



Villagers completing a community-based monitoring and evaluation report card in Bhor Block, Maharashtra state, India (2011). Oxfam / Cecile Unternaehrer

HELD TO ACCOUNT

Putting democratic governance at the heart of development finance

Unaccountable government is a substantial obstacle to development. It prevents people from exercising their rights and accessing health care, education and the other essential services they need in order to work their way out of poverty. At best, poor governance leads to mismanagement of public funds; at worst to outright corruption. The experiences of Sierra Leone and India in health reform show how citizen activism, combined with democratic reforms, can improve both service delivery and health outcomes. The key objective of development finance should be increased transparency, participation, and accountability, and aid donors should assist the efforts of community organizations to influence government and engage the public in demanding their rights.

SUMMARY

The right of citizens to hold public officials to account is at the heart of democratic governance. When citizen oversight is absent and the power to allocate public resources lies in the hands of a few decision makers, it is all too easy for resources to be diverted from their intended use and abused for private gain. Such corruption denies people the health care, education, and other public services to which they are entitled, and which would otherwise give them the means to work their way out of poverty.

This paper aims to show that increasing the capacity of citizens to influence government can reduce the potential for mismanagement and corruption – and that the resulting shift in power from narrow elites towards more representative citizens' groups is crucial to achieving sustainable development.

The recent experiences of Sierra Leone and India demonstrate how greater accountability can dramatically improve delivery of public services, while minimizing incentives and opportunities for the diversion of resources. In both cases, democratic governance reforms that encouraged citizen involvement in monitoring and evaluation of health service delivery led to better management and improved health outcomes. NGOs and donors worked with government agencies, testing different approaches, debating results, preparing background arguments, and building up expertise. Through policy dialogue and advocacy, they encouraged reluctant stakeholders to embrace new and more open approaches.

Through this process stakeholders underwent a profound change in attitude. Citizens became more aware of their rights and came to expect more opportunities for participation and better development outcomes. Those in authority, meanwhile, accepted that they would have to provide more information, create new opportunities for public involvement, and receive feedback on their performance. Through institutionalizing these processes they can continue to act as a counter-balance against corruption.

The examples of Sierra Leone and India highlight the importance of working in parallel on several aspects of democratic governance. Without credible sanctions, any demands for accountability will be in vain. Without more widely disseminated information, citizen participation will be an empty gesture. Without continuous follow-up, mindsets will not change. With these elements in place, however, active citizens become accustomed to voicing their concerns; they begin to expect those in positions of power to respond and for sanctions to be applied in cases of mismanagement.

In practice, of course, the process is not straightforward. Smooth progress can be followed by sudden reversals, and erratic progress can usher in unexpected advances. Neither 'decision makers', 'citizens', nor any other group of stakeholders are homogenous, and negotiations between them will always be an ongoing process.

However, the experiences of Sierra Leone and India are very encouraging, and suggest new ways to make aid effective in the fight against mismanagement and corruption.

Donor support for ad-hoc anti-corruption efforts tends to miss this broader picture. While donors should not become actors in national politics, they have a legitimate role to play in encouraging an enhanced social contract between citizens and the state – one characterized by citizen participation, government transparency and accountability, and a rights-based framework for development.

This paper argues that donors should support the capacity of citizens, especially of poor and excluded groups, to hold public officials to account; in part by promoting public opinion as a democratic force and a deterrent against corruption. In parallel, donors should also use their technical and financial influence to promote the institutionalization of procedures that encourage transparency, participation, and accountability.

Prime areas for donor investment could include strengthening the links between civil society organizations, improving the effectiveness of their work with government officials, and generating data and evidence to inform national debates. Donors could intervene as knowledge brokers and facilitators, offering aid to different types of stakeholders (such as journalists or lawyers) and promoting the formation of interest groups to bring a range of voices into policy dialogues.

Aid should seek to achieve sustained changes in the mindsets of both citizens and those in authority – changes that constitute longer-term objectives than most donors currently contemplate. In 2005, a mere 15 per cent of total Official Development Assistance (ODA) was targeted at strengthening government and civil society organizations. The proportion has since fallen steadily, and in 2010 represented only 11.6 per cent of total ODA.¹ Moreover, most of the programmes funded sought to improve the management of aid funds or reporting to donors, rather than to strengthen the accountability of governments to their citizens.

Donors, governments and civil society should consider making use of the Global Partnership for Effective Development Cooperation, formed at the Busan High Level Forum on Aid Effectiveness in 2011, to put democratic governance at the heart of development finance.²

RECOMMENDATIONS

- In order to have a wide and lasting impact on corruption, donors should support the embedding of democratic governance procedures within institutions, and the emergence of informed public opinion to hold decision makers to account;
- Donors should increase the aid provided as budget support in order to improve domestic accountability processes and enhance the social contract between citizens and the state;
- National governments and aid donors should acknowledge the crucial role of active citizenship in democratic governance, and should work toward an enabling environment for civil society organizations to foster participatory decision-making;
- Donors should use their capacity as brokers to bring together a diverse range of stakeholders in developing countries to facilitate dialogue and alliance-building;
- Donors should invest in strengthening judiciary and parliamentary bodies that provide checks and balances on executive power;
- Donors should support improved data collection and public reporting systems, and incorporate this goal into the post-2015 development agenda.

1 INTRODUCTION

Unaccountable government represents a substantial obstacle to development, preventing people from exercising their rights and accessing essential services. At a minimum, it can lead to mismanagement of public funds; at its worst, it can lead to outright corruption.³ When citizen oversight is absent and the power to allocate public resources lies in the hands of an elite group of unaccountable decision makers, it is all too easy for resources to be diverted from their intended use and abused for private gain. As a result, people fail to receive the public services, such as health care and education, to which they are entitled and which would enable them to work their way out of poverty.

Transparency,⁴ participation,⁵ and accountability⁶ are at the heart of democratic governance. They open the door for citizens to gain influence over government priorities and the allocation of public resources. Increasing citizens' capacity to influence government can reduce the potential for mismanagement and corruption, while improving public services and development outcomes. The consequent shift of power away from narrow elites to more representative citizens' groups and their allies is a crucial step towards sustainable poverty reduction and development.

2 ENTRY POINTS FOR DEVELOPMENT FINANCE

To have a lasting effect on corruption donors should support the institutionalization of procedures that enhance transparency, participation and accountability. At the same time they should also promote effective citizen activism as a tool to hold public officials to account. Supporting the emergence of public opinion as a political factor in government decisions is crucial for enhancing accountability to the wider public.

Donors can directly support outreach by civil society organizations to enhance community involvement in government decision-making. To help build aggregate demand for greater transparency, participation and accountability, the development finance provided by donors should be employed to strengthen the links both among communities and between communities and government representatives. It can also be used to bolster local, national and international NGOs, academic institutions, journalists, technical bodies, and other stakeholders.

Development finance can be used to generate information and data enabling stakeholders to feed into policy design. It can also strengthen institutional bodies, such as parliaments and judiciaries, which provide checks and balances and redress for citizens.

Technical assistance could help the public sector to become more responsive to citizens' demands and, in parallel, help NGOs and community organizations to acquire the analytical skills and relevant information they need to influence government decision making.

To build the clout of public opinion, aid can also be used to develop a more active media through support for training journalists, together with large-scale awareness campaigns, and the development of protection mechanisms for whistle-blowers. At the same time, donors can publicize their data in order to help galvanize public opinion.

The way aid is channelled will need to be reassessed if donors are to address such priorities. The timeframes often used for projects and programmes usually span one to three years; however, this is too short a time to achieve changes in the mindsets of either citizens or officials. Donors should consider setting longer-term objectives, allowing for adaptation to evolving contexts and changes in skills and attitudes. Local stakeholders involved in this work could then count on continuous support and could plan their work strategically.

Within donor agencies, these new objectives and timeframes will require new performance criteria capable of measuring such factors as participation, inclusiveness and rule of law. Good governance criteria, currently used to measure the situation in a given country, could serve as a basis to define criteria to measure a donor's contribution and impact.

Donors should also acknowledge that the accountability of national governments to external donors can impede domestic accountability mechanisms, especially when aid is channelled outside the national budget. For example, in Sierra Leone, before the reforms described below, donors required a separate financial account for each project, which made monitoring spending difficult. The reforms consolidated all 120 accounts and several donors agreed to use national procedures for monitoring and audits.

Providing aid as general budget support would take domestic accountability a step further, by allowing parliaments to exercise greater oversight, and recipient governments to manage and spend aid according to their development priorities.

Genuine change in social dynamics and political processes involves many different stakeholders. Currently, donor support is mainly focused on governments. This overlooks the diversity of actors, as well as their complex interactions. The judiciary, the media, parliament, co-operative groups and local NGOs can all play key roles and are in need of the technical and financial support donors can provide.

Through policy dialogue, donors also have the power to highlight issues that are often neglected, such as gender equality, social inclusion and land rights. They can keep on the agenda issues that may appear of secondary importance in the short term, but are vital in the medium to long term, such as environmental sustainability. The combination of budget support, based on improved checks and balances in the management of aid, and an inclusive policy dialogue, where all relevant stakeholders are involved, is likely to have a greater overall impact on democratic governance and corruption than ad hoc anti-corruption initiatives.

Donors' and governments' efforts to strengthen domestic accountability can also form the basis for an exit strategy from a dependence on aid. Donors can help bolster taxpayer groups working to increase public awareness, alongside strengthening the administrative capacities of the state. This can lead to greater demand for government transparency regarding tax collection and public spending, and thus to pressure for fairer domestic tax systems, increased tax collection and higher social spending.

In 2005, a mere 15 per cent of total Official Development Assistance (ODA) was targeted at strengthening government and civil society organizations in developing countries. The proportion has since fallen steadily, and in 2010 represented only 11.6 per cent of total ODA.⁷ Moreover, most of the programmes funded sought to improve the management of aid funds or reporting to donors, rather than to strengthen the accountability government to its citizens.

The donor community has a vital role to play and can clearly do more. The Global Partnership for Effective Development Cooperation, formed at the Busan High Level Forum on Aid Effectiveness in 2011, provides donors, governments and civil society with a framework for putting democratic governance at the heart of development finance.

3 FIGHTING CORRUPTION IN THE HEALTH SECTOR

Sierra Leone and India have both used positive incentives to improve democratic governance in recent years. In Sierra Leone, aid donors worked with the government to devise a maternal and child health care initiative that would address mismanagement and corruption in the health sector, while improving health outcomes. In India, a programme of expanded government health services included extensive monitoring by communities mobilized by civil society organizations. Both initiatives enhanced citizen participation, as well as government transparency and accountability, and in the process transformed the mindsets of health care staff and the approaches of NGOs and the government.

In Sierra Leone, the government responded to donors' requests for more efficient management of its health care sector with reforms to human resources, financial administration, and procurement procedures. The government's Anti-Corruption Commission (ACC) was involved from the outset, improving accountability by delivering a complaint mechanism which ensured a thorough process from complaint to investigation, prosecution (where needed), and then back to communities to ensure the effort had improved the quality of service delivery.

In India, NGOs were at the forefront of pushing for a community-based monitoring and planning (CBM) process, making the case that the poor quality of health care was linked to a failure to enforce citizens' rights. The Indian government's programme of health reform and investment, the National Rural Health Mission (NRHM), relied on NGOs to implement CBM, giving them an official mandate to bring an innovative rights-based approach to public health services. Initial successes and consistent follow-up prompted more stakeholders to take part in giving a voice to groups who had previously been excluded.

The two cases show that citizen participation and consistent dialogue between patients, health care providers, and government officials, offers a successful route toward eliminating inefficiencies and corruption in the health care system, while improving services to the public.

SIERRA LEONE

In 2007, Sierra Leone was ranked third from last on the Human Development Index. Abysmal rates of life expectancy, under-five mortality, and maternal mortality were accompanied by minimal government spending on health (\$37 per capita). In addition, according to Transparency International's 2009 Global Corruption Barometer, 36 per cent of Sierra Leoneans reported having paid a bribe to access public health services in the previous 12 months.⁸

The country's National Anti-Corruption Strategy lists the following problems in the health sector: biased selection of medical suppliers; delays in the delivery of drugs to health facilities (in some cases, drugs had even expired before clearing customs); purchase of counterfeit medicines; drugs going missing along the supply chain⁹ generating shortages at health facilities; personnel not reporting for work or receiving salaries while employed in other institutions (known as 'ghost staff'); and limited accountability for revenue and expenditure leading to the diversion of public funds.¹⁰

A programme of free health care for children under five and pregnant and lactating women, launched by government and donors in 2010,¹¹ included anti-corruption reforms to tackle these problems. An independent company was hired to remove ghost staff from payrolls; about 1,200 medical staff who had previously volunteered became officially employed by the Ministry of Health and Sanitation; and salaries were increased by between 100 and 200 per cent to motivate staff and reduce the incentive to ask patients for additional payments.¹²

In January 2011, a sanctions framework came into force whereby staff who had accrued six or more days of unexcused absences would lose one month's pay. The framework also enforced on-the-spot checks, with up to ten per cent of health facilities visited each month. Health workers were sent to understaffed regions to ensure better coverage across the country, in exchange for which they received a remote living allowance.

Much of the programme could be characterized as 'top-down' administrative reform. For example, drug procurement was converted from a 'push' system based on centrally determined demographic and morbidity data, into a 'pull' system based on the specific needs reported by local health facilities and district storage centres. Prior to the reforms, lump sums calculated on the basis of a central budgetary work plan were transferred from the Ministry of Health and Sanitation to district accounts. District officials would then report on details of the activities funded. Under the new system, local councils responsible for disbursing funds to health facilities made quarterly requests to the Ministry of Health and Sanitation.

Participation: a key element in the strategy

Citizen participation was a key component in the anti-corruption strategy. To prevent leakages in the medicine supply chain, for example, representatives from local health committees and the local civil society group, the Health for All Coalition, were encouraged to be present at each point of delivery, along with representatives from the ACC and the Office of National Security. UNICEF local staff and health authorities agreed to make on-the-spot checks of about 260 storage facilities per month, out of a total 1,140 nationwide.

The ACC held public meetings in communities to explain what an offence consisted of and how to report one. A complaint hotline was set up and women in villages were given mobile telephones allowing them to report incidents of mismanagement or misconduct. Health charters were also

displayed in health facilities to inform patients of their rights. The ACC presented the results of its investigations at public hearings, where community members had the opportunity to discuss, accept, or challenge them.

Transparent evaluation criteria and community participation

Sierra Leone's programme of health reform established a number of clear and transparent criteria for evaluating health facilities, which could be easily measured and monitored (below). These provided an effective entry-point for increased community involvement.

1. The number of women of reproductive age using modern family planning methods for protection against unwanted pregnancy and to achieve the desired space between pregnancies;
2. The number of pregnant women receiving four appropriate antenatal consultations for protection against pregnancy risks;
3. The number of deliveries conducted under safe conditions in an appropriately equipped health facility and attended by a suitably qualified health professional;
4. The number of women receiving three postnatal consultations for protection against post-delivery risks;
5. The number of children under the age of one receiving a full and timely course of immunizations against communicable diseases;
6. The number of outpatient visits for curative services for children under five years old delivered according to the protocol for Integrated Management of Neonatal and Child Illnesses.

The combination of removing user fees and adopting anti-corruption measures resulted in a 250 per cent increase in the use of health facilities and marked improvements in health indicators. In 2010, life expectancy in Sierra Leone was 48 years for men and 50 for women, up from 46.5 years for men and 48 years for women in 2007. Under-five mortality had fallen from 200 to 174 per 100,000 live births, and maternal mortality from 970 to 890 per 100,000 live births over the same period.¹³ Government spending on health rose by 15 per cent to about \$42 per capita.¹⁴ There has also been a marked drop in absenteeism since the reforms were put in place; while removing ghost staff and reducing drug leakages have resulted in dramatic savings.¹⁵

Despite these achievements, abuses have still been observed in many health facilities.¹⁶ At a public hearing organized by Health Alert and Save the Children in April 2012, representatives from various districts highlighted concerns about the number of medical staff, their qualifications, and their attitude, as well as shortages of medicines. Unhelpful behaviour of staff toward patients was reported across all districts because 'medical staff no longer expect direct payment for services'.¹⁷ The ACC notes that in most local clinics, very poor patients are still consistently asked to pay for treatment in cash or in kind, for example with rice, oil, or fowl.¹⁸

Community participation has also been limited by decision-making processes that have remained largely top-down. Despite efforts to raise awareness, few communities have been able to monitor health service delivery effectively. For example, communities or their representatives were only informed on the day a medicines delivery was made, and received no information on the quantity of drugs or their intended use. Community representatives on village health committees and district anti-corruption councils often don't know how to report corruption and mismanagement. In addition, few cases of mismanagement have actually been taken to court and, where court cases have been brought, penalties have been light, providing little deterrence against corruption.

Making the free health care initiative permanent through legislation and establishing an institutionalized complaint mechanism would strengthen bottom-up monitoring. A stronger partnership between the judiciary, the ACC, parliament, NGOs, citizens, and donors would help make sanctions credible. Given that the initiative depends a great deal on aid, there is an important role for donors in supporting these next steps.

Women are more vulnerable to corruption

Within communities, 'corruption affects women differently from men. [...] Women constitute the majority of the global poor and remain a minority in decision-making bodies, which adds to corruption's differential and disproportionate impacts on women. [...] [They] are confronted with corruption in a specific manner and tend to be the target of corrupt officials more often than men, possibly because service providers consider women to be more susceptible to coercion, violence, or threats, or less aware of where or how to file a complaint. [...] Leakages are more common with resources earmarked for marginalized groups, as these groups often lack the political power to protest corruption. [...] The cost of transactions paid in sexual services is exceptionally high for women because of existing gender discrimination in laws and in practice. Women have fewer opportunities than men to obtain an education, own land or other productive assets, receive credit, or earn wages equal to men's – all factors that increase women's vulnerabilities to corruption.'

From 'Corruption, Accountability and Gender: Understanding the Connection', UNDP and UNIFEM, 2011

INDIA

If per capita government expenditure on health in 2010 seems abysmal in Sierra Leone at \$42, consider India where, in the early 2000s, it was as low as \$18.¹⁹ Reports were rife with incidents of denial of treatment, absence of health staff, and a lack of information on the services to which patients were entitled. Those who could afford private health facilities preferred them because public facilities were so poor. In fact, the public health system served only 20 per cent of the population, mostly in rural areas.²⁰

Prior to 2000, India's public health system was utterly top-down, geared toward reaching pre-set targets whether or not these met the needs of

patients. However, in 2000, the formation of the People's Health Assembly movement successfully put health rights on the legislative agenda. The People's Health Charter²¹ was adopted by the Assembly and the People's Health Movement-India or 'Jan Swasthya Abhiyan' (JSA) began. Based on the JSA initiative, the Indian National Human Rights Commission in 2004 supported health-rights initiatives. Following massive public mobilizations from the village-level up, which made health rights an election issue in 2005, the Indian government announced the formation of the NRHM. Several civil society activists were invited to help design its remit and proposed the CBM process to complement the NRHM's financial and managerial reforms. In 2007, CBM was launched as a pilot scheme in 35 districts across nine states. This section focuses on the implementation of CBM in Maharashtra state. The pilot scheme first began in five districts and was later expanded to 13 in 2011.

The NRHM mandated NGOs at different levels (state, district and block) to organize monitoring committees at village, primary health centre (PHC), block, and district levels, in order to assess the health situation and examine issues reported by patients, whether financial, logistical, technical, or staff-related. Health, Sanitation and Nutrition Committees were formed under NRHM in each village, and included auxiliary nurse midwives, multi-purpose health workers, accredited social health activists (trained, equipped and compensated through the NRHM), and interested members of the community wishing to join. Committees at higher levels were composed of elected representatives from local government bodies, medical officers, NGOs, and community organizations, as well as representatives of lower-level committees. Previously excluded social groups were represented, and each committee was required to have gender equality. Lists of committee members and their phone numbers were made publicly available.

The CBM process was based on survey report cards (written in the local language and with pictograms for illiterate participants) which were completed by committee members at all levels. Questions in the village report card relate to immunization, antenatal and postnatal care, disease surveillance, treatment of minor ailments, the work of the auxiliary nurse midwife, and maternal and infant deaths. Depending on the level of satisfaction, committee members assign either a green, yellow, or red mark. The health report card was then publicly displayed in the village or in the relevant health facility. It therefore acted as a tool for the community to give feedback about access, quality, regularity and accountability of the health services guaranteed by the NRHM.

Public hearings also took place at which community members, NGOs, government officials, and medical staff were able to discuss the issues identified, and explain how these were to be addressed. Local news media covered a number of these events; the presence of the media as 'witnesses' increased the credibility of any commitments made by officials. Initially these hearings were tense affairs and medical staff often felt offended by the views that were aired. However, as time went on, staff found that they could raise their own concerns. The hearings evolved into public dialogues where all stakeholders could take part in in-depth discussions.

Improvements to health services

The districts of Maharashtra state where CBM was implemented saw significant improvements in health service delivery: medical staff were present more regularly in the health centre or hospital, vacant staff positions were more readily filled, and outreach staff visited villages more frequently and according to a pre-determined calendar. Medicine stocks and budgets were displayed in health facilities, limiting the potential for illegal charges and mismanagement.

The most noticeable change has been the increased levels of trust in public health services, with many more people using their services and purchasing medicines through health facility pharmacies, rather than from private ones. Several dysfunctional sub-centres and PHCs have become operational again. Some health centres also acquired new facilities, such as ambulances and hot water, resulting in an increase in the number of visits and childbirths in hospital.

Such changes indicate a synergy between the NRHM 'top-down' push and the CBM 'bottom-up' pull.²² The 'good' rating of PHC services in CBM areas has increased from 42 per cent to 74 per cent.

As well as an improvement in the quality of health service delivery, the mindset of staff has begun to evolve from a target-centred to a patient-centred approach. In Oxfam interviews in Maharashtra state, community members confirmed significant improvements in the attitudes of medical staff towards patients, following the requirement to respond to patient queries and complaints, and listen to patients' suggested solutions. Public promises to tackle problems have allowed community members to undertake consistent and broad-based follow-up.

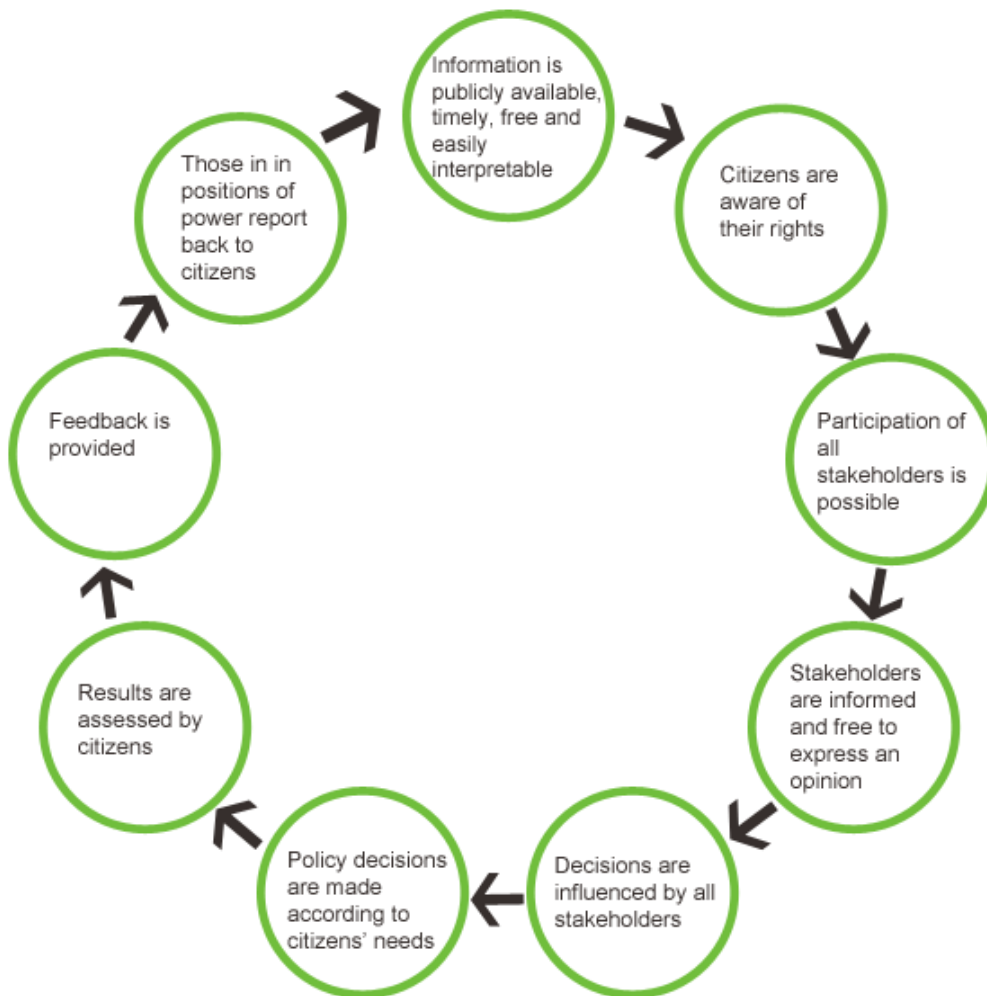
The number of people involved in the CBM process has increased, either because they see change happening or because they have begun to feel that their concerns will be taken into account. Interviewees showed greater awareness of the services they have a right to receive, and greater willingness to speak out; women said their participation in committees, public hearings, and monitoring has been strongly supported and their contributions valued.

The role of grassroots organizations was crucial to the CBM's success. NGOs brought local expertise that complemented the top-down approach of official bodies, and directly mobilized community participation. Over time, their role is likely to shift as communities become more empowered, and elected representatives strengthen their involvement. Activists foresee communities taking up the baton and becoming initiators of change – not simply beneficiaries of it – for example in planning and budgeting processes.

However, participants interviewed by Oxfam reported that the mindsets of intermediate level administrators, who wield significant power in the health system, had yet to evolve. Until they do, citizens and medical staff will be unable to address fundamental problems such as medicine procurement, recruitment policies and grievance procedures, or the more complex challenges which exist at the policy level.

Though CBM proved to be unsustainable in several of the states in which it was piloted, CBM principles could be incorporated into programmes in other states. Donors could support this through, for example, incorporating CBM into mainstream monitoring and evaluation for all externally-funded programmes, thus helping to overcome the reluctance of some authorities to implement it. Donors could also fund evidence-based expertise to support Indian NGOs and community organizations in their work.

Figure 1: How continuous democratic governance can be built into a system



DYNAMICS OF CHANGE IN SIERRA LEONE AND INDIA

The piloting of the NRHM in India and the launching of the free health care initiative in Sierra Leone acted as triggers to apply ideas and approaches that had been germinating for some time. In both cases, a central initiative sought to influence the behaviour of intermediary and local administrative bodies.

In Sierra Leone, donors engaged in a dialogue with top-level administrators. In India, pressure from NGOs and community organizations mobilized public concern, convincing the central government of the political benefits of improving the quality of public health services. The Indian case relied heavily on NGOs to implement the CBM process, while the Sierra Leone case depended on the extended mandate of the ACC to engage constituencies in promoting health sector reforms. In both cases, actors sought to raise awareness in communities about citizens' rights to health care and to encourage ordinary people to voice their concerns.

Indian and Sierra Leonean health staff and local authorities resisted change at first, but this reluctance was overcome through pressure from 'below' (including testimonies, public hearings, and follow-up from communities) and through continued administrative directives from 'above'. These pressures and the increased levels of accountability they wrought helped reduce the incentives for and risks of corruption and mismanagement. Citizens became more aware of their rights, while authorities created new opportunities for participation, and agreed to provide information and listen to feedback. Through this iterative process, the delivery of health services eventually became more responsive to service users' needs.

Overall, these initiatives produced a fundamental change in incentives: they gave citizens and governments a process in which all players had a stake. This could not have occurred without the NGOs in India and the ACC in Sierra Leone acting as catalysts for change through awareness raising, training, and guidance.

In practice, of course, the process of building more democratic governance is not straightforward. Depending on circumstances, stakeholders can act for or against democratic governance. They may also interact: communities and the private sector may join forces to seek improved public services; the media and anti-corruption bodies may work together to expose mismanagement; and local government may form alliances with NGOs to win support from central government. But the converse may also be true, depending on the collaborative or antagonistic interests at play.

Citizen participation was crucial in each case, and shortfalls can be linked to the limited involvement of certain stakeholders (in particular, communities in Sierra Leone and intermediate-level administrators in India).

Smooth progress can be followed by sudden reversals and erratic progress can usher in unexpected advances. Neither 'decision makers', 'citizens', nor any other stakeholder group is homogeneous, and a degree of conflict is probably unavoidable. However, the experiences of Sierra Leone and India in the health care field are very encouraging.

Such progress in fighting mismanagement and corruption is certainly helped along by the goodwill of governing elites, but in order for change to be sustained, a country's political system must incorporate checks and balances by embedding them within systems and organizations.

Institutionalized democratic governance integrates transparency, participation and accountability procedures into the decision-making process.

These procedures must not only be systematic, but iterative. Repetition, constant follow-up and clear consequences create new incentives for stakeholders. These, in turn, have the potential to generate changes in people's mindsets and the eventual normalizing of democratic governance. In addition, the growing influence of public opinion will bolster vigilance against corruption and help reinforce good governance structures over the long term.

EIGHT AREAS FOR DONOR SUPPORT

The Institute for Development Studies and the Development Research Centre have identified eight key areas where appropriate funding can help foster citizen engagement: rights awareness; access to information; articulating needs; networking and alliance-building; informal spaces for participation; monitoring implementation and impact; the judiciary; and institutionalization.²³

Rights awareness

Democratic governance is enhanced when all members of a community are aware of their right to make informed choices, to take part in the decisions that affect their lives, and to hold government to account. Local NGOs, supported by international NGOs or donors, can help raise awareness of these rights, as occurred through village meetings in both Sierra Leone and India.

Access to information

The disclosure of information is essential for stakeholders to make informed decisions and to monitor the spending of public resources, such as the proportion of a national budget earmarked for education or the procurement mechanisms for medicines in the health sector. In India, the right to information – established as a law following extensive campaigning by NGOs, journalists, and the public – became a cornerstone of success in improving service provision. In both Sierra Leone and India, community participation in gathering and processing such information proved a crucial step in democratic governance.

Articulating needs

Public debate within communities provides citizens with the opportunity to clarify and express their needs, and to articulate these to those in power. Communities can then gather evidence and testimony to illustrate their concerns and reinforce their demands. In India and Sierra Leone, local NGOs played a key role in helping communities identify and promote their needs. Donors and international NGOs can also work to ensure that the needs expressed do not exclude certain groups, such as members of marginalized castes or women.

Networking and alliance-building

To make their participation in the decision-making process effective, communities often need to build alliances with other stakeholders who share their interests. Through alliances with other communities, as well as NGOs, government officials, donors, the private sector, and religious and traditional leaders, communities can increase their bargaining power, and gain access to complementary skills and influential groups. Donors can help build the

capacity of communities to identify allies, build networks, and co-ordinate and act collectively. Donors and NGOs can also support communities in their work with the media to help them reach further potential allies.

Informal spaces for participation

Official channels of participation may be of little use if key decisions are made outside formal institutions. To identify entry points for influencing those with power, communities require political skills, including the ability to understand the underlying issues at stake and the implications of alliances. International NGOs can offer experience in power analysis and advocacy to help with this, while donors can provide technical, human, and financial resources for a thorough contextual analysis. In India, networking, strategic alliances and personal interactions enabled the CBM process to move forwards in spite of opposition from local officials.

Monitoring implementation and impact

Once government commitment is won, communities must monitor implementation and judge the effectiveness of any new initiative, for example though its impact on the quality of education or the timely procurement of medicines. Local groups, NGOs, donors, government agencies and oversight bodies can conduct audits and on-the-spot checks. Evaluation mechanisms should allow citizens to provide feedback on the quality of services delivered.

The judiciary

Where implementation and/or impact fail to meet expectations, communities must then find ways to hold those responsible to account. The judiciary can play a key role in providing redress for communities when policies and programmes do not deliver effectively, as long as it has adequate technical, human and financial resources to investigate, pass judgement and implement sanctions.²⁴ An effective system of redress also requires organizations that stimulate and aggregate demand. Networks of NGOs and communities can then be used to monitor checks and balances within the judiciary, and can work to keep it independent from political interference.

Institutionalization

Government and other structures responsible for delivering services may not react positively to feedback. Similarly, some government responses, such as the creation of anti-corruption laws, may be tokenistic – created merely to please external observers.²⁵ If democratic governance processes are to be sustainable over the long term they must be embedded in institutions in ways that allow citizens to engage with authorities on a continuous basis. Effective follow-up should be centralized and direct, involving active monitoring by the state of staff in public agencies, and decentralized to the communities that have a specific interest in benefiting from the planned service. Both areas are appropriate for donor financing.

4 CONCLUSION AND RECOMMENDATIONS

Citizens holding the state to account is the essence of democratic governance. In the absence of accountability, power within state institutions will become monopolized by an elite few, leading to mismanagement and corruption. However, strong, people-led accountability measures that involve stakeholders in the implementation, monitoring and evaluation of public services can provide the necessary oversight to reduce abuses of power and greatly improve democratic governance.

Such involvement must be founded in a redistribution of knowledge, agency and power: when citizens are aware of their rights, and have the organizational and political skills to participate and hold public officials to account, they can create positive incentives in favour of democratic governance.

The examples of Sierra Leone and Maharashtra state in India highlight the importance of working in parallel on several aspects of democratic governance. Without credible sanctions, demands for accountability will be in vain. Without more widely disseminated information, citizens' participation will be an empty gesture. Without continuous follow-up and iterative processes, mindsets will not change.

With these elements in place, however, active citizens can become accustomed to voicing their concerns; they start to expect those in positions of responsibility to respond and the judiciary to apply sanctions in cases of mismanagement. What's more, public officials become more responsive and public services improve.

Success in fighting corruption and mismanagement is rarely sustainable through ad hoc initiatives. Aid donors have a key role to play in a broader approach that seeks to institutionalize transparency, participation and accountability procedures, while promoting citizen activism. Donors should embrace the goals of embedding democratic governance procedures within institutions and promoting the emergence of informed and influential public opinion. To fit these objectives, donors must adapt how they channel their aid and the criteria by which they measure success.

RECOMMENDATIONS

In order to have a wide and lasting impact on corruption, donors should:

- Support the embedding of democratic governance procedures within institutions, and the emergence of informed public opinion to hold decision makers to account;
- Increase the level of aid provided as budget support in order to improve domestic accountability processes and enhance the social contract between citizens and the state;
- Use their capacity as brokers to bring together a diverse range of stakeholders in developing countries to facilitate dialogue and alliance-building;
- Invest in strengthening judiciary and parliamentary bodies that provide checks and balances on executive power;
- Support improved data collection and public reporting systems, and incorporate this goal into the post-2015 development agenda.

National governments and donors should:

- Acknowledge the crucial role of active citizenship in democratic governance, and should work towards an enabling environment for civil society organizations to foster participatory decision-making.

NOTES

- ¹ Data on ODA allocated to government and civil society by all donors extracted from the OECD Statistics Database, 'Aid (ODA) by sector and donor [DAC5]; 1.5.a. Government & Civil Society-general', <http://stats.oecd.org/Index.aspx?DatasetCode=TABLE5>
- ² For more information on the Global Partnership for Effective Development Cooperation, please see <http://effectivecooperation.org/>
- ³ As defined by Transparency International; this can relate to both financial and non-financial gain.
'FAQs on Corruption', Transparency International, http://www.transparency.org/whoweare/organisation/faqs_on_corruption
- ⁴ Data and information are available in a public, timely, free and easily interpretable manner. Kim *et al.* (2005) 'Towards Participatory and Transparent Governance: Report on the Sixth Global Forum on Reinventing Government', *Public Administration Review* 65.6: 646–654.

'Openness of the governance system through clear processes and procedures and easy access to public information for citizens [stimulating] ethical awareness in public service through information sharing, which ultimately ensures accountability for the performance of the individuals and organizations handling resources or holding public office.'
- ⁵ Involvement of stakeholders through analyses, information-sharing, public awareness campaigns and educational initiatives, dialogue and networking for consultation, oversight, audits and issue-mapping by citizens, community advocacy groups or partnerships through collaboration in public policy forums where stakeholder preferences are represented. S. Lister (2010) 'Fostering Social Accountability: from principle to practice', UNDP Guidance Note, http://www.undp.org/content/undp/en/home/librarypage/democratic-governance/oslo_governance_centre/analysis_and_learning/fostering_socialaccountabilityfromprincipletopractice/
- ⁶ The right of the people to hold their government responsible in addressing their socio-economic concerns and delivering essential services. S. Lister (2010) *op. cit.*
- ⁷ Data on ODA allocated to government and civil society by all donors extracted from the OECD Statistics Database, 'Aid (ODA) by sector and donor [DAC5]; 1.5.a. Government & Civil Society-general', <http://stats.oecd.org/Index.aspx?DatasetCode=TABLE5>
- ⁸ Transparency International (2009) 'Global Corruption Barometer', http://www.transparency.org/whatwedo/pub/global_corruption_barometer_20091
- ⁹ Estimated at six per cent by UNICEF in 2011.
- ¹⁰ Anti-Corruption Commission of Sierra Leone, 'National Anti-Corruption Strategy 2008-2013', http://mpwiis02-beta06.dfs.un.org/portals/unipsil/sections/nacs_strategy_2008-2013.pdf
- ¹¹ The UK's Department for International Development (DFID) and the Global Fund to Fight AIDS, Tuberculosis and Malaria provided strong financial support and UNICEF assisted in the supply of medicines. The World Bank also took part through its programmes to reinforce administrative capacities and decentralize service delivery.
- ¹² Salaries reached an average of \$185 per month; in comparison, the average monthly wage for a teacher stands at \$40. V. Turrent (2012) 'The teacher salary system in Sierra Leone', Washington: Brookings Institution, <http://cdn.cfbt.com/~media/cfbtcorporate/files/research/2012/r-building-effective-teacher-salary-systems-sierra-2012.pdf>
- ¹³ WHO Global Health Observatory Data Repository, 'African Region: Sierra Leone statistics summary (2002 - present)', <http://apps.who.int/gho/data/view.country.17800>
- ¹⁴ *Ibid.*
- ¹⁵ Removing 'ghost workers' has saved between \$200,000 and \$300,000 since 2010; reducing drug leaks has saved about \$500,000 since 2010.
- ¹⁶ Women interviewed by Oxfam say that they delivered in hospitals and were not charged for medicines during the birthing process. However, patients say hospital pharmacies are short stocked and patients are expected to purchase medicines at private pharmacies, a cost many cannot afford to bear. Patients also reported being asked for payments for basic services, for example, 1,000 *Leones* (about \$0.23) for a bucket of water to wash the baby and 5,000 *Leones* (about \$1.14) for the actual service of washing of the baby. The interviewees had never heard of the charter stating the services they were entitled to and said they have no one to complain to.
- ¹⁷ *Ibid.*
- ¹⁸ Anti-Corruption Commission of Sierra Leone, 'Monitoring of the Health Review Recommendations: Towards a better health service delivery in Sierra Leone 2010/2011'. The ACC also reports that bank accounts have not been systematically opened as requested for each health facility, and documents on financial management are not made available for reference in health facilities, sometimes deliberately so.
- ¹⁹ As calculated using purchasing power parity – national currency unit per \$. Figure based on WHO NHA indicators, <http://apps.who.int/nha/database/DataExplorer.aspx?ws=0&d=1>. By 2011, India's government expenditure on health care had doubled to \$36 per capita.
- ²⁰ Eighty per cent of India's population turned to private entities for their health needs, even though patients and their families had to pay out of pocket for the services rendered. According to WHO 2010 and the Central Bureau of Health Intelligence (CBHI), 'National Health Profile of India (NHP) 2010', 91.4 per cent of health expenditure was made up of direct payments from service users in 2006.

- ²¹ 'Indian People's Health Charter', <http://healthydocuments.org/rights/doc5.html>
- ²² In CBM-covered public health centres, the average annual number of childbirths increased from 104 in 2007–08 to 209 in 2009–10, a 101 per cent increase. The average monthly outpatient attendance for public health centres (PHCs) in the entire Thane district increased from 741 visits (2007–08) to 869 visits (2009–10), an increase of 17 per cent. For the same period, the average number of monthly outpatient visits in PHCs covered by CBM increased from 767 (2007–08) to 1,028 (2009–10), a 34 per cent increase. Similarly, inpatient visits have increased over the same period by 50 per cent across the entire district, and by 73 per cent in CBM-covered PHCs. SATHI, 'People are reclaiming the public health system', http://www.sathicehat.org/uploads/CBMPublications/People%20are%20reclaiming%20the%20public%20health%20system_Part%201.zip
- ²³ J. Gaventa and G. Barrett (2010) 'So what difference does it make? Mapping the outcomes of citizen engagement', IDS Research Summary of IDS Working Paper 347, Brighton: Institute of Development Studies, <http://www.ids.ac.uk/idspublication/so-what-difference-does-it-make-mapping-the-outcomes-of-citizen-engagement1>
- ²⁴ Studies have found that the frequency of demands for redress regarding basic services depends not on the quality of the complaint mechanisms per se but rather on the credibility of sanctions. V. Gauri (2011) 'Redressing grievances and complaints regarding basic service delivery', Policy Research Working Paper 5699, Washington: World Bank, <http://elibrary.worldbank.org/content/workingpaper/10.1596/1813-9450-5699>
- ²⁵ OECD DAC Network on Governance – Anti-Corruption Task Team (2009) 'Integrity in statebuilding: Anti-Corruption with a Statebuilding Lens', Paris: OECD, <http://www.oecd.org/dac/governance-development/45019804.pdf>

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