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Citizen-Led Gender-Responsive Budgeting In Health

A theory-based approach to evaluating effectiveness

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Citizen-led gender-responsive budgeting in health: a theory-based approach to evaluating effectiveness

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Abstract

It is widely acknowledged that gender inequality impedes the attainment of development objectives. Specific to the health sector, inequality is evidenced through excess mortality of females and differences in life expectancy that are contrary to biological norms (Stotsky, 2006). Citizen-led gender-responsive budget initiatives have been undertaken in various sectors to promote gender equality in public resource allocation and utilization and to improve transparency and accountability in public service delivery. Thus far, existing literature on the effectiveness and impact of different kinds of gender-responsive budget initiatives is mostly policy-oriented or practitioner-oriented, and is largely descriptive; while empirical literature has focused on evaluating specific interventions rather than sectors.

This paper focuses on the health sector in Uganda and explains an approach to empirically evaluate the effectiveness of citizen-led gender-responsive budget initiatives at local government level, taking due consideration of the question of causality. First, the paper adopts the *theory-based evaluation approach* to describe the causal step process and underlying assumptions that link citizen-led gender-responsive budget initiatives to the outcome of gender equality in health outcomes. Next, the paper proposes the use of *theory-testing process-tracing* methods to investigate whether the causal theory and mechanism leading to the outcome were present in the case and functioned as predicted. The paper further proposes evaluation of the counterfactual using congruence methods to enhance the internal validity of the mechanism, by ascertaining that no alternative explanations are more congruent in leading to the outcome than the theorised mechanism.

Besides providing empirical evidence of the effectiveness and impact of citizen-led gender-responsive budget initiatives, the approach proposed in this paper enables the identification of specific stages along the causal chain that impede the achievement of the intended goal of gender equality in health outcomes.

Keywords: Citizen-led, gender-responsive budgeting, theory-based evaluation, theory-testing process-tracing

1. Introduction

In the last two decades, gender equality has increasingly gained prominence as a strategy to foster the attainment of development goals across sectors worldwide. To-date, a variety of policy measures have been implemented to promote gender equality, among which include gender responsive budgeting. Gender responsive budgeting (GRB) refers to the explicit integration of a gender perspective into any or all parts of the decision-making process regarding resource allocation and revenue generation (Rubin & Bartle, 2005). It involves analysing any form of public expenditure, or method of raising public revenue, for its implications and impacts on women and girls as compared to men and boys, with a view of promoting gender equality and equity (Elson, 2002). Different authors (Cagatay et al., 2000; Elson, 2002; Budlender et al., 2005) have categorized GRB initiatives according to origin and political location, notably inside-government initiatives, outside-government initiatives, or a collaboration of inside- with outside-government initiatives. The origin of the initiatives is said to play a role in shaping the objectives, scope, activities, methods and tools used, as well as actors targeted as allies and stakeholders (Budlender & Hewitt, 2006).

This paper focuses on outside-government initiatives and more specifically, citizen-led GRB initiatives in the health sector at local government level. Citizen-led GRB initiatives refer to initiatives typically started by civil society non-government organizations, social movements, or associations representing groups of citizens, to encourage greater public participation in budget processes so as to enhance transparency and accountability (Carlitz, 2013). Although the number of GRB initiatives has grown to hundreds in over 100 countries since the 1990s, limited literature exists on their true impact and effectiveness (Carlitz, 2013). A synthesis review by McGee and Gaventa (2010) revealed that most of the existing literature is policy- or practitioner-oriented, largely descriptive, and very few comparative studies discuss and explain the degree of effective implementation. Among the empirical studies that have evaluated the impact of citizen-led initiatives (Björkman & Svensson, 2009; Reinikka & Svensson, 2005; Gaventa & Barrett, 2010), the focus has been on evaluating specific interventions (community score cards, public expenditure tracking systems) rather than sectors, using methods such as randomized controlled trials, qualitative case studies, or participatory evaluation (Joshi, 2013). Randomized controlled trials, although statistically robust, have come under criticism for being narrow-focused and inadequate in explaining the issue of causality (Joshi, 2013). Similarly, the quality of evidence from qualitative studies has varied greatly, with many studies presenting anecdotal claims of impact; while participatory evaluations have been criticized for being biased in mainly reporting successes (Joshi, 2013; Joshi & Houtzager, 2012).

In this paper, I discuss an approach to empirically evaluate the effectiveness and impact of citizen-led GRB initiatives in health, taking due consideration of the question of causality. Cognizant that GRB initiatives are generally context-specific, I argue for the use of the *theory based impact evaluation approach* to explicitly articulate and explain the programme theory of the particular initiative, followed by *theory-testing process tracing* to investigate the causal claims and mechanisms so as to draw valid causal inferences.

The paper is divided into five sections. Following this introduction, Section 2 presents a brief synopsis of the origin and rise of citizen-led GRB initiatives and makes a case for citizen-led GRB initiatives in the health sector. Section 3 discusses the principles and application of the theory based impact evaluation approach and elaborates the programme theory of change of citizen-led GRB initiatives in health, taking Kyabuhangwa Village Budget Club in

Kabale District, Uganda as the case study. Section 4 discusses process tracing methodology and its appropriate application in the investigation of the causal mechanisms and claims underlying the programme theory. A discussion is also made of the evaluation of the counterfactual, followed by a conclusion presented in section 5.

2. The roots and rise of citizen-led GRB initiatives

Most GRB initiatives emerged in the aftermath of the 1995 Fourth World Conference on Women, where it was recommended that "Governments should make efforts to systematically review how women benefit from public expenditures; adjust budgets to ensure equality of access to public expenditures" (United Nations, 1995: 128). While early GRB initiatives were predominantly technical and focused on effecting changes to policies and budgets at a macro (national) level, many initiatives are now also being undertaken at lower levels of government, with some involving the direct participation of citizens at the grassroots. Various authors (Joshi & Houtzager, 2012; McGee & Gaventa, 2010; Robinson, 2004; Krafchik, 2002) attribute the emergence and recent growth of the latter GRB initiatives – particularly in transitional and developing countries – to global developments, notably democratization, decentralization and increasing demands for budget transparency and accountability among aid donors.

Robinson (2004) argues that the political imperative to increase citizen engagement in public deliberation in several countries, during the 1990s, was a motivating factor behind many civil society and legislative initiatives, especially at provincial levels. Following the inadequacies of traditional mechanisms to deliver accountability to the citizenry, notably through elections and intra-government bureaucratic controls, a range of mostly outside-government initiatives emerged to empower citizens to hold governments to account (Gaventa & McGee, 2013). The era of the good governance agenda also placed emphasis on 'accountability', 'transparency' and 'participation' as desirable attributes of effective states, which contributed to greater openness of budget processes to legislative and citizen oversight and the emergence of GRB initiatives (Robinson, 2008).

Institutionalized opportunities for citizen engagement in public decision-making processes were also created with the decentralization of powers from central to lower levels of government in several states. Budlender (2005) asserts that a number of GRB initiatives, such as Forum for Women in Democracy in Uganda, expanded their scope to lower levels of government out of concern about the implications of decentralization for gender equality and the participation of women in governance. McGee and Gaventa (2010) and Carlitz (2013) further propose that the increasing demand for budget transparency and accountability among aid donors (the providers of budget support), as well as concerns about the (in) effectiveness of government spending, contributed to a wide array of civil society-led and government-led initiatives at various stages of the budget process, to ensure that donor funds are appropriately spent for intended purposes.

Broadly, GRB initiatives have three aims, namely to raise public awareness about the differential effects of budgets on women and men; hold governments accountable for their commitments to gender equality; and achieve gender responsive budgeting in sectors (International Labour Organisation, 2006: 3). Many GRB initiatives, and more so citizen-led initiatives, focus 'downstream' on how public funds are spent in selected sectors (mainly health, education, agriculture), while a few – such as the National Taxpayers Association in Kenya – also engage in the revenue side of budgets (McGee & Gaventa, 2010; Carlitz, 2013).

2.1. The case for citizen-led GRB initiatives in health

Health is one of the sectors that most GRB initiatives have concentrated efforts. According to the World Development Report (WDR) 2012, the rate at which women die relative to men in low- and middle-income countries in many regions of the world is higher, compared to developed countries (World Bank, 2011: 77). Biologically, the average life expectancy of women is higher than that of men in virtually all countries, thus excess mortality of girls and women contrary to biological norms depicts inequalities in health (Stotsky, 2006). The table below, extracted from the Human Development Report 2013, illustrates the ratio of female to male adult deaths across countries with different levels of human development.

Table 1: Adult mortality rates by human development index (HDI) group in 2013

HDI group	Deaths per 1,000 adults		
	Female	Male	Female to male ratio
Very high human development	60	114	0.53
High human development	105	221	0.48
Medium human development	132	204	0.65
Low human development	287	346	0.83

Source: Excerpt from Table 7 in United Nations Development Programme (2013: 169)

From table 1 above, it can be seen that male adult mortality[1] is generally higher than that of females across all human development index groups. However, the table also shows that the ratios at which females die relative to men among low- and medium human development index countries is higher at 0.83 and 0.65 respectively compared to high- and very high human development index countries at 0.48 and 0.53 respectively.

Despite economic growth in countries between 1990 and 2008, comparative research by the World Bank showed negligible changes in excess female mortality, as reductions in infant and childhood mortality were offset by dramatic increases in the reproductive ages (15 to 49 years), particularly in Sub Saharan Africa (World Bank, 2011). As a case in point, whereas the change in missing girls at birth between 1990 and 2008 among low HIV-prevalent countries in Sub Saharan Africa was negligible (42,000 in 1990 and 53,000 in 2008), excess female mortality during the reproductive years nearly doubled (264,000 in 1990 and 423,000 in 2008) (World Bank, 2011: 121). Different authors (Sen, et al., 2002; Vlassoff, 1994; Shen & Williamson, 1999) allude to the low status of women relative to men as being responsible for the gender differentials in health. In many societies, preference is given to the health needs of boys and men relative to girls and women. Furthermore, community norms and values regarding women's and men's sexuality, reproduction and rights reinforce gender biases that put women's lives at risk (Sen et al., 2002).

Considering that many developing countries lack resources to make the necessary investments in the health sector, GRB initiatives help to reveal the differentiated impact of government fiscal policy measures on various social groups (Holvoet, 2007). GRB initiatives also promote gender responsive allocation of the available resources towards meeting the needs of the poorest and most vulnerable groups of the population. On the demand-side of the public health system, GRB initiatives may complement public health by equipping citizens with knowledge about their health rights and entitlements and the type of health services available so as to

[1] Male adult mortality refers to the probability that a 15-year old male will die before reaching age 60, as expressed per 1000 adults.

increase demand for healthcare. Additionally, GRB initiatives advocate challenging social practices that undermine the status of women and girls in communities to increase their access to healthcare.

An evaluation of the effectiveness of citizen-led GRB initiatives in the health sector, therefore, seeks to determine the extent to which such initiatives achieve their stated goals (McGee & Gaventa, 2010). The next section proposes the use of the theory-based evaluation approach to articulate the programme theory of citizen-led GRB initiatives in health so as to permit the evaluation of effectiveness.

3. Overview and core principles of the theory-based evaluation approach

Theory-based evaluation – also known as theory-driven evaluation, programme evaluation, or theory of change – can be traced back to Tyler in the 1930s, who had the notion to formulate and test programme theory for evaluative purposes (Coryn et al., 2011). Over the years, numerous authors such as Suchman (1967), Weiss (1972), Chen and Rossi (1980), Rogers et al. (2000) and Donaldson (2007), among others, have contributed to the development of the theory-driven approach to evaluation (Leeuw, n.d.; Coryn et al., 2011). Theory-based evaluation can be defined as consisting of "an explicit theory or model of how the programme causes the intended or observed outcomes and an evaluation that is at least partly guided by the model" (Rogers et al., 2000: 5). Central to theory-based evaluations is the integration of the programme theory into the evaluation process, which Chen (1990) refers to as a set of interrelated assumptions, principles and/or propositions about how a programme is supposed to work. The programme theory must be concisely articulated and explained in a testable way to enable the investigation of whether, why or how the programme intervention (or policy) causes the intended or observed outcomes (Leeuw, n.d.).

White (2009: 274) advances six principles of theory-based evaluations, namely (1) mapping out the programme theory; (2) understanding the context; (3) anticipating heterogeneity; (4) rigorous evaluation of impact using a credible counterfactual; (5) rigorous factual analysis; and (6) use of mixed methods.

Mapping out the programme theory involves a clear identification of the intervention under evaluation, including its objectives and outcomes (intended and unintended), along with the underlying theory of change through which intervention inputs are expected to produce the outcomes (White, 2011). The starting point to developing the theory is a thorough review of programme documentation to obtain a proposed theory of how the programme will achieve its ends, followed by running of the theory by programme architects, managers or practitioners to ascertain how the intervention will generate the desired change (White, 2009; Leeuw, n.d.). The evaluator additionally visits the programme location to observe the functioning of the programme, reviews existing evaluation studies and academic literature on the particular intervention and/or similar interventions, and interviews fieldworkers and programme beneficiaries to obtain different perspectives of the programme theory (White, 2009; Rossi et al., 2004). As put forward by Pawson and Sridharan (2010), eliciting the programme theory is a process that often leads to the discovery of several potential theories as to how the programme works, all of which must be sifted through to select the dominant theory for investigation. The selected programme theory is then transformed into a hypothesis or hypotheses suitable for empirical research.

The second important principle of theory-based evaluations is to understand the context. Programme contexts generally include the social, economic and political structures; organizational context; programme stakeholders and staffing; geographical, historical and environmental contexts; among others (Leeuw, n.d.). The context influences how the programme theory is implemented, as similar programmes operating in different settings and through different change mechanisms may have different outcomes (White, 2009; Leeuw, n.d.). Specific to GRB transparency and accountability initiatives, McGee and Gaventa (2010) assert that the operative context determines the kind of initiatives that are feasible and desirable, as well as the interactions that the initiatives will have with broader external factors.

An understanding of the programme context helps to generate knowledge on what works for whom, in which contexts particular programmes work or do not work?, and what mechanisms are triggered by what programmes and in what contexts?, to facilitate the generalization of evaluation results to similar programmes operating in similar contexts (Leeuw, n.d.). Information about the context can be obtained through reading programme documents and general literature on the anthropology and political economy of the programme area, as well as through participatory methods such as observation and interviews (White, 2011; Rossi et al., 2004).

Relating to the third principle of theory-based evaluation, White (2009) suggests that an in-depth understanding of the programme context, such as the intervention design, beneficiary characteristics and socio-economic setting enables the researcher to anticipate heterogeneity and deal with it accordingly. Lastly, investigating the underlying programme theory requires the collection and analysis of data for each step along the causal path of the programme from inputs to the desired outcome (Birkmayer & Weiss, 2000). The fourth, fifth and sixth principles relate to rigorous evaluation of impact using an appropriate counterfactual; rigorous factual analysis of elements in the programme theory (causal chain); and the use of mixed methods; all of which will be discussed under Section 4 of this paper.

Typically, programme theories are represented as graphical diagrams, tables, or narratives describing inputs, activities and outputs – the programme process theory; initial (immediate, proximal or short-term) outcomes; intermediate (medial) outcomes; and long-term (distal) outcomes or impact – the programme impact theory (Coryn et al., 2011). By testing the micro-steps or linkages along the causal chain, the evaluator is able to confirm whether the necessary conditions were/are in place to achieve the desired outcome; and can identify the point at which breakdown occurs along the posited sequence to prevent the programme from reaching its distal goal (Rogers et al., 2000).

3.1. Eliciting the programme theory using the theory-based evaluation approach

This sub-section applies the principles of the theory based evaluation approach to elicit the programme theory of citizen-led GRB initiatives in health, taking Kyabuhangwa Village Budget Club, Kabale District as a case example. It starts with a description of the programme intervention and its operative context, and ends with a graphical representation of the programme theory.

3.1.1. Setting the context: Kyabuhangwa Village Budget Club, Kabale District, Uganda

Kyabuhangwa Village Budget Club (VBC) is a citizen-led GRB initiative operating in Kyabuhangwa Parish, Kamwezi Sub County in Kabale District. The VBC is one of several community groups started by Forum for Women in Democracy (FOWODE), a non-partisan Women's Non-Government Organization in Uganda. Kyabuhangwa VBC started in 2012 under FOWODE's Grassroots Gender Accountability Project with the objectives of: (1) promoting community participation – especially women and marginalized groups – in budget processes; (2) promoting gender sensitive policy-making and gender-responsive service delivery; and (3) increasing

accountability and reducing corruption amongst holders of public office (FOWODE, 2013a). Whereas the general aim is to influence gender-responsiveness of budget processes and budgets, the VBC intervention focuses efforts on community monitoring of public service delivery in specific sectors of health and education; promoting transparency and accountability among the holders of public office; and community sensitization on gender, citizen rights and entitlements. The overall goal (distal outcome) of the intervention is "increased accountability towards women-centred economic and political processes" at local government level (FOWODE, 2013b: 10).

Kyabuhangwa VBC is composed of 20 members (12 women, 8 men) who were elected by community members at village level to voluntarily represent the lowest echelon of society at the level of the Parish (FOWODE, 2013a). The majority of VBC members are illiterate and were elected on the basis of individual qualities of trustworthiness, responsibility and commitment towards advancing gender equality and other VBC objectives. The VBC is led by a committee comprising of a chairperson, vice chairperson, secretary, treasurer, mobilizer and a community budget advisor who is facilitated by FOWODE. On a quarterly basis, FOWODE supports the VBC with funds to undertake its activities and in turn receives reports on the VBC's activities, achievements, lessons learnt, implementation challenges and opportunities. The VBC has also been supported to start a group income generating activity to enable it sustain its operations after funding completion from FOWODE.

Geographically, Kyabuhangwa Parish is located in the South East of Kabale District and borders the Republic of Rwanda. The terrain of the Parish comprises of high hills, steep slopes and narrow valleys, with most of the hills bare with little or no vegetation cover (Republic of Uganda, 2010). The population density is 179 people per square kilometre (44 per cent male and 56 per cent female) dominated by the Bakiga tribe (85 per cent), followed by the Banyarwanda (15 per cent) (Republic of Uganda, 2010). Agriculture is the main source of livelihood for households in Kyabuhangwa, most of who are mixed peasant farmers of subsistence crops and livestock (ibid.). Kyabuhangwa Parish has no health facility, making access to effective health services a problem. Patients have to travel long distances over rugged terrain to access healthcare from health facilities in neighbouring parishes. Females are also less likely to access health services when ill compared to their male counterparts owing to economic, social and cultural barriers (ibid.).

Politically, the 1995 Constitution of the Republic of Uganda establishes the district as the highest level of local government, under which, are lower levels of local government comprising of municipalities, city divisions and town councils in urban areas; and sub-counties and parishes in rural areas (Kakumba, 2010). Kabale District Local Government has three rural counties (Ndorwa, Rubanda and Rukiga) and Kabale Municipality as the only urban area (Republic of Uganda, 2011). The three rural counties are divided into 19 sub-counties, while Kabale Municipality has 3 town-councils. The sub-counties and town councils are further divided into 119 parishes and 1,354 villages respectively (ibid.). Institutionally the local government system provides for effective involvement of communities in the articulation of needs and participation in programmes that foster local development (Kakumba, 2010). Article 38 (1) of the 1995 Constitution of the Republic of Uganda also accords every citizen of Uganda "the right to participate in the affairs of government, individually or through his or her representatives, in accordance with law". Local government plans and budgets are prepared through a bottom-up process at three levels, starting with the parish, followed by the sub-county and lastly the district level, in accordance with the 2003 Harmonized Participatory Planning Guide for Lower Local Governments. VBC members mobilise other community members to participate in local

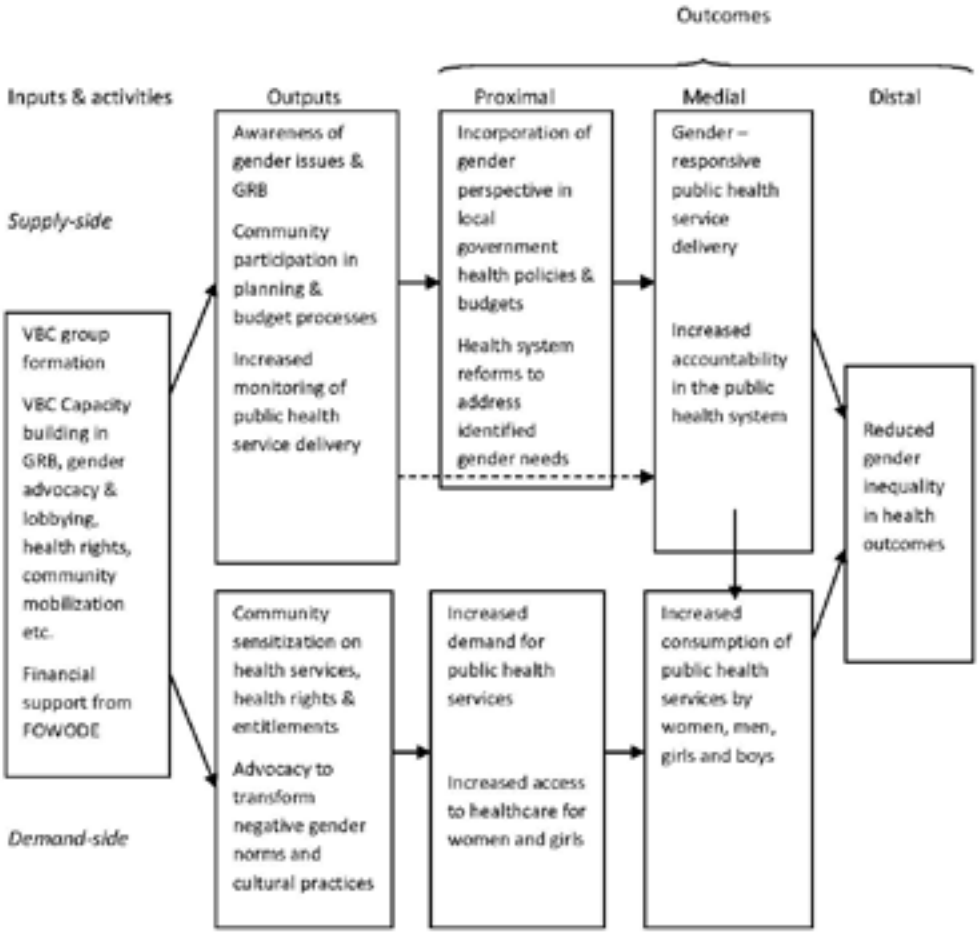
government planning and budgeting processes.

Culturally women and girls in Kyabuhangwa – and Kabale District in general – are of a lower status compared to men and boys. The Kamwezi Sub-County Five-Year Development Plan 2010/11 – 2014/15 highlights that female participation in decision-making at household and community level is very low compared to the male population and access to resources and development opportunities is unfairly distributed (Republic of Uganda, 2010: 51). According to the 2013 Statistical Abstract for Uganda, 61 percent of females aged 18 years and above are literate compared to 81 percent of their male counterparts; while 24.1 percent of females in households have never attained formal schooling compared to 9.8 percent of the males (Uganda Bureau of Statistics, 2013). Females do not inherit property from their parents and thus do not control resources (Republic of Uganda, 2010). Females also provide nearly 90 per cent of the labour force (remunerated and unremunerated); however, the proceeds from labour, crop and animal sales are managed by the men (ibid.).

3.1.2. The programme theory: Kyabuhangwa VBC initiatives in the health sector

Figure 1 below is a graphical representation of the programme theory of Kyabuhangwa VBC GRB initiatives in the health sector at local government level.

Figure 1: Programme theory of Kyabuhangwa VBC GRB initiatives in health at local government



The programme theory is premised on the assumption that gender inequality in health outcomes is a result of the low integration of gender issues in health programmes and deficiencies in public health service delivery (the supply-side); as well as poor health seeking behaviour among potential users of healthcare (the demand-side). The lack of awareness among the legislature, executives and health service providers about gender-specific health issues affecting communities, coupled with lack of effective participation of citizens – and more so women – in decision-making and budget processes affects the development and implementation of gender responsive health policies and budgets in local governments. In response to the identified gaps, community-based citizen groups, supported by a civil society non-government organisation (FOWODE), are mobilised to participate in budget processes and to sensitize fellow citizens to their rights and entitlements to enable them demand for effective implementation of health programmes that are responsive to localised gender needs.

The VBC interventions aimed at promoting gender equality in health outcomes target both the supply- and demand-side of the public health system at local government level. On the supply-side, it is theorised that capacity building in gender responsive budgeting, gender advocacy and lobbying and health rights and entitlements, backed with financial support from FOWODE equips VBC members to effectively participate in local government planning and budget processes, as well as monitoring of public health service delivery. With increased citizen participation in public decision-making processes, it is theorised that a gender perspective will be incorporated into local government health policies and budgets and duty bearers will be pressured to reform the health system so as to address identified gender-related health issues. The health system reforms are expected to lead to improvements in gender-responsive public health service delivery, as well as accountability of policymakers and public health service providers towards health service users. The improvements in health service delivery and accountability are further theorised to contribute towards increased consumption of public health services and, ultimately, gender equality in health outcomes.

On the demand-side, capacity building and financial support given to the VBCs is theorised to lead to increased community sensitization on the availability of health services, health rights and entitlements, as well as advocacy to transform negative gender norms and cultural practices that hinder access to healthcare. The combined result of the preceding outputs is theorised to lead to increased demand for public health services and increased accessibility to public healthcare by women and girls; and, in the medium term, overall increased consumption of public health services among women, girls, men and boys. It is theorised that the gender-balanced increase in the consumption of health services will lead to an improvement in health outcomes and reduced gender inequality in health in the long-term.

The underlying assumptions for the programme theory are that: 1) there is political will among the executives, politicians and service providers towards gender, poverty, government transparency and accountability and citizen participation; 2) there is effective devolution of powers to the local government to make local plans and budgets for the health sector; 3) the legal and institutional frameworks provide formal spaces for civil society and citizen participation, especially for women and other marginalised groups, and are abided accordingly; 4) there are effective horizontal and vertical accountability mechanisms in place to foster compliance among the executives and health service providers; and 5) citizens are willing and committed to participating in budget processes and advocacy to influence gender-responsive health service delivery and use of health services.

4. Investigating the programme theory using process-tracing methods

This section introduces process-tracing methodology and discusses how it can be applied in testing the causal mechanism of the programme theory. With the study still ongoing, the focus of the section is not to present results, but rather elaborate the design that will be used to systematically test the presence or absence of the hypothesized mechanism of the effectiveness of citizen-led GRB initiatives in health at local government level.

4.1. Overview and principles of process-tracing methods

Process-tracing refers to "attempts to identify the intervening causal process – the causal chain and causal mechanism – between an independent variable (or variables) [X] and the outcome of the dependent variable [Y]" (George & Bennet, 2005). The aim is not to prove that the programme theory is correct, but rather that "it has utility in providing the best possible explanation" (Beach & Pedersen, 2013: 13). According to Beach and Pedersen (2013), process-tracing methods have three variants, namely theory-testing process-tracing, theory-building process-tracing and explaining-outcome process-tracing. Each of the variants has a unique research purpose and differs from the other two in relation to how causal mechanisms are understood, the types of inferences that can be made and whether and how the variant can be nested in a mixed-methods design (Beach & Pedersen, 2013: 3).

Theory-testing process-tracing tests whether a hypothesized causal mechanism is present in a particular case and has functioned as predicted; while theory-building process-tracing starts with existing empirical evidence to build a generalizable theoretical explanation for the facts of a particular case (Beach & Pedersen, 2013). Explaining-outcome process-tracing, on the other hand, is case-centric and seeks to "craft a minimally sufficient explanation of a puzzling outcome in a specific historical case" (Beach & Pedersen, 2013:3).

Having developed the programme theory, the relevant process-tracing method adopted for this paper is theory-testing process-tracing. Beach and Pedersen (2013) suggest that theory-testing process-tracing should start with a careful definition of theoretical concepts (the constitutive dimensions of a concept and how they relate to each other) and causal mechanisms (the processes in a concrete system that are capable of bringing about or preventing some change in the system as a whole or in some of its sub systems). Theoretical concepts and causal mechanisms should be formulated in set-theoretical terms, implying that each concept should be carefully defined along with its absence; while causal mechanisms should describe the scope conditions, the initial condition of the causal mechanism (X), the outcome (Y) and the theoretical mechanism between X and Y (Beach & Pedersen, 2013).

While theorising the causal mechanism, the evaluator must decide on the appropriate level at which the causal mechanism will be conceptualized and tested, with the choice being guided by the level at which empirical manifestations of the mechanism can best be studied (Beach & Pedersen, 2013). Four levels are distinguished, namely the macro-level, macro-to-micro level, micro-level and micro-to-macro levels respectively. The evaluator should, additionally, identify the type of theoretical explanation that will be used for the causal mechanism, whether it is structural, institutional, ideational or psychological (ibid.).

To permit a systematic investigation of the causal mechanism, the evaluator should disaggregate the causal mechanism into a series of parts composed of entities engaging in ac-

tivities, with each part being seen as an individually insufficient but a necessary part of the overall mechanism (Beach & Pedersen, 2013). Entities represent the factors engaging in activities (the parts of the mechanism), whereas activities are the producers of change (what transmit causal forces through a mechanism) (Beach & Pedersen, 2013: 29).

The next step in theory-testing process-tracing is operationalization of the hypothesized causal mechanism by "translating theoretical expectations into case-specific predictions of what observable manifestations each of the parts of the mechanism should have if the mechanism is present in the case" (Beach & Pedersen, 2013: 14). Case-specific predictions are drawn from existing empirical evidence relevant to the phenomenon under study and should be formulated to capture both the entity and the activity involved in each part of the causal mechanism (Beach & Pedersen, 2013; 101). Under process-tracing, predicted evidence may take many different forms depending on the type of evidence that is best suited to testing a particular hypothesized part of the causal mechanism (Beach & Pedersen, 2013: 99). The types of evidence relevant to process-tracing analysis include (1) patterns – predictions of statistical patterns in the evidence; (2) sequence – temporal and spatial chronology of events predicted by a hypothesized causal mechanism; (3) trace – evidence whose mere existence provides proof that a hypothesized mechanism exists; and (4) account – evidence dealing with the content of empirical material (Beach & Pedersen, 2013: 99-100).

In the following step, the evaluator collects empirical material in form of causal process observations [insights or data that provide information about the context or mechanism] (Beach & Pedersen, 2013). The empirical material must be assessed for accuracy using case-specific contextual knowledge and interpreted in context before it can be regarded as empirical evidence. Empirical evidence is then used to make causal inferences about whether the hypothesized causal mechanism was present in the case, or only some parts of the mechanism were present; and whether the mechanism functioned as predicted (Beach & Pedersen, 2013). Process-tracing methods use Bayesian logic of inference to evaluate "whether finding specific evidence confirms or disconfirms a hypothesis that a part of the causal mechanism exists relative to the prior expected probability of finding the evidence" (Beach & Pedersen, 2013: 83). In other words, importance is not placed on the number of pieces of evidence within a case that fit one explanation or the other, but rather, "the likelihood of finding certain evidence if a theory is true versus the likelihood of finding evidence if the alternative hypothesis is true" (Beach & Pedersen, 2013: 83). Confirmation of the hypothesis increases evaluator confidence in the validity of a theory, especially if the found evidence is highly unlikely unless the hypothesized theory exists (ibid.).

4.2. Evaluating the counterfactual

As already mentioned under section 3, one of the core principles of theory-based evaluation is rigorous evaluation of effectiveness and impact using a credible counterfactual. Evaluation of the counterfactual enhances internal validity (the extent to which a causal claim in a specific case is valid) and allows evaluators to make strong causal inferences about the hypothesized causal mechanism (Waddington, et al., 2012; Khagram et al., 2009). Khagram et al. (2009) argue that while evaluation of the counterfactual (what would have happened if some of the events had turned out differently) commonly applies to comparative case studies, it can also be evaluated in a single case through the application of counterfactual reasoning to each step of the causal chain.

Methods such as congruence and parallel demonstration of theory permit the ruling out of counterfactuals by arguing that only the purported causal mechanism is congruent with the theory (Khagram et al., 2009). The congruence method tests whether, on the basis of the value of the independent variable (X), the predicted outcome that should follow from the theory is congruent with the findings in the case, either temporally or across other aspects of outcomes (Beach & Pedersen, 2013). Parallel demonstration of theory, on the other hand, juxtaposes historical cases with the current case to demonstrate that the theory in question is valid if its theoretical arguments convincingly apply to multiple other cases. Where process-tracing precedes the congruence method, alternative explanations of the outcome are tested for greater congruence with the outcome than the theorised mechanism (ibid.).

Rigorous evaluation of effectiveness also requires the use of mixed methods in data collection and analysis, which should be informed by the type of evidence that is required to answer the evaluation question (White, 2011).

4.3. Conceptualizing and operationalizing the theory using theory-testing process-tracing

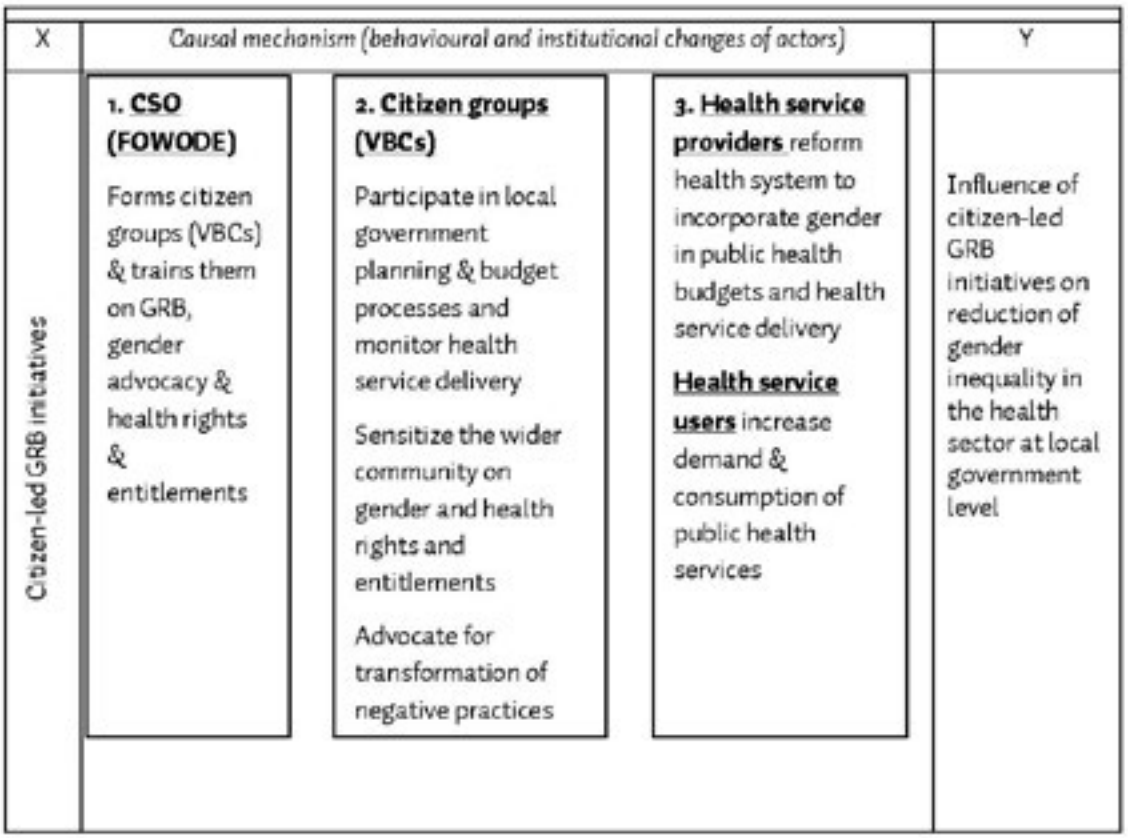
The basic question being assessed is whether citizen-led GRB initiatives play a role in influencing gender equality and improved health outcomes in the health sector at local government level. Social accountability literature reveals that when citizens are equipped with information and awareness about their rights and entitlements, they become key drivers to improvements in public service delivery and increased usage of public services (Joshi, 2013; World Bank, 2012; Björkman & Svensson, 2009).

The literature suggests that an increase in information and awareness initiates behaviour changes among citizens, individually and collectively (World Bank, 2012). Citizens are spurred to actively participate in public decision-making processes on issues that directly affect them, with the objective of influencing policy changes in their favour (ibid.) Citizens develop an information-seeking behaviour and seek out information on policies, budgets and service delivery from duty bearers (politicians, executives and service providers), thereby shifting the relationship between service users and service providers (ibid.). The interface and dialogue between citizens and duty bearers, in turn, increases citizens' understanding and sense of ownership of government programmes, resulting in an accountability-seeking behaviour for improved and responsive public service delivery (ibid.). The direct interface with citizens further avails public service providers – in this case from the health sector – with a better understanding of service user needs, influencing them to change behaviour and make their services and processes more responsive (ibid.). On the demand-side, the increased understanding of rights and entitlements is theorised to increase citizen demand for public health services, which if found appropriate and responsive, lead to better health outcomes.

Theory-testing process-tracing requires the reconceptualization of the above-mentioned causal theory into a three-part causal mechanism, with each part individually insufficient but necessary for the entire mechanism. The independent variable (X) is the demand- and supply-side interventions of citizen-led GRB initiatives in health, while the outcome (Y) is improved gender equality in health outcomes. The causal mechanism constitutes the behavioural and institutional changes of health service providers and users that are triggered by citizen interventions in GRB.

In testing the theory of the causal mechanism of citizen-led GRB initiatives in health, the study adopts an institutional theoretical explanation, which presupposes that "certain intersubjectively present institutions channel actors unintentionally in a certain direction" (Beach & Pedersen, 2013: 53). The premise of the argument is that institutions [formal or informal rules, conventions or practices, norms and institutional cultures] are man-made and can therefore be manipulated and ultimately transformed (ibid.). The causal mechanism is conceptualised as a transformational mechanism (micro-to-macro level) whereby "individuals, through their actions and interactions, generate various intended and unintended social outcomes at the macro level" (Beach & Pedersen, 2013: 42). Figure 2 below depicts the conceptualised causal mechanism.

Figure 2: A causal mechanism of how citizen-led GRB initiatives influence reduced gender inequality in health outcomes



The causal mechanism in figure 2 above leads us to the following predictions that can be tested using congruence methods to validate the presence or absence of the hypothesised mechanism and its functioning. For part 1 of the mechanism, we expect to see a citizen group comprising of 'ordinary' women and men who have knowledge in GRB, gender advocacy, citizen health rights and entitlements. The type of evidence to measure this prediction is trace evidence - the mere existence of Kyabuhangwa VBC, actively engaging in GRB interventions in health at local government level with links to FOWODE.

For part 2 of the causal mechanism, we expect to see priorities in local govern-

ment plans and budgets that are reflective of localized gender-specific needs on the one hand, and citizens who are more knowledgeable of their gender and health rights and entitlements on the other hand. The type of evidence to measure this prediction is account evidence, notably minutes of interface meetings and dialogues with duty bearers during planning and budget processes; activity reports of community sensitization meetings conducted; VBC monitoring reports of health service delivery; and gender analysis reports conducted by the VBC, among others. Sequence evidence of increased citizen participation following mobilization and training by the VBCs will also be obtained, as well as pattern evidence of increased knowledge among households of gender equality, health rights and entitlements.

For part 3 of the causal mechanism, we expect to see gender-responsive service delivery that is reflective of identified local health needs, as well as increased use of public healthcare by the citizens, and more so women and girls. The types of evidence to measure this prediction include account evidence of gender responsive health sector budget allocations and local government gender-aware budget statements that reflect specific local health needs; sequence evidence of improvements in service delivery following citizen intervention; and trace evidence of gender-sensitive health policies and testimonies of citizens increasing their use of public health services.

For the outcome, we expect to see manifestations of gender equality in health service provision and utilization as well as general improvements in health outcomes in Kamwezi Sub County. The type of evidence to measure this includes pattern evidence of statistical trends in access to public health services by women, men, girls and boys, as well as account evidence from health management and information system records of the use of public health services and the status of female mortality relative to that of males.

With the case predictions and the types of evidence specified, the next step in the evaluation is to collect empirical evidence which will be tested using Bayesian logic to confirm whether the causal mechanism is present, or only parts of it; and whether it functioned as predicted. A detailed analysis of the context in which the causal mechanism operated will be undertaken to understand what worked or did not work; for whom it worked; how and why it worked.

Conclusion

The focus of this paper has been to elaborate an approach to empirically evaluate the effectiveness and impact of citizen-led GRB initiatives in the health sector. The paper started by tracing the origin and development of citizen-led GRB initiatives and argued the case for GRB interventions in the health sector as being to reduce gender inequalities in health outcomes. Next, the paper presented the principles and application of the theory-based evaluation approach and developed a programme theory of citizen-led GRB initiatives in health. This was followed by a discussion of process-tracing methods, their appropriate application in investigating the causal mechanism and claims and an elaboration of the causal mechanism of citizen-led GRB initiatives in health.

The paper has argued for the use of the theory-based evaluation approach to explicate the programme theory of citizen-led GRB initiatives, followed by theory-testing process-tracing to test for the presence or absence of the theorised causal mechanism and whether it functioned as was predicted to yield the intended outcome of reduced gender inequalities in health outcomes. Noting that the validity of the causal mechanism is enhanced by evaluation of the counterfactual, the paper proposes the use of the congruence method after theory-testing process-tracing to ascertain that the theorised causal theory and mechanism are more congruent than any alternative explanation. The combination of theory-based evaluation with theory-testing process-tracing facilitates the understanding of, not only whether citizen-led GRB initiatives in the health sector are effective, but also how and why they are effective. It also allows the identification of specific stages along the posited programme theory at which citizen-led GRB initiatives may fail to achieve the intended outcome of gender equality in health outcomes.

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