gullo, S., Kuhlmann, A. S., Galavotti, C., Msiska, T., Nathan Marti, C., & Hastings, P. (2018). Creating spaces for dialogue: A cluster-randomized evaluation of CARE's Community Score Card on health governance outcomes 11 Medical and Health Sciences 1117 Public Health and Health Services. *BMC Health Services Research*, *18*(1), 1–12. https://

doi.org/10.1186/s12913-018-3651-3

Ho, L. S., Labrecque, G., Batonon, I., Salsi, V., & Ratnayake, R. (2015). Effects of a community scorecard on improving the local health system in Eastern Democratic Republic of Congo: Qualitative evidence using the most significant change technique. *Conflict and Health*, *9*(1), 1–11. https://doi.org/10.1186/s13031-015-0055-4

Holvoet, N (2019) *Community-based monitoring* [Power point slides]. Local Institutions and Poverty Reduction. Retrieved from https://blackboard.uantwerpen.be/

Honig, L. (2019) Traditional Leaders and Development in Africa. *Oxford Research Encyclopedia of Politics*. Retrieved 27 Jan. 2022, from https://oxfordre.com/politics/view/10.1093/acrefore/9780190228637.001.0001/acrefore-9780190228637-e-821.

Joshi, Anuradha. (2013). Do they work? Assessing the impact of transparency and accountability initiatives in service delivery. *Development Policy Review*, *31*(S1), 29–48. https://doi.org/10.1111/dpr.12018

Joshi, Anuradha. (2014). Reading the local context: A causal chain approach to social accountability. *IDS Bulletin*, *45*(5), 23–35. https://doi.org/10.1111/1759-5436.12101

Joshi, Anuradha, & Houtzager, P. P. (2012). Widgets or Watchdogs?: Conceptual explorations in social accountability. *Public Management Review*, *14*(2), 145–162. https://doi.org/10.1080/14719037.2012.657837

Katahoire, A. R., Henriksson, D. K., Ssegujja, E., Waiswa, P., Ayebare, F., Bagenda, D., Mbonye, A. K., & Peterson, S. S. (2015). Improving child survival through a district management strengthening and community empowerment intervention: Early implementation experiences from Uganda. *BMC Public Health*, *15*(1), 1–11. https://doi.org/10.1186/s12889-015-2129-z

Keefer, P., & Khemani, S. (2014). Mass media and public education: The effects of access to community radio in Benin. *Journal of Development Economics*, *109*(February 2011), 57–72. https://doi.org/10.1016/j.jdeveco.2014.03.010

Kiracho, E. E., Namuhani, N., Apolot, R. R., Aanyu, C., Mutebi, A., Tetui, M., Kiwanuka, S. N., Ayen, F. A., Mwesige, D., Bumbha, A., Paina, L., & Peters, D. H. (2020). Influence of community scorecards on maternal and newborn health service delivery and utilization. *International Journal for Equity in Health*, *19*(1), 1–12. https://doi.org/10.1186/s12939-020-01184-6

Lieberman, E. S., Posner, D. N., & Tsai, L. L. (2014). Does information lead to more active citizenship? Evidence from an education intervention in rural Kenya. *World Development*, *60*, 69–83. https://doi.org/10.1016/j.worlddev.2014.03.014

Lindberg, S. I. (2013). Mapping accountability: Core concept and subtypes. *International Review of Administrative Sciences*, *79*(2), 202–226. https://doi.org/10.1177/0020852313477761

Lodenstein, E., Dieleman, M., Gerretsen, B., & Broerse, J. E. (2013). A realist synthesis of the effect of social accountability interventions on health service providers' and policymakers' responsiveness. *Systematic Reviews*, *2*, 98. https://doi.org/10.1186/2046-4053-2-98

Malena, C., Forster, R., & Singh, J. (2004). An Introduction to the Concept and Emerging Practice. *Social Development Papers Participation and Civic Engagement*, *76*, 18. http://siteresources.worldbank.org/INTPCENG/214578-1116499844371/20524122/310420PAPER0So1ity0SDP0Civic0no1076.pdf

Mbiti, I., & Serra, D. (2021). Health workers' behavior, patient reporting and reputational concerns: lab-in-the-field experimental evidence from kenya. In *Experimental Economics* (Issue 0123456789). Springer US. https://doi.org/10.1007/s10683-021-09721-y

Molina, E. (2015). Can Bottom-Up Institutional Reform Improve Service Delivery? *SSRN Electronic Journal*, *September*. https://doi.org/10.2139/ssrn.2559636

Molina, E., Carella, L., Pacheco, A., Cruces, G., & Gasparini, L. (2017). Community monitoring interventions to curb corruption and increase access and quality in service delivery: a systematic review. *Journal of Development Effectiveness*, *9*(4). https://doi.org/10.1080/19439342.2017.1378243

Musgrave, M. K., & Wong, S. (2016). Towards a More Nuanced Theory of Elite Capture in Development Projects. The Importance of Context and Theories of Power. *Journal of Sustainable Development*, *9*(3), 87. https://doi.org/10.5539/jsd.v9n3p87

Nyqvist, M. B., de Walque, D., & Svensson, J. (2017). Experimental evidence on the long-run impact of community-based monitoring. *American Economic Journal: Applied Economics*, *9*(1), 33–69. https://doi.org/10.1257/app.20150027

O'Meally, S. C. (2013). *Mapping context for social accountability: A resource paper*. 118. http://siteresources.worldbank.org/EXTSOCIALDEVELOPMENT/Resources/244362-1193949504055/Context_and_SAcc_RESOURCE_PAPER.pdf

Olken, B. A. (2007). Monitoring corruption: Evidence from a field experiment in Indonesia. *Journal of Political Economy*, *115*(2), 200–249. https://doi.org/10.1086/517935

Pan, L., & Christiaensen, L. (2012). Who is Vouching for the Input Voucher? Decentralized Targeting and Elite Capture in Tanzania. *World Development*, *40*(8), 1619–1633. https://doi.org/10.1016/j.worlddev.2012.04.012

Peruzzotti Enrique and Smulovitz Catalina. (2006). *Enforcing rule of law: Social accountability in the new Latin America Democracies* (Eds). University of Pittsburgh Press.

Pieterse, P. (2019). Citizen feedback in a fragile setting: social accountability interventions in the primary healthcare sector in Sierra Leone. *Disasters*, *43*(S2), S132–S150. https://doi.org/10.1111/disa.12331

Pollock, A., & Berge, E. (2018). How to do a systematic review. *International Journal of Stroke*, *13*(2), 138–156. https://doi.org/10.1177/1747493017743796

Pradhan, M., Suryadarma, D., Beatty, A., Wong, M., Gaduh, A., Alisjahbana, A., & Artha, R. P. (2014). Improving educational quality through enhancing community participation: Results from a randomized field experiment in Indonesia. *American Economic Journal: Applied Economics*, *6*(2), 105–126. https://doi.org/10.1257/app.6.2.105

Ravallion, M., Van De Walle, D., Dutta, P., & Rinku, M. (2013). Testing Information Constraints on India's Largest Antipoverty Program. *World Bank Policy Research Working Paper*, *6598*, 1–29.

Reinikka, R., & Svensson, J. (2005). Fighting Corruption to Improve Schooling: Evidence from a Newspaper Campaign in Uganda. *Journal of the European Economic Association*, *3*(2–3), 259–267. https://doi.org/10.1162/jeea.2005.3.2-3.259

Reinikka, R., & Svensson, J. (2011). The power of information in public services: Evidence from education in Uganda. *Journal of Public Economics*, *95*(7–8), 956–966. https://doi.org/10.1016/j.jpubeco.2011.02.006

Renmans, D., Holvoet, N., Orach, C. G., & Criel, B. (2016). Opening the "black box" of performance-based financing in low- and lower middle-income countries: A review of the literature. *Health Policy and Planning*, *31*(9), 1297–1309. https://doi.org/10.1093/heapol/czw045

Ringold, D., Holla, A., Koziol, M., & Srinivasan, S. (2011). Citizens and Service Delivery. In *Citizens and Service Delivery* (Issue November 2014). https://doi.org/10.1596/978-0-8213-8980-5

Schaaf, M., Topp, S. M., & Ngulube, M. (2017). From favours to entitlements: Community voice and action and health service quality in Zambia. *Health Policy and Planning*, *32*(6), 847–859. https://doi.org/10.1093/heapol/czx024

Schedler, A. (1999). Conceptualizing Accountability. *The Self-Restraining State: Power and Accountability in New Democracies*, 13–28.

Singh, R., & Vutukuru, V. (2010). *Enhancing Accountability in Public Service Delivery through Social Audits: A Case Study of Andhra Pradesh, India*.

Stiglitz Joseph. (2002). Participation and Development: Perspective from the Comprehensive Development Paradigm. *Review of Development Economics.*, *6*(163–82). https://doi.org/10.1111/1467-9361.00148.

Tembo, F. (2013). *Rethinking social accountability in Africa: lessons from the Mwananchi Programme*. 132.

The World Bank Group. (2003). *World Development Report 2004: Making Service for Poor People Overview*.

Van Campenhout, B., Bizimungu, E., Smart, J., & Kabunga, N. (2018). Impact pathways of a participatory local governance initiative in Uganda: a qualitative exploration. *Development in Practice*, *28*(8), 1046–1056. https://doi.org/10.1080/09614524.2018.1509944

Waddington, H., Sonnenfeld, A., Finetti, J., Gaarder, M., John, D., & Stevenson, J. (2019). Citizen engagement in public services in low- and middle-income countries: A mixed-methods

systematic review of participation, inclusion, transparency and accountability (PITA) initiatives. *Campbell Systematic Reviews*, *15*(1–2). https://doi.org/10.1002/cl2.1025

Westhorp, G., Walker, B., Rogers, P., Overbeeke, N., Ball, D., & Brice, G. (2014). *Enhancing community accountability, empowerment and education outcomes in low and middle-income countries : A realist review* (Issue May).

World Bank Group and CPIA Africa. (2020). *Safe guarding human capital during and beyond COVID-19*. *August*.

Appendix

Description of the included studies

Source	Country	Sector	Social accountability interventions	Description of intervention	Study design	Outcome measure	Implementation time	Facilitator
Aker & Ksoll (2019)	Niger	Education	Mobile community-based monitoring	Two regions, Maradi and Zinder, were purposefully selected. 134 villages were randomly selected to participate in the research. 114 villages were randomly assigned to adult education programs with "mobile phone monitoring" and "no mobile phone monitoring," and 20 villages served as control.	RCT	Access to service: Changes in dropout Quality of service: Changes in math and reading test score	2years	NGO& Ministry of Non -Formal Education
Alhassan et al. (2019)	Ghana	Health	Systematic community engagement (SCE) with Community scorecards	The study was conducted in 16 districts in Great Accra and Western regions. 64 primary health care facilities were equally randomly assigned to the treatment and control groups.	RCT	Access to service: child immunization, female condoms distributed, HIV test to pregnant women, and malaria test Quality of service: Changes in the number of spontaneous vaginal delivery	1 year	N/A
Arkedis et al.(2021)	Tanzania	Health	Community Score Cards	The randomized control trial was implemented in 200 villages randomly selected within two purposively selected regions. The health facilities and one or two communities within the catchment areas were randomly assigned to the treatment and control arm. Surveys were administered to 3000 & 6008 recent mothers at the baseline and end-line. Interviews, focus group discussions, and observations were used.	Mixed methods	Access to service: Utilization of Maternal and Newborns Health services Quality of service: Improved content of health care Health outcomes: Increase in weight of age and Height of age of children.	1years	CSO: Clinton Health Access Initiative(CHAI)

Argaw et al. (2021)	Ethiopia	Health	Community Score Cards	The study was conducted in two purposively selected administrative zones, namely Amhara and SNNP region. 641 villages in 31 districts with 159 Primary health Care units (PHCUs) in selected administrative zones were included. A total of 38,556 community members and 4053 Client council members participated in the focus group discussion.	Pre and post longitudinal design	Access to service: Availability and utilization of Maternal, postnatal, and child service Quality of service Patient waiting time, ambulance service, facility infrastructure, cleanness, and safety of health facility	1 year	Consortium Organization includes international and local development Pathfinder International, JSI Research & Training Institute, Inc., EnCompass Malaria Consortium, Abt Associates Inc., and Ethiopian Midwives Association in collaboration with local government and NGO partners.
Barr et al. (2012)	Uganda	Education	Community scorecards	100 rural primary schools in four districts in Uganda were selected. 30 schools each were randomly assigned to treatment (standard and participatory scorecards), and the remaining 40 served as control.	RCT, DID	Quality of service: Changes in math and literacy test score and teacher's attendance Access to service: changes in pupil's attendance	2years and 5month	Ugandan Government agencies- CCT
Bjorkman & Svensson (2009)	Uganda	Health	Community scorecards and Information campaign	The intervention involved 50 public dispensaries in nine districts covering four regions in Uganda. 25 health facilities were randomly assigned to the treatment group, and the remaining facilities were randomly assigned to the control group.	RCT	Access to services: changes in utilization of service and immunization. Quality of service: improvement in treatment practices such as waiting time, absenteeism rate, equipment used, drugs stock out, and management of health facilities Improved wellbeing: Changes in weight for age, the under-5 mortality rate	1 year	Local NGO-(CBO)

Blake et al.(2016)	Ghana	Health	Scorecards	The intervention was piloted in 37 health facilities in 8 districts of Volta and Ashanti. The quantitative component comprised pre and post interventions facility assessment, whereas the qualitative part assessed the impact of changes in policy, attitudes, or practices.	Mixed	Access to service: Utilization of health facility Quality of to service: Changes in availability of drugs and essential equipment. Improvement in water and sanitation infrastructure. Changes in provider-client interaction	1 year	DFID- Evidence for Action Program
Duflo et al. (2015)	Kenya	Education	Community-based monitoring	210 schools in Western Province were randomly selected for the study. 70 schools were randomly assigned to the control group, while 140 schools were randomly assigned to the treatment group (The ETP-Extra Teacher Program). Out of 140, 70 were randomly assigned to the tracking ETP program and remained 70 to the non-tracking program. 34 of 70 non-tracking programs were randomly assigned to participate in School-Based Management Training (SMT) SMT empowered the school's committees, specifically the parents, to monitor the implementation of the ETP program, and the rest of the parents were informed about the ETP program.	RCT	Access to service: Changes in student attendance Quality of service: Changes in test scores in math and literacy	1year and 6month	NGO- International child support (ICS)
Falisse & Ntakarutimana, (2020)	Burundi	Health	Information campaign	A randomized control trial was implemented in 251 public-funded Health Facilities (HFs) in seven provinces of Burundi. 83 randomly selected HFs served as control, 84 randomly selected HFs benefited from training intervention, and the remaining randomly selected HFs were provided training and information intervention. The intervention was channeled to randomly selected 168 Health Facilities Committees. Two rounds of A cross-sectional survey to 30 households randomly selected were also held.	Mixed design	Access to service: The perceived access to service by households Quality of service: The perceived quality of service The use of service: Curative care, postnatal, family planning, immunization, and referral.	2years	Local NGO -COPED in collaboration with International NGO-CORDAID and Ministry of Health, Burundi.

Francetic et al. (2021)	Tanzania	Health	Community-Based Monitoring	The Social accountability monitoring (SAM) intervention purposively selected two (2) districts of the Dodoma region as treatment while the other five (5) districts served as control. All seven were under the district Health Promotion and System Strengthening (HPSS) project. SAM interventions were further extended to other selected districts. Surveys were carried out to randomly selected households and health facilities in the treatment districts.	DID	Quality of service: Reduction of stock out of essential medicine, improve health facility infrastructures, improve resource allocation and Improve financial management and governance.	5years	SIKIKA- Local NGO
Gullo et al. (2017)	Malawi	Health	Community score-cards	The Ntcheu district has 33 health facilities; out of those, 20 health facilities were purposively selected. Health facilities were matched in pairs, and one facility from each pair was randomly assigned as a treatment group, and the other was assigned as a control group. Surveys were administered to 1301 women (649 control and 652 treatment) who gave birth within the last 12 months at baseline (November-December 2012) and 1300 women who gave birth within the last 12 months at end-line (November-December 2014).	RCT, DID, LATE	Access and use of service: Antenatal and postnatal care utilization, use of modern contraceptives Quality of service: service satisfaction	2years	CARE-Malawi
Gullo et al. (2018)	Malawi	Health	Community score-cards	The Ntcheu district has 33 health facilities; out of them, 20 health facilities were purposively selected. Health facilities were matched in pairs, and one facility from each pair was randomly assigned to the treatment group, and the other was assigned to the control group. Cross-sectional surveys were administered at the end-line, with 651 sampled in intervention and 649 sampled in the control group. Women aged 15–49 who gave birth within the prior 12 months and whose baby was still living were eligible.	RCT, LATE	Access to service: Utilization of modern family planning Quality of service: home visit by health workers, service satisfaction	2years	CARE, Malawi

Gullo et al.(2020)	Malawi	Health	Community Scorecards	20 health facilities were purposively selected for CSC intervention based on four inclusion criteria. Health facilities were matched in pairs, and one facility from each pair was randomly assigned to the treatment and control group. Health workers surveys were administered to all health workers in 20 selected health facilities. A total of 231 health worker end-line surveys were used for estimating impact.	LATE, ITT&IV	Quality of service: Provision of comprehensive Antenatal care, Family planning, home visits, and the number of home visits by health workers.	2years	CARE, Malawi
Ho et al. (2015)	Congo	Health	Community score-cards	Two districts, South Kivu and Katanga, in the eastern Democratic Republic of Congo, were selected purposively. 10 Community score-cards sites were selected in South Kivu, and 15 Community scorecard sites were selected in the Katanga district. There was no comparison group.	Qualitative-Most significant change technique	Access to service: Increase in access to health care services Quality of service: Changes in availability of drugs, equipment's, reduction of the user fee, and physical infrastructure	1year and 6months	Tuungane project facilitated by CARE International and International Rescue Committee (IRC)
Katahoire et al. (2015)	Uganda	Health	Community dialogue based on Citizen report cards	Five districts in Uganda were purposely selected for this intervention. 38 semi-structured interviews were held with members of District Health teams and two implementing partners. Observation and document review were also conducted. There was no comparison group.	Qualitative	Access to service: Improved utilization of service	2years	Advocates Coalition for Development and Environment(ACODE), Child Fund International(CFI), and Liverpool School of Tropical Medicine(LSTM)
Keefer & Khemani (2014)	Benin	Education	Information campaign	Household and pupils in villages with access to community radio were assigned to the treatment group, while the households and pupils in the villages without access to radio were assigned to the control group. A total of 4,200 households from 210 villages and 32communes were included in the study.	Quasi experimental design	Quality of service: Changes in literacy test score for grade two pupils	N/A	N/A

Kiracho et al.(2020)	Uganda	Health	Community score-cards	The Community Score Cards (CSC) intervention was implemented in Five sub countries and one town council in the Kibuku district in Uganda. Both demand and sup-ply-side actors responsible for Maternal and Newborn Health services were included in a series of meetings, including interface meetings. Quantitative data were obtained during the Community scorecards interface meeting. 30-50 actors were involved, and five (5) interface meetings were conducted. Qualitative data were collected from 17 Key informants' interviews (KIIs) and 10 Focus group discussions.	Mixed design	Access to service: Mothers attending Antenatal Care (ANC) 1st trimester Quality of Service: Availability of Midwives, delivery beds and drugs, decrease in Traditional Birth Attendants (TBA) deliveries	1years	The Future Health Systems Research Program Consortium
Nyqvist et al. (2017)	Uganda	Health	Community scorecards and Information cam-paign Community score-cards	A total of 75 public dispensaries in rural Uganda were randomly selected. In the information and participa-tion intervention, 25 facilities were randomly assigned to the treatment and control groups each. While in the participation intervention, 13 facilities were randomly assigned to the treatment group, and 12 were randomly assigned to the control group.	RCT	Access to services: chang-es in utilization of service and immunization. Quality of service: improve-ment in treatment prac-tices such as waiting time, absenteeism rate, equip-ment used, drugs stock out, and management of health facilities Improved wellbeing: Changes in weight for age, the under-5 mortality rate	4years 2years	Local NGO-CBO
Pieterse (2019)	Sierra-Leone	Health	Community score-cards	A randomized control trial was carried out in four districts in Sierra- Leone. 25 health facilities in the Tonkolili district were randomly selected to participate in commu-nity scorecard intervention. The Qualitative study was purposively carried out in six health facilities. Six Focus group discussions with healthcare users qualified for free healthcare were held both in treatment and control facilities. Interviews were held with clinics' workers, facility and district man-agement committee members, min-istry of health staff, NGO staff, and donor agency employees.	Qualitative	Quality of service: Patients entitled to free care and medicine receive the ser-vice, reduced absenteeism Access to service: Utilization of health fa-cilities	2years	NGO

Reinikka & Svensson (2005; 2011)	Uganda	Education	Information Campaign	The distance to the newspaper's outlet was used to construct the treatment and control group. The sample of 218 schools (i.e., for which survey data are available for the year 1991-95 and 2001) and 388(218+170)(i.e., for which survey data are available for the year 2001) were used.	DID, IV	Quality of service: Changes in aggregate test score (Math, Science, English, and Social studies Access to service: changes in grade 7 enrollment	N/A	The Government of Uganda, through New vision and Monitor newspaper
Schaaf et al. (2017)	Zambia	Health	Community score-cards and social audit	The Citizen Voice and Action (CVA) program was implemented in three rural districts in Zambia. Five health facilities were purposely selected. In-depth interview was administered to district health officials, traditional community leaders, and rural health centre staff, while focus group discussions were held with community and Citizen, Voice, and Action members. There was no comparison/control group.	Qualitative	Quality of service: Changes in essential drugs availability, improved infrastructure, and new nurses hiring	5years	World Vision International
Van Campenhout et al. (2018)	Uganda	Local government	Information campaign through Citizen advocacy forum known as "Baraza."	The "Baraza" events were conducted in Bagezza and Masindi sub-county in Uganda between September and October 2016. Semi-structured interviews and focus group discussions were administered to political leaders, civil servants, service providers, citizens, and community "Baraza" facilitators.	Qualitative	Quality of service; Changes in public service delivery (i.e., health, education, water, sanitation, infrastructure, and agriculture)	N/A	Office of Prime Minister.

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