

incorporates all feedback, final comments welcome

Reinforcing social accountability in health services in Sud Kivu and Kongo Central provinces

final evaluation of the GPSA/CODESA
project

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ACRONYMS

AAP: <i>Agence d'Achat de Performance</i> (NGO, partner of Cordaid)
CAC: <i>Cellule d'Action Communautaire</i> (village-level group of Community Health Workers)
CBO: <i>Community-based Organisation</i>
CODESA: <i>Comité de Développement Sanitaire</i> (Sanitary Development Committee)
HF: Health Facility (typically, a primary health-care centre)
HFC: Health Facility Committee
HP: Health Province
HZ: Health Zone
PBF: Performance-based Financing
REC: <i>Relais Communautaire</i> (Community Health Worker)

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EXECUTIVE SUMMARY

This report looks at the GPSA-funded project implemented by the Dutch NGO Cordaid to reinforce the CODESAs in the Democratic Republic of the Congo (DRC). The *Comité de Développement Sanitaire* (Sanitary Development Committee), or CODESA, is a committee made of community members who co-manage their primary health-care facilities (HF) and lead the sanitary development of their area. The GPSA/CODESA project took place in two provinces, Sud Kivu and Congo Central, which are located 1,800 km apart and differ in terms of their socio-economic situation and political stability. The Congolese health system is largely decentralised (with core regulations and some vertical programmes still managed by the national Ministry of Health) and benefits from substantial international aid, especially in the eastern part of the country, including Sud Kivu. This aid is provided in the form of technical assistance, material, and also input-based and output-based (performance-based financing, PBF) financing. Substantial power resides with health provinces, which have their own Provincial Ministries of Health and may be at times relatively cut off from Kinshasa given the poor transportation in a huge territory and important security in some areas. They are allocated a budget and distribute resources to health zones (HZ) and primary health facilities (HF). HFs have some degree of autonomy in management, which has been extending by or due to decentralisation, insecurity, and PBF.

Project design and theory of change

Cordaid and the Ministry of Health (at the provincial level) implemented GPSA/CODESA in 182 CODESA in 12 HZs of Sud Kivu and Kongo Central between 2015 and 2019. They also implemented a smaller extra Kinshasa project targeting two HZs in Kinshasa in 2019, which this report also considers. The main activities were:

- (1) the training and accompanying of CODESAs on HF management using Community Score Cards and CODESA charters;
- (2) the funding of CODESAs' day-to-day activities via a subsidy;
- (3) providing matching grants for CODESA projects;
- (4) implementing mainstream and pilot interventions of (social and financial) inclusion of the most vulnerable in the CODESA and CODESA's activities; and
- (5) developing the coalition of actors in favour of the CODESA.

The project's main intended outcomes, which are the core of this study, are to enable: (1) fully functional CODESAs as a mechanism of social accountability; (2) the community-led rehabilitation of health-care infrastructure; (3) CODESAs promoting social inclusion; and (4) a wide support/coalition of actors in favour of the GPSA/CODESA and social accountability practices in the DRC. The theory of change, which was only relatively loosely formulated in project documents, relied on the idea of the CODESA unlocking community participation and making health services more responsive to people's needs because they are better represented.

The evaluation used mixed methods to assess the contribution of the project to its intended outcomes. It primarily drew on a phone survey with HF chief nurses and CODESA presidents in 157-164 HFs that benefitted from the project, as well as over 63 interviews and focus groups with key actors in the field in addition to policymakers and key stakeholders. An approach in which people are asked to talk about the 'most significant change' (following the eponymous research method) was used to elicit the key elements in relation to the four outcomes analysed in the study. The data analysis considered four different contexts: (1) areas of Sud Kivu with a long experience of CODESA strengthening (5 years at the beginning of GPSA/CODESA); (2) areas of Sud Kivu with a shorter experience of CODESA strengthening (0-3 years prior to GPSA/CODESA); (3) Kongo Central where CODESA strengthening by Cordaid was new and where Cordaid mainly relied on a partner (AAP Kongo Central) for project implementation; and (4) Kinshasa where CODESA strengthening by Cordaid strengthening was also new.

Main findings

Implementation

Most project's activities were implemented, although some over a shorter period of time than initially planned: often 1.5 to 2 years instead of 3 to 3.5. An initial 9-month delay of the funding somewhat destabilised the implementation of the activities, with a direct effect on the credibility of the project's partners in the field. Overall, GPSA/CODESA engaged less with the national level than expected, due to a combination of implementation issues, political change, and most work being carried out at the provincial level. A central part of the project, the financial support provided to the CODESAs (subsidies and grants), ended up being implemented slightly differently in Sud Kivu and Kongo Central: the implementation period was shorter in Kongo Central and the matching grants there were easier to get and more frequent but less generous than in South Kivu. This may have created a slightly different set of incentives.

The funding of the CODESA (\$77 – \$175 per CODESA per semester) was through the performance-based financing system. The indicators sought to reflect the functioning of the CODESA (meeting, planning, membership) are were described as a subsidy that covered the basic costs of the CODESA and their members rather than a performance premium.

The project took place in tense security and economic context, which put to the fore people's interest in democratic processes and decentralisation and led to adaptations. Consequently, (1) some of the monitoring and support was conducted through phone; and (2) the amount of the community contribution was lowered between the first and second round of the matching grant implementation in Sud Kivu.

Committees with representatives of the CODESA (HZ CODESA) of a HZ were supported, and sometimes set up, by Cordaid. This was unplanned and gave CODESAs more leverage.

Political economy of the CODESA

The role the CODESA plays in local communities varies across regions. A possible issue is that CODESA actions go unnoticed in some areas because their members have multiple affiliations. Precise trends are hard to establish, but the qualitative material suggests that in numerous instances in Sud Kivu and even some cases in Kongo Central, the CODESA has become a legitimate actor due to its association with powerful external players (Cordaid, the HZ and Health Provinces) and newly acquired planning abilities. There are also suggestions that the CODESAs are now better able to navigate their local contexts. In those cases, the position of the CODESA is best understood as being a catalyst in the sense of (1) facilitating of other external projects; (2) facilitating new local community projects; and (3) being an example for other community-level projects.

Relationships between CODESA and chief-nurses and nurses are sometimes tense when the CODESA is set up, linked to HF staff fear that the CODESA will seek to police HF activities.

The evidence of a provincial-level coalition of actors in favour of the CODESA model was not found in Kongo Central or in Kinshasa, but there is ample evidence that a positive dynamic, a form of virtuous circle, is unfolding in Sud Kivu. With the strong support of the provincial health authorities, key international aid actors (GIZ, UNICEF, USAID, IRC) report using approaches derived from the GPSA/CODESA experience –often after having witnessed it in the field.

GPSA/CODESA, and beyond the project the positive projects involving the CODSA, remain largely unknown by national-level government actors. The national level is obviously relevant, but its importance should not be overplayed in the context of DRC and the report highlights substantial collaborative action at levels that are more directly concerned with the practical strengthening of the CODESA (provinces and health zones). A surprising positive effect of the turnover in project managers is that all of them ended up in influential positions in other institutions and, when interviewed, suggested that they were using CODESA ideas in the design of UNICEF, World Bank, and USAID large programmes. There is also evidence that GPSA/CODESA influenced the set-up of

social accountability mechanisms in the education sector. A key question is whether, in a country like DRC, a meaningful and impactful coalition of actors should or could be constituted at the national level.

The CODESAs as social accountability

The perception of the CODESA as 'just' a group of community health workers (or *Relais Communautaire*, RECO) mostly preoccupied with health promotion and not so much with HF management remains an issue, mostly in Kongo Central, in Kinshasa, and among some demographics (some HZ officials) in Sud Kivu. While RECO may lead to more comprehensive collective action (and thereby be considered a form of social accountability), they are also often simply and solely executing tasks dictated to them by nurses and doctors. In some instances, in Kongo Central, the CODESA is indeed simply a tool to extract information from the population and transmit it to the upper level (then, after that information has been analysed at the upper level (chief-nurse, HZ), the CODESA is told what to do).

The qualitative and quantitative data reveal a more positive picture in Sud Kivu, where CODESAs seem more active in HF management as evidenced by that fact they are generally more likely to meet and interact with the chief-nurse and they claim and are said to have more decision rights at the HF when it comes to planning (including through performance-based financing development plans when present) and monitoring expenditures (equipment, drugs, human resources). There does not seem to be a trade-off between the CODESA getting involved in HF management and its role of health promotion as a RECO. Overall, there is a (self-declared) relatively high level of involvement of the CODESAs in HF affairs, especially in HFs that have benefited from CODESA strengthening over time (the 'old' intervention areas).

The difference between Sud Kivu and Kongo Central may be explained by (1) different relationship of the communities with international aid and community participation, with Sud Kivu receiving more aid and having communities who live in more extreme conditions; (2) different patterns of CODESA strengthening by Cordaid, with Sud Kivu benefitting from direct support from Cordaid since 2012 for some region while the CODESAs of Kongo Central were only supported with GPSA/CODESA and through a partner of Cordaid rather than Cordaid directly.

Two main tools were introduced to the CODESAs: the charter and the community scorecard. The tools provided to the CODESA are key for its organisation and its capacity to hold the HF into account, but there are some questions marks around whether they deepened the relationship between citizens and HF/CODESA.

The charter's main use seems to be to discipline CODESA members and organise the CODESA. Other parties such as the HZ CODESA have been using the charter to hold into account CODESA members, thereby creating unexpected –and probably very useful– new channels of accountability. Less frequently, it is used to solve issues with third parties (e.g. church-CODESA disputes). A more systematic examination of charters would help understand whether they are CODESA 'bylaws' or proper social contracts between the CODESA and the different local actors.

Across contexts, the community scorecards are defined as the most useful tool of the CODESA and its 'compass'. In rare cases, they were used as an excuse for the CODESA to bypass HF users (they would not revert to citizens after having drafted the card).

Phone survey data looking into the most significant change happening at the HF in the last three years show 96.5% of chief-nurses explaining that the CODESA played a role in this change. In 35% to 45% of the cases, it is 'the CODESA being more of what the CODESA guidelines say it should be' (e.g. CODESA organisation, meetings with the different parties, etc.) that is given as the channel through which the change took place. Over 60% of the most significant changes that have happened at the CODESA are related to the CODESA becoming a more dynamic and better organisation that is actively involved in HF management.

Rehabilitation of Health Facilities

There are many ways in which the CODESAs contribute to the rehabilitation of their HF via the matching grants (\$320 – \$500), but the focus seems to be on the construction of new infrastructure. The interviewees found such projects generally appropriate, although the understanding was also that the matching grant could be used to ‘risk’ something new. There is some uncertainty about the level of completeness of some projects. Many CODESAs engaged in HF construction and rehabilitation without a matching grant. It might be because infrastructure is a lower hanging fruit than HF management and provides a lot of visibility to the CODESAs.

Inclusion of vulnerable populations

CODESAs appear to have come a long way for integrating the most vulnerable categories of the population, and especially the category of people identified as the ‘indigents’ who now participate, and reportedly influence, the decisions of the CODESA. Regarding other aspects, such as gender, progress is less visible.

A pilot intervention evaluation (randomised control trial) suggests that the CODESA could do even more for the indigents: targeted meetings and financial support through CODESA activities have meaningfully improved access to care for the indigents at a minimal cost.

Sustainability

In Sud Kivu, GPSA/CODESA and the broader Cordaid interventions may have created the circumstances where support to the CODESAs –since the success of the CODESA model requires higher-level connections and frequent re-training– will be embedded in the activities of other organisations. While CODESAs will require refreshers, especially when a new committee is elected, there is anecdotal evidence suggesting that some of the management tools such as the charter and the scorecards are sustainable and have spread beyond the CODESA.

The outcomes may be harder to sustain in Kinshasa and parts of Kongo Central without further support. The interventions took place over a short period of time and do not seem to have generated a favourable and enabling context.

Part of the issue with instilling Sud Kivu-like dynamics in other parts of the country is a form of “chicken and egg problem”: it requires the local and provincial (or the level above the CODESA, generally speaking) to act at the same time and draw support from each other. Self-sustained CODESA is simply not an option: CODESAs do require higher-level support to flourish. Yet, at the very same time, the investment in the CODESAs is only happening if they prove to be a reliable and efficient partner. In Sud Kivu, the strength of GPSA/CODESA has been that it made it possible to consolidate years of work (that was promising but clearly not mature after CSF/CODESA in 2012-2013) on a ‘homegrown’ product.

Theory of change

The project validates GPSA’s theory of change and its central tenet of “collaborative governance” but invites to re-conceptualise ‘government’, and especially the fact that different levels are engaged differently. It also suggests that flexible and locally prioritised projects help gain the trust, confidence, and buy-in of authorities. Finally, by contrasting Sud Kivu and Kongo Central, it emphasizes the need to pay even greater attention to two elements: (1) ‘government’ as a non-monolithic entity, different levels are engaged differently; and (2) the timeframe of social accountability strengthening initiatives, decade(s) rather than a few years, which seems to be a main explanation for the contrasted results between Sud Kivu and Kongo Central.

The report also examines the main results of the projects considering the broader outcomes of GPSA (as stated in August 2019), it finds elements suggesting that elements of collaborative social accountability are taken up by governments beyond individual GPSA projects when provincial

governments are considered. It also suggests that two obstacles to improved service delivery, the targeting of actions to meet citizens needs and the asymmetries of power, are indeed issues that seem to improve with efficient CODESA.

Overall effectiveness

GPSA/CODESA appears to have generally contributed to its expected outcomes: functional CODESAs appear to be in place in most of the target HZs of Sud Kivu (but less so in Kongo Central and not much in Kinshasa) and it does seem to be an efficient mechanism of social accountability, albeit there are slight risks that it becomes disconnected from the people it represents.

The CODESA's actions are also widely, and again especially so in Sud Kivu, associated with the community-led rehabilitation health infrastructure. This is on infrastructure that the committee sees as crucial, which might be different from the views of HF managers and the health system. This is both through the matching grant and to mechanisms developed by the CODESAs without the direct support of GPSA/CODESA.

There is ample evidence of a wide support/coalition of actors in favour of the GPSA/CODESA and social accountability practices in Sud Kivu but also in different parts of the DRC, through a wide informal network of supporters. The coalition still needs to emerge more explicitly in Kongo Central and in Kinshasa.

The cost-effectiveness of the programme is hard to assess, mostly because the outputs are not easily quantifiable. There are obviously ways to cut down such budget after the pilot phase, but the total investment was about US\$ 4,000 per committee, this is including all the costs of the project (staffing costs are almost half the total costs) and the subsidies and matching grants. The recurrent costs of supporting the CODESA may be much less though, possibly around US\$ 200 for the essential support, namely basic funding for functioning and refresher sessions (this is based on the project financial audit).

Recommendations

At a systematic level, the following points need to be considered:

- Strengthening the CODESA takes time, but seems to eventually pay off (e.g. Sud Kivu), and Cordaid and other actors involved in this work need not only to continue their support to the CODESA and similar activities but also develop plans that stretch over long periods of time.
- Provincial and HZ authorities are critical to the development of the CODESAs. The World Bank, Cordaid, and other actors are instrumental in creating the financial and technical conditions where the provincial and HZ authorities feel supported.

Based on our analysis, technical low-hanging fruits can and should be addressed very soon:

- The authorities and partners can create the legal and technical space for a "federation of CODESA", which is documented as improving the catalyst role of the CODESA, to be constituted.
- CODESA could still be more inclusive, especially of women. National and provincial authorities can amend the CODESA regulations so that women have a clearer place in them.
- More work is required to determine the cost-effectiveness of CODESA strengthening vis-à-vis other measures at the local level such as PBF. However, those may miss the fact that some of the benefits of the CODESA are hard to quantify and multifaceted.

A. INTRODUCTION

In the last two decades, policymakers and researchers alike have regularly presented social accountability as a key opportunity for improving health-care delivery. In particular, social accountability mechanisms relying on the direct participation of citizens in the management of their public service delivery are promoted in contexts marked by socio-economic fragility and instability, where the democratic system may be weak or slow (World Bank 2004). In the health sector, such ‘short route’ for accountability has encountered a longer history of involving the population in service delivery and service management. Such movement that became particularly visible with the 1978 Alma Ata Declaration on primary health care (organised by the World Health Organisation, see Lawn et al., 2008) and the 1987 Bamako Initiative that emphasized the idea of citizen committees overseeing health facilities (Ridde 2011). Nowadays, most African health systems have such committees in place. However, Health Facility Committees often suffer from a lack of consideration and support and, often, very little is known of their effects (Lodenstein et al. 2017).

In 2015, the Dutch NGO Cordaid received a USD 800,000 funding from the World Bank Global Partnership for Social Accountability (GPSA) to continue its work on the *Comité de Développement Sanitaire* (Sanitary Development Committee, CODESA), the committee-elected committee in charge of health development in the public and publicly-funded Health Facilities (HF) of the Democratic Republic of the Congo. The project (which will be referred to as GPSA/CODESA in this document), proposed new ways of strengthening the CODESA: training sessions would promote the use of Community Score Cards (CSC) and locally-designed charters; matching grants would help the CODESAs develop community-relevant projects¹; and pilot social and financial interventions would seek to improve the inclusion of the most vulnerable in the local health-care system. Later, Cordaid benefitted from smaller funding from World Bank Nordic Trust Fund (*Pilot on Revitalizing the Community System by Strengthening Social Accountability Mechanisms*) to explore the relevance of the CODESA approach in an urban context, in the megalopolis of Kinshasa.

The present document reports and discusses evidence on to the contribution of GPSA/CODESA and the Kinshasa pilot to four main outcomes: (1) the functioning of the CODESA as a mechanism of social accountability ; (2) the community-led rehabilitation health infrastructure ; (3) the role of the CODESA in promoting social inclusion ; and (4) the coalition of actors around the CODESA and the general contribution of GPSA/CODESA to developing social accountability practices in the DRC. Original material was collected through phone surveys with Health Facility chief-nurses and CODESA presidents. In addition, 65 interviews and focus groups were conducted in three distinct parts of the DRC: the provinces of Sud Kivu in the far east of the country (which we further divide into two parts, depending on the duration of CODESA support) and Kongo Central in the far west, and Kinshasa, DRC’s capital city.

The first part of the document provides background information on the DRC, its health system, and the CODESA. The emphasis is on the contextual elements, historical and socio-economic that may have an impact on participatory mechanisms of social accountability. The background section then looks into the activities of the World Bank and Cordaid in the DRC: GPSA/CODESA followed other interventions in the country, which are important to bear in mind. The theory of change and activities of GPSA/CODESA is then exposed. The second and third parts of the report introduce the objectives and methods. The findings are presented, and also discussed, in the five subsections (one on the project implementation and one for each key outcome) that constitute the core part of

¹ GPSA/CODESA matched the cash or in-kind contribution of the CODESA/community (to a limit), this is to fund projects relevant to the well-being of the population and the quality of its HF.

the document. The last part, discussion and conclusion, is mostly concerned with the sustainability of GPSA/CODESA's outcomes and how the experience affects the theory of change developed by GPSA. Boxes recap the main points of each key subsection.

B. BACKGROUND

S1. DRC: GENERAL BACKGROUND

The Democratic Republic of Congo (DRC) has experienced decades of violence and conflict. The democratic experience that directly followed accession to independence from Belgium in 1960 ended abruptly in 1965 when Mobutu Sésé Seko captured power. His violent and corrupt regime collapsed in the 1990s, and the country was torn apart as the central piece of a complex war opposing Congolese and foreign armed forces. The long-time opponent Laurent-Désiré Kabila finally toppled Mobutu in 1997, but war in the DRC resumed when his alliance with Rwanda deteriorated in 1998. The second Congo war (1998-2003) formally ended in 2002 with the Pretoria Agreement (July 2002), but the eastern part of the country remains beset by a high level of violence and insecurity. In the Kivu alone (provinces of North and Sud Kivu), more than 120 armed groups have been reported.²

In 2012, when the pilot project that would eventually lead to the CODESA/GPSA project began, the World Bank described DRC as one of "Africa's fastest-growing economies, but the lack of employment opportunities poses significant risks". Economic growth in 2012-2015 was very high, often estimated at above 6%, but it crashed in the years that followed (2.4% in 2016), undermined by the uncertainties surrounding the presidential election. During the main period this study considers (2014-2019), the economic situation in DRC was worrying, especially in 2017-2018. Not much had changed since the World Bank reported in 2013 that "poverty is widespread in the country, but it is more likely to affect people in rural areas (75%) than those in urban areas (61%)." The country is vast, and has been often dubbed 'a continent': Sud Kivu province, a focus of this report, has one of the highest poverty rate in the country (above 85% as per 2008 UNDP estimate) while Kongo Central, the other province this country looks at, is in a slightly better situation (69% as per the same estimate). As in many places in the world, poverty is gendered and affects rural and urban areas in different ways.

It would be a euphemism to say that DRC does not do well in terms of human development indicators. The 2017 Human Development Index (HDI) ranked DRC 176 out of 187 countries, a very slow progression since 2012. According to the World Health Organization (WHO, 2016), life expectancy at birth is 59.6 years, and the maternal mortality rate is a staggering 846 per 100,000 live births. Lack of infrastructure and resources have undermined the government's efforts to achieve the Global Development Goals 4, 5 and 6. In addition, there are now over 3 million internally displaced people in DRC³, while over 850,000 Congolese refugees are hosted in the region⁴. This means that about one in ten Congolese is forcibly displaced – this figure has increased over the period of time covered by the project (there were 2.3 million IDP and 323,000 refugees in 2013). In volatile areas of the country, the humanitarian emergency persists, and rates of sexual violence are alarmingly high. The country has been repeatedly affected by Ebola epidemics. They have grown in intensity over the years: while the 2018 epidemic in the province of Equateur was terminated within just a few months, the epidemic that started in August 2018 in the east of the

² see <https://kivusecurity.org/>

³ <http://www.internal-displacement.org/countries/democratic-republic-of-the-congo>

⁴ <https://data2.unhcr.org/en/situations/drc>

country was still ongoing, and growing, at the time of writing this report. According to official reports, it had already killed 2,074 by 13 August 2019.

Civil society organisations in DRC face challenges, especially in the east when they operate in a context of widespread human rights abuses. The legal framework⁵ under which they operated has improved, but many organisations still have difficulties registering (which exposes them to intimidations by various actors). Funding is a key issue, and a majority of civil society organisations rely on donor grants and international organisations, pushing them to a state of aid-dependency (Clark 2013).

key point(s) 1 DRC background

- DRC is one of the poorest countries in the world, with disparities between the two provinces the study looks at (Sud Kivu is poorer and more unstable than Kongo Central/Kinshasa).
- Civil society actors face challenges, including security, aid-dependency, and legal recognition.

2. DRC: HEALTH SECTOR⁶

Despite numerous efforts, the health sector in DRC still faces significant challenges due to poverty, poor governance and years of conflict and underfunding. By the end of the war in 2002, the health sector had almost totally collapsed, with the government's health expenditures representing only 1% of the total budget. The government introduced a plan to strengthen the sector in 2006 but, despite renewed efforts, DRC remains one of the countries with the lowest health expenditure per capita (\$32, most coming from international aid, in 2014, according to the WHO). The Global Health Initiative points out that "the main indicators of health in DRC are among the worst in the world". At the beginning of the CODESA / GPSA project, infant mortality (97 per 100,000 live births) and the chronic malnutrition of children under 5 (40%) were among the highest in the world.

The health system of DRC is decentralised and became even more decentralised in 2016 when provisions of the 2006 Constitution for further decentralisation were enacted. The health sector has three main levels. The central level is responsible for the development of health standards and national programmes for the control of certain diseases. The second level is the Health Province, which corresponds to (one of the 26) administrative province. It is responsible for the delivery of most health care, and each province has its own Ministry of Health and Provincial Division of Health (DPS). The third level is made of (516) Health Zones that are each under a Health Province and are responsible for frontline Health Facilities. The Health Centres (*centres de santé*, referred to as Health Facilities, HF, after this subsection), the core unit GPSA/CODESA focused on, are the first point of contact in the health system.⁷ Under the referral and counter-referral system, it is the entry point expected of new patients. Above these are different classes of hospitals: zone, provincial and national, also classified as first-, second- and third-reference hospitals, offering services for less common but more complicated pathologies.

Funding remains a key issue: between 2008 and 2011, household spending on health accounted for an average of 42% of total health expenditure. After households, donors (23%) and the central government (17%) were the main sources of funding. It is important to note that during this period, provincial health expenditures accounted for less than 0.1% of total health expenditures. The donor community has played an important role in health funding. It is responsible for financing nearly a

⁵ The key document is Law 004 of 20 July 2001.

⁶ This section partly draws on Cordaid's GPSA/CODESA proposal and Falisse (2016).

⁷ In very rare cases, health centres run a health outpost.

quarter of total health expenditure in DRC, contributing \$ 300 million a year at the onset of GPSA/CODESA (and amount that increasing). The Donor Coordinating Group for Health and the National Executive Committee are the coordinating mechanisms used to coordinate the use of this fund in the health sector. Some of the aid is channelled to the sector through Performance-based Financing (PBF) mechanism. PBF, which has been advocated and promoted by Cordaid and is implemented in the GPSA/CORDAID provinces of intervention, operates as follows: an independent purchasing agency signs agreements with service providers on the basis of their business plan. An external evaluation agency monitors these agreements and the services provided under them, which are then verified by the beneficiaries.

Health Facilities enjoy a significant de facto degree of management autonomy, which is derived from the formal decentralisation process. It has also been further pushed by PBF, which has insisted that autonomy “a precondition for the success of performance-based financing is that authorities must respect the autonomous management of health facilities” (Soeters et al., 2006; see Falisse et al., 2012 for a discussion, using the example of Burundi). In the Kivu, the periods of war repeatedly cut the HFs off from their health authorities and pushed them to operate quasi-independently for years and sometimes decades. A chief-nurse – the *infirmier titulaire*, is responsible for the daily management of the health centre. In some exceptional cases, a physician is also working at the health centre (a couple of cases were reported in Kongo Central during our study, but none in Sud Kivu). Nurses usually have one to three years of post-secondary school vocational training or, in many cases, just a vocational secondary school education. Specialised nurses can include a laboratory assistant (*laborantin*), and some health centres have a cashier/manager. The health centre staff varies in size from a few people to a dozen. They often count on loosely identified ‘support staff’, who are cleaners (*travailleurs*), or auxiliary nurses (*aide-soignant*) typically trained on the spot.

Each HF has responsibility for its own ‘community’ – as reflected in the concept of the catchment area or responsibility area (*aire de responsabilité*) made of a series of villages. The strength or consistency of the ‘community’ can always be discussed (Rifkin 1986), but the village is a prime constituent of people’s identity in the region.

key point(s) 2 DRC Health Sector

- DRC’s main health indicators are among the worst in the world. Major financing issues.
- DRC’s health system is decentralised with health provinces, health zones (HZ), and primary health-care facility (HF). HFs have some degree of (legal and de facto) autonomy in management created by decentralisation, insecurity, and performance-based financing (PBF).

3. WORLD BANK WORK IN THE DRC

The World Bank reengaged in the DRC in 2001 after nearly a decade of the suspension of its activities. In recent years, its “portfolio has shifted from emergency assistance to sustainable development. The portfolio comprises 29 projects (including regional integration projects) and 57 trust funds. These commitments total \$4.12 billion, of which 45.53% has already been disbursed for national projects. The portfolio is distributed across the various sectors: 63% for infrastructure (transport, energy, urban development, and water); 16% for human development; 15% for development of the private sector and agriculture; and 6% for governance and mining.”⁸

⁸ <https://www.worldbank.org/en/country/drc>

The World Bank has been supporting a series of ongoing reforms in the DRC, via different instruments. The most relevant for understanding GPSA/CODESA include:

- The Country Assistance Framework (2007-2010) that stressed local governance, improving access to basic social services and reducing vulnerability.
- The last Country Assistance Strategy (2013-2016) whose strategic objectives one (“to increase state effectiveness and improve good governance”), three (“to increase access to social services and raise human development indicators” and in particular “3.2. improved access to health services in targeted areas”), and four (“to address fragility and conflicts in the Eastern provinces”) are close to some of the core outcomes of GPSA/CODESA. The latest DRC Systematic Country Diagnostic for the DRC was completed in 2018 and stresses other topics close to GPSA/CODESA such as ‘building inclusive institutions and strengthening governance’ (World Bank 2018a). The World Bank is currently developing a new Country Partnership Framework for 2018–2021.
- A series of large programmes that are important to bear in mind to understand the practical direction of the World Bank’s support:
 - o The 7-year (2014-2021) USD 514.53 million ‘Health Systems Strengthening for Better Maternal and Child Health Results Project’ (*Projet de Développement du Système de Santé*, PDSS) seeks to improve utilisation and quality of maternal and child health services, with a strong focus on the good management and governance of health facilities.
 - o The 5-year (2014-2021) USD 5 million ‘Public Financial Management and Accountability Project for Democratic Republic of Congo (DRC)’ seeks to “enhance the credibility, transparency, and accountability in the management and use of DRC’s central and selected sub-national public finances”.
 - o The 6-year (2014-2020) USD 133 million Eastern Recovery Project seeks “to improve access to livelihoods and socio-economic infrastructure in vulnerable communities in the eastern provinces of Democratic Republic of Congo (DRC)”. It has a strong focus on community resilience and inclusive community participation.
 - o The newly approved 5-year (2019-2025) USD 502 million ‘Multisectoral Nutrition and Health Project for Democratic Republic of Congo’ seeks to increase the utilisation of nutrition-specific and nutrition-sensitive interventions. It has a strong community anchoring.
 - o The ‘Great Lakes Emergency Sexual and Gender Based Violence and Women’s Health Project’, part which is in Nord and Sud Kivu (USD 73.86 million). It ends is ending December 2019, and has sought to ‘expand the provision of services to mitigate the short- and medium-term impact of sexual and gender-based violence; and expand utilization of a package of health interventions targeted to poor and vulnerable females.’
 - o The 2015-2020 Human Development System Strengthening Project, a USD 52 million project with the ambition of strengthening management systems for education.
 - o And finally, the Regional Surveillance Systems Strengthening Phase IV (REDISSE IV) part of which is in the DRC (USD 150 million). It seeks to “strengthen national and regional cross-sectoral capacity for collaborative disease surveillance and epidemic preparedness in ECCAS Region”.

4. THE CODESA IN THE HEALTH SYSTEM AND CONGOLESE SOCIETY⁹

In the DRC, the *République du Zaïre* until 1997, attempts to create health committees came even before the 1977 Alma-Ata declaration. In 1971 already, the Kasongo health zone experience in Maniema province (Daveloose 1979) included the compulsory presence of a health committee. This experience and a series of others (Pepin et al. 1989) influenced the health policy of the DRC towards the primary healthcare approach (DRC Ministry of Health, 2006). By 1977, the Alma Ata initiative had made primary healthcare a global health priority and Zaïre elaborated its 1982-1986 sanitary action plan and its 1984 health policy in this spirit (World Health Organisation 1983). The establishment of the first policy of decentralisation of health services, with the creation of the Health Zones in 1985, marked the beginning of the scaling-up of the health committee approach.

The wars of the 1990s and early 2000s badly affected the health committees. The priorities of the country and its partners shifted as the state lost control over its territory. Aid becomes humanitarian rather than developmental. What happened to the committees is unclear. There are accounts of health committees surviving the war and facilitating access to their areas for aid organisations, such as in the Ituri conflict (1999-2006) in Eastern DRC (Pottier 2006). Nevertheless, for Sud Kivu and Kongo Central, it appears to be the case that the war weakened an institution in its infancy.

After the war, the 'Health Development Master Plan' (PDDS 2002-2009) of the Ministry of Health (MoH), with support from UNICEF, renamed the *comité de santé* (health committee), *Comité de Développement Sanitaire* (CODESA). Other regulatory documents give more details; they include the community health guidelines (2012) and Health Zone Norms (2006). Here is how they define the CODESA:

“The CODESA is a mechanism of community participation, it is representative of all the villages/streets in the health area, and it is multi-sectoral and multidisciplinary in its composition. The CODESA members are the partners of the medical staff and other stakeholders in the health area. They have the capacity to develop micro-planning activities, co-manage and mobilise local resources for the revitalization of health services, but also strengthen community capacity in the mobilisation of local resources.” (Ministry of public health, the DRC, 2012)

In practice, the CODESA is responsible for:

- (1) the technical co-management of the HF: mostly informing the HF staff about the health situation of the population, as well as planning
- (2) the administrative co-management of the HF: prices monitoring, liaison with administration, inventories, etc.
- (3) the financial and strategic co-management of the HF: review and action plans
- (4) the co-management of the human resources of the HF, and
- (5) the promotion of the HF among the population.

The CODESA is made of members elected among the Community Health Workers, the Relais Communautaires (RECO). The RECO are volunteers active in health promotion, who are sometimes grouped in village-level cells named Cellules d'Action Communautaire (CAC). The RECO and CAC focus on health promotion, hygiene, and sanitation while the CODESAs are tasked with the co-management of the GF, as explained earlier. The CODSA typically includes a resource commission

⁹ This section largely draws on Falisse (2016).

(*Commission de Ressources, CORE*) and a social commission (*Commission Sociale, COSOL*) that is concerned with access to care for all.

How effective are the CODESAs in practice? The general sense of health practitioners, which was confirmed by the interviews conducted for this report, is that the CODESAs are usually not well supported and not very effective. The academic literature on the topic of health committees in DRC is also scant and the two main researchers who have worked on the topic are authors of the present report (see methods section for details on their exact engagement). Jean-Benoît Falisse worked on the CODESA of Sud Kivu, he mostly studied Cordaid's interventions, and some of his findings are presented in the next section –his assessment based on work carried out in 2012-2015 is that the CODESAs of Sud Kivu are not very efficient but can be rapidly reinforced through training sessions. Eric Mafuta worked in a very different context, at the other end of the country –his study does not look at a particular intervention, and he is generally cautious about the role played by the CODESA, which is not the favoured way for the population to express its concern. Moreover, he notes that social accountability is not a widespread strategy: “Social accountability is relatively inexistent in the maternal health services in the two health zones. For social accountability to be promoted, efforts need to be made to create its mechanisms and to open the local context settings to dialogue, which appears structurally absent.” (Mafuta et al. 2015)

key point(s) 3 The CODESA

- The CODESA is a committee made of community members who co-manage their health facility (HF) and lead the sanitary development of their area.
- Community Health Workers (RECO) are elected to the CODESA. RECOs are also organised in village-level action cells (CAC). CAC and RECO focus on health promotion.
- The roots of the CODESA are back in the 1970s. They have a clear legal framework.
- There seems to be substantial variations in the level of social accountability through channels such as the CODESA across the territory, in particular between Kongo Central and the Kivus (more effective CODESAs in Sud Kivu).

5. CORDAID'S EARLIER ENGAGEMENTS WITH THE CODESA

GPSA/CODESA was not the Cordaid's first project on the CODESAs. It is important to understand the history of Cordaid's engagement with the CODESAs to understand GPSA/CODESA:

1. Before 2012, Cordaid was working with the CODESAs as part of its performance-based financing strategy (PBF), which started in 2006 in some of the HZ of Sud Kivu (Soeters et al. 2011) that would later be part of the GPSA/CODESA project. In the PBF model, the CODESAs were tasked with co-developing the business plan of the HF. In practice, though, little support was provided to the CODESAs.
2. The decisive engagement of Cordaid with the CODESAs took place in 2012-2014 in four HZ of Sud Kivu (Walungu, Miti Murhesa, Katana and Idjwi). Supported by a USD 100,000 grant of the Civil Society Fund of the World Bank and an additional USD 50,000 from Cordaid, a pilot project was implemented (CSF/CODESA). It consisted of training the CODESAs and equipping them with an early version of the Community Score Cards and charters (see next section) and was set up in close collaboration with the Provincial Health Authorities. The experience was carefully monitored and documented. It was evaluated through a Randomized Control Trial (see results in the Table below). From all accounts, qualitative, RCT, but also the experience of the project officer and the health authorities, the project was a huge success (interviews with project office and Ministry of Health Officials). In just a

year time, CODESAs became better organised, acquired a voice at the HF and became involved in decision-making, and, importantly, this seemed to have then affected the management of the HF whose situation in terms of infrastructure and human resources improved.

Table 1 Effects of CSF/CODESA

<i>Mean effects (dimensions)</i>	effect (z-score)	p-value	FWER p-value	N
1. CODESA organisation	0.419	0.000	0.007	156
2. Accountability	0.457	0.015	0.012	156
3. Management	0.348	0.001	0.009	156
4. Equity in access	0.025	0.65		4,039
5. Quality of service	0.075	0.49		4,589
6. Provision of services	0.018	0.91		154

Source: Falisse (2016). Also in pending academic publication.

3. Cordaid and the Ministry of Health then implemented a second project (CODESA II). It covered the same areas and sought to consolidate the results of CSF/CODESA, as a core finding suggested that regular support was instrumental to the development of the CODESAs. The 2-year project (2014-2016) also experimented with the matching grants that would be further developed in GPSA/CODESA.

key point(s) 4 Earlier projects

- CODESA/GPSA is Cordaid's third project on the CODESAs. It builds on the demonstrated impact of 2012-2014 World-Bank funded project in four pilot HZs of Sud Kivu.

6. THE GPSA/CODESA PROJECT

Cordaid DRC and its partners, the Provincial Health Government of Sud Kivu and Kongo Central, implemented the CODESA/GPSA project in eleven HZ of DRC for three years. In the last year, Cordaid also implemented a complementary pilot in two extra health zones in the city of Kinshasa.

The overarching goal was to reinforce the capacity and inclusiveness of the CODESAs. The project consisted of four components, each with specific objectives (see project documents for more details):

- *Component 1: Strengthening the system of health facility committees.* The activities of this component included training on the role and responsibilities of CODESAs, as well as retraining and strengthening CODESA coaches.
- *Component 2: Rehabilitation of the FOSA through community projects.* The activities of this component included matching grants to empower the CODESAs and strengthen their work in the communities.
- *Component 3: Integration of the poorest and most vulnerable sections of the population into CODESA and health care services.* The activities of this component aimed at integrating the most vulnerable. It included activities seeking to make the CODESAs more inclusive as well as a pilot intervention on the social and financial integration of the 'indigents' in the local health and social tissues. This last activity resulted in a separate evaluation, which will be only briefly presented.
- *Component 4: Integration of the CODESA into the health system and beyond.* The activities of this component included exchange and advocacy activities to implement the approach at the national level.

184 CODESA received support through the project; they were located in four different contexts (see figure below). Each has its own specificity:

1. The CODESAs of four of the health zones of the province of Sud Kivu started receiving support in 2012, through a project supported by Cordaid and the World Bank Civil Society Partnership. The novelty the CODESA/GPSA project introduced in those zones was mostly around (1) the introduction of community matching grants; and (2) the development of a pilot approach to make the CODESAs more inclusive of and beneficial to the poorest.
2. The CODESAs of four extra health zones of Sud Kivu, which are less stable (with ongoing severe security issues in two of them) than the first four, and where the CODESAs had not been supported until the GPSA project.
3. The CODESAs of three health zones of Kongo Central (former Bas Congo), which had not been supported either until the project started and are located in a context that is far less tense than the troubled province of Sud Kivu. It is already an area in which Cordaid has had less intense contact with the health authorities.
4. The CODESAs of two health zones of Kinshasa, also unsupported by external partners until the beginning of the project, are located in a semi-urban area. The pilot activity there only lasted three months.



Figure 1 Intervention areas

Until CODESA/GPSA, Cordaid's interaction with the health authorities (on the topic of the CODESA) had mostly been at the provincial level. It must be noted that DRC's provincial ministries of health enjoy relative autonomy, especially in the east of the country where Sud Kivu is located

Actors

The project was led and coordinated by Cordaid DRC, who was responsible for the overall management of the project. It ran in partnership with the provincial ministries of health Sud Kivu and Kongo Central via their technical teams. Both organisations provided strategic direction, training and support to the health zones and CODESAs directly. They were also responsible for operational activities, project monitoring, and the development of advocacy activities included in the project (e.g. exchange of experiences, strategic workshops, etc.).

The project was supported by the Washington DC-based World Bank GPSA team. Capacity building and implementation advice also came from the World Bank team in Kinshasa. GPSA supported the

project by providing technical assistance and advice on specific methodological challenges related to the implementation of social accountability tools.

In addition to the citizens living in the 184 HF catchment areas covered by the project, the beneficiaries and participants of GPSA/CODESA included:

- The CODESAs, CAC, and RECO
- Health Facility staff
- Community-based Organisations (CBO) contracted out to verify the situation in the CODESA and HF (with regard to the level functionality on which the subsidy was granted and the projects developed with the matching grants).
- The Health Zone management teams (*Equipes Cadres de Zone*, ECZ) exert a regulatory function: they provide leadership and governance within the health zones. In the project, they supported CODESAs, CAC and all RECOs with supervision to improve their skills.
- The Provincial Health Division (*Division Provinciale de la Santé*, DPS) is the regulatory body at the provincial level; it technically and logistically assisted the health zones in the management of the health action for the well-being of the catchment areas of the health centres.
- PartiCom (community participation department): located at the central level of the health system, this department is in charge of developing guidelines and ensuring compliance with legal and technical provisions in the field of community health.

<i>level</i>	<i>actors</i>
 / national (Kinshasa)	<ul style="list-style-type: none"> • PartiCom • Cordaid country office
 Sud Kivu Kongo Central / provincial	<ul style="list-style-type: none"> • Health Province authorities • Cordaid (Bukavu office) • AAP Kongo Central (Cordaid partner) • Partner country offices
 health zone (HZ)	<ul style="list-style-type: none"> • HZ Staff • HZ CODESA (see E.1)
 community / local	<ul style="list-style-type: none"> • CODESA, CAC, and RECO • CBO • Health Facility Staff

Figure 2 key actors

Outcomes

Ultimately, GPSA/CODESA sought to contribute to the reduction of morbidity and mortality by improving the quality and access to health services in DRC through the strengthening of CODESA's

capacities to collaborate with health workers, the population, and other state and non-state actors. In practice, this was a matter of:

- Reinforcing about 190 CODESA in 11 Health Zones in the provinces of Sud Kivu and Kongo Central –which meant developing a transparent and accountable resource management model for health care while strengthening the capacity, representation and voice of specific groups in the health sector.
- Increasing access to health services for vulnerable groups.

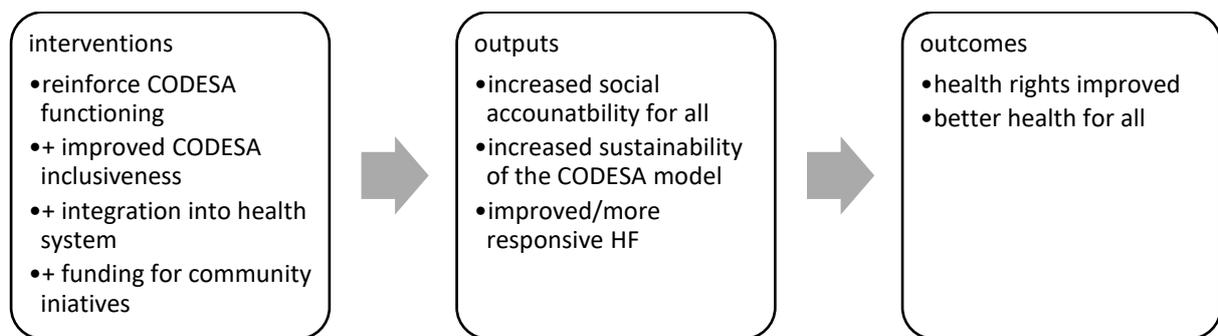


Figure 3 Implicit causal chain of GPSA/CODESA

Each of the four components of the project was associated with an outcome:

1. *Strengthened CODESA that improve access to health care.* The GPSA/CODESA project aimed to improve the quality and access of primary health care services in DRC by strengthening the capacity of CODESA. The aim was to enable beneficiaries to make their voices heard.
2. *Rehabilitated HF, in line with people needs.* GPSA/CODESA aimed to contribute to the rehabilitation of HF in a participative manner.
3. *Poorest and most vulnerable sections of the population integrated into CODESA and health care service decisions.*
4. *CODESA integrated into the health system and beyond.* The CODESA is a key local actor and facilitates collaboration between social responsibility initiatives of civil society actors and state institutions. This outcome is related to the emergence of a coalition of actors pushing for social accountability, which is core to the GPSA approach.

Rather than focusing solely on bottom-up grassroots action, GPSA/CODESA sought to "close the loop" between state-society interactions by encouraging the government to respond to citizens and civil society actors (with respect to citizens' preferences for public service delivery).

The project was in line with the government's Health System Strengthening Strategy, the efforts of other donors, and the World Bank's engagement with the country. The government's strategy recognizes the importance of community participation, particularly "more publicized actions, such as the participation of health professionals in decision-making".

Theory of Change and Results Framework of the GPSA

GPSA/CODESA

The accessed documents do not really present a very clear theory of change of the project, with a graphical representation, the following is adapted (and partly) translated from the documents submitted by Cordaid at the onset of GPSA/CODESA.

The project sought to establish a new, fast, way to build more accountability in health care services. The health committees (CODESAs) constitute an interface of direct contact between the service provider and the population. Made up of volunteers chosen by the population, they also guarantee a form of democratic control of health facilities (HF). CODESA members use social accountability tools such as community score-cards or community audits of HF. The members of the CODESA collect information that can be shared and discussed with the HF staff and the population. The CODESA also has the power to make decisions within the health facility; in case of a stalemate, it can contact health and administrative authorities.

The mechanism is not new but has not been supported for a long time. A pilot project (CSF/CODESA) had shown that, in addition to basic training on the roles and functions of health facility committees, two innovative tools have significant potential for energizing health facility committees: (1) the CODESA charter which is established jointly with medical staff and (2) community scorecards to identify and resolve problems. In addition, GPSA/CODESA proposed introducing matching grants that would allow medical staff and the public to better take into account the CODESA, as these grants could be used to better address the problems identified by community cards. There was also a clear synergy with existing Cordaid project that align with World Bank priorities. Indeed, the project complemented performance-based (Performance-Based Financing (PBF) initiatives of Cordaid that did not have a highly developed accountability mechanism at the grassroots level: the CODESA is on paper contributing to the PBF business plan of the HF but this is rarely a practical reality (Falisse, 2016). Similarly, the Community Client Satisfaction Surveys of many PBF schemes are one-way opportunities for people to share concerns (when well implemented, which has not been the case in the DRC) rather than mechanisms for discussion and exchange.

The pilot project had shown that trained local authorities (provinces and areas) could be reliable actors, able to supervise and support health facility committees. The project also aimed to develop handover procedures to ensure continuity between the old and newly elected CODESAs (e.g. through textbooks). Feedback from national experience and lobbying provincial health authorities was expected to trigger a new national strategy for health committees. Once the tools were finalized and the officials master them, it was expected to be easy to move on to other areas and train trainers. Committees are a reality in the health system of DRC, and GPSA/CODESA assumed that different actors in other provinces are looking for effective ways to strengthen.

GPSA theory of change and connection with the GPSA/CORDAID theory of change

The overall GPSA theory of change has seen different iterations. In this report, we seek to engage with the key points made by the latest iteration of the theory of change that was available at the time of finalising this report. This version is available in appendix, and we will only stress a series of key points here, explaining how they relate, in theory, to the GPSA/CODESA set of interventions. This is based on the project documents and the report will later re-examine the validity of those assumption in light of the findings. collaborative governance”. Since social accountability issues are better understood as complex problems, “lack of collaborative governance can undermine policies to address complex problems, that no single actor can solve alone. An added challenge is that as citizens and governments may lack previous experiences problem-solving together, they often do not have the capacities to engage in these kinds of processes”. This means that social accountability intervention should be “connecting” actors and should be “complementary of broader government policy and programs, including service delivery systems”. Looking at the project documents, and in particular the Implementation Status and Results Reports produced by the TTL of the project, there is little doubt that this collaborative governance is at the core of the

project, with collaborations planned with the Ministry of health at different levels, as well as the local civil society.

A second key point highlighted in the theory of change concerns the “flexible funding for civil society-led coalitions to work with government to solve problems that local actors have prioritized with” and “sustained non-financial support to meaningful engagements, including implementation support, capacity building, facilitation, and brokering”. The matching grant appears to be the main flexible funding mechanism and the non-financial support deployed in the project is, again using project documents, the facilitation that is suggested by the GPSA/CODESA team. The documents presenting the project are, otherwise, relatively traditional in terms of proposing different stages in the activities.

A third key point of the GPSA framework is to “establish civil society-led multi-stakeholder compacts, civil society groups use GPSA advice and guidance, information about government reform efforts and country systems, insights from social accountability practice from relevant contexts, and other resources”. The whole CODESA system could be seen as such a compact. The CODESA framework is very much in line with the GPSA’s idea of “these compacts to contribute to addressing proximate or systemic causes of pressing local development priorities”. As explained earlier, the idea behind the CODESA is precisely to create spaces where local development priorities can be addressed. However, the theory of change of CODESA/GPSA appears slightly less clear when it comes to engagement at levels of government that are above the local. The core idea for the national level is lobbying based on field experiences. This is not dissimilar with the GPSA framework that suggests a scale up approach “The nature of GPSA grants are small experimental investments intended as a way to demonstrate success. If they are successful they may be scaled up”.

A fourth point stressed in the GPSA framework is the “meaningful engagement between civil society and governments”, with World Bank sector teams there to “help open the door to engagement with governments as they have a unique viewpoint of sectoral reform efforts and can support civil society groups in identifying concrete opportunities for citizen input in the policy and service delivery processes”. Again, the framework proposed by GPSA/CODESA seems in line with the broader GPSA theory of change, with RBF taken as an entry point for engaging with the government. It must be noted here that GPSA/CODESA benefits from the fact that Cordaid has been partnering with the World Bank on many RBF projects in the past.

A fifth point is “adaptive learning and politically informed action by all stakeholders, including the GPSA, during the lifetime of a particular intervention and critically, beyond the lifetime of the project”, GPSA/CODESA is not necessarily explicit as to how this might be taking place but it does encompass pilot approaches, such as the one focussing on the indigents.

A sixth point seems equally tricky to exactly find in the GPSA/CODESA project is related to government support and consent. It is certainly useful to distinguish different levels of government, and the theory of change GPSA/CODESA seems mostly based on the existing good relationship with the Sud Kivu authorities (as evidenced by past projects mentioned in documents presenting the project).

Finally, the GPSA theory of change also mentions that in “the most challenging contexts, with low civil society institutional capacities, where civic space is closing or in fragile, conflict and violence-affected settings, the critical task is to empower local stakeholders to develop their individual and collective capacities. This can be aided by processes of joint learning which can foster skills for reciprocity and information-sharing while building trust and capacity to co-produce solutions to shared problems”. There is little doubt that the focus of GPSA/CODESA is, based on documents presenting the project, on the more local level and solutions at that level.

How those mechanisms look in practice is a core interest of this report, and we will get back to it after presenting of the results.

key point(s) 5 The GPSA/CODESA project

- GPSA/CODESA was implemented by Cordaid with the Ministry of Health (at the provincial level) and CBOs. The main activities were (1) training and accompanying CODESA on management, using Community Score Cards and charters; (2) funding CODESA day-to-day activities via a subsidy; (3) providing matching grants for CODESA projects; (4) implementing mainstream and pilot interventions of social and financial inclusion of the most vulnerable; and (5) developing the coalition of actors in favour of the CODESA.
- The project main intended outcomes, which are the core of this study are: (1) fully functional CODESA as a mechanism of social accountability; (2) community-led rehabilitation health infrastructure ; (3) CODESA promoting social inclusion ; and (4) wide support/coalition of actors in favour of the GPSA/CODESA and social accountability practices in the DRC.
- GPSA/CODESA was implemented in 182 CODESA in 12 HZ of Sud Kivu and Kongo Central, with extra Kinshasa project targeting two CODESA in Kinshasa.
- The theory of change, which was only relatively loosely formulated in project documents, relied on the idea of the CODESA unlocking community participation and making health services more responsive to people's needs because they are better represented.
- GPSA/CODESA is generally in line with the broader GPSA theory of change with respect to collaborative governance, flexible funding, the establishment of compact between civil society and government (at local level, the GPSA/CODESA theory of change has less on other levels); it is slightly less clear in terms of how the adaptative learning described in the GPSA theory of change is meant to take place and engagement with some levels of government.

C. OBJECTIVES

The main objective is to carry out the evaluation of projects "Reinforcing Social Accountability of Health Services in Sud Kivu and Bas Congo Provinces" (GPSA/CODESA - GPSA Grant TFO 181644) and "Pilot on Revitalizing the Community System by Strengthening Social Accountability Mechanisms" in Kinshasa. The focus is on assessing the projects' relevance, efficiency, effectiveness, impact and sustainability, paying attention to the context and adaptation processes.

SPECIFIC OBJECTIVES

The evaluation is part of a wider set of evaluations of GPSA-funded projects, and it will seek to:

1. Generate learning and knowledge of the conditions under which the project has achieved its outcomes. The objective is to inform improvements in theories of change, strategies, projects and projects of accountability and social responsibility.
2. Explore the results and social return of the project. Accountability is a multidimensional concept: top-down (donors and government), bottom-up (target communities and beneficiaries) and horizontal (among project partners).
3. Provide material that GPSA can use in the future, for advocacy or other.
4. It also seeks to evaluate the broader theory of change of GPSA (see above as well as appendix), and in particular the particular outcomes:

- a. Civil society partnerships (lead grantee and partners) and relevant government counterparts engage in collaborative social accountability processes that include citizens.
- b. Elements of collaborative social accountability are taken up by governments beyond individual GPSA projects.
- c. Social accountability mechanisms are used to address obstacles to improving targeted service delivery.
- d. Civil society grantees have improved capacity to engage meaningfully and collaboratively in the policy making and implementation and service delivery processes.
- e. Civil society grantees lead multi-stakeholder compacts. [intermediate outcome]
- f. World Bank sector teams support meaningful engagement between civil society and government. [intermediate outcome]
- g. Lessons from experience inform GPSA engagement. [intermediate outcome]

MAIN QUESTIONS

In the context of GPSA/CODESA, the main questions this evaluation will look into are:

1. Has the project's strategy contributed to the expected outcome? If so, for whom, to what extent; and in which circumstances?
2. What unexpected results (positive and negative) have been produced, including the spill-over effects?
3. To what extent do the results validate GPSA's theory of change and its adaptation to the health and governance contexts in the two provinces of DRC? The interest here is in particular on the strengthening of the system and the capacity for collective action.
4. Under what conditions will the results be sustainable? What is the risk that the results obtained are not sustainable?

D. METHODS

The evaluation considers the project's four main outcomes (fully functional CODESA, rehabilitation of infrastructure, social inclusion, and building a coalition of actors), the project implementation, and the extent to which and how key stakeholders (citizens, government, civil society) have adhered to, perceived, and shaped the project and ideas of social accountability.

Understanding the interaction of the interventions with the context is crucial: Sud Kivu is known to have supportive authorities (in the case of Cordaid) and a history of community participation, this is less the case in Kongo Central and even less in Kinshasa, which is also a semi-urban context. The interventions also took place in very different timeframes. The implementation of GPSA/CODESA was shorter in Kongo Central (1.5-year of sustained support) than in Sud Kivu (2 years), due to Cordaid being better established and more experience with the CODESA in Sud Kivu. In Kinshasa, the pilot project was meant to last six months (it ended up lasting 3 months only, see below) and was implemented at a time that coincided with the last months of GPSA/CODESA. As explained earlier, previous research had also pointed out to potential discrepancies between experiences of social accountability in the east and west of the country. The general approach has, therefore, been to consider four different contexts, which are summed up below and were discussed earlier in this document.

Table 2 Areas of intervention and survey

<i>group</i>	<i>health zone</i>	<i>number of HF /CODESA</i>	<i>context</i>
'new' Health Zones in Sud Kivu	Kalehe	15	mostly rural, fragile/conflict-affected, 4-year intervention (2-year sustained support), history of community participation
	Lemera	24	
	Mubumbano	15	
	Uvira	21	
'old' Health Zones in Sud Kivu	Idjwi	21	mostly rural, fragile, 4-year intervention (1.5-year sustained support) on top of continuous CODESA support since 2012, history of community participation
	Katana	18	
	Miti-Murhesa	18	
	Walungu	23	
Health Zones in Kongo Central	Boma Bungu	11	mostly rural, more stable, 4-year intervention (2-year sustained support)
	Muanda	10	
	Kitona	6	
Kinshasa		2	urban, 3-month intervention

The comparison between the findings in the different contexts is used to understand what, in the context, matters –with particular attention paid to the duration of CODESA interventions, histories of community participation, and urban versus rural context. Some of the key findings are below

Table 3 Summary of key findings per area of intervention

	<i>summary of key findings</i>
'old' Sud Kivu	active and dynamic CODESAs appear to be catalysts for community and collective action, probably fostered by GPSA/CODESA; strong provincial-level dynamic in favour of the CODESA and CODESA-like mechanisms; encouraging results of pilot project aiming at improving the situation of the most vulnerable; some infrastructure rehabilitated through CODESA
'new' Sud Kivu	active and dynamic CODESAs appear to be catalysts for community and collective action, probably fostered by GPSA/CODESA; strong provincial-level dynamic in favour of the CODESA and CODESA-like mechanisms; some effects on social exclusion; some infrastructure rehabilitated through CODESA
Kongo Central	CODESAs often focussed on sharing medical information, lower evidence of a systematic change; positive a priori from other actors (e.g. health authorities, civil society) but limited commitment in their favour; some infrastructure rehabilitated through CODESA
Kinshasa	early, one-off, intervention suggests CODESA may also be meaningful in the urban space but evidence and intervention are limited in scope and suggest CODESA with very peripheral roles

The methodology was refined at the onset of the project, after consulting evaluations of GPSA projects in other countries and discussing with Cordaid and the GPSA and DRC World Bank teams. It also benefitted from precious inputs from the co-researchers. Three documents were key to refining the methodology and scope of the evaluation:

- The GPSA Results Framework (October 2015)
- The evaluation of the Indonesia GPSA project (Maternal, Newborn and Child Health Project)
- The PhD Theses and academic work of two of the researchers (Falisse and Mafuta)

A comprehensive method note (in French) was shared with World Bank and Cordaid in May 2019; it contains the different instruments used in the evaluation (survey forms, as well as interview guides). A shorter 3-page note (in English) was subsequently developed to iron out the approach with all partners; it emphasized the need for an evaluation that fully considers the political economy of the project.

Both the timeframe and budget for this evaluation were limited. 34 days of work, including the definition of the approach, data collection in remote places of DRC, data analysis, writing-up, and the integration of feedback do not allow to exploit every corner, and the methodological choices presented below reflect the need to ‘know fast’. The timeframe for the study was initially one month from March 2019 –that window was fortunately extended until the end of July but, even then, some of the participants could not be reached.

TIMELINE AND TEAM

The field research –which mainly consisted of the interviews and focus groups mentioned earlier– was conducted in June and July 2019. Dr Eric Mafuta (*Kinshasa School of Public Health*) led the data collection and translation in Kinshasa and Kongo Central while Philémon Mulongo, MPH (*ISTM Bukavu*) led the fieldwork in Sud Kivu. Both also organised the phone survey (May-June 2019) and contributed to the research design (May-June 2019) and data analysis (July 2019), which were both led by Dr Jean-Benoît Falisse (*University of Edinburgh*).

The tight timeframe means that the data analysis has been entirely geared towards the main goal of the evaluation: looking at four main intended outcomes of GPSA/CODESA. The rich material may, however, reveal useful to explore connected issues.

Two of the core researchers had a pre-existing relationship with Cordaid as external evaluators and/or advisors, which facilitated the work. Jean-Benoît Falisse was a technical advisor on the CSF/CODESA project: he led the Randomised Control Trial (RCT) research dimension of the project and, similarly, led the RCT research on supporting the indigents that was part of GPSA/CODESA. Eric Mafuta worked with Cordaid in 2012-2017 during his PhD research. Both Eric and Jean-Benoît wrote their PhD dissertations on social accountability in health in the DRC and continue to research and publish on the topic.

DATA SOURCES AND DATA COLLECTION

The evaluation seeks to provide both an overview of the general trends and an understanding of the dynamics at play in the catchment areas covered by the project. To do this, the most suitable approach was deemed to be a mixed-methods approach where:

- (1) general information on trends collected via a survey and secondary data analysis is combined with
- (2) qualitative data from interviews and focus groups with key actors of GPSA/CODESA (elite interviews) as well as field interviews and focus groups in key places (areas where GPSA/CODESA is known to have worked well or less well).

We first reviewed the existing sources of data, which mainly included Cordaid’s GPSA/CODESA funding tracking documents as well as project documents (grant agreement, operational manual,

progress reports, status of implementation and reporting of results). While we had initially hoped to gain access to the Health Information System, this was not possible within the short time frame of the study. More importantly, some data on the baseline situation in HF, which had, supposedly, been collected at the onset of the project, was not available either.

The table below presents the different sources of information used in this research, as well as the potential gaps for each:

Table 4 Data sources

<i>source</i>	<i>number</i>	<i>observation</i>
<i>Survey and large-scale</i>		
Original phone survey with:		
- chief-nurse	164	missing 18 chief-nurses and 25 CODESA (could not be reached)
- CODESA president	157	
Data on subsidy allocation from Cordaid	1/1.5 year	per semester. 1 year (out of two) for Sud Kivu, 1.5 for Kongo Central (full set)
Data on grant allocation from Cordaid	2/1.5 year	per semester. 2 years (full set) for Sud Kivu, 1.5 for Kongo Central (full set)
<i>Interview/qualitative material</i>		
Key informant interviews	14	GPSA/CORDAID decision- and policy-makers
HF/HZ interviews/focus groups	(10 sites)	sites selected to be representative of well and badly functioning CODESA (as defined by the Cordaid team). HZ include Walungu, Uvira, Katana, Kalehe, Boma Bungu and Muanda, as well the two Kinshasa sites
- chief-nurse	10	
- CODESA	10	
- population	10	
- CBO	10	
- HZ CODESA		
- HZ authorities		
<i>grey material</i>		
CBO reports	6	all in Sud Kivu, Cordaid did not provide this information for Kongo Central
Annual reports	11	including the eleven reports found on the World Bank website
Various presentations	5	

Besides contacting Cordaid and third parties for secondary data, the main efforts in terms of data collection consisted of:

1. A phone survey with HF chief-nurses and CODESA presidents. This approach was selected due to financial and time constraint. It was simply not possible to visit every HF that had benefited from GPSA/CODESA –other options such as an internet survey or gathering the chief-nurses and CODESAs were also impractical. We collected phone numbers from Cordaid and HZ officers. Given the logistical constraint, the survey only counted 13 questions (though some had multiple items) and had been designed to be answered in less than 15 minutes. It often took more time and the tenacity of the enumerators, who often had to repeatedly call various numbers before they could reach the person they wanted to talk to, must be commended. The dataset is not complete: out of 182 HF, 164 HF chief-

nurses and 157 CODESA presidents could be interviewed. The missing observations are often due to HF located in remote areas without good phone coverage (there was a minimum of three attempts for each missing observation). Obviously, a phone survey comes with clear limitations: it is not possible to gather cues from body language or direct observation, but it was the only option to gather specific information on the CODESA on a large-scale.

2. A total of 35 interviews and 16 focus groups (5-9 participants each) were organised in HF catchment areas (chief-nurses, CODESAs, community-based organisations, population) and HZ (chief-doctor, HZ CODESA). Two sites were selected for Kongo Central, two in the 'old' intervention areas of Sud Kivu, two in the new ones, and two in Kinshasa. The detailed list of interviews and locations is in the appendix.
3. Key informant interviews were also important: 14 were organised in total (see the list in appendix). They include four of the six project managers who have worked on GPSA/CODSA and could be interviewed, as well as the project officer, the World Bank focal point, three officials from the Sud Kivu and Kongo Central Ministry of Health, two representatives of faith-based organisations running health centres (Catholic (BDOM) and Protestant (CEPAC)), and two representatives of NGOs working in community health. A dedicated semi-structured interview guide was prepared for those interviews (see appendix).

APPROACH AND DATA ANALYSIS

The first step was to document what had actually been achieved in each of the four dimensions of the project. This was only a brief review since Cordaid had already documented those aspects in its reports (the main source for this was precisely Cordaid's own reports and financial information on the CODESA subsidy and matching grants). A key element of this first phase was also to use the interview and qualitative material to look more closely at the general perception of the project, as well as its adaptations in the field.

The second step was to see to what extent the project contributed to its intended outcomes. A key approach that has been used in both the qualitative and quantitative research is the most significant change, a technique for collecting stories about changes that occur as a result of a program (Davies and Dart 2005). It is useful for getting insights into how change happens (how) and when these changes take place and, therefore, examining theories of change. The most significant change approach suggests to:

- Ask the higher-level actors to explain what they perceive to be the most significant change – in our case, we asked for the most significant change in (1) the provision of rural health services and (2) the involvement of the community in provisioning and developing healthcare.
- Then ask the same questions at the more local levels (e.g. zone, Health Facility). Respecting this order makes it possible to see, in the interviews, if the explanations and perceptions of the actors of the higher levels are validated at the level of the base.

This is the procedure that was followed for the qualitative part of the research. For the phone survey (a mix of close and open-ended question, see appendix), which did not allow easily recording a comprehensive response or easily integrating information from other levels, the approach was simply to ask the most significant change questions.

Quantitative data analysis. The general procedure for analysing the data was the following:

The telephone survey with CODESA presidents and chief nurses, as well as secondary data analysis, provided a general background for each section. The analysis was limited to basic descriptive

statistics for the sake of clarity (also because the data set is very limited in terms of control variables). Answers to open-ended questions were noted by interviewers and coded by the core researcher team without using any pre-determined category: the categories were created purely on the response of the participants. In most cases, the results are presented separately for each context/region (see above), this allows exploring the contextual factors that matter.

Qualitative data analysis. After the general trends and key patterns had been established through the phone survey data analysis, the qualitative data was analysed. The objective with this second phase of data analysis was both to explain the phone survey patterns and to explore themes that either could not be captured in the phone survey or were not envisaged in the initial research:

The HF/HZ-level data followed a clear, structured format, and we did a thematic analysis of each answer, establishing what the main themes, how the different actors (CODESAs, chief-nurse, etc.) position themselves, and selecting representative quotes. The aim of that phase was to ensure that we were not cherry-picking answers. The data was then compared with the survey findings, with the idea of trying to make sense of the different patterns and to highlight the dynamics at play.

The key informant interviews are of a different nature. The analysis was also different in that it also sought to simply place and identify key policy decisions: who did what, when, and why (not). Those interviews also sought to map out the network of actors working on the CODESA.

The sources of information are duly referenced throughout the document. The system used to reference the interviews is explained in the appendix.

key point(s) 6 Methods

- The evaluation uses a mix of interviews, focus groups, phone surveys, and grey literature review. It primarily draws on a phone survey with HF chief nurses and CODESA presidents in 157/164 HFs that benefitted from the project, as well as over 70 interviews with key actors in the field in addition to policy-makers and key stakeholders.
- A Most Significant Change approach was used to elicit the key elements in relation to the four outcomes analysed in the study. It was used both in the qualitative research and in the phone surveys.
- Data analysis sought to consider the different situations in which the CODESAs were in at the onset of the programme. Some CODESAs were well-functioning and well-supported for some time, while others were barely functioning. Research has highlighted that social accountability takes time to build, which means that the project could have had different effects depending on different 'baseline' situation. The focus therefore included: (1) areas of Sud Kivu with a long experience of CODESA strengthening; (2) areas of Sud Kivu with a shorter experience of CODESA strengthening; (3) Kongo Central that had seen very little prior support to CODESA; and (4) Kinshasa where CODESA are largely not engaged with by the health system and donors.

E. MAIN FINDINGS

The findings are divided into five main sections. The first one looks at the implementation of GPSA/CODESA and seeks to answer a preliminary question: (1) how much of the planned project was effectively implemented, and which were the adaptation. It mostly serves to provide the backdrop to the next four sections, which each look at one of the main intended outcomes of GPSA/CODESA –some themes are, obviously, cross-cutting. We start with what initially the fourth outcome of the project, (2) the set-up of a wide support/coalition of actors in favour of the GPSA/CODESA and social accountability practices in the DRC (so that ‘the CODESA are fully integrated into the health system and beyond’) as it is useful to understand better the other outcomes, which are, in turn, explored: (3) the question of how functional CODESAs are as a mechanism of social accountability, (4) the rehabilitation of the community-led rehabilitation of health-care infrastructure, (5) and social inclusion and its promotion via the CODESA. A last section considers the sustainability of GPSA/CODESA.

1. IMPLEMENTATION AND ADAPTATION

Cordaid has already provided, in its annual and mid-term reports, an assessment of how much the initial project plan has been executed.¹⁰ The overall situation regarding each domain of activity is the following:

Table 5 Overview of implementation

<i>Dimension</i>	<i>Project Outputs</i>
1. training and support of the CODESA, including recap sessions	overall, main activities have been achieved <ul style="list-style-type: none"> • Supervision system put in place (see below) • Contracting system in place, effective between S2 2017 and S3 2018 in Kongo Central, so 1.5 year instead of 3 years as initially planned. • 182 CODESA trained (out of 190 planned – the target had been miscalculated and the actual number of CODESA in those areas was 182), all with direct (on-site, Cordaid led) or indirect recap session (via the Zone CODESA or via Cordaid phone support, see below).
2. rehabilitation / matching grants for CODESA	overall, main activities have been achieved <ul style="list-style-type: none"> • 148 matching grants in Sud Kivu • 81 matching grants in Kongo Central • Projects audited and followed by external party (contracted community-based organisation)
3. integration of the poorest and the most vulnerable	overall, main activities have been achieved <ul style="list-style-type: none"> • integration of at least one indigent in each CODESA • social commissions set up inside each CODESA • pilot project in the old areas of intervention, results shared
4. CODESA integration into health system	only part of the planned activities undertaken: <ul style="list-style-type: none"> • all health authorities trained • participation in provincial forums • some media documents • limited participation of the project in national-level forums, no change in policy-making (most efforts focussed on the provincial level).

¹⁰ see the project result framework attached to those documents

In short, most activities could be implemented, but most ended up being considerably shorter in time than initially planned, among others because of episodes of violence in some areas of Sud Kivu, as well as political instability in the entire country (see below). The reason why some of the activities of the fourth dimension could not be undertaken has been described by the World Bank and Cordaid staff alike as having to do with lack of adequate funding but also the need to focus on volatile areas of Sud Kivu that required more energy than expected and the succession of project managers (see below) has been pointed out as contributing to the problem by others.

A brief review of the implementation of key activities

The bulk of the budget of GPSA/CODESA was dedicated to three activities: (1) the training and retraining of the CODESA, (2) the matching grants, and (3) the financial support of the CODESAs. The matching grants were for new, one-off, CODESA-led projects at the HF-level while the financial support was for the CODESAs to carry out their routine activities.

1. Training. The trainings covered the following topics: roles of the CODESA, functioning of the HF and the Congolese health system, HF finances, and design of community score cards (CSC) and CODESA-HF charters (see below). No major issue was reported by the research participants, CODESA members and project implementers alike, regarding the training sessions. In many cases, the training or retraining of the CODESA included helping to organise elections because the CODESA was old or not functional anymore.¹¹ The retraining was systematic and focussed on area the CODESA identified as weaker (among the aforementioned topics). The figure below indicates the mean age of the CODESAs in each of the three main areas: the CODESAs of the new interventions areas of Sud Kivu were all elected at the onset of the project. Importantly, all the surveyed HF had indeed a CODESA, and 67% recalled a recent complete training of the CODESA members (in the two years before the phone survey).

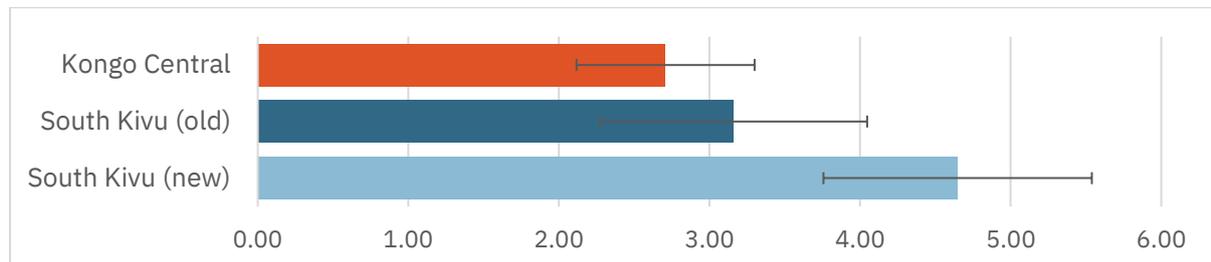


Figure 4 Years since this committee has been in place

/ source: phone survey with CODESA president (n=157) | Error bars are standard deviations

2. Matching grants. A total of 146 1:1 matching project grants were attributed to the 155 CODESAs of Sud Kivu. The few CODESAs that did not receive a grant failed to meet the conditions for obtaining it: either the project was not evaluated as sustainable and/or the project did not have at least the equivalent of 50% of its cost funded by the community or CODESA. The 27 CODESAs of Kongo Central received 81 grants in total, one each semester the grant project was implemented.

Based on discussions with the CODESA/GPSA project officer and data analysis, it appears that the rules for obtaining a grant have been slightly different in the two parts of the country:

- In Sud Kivu, a committee at the HZ level, supported by the Health Province and Cordaid, would evaluate the project and assess whether the project was indeed relevant (to the benefit of the community and the HF, given the local context), but also realistic in terms of financial planning and general delivery, and meeting the project criteria of being a durable

¹¹ The MoH guidelines suggest an election of the CODESA members every 4 years.

project. Of the 12 rejected projects, 10 had ‘unrealistic budgets’, two were deemed irrelevant, and two were not deemed durable (some projects combined characteristics). All the projects requested (and received, when eligible) the maximal amount they could request, USD 500.

- In Kongo Central, a different approach was used. The CODESAs were given a chance to apply for a grant multiple times but the evaluation committee –roughly similar to the committee of Sud Kivu in term of composition– would allocate the money available using a mark out of 100 (based on similar criteria). The money the CODESA received each semester was, therefore, USD 349 (the money available on average per semester per CODESA) adjusted by their score. The variance is small (USD 9.94), and reduces over the course of the project. The amounts given to the CODESA effectively oscillated between USD 320 and USD 376.

In both cases, community-based organisations (CBO) were selected to check the implementation of the CODESA community projects.

3. Financial support. Another key part of the project was the subsidy that would go the CODESAs every semester. It was based on them meeting some basic conditions (and has been presented by Cordaid as a form of community-based performance-based financing). The list was established early on in the project and relied on previous projects set up by Cordaid (Table below). The indicators were verified by community-based organisations (CBO) especially recruited for this task, and the HZ would request the money from Cordaid and pay the CODESAs using the reports provided by the CBO.

Table 6 Semesterly CODESA subsidies

indicators	Subsidy in USD
1. Uses of community maps (CSC)	25
2. Work plan of quarterly activities	15
3. Commissions (Resources, Social Mobilization and LDCs) in place	15
4. Regular meetings with the FOSA, CODESA, and population	20
5. List of active and non-active members of RECO and CODESA	25
6. General Assembly meetings with the FOSA, CODESA, and population	10
7. Updated list of indigents	10
8. Indigents informed about free healthcare	15
9. Indigents involved about CODESA in quarterly meetings	15
Total	135

The maximal amount available was officially USD 150 in Kongo Central, as per the table above. In practice, though, there seems to have been the same issue as in the case of the matching grant, and the amount of money available was, in fact, USD 90 per CODESA per semester. The scores appear to have been weighted with the maximum amount of money given to a CODESA in one semester USD 114 and the minimum USD 77. Again, the variance is very small (USD 3.78) and reduces substantially over time.

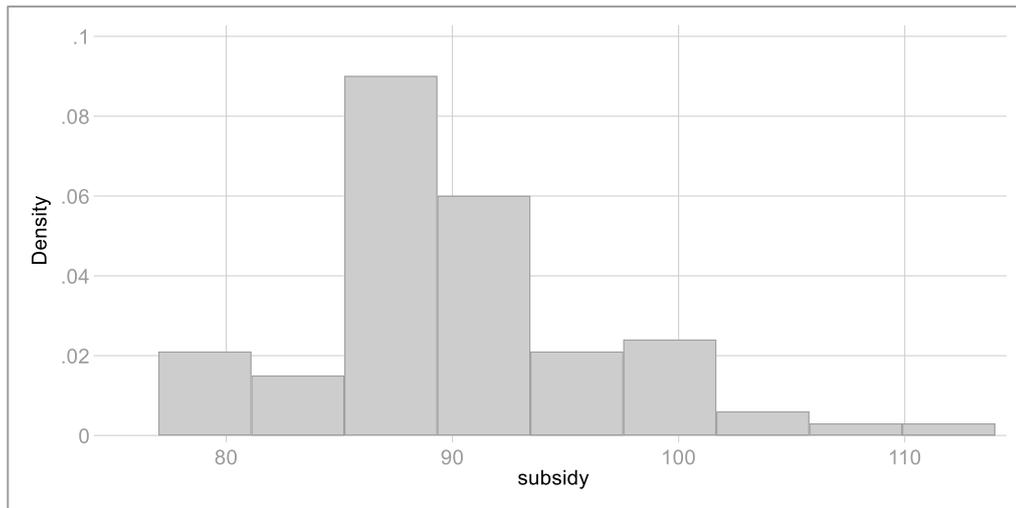


Figure 5 Distribution of subsidies in Kongo Central (S2 2017, S1&S2 2018 – full series)

In Sud Kivu, again, the implementation was slightly different. In Kongo Central the implementation went on for one year and a half (S2 2017, S1 and S2 2018, all data were accessible), with semesterly grants while in Sud Kivu, there was only one round of award for years, both in 2017 and 2018. We only got access to the 2018 data for Sud Kivu, but the maximal amount given to a CODESA was USD 175¹², and the minimal amount 115. The same de facto re-adjustment of subsidy also applies, though, with the amount available per CODESA at USD 164 per semester and, therefore, USD 164 as mean value (standard deviation is USD 12.1 and does not vary much over time). The distribution, however, is quite different: none of the distributions passed the test of normal distribution, but Kongo Central’s is much closer (especially given the lower number of observations) –the distribution in Sud Kivu is skewed to the left.

From the point of view of incentives, and if the subsidy is meant to be a form of performance-based financing, it is clear that the Kongo Central model is much better suited: there is simply no room left for improvement for most CODESA in Sud Kivu. The difference is, again, due to different ways of scoring the CODESA by the CBO but also by the Health Zone, Health Province, and Cordaid that exploit the data.

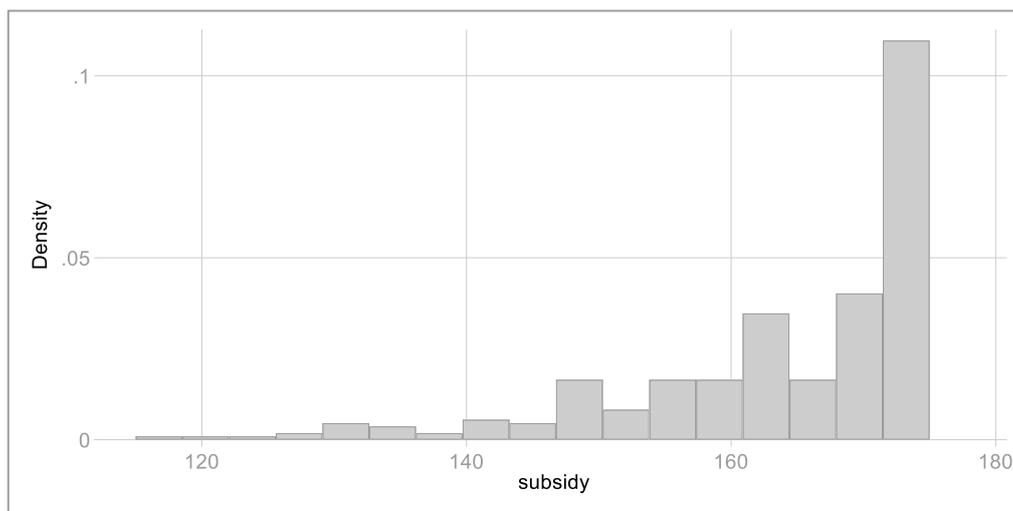


Figure 6 Distribution of subsidies in Sud Kivu (S1&S2 2018)

¹² the project officer explained that the subsidy r had been bumped up from the USD 150 maximum

key point(s) 7 Scope of activities implemented

- Most activities were implemented as planned, although some over a short time, often 1.5 to 2 years instead of 3. It seems that not all activities planned at the national level could be conducted.
- A central part of the project, the financial support provided to the CODESA (subsidies and grants), ended up being implemented differently in Sud Kivu and Kongo Central. They may have created a slightly different set of incentives (pass or fail in Sud Kivu, more incremental in Kongo Central). It is not clear what, apart from budgetary constraints, drove those adaptations. One possible hypothesis is that the 'demand' for financial support is also a function of the level of organisation of the CODESA (better in Sud Kivu).

Implementation issues

The GPSA/CODESA contract between the World Bank and Cordaid was signed on the 18th of November 2014. However, Cordaid only received the first part of the WB funding (USD 123,296) in June 2015, which means that the beginning of the activities was seriously delayed. The mid-term report by Cordaid reads: "A significant major constraint recorded during this period remains the delay in disbursement of funds through the system Client Connection of the World Bank, for technical reasons". The restructuring paper of the World Bank mentions "holdups in the signing of agreements with Regional Government entities" (World Bank 2018b) and it must be noted that the project was eventually extended (at no additional cost) by three months and finished on 18 February 2019.

This could explain, in part, why the timetable of the GPSA/CODESA somewhat diverged from its original plan. It would be year 3 before some of the year 1 targets of the project are effectively reached, and activities that had been planned over two to three years, such as subsidies and grants, were effectively delivered over 1.5 year –in the last 24 months of the project. Similarly, the pilot project involving new ways of supporting the indigents started over a year later than expected, with two direct consequences: (1) the duration of the pilot was shortened, and (2) the lessons from the pilot on integrating the indigents (see section 5 of the results) were harder to integrate in the rest of the project, given that it was already nearing the end.

The initial delay in funding not only affected Cordaid. In multiple instances, health authorities reported that delays in payment (attributable to the initial issue, or possible to some other implementation problems) put them in a difficult position. This was especially the case at the beginning of the project as the training team had already started its work but was not able to (immediately) follow up on their promises of subsidies and matching grants –as one health zone chief-doctor in Kongo Central put it:

"we had problems with the CODESA. They called us jokers, and I began to avoid them. It tried to explain that the situation [the delay in funding/activities] did not depend on me and that the money would come later. This is hard to explain to people, and they did not trust me"

This problem was further compounded by organisational problems. Although the project officer, who had been working on the CODESA for years, remained in place –and was, according to health officials, key in making the project work– the project went through four different project managers, some of whom had little experience with community health and were in charge of an already busy

portfolio. It is possible to identify no less than five periods in terms of project management: (1) the first manager between November 2014 – December 2015; (2) the second manager between December 2015 – August 2016; (3) an interim period (with an interim programme manager), (4) the fourth manager between October 2016 – June 2018, and (5) the fifth manager between July 2018 and the end of the project. Most of those changes were due to people leaving Cordaid, they had clear destabilising effects on the project and generated further delays as the new project manager would necessarily need time to get up to speed with the project –yet, at the same time and as will be shown in the next section, they may also have helped reach some objectives of the project that could not be reached using the planned channel.

Those two ‘organisational’ problems are by no means exceptional in NGOs and civil society organisations. The key questions they raise are about adaptability (in the case of Cordaid, so activities could be pre-funded) and proactivity (here GPSA/CODESA relied on a dynamic and proactive project officer).

Contextual issues: opening and closure of the economic and political space

The project took place in a tense national socio-political environment that complicated work with the authorities and the implementation of activities in the field.

On the one hand, the uncertainties and tensions related to the presidential election that was postponed multiple times made it complicated for the project team to build strong relationships with higher-level officials. It must be pointed out that, at the same time, the situation was putting to the fore questions of democracy, accountability and representativeness and may, in fact, have strengthened local interest in the GPSA/CODESA. As the third annual report of the project put it: “far from discouraging the efforts of the communities, this [...] has given rise to a collective – even though the means are very limited. We are seeing more and more citizens who are trying to keep their voices heard, to network and to join groups of civil society to express their opinions; that is, to hold state officials accountable”.

On the other hand, the security situation in two of HZ of Sud Kivu, in Lemera and Uvira, degraded rapidly and soon prevented Cordaid’s team from working in the field. The security situation in Uvira and Lemera was worsened by the tension around the elections, but its root causes go well beyond it and related to land and communal conflicts in the Ruzizi plain.

In the backdrop of the project, the decentralisation process in the DRC, including in the health sector, accelerated from 2016, making everybody –government and government partners– more receptive to decentralised and participatory institutions such as the CODESA. This was noted in Cordaid’s second annual report: “The role and place of the HFCs have been put at the centre stage in this process. This impacted the attitude and motivations of the provincial health authorities to consider HFCs seriously. The whole decentralization dynamic is positive and an opportunity for the project objectives.” Sud Kivu and Kongo Central (which was not called Bas Congo anymore) were among the very few provinces that were not divided into multiple smaller provinces and therefore benefited from the renewed interest for decentralisation without having to restructure radically.

key point(s) 8 Implementation and contextual issues

- An initial 7-month delay in receiving the funding somewhat destabilised the implementation of the activities, with a direct effect on the credibility of the project’s partners in the field.
- The project went through five consecutive managers over four years, leading to further destabilisation.

- The project took place in tense security and economic context, which, however, put to the fore people's interest in democratic processes and decentralisation.

Adaptations

The design of the project involved slightly different set up between Sud Kivu where Cordaid is well-known and very active and choose to implement the project directly, and Kongo Central and Kinshasa where it is less present and worked through a close partner with a good presence on the ground, AAP Kongo Central. As reflected in the GPSA/CORDAID's bi-annual technical reports, the four different contexts mentioned above were engaged differently by Cordaid, reflecting their human capacity and expertise at given times and places; they mobilised partners when useful. The same bi-annual reports and interviews suggest that Cordaid was stronger (in terms of resources and expertise) in areas that already had stronger CODESAs at the onset on the project (Sud Kivu); Cordaid did fly in their best expert (the project officer) to Kongo Central and Kinshasa to support activities there but, ultimately, some of the imbalance may have remained. The imbalance was, in essence, structural, and hard to correct.

In response to the delay in funding, Cordaid did manage to retain the project officer, who had been working on previous CODESA-related project, so that they would be ready to work when the funding would come. Cordaid was not, however, in a position to pre-finance the planned activities. Later on, budgeting issues led to effectively weighting and capping the subsidies given to the CODESAs, as explained in the last section. This appears to be a sensible adaptation that did not jeopardise the main efforts of the project.

The response to the turnover in manager has been a reliance on the project officer and nominating interim programme managers who had a sense of what the project.

In response to the security and economic situation, there is a clearer sense of 'adaptative learning' at work. The success of Cordaid with regards to this specific challenge may reflect Cordaid's long experience working in ever-changing environments in eastern DRC.

- To access the no-go areas in Lemera and Uvira health zones, the project officer soon developed a pragmatic and apparently –according to the CODESAs– efficient way of supporting the CODESAs through the phone.
- The economic crisis that came along with the political tensions led Cordaid to change the minimal financial participation required from the community from “30 to 40%” of the total estimated cost to “20 to 30%” –as noted in the third annual report of Cordaid: “in the provinces where the GPSA project is being implemented, there is a marked decline in the socio-economic conditions of the population, resulting in a decrease in the Community contribution to the achievement of micro-projects”

In the field, there are many ways in which the CODESAs adapted the Cordaid CODESA model to their need and circumstances, and those are described in the next section. Indeed, they do not really consist in an 'adaptation' as the idea of GPSA/CODESA was to kickstart community participation which is, by definition, hard to predict (Mansuri and Rao, 2012). As one chief-nurse of Sud Kivu put it: “Cordaid only gave a boost to the CODESA project and they, in turn, had to develop their own plans”. At this stage, let's maybe point two elements that cut across cases.

Health Zone CODESA

Health Zone CODESA (HZ CODESA), a committee made of the representatives of each CODESA of a HZ were not really envisaged at the time when Cordaid submitted the GPSA/CODESA proposal.

There had been some ideas around experience sharing between CODESA but nothing resembling a “committee of committees” was on the table. Relatively early on, Cordaid decided to help set up such committees –together with the Ministry of Health– in Sud Kivu, using a funding source different from GPSA/CODESA (but certainly to the benefit of GPSA/CODESA activities). The inspiration was in part coming from encountering, in Kongo Central the *Comité Territorial/Communal de Développement* (COCODEV: the Territorial/Communal Development Committee) that does not only look at health but is uniting the interests of representatives of different catchment areas. In Kinshasa, similar instances exist too, and their actions cover typical CODESA activities but also the monitoring of CODESA activities in each catchment area (Kin.HZC).

The advantages of the HZ CODESA are obvious and span from sharing experience to setting up another upward mechanism of accountability for the CODESAs. The HZ CODESA is described (SKi.HZcodesa.Kat.1) as a key vehicle for lobbying the HZ but also attracting new external partners to the HZ. In a tense security context, the HZ CODESA has also been used by Cordaid as a proxy for maintaining support to unreachable CODESAs.

Financial contributions

A dynamic that seems to have taken root in many CODESA is the idea of HFC members directly contributing to the CODESA functioning. CODESA members and chief-nurses insist on this (K.chief-nurse.4): “first of all, we ourselves have to self-finance. It is a problem of self-financing and self-responsibility.” While the project certainly stressed self-reliance, it was not seeking to impose, in any sense, that CODESA members would be paying out of their own pocket, for CODESA activities. Yet, this also seems to be one of the first things that HZ CODESA and CODESA establish when a new CODESA is elected: making contributions possible to help fund a specific project. (Ski.HZcodesa.Kat): “Yes, the members of the HZ CODESA make contributions because we are the ones responsible for the CODESA and we want to do what we preach”.

One possible way to understand those financial contributions is to think of them in the local context of Kongo Central as well as Sud Kivu. The CODESA is said to tap into pre-existing forms of solidarities in Bantu societies and in particular the community savings groups or *likemba* (Interview HZ chief-doctor 1, Kongo Central) that are possibly one of the most widespread forms of community mobilisation. What the members of a CODESA in Kongo Central explain in terms of how their financial contributions work is, in fact, quite close to the idea of a community savings group:

“The subscription is \$20 each, and the period is six months. It is needed, so we commit ourselves. But we are also supported. When there is a cost, we ask for a quote, and we divide the total sum between us (RECO and CODESA). (Kon.codesa.2, participant 2).”

key point(s) 9 Adaptations

- Due to the security and economic context, (1) some of the monitoring and support was conducted through phone; and (2) the amount of the community contribution was revised.
- Committees with representatives of the CODESA of a HZ (HZ CODESA) were supported, and sometimes set up, by Cordaid. This was unplanned and gave CODESAs more leverage as they came with the endorsement of a powerful organisation (Cordaid is well-known for its projects in health and education, especially in Sud Kivu).
- Unexpectedly, many CODESAs required financial contributions from members, in line with savings group mechanisms that are the backbone of community participation in the DRC.

2. LOCALLY INTEGRATED? A POLITICAL ECONOMY OF THE CODESA

GPSA/CODESA and the CODESAs are part of the larger political economy of social accountability in the DRC. This section highlights how CODESA contribute to local and national-level dynamics. It suggests that, overall, GPSA/CODESA has been able to work in collaboration with key local stakeholders rather than as a “lone crusaders” (Guerzovich 2014). This was the case in Sud Kivu more than in Kongo Central, possibly because many of the collaborations have relied on pre-existing rapports and the fine understanding of the local context of the project officer in Sud Kivu, while in Kongo Central GPSA/CODESA has had to rely on a local partner for implementation.

Local dynamics

The quantitative material provides insights into the interaction between CODESA members and other parties. It suggests that CODESA members –in their CODESA capacity– and the RECO and the community interact, on average, a few times a month. The question did not cover the type of interaction, but it must be understood in a broad sense. For instance, in the case of the meeting with the community, CBO reports suggest that most interactions are a simple home visit or an informal gathering. Comprehensive general assemblies remain rare. There is also a degree of interaction with local leaders, including those above the village level, which the interviews suggest is primarily driven by the HF president.

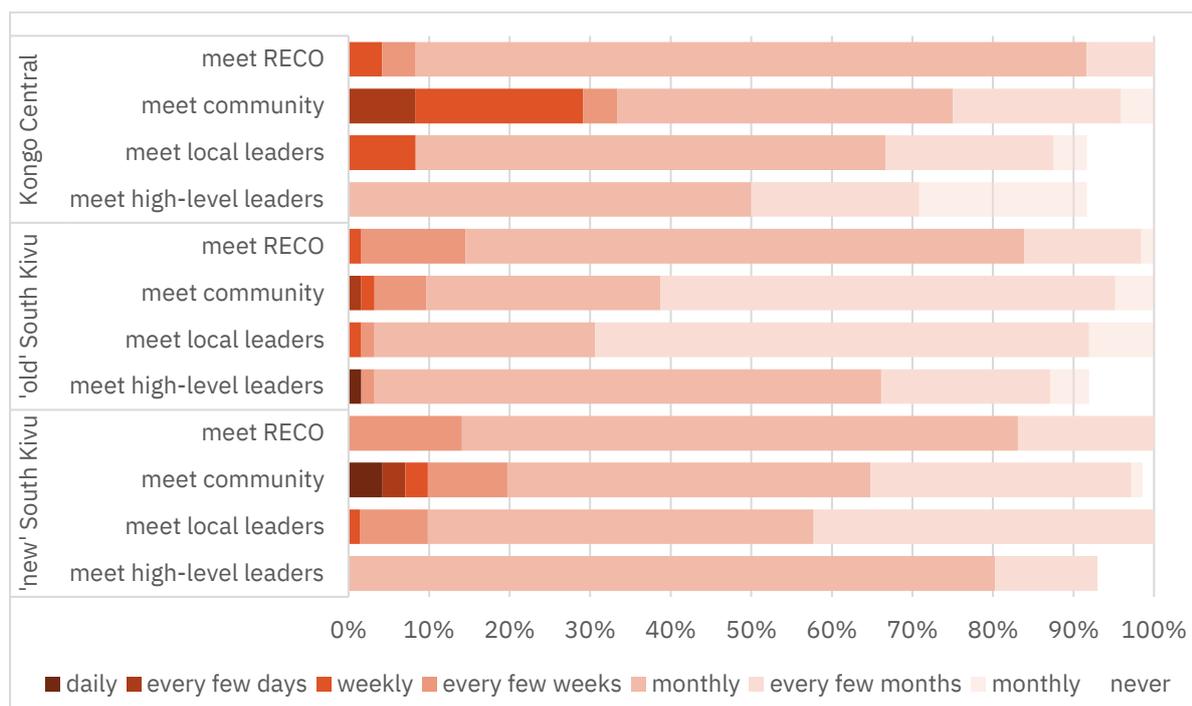


Figure 7 Interactions of the CODESA – according to CODESA president

/ source: phone survey with CODESA president (n=157)

The same picture emerges when asking not the CODESA president but the chief-nurses, as the figure below shows. If anything, the chief-nurses seem to report that the CODESA interacts with local actors slightly more than the CODESA reports itself.

The key change at the local level seems, however, to go beyond the interactions between the CODESA and the actors it is expected to meet. As interviews in both Sud Kivu and Kongo Central, the main novelties brought about by the GPSA/CODESA has been to instil a multi-sector dynamic around participation –CODESAs reported that they engaged with other basic service providers such

as schools, water (pumps and dwells), and road infrastructure. This is both in terms of inspiring participatory responses to issues in those areas and in terms of directly engaging with the provision of those services. In many instance, in Sud Kivu, the ‘sanitary development’ in the name of the CODESA far exceeds the strict management of the HF or even health promotion (Kon.cn.2). The difference between Sud Kivu, Kinshasa, and Kongo Central is in terms of the centrality of the CODESA in its community.

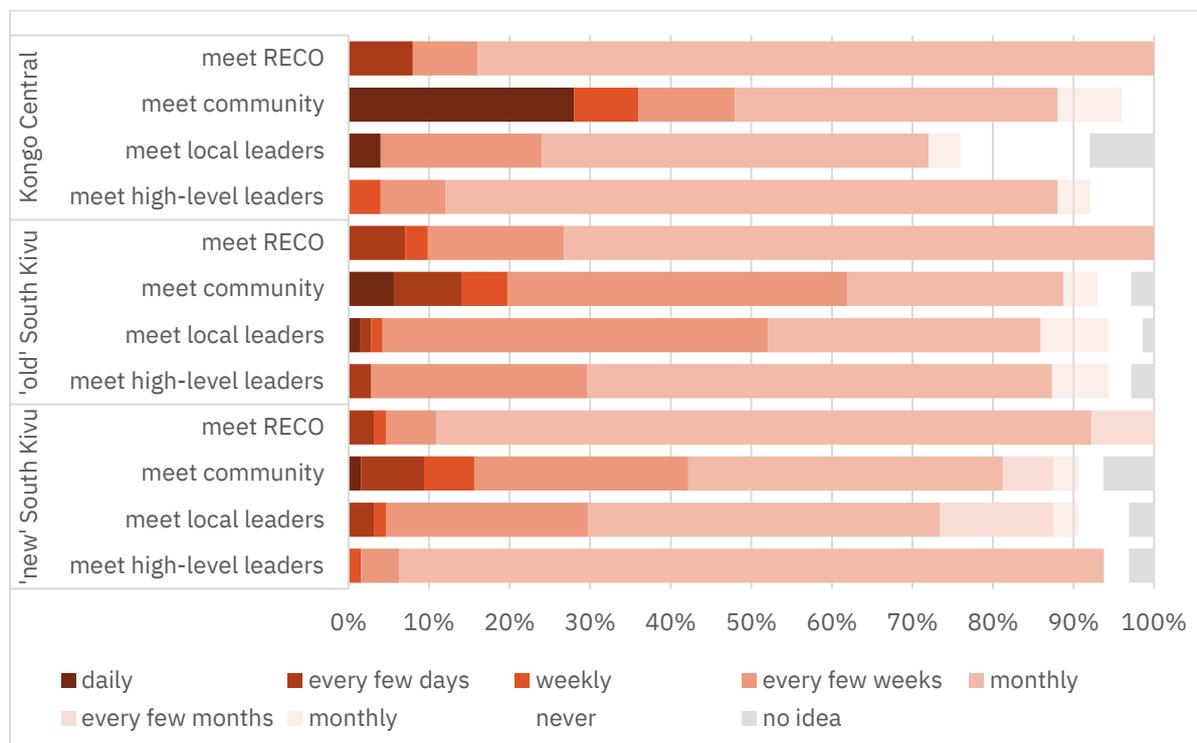


Figure 8 Interactions of the CODESA – according to HF chief nurses

/ source: phone survey with HF chief-nurse (n=164)

A central actor?

In Kongo Central, the population, chief nurses, and even CODESA members sounded undecided about the place of the CODESA in the local community: some gave it a relatively central place while others treated it as a marginal actor. One factor that seems to be playing out is that many of the CODESA members are apparently already members of other key organisations: this can give the CODESA clout and a good network but also means that the actions of individual CODESA members are not necessarily associated with the CODESA (Kon.pop.1). The same is reported by chief-nurses who note that, for instance, local mayors (*bourgmestres*) are CODESA members –but they would always be seen as acting as mayors, not as a CODESA member.

The dynamic in the couple of Kinshasa CODESAs suggested that the RECOs, rather than the CODESA per se, are actively involved in the local tissue, as revealed by this anecdote (Kin.pop.2):

“to be RECO, you must be someone who has done a lot of time in the community and who stays around. For example, when we are asked to look for the needy, I go to see the head of the locality, and I flatter him by saying that he is the one who knows us all and that he is in the best position to find these people. And he, too, on his side when there are cases of illness in his community, he calls me because he has confidence in the RECOs and if we have drugs on the spot, we intervene, or we go to the centre of health if necessary.

The neighbourhood leaders support us; they take into account the reports made to them. When we see that there are offenders [*délinquants*] in the neighbourhood, for example, we notify them, and a few days later, you will find that these offenders have moved out. This shows that the chiefs help us a lot.”

Something similar is reported by the chief-nurse.

“Since we initiated community participation, we are really seeing a big change. It's dynamic because we do not work only with health workers, it is multi-sectoral, there are teachers in it and various people coming from different horizons. We are really very close to these people, more than before. All started with the RECO and CODESA training.”

The GPSA/CODESA experience in Kinshasa has been very short in time, and it would be hazardous to conclude that it is a success, but what the interviews and focus groups suggest is that, at the very local level, the RECO –and to some extent the CODESA– model can be meaningful. A possible reason it may work is because, as a CODESA located in another urban area (in Uvira) suggests, is that the CODESA membership has cast its net wide: “We believe that this idea [the CODESA] can work in an urban context because there are intellectuals, volunteers and civil society actors.”

In Sud Kivu, CODESA members seem –especially in the areas where Cordaid has been active for many years– to have taken yet another dimension. CODESAs are presented as a catalyst for activities undertaken at the HF and in the catchment area of the HF in general: this covers typical health sensitization activities such as the distribution of impregnated mosquito nets but also census activities (Ski.HZ.Uvi) and a wide range of projects that benefit the community (as we will develop in the next sub-sections).

Legitimacy

The ‘catalyst’ position of the CODESA in some HF of Sud Kivu is said to be possible because of its active planning at the HF (Ski.HZ.Wal) and because it is fully trusted by other key local actors such as churches or local community radios. A core element in the interviews, that has come up almost every single time, is the portraying of the CODESA as changing the local narrative by promoting local solutions and self-sufficiency, this is in a context where aid-dependency has been a major concern of local officials (Ski.HZ.Wal). The same change in the narrative may be on its way in Kongo Central where the provincial chief-doctor explained

“CODESA have understood that local initiatives must come from themselves –they do not have to wait [for somebody else] each time to be able to bring them something. They, themselves, can have their small initiatives”

In turn, this narrative reinforces the trust key actors such as HZ chief-doctors put in them:

“And that's what I always wanted, and I liked, and that's a big change because now when you want to develop a project, be sure you have at least a 30% contribution from the community as a base; we come to complete, we come to help you to achieve the expected results.” (Ski.HZ.Wal)

Another factor that was mentioned by a CBO is that the action of Cordaid, together with the health province in favour of the CODESA, has given them confidence. As the chief-nurse of a HF in Katana (S.cn.Kat.1) explained: “CODESA thought they were parasites and today they have their small projects and have become gradually independent.” This is also echoed by GPSA/CODESA staff members who stressed that, beyond Cordaid, the project had brought the Health Province and Zones closer to the CODESA (GPSA/CODESA annual report 1).

Finally, the metamorphosis of the CODESA is also one of membership, a point that will be developed further later in the report:

“The activities have changed; they have specific activities listed on the community scorecards they establish. [...] The educated people are part of CODESA today, whereas earlier in time, it was not the case.” (Ski.cn.Kat.1)

The catalyst position of the ‘better’ examples of CODESA in Sud Kivu is understood as the CODESA being: (1) facilitators of other external projects; (2) facilitators of new local community projects; and (3) an example for other community-level projects.

1. Reinforced CODESAs are instrumental in making the community strategies of other aid actors work; this is, for instance, the case of the large hygiene promotion campaign “Villages et Ecoles Assainis” (sanitized villages and schools) led by UNICEF (Interview HZ chief-doctor, Walungu). The dynamic may well be that it becomes a key institution on which others may piggy-back on (SKI.HZ.Uvi). In Sud Kivu, chief-doctors even described the CODESA as key for achieving inter-sectoral initiatives.
2. The CODESA works as community organisers, at the crossroads of different local institutions. The following anecdote is quite telling (Kon.codesa.1):

“the flow goes really well with the local chiefs. The chief-nurse does not know these things. Once we noticed a boy, who was coughing. When we [the CODESA] were told this started 3 months ago, we recommended to the boy to go the HF. The chief-nurse shared the note with us, and we went around: we gave something, the village chief gave 5,000FC, then another person gave 5,000FC. The family had 15,000FC. His uncle gave the rest. Now the boy has been treated and is going well. Between the village chiefs and the health centre, the flow is going well.”

3. It seems the well-functioning CODESA of Sud Kivu may also be examples for other organisation, as reported by one CBO of Walungu:

“we have what we call ‘safe spaces for young people’. In this space, we try to talk about the CODESA [...] the idea is that, afterwards, young people bring information back to their young peers, and that, this the way, there is effective communication.”

The CODESA of the same locality explains:

“I have seen local associations, the chapels, as well as the community coming to ask us for advice to carry out their work. [...] Often, we organize exchange morning session. Sometimes they ask us to come to visit or bring us home to teach them what to improve in their way of doing things.”

Local chiefs are instrumental in unlocking the potential of the CODESA; they largely guide access to the community. They give the authorisation for local communication and sharing information with the population. As a HZ CODESA reported (Ski.HZcodesa.Kat):

“local chiefs are always with us in the works; we are still working hand in hand. And where they are not satisfied, we can correct so that we are all happy. They accompany us favourably, and sometimes when we work somewhere in the area, they accompany us and they are happy with what we do. They even help us to bring the tools; it can happen that we do not have many tools and that we are numerous, they bring us the tools, and we do it together. We teach them what we do to improve their way of doing things.”

The findings of the CODESAs as catalysts are in line with some of ‘global’ theory of change of GPSA, which itself builds on idea summed up in the World Development Report (World Bank 2017) that

see social accountability as a multi-stakeholder process that goes beyond the implementation or design of laws that are, on paper, technically sound.

Overall, the analysis shows an intervention that builds on leveraging traditional leaders and other organisations rather than opposing them. This is generally in line with the empirical literature on social accountability promoted by GPSA (Guerzovich 2014). At the local level, GPSA/CODESA was able, in Sud Kivu especially, to collaborate with existing local actors and partners (e.g. local Civil Society Organisations, Health Authorities, local chiefs who are part of CODESA). In Kongo Central, there appear to be a general positive view of the CODESA but much less of a proper leverage.

Opponents

At the local level, the interviewees usually claim that the opposition to the CODESA and the philosophy behind them is quite limited. In a few instances, especially in Kongo Central, the chief-nurse and the nurses, in general, are said to be a force that may hamper the work of the CODESA. This is consistent with earlier findings from DRC and other contexts (Falisse 2016; McCoy, Hall, and Ridge 2012). One has to bear in mind that in many HFs, the staff is de facto paying itself and funding the functioning of the HF through paid-for services and drugs (especially so when government and donor funding is limited). It may, therefore, not be particularly keen to lower fees. This appreciation of the situation comes from all across the spectrum: population, CODESA, CBOs, and even the health authorities themselves, as it was pointed out by the CODESA focal point at the provincial Ministry of Health in Bukavu:

“Some chief-nurses who do not understand the logic that they are members of these CODESA as a technical expert. There is a lot that is new for them, and they think that having a representative of CODESA with them is like having the police. They feel threatened in their management, which has often been quite isolated from anyone really.”

This was echoed by many other actors, including the Protestant health-care coordination of Sud Kivu: “it is observed that some IT or MCZ or MD less edified on the scope of the actions of the CODESA block the road and treat them of the incompetents or the spies.” Or in the word of a CBO organisation in Sud Kivu (K.CBO.K.3): “I will say that at the beginning, some chief-nurse thought we were there to be the vigil or police and did not understand the role of the CODESA.” As everywhere, the careful work of building trust and rapport can be brought down easily by rumours, as the members of a CBO (K.CBO.3) explain: “in the old days, some members thought that the CODESA president or his vice-president was blowing money away from the population, but then an audit disproved it. Now there are no more people who are against the CODESA.”

Even in Kinshasa, where the work on CODESA started late, a chief-nurse explained that the social accountability approach is shared with other sectors such as schools (although the interviewee did not make it clear whether this was driven by Cordaid’s intervention or the intervention of another partner, MAGNA).

The only consistent opponent to the CODESA seems to be religious groups that are hostile toward biomedicine or external interventions. They include Jehovah Witness and local Christian sects such as the ‘Babas’, the ‘Eglise des Noirs’ and the ‘Nzambe Malamu’ church (the latter three seem more widespread in Kongo Central). As the participant of a CODESA focus group explains (Kon.codesa.02, participant 3):

“they do not want any message of development, even if they are explained to them at length. They say to you “you work with partners who give you money for us, and you eat that money, we will not welcome you and your diseases that kill our children.”

The issue only came up in a few interviews and may not be too important. Overall, the engagement of the CODESA and Cordaid with the faith-based organisation that are predominant and run some of the health centres seems good: Cordaid is Caritas Netherlands, which means it commands a lot of respect among Catholics and Catholic organisations. It also has good relationships with mainstream Protestant churches. The core question is whether CODESA and Cordaid could or should engage with groups that are more fringe or radical (including those that are best characterised as sects). Many of those groups fiercely refuse engagement with most if not all external parties and it is unsure that much progress can be easily achieved through more sensitization or trust building activities. It may be a lot of efforts for an issue that may be quite limited in scope.

Politics and politicians are generally not mentioned as an opponent to the CODESA. Part of the reason could be the ‘silo’ nature of healthcare that remains largely separate from the local administration, having its own hierarchies and structures. The stakes, or potential rents, that can be extracted from health-centre are also quite low comparing to other services (e.g. road tolls) and industries (especially extractive industries).

key point(s) 10 Place of the CODESA: local level

- The place of the CODESA at the local level varies across HZs; a possible issue is that CODESA actions go unnoticed because their members have multiple affiliations.
- Precise trends are hard to establish, but the qualitative material suggests that in numerous instances in Sud Kivu and even some cases in Kongo Central, the CODESA has become a legitimate actor due to its association with powerful external players (Cordaid, the HZ and Health Province) and newly acquired planning abilities.
- In those cases, the position of the CODESA is best understood as being a catalyst in the sense of (1) facilitating of other external projects; (2) facilitating new local community projects; and/or (3) being an example for other community-level projects.
- Relationships between CODESA and chief-nurses and nurses are often tense when the CODESA is set up, linked to HF staff’s fear that the CODESA will seek to police HF activities. The CODESAs are also facing difficulties engaging with fringe religious groups and sects.

Provincial dynamics

At the provincial level, GPSA/CODESA is very much a tale of two stories: in Sud Kivu, Cordaid had pre-existing excellent relationships with the provincial health authorities that had accompanied CSF/CODESA and CODESA II and had seen the positive change instilled by those projects. In Kinshasa and in Kongo Central, the project seems to have gone almost unnoticed by the key policymakers and authorities.

Table 7 contrasting Sud Kivu and Kongo Central provincial dynamics

Sud Kivu	Kongo Central
<ul style="list-style-type: none"> - Heavy commitment of the provincial health authorities in favour of the CODESA. - Integration of the CODESA in health planning. - Interest of NGOs and civil society for the CODESA ‘model’. New CODESA inspired initiatives 	<ul style="list-style-type: none"> - Generally positive attitude towards the CODESA. - Still doubts about the capacity of the CODESA to do meaningful planning - No specific engagement of the local civil society with CODESA/GPSA project and CODESAs

It is important to note that the Health Province remains a priority for many CODESAs, as explained in Walungu by one of them:

“The provincial chief-doctor is like our direct father because at the end of each activity, we send him the report. He supports us for our sources, in training to strengthen our management skills, and if we cry, he comes to see how we are. And in the exchanges at the monthly meetings to the monthly magazine, where there is fault it shows us how to correct.”

In Kongo Central and Kinshasa

There is little to say about the dynamics in Kongo Central and Kinshasa: GPSA/CORDAID has engaged with the regulator, and the interviews suggest that the philosophy of the project was well-understood, and even supported, but there is no evidence that a wider coalition of actors was set in motion by the project. In fact, actors that are not directly related to the project typically have not heard of it. It is important to note that AAP Kongo Central (which normally handles PBF) was contracted to run the project in Kongo Central and that the core of the interventions took place in just 1.5 years. As explained earlier, this form of outsourcing of the project, which is was originally driven by Cordaid’s limited presence in Kongo Central, may have contributed to ultimately increase the imbalance of the project (in terms of resources and expertise) in favour of Sud Kivu. Such outsourcing is probably less conducive to the civil organisation being able to make the case for the CODESA, in the same way Cordaid did make the case for the CODESAs in Sud Kivu.

In the Kivus

In Sud Kivu, the Provincial Ministry of Health is actively engaging with different partners on the theme of the CODESA. Their approach mainly includes disseminating and having partners abide by the new norms of community participation that were elaborated with Cordaid’s support for the CODESA part (Ski.hp). A clear organisation has been set up to support the CODESA, as explained by the Sud Kivu CODESA focal point in Bukavu:

“We do follow-ups according to a well-defined program, they are quarterly harmonised with the partners who support us. In these follow-ups, we do either planned activities or supervisions training based on their community scorecards.”

This practice clearly illustrates points made by other about the fundamental reasons behind successful collaboration with local authorities in social accountability project. Guerzovich, Mukorombindo, and Eyakuze (2017b) look at social accountability programmes in the province of Muchinga in Zambia and they stress the importance that local authorities are provided with respect, resources, but also training, mentoring and technical assistance. Those features appear clearly in the interviews in Sud Kivu, where GPSA/CODESA may have “nurtured capacity enhancing processes” (Guerzovich, Mukorombindo, and Eyakuze 2017a) when it comes to community participation in health, this is mostly through the permanent between Cordaid and the Ministry of Health of Sud Kivu.

Besides the health authorities, support for the CODESA, which when the project started was mainly coming from Cordaid and the International Rescue Committee (IRC), is now coming from a wider range of actors including Cordaid again in two health zones of North Kivu (Goma and Kirotshe, with a different funding source), the German cooperation (GIZ PASS), UNICEF, and USAID.

The latter is leading a project in the peri-urban area of Kadutu, near Bukavu, which is reportedly just starting. Its local partner is the BDOM, which has been working with Cordaid on the CODESAs for a long time and is sharing ideas learnt through the projects. Similarly, UNICEF’s approach is said to be changing, it used to be very vertical, more about information, and is now embracing principles of

community accountability following meetings with Cordaid and field visits. Last but not least, the IRC, which has been supporting CODESAs for a long time in other areas of Sud Kivu is now using specific tools developed as part of CODESA/GPSA. As confirmed by their project officer:

“Colleagues of mine have taken the Miti-Murhesa CODESA model [Miti Murhesa is one of the ‘old’ areas of intervention] and see if it will work on the Uvira axis [the health zones located on the way and beyond Uvira]. They plan to use the approach of micro-projects planned and executed by the CODESAs.”

It is hard to pinpoint how exactly the coalition of actors and the positive dynamic at the provincial level started, but it is probably related to the long-term efforts of the provincial ministry, Cordaid, and other actors. It seems that we are in a ‘learning’ phase, where organisations try to learn from each other rather than compete. At the health zone level, the project has generated an important demand for CODESA support (GPSA/CODESA annual report 2), and CODESAs have reported ad hoc collaborations with IRC and World Vision. Mercy Corps is another NGO which the CODESAs apparently work with and do sensitization for (in a different field as they share seeds (Ski.HZcodesa.Wal). Two elements are important to comprehend the situation. The first one is the very high number of aid organisations in the Kivus, one of the ‘aid hubs’ of the world –there are a lot more different aid actors in Sud Kivu than in Kongo Central, and therefore a higher chance that at least some of them get interested in the CODESAs. The second element has to do with aid coordination and the fact that, to some extent, aid actors operate in different areas which means that the competition between them is reduced. This repartition is, however, not total and there is a risk that, with the multiplication of actors working on and with the CODESAs, the provincial dynamics become counter-productive. Coordination is essential; currently it is done through both international aid clusters and the health authorities.

key point(s) 11 Place of the CODESA: provincial level

- The evidence of a provincial-level coalition of actors in favour of the CODESA model was not found in Kongo Central or in Kinshasa, but there is ample evidence that a positive dynamic, a form of virtuous circle, is unfolding in Sud Kivu. With the support of the provincial health authorities, key international aid actors (GIZ, UNICEF, USAID, IRC) report using approaches derived from the GPSA/CODESA experience –often after having witnessed it in the field.

National dynamics

At the national level, the formation of a coalition of actors pushing for social accountability and the CODESA was much less formal than planned. It does seem, though, that key elements of GPSA/CODESA are now being picked up by various actors. Cordaid was invited to contribute to the national level community health policy early into the GPSA/CODESA project. The project manager in the day (now with UNICEF) confirmed that:

“The national sectoral health guidelines in the DRC on community participation were reviewed in December 2016, after a review of the experiences implemented in the country by various actors. I had the chance to present the CODESA approach as well as its results and perspectives [those results were mostly based on the CSF/CODESA project, as GPSA/CODESA was only starting]. I also took part in the national meetings that validated the guidelines and tools. The CODESA project has notably influenced the initiatives for motivating the CODESA.”

GPSA/CODESA could not organise meetings with the national-level authorities in charge of community participation at the Ministry of Health (the Particom, *Division Participation Communautaire*) later. The only other key forum in which GPSA/CODESA was presented was the

national Health Cluster led by WHO. This cluster gathers monthly most of the health actors (public and civil society) and the CORDAID/GPSA team introduced the project as it was in its second year. WHO and other donors expressed their interest in this approach (GPSA/CODESA annual report, year 2) but, by the end of the project (and despite a six-month extension), not much had materialised. This could be due to (1) the typical focus and experience of Cordaid DRC being more on service delivery than advocacy, (2) the turnover in project managers, and (3) the fact that creating a forum at the national-level demanded important investments (for potentially little gain, as health policy is de facto crucially shaped by the provincial level) at a time when the project was already quite busy. It must be noted, though, that a new community health strategy was being designed by non-GPSA/CODESA related actors as we are writing this report. The CODESAs are an institution of DR Congo and therefore never totally off the table, the question is how central an item on the agenda they become.

GPSA/CODESA is described by World Bank and Cordaid staff, as well as direct beneficiaries (the CODESA, HF staff, and the zone, district and national health authorities who know it), as liked and welcomed at the local and intermediary levels. Contacts with officials at the national level (ex-PartiCom) suggest, however, almost total ignorance of the project at the central level of the Ministry of Health and a limited interest for the CODESAs that are seen as a past fad.

Yet, an unexpected advantage of the high turnover in project managers is that each of them went on to continue their career either in a different organisation or in a different unit of Cordaid DRC and there now a clear sense that ideas on social accountability derived from the CODESA experience are being spread out. They all seem to have brought lessons from GPSA/CODESA with them:

1. One former project manager is now working with the Integrated Health Project + (IHP/PROSANI), a flagship USAID-funded project in 126 HZ across nine provinces. A core component of the project looks at community-level interventions, and the project is reportedly building its strategy for reinforcing the CODESA on the GPSA/CORDAID project (Kin.int.1).
2. Another project manager is now with UNICEF in Mbandaka province. He explained how he imported some ideas from GPSA/CODESA into his work:

“It is with enthusiasm that I am duplicating at the CAC level the incentive schemes (micro-projects) borrowed from CODESA project. [...] The use of scorecards, even if called community action plan in UNICEF jargon, is courtesy of the CODESA [GPSA/CODESA] project that I put at the service of my work in UNICEF.”
3. A third former project manager is now working for PDSS and, there too, the spill-overs from GPSA/CODESA are visible, as written by Cordaid in their last project report:

“the Health Sector Development Project (PDSS), a World Bank-funded project of the Ministry of Health, would like to extend the CODESA approach developed under the GPSA project in all 156 targeted health zones for creating demand for service through the revitalization of CODESA.”
4. Last but not least, another former project manager has been affected by the education unit of Cordaid, working on the large WB-sponsored project PAQUE. The equivalent of the CODESA, the COPA are being given a central role in the approach (Kin.int.2)

Other large health systems strengthening projects such as DfID’s ‘Access to Health Care in the Democratic Republic of Congo’, which is implemented across 52 HZ is also reportedly “giving a central place to CODESA reinforcement” (Kin.int.3)

A key question, though, is whether in a country such as DRC, where a disconnect if not a tension between national, Kinshasa-based, politics and provincial dynamics is regularly pointed out (for instance in the World Bank’s Country Assistance Strategy), the coalition of actors that is most instrumental and relevant is at national level. The experience of GPSA/CODESA seems to suggest that provincial-level are perhaps a more realistic, and relevant, level at which a coalition can be constituted. What is more, it should be noted that Cordaid is mostly working on service delivery in the field —and often seeks to maintain good relationships with ministers for that reason. It may not have been best equipped or experienced for activities more akin to advocacy or lobbying.

Finally, it is useful to note, that, internally, Cordaid seems to have picked up inspiration from GPSA/CODESA, or at least claims to have done so, as they say in their last report:

“Finally, in its 2018-2020 triennial strategic plan, Cordaid advocates the use of the GPSA approach as a cross-cutting strategy in all its community-based projects to generate community participation. For example, in the current Global TB HIV / AIDS Program 2018-2020, Cordaid is developing citizen engagement in the fight against HIV and TB at the community level. [...] All this will be based on the GPSA approach to stimulate community involvement and improve the demand for services offered under this program. [...] In our Lobby and Advocacy program, we are already working with CODESA in raising awareness of communities in relation to the promotion of mutual health organizations to achieve universal health coverage.”

key point(s) 12 Place of the CODESA: national level

- The project only delivered part of what it had planned to do in terms of engaging with national actors. The CODESAs are not seen as a priority or a vehicle for change by many national-level actors. Putting together a coalition at the national level seems to require substantial human, social, and financial resources that the project did not commit. It might be reasonable (even if somewhat inadvertently so). Indeed, a key question is whether, in a country like DRC, substantial efforts should be directed to constitute a coalition at a level that is often described as distant (when not disconnected) from local realities.
- A surprising positive effect of the turnover in project managers is that all of them ended up in influential positions in other institutions and, when interviewed, suggested that they were using CODESA ideas in the design of UNICEF, World Bank, and USAID large programme. There is also evidence that CODESA influenced the set-up of social accountability mechanisms in the education sector.

3. CODESA AND SOCIAL ACCOUNTABILITY

The extant literature on social accountability in health in the DRC (Falisse 2016; Mafuta et al. 2015, 2016) and in other contexts (Lodenstein et al. 2017; McCoy, Hall, and Ridge 2012; Molyneux et al. 2012) all point to the fact that CODESA often struggle to be genuine mechanisms of social accountability. Although Cordaid did not do a proper baseline study at the onset of the project, this is a view that was widely shared by the different interviewees.

This section first looks at the perceptions of the CODESA before considering the sort of influence they have through (1) looking at how local information is used and (2) the rights the CODESA claims to have. We then turn to the core activities of the CODESA and what they can tell about the CODESA playing its role as a social accountability mechanism. Finally, we consider different tools that were implemented (Terms of Reference / Charter, Community Score Card, Subsidy) to make it an effective social accountability mechanism. It shows some promising avenues for the CODESA.

Perceptions

A key challenge of GPSA/CODESA was to make the CODESA real social accountability actors who have a say in the management of their HF, and not simply RECO (community health workers) who go in the community on behalf of the chief-nurse (Cordaid GPSA/CODESA proposal, 2015). The data collected in previous Cordaid projects on the CODESAs had shown that whenever CODESA was active, it was usually more in the sense of them being ‘just’ a group of RECO who met at the HF, without much involvement in HF affairs.

Across all interviews, there was an agreement that the CODESA are useful, but they were still different perspectives as to what the main advantage of the CODESA is.

Kongo Central and Kinshasa

The population of Kongo Central rarely showed much awareness of the CODESA. They had a sense of who the RECO –which are known in Lingala as *papa* or *mama bonsiga* (Kon.Pop.1)– were, but even then, their answers often remained vague. The CODESAs are “the people we go to when we have a health problem because they are close to the health facility” (Kon.Pop.2, participant 6). Some of those health needs are localised and certainly important. For instance, the CODESA is cited by provincial health authorities as key for reporting cases of Human African Trypanosomiasis, also known as sleeping sickness, which is endemic in Kongo Central (but absent from Sud Kivu). The population does not, however, identify them as people who would ask questions about the management of the HF (Kon.Pop.4).

Our sample is not representative, but it seems that the population in Kinshasa had a better sense of the function of the RECO than some in Kongo Central: “They give us ear-bashing on self-medication and advise us to take the children to the health centre and not to treat it ourselves.” (Kin.Pop.2, participant 8)

For most mid-level health officials in Kongo Central and Kinshasa, from the HZ down to the HF, the CODESA is, first and foremost, a group of RECO. In the view of those officials, the main advantage of the CODESA relative to other RECO is that they are closer to the HF: under the orders of the HF chief-nurse, they deploy their network of volunteers deep into the community. As one chief-nurse of Kongo Central explained (Kon.cn.4): “the activities of the CODESA are about sensitization and bringing patients to the health facility, really”.

Switching both down to the CODESA and up to the provincial-level in Kongo Central, the view is slightly different. They often mention the ability of the CODESA to come with local solutions of their own. As the chief-doctor of Kongo Central put it:

“There are times when the solutions come from the field. We do not know what is going on in every single village, but the CODESA [and RECO] are in a position to identify local problems. Let me take an example: some women refuse to come to the prenatal check-up, the head of the health centre will give you a reason but that might not be it, the RECO they can go to the woman and see with her and she trusts them and tell them what is wrong –for instance that the nurses behave badly.”

Sud Kivu

At the other end of the country, in Sud Kivu, there are also instances in which the CODESA was described as solely a group of community health workers. Those views were typically expressed by mid-level health officials, such as the chief-doctor of one of the Health Zones who described the CODESA as:

“an organization that is well respected in the health zone. We, technicians, identify problems and devise solutions, and they are the ones we are sending to the community to implement the solutions.”

In most cases, though, the people we interviewed (at all levels) had a clear sense of the CODESA as representing the community and shaping HF service delivery. The direction generally was not depicted as imposed or shaped by Cordaid. On the contrary, in a few instances it was explained that CODESAs “help solve local problems locally” (SKi.cn.Kal), which embodies quite well the philosophy behind GPSA(/CODESA) but also community participation in health more generally. Whether this corresponds to the actual situation or to a form socially acceptable answer (for this is the sort of rhetoric that was used the CODESA training) remains to be fully established (and would require a longitudinal observation that we could not do). Yet, there are clear signs that the CODESA are developing initiatives of their own that are not within the typical remit of the CODESA as formalised in the Ministry of Health CODESA guidelines. As a key Sud Kivu civil society actor explained when asked what the most significant change in HF had been:

“The change is in terms of health facility co-management, and the planning and monitoring and evaluation of CODESA activities. It is also in terms of community involvement: they [the CODESA] now organize community-based health insurances (*mutuelles*) and small projects that strengthen cohesion among community members.”

In this perspective, which we have already touched on already, the key benefit and role of CODESAs go even beyond social accountability in terms of health facility social accountability; it is more of a broader change of the community’s capacity for collective action.

key point(s) 13 Perception of the CODESA

- The perception of the CODESA as ‘just’ a group of community health workers, which means a group of people mostly preoccupied with transmitting health information and not with HF management or broader questions of collective action, remains an issue, mostly in Kongo Central, in Kinshasa, and among some demographics (some HZ officials) in Sud Kivu.
- In Sud Kivu mostly, there is some perception of the CODESA as a broader vehicle for collective action at the HF and beyond.

Information and power

The role of the CODESA in terms of collecting and acting upon data is crucial to understand; it dramatically influences the CODESAs’ capacity of action. Information is also an important component of what is understood by “social accountability”, this is along with other elements highlighted by the second generation of social accountability frameworks (Carothers 2016) such as the capacity of collective mobilisation and collectively solving local issues (as assessed in the previous sections). The broader GPSA framework is very much part of this second generation of framework, so information should be seen as central but not as the only channel through which social accountability is assessed (Guerzovich 2019).

Scenario 1: Kongo Central and Kinshasa (mostly)

In a series of cases in Kongo Central (as well as less frequent cases in Sud Kivu), the chief-nurse is the repository of knowledge and uses this position to exert its authority. The information gathered by the CODESA members and RECO in the community goes to him (more rarely, her) and he/she uses it to organise the work of the CODESA and RECO. As a chief-nurse of Kongo Central explained (Kon.cn.4):

“the competence of the CODESA comes from the expertise of chief-nurse. Because it is the chief-nurse that gives them the material, although they themselves can do something. Very often, it is the chief-nurse that must at least supervise them, raise their awareness, give them the material, tell them what to do, what not to do!”

In this scenario, the role of the monthly meeting between the chief-nurse and the CODESA is not so much to co-manage HF as it is to transmit information, as explained by a CODESA member (Kon.CODESA.2, participant 12): “[as a secretary] I write the minutes that I bring to the HZ or the CODESA union [also known as HZ CODESA]. Then, after transmitting information, our work is to promote good health practices”. The community officer of one of the health zones of Kongo Central confirms:

“During these meetings and through the reports sent, the Community Animator (from the Health Zone) collects important information about what is happening in the community and the activities carried out in different CODESA. During these meetings, the CA also takes the opportunity to give them the information on the Health Zone.”

The meetings are also an opportunity to share new information with the CODESA, or rather to direct them further, as explained by a chief nurse (Kon.cn.1):

“The information I share is about finding children who are not vaccinated, [...] there are addresses and phone numbers that I have, and I send the list to the RECO who will, in turn, raise awareness.”

Another chief-nurse (Kin.cn.4) in Kinshasa elaborates:

“the chief-nurse must report on all activities. If curative car indicators are low, you tell the CODESA ‘this is the problem we have, and if we have it is because you are not doing your work.’”

It is interesting that the population in Kongo Central described the role of the CODESA as a ‘bridge between the HF and the population’ but not in the sense of the population getting involved in HF activities, rather as a vehicle to transmit medical information. This is certainly important and in line a few decades of experiences with community participation in biomedical health-care as promoted as by the 1977 Alma-Ata declaration and the more recent renewal of international commitments towards primary health-care in the 2018 Astana declaration.

Those cases clearly show how localised data about HF performance can be used not to collectively decide on the best course of action, but rather to impose decisions on CODESA members. In this context, when asked whether they decide on anything, the CODESA members are quite clear: “the decisions that are made, when they reach us, and they say, for instance, that we must work, well then we go and work”. (Kon.codesa.1, participant 5). There is a clearer blockage around information sharing, as explained by CODESA members (Kon.codesa.0) of the Boma Health Zone:

“we would like to know what is going on with the investments of the centre because it is our heritage, but it's become a taboo topic, we are not allowed to enquire”.

There are, however, cases in Kongo Central in which the information gathered by the CODESA is used to hold the HF into account or generate social change. In fact, the situation in Kongo Central seems to be one of CODESAs of varying levels of engagement with HF management.

The central question raised in Kongo Central by both the ‘Community Health Worker nature’ of the CODESA work (see previous subsection) and their relationship to information is whether this should be regarded as the seed for other, wider, forms of engagement. There is no clear-cut answer to this question. On the one hand, there is a long history in DRC and beyond of ‘using’ community actors to perform tasks decided at the upper echelons, without giving those actors much space to make their

own decisions. On the other hand, the Sud Kivu example, and potentially some of the dynamics observed in Kongo Central, suggest that the process is gradual and further engagement may, potentially but not necessarily arise from CHW-types of engagement. What it takes for this transition to happen is, in part, what the rest of the report, and especially the sections on Sud Kivu, is about.

Scenario 2: the better case (often in Sud Kivu)

The descriptions of the ‘information journey’ are often smoother in Sud Kivu. Even the population sometimes gives a description of the CODESA that reflects (a good understanding of) responsive, socially accountable, services (SKi.pop.Uv):

“If I have a problem with the health centre, I go and see the CODESA or RECOs. They pass on my suggestions to the HF without any problem. The CODESA represents the whole population because our problems are known by them.”

In this perspective, the information the CODESA collect is not only useful for those higher up in the health system, typically the zone of provincial officials, it is also useful because it can be actioned locally, by the CODESA itself. As a Sud Kivu chief-doctor explained:

“The information collected by the CAC in the villages can directly arrive at the CODESA, which is the community participation body. There, they will treat the problem with the chief-nurse. The chief-nurse will be aware of the problem, and the minutes will be shared with the health zone.”

In addition to the information it produces, the CODESAs of Sud Kivu also receive information from the HF. Contrary to the previous scenario, they are able –and in fact required– to act upon it, as summed up by a CODESA president: “Yes we receive information related to services and community activities. We are involved in the decisions of the health centre, whenever there are problems we get together with the chief-nurse.”

The CODESAs and chief nurses of those ‘better cases’ in Sud Kivu and Kongo Central also explain that they use community radios and have frequent phone contact between them. Those CODESAs also seem to benefit from information from third-party actors such as the CBO involved in the verification of HF performances in the PBF system: “for our part, we send them information about meetings, activity and good governance.” (SKi.cbo.Uv.2)

In this scenario, information flow is described by informants, such as chief-nurses, as going either way and being a form of loop –the metaphor of the CODESA as a bridge is now one of a two-way bridge: “the CODESA is the bridge from the health centre to the community and from the community to the health centre, so they send messages to the health centre, and they bring messages back to the community. They leave messages in the community, and they take messages back to the health centre.” (Ski.cn.Kal.1)

key point(s) 14 Information flows

- When it comes to information sharing, two scenarios have been identified. In the first one, the CODESA is simply a tool to extract information from the population and transmit it to the upper level. Then, after that information has been analysed at the upper level (chief-nurse, HZ), the CODESA is told what to do.
- In the second scenario, which was encountered more often in Sud Kivu (but it is hard to make generalisations as the qualitative data was not meant to be representative), the information from the community is still transmitted but also used by the CODESA, together with the nurses, to decide on actions and strategies.

Decisions 'rights': how influent are the CODESAs?

The more quantitative data collected over the phone are precious to understand further the role played by the CODESA at the HF. In particular, the key question is to understand the extent to which it is involved in making decisions regarding different aspects of HF management. In line with research instruments designed as part of our previous research (Falisse 2016), we asked the CODESA president and the chief nurse of each facility about the involvement of the CODESA in key domains of activity (see figures below).

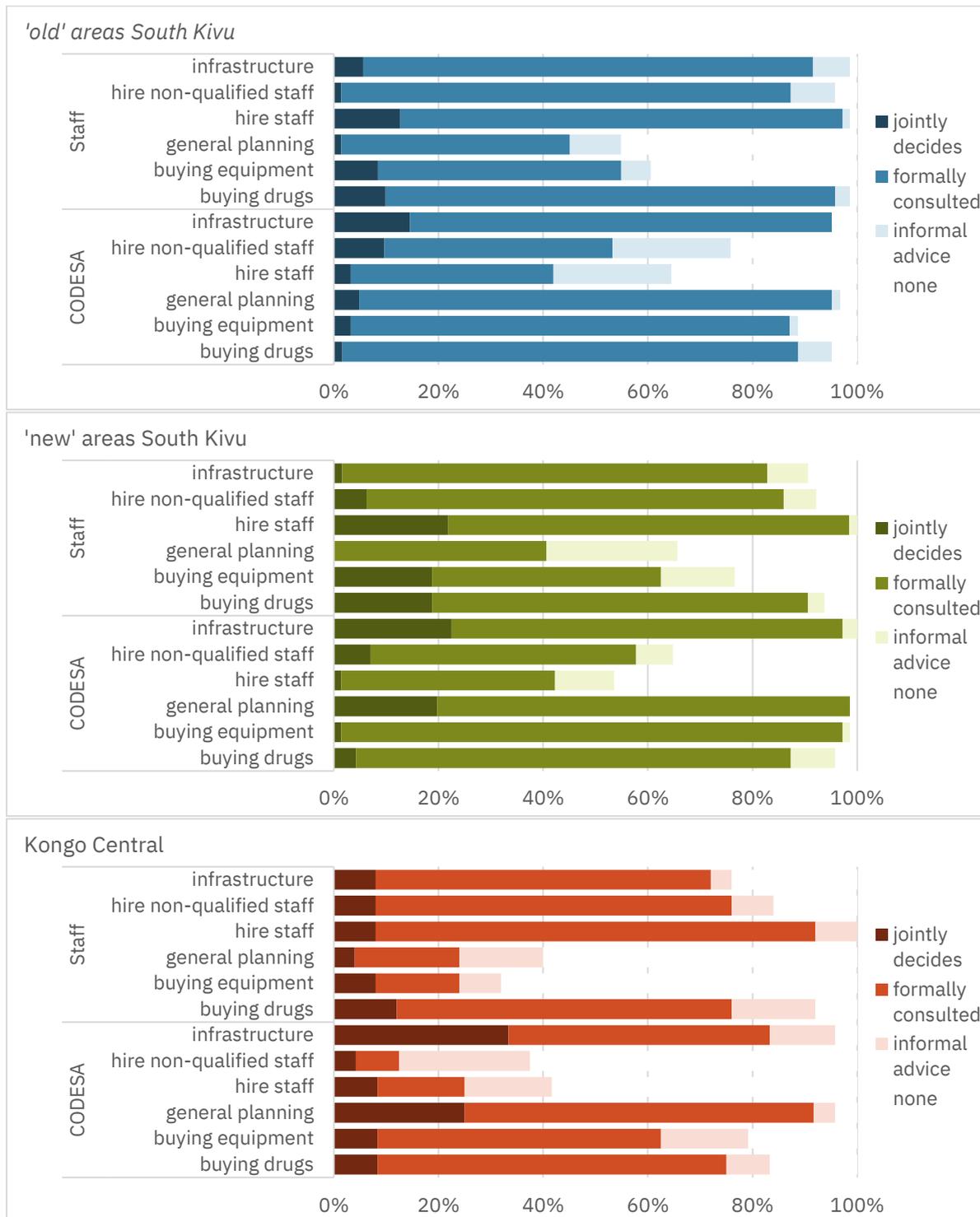


Figure 9 Decision rights at the HF, views of CODESA president and chief-nurse (staff)

/ source: phone survey with CODESA president (n=157) and chief-nurses (n=164)

The results reflect the points mentioned above: CODESA typically have more rights at the HF in Sud Kivu than in Kongo Central, and the 'old' areas of interventions are those where the CODESA as most rights, according to both the CODESA and chief-nurse. This may suggest that CODESA rights at the HF build over time.

Overall, the findings seem to support the analysis of the qualitative data on perceptions and information: the CODESAs of Kongo Central have indeed, fewer decision rights at their HF. This is bearing in mind that many CODESA presidents and chief nurses may have given the 'socially desirable' answer to this question, which is to claim the CODESA has more rights (as promoted by GPSA/CODESA) than it has in reality. The general picture, though, is one of important engagement of CODESA in HF affairs, especially when it comes to infrastructure, drugs provision, and equipment. The views on the role of the CODESA vis-à-vis human resources is a bit less clear: chief nurses claim that the CODESA is well involved but chief nurses often disagree: less than 50% of the CODESA presidents of Sud Kivu and less than 25% of those of Kongo Central say that the CODESA is formally consulted in hiring decisions.

Core activities

A similar exercise can be conducted with the involvement of the CODESA in a series of core activities, some related to social accountability and others to the CODESA members doubling up as RECO.

The table below shows the participation of the CODESA in RECO-type of activities. It is important to first note that the RECO/health promotion type of activities remain, by far, the most time-consuming commitments of the CODESA across the different contexts.

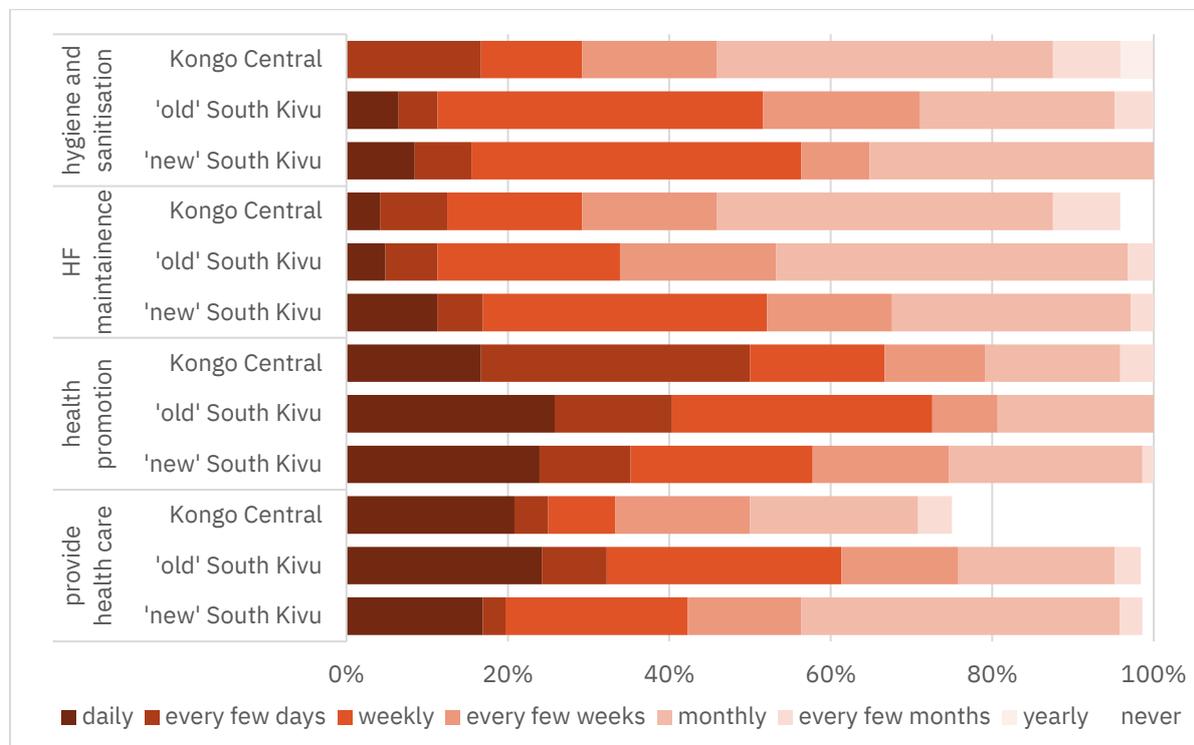


Figure 10 RECO type of activities undertaken by the CODESA

/ source: phone survey with CODESA president (n=157)

They are also the activities that are executed the most frequently. There are differences between provinces, with the Sud Kivu CODESAs being generally more active. This is interesting because they are also those that seem to have slightly more rights and play more of a role of agents for social accountability (see previous table and discussion above). It suggests that the question is not necessarily for the CODESA member to pick between being a RECO or somebody involved in HF management.

In terms of activities seen as more core to the business of the CODESA (table below), such as meeting as a CODESA and meeting the HF staff, there is no major difference between the different groups of CODESA (the Kivu CODESA seem to meet a bit more). Referring to the actual level of planning shown earlier, there is a difference between Kongo Central and Sud Kivu, with Sud Kivu more involved in planning, but maybe not to the extent that the qualitative material may have led us to think. Overall, the differences remain limited.

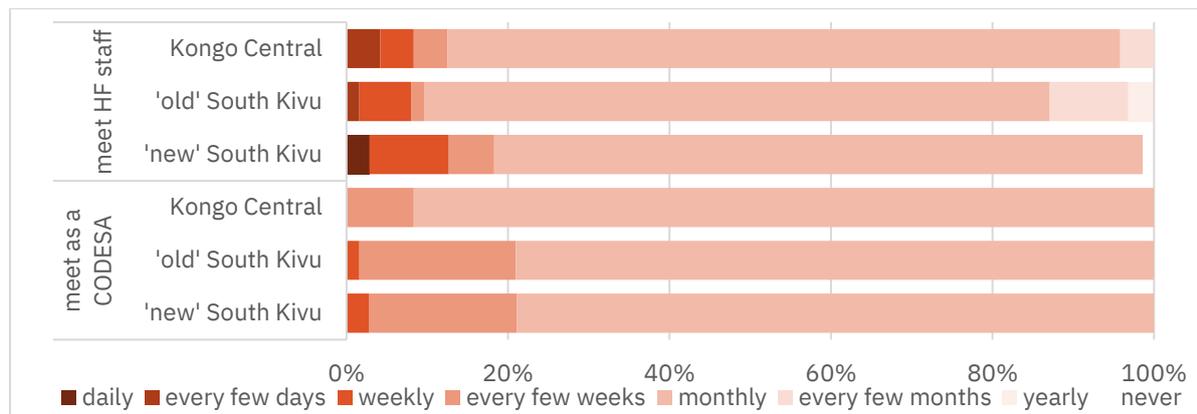


Figure 11 Interactions CODESA HF

/ source: phone survey with CODESA president (n=157)

While there is a conceptual distinction between the RECO type of activities, which are more community-based and more related to health prevention and medical information, and activities happening at the HF-level, there does not appear to be a trade-off between the two: CODESAs can be strong in both. Interviews and quantitative data alike suggest that RECO-type of activities and HF-level 'CODESA' types of activities are not antagonistic. In many cases of Sud Kivu, they almost look complementary: a strong engagement in RECO-type of activities seems to come along with CODESA members being in a better, more informed and more confident, position to meet HF staff and get involved in HF management. It is less the case in Kongo Central, where many CODESA appear less involved in HF management; this is, however, not because they are devoting time, resource, and energy working on RECO type of activities. As explained earlier, the issue is rather one of power asymmetries at the HF.

key point(s) 15 Place of the CODESA: national level

- The phone survey data confirms that Sud Kivu CODESAs are generally slightly more likely to meet and interact with the chief-nurse. They also have more decision rights at the HF, *and* they are also more involved in RECO-type of activities (health promotion).
- Overall, there is a (self-declared) relatively high level of involvement of the CODESAs in HF affairs, especially in HFs that have benefited from CODESA strengthening over time.
- There does not seem to be a trade-off between the CODESA members getting involved in HF management (social accountability role) and their role in health promotion as RECOs.

Tools for efficiency?

A key element of the GPSA/CODESA strategy was to introduce tools to help the CODESA manage their HF and engage with the population, based on the past experience of Cordaid. The tools were suggested by project, and incentivised through a subsidy (below) but they were not imposed -HFC were free to use them the way it pleased them. The Community Score Cards and CODESA charter seem to have been better picked up in the case of the Kivu. This should not be considered in a normative sense, though, as the core interest of this evaluation is not whether specific tools were adopted but rather what has changed in terms of collection and social accountability. There has been some confusion around the names of the different tools: the charter has also been called (including by project managers) 'terms of reference' or 'regulations' and the term card is not the clearest in French (see discussion below). This may explain part of the low score in Kongo Central.

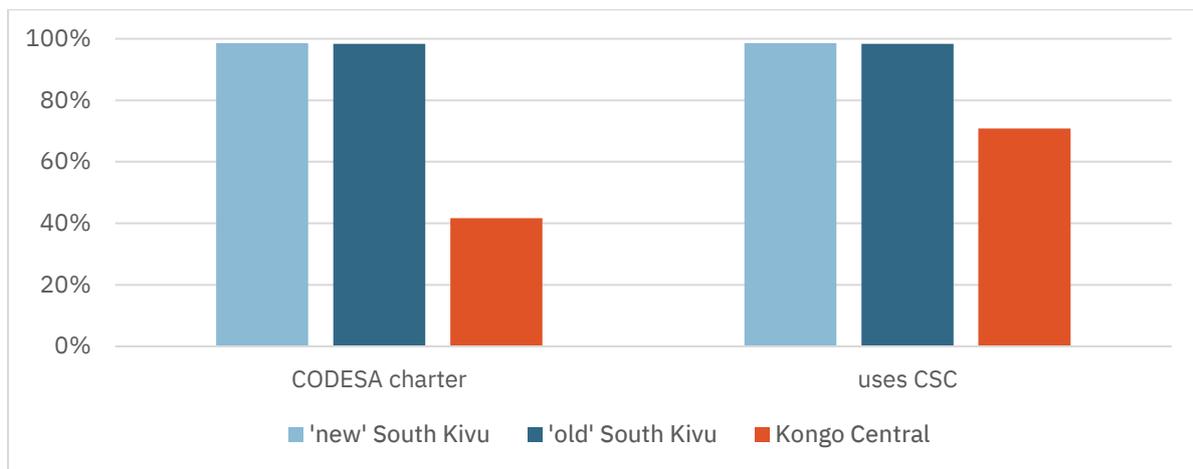


Figure 12 Use of the charter and CSC

/ source: phone survey with CODESA president (n=157)

CODESA charter

The charter is typically the one designed by the CODESA and chief-nurse as an output of the Cordaid/MoH training. Looking more closely at the CODESAs that have a charter, the discrepancy between Sud Kivu and Kongo Central remains: the Kivu CODESAs seem to use their charter more often (figure below).

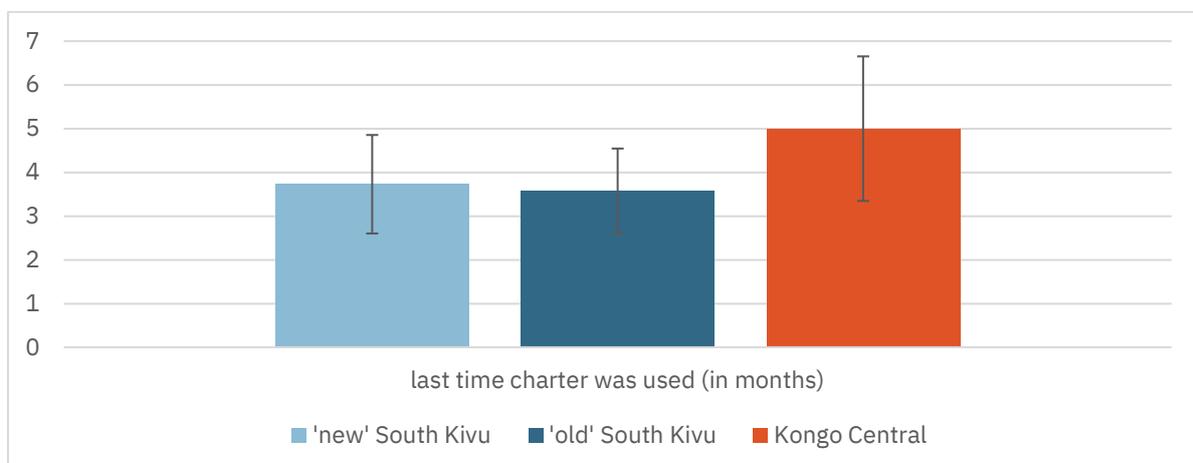


Figure 13 Last use of the charter

/ source: phone survey with CODESA president (n=157) | error bars are standard errors

The charter's main use seems to be to discipline and organise the CODESA. For instance, in a CODESA of Kongo Central, members explained that the charter stipulates that members cannot be absent more than three meetings in a row, and so it is used to expel people with a poor attendance record. The CODESA of Sud Kivu do not say anything different: the main interest of the CODESA is that it can be used to sanction and discipline committee members.

“We often use it [the charter] when there is a problem between CODESA members –for example, a member had diverted the money from the fund, we went to see the HZ chief-for instance who told us to turn back to the charter [*règlement d'ordre intérieur*] to solve this problem. [...]

[other CODESA member speaking] The charter is very useful because when the CODESA has problems, it can refer to it to solve it. If a member has made a serious mistake, he will be aware of the punishment that will be inflicted on him. The charter sums up our responsibilities and relationships to the HF and the community.” (SKi.codesa.Wal)

The charter is also used by others to help solve problems in CODESA: the HZ chief-doctor in the example above but also the HZ CODESA. The president of the HZ CODESA of Walungu mentioned two cases where the charter was used to sanction CODESA presidents who were, in one case, embezzling funds and, in the other case, mobilizing RECOs against the chief-nurse for no legitimate reason. Charters were developed in Kinshasa but the CODESA said it was too soon to say whether those were in fact useful (they had not used them, but the focus groups only took place a few months after the charters were drafted).

The HZ CODESA story is important because it shows how the charter tool is used to effectively put in place another mechanism of upward accountability: CODESAs not only need to justify their actions to the chief-nurse, they also need to do it vis-à-vis an actor that is less part of the formal health system. Adding to the CODESA system the HZ CODESA –which is rendered effective by its use of its own charter as well as the charters of the CODESA it oversees– means that more of a two-sided accountability of the CODESA is in place: it is upward (to the HZ CODESA) and downward (to the population). The relationship to the HZ authorities, which may be problematic because of the close connections between the HZ and HF staff, still exists but it is not the only form of upward accountability of the CODESA anymore.

It is important to bear in mind that in some of those HFs, Cordaid has been active for almost eight years, with a CODESA recalling (SKi.codesa.Wal):

“let's start with a little history of this CODESA. We are in place since 2008. Back then, there was no guardian here. Cordaid came to us [and the CODESA started] [...] we increased HF attendance [...] the charter [*règlement d'ordre intérieur*] is applied, as well as the scorecard. We are now very enlightened, and we even archive our data. Today you will see that we put everything in place.”

A final question regarding the charter is how much it is a tool that is strictly for the organisation of the CODESA versus, as Cordaid originally intended it, a formalised social contract between the CODESA and other parties (HF, community). The reality seems mixed: in some HF, CODESA acknowledge that what they have is not really a charter or even terms of references but rather only internal regulations (the French word *règlement d'ordre intérieur* is used a lot) which are described as crucial as “we cannot live like in the jungle” (Kon.codesa.0). Interestingly, the few examples of CODESA that are seeking legal recognition as not-for-profit organisations say that they use this document (charter/bylaws) as their founding document. There are, however, a series of cases where the charter is more in line with the original intention, with examples of it being used to help

solve problems between the CODESA and third parties such as chief-nurses or churches. A more systematic review of charters could be useful to further characterise the use of that document.

Community Score Cards

The community scorecards (see appendix for a sample) are another *key* tool introduced by GPSA/CODESA with the aim of helping CODESA structure their actions. It is described as such in many cases, for instance by a CODESA of Uvira that calls it the “CODESA compass”. In Kalehe, the prime importance of the CSC in improving the functioning of the CODESA is reported by the chief-nurse:

“really, the first thing is the community scorecard; it helps us to know the problems in the catchment area. When these problems when they are listed, we work on them progressively, and we also have deadlines for the completion of each task.”

The CODESA of the same site further adds:

“The CSC is very useful because it tells us how we work; it informs us when we have moved forward or backwards.”

In short, in Sud Kivu, the CSCs are typically described as what they are meant to be: a planning and prioritisation tool. It is also, as a CODESA explains, used in coordination between the CODESA and the nurses:

“first, we sit down to think and identify the different issues. We put them on paper and give them points. We then start working on the problems that have most points, and over time we reach the other problems.” (SKi.codesa.Wal)

Yet, there is again a clear sense that the tool is more useful, and more used, in Sud Kivu. The data on how frequently it is updated (below) confirms that story.

In fact, in Kongo Central, the CSC was often mistakenly assumed to be the map of the catchment area or a CODESA membership card (the word *carte* in French means both card and map). In another instance in Kongo Central (K.chief-nurse.1 and Kon.codesa.1) the card was displayed and seemed to be used but it appeared to be a tool used by the chief-nurse to have the CODESA act upon something rather than a tool of collective action and collective decision.

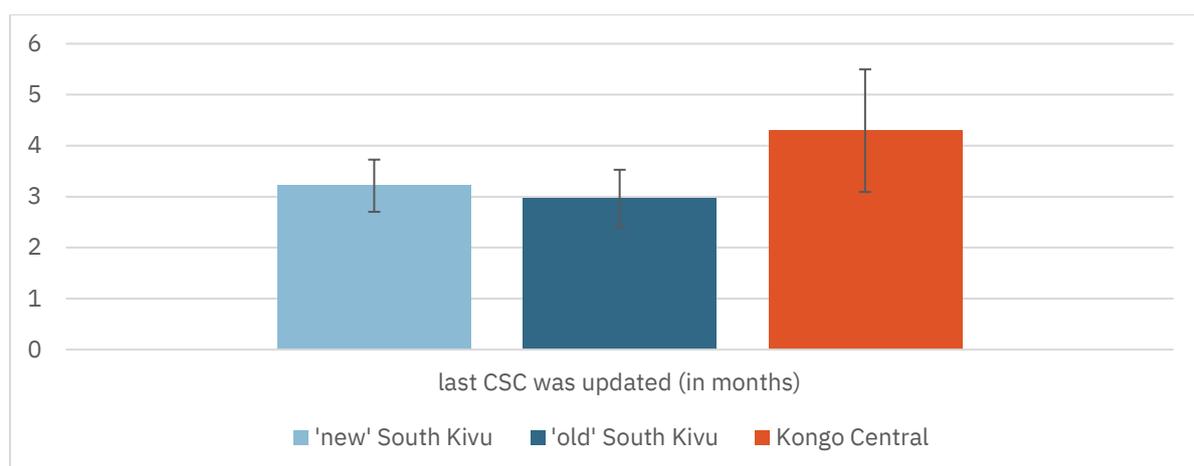


Figure 14 Last update of the Community Score Card

/ source: phone survey with CODESA president (n=157) | error bars are standard errors

Finally, it is important to point out that there is a slight risk that, in some instances, the CSC is established in isolation from the rest of the community and becomes the instrument for a technocratic confiscation of power:

“previously, decision-making was done in collaboration with the community. [using the CSC] The current CODESA and chief-nurse forget that a single individual cannot make a decision and search alone for a solution.” (SKi.codesa.Kal)

The issue here seems to be that not all CODESA revert to their communities once priorities and actions have been penned out. Our data does not allow to give a fined grained picture of the situation, but the conditions for having a formal feedback on the scores cards are only met in around 85% of the CODESA (those that meet with the population at least monthly, as shown in Figure 6.

Overall, CSC appear to have been used in the way Cordaid expected the CODESAs to use them. Because the use of scorecards was incentivised by GPSA/CODESA, and because there is not good counterfactual (no CODESA without cards), the exact contribution of the scorecard to CODESA strengthen is hard to assess. One would simply expect that CODESA create cards and update them, if only to be paid the small fees. Most stories are positive, though, and the CODESAs seem to update their cards more often than one would if they were simply trying to game the system. There are also unintended consequences —such as the case where the CSC is used by the HF to discipline the CODESA.

Subsidy

A question that regularly comes to the fore is the payment of the CODESA. GPSA/CODESA has introduced a more systematic way of funding the functioning of the CODESA, but it is not quite clear where the money flows: it seems that in many cases it is redistributed to CODESA members. Before GPSA/CODESA, multiple practices existed, including giving the CODESA 5% of the HF revenue, as initially suggested in the PBF system (Kon.codesa.0). It must be noted that none of those practices were part of the official World Bank funded PBF system implemented from 2015 (there is no mention of the 5% or any CODESA subsidy in the PDSS documents).

It is hard to see with clarity the effects of the subsidy. Recent literature suggests that paying CODESA members does not make much of a difference (Lodenstein et al. 2017) and in terms of this research, two issues came out: (1) it is hard to see the effects of the incentive mechanism since, as shown in section 1 of this chapter, the subsidy is often the fact capped and the variance between committees is limited and (2), and perhaps more importantly, it is just really hard to meaningfully discuss the question of payment with CODESA members. No matter the way of introducing the research, external investigators are always seen as scouts for aid organisations and the answer to the payment question is always that there is not enough of it (when it does not come with a long wish list of items whose connection with the CODESA’s activities is sometimes far from obvious).

Ultimately, and in line with previous research, it seems that many CODESA members and RECO still hold to the hope that this position may be useful to secure some income or revenue. It is never cited as a prime motivator, but the idea often transpired through the interviews and focus groups.

Collectively, the charter, score card, and subsidy seem to have helped the CODESAs organise, which is quite crucial when considering the place the CODESAs have come to occupy in Sud Kivu (see section 2). The CODESA came to be regarded for their capacity of action, which seems partly related to the score card and charter. The tools are generally used in the way intended by Cordaid, with some notable deviations. The cases of ‘misuse’, or rather use in a way that is not beneficial to

the CODESA, remain a minority. The new tools also come along with tensions, but it seems that those has often been latent for a long time and then took a more visible form when the charter was introduced, which could be argued is in a sense useful to help the CODESA move on.

key point(s) 16 CODESA tools

- The charter’s main use seems to be to discipline CODESA members and organise the CODESA. Less frequently, it is used to solve issues with third parties. A more systematic examination of charters would help understand whether they are CODESA bylaws or proper social contracts.
- Other parties such as the HZ CODESA and HZ authorities have been using the charter to hold into account CODESA members, thereby creating unexpected new channels of accountability.
- The community scorecards are defined as the most useful tool of the CODESA and its ‘compass’, across contexts. In rare cases, they were used as an excuse for the CODESA to bypass HF users (they would no revert to citizens after having drafted the scorecard).
- Overall, the tools provided to the CODESA are key for its organisation (and its capacity to hold the HF into account), but there are some question marks around whether they deepened the relationship between citizens and HF/CODESA.

A reinforced CODESA?

This section has already pointed out to improvements in the way the CODESA system functions. The perceptions of the CODESA members vary across provinces: they seem to have a more central place and are less ‘exploited’ by the nurses, in Sud Kivu. They also claim –and seem to have some decision rights– at the HF, and this is not necessarily excluding them remaining involved in health promotion and community mobilisation activities. The charter and CSC seem instrumental in ensuring that the full potential of the CODESA is achieved.

The last element worth considering is the perception of how CODESAs have changed since GPSA/CODESA. The qualitative research shows that chief-nurses systematically point to improvements in the way the CODESA functions and its more central place at the HF, even in Kinshasa where the intervention was brief: “[the main change at our HF] is the involvement of the community in the HF development” (Kin.cn.4).

Overall, as expressed by this CBO leader in Kongo Central, there is a clear sense that the CODESA is now a lot more able to do their work:

“they are considered, they are recognized by people who know who they are. This further motivated them in being good CODESA and to take care of activities they have themselves generated.”

The quantitative data is also useful to explore this issue. When asked what the most significant change at the HF has been (see figure below), the CODESA and chief-nurse, the items that came first included the HF usage (number of visits), the rehabilitation of infrastructures and access to health care. The answer to this question was free and coded during the analysis phase. The category ‘range of services’ reflects the opening of new service at the HF, for instance, forms of Accident & Emergency (A&E, *permanence*). ‘Epidemic management’ is the observation that endemic diseases seem to be declining –for instance, malaria or sleeping sickness (Kongo Central) or cholera (Sud Kivu). ‘Equipment and staff’ reflect changes in the non-financial resources available, while ‘income-generating’ reflects an increase in revenue either through patient fees or through activities set up by the CODESA or HF (farming, etc.). The big ‘HF usage’ categories is when CODESA

presidents / HF chief-nurses explain that there are simply more people going to the HF, while the 'general access for all' is when they mention specific mechanisms for improving access to specific groups (e.g. indigents, pregnant women, 'poor').

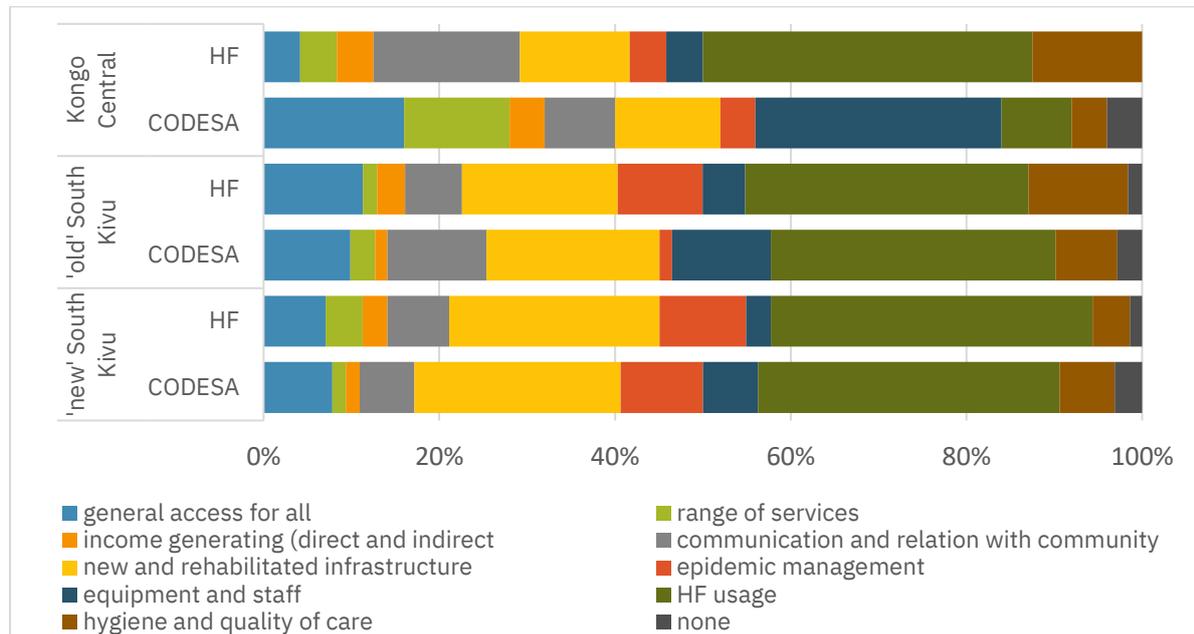


Figure 15 Most significant change at the HF

/ source: phone survey with CODESA president (n=157) and chief-nurse (n=163)

There are differences between the point of view of the chief-nurse and the point of view of the CODESA president in the case of Kongo Central. In Sud Kivu, the most significant changes are remarkably consistent across groups. This may suggest that the most significant change is so significant that it is reported by both parties, despite them having different points of views.

The link between those improvements and the action of the CODESA is clearly established for 97.4% of the CODESAs and 96.5% of the chief-nurses that were interviewed. They also point out to the first possible channel through which they improved the HF (see below):

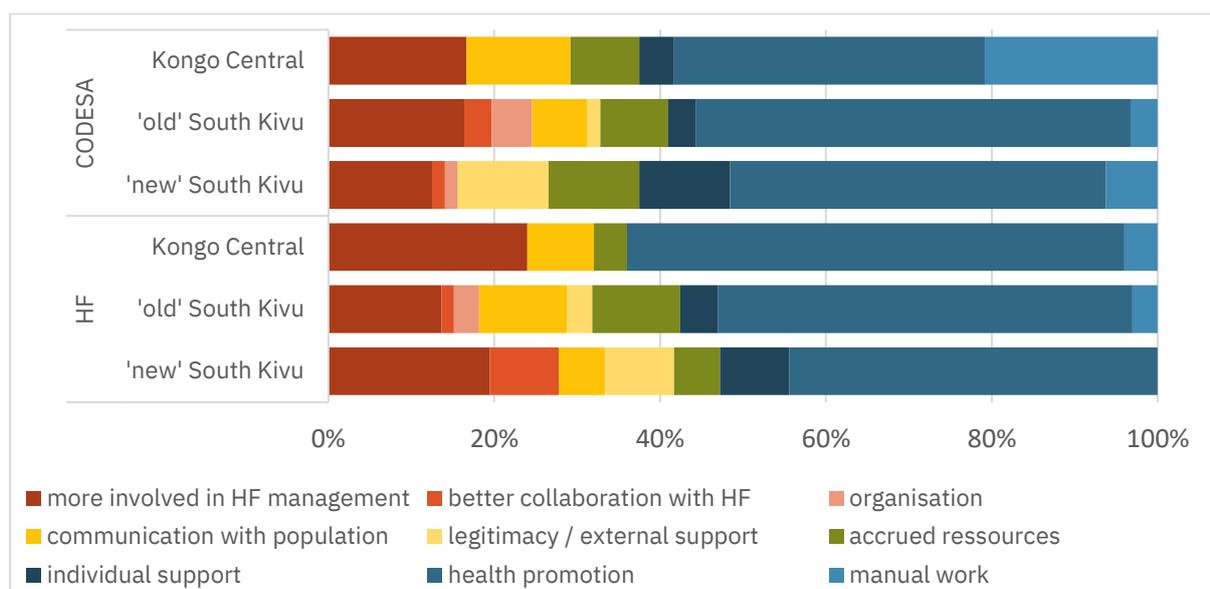


Figure 16 Reason the CODESA is behind the most significant change at the HF

/ source: phone survey with CODESA president (n=157) and chief-nurse (n=163)

In very first position come activities related to the RECO-package: support to individual patients who need to be accompanied to the HF, general health promotion, and manual labour to improve the HF and its surrounding. Then comes, in 18 to 28% of the cases, the improvement of the CODESA per se: its organisation but also its involvement in HF management via collective decision making or better collaborations between the HF and CODESA (often cases where the respondents said there are fewer conflicts). The third category covers the relationship between the CODESA and third parties, such as the population or health authorities that have increased its legitimacy. Finally, the CODESA is also, in a handful of cases, associated with accruing the resources available, often CODESAs setting up community health insurance or starting income-generating activities.

Overall, this suggests diversity in the ways in which the CODESA changes local dynamics. Most still relate to RECO type of activities, but in 35% to 45% of the cases, it is 'the CODESA being more of a CODESA' –and, therefore, possibly the GPSA/CODESA intervention– that is associated with the change. Those findings would benefit from being triangulated by other studies but they are, overall, very encouraging in terms of the potential of social accountability reinforcing the health system from the bottom.

This idea is further confirmed by a last piece of evidence from the quantitative data: the most significant change in the CODESA, still according to the chief-nurse and CODESA president (figure below). Again, the survey let the participants free to answer what they wanted, and categories and families of categories were created for the analysis. The first family encompasses strict CODESA reform: an increased involvement in HF management, better collaboration with the HF, and a general sense that the CODESA is a more dynamic and better organisation. The second family of significant change is around resource mobilisation, often cited in the older public health literature (Rifkin 1986; Rifkin, Muller, and Bichmann 1988) as a key evidence of effective community participation: assisting with the rehabilitation of the HF and the construction of new infrastructure; setting up income-generating activities to help patients, CODESA members, or the HF; purchasing and installing new equipment, including for instance solar panels; and facilitating access through loans or community health insurance. The last family (in blue) is more related to changes in terms of improving health promotion.

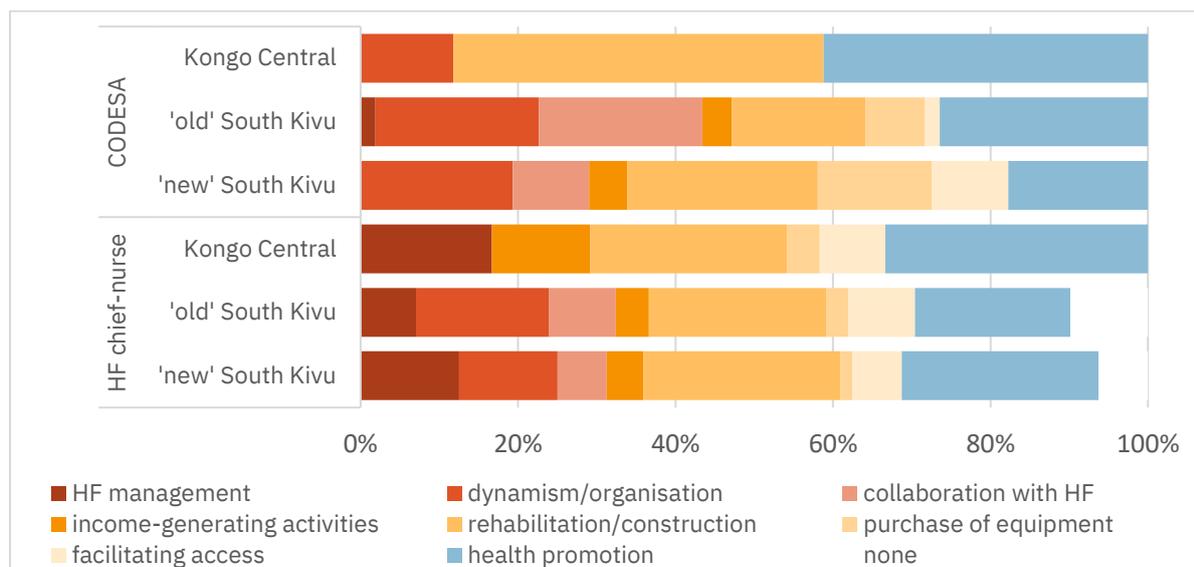


Figure 17 Most significant changes at CODESA-level

/ source: phone survey with CODESA president (n=157) and chief-nurse (n=163)

The most interesting finding, which echoes some of the earlier findings of this section, is that the main positive *changes* –as opposed to main activities– are, in over 60% of the cases, happening in areas that are not related to RECO activities. This is valid even in the case of Kongo Central, where the qualitative research has shown difficulties in perceiving the CODESA as anything else than a group of community health workers. Overall, this suggests that important change is ongoing, towards making the CODESA a real actor at the HF. It is useful to note that we could not formally directly link this to changes in the quality of or access to services: respondents often suggested such links but the study design does not make it possible to assess such causation.

key point(s) 17 Most significant changes

- Phone survey data looking into the most significant change happening at the HF in the last three years finds 96.5% of chief-nurse explaining that the CODESA played a role in this change. In 35% to 45% of the cases, it is ‘the CODESA being more of what the CODESA guidelines say it should be’ (e.g. CODESA organisation, meetings with the different parties, etc.) that is given as the channel through which the change took place.
- Over 60% of the most significant changes that have happened at the CODESA are related to the CODESA becoming a more dynamic and better organisation that is actively involved in HF management.

4. REHABILITATING HEALTH FACILITIES THROUGH GPSA/CODESA

The discussion of the most significant changes at the HF and in the CODESA has already stressed the centrality of activities of rehabilitation activities. This in part through a mechanism of matching grants organised by GPSA/CODESA. Section 1 has already discussed the difference in the modalities of grant provision between Sud Kivu and Kongo Central. This section will explore the trends in the types of ‘micro’ projects, as well as the processes through which the CODESA decides about their project and then implement it.

It is important to note that the matching grant part of the project took a liberal view of HF rehabilitation: it included not only the physical infrastructure but also the broader idea of rehabilitating the place of the HF in the community –which includes questions of access and resources available to those working at the HF. In this document, though, we use ‘rehabilitation’ to qualify infrastructure work.

Types of projects

Full information on the nature of the projects was only provided for the province of Sud Kivu, the information for Kongo Central is only on 13 projects from 9 HF.

Using the titles of the projects proposed by the CODESAs, we find that a majority of HF, the CODESAs decided to carry out a project that had to do with physical rehabilitation, either via refurbishment, or construction or buying new equipment (see figure below). In at least one case in Kongo Central, the money was used for legal action to recover the property title of the land on which the HF was build (land disputes are a considerable concern in many parts of DRC).

There is a neat different between the areas where Cordaid had previously intervened and the new areas, which is largely artificial as GPSA/CODESA pushed for projects in favour of the ‘indigents’ in the ‘old’ catchment areas (see next section). The ‘natural’ preference of the CODESA is, in the complete sample of Sud Kivu, heavily skewed towards infrastructure and equipment.

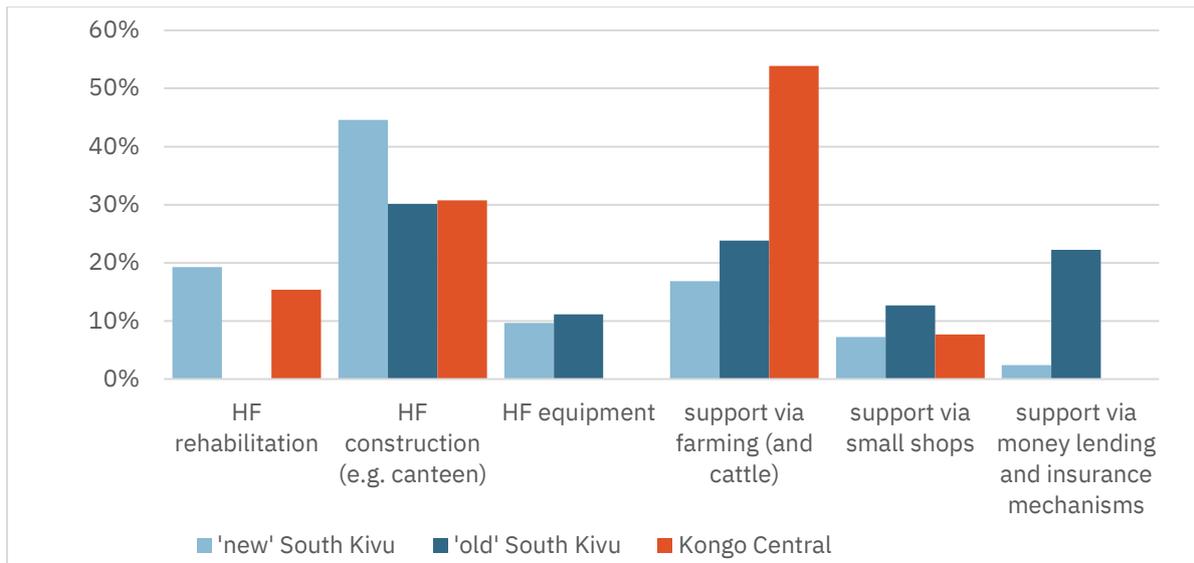


Figure 18 Type of projects

Cordaid’s data also provides insights into the financial amount committed by the CODESA (for South Kivu only), which is obviously constrained by the minimal community input required by Cordaid (see section 1) but nevertheless reflects the ambition of the CODESA. Cordaid’s data is not entirely clear whether amounts are all in cash or may also include the value of in-kind contributions. It is interesting to note that (in addition to minor problematic projects that seem to have very little community funding), even if the median is slightly higher in the case of the ‘new’ areas and even if those areas see to have few outliers of projects with very high community contribution, there are more projects where the community commits more than the mandatory 30% in the ‘old areas’, which could be because the CODESAs are now more at ease with the process. Overall, though, and probably not surprisingly, most CODESAs do not go beyond the level of participation that is expected from them (30%).

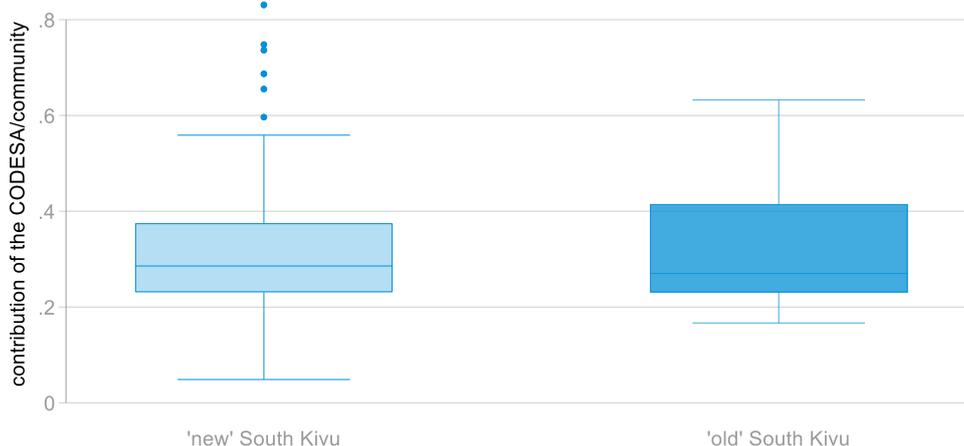


Figure 19 Ratio amount committed by the community/value of the project

/ total of 146 projects. Boxes encompass the projects between the 25% and 75% percentiles, with the line in the box being the media. Error bars indicate the range between 5% and 95% percentiles. Dots are outliers.

Some criticised the amount of money offered through the matching grants. As participants to a Kinshasa CODESA focus group (part of the pilot activity implemented by AAP Kong Central and Cordaid) explained the amount of money is probably too low to get a project done in some areas,

especially in more expensive urban areas: “what can we do with USD 140 [it is unclear where that amount came from, as not USD 140 grant was recorded, but the point remains valid]? This is the reason the well and shed are not finished; there is no money anymore”.

Perceptions and implementation of the matching grants

Generally, there is a sense that letting the CODESA decide what should be done with the matching grant is the best approach. Some of the decisions, such as building separate office to host the CODESA may seem surprising at first sight but they actually reflect local needs –for instance, a CODESA office helps making it independent from the HF staff, which is crucial if it wants to monitor it. As the chief-doctor of Walungu Health Zone explained:

“as I said, let people have the autonomy to manage themselves. These grants allow them to create income-generating activities, for instance, and these income generating activities now strengthen them. They have started sustainable activities so, now, they have to have something, a starting point. So it is not eaten up [*mangé* – a Congolese way of saying that money distributed for the public purpose has been dilapidated or embezzled].”

There is also, in what different officials expressed, a sense that some level of risk with the matching grants is perfectly acceptable, but that more guidance could be provided in turning the projects into more sustainable projects:

“Well, these are tests, eh! These are tests [...] it is up to them to make this thing last. [...] We need to focus more on investment stories; investment is what matters.” (Ski.hz.Wal)

The implementation of the grant activities was overseen by CBOs. As explained earlier, in practice what they did was not only evaluating the projects, it was also providing both the HZ/Cordaid and the CODESA with very practical suggestions as to how to improve the functioning of the CODESA and the matching grant projects. A key, and commendable, feature of the reports sent by the CBO is their critical stance. Once, for example, read, regarding a project funded through GPSA/CODESA:

“In our analysis, reselling phone units is a project whose impact is not very visible in the field, and presents many dangers. It looked a grossly unprepared to us. In the interviewers' opinion, some CODESAs tend to lie in order to obtain compliments, which does not advance the development of the social and health milieu of the community.”

We could only access the reports for three health zones; they did not point to major issues with the matching grants. Yet, even the last reports point out that many of the projects are still not finished.

Infrastructure work at the HF is reported as the main achievement of the CODESA in the past three years has been –note that this is different from asking what the most significant change is, either at the HF or in the CODESA. As shown in the figure below, it is the ultra-dominant category across categories of respondents and across regions. Contrasting the figure with the data on the type of matching grant project presented earlier, it is clear that a lot of the HF rehabilitation is happening outside the matching grant mechanism. What the figure fails to encompass, though, and which was poorly captured in the phone survey, is the size of the rehabilitation –which is possibly larger in the case of CODESA that received a grant.

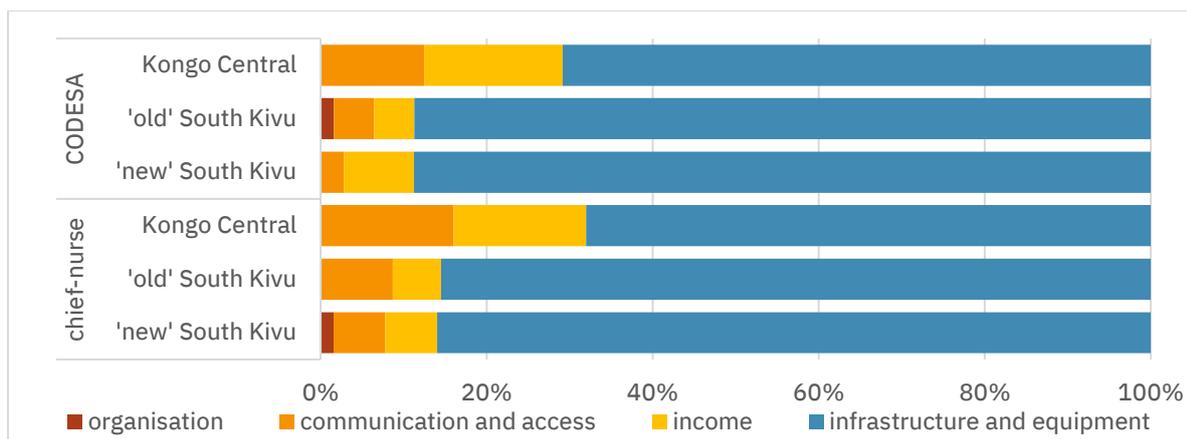


Figure 20 Most significant achievement of the CODESA in the last three years

/ source: phone survey with CODESA president (n=157) and chief-nurse (n=163)

Similar observations also emerged from qualitative research. As a chief-nurse noted (SKi.cn.1):

“For us the change in the last three years... you can first see the external aspect of HF, it is not only the work of the HF, but it is the strength of the CODESA through small subsidies. We even changed the roof of the house of our maternity; there is also the ceiling that we started at the maternity... there was neither frame nor ceiling.”

The centrality of the physical infrastructure in the general outcomes of GPSA/CODESA may be explained in different, possibly complementary, ways. First, an assumption of the project, which is amply documented, is that the health infrastructure is poor in most of DRC and it is simply one of the most urgent, but also more immediately tangible, things to do. This is in fact in line with the impact evaluation of CSF/CODESA, which did not include matching grants but nevertheless suggested that freshly reorganised CODESA first acted on relatively low-hanging fruits, such as infrastructure, which are much easier to achieve than more complex questions around the quality of care or the responsiveness of service (that are typically envisaged as the core business of social accountability mechanisms). Secondly, there is also a sense that the CODESAs are yet to prove to the HZ, Cordaid, the population, and, above all, the HF staff that they are worth it. Significantly improving infrastructure, which is what more than half of them do with the matching grant when given a choice, is a way of rapidly and very visibly improving their legitimacy.

key point(s) 18 Rehabilitation of HF

- There are many different ways in which the CODESAs contribute to the rehabilitation of their HF via the matching grants. The focus is often on the construction of new infrastructure. All interviewees agreed that the projects were usually appropriate, although the understanding was also that the matching grant could be used to ‘risk’ something new. There is some uncertainty about the level of completeness of some of the projects.
- Infrastructure and HF rehabilitation was not confined to matching grants. In fact, a lot of CODESAs engaged in such activities without a matching grant. It might be because infrastructure is a lower hanging fruit than HF management and provides a lot of visibility to the CODESA.

5. SOCIAL INCLUSION THROUGH GPSA/CODESA

The ability of the CODESA mechanism to genuinely benefit the poorest was at best unclear after CSF/CODESA: the results showed that poorer people had limited access to the CODESA and, more importantly, were frequently denied primary health-care (Falisse, 2019)(Falisse 2016)(Falisse 2016)(Falisse 2016)(Falisse 2016)(Falisse 2016). To what extent could the successful CODESA system benefit disadvantaged community members?

The disadvantaged categories of the population may include a wide range of individuals but, in the context of the DRC, one group strikes as quite central: the so-called ‘indigents’ (*indigents*) who are a legally-recognised category of people in need in the DRC. They are typically identified by the CODESA, or other community actors and the state officially guarantees them free health-care and free education. In practice, though, impoverished schools and health facilities frequently fail to meet obligations towards the ‘indigents’ (Ponsar et al. 2011). The first phase of the pilot project documented below study has shown the difficulty for them to claim their rights when they live in dire poverty, in an already impoverished context –without material and social means, charity is often all they can hope. Our survey of over 2,150 such ‘indigents’ (see the section ‘Key Findings of the Pilot Evaluation’) confirms the very critical conditions the ‘indigents’, a majority of whom are women, live in: 78% say they suffer from hunger, 28% are severely disabled and, overall, their average levels of disability (WHODAS-12 index) and depression (PHQ-9 index) is well higher than 85% of the population. In this context, it is often the CODESA members and the community health workers or *Relais Communautaires* (RECO) who are the best positioned to help the ‘indigents’ access to health care.

GPSA/CODESA led to the implementation of two main activities towards the indigents: (1) the inclusion of indigents as CODESA members and (2) the promotion of activities of social and financial inclusion in a pilot project in the ‘old’ areas of intervention. The next section considers the first activity and the general inclusion activities undertaken by the CODESA.

General inclusion activities

A key change that has been noted by both Cordaid project managers and representatives of CBOs is the change in the composition of the CODESA throughout the project:

“It is important that young people are made aware of being members of CODESA, all intellectual layers, traders, politicians in order to face the problems that arise in the community” (GPSA/CODESA project manager)

This being said, the CODESA is still far from including a reasonable proportion of the different groups that make up Congolese society. On gender, for instance, CBO reports point to necessary efforts. This issue has also been highlighted in earlier work, in CSF/GPSA and CODESA II, and GPSA/CODESA insisted that at least 30% of committee members are female, but this does not seem sufficient. When not purposefully sample, most ‘natural’ respondents (who in the CODESA would come to the focus groups) were male.

It is reported at the provincial level that a fair representation remains an issue for two main reasons: (1) extreme poverty is making commitment to the CODESA challenging, with many members giving up when they realise there is little money to be made; and (2) the chief-nurse often keeps designating the RECO –so even if 98.09% (154/157) of the CODESA surveyed said they were elected (in Kongo Central, two committees were not elected, and one was only elected in part) the pool of potential candidates, since CODESA members must be RECO, is biased.

On the question of the indigents, though, CODESAs seem to have come a long way. Integration in the CODESA is seen as a key vector for improving the situation of the most marginalised, as explained by the members of a CODESA of Sud Kivu (SKi.codesa.Kal):

“These people were unassisted, and it was difficult for them to integrate into our community. The only way to help them was to participate in our activities as CODESA.”

The issue seems to have been one of accessing parts of the population who, despite living in the same place as CODESA members, are effectively living in very different social circles. As the chief-doctor in Walungu, the integration of the intervention is good because “indigents know better about the lives of other indigents, and so an indigent can plead for other indigents”. The interviews with the CODESA and indigents are not entirely as to how much the integration is, effectively, giving a voice to the indigents –the direct observation of CODESA discussions would be helpful.

Change is clearly underway in some HF. As suggested by a focus group with indigent people in Sud Kivu, the GPSA/CODESA activities, and in particular the pilot interventions described in the next section, may have created more opportunities in engaging in decision making with the indigents. One of the focus group members explains that when came the time to decide what to do:

“We, the indigents, we were gathered. We were asked if we wanted money in cash or animals instead. We opted for the animals: money can be consumed in one day, but rabbits or guinea pigs remain for a long time. They serve us anytime we have no one to help us.”

Among the changes are also interventions in favour of the indigents and most vulnerable, as reported in section 3. A participant in a population focus group in Walungu, explains:

“Yes. The first change in the actions of CODESA there is this love and this pity for the poor. In recent times, when a poor man has failed to pay for his care, CODESA has repeatedly begged the HF to treat those in difficulty. They would pay for them later after. For others, CODESA members have paid.”

As the figure below shows, paying for indigents care is taking place (with a frequency that varies) in 40% of the HF.

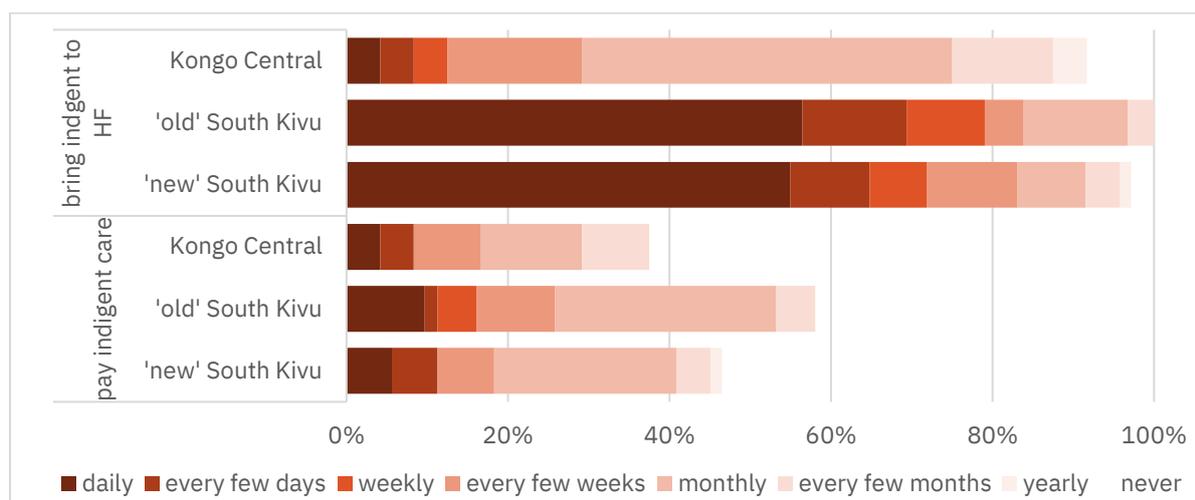


Figure 21 Pro-indigent activities (according to the CODESA president)

/ source: phone survey with CODESA president (n=157)

There are three main ways this is achieved. First, as explained in section 1, some CODESA members simply pay out of their pocket (or via their self-help group, but this remains their own money). Second, some CODESA, as it has already been touched on, have developed income-generating activities whose aim is to directly pay for the indigents' care. Third, some fee exemption (or payment by another party) is achieved through negotiations with the HF, HZ, or partners. In theory, the latter should be what should be happening given that by law the indigents are entitled to free health-care, but the CODESAs also know that the HF are rarely compensated (by the Ministry of Health or other funders) when giving free health-care. As the Kalehe HZ CODESA explains:

“On the sanitary side, despite the difficult economic situation, we tried to reduce the billing. We lobby partner that comes to the HZ. They support us in medicine and thanks to these drugs, there is a reduction in the cost of medical care.”

Key findings from the pilot evaluation

In the 'old' intervention areas, GPSA/CODESA experimented with two approaches to better integrate the indigent in the health systems: (1) one is through matching grants that are specifically devoted to indigent support and (2) the other one is through the (subsidized) facilitation of indigent-CODESA meetings where the indigents can seek social support when trying to access health care. Despite a short implementation period, the interventions —evaluates through a randomised control trial in 80 HFs (2,160 indigents were surveyed each round). Both interventions in favour of the indigent have had a concrete and measurable impact on the indigents: they feel healthier, face fewer barriers accessing to the health centre, engage in fewer catastrophic expenditures, and are more part of the social fabric. The combination of the two interventions is the most effective. The social intervention and the combination of both interventions have a clear negative effect on denial of access to care (between -5.3 and -6.5 percentage points, significant at $p < 0.05$). The combination of both interventions, but not the interventions taken separately, is found to have a positive effect on subjective measures of well-being: the effect is + 0.21 standard deviations for physical well-being ($p < 0.1$) and +0.25 for mental well-being ($p < 0.05$). Those findings are quite encouraging given that the project was implemented for less than a year.

A more detailed summary of the findings is below

/ This subsection is adapted from the executive summary and findings section an earlier report sent to Cordaid in December 2018.

Falisse, J.-B. (2018). *Etude d'impact des interventions de soutien aux personnes vivant en situation d'indigence interventions mises en place par Cordaid dans le cadre du projet CODESA/GPSA dans les zones de santé de Katana, Miti-Murhesa, Idjwi et Walungu en province du Sud Kivu (RD Congo)*, Bukavu : Cordaid

Background and evaluation design

After a preliminary study (Falisse and Mirindi 2016), Cordaid decided to pilot two interventions to support the indigents.

- (1) The first intervention sought to integrate the indigents into the existing CODESA system better : a 1-day training session involving CODESA members, HF staff members, and indigents was organised, and followed by monthly meetings between the CODESA and the indigents –a US\$ 25-compensation per committee per semester was provided to cover the CODESA's expenses. The idea of this so-called 'social' intervention is to bring the indigent person closer to the community and CODESA, hopefully leading to changes in the behaviour of both parties. Potential channels include accrued information, higher interest of the CODESA to defend the indigents' rights, and higher social integration of the indigents.

- (2) The second intervention is financial and is a more direct support to the CODESA so that they can compensate for the health facilities for the care of the indigents. To make this sustainable, matching grants of US\$ 500 were offered to the committees who had to come with a compelling project, often an income-generating activity, in favour of the indigents (and which would demonstrate in-cash or in-kind contribution matching Cordaid's). Here the expected channel to impact is through reassuring the indigent that they can go to the health centre without financial risk.

The piloting of these two interventions was randomised across the 80 health facilities (around 10,000 indigents) of four health zones where the CODESA are known to function well: Miti-Murhesa, Katana, Idjwi, and Walungu. 20 randomly selected HF benefited from the social intervention, 20 from the financial intervention, and 20 from both; 20 were kept as a control group (factorial design). It must be noted that this was only for an initial 1-year period; all HF would eventually benefit from all interventions after the pilot period (pipeline design). Before the interventions, a survey was carried out among 27 indigents living in the catchment areas of each of those 80 health facilities. It was repeated in September 2018 and came along with qualitative interviews and a survey of health facility chief-nurses. This Randomised Control Trial (RCT) design of the study guarantees a state-of-the-art robust impact evaluation. The main outcome variables of interest are the indigents' well-being, access to care, and social integration.

Although the initial workshops launching the two interventions in the communities took place in June 2017, it must be noted that it was not before February 2018 that the matching grants and compensations were released. Therefore, the end-line data collection had to be postponed from May to September 2018 to capture at least some of the interventions' effective implementation.

The interventions were preceded by an update of the indigents' lists in each health facility. It is interesting that this first stage, whose effects were not evaluated, was reportedly highly appreciated by all parties who find the list very useful to recognise the indigents. However, respondents also indicated that the updated lists were not enough: they make a discussion about free health-care entitlement possible but do not guarantee a favourable outcome, especially if the CODESA is not present and/or in cases when the health facility is in a position to argue that taking care of the indigent jeopardises its already shaky finances. At the time of the study, it was financially disadvantageous for facility managers to exempt the indigents. It is interesting to note that the PDSS programme has taken interest in this issue (although the solution found at the hospital-level seems more convincing than the one found at the HF-level).

Main effects and discussion

Overall, both interventions yielded positive results regarding access to care, social support, and well-being. Those results are generally robust to different specifications, and they are especially encouraging given the delays in implementation.

The interventions have a positive, but non-significant, effect on the propensity to go to the HF when feeling unwell. The social intervention and the combination of both interventions have a clear negative effect on denial of access to care (between -5.3 and -6.5 percentage points, significant at $p < 0.05$): when provided social support, indigents are less likely to be turned down at the health facility. Similarly, the social, and even more so the financial intervention, had a negative effect on catastrophic health expenditures and catastrophic work. When benefiting from the intervention, the indigents are less likely to have to resort to selling goods or take up work that they struggle doing to pay for their medical expenses (the effect is -8.4 percentage points for catastrophic selling, significant at $p < 0.1$, in the case of the financial intervention).

The social intervention also had a positive impact on the number of people the indigents interact with and the likelihood to be a member of a solidarity group (+6 percentage points, significant at $p < 0.1$). The effects in the case of the financial intervention and the combination of both are also positive but not statistically significant. They suggest that combining the two interventions may add to the workload of the CODESA to the extent that they cannot work fully on both interventions and/or that there is a ceiling in terms of what can be achieved through these interventions. In fact, the qualitative research revealed the need for interventions that are even more holistic, with many interviewees pointing out that without a substantial push on other key elements –and, in particular, nutrition– lasting and decisive change will be hard to achieve.

The combination of both interventions, but not the interventions taken separately, is found to have a positive effect on subjective measures of well-being: the effect is + 0.21 standard deviations for physical well-being ($p < 0.1$) and +0.25 for mental well-being ($p < 0.05$). Those results are stronger in the case of the indigents who suffer from greater disability at the baseline level. Note that there is no impact on the more objective indicators based on the PHQ and WHODAS grids, which are known to change less easily. It is important to qualify these encouraging results: they require a real combination of social support and financial support to be visible.

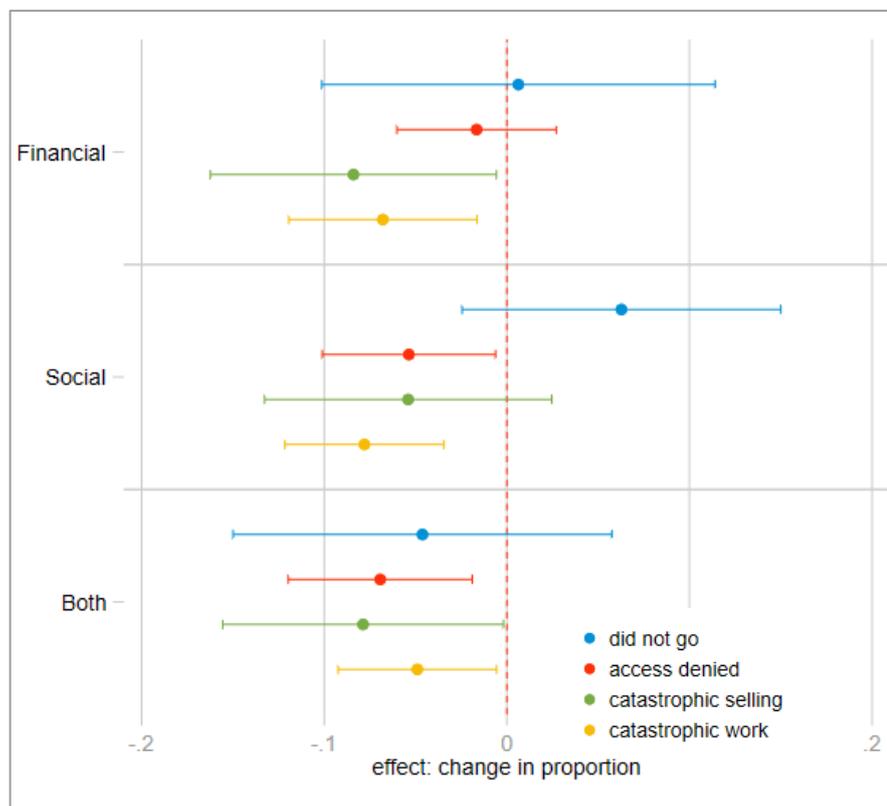


Figure 22 Effect of the pilot interventions on access to HF and health-care

Both interventions in favour of the indigent have had a concrete and measurable impact on the indigents: they feel healthier, face fewer barriers accessing to the health centre, engage in fewer catastrophic expenditures, and are more part of the social fabric. Cordaid's interventions were a first attempt to integrate the poorest into the process of social accountability of health committees. One of the main challenges was to give them more 'voice' at CODESA level: this was done through regular consultation meetings that seem to be bearing fruit. This is, however, is not enough. What our study shows is that the indigents are rarely in a position to be heard or assert their rights. It is at this level that CODESA and its RECO intervene in their role of facilitators: by helping the indigents to

become more visible and respected members of the community, but also by becoming their financial guarantee, they restore some of the indigents' rights. The financial counterpart is important in a context of intense insecurity like that of Eastern Congo where health services are under intense pressure. Poverty remains a constant challenge and the main threat to initiatives for the indigents. In short, the road to restoring the poor in their rights and develop social accountability remains long, but Cordaid's project seems to be moving in the right direction.

In terms of cost-effectiveness, the interventions are promising too: excluding fieldwork visits, the matching grants cost US \$ 2.96 per indigent while the social intervention cost a mere US \$ 1.67 per indigent. Both are easy to integrate into the existing CODESA or Result-based Financing frameworks and see highly cost-efficient, especially given their positive externalities regarding community cohesion. It is useful to note that, contrary to some other RBF schemes, there was no specific provision for indigents in the PBF implemented by Cordaid at the time of project.

key point(s) 19 Social Inclusion

CODESAs appear to have come a long way for integrating the most vulnerable categories of the population, and especially the category of people identified as the 'indigents' who now participate, and reportedly influence, the decisions of the CODESA. Regarding other aspects, such as gender, progress is less visible.

A pilot intervention evaluation (randomised control trial) suggests that the CODESAs could do even more for the indigents: targeted meetings and financial support through CODESA activities have meaningfully improved access to care for the indigents at a minimal cost.

6. SUSTAINABILITY

The question of sustainability is, very much like the question of CODESA members' remuneration, one that was hard to explore directly with the research participants. In the context of the DRC, it is next to impossible for researchers and evaluators not to be associated with development aid and absolutely every single interviewee explained that "the CODESA is not yet mature enough" to be efficient and subsist over time without external (international aid) support –possibly hoping that development aid, the second 'economic sector' of DRC after mining, does not stop. In Kongo Central a Health Zone chief-doctor reflected:

"we have already had support [to the CODESA] a long time ago. It was the WHO, they organised income-generating activities etc. but they managed it badly. We do not want the current project to end in this way."

Explaining that the CODESAs are not mature enough is, nevertheless, a very relevant point. It is certainly true, especially when considering that new CODESAs are elected every four years and there might not yet be a large enough experience at the local level to expect the members to be trained locally. Yet, the question is more complex. It is in great part about the tissue that has been built around the CODESAs at different levels.

The question of sustainability is different in the case of Kinshasa –and to some extent with some of the CODESAs of Kongo Central– the project was limited to a first initial intervention and, within the scope of the project, there has not been room to learn, adapt, or grow (Guerzovich, Mukorombindo, and Eyakuze 2017a) as the project only lasted a few months. Of course, it does not mean that learning and scaling up can take place, but they will need to take place outside of the framework of the project. The eagerness of key stakeholders to do that without further support is at best unclear: as explained earlier, many envisage the CODESAs as mostly a group of RECO (see out above discussion on what this means for social accountability), and our findings show that they are partly right. The lesson from Sud Kivu is

that building favourable local and provincial environments takes time and repeated efforts. Six months to one year and a half (in Kongo Central) are short of achieving something meaningful, especially when the process is iterative. After all, in Sud Kivu, it is only during the GPSA/CODESA project, six years after a successful first ‘proof of concept’ was executed by Cordaid and the provincial Ministry of Health, that provincial (and health zone) actors started to coalesce more closely around the CODESAs.

The early findings from Kinshasa, including the end of project report and focus groups there, are promising, though: contrary to what was suspected, community dynamics favourable to a mechanism like the CODESA seem possible in urban and semi-urban communities. There may be some overlooked particularisms linked to the HF of *Nsele Pêcheurs* that was the most inspiring case study, but overall, there seems to be some potential –if more support can be provided.

There are, especially in Sud Kivu, clear hints that some –possibly many, a key shortcoming of the present study is that it did not have the means to have a full survey– CODESAs have achieved a high level of maturity. They have become catalysts for participatory projects in their local communities. Our section E1 clearly documents those cases. The capacity of some of the CODESAs to meaningfully interact with external actors seem to have improved quite substantially, as reported in section E3, or to use the words of a CBO of Walungu (Ski.CBO.Wal.1):

“The most significant change is that the CODESA feels empowered to design projects to be submitted to both national and international organizations in order to meet the needs of their community.”

The significant change is in the *capacities* of the CODESA, in its *organisation and ability* to engage with different actors. This is crucial for achieving other outcomes but also points to a potential risk, highlighted in different points of the study, that some CODESA becomes too disconnected from the ordinary people they are meant to represent. The risk is that CODESA see themselves as technicians and semi-professional managers rather than (also) representative of the people. Working on social inclusion should partly solve this issue, but –as section E5 has shown– it is only the beginning, and most tools are still in an early stage. There is no guarantee that the inclusion of the indigents in the CODESA (or the 30% of women) will withstand without GPSA/CODESA support. What has been, and will likely continue to be, a game-changer in Sud Kivu is the strong commitment of the provincial, and health zones’, authorities. It now seems that the province is past the tipping point: key players ranging from the local civil society to churches (the BDOM and CEPAC) and international NGOs have joined the ranks of those promoting the CODESA. Having a functioning CODESA and knowing the CODESA approach has become a useful asset in Sud Kivu. This bodes well for the future, and the speed at which the CODESAs of the ‘new’ intervention areas seem to catch up shows the difference a favourable context can make.

Part of the issue with instilling Sud Kivu-like dynamics in other parts of the country is a form of “chicken and egg problem”: it requires the local and provincial (or the level above the CODESA, generally speaking) to act at the same time and draw support from each other. Self-sustained CODESA is simply not an option: CODESAs do require higher-level support to flourish. Yet, at the very same time, the investment in the CODESAs is only happening if they prove to be a reliable and efficient partner. In Sud Kivu, the strength of GPSA/CODESA has been that it made it possible to consolidate years of work (that was promising but clearly not mature after CSF/CODESA) on a ‘homegrown’ product.

In terms of rehabilitating the HF infrastructure, the priority of the CODESA has, almost naturally, gone to what seems the most urgent and visible, and this may have engendered dynamics where citizens ‘care more’ because they can relate more closely.

Ultimately, though, the CODESAs are made of elected community volunteers. They are eager, and they are becoming quite competent at what they do in some parts of Sud Kivu, but what can be reasonably asked from volunteers in a context of extreme deprivation and insecurity must be thought out carefully. The success of GPSA/CODESA in parts of Sud Kivu has gone through financial support but also to personal support via the HZ, HP, and Cordaid staff, and it is also their presence that makes the legitimacy and strength of the CODESA. CODESAs are not a substitute to the state; they are a (special) part of the Congolese state. State institutions, as the experience of DRC shows, require sustained attention and investment. It is unclear that the provincial authorities could do this by themselves in the short run (or even should, as CODESAs may benefit from double upward accountability mechanism). The question may, however, not be so much who will be the next actor to start a large CODESA support project but perhaps more –and this is what seems to have started in Sud Kivu– how can CODESAs be more systematically part of provincial and health zone-level interventions and dynamics.

key point(s) 20 Sustainability

- The outcomes cannot be sustained in Kinshasa and parts of Kongo Central without further support. The interventions were too short-lived to generate a favourable and enabling context.
- The situation may be different in Sud Kivu, where the coalition of actors is stronger. It may have created the circumstances where support to the CODESAs –since the success of the CODESA model requires higher-level connection and frequent re-training– will be embedded in the activities of other organisations.

F. REVIEWING GPSA'S THEORY OF CHANGE

By providing a nuanced case study from a country where, by all accounts, state governance is at best difficult, we can help nuance some elements of GPSA's theory of change. Before explaining exactly how elements of the theory are validated or, on the contrary, challenged by the findings, we go back to the findings and show how they relate to GPSA's main outcomes.

MAIN OUTCOMES

This section goes through the relevant main outcomes of GPSA as reported in the appendix and seeks to evaluate each outcome considering the results presented in chapter E. No new evidence is presented, instead we seek to systematically link up or map findings (that are structured around the main evaluation questions in chapter E) with the outcomes that GPSA seeks to achieve globally as a partnership.

Civil society partnerships (lead grantee and partners) and relevant government counterparts engage in collaborative social accountability processes that include citizens. The annual technical reports of the grantee (the main technical reports we could access) clearly mention a series of social accountability interventions/processes that include citizens (members of or represented in the CODESAs). This is in particular through the GPSA/CODESA training, CODESA functioning funding, and matching grants as explained in section E1. As evidenced by the research carried out for the present report and presented in section E3, the CODESAs are now in place and effective in the target health zones of Sud Kivu and Kongo Central, they play more roles and are more of a social accountability catalyst in Sud Kivu than in Kongo Central. The collaborative nature of the CODESA type of social accountability was confirmed by the different interviews (see section E2 on local and

provincial dynamics) that suggested a key presence of the government authorities at the local level (including civil servants such as nurses) as well as, in some cases, provincial level (in particular in Sud Kivu).

Elements of collaborative social accountability are taken up by governments beyond individual GPSA projects. Section E2 is largely devoted to this question and shows how the understanding of government needs to be broad to fully appreciate the situation (also see below). At the very local level, and in particular, in Sud Kivu, there is an evident sense that may CODESA act as a catalyst for community mobilisation and social accountability. They inspire local initiatives and, as a participatory citizens' forum, their reach seems to go beyond health and is encouraged and strengthened by the active participation of local authorities and health centres. The evidence is less clear in the case of Kongo Central. We could not find much evidence of a change in governmental policy at the national level, but it also seems, as explained in sections E2 and E6 that the provincial level may be the priority. In Sud Kivu, the Ministry of Health has facilitated the mainstreaming of social accountability mechanisms, and there is ample evidence of non-governmental partners drawing inspiration from CODESA/GPSA.

Social accountability mechanisms are used to address obstacles to improving targeted service delivery. Not all the obstacles mentioned in the theory of change seem relevant to explore here, and in fact some have little to do with the GPSA/CODESA baseline assessment of challenges and the subsequent GPSA/CODESA-specific theory of change. (e.g. "stakeholders alignment" or "risks associated with the implementation of interventions"). Two obstacles are worth mentioning, though, the CODESAs seem to improve service delivery by improving (1) "the targeting of government actions (health-care delivery) to address citizens' needs": this is evidenced by sections E4 and E3 that show how the CODESAs have permitted the rehabilitation of health facilities in line with priorities defined by the citizens themselves and how community score-cards have enabled actions reflecting the priorities set by community representatives. Those findings seem valid in the contexts of both Sud Kivu and Kongo Central. Another obstacle that the CODESA, or rather GPSA/CODESA, seem to have been able to tackle is in terms of the (2) "asymmetries of power and other political risks that undermine the implementation of reforms and policies". Section E2 explains in some length how the legitimacy of the CODESA has been reinforced through the interventions and how asymmetries of power between HF staff and CODESA have diminished.

Civil society grantees have improved capacity to engage meaningfully and collaboratively in the policymaking and implementation and service delivery processes. The assessment of this outcome is different depending on the level that is considered: Cordaid or the main end beneficiaries of the grant, the CODESAs. The CODESAs have, on their side, generally improved (Kinshasa and Kongo Central) or even greatly improved (Sud Kivu) their capacity of engagement. There is clear evidence of their improved ability to sustain collective action as pointed out in sections E2 (and E3 on the CODESA as a local catalyst); there is also no doubt of their increased collaboration with government (HF staff and health authorities) and the management and implementation of project is also generally improved as section E4 on the matching grant show. Regarding Cordaid as a grantee, it is slightly harder to assess the situation due to the type of information that was collected and the brevity of the main reports consulted; overall, it seems that the situation has improved, especially in terms of establishing a coalition of actors on social accountability not only with the CODESAq themselves and the Ministry of Health but also with other parties such as international NGOs and the United Nations. This is evidenced in the case of Sud Kivu, as reported in section E2. Section E1 also sums up a series of adaptations of the programmes, taking into account delays but also political and social events, that show "adaptability, ability to course correct based on emerging knowledge and learning, new data and information, others' insights and changes in the context" and this in coordination with government officials and providers.

Civil society grantees lead multi-stakeholder compacts. [intermediate outcome] As explained in section E2, there is a clear sense that Cordaid is now in a position where it can advise and potentially coordinate multiple stakeholders interested in supporting the CODESA and social accountability –nothing systematic has been put in place (no formal compact), though, and exchanges have remained mostly informal. In the field, at their level, some CODESAs clearly appeared to be leading compacts (E2), albeit again the term “compact” should be understood in the sense of an informal coalition or forum. Outside of Sud Kivu, there is much less evidence of such outcomes materialising.

World Bank sector teams support meaningful engagement between civil society and government. [intermediate outcome] This outcome is, again, harder to evaluate given the design of this report. One issue here is related to the fact that the meaningful engagement with government happened at the provincial and even more local levels and those levels are (1) levels that the grantee (Cordaid) knew well already and (2) levels at which the World Bank is typically not directly intervening. The main engagement that is probably worth stressing here is the engagement between Cordaid and its civil society and the World Bank on the topic of Results-based Financing (RBF), which GPSA/CODESA has been using in part and which has been reformed, scaled up, and supported by the World Bank. While engagement on that topic was supported, it is not clear from this report that GPSA/CODESA, or CODESA experiences in general, have affected the governments’ RBF.

Lessons from experience inform GPSA engagement. [intermediate outcome] There is ample evidence, presented in the background sections of this report but also clearly mentioned in documents presenting GPSA/CODESA that the project is a follow up of a series of projects on reinforcing social accountability and the CODESA that started with an initial World Bank Civil Society Fund Grant in 2012. The main hypotheses and the theory of change of the project are directly derived from there. Other GPSA grantees are not directly mentioned in the different reports and interviews, although the project officer does mention learning from the GPSA forum and exchanges with the GPSA team (the content of that learning could not be pinpointed though). As section E1 shows, GPSA/CODESA had to adapt and adapted successfully to a series of obstacles including a difficult security situation that led to innovative ways to connect and support the CODESA at distance. There was limited time for integrating/iterating all learning within the framework of the project (e.g. the integration of the indigents mentioned in section E5, also see section E6).

THEORY OF CHANGE

Let us now turn to the theory of change of GPSA per se. The focus will be on the elements of that theory of change that are somehow challenged by GPSA/CODESA.

Overall, the project seems to confirm many of the ideas of the theory of change, including “collaborative governance”: complex problems require collaboration between actors and social accountability, such as the CODESA, seem to indeed connect those actors and lead to solutions. Similarly, the idea that “social accountability is more likely to be effective and scale if is complementary of broader government policy and programmes” also seems to make sense in the case of GPSA/CODESA, but only *if* we consider government policy at the local and provincial rather than national level. It is there that the scale up and “demonstrating success” approach of the theory takes place. What matters, though, is not so much the policy or the legal text –the chief-doctor of Kongo Central who was interviewed is eager and knowledgeable about the CODESA– it is the programmes and field realities. This is also where things become complicated in a context like the DRC: government programmes are limited, and many depend on international support. The context is favourable in Sud Kivu because the HZs and HP authorities are able to demonstrate

commitment through concrete actions –that somewhat rely on the trust (and resources) granted to them by international aid support, at least for now.

A key question around GPSA/CODESA is the extent to which government support relates to the scale of the project, which is very local and therefore not disturbing important players. There is no clear answer to that, but integrating the question of the levels of action to the theory could help better understand complex realities. What GPSA/CODESA also leads to is to unpack the idea of government. In vast countries and in countries deemed fragile or decentralised, the government that matters most for grass-root social accountability change and the government that needs to be on-board the coalition of actors is not necessarily, in a first phase, the central one. DRC and GPSA/CODESA, with the tensions between the central and provincial authorities, is a case in point.

The case of GPSA/CODESA is then an invitation to incorporate into the theory of change of GPSA some elements of the relationship between different levels of government: in a country like DRC, the trickle-down of ideas, information, or even policy from national to provincial-level should not be assumed. This means that the most meaningful strategy, as expressed in some GPSA documents (Guerzovich and Poli 2013), might actually be of a strategy that varies across levels of government. It also means that institutions such as the World Bank, which mainly operates through large projects and programmes (in agreements that are often directly with the national government) may have limited brokerage ability when it comes to non-capital-based, regional, civil society actors and government.

Another element that is somewhat questioned or nuanced by the project is the time-frame of the “adaptative learning” and of the “meaningful engagement between civil society and governments”. While the theory of change is careful not to mention any given time, the experience of GPSA/CODESA and especially the comparison between the results of Sud Kivu and Kongo Central suggests a time frame that is of almost a decade of almost continuous support and engagement before the fruits of social accountability are plainly visible. It does not mean that some effects cannot be seen earlier but suggest that the sort of comprehensive social accountability suggested by the theory of change needs a lot of time to mature (obviously this will change with contexts and projects).

The project confirms the validity of an approach that is flexible and works with governments, or rather local government and public administration in the case of GPSA/CODESA, to solve problems that local actors have prioritised. In fact, flexibility and letting local actors prioritise and, to a large extent, solve their problems is what convinced the local administration and state authorities to support the GPSA/CODESA approach (this is in Sud Kivu). Many interviews clearly point in that direction. It is a key element in a context like the DRC that is somewhat saturated with good but also less useful development projects and interventions that local authorities see passing over the years.

key point(s) 21 Theory of change

- The project validates GPSA’s theory of change but invites to re-conceptualise ‘government’, and especially the fact that different levels are engaged differently. It also suggests that flexible and locally prioritised projects help gain the trust, confidence, and buy-in of authorities.
- The time frame of the theory of change (for the effects to be seen) seem to be over a much longer time than the timeframe of the project, as suggested by the example of Sud Kivu.

CONCLUSION

In the context of GPSA/CODESA, the main elements to answer the questions of the evaluation are the following:

Has the project's strategy contributed to the expected outcome? If so, for whom, to what extent; and in which circumstances?

GPSA/CODESA appears to have generally contributed to its expected outcomes:

- (1) functional CODESAs (by which we understand CODESA that meet, know what they are expected to do, and perform the main tasks defined by the Ministry of Health regulations) appear to be in place in most of the target HZs of Sud Kivu (but less so in Kongo Central and not much in Kinshasa) and it does seem to be an efficient mechanism of social accountability, albeit there are slight risks that it becomes disconnected from the people it represents;
- (2) the CODESA's actions are also widely, and again especially so in Sud Kivu, associated with the community-led rehabilitation health infrastructure. This is both through the matching grant and to mechanisms developed by the CODESAs without the direct support of GPSA/CODESA;
- (3) CODESAs promote the social inclusion of the most vulnerable, and especially the indigents. At this level, GPSA/CODESA has validated different approaches, but those still need to be scaled up; and
- (4) there is ample evidence of a wide support/coalition of actors in favour of the GPSA/CODESA and social accountability practices in Sud Kivu but also in different parts of the DRC, through a wide informal network of supporters. The coalition still needs to emerge more explicitly in Kongo Central and in Kinshasa.

What unexpected results (positive and negative) have been produced, including the spill-over effects?

The project, as many projects involving community participation, had unexpected results. As often, social accountability is often an unpredictable story.

The most remarkable is probably the emergence of a coalition of actors at the intermediate level, such as the Health Zone CODESA, a coalition of CODESA at a level that was not seen as key at the onset of the project. The extent to which the CODESA would, in Sud Kivu still, engage in activities and social accountability processes that seem quite distant from health-care was also not fully envisaged in the initial documents of the project —the catalyst nature of the CODESA in Sud Kivu is a positive surprise. Still in Sud Kivu, it is worth noting a clear spill-over at the provincial level with NGOs and other organisations supporting the CODESA, reportedly inspired by GPSA/CODESA.

Another unexpected result is the extent to which the matching grant part ended up being geared towards the rehabilitation of infrastructures, apparently a priority in communities.

Finally, GPSA/CODESA has many questions about the potential of CODESA in an urban context and the Kinshasa experience proves CODESA may be viable in urban contexts.

To what extent do the results validate GPSA's theory of change and its adaptation to the health and governance contexts in the two provinces of DRC?

The project validates GPSA's theory of change and its central tenet of "collaborative governance" but invites to re-conceptualise 'government', and especially the fact that different levels are engaged differently. It also suggests that flexible and locally prioritised projects help gain the trust, confidence, and buy-in of authorities. Finally, by contrasting Sud Kivu and Kongo Central, it emphasizes the need to pay even greater attention to the needs and ideas of governments when the

aid industry is powerful, and it suggests that the time-frame of social accountability is a long one, decade(s) rather than year(s).

Under what conditions will the results be sustainable? What is the risk that the results obtained are not sustainable?

The contributions of the project are a lot more visible in the context of Sud Kivu which is marked by (1) a longer history of collaboration with communities and health authorities on ‘homegrown’ CODESA projects; (2) a history of community participation; and (3) a growing coalition of actors pushing for local social accountability and the CODESA. It is hard to gauge the relative importance of each factor.

Part of the issue with instilling Sud Kivu-like dynamics in other parts of the country is a form of “chicken and egg problem”: it requires the local and provincial (or the level above the CODESA, generally speaking) to act at the same time and draw support from each other. Self-sustained CODESA is simply not an option: CODESAs do require higher-level support to flourish. Yet, at the very same time, the investment in the CODESAs is only happening if they prove to be a reliable and efficient partner. In Sud Kivu, the strength of GPSA/CODESA has been that it made it possible to consolidate years of work (that was promising but clearly not mature after CSF/CODESA in 2012-2013) on a ‘homegrown’ product.

RECOMMENDATIONS

Based on our analysis, technical low-hanging fruits can and should be addressed very soon:

- Based on sections E1 and E3. CODESA do not thrive without support. This support is technical and financial. The technical support is the guidance that is provided by health authorities, which also reinforce the legitimacy of the CODESA. Therefore, supporting the CODESA also means supporting local health authorities. More research is required to determine the best way to channel support the CODESA and its members, research from different context have demonstrated that a basic compensation of people’s time and movement is essential to the durability of institutions made of volunteers in low-income countries. PBF can be a way to channel this support but it seems dangerous to see the subsidy of CODESA as a performance premium, as the performance of aa CODESA is highly context-dependent.
- Based on section E1 and E2, there is evidence that giving the CODESA a stronger voice and ensuring collaborative governance can also happen through the federation of CODESAs at the HZ-level or other. The authorities and partners can create the legal and technical space for such federation of CODESA to be constituted.
- Based on section E5. CODESA could still be more inclusive, especially of women. Organisations that support the CODESA can push for the inclusion of more women in the CODESA and create fora where problems are discussed from the perspective of women (along the lines of what is described by in the indigents pilot). National and provincial authorities can amend the CODESA regulations so that women have a clearer place.
- Based on section E5 still. The ‘two indigents’ pilot interventions had clear and beneficial impacts and need to be (1) integrated into the basic guidelines on the organisation of the CODESA that are set up by the authorities and (2) integrated into the financial support provided to the CODESA.
- More work is required to determine the cost-effectiveness of CODESA strengthening vis-à-vis other measures at the local level such as PBF. However, those may miss the fact that some of the benefits of the CODESA are hard to quantify and multifaceted.

At a more systematic level, the following points need to be considered:

- CODESA members and RECO give a lot to the community and indigents, financially as well as emotionally. The sustainability of the project's outcomes will depend on the capacity of Cordaid and its partners to encourage and support, but also to not overburden, the RECO and CODESA. Fair compensation is important.
- Strengthening the CODESA takes time, but seems to eventually pay off (e.g. Suk Kivu), and Cordaid and other actors involved in this work need not only to continue their support to the CODESA and similar activities but also develop plans that stretch over long periods of time. CODESA members require training every time they are newly elected. Support will likely keep being necessary in all areas, including Sud Kivu, for many years until the CODESAs are even more part of the social fabric.
- Provincial and HZ authorities are critical to the development of the CODESAs. In line with the work done in GPSA/CODESA, they need to be supported to be at the forefront of CODESA strengthening. This will help generate virtuous circles through which strong pro-social accountability coalitions of actors are built. The World Bank, Cordaid, and other actors are instrumental in creating the financial and technical conditions where the provincial and HZ authorities feel supported.

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APPENDIX

SAMPLE COMMUNITY SCORE CARDS LIST OF INTERVIEWEES

We provide basic information about the interviewees below. The names of key informants are not hard to retrieve but our policy is to protect as much as possible the anonymity of our informants.

Key informants, with references used in the text

Project staff

- 4 Current and past project managers (kin.1 – kin.4)
- Project Officer (kin.5)
- World Bank focal point in Kinshasa (kin.6)

Officials:

- Chief-doctor in Kongo Central (Kon.hp)
- CODESA focal point in Sud Kivu (Ski.hp.1)
- Former Director of Community Health in Sud Kivu (Ski.hp.1)

Civil Society:

- Focal points in faith-based networks (BDOM and CEPAC) (Ski.ngo.1 - Ski.ngo.2)
- IRC Programme Officer (Ski.ngo.3)

Field interviews

Referencing system: province (Kin = Kinshasa, Kon = Kongo Central, Ski = Sud Kivu) then type of informant (cn = chief-nurse, codesa = CODESA, pop = population, HZ = staff health zone, cbo = community-based organisation) then a number or an indication of the health zone (Wal = Walungu, Kat = Katana, Kal = Kalehe, Uvi = Uvira) and a number. The number is used when there were different respondents of the same category.

Kongo Central

- Chief-doctors of the health zones of Boma Bungu, Muanda, and Kitona (Kongo Central)
- Provincial chief doctor
- Kitona: 1 focus group population, 1 focus group CODESA, 1 interview chief-nurse, 1 interview CBO
- Muanda: 1 focus group population, 1 focus group CODESA, 1 interview chief-nurse

Kinshasa

- Nsele Pêcheur: 1 focus groups population, 1 focus group CODESA, 1 interview community facilitator (HF staff)
- Binza Ozone: 1 focus groups population, 1 focus group CODESA, 1 interview chief-nurse

Sud Kivu

- Katana: 1 focus groups population (with indigents), 1 focus group CODESA (gender balanced), 1 interview chief-nurse, 2 interviews CBOs, 1 interview HZ chief doctor, 2 interviews HZ CODESA members
- Kalehe: 1 focus groups population (with indigents), 1 focus group CODESA (gender balanced), 1 interview chief-nurse, 2 interviews CBOs, 1 interview HZ chief doctor, 2 interviews HZ CODESA members

- Uvira: 1 focus groups population (with indigents), 1 focus group CODESA (gender balanced), 1 interview chief-nurse, 2 interviews CBOs, 1 interview HZ chief doctor, 2 interviews HZ CODESA members
- Walungu: 1 focus groups population (with indigents), 1 focus group CODESA (gender balanced), 1 interview chief-nurse, 2 interviews CBOs, 1 interview HZ chief doctor, 2 interviews HZ CODESA members

/ as shared by the GPSA team (under review, as of August 2019)

Evidence shows public service delivery can be more effective, and government policies can be stronger and more sustainable, when governments and citizens interact to help shape, execute, manage, deliver, monitor, and adjust their policies and service delivery programsⁱ – processes best described as ‘collaborative governance’ⁱⁱ. Governance “is the process through which state and nonstate actors interact to design and implement policies within a given set of formal and informal rules that shape and are shaped by power.”ⁱⁱⁱ Yet, as the World Development Report 2017 *Governance and the Law* argues, carefully designed, sensible public policies too often are not adopted or implemented because there are governance failures. Too often, the WDR asserts, different individuals and groups in societies fail to *commit, cooperate and coordinate* to achieve desirable development goals. Lack of collaborative governance can undermine policies to address complex problems, that no single actor can solve alone. An added challenge is that as citizens and governments may lack previous experiences problem-solving together, they often do not have the capacities to engage in these kinds of processes^{iv}.

International actors can support rules and provide resources that help connect civil society and governments for collaborative governance towards problem-solving. The GPSA’s theory of action is one way where the World Bank addresses governance deficits that undermine effective development, supporting a new generation of social accountability efforts.^v A key lesson from the GPSA^{vi} and global experience^{vii} is that social accountability is more likely to be effective and scalable when it is complementary of broader government policy and programs, including service delivery systems.

By engaging with both civil society partners and governments, and leveraging existing service delivery systems (programs, policies, chains and decision-making arenas), the GPSA attacks heads on the problems of lack of collaborative governance and capacities for it. GPSA blends (i) flexible funding for civil society-led coalitions to work with government to solve problems that local actors have prioritized with (ii) sustained non-financial support to meaningful engagements, including implementation support, capacity building, facilitation, and brokering. The aim is to contribute to country-level governance reforms and improved service delivery through developing more sustainable and effective CSOs supporting collaborative social accountability initiatives.

GPSA-supported civil society-led coalitions develop capacities to engage meaningfully and collaboratively in the policy making and implementation and service delivery processes. To establish civil society-led multi-stakeholder compacts, civil society groups use GPSA advice and guidance, information about government reform efforts and country systems, insights from social accountability practice from relevant contexts, and other resources.^{viii} A key outcome of the GPSA are civil society partnerships and relevant government counterparts that engage in collaborative social accountability processes which include citizens.

These multi-stakeholder compacts are a vehicle to strengthen interactions that feed actionable information to decision-makers and shift their preferences and incentives for achieving locally prioritized development goals. The GPSA expects these compacts to contribute to addressing proximate or systemic causes of pressing local development priorities. They use social accountability mechanisms to address obstacles to improving targeted service delivery.^{ix}

Also, World Bank teams support meaningful engagement between civil society and governments. GPSA-supported civil society coalitions benefit from information about service delivery reforms efforts gathered by the GPSA as it calls for proposals to specific in-country challenges through implementing collaborative processes. Development partners, including World Bank country teams, help identify service delivery entry points that are ripe for action. World Bank sector teams help open the door to engagement with governments as they have a unique viewpoint of sectoral reform efforts and can support civil society groups in identifying concrete opportunities for citizen input in the policy

and service delivery processes. With this improved environment for engagement, civil society and government implement collaborative social accountability processes that, unlike earlier generations of social accountability,^x complement public management, service delivery chains and country systems with citizen-driven action. It is the synergy between the work of civil society and coalitions within the public sector – who can obtain new information, legitimacy, resources through joint action - that enables collaborative social accountability processes to contribute towards more effective and sustainable development policies and, in turn, results.^{xi}

The GPSA expects elements of collaborative social accountability to be taken up by governments beyond individual projects. Over time and with the benefit of joint experience, civil society, government, and development partners seek to adapt insights from such collaborative processes to sustain or scale them through programs or policies that apply them in additional localities or sectors, sometimes beyond the timespan of GPSA's support. The nature of GPSA grants are small experimental investments intended as a way to demonstrate success. If they are successful they may be scaled up. It is in the scaling that the GPSA demonstrates success. It is not known in advance of giving the grant what will happen. As we learn more information about what is happening and how we measure it, the indicators may have to change.

Leveraging multi-stakeholder collective action, as per the WDR 2017, calls for thinking beyond technical reforms and capacities. Adaptive learning and politically informed action by all stakeholders, including the GPSA, during the lifetime of a particular intervention and critically, beyond the lifetime of the project, are important towards the effectiveness of collaborative social accountability.^{xii} This means adjusting traditional project approaches.^{xiii}

Partner countries are identified from among those with the highest potential impact from collaborative social accountability linked to specific aspects of public service delivery, where there is government consent and support, and typically where the World Bank has a committed sector team with a relevant project early in implementation or in the pipeline.

These contextual conditions increase the likelihood that GPSA-supported collaborative social accountability can be effective in mitigating power imbalances that engender exclusion, capture and clientelism, which are at the heart of policy failures. This can also foster the development of new capacities to shift the incentives of those in power, reshaping their preferences in favour of good outcomes, and taking into account the interests of previously excluded citizens. In the most challenging contexts, with low civil society institutional capacities, where civic space is closing or in fragile, conflict and violence-affected settings, the critical task is to empower local stakeholders to develop their individual and collective capacities. This can be aided by processes of joint learning which can foster skills for reciprocity and information-sharing while building trust and capacity to co-produce solutions to shared problems.^{xiv}

The GPSA recognizes that for social accountability to accelerate positive outcomes in development, its programmatic work must be complemented by investments in building the social accountability field. The GPSA works to amplify the diversity and collective knowledge of its Global Partners—a network of relevant stakeholders from civil society, academia, donors, private sector, and governments—that can deliver collaborative approaches beyond direct GPSA grants. It provides a global platform that enables networking, knowledge exchange, and learning both online and offline. The GPSA uses the experiences of the initiatives it funds to contribute to the generation and application of knowledge base about what works and what does not in social accountability, and to increase recognition for the value of collaborative social accountability to governance and development. Knowledge and learning are difficult areas to measure, and little guidance is available on doing this effectively. The GPSA is making every effort to do so, and continuing to develop better ways of doing this.

Outputs	Potential indicators	Methodological approach	Data Source(s)	Responsibility
Outcomes				
<i>Outcome 1: Civil society partnerships (lead grantee and partners) and relevant government counterparts engage in collaborative social accountability processes that include citizens.</i>	Share of grants in which CSO partnerships and government counterparts engage in collaborative social accountability processes.	<p>Independent evaluators of individual grants will assess the extent to which governments and providers collaborate with citizen groups in setting priorities, planning policies, designing programs, and/or managing, delivering, or monitoring service delivery.</p> <p>Evaluators will validate grantee assessment of quality of processes in biannual technical reports.</p>	<p>Independent evaluation of individual grants, building on inputs from biannual technical reports, ISRs, ICRs</p> <p>Biannual technical reports</p>	<p>GPSA Secretariat assesses grantee capacity at proposal. Grantees submit timely and complete biannual technical reports, reviewed by GPSA Secretariat and TTL in real time and by evaluator at mid-term and completion. Independent evaluators assess grantee capacity at mid-term and completion. GPSA responsible for assigning independent evaluations and developing TOR.</p>
<i>Outcome 2: Elements of collaborative social accountability are taken up by governments beyond individual GPSA projects.</i>	Share of grants in which governments seek to: (i) apply or sustain elements of collaborative social accountability mechanisms after life of the project; (ii) adapt insights from GPSA projects to scale them through	<p>Independent evaluation of individual grants will assess the extent to which governments sought to adopt social accountability processes and sectoral lessons beyond individual grants, building on inputs from biannual technical reports</p> <p>Evaluators will use multiple sources in</p>	<p>Independent evaluation of individual grants, using survey of Bank Sector teams and interviews with government official and civil society</p>	<p>GPSA Secretariat responsible for assigning independent evaluations and developing TOR. Independent evaluators responsible for assessment at</p>

	<p>programs or policies; or (iii) apply them in additional localities or sectors.</p> <p>Note: this can be done through the government's own reform program, donor-funded programs, or Bank-financed programs. [Target: 25%]</p> <p>Number of reforms in which a GPSA project has played a substantive role</p>	<p>their judgements, including documentation provided by grantees in biannual technical reports, survey of Bank sector teams, and feedback from government and civil society partners. Evaluators will judge whether government expansion of social accountability mechanisms are plausibly linked to GPSA grant and dialogue.</p> <p>Indicative survey questions of Bank Sector teams as input for evaluator:</p> <ul style="list-style-type: none"> - Has the government introduced new social accountability mechanisms in your sector besides those supported by GPSA grants? - Has the government introduced new social accountability mechanisms in other sectors using insights from the GPSA grant? <p>Survey and interview questions for grantees such as the following:</p> <ul style="list-style-type: none"> - On which government reforms have you been consulted by government? - On which government reforms have you advocated a position with government? 	<p>partners. ICRs</p> <p>Survey of grantees or representative sample of grantees</p>	<p>completion. GPSA Secretariat responsible for fielding survey to relevant Bank Sector team and reporting results to evaluators and in aggregate.</p> <p>GPSA Secretariat</p>
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<p><i>Outcome 3:</i> Vibrant global partnership advances stronger social accountability community that can deliver collaborative approaches beyond direct GPSA grants</p>	<p>Percentage of participants from the Global South in GPSA forum and other events including hosted by the GPSA Knowledge Platform (distinguishing current and former grantees and non-grantees)</p>	<p>Data aggregated from registration for GPSA forum and learning events</p>	<p>GPSA Forum registration records</p>	<p>GPSA Secretariat</p>
<p><i>Outcome 4:</i> Promote learning and knowledge about what works and does not for social accountability</p>	<p>Share of pre-identified global intermediaries of knowledge in the social accountability space (e.g. funders, social accountability and M&E advisors of INGOs, academics) who report that collaborative social accountability has been applied to their model, programs or knowledge</p>	<p>Collect results stories from a sample of global partners</p>	<p>Baseline and methodology developed in programmatic independent evaluation</p>	<p>GPSA Secretariat</p>
<p><i>Outcome 5:</i> <i>Social accountability mechanisms are used to address obstacles to improving targeted service delivery.</i></p>	<p>Share of GPSA grants in which social accountability mechanisms addressed the proximate cause of service delivery failure</p>	<p>Independent evaluators of individual grants will assess the extent to which social accountability mechanisms helped to address one or more of the following obstacles to service delivery, or other relevant obstacles, given existing service delivery chains and systems and political economy contexts:</p> <ul style="list-style-type: none"> • Poor targeting of government actions to address citizens' needs 	<p>Independent evaluation of individual grants, building on inputs from biannual technical reports and feedback from Bank Sector Teams Biannual technical reports, ISRs, ICRs Survey of Bank Sector</p>	<p>Grantees responsible for completing biannual technical reports, with TTL input and supervision and with GPSA Secretariat technical assistance GPSA responsible for assigning independent evaluations and developing TOR.</p>

		<ul style="list-style-type: none"> • Bottlenecks in service delivery chains and public management. • Risks associated with the implementation of interventions • Asymmetries of power and other political risks that undermine the implementation of reforms and policies. • Supported stakeholder alignment <p>Evaluators will use multiple sources of evidence, including biannual technical reports, interviews with stakeholders, and survey of Bank Sector Teams, relevant sectoral documents, policies and strategies.</p>	Teams	Independent evaluators responsible for assessment. GPSA responsible for assigning independent evaluations and developing TOR.
<p><i>Outcome #5: Civil society grantees have improved capacity to engage meaningfully and collaboratively in the policy making and implementation and service delivery processes.</i></p>	<p>Share of grantees with improved capacity to engage meaningfully and collaboratively with government.</p> <p>There will be a measure of improvement in service delivery in each project, based on the requirements of each grant.</p>	<p>Independent evaluator assesses capacity at grant closing, and judges change in capacity on a four-point scale:</p> <ul style="list-style-type: none"> - Greatly improved - Improved - Neither improved nor deteriorated - Deteriorated <p>Evaluators will use initial grant proposal, GPSA team and external expert reviews of initial proposals, and early biannual technical reports to evaluate capacity at entry.</p>	Independent evaluator's assessment in comparison to initial GPSA Secretariat assessment at proposal	<p>GPSA Secretariat assesses grantee capacity at proposal. Grantees submit timely and complete biannual technical reports, reviewed by GPSA Secretariat and TTL in real time and by evaluator at mid-term and completion. Independent evaluators assess grantee capacity at mid-term and completion.</p>

		<p>Assessment of grantee capacity is made across multiple dimensions, including:</p> <p>(1) ability to create and sustain collective action with civil society partners – organizations and citizens (joint problem-solving, relational abilities, responsiveness to context)</p> <p>(2) ability to create and sustain collaboration, coordination, commitment of providers and government officials (joint problem-solving, relational abilities, responsiveness to context)</p> <p>(3) organizational and operational capability to manage and implement projects</p> <p>(4) analytical capacities, ability to apply problem-driven approaches for results and other relevant technical competencies</p> <p>(5) adaptability, ability to course correct based on emerging knowledge and learning, new data and information, others' insights and changes in the context</p>		<p>GPSA responsible for assigning independent evaluations and developing TOR.</p>
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		GPSA aggregates and analyzes assessments across portfolio, calculating the percentage of grantees rated to have “improved” or “greatly improved”.		
Intermediate results				
<i>Output 1: Civil society grantees lead multi-stakeholder compacts.</i>	Share of grantee-led compacts with involvement from at least 3 fit-for-purpose stakeholder groups	<p>Survey and interview questions for grantees such as the following:</p> <p>- Which counterparts did you collaborate with?</p> <p>Data reported by grantees in biannual technical reports. Assessment of fit-for-purpose, aggregation, and analysis completed by GPSA Secretariat.</p>	<p>Survey of grantees or representative sample of grantees</p> <p>Biannual technical reports</p>	<p>GPSA Secretariat assesses grantee capacity at proposal. Grantees submit timely and complete biannual technical reports, reviewed by GPSA Secretariat and TTL in real time and by evaluator at mid-term and completion. Independent evaluators assess grantee capacity at mid-term and completion. GPSA responsible for assigning independent evaluations and developing TOR.</p>
<i>Output 2: World Bank sector teams</i>	Number of grants for which World Bank sector teams	Survey and interview questions for grantees such as the following:	Survey of grantees or representative sample	GPSA responsible for collating the

<p><i>support meaningful engagement between civil society and government.</i></p>	<p>supported engagement between civil society and government</p>	<p>- To what extent did the World Bank sector team support engagement between civil society and government?</p>	<p>of grantees Survey of grantee partners or representative sample of grantee partners</p>	<p>documentation and collecting data from grantees through bi-annual technical reports Independent evaluators assess grantee capacity at mid-term and completion. GPSA responsible for assigning independent evaluations and developing TOR.</p>
<p><i>Output 3: Lessons from experience inform GPSA engagement.</i></p>	<p>Share of grants in which lessons learned from other grants informed project design and implementation Share of grants in which lessons learned during implementation informed course corrections Extent to which GPSA adapts its operational strategies and overall strategy using</p>	<p>Independent evaluators of individual grants will assess the extent to which relevant lessons have informed project design and course corrections. Evaluators will rate extent of utilization of lessons on a four-point scale using evidence reported in biannual technical reports Independent evaluator of the portfolio will judge the extent to which each of the GPSA's work streams (Operations, Capacity Building and Implementation Support, Knowledge and Learning,</p>	<p>Independent evaluations for individual grants Bi-annual technical reports, ISRs, ICRs Independent evaluation</p>	<p>GPSA Secretariat assesses grantee capacity at proposal. Grantees submit timely and complete biannual technical reports, reviewed by GPSA Secretariat and TTL in real time and by evaluator at mid-term and completion. Independent evaluators assess grantee capacity at mid-term and completion. GPSA responsible for assigning independent evaluations and</p>

	monitoring, reflection, research, and/or evaluation.	<p>Partnerships, Communications, and Strategic Management) is able to justify its adaptive learning on a four-point scale:</p> <ul style="list-style-type: none"> - Well-Justified - Justified - Poorly Justified - Unjustified <p>GPSA team will self-report in updates to the program document as well as required reports to World Bank Management, Steering Committee, funding proposals and GPSA Partners' Forum</p>	<p>Documents, Presentations of GPSA updates, funding proposals</p>	<p>developing TOR.</p> <p>GPSA Secretariat and independent evaluator</p> <p>GPSA Secretariat</p>
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ⁱ See, e.g. Holland et al., “Macro Evaluation of DFID’s Policy Frame for Empowerment and Accountability,” Empowerment and Accountability Annual Technical Report 2016: What Works for Social Accountability, 2016. Waddington, H. et al. (2019) Does incorporating participation and accountability improve development outcomes? Meta-analysis and framework synthesis, 3ie Systematic review 43.

ⁱⁱ “Collaborative governance refers to those processes in which different types of actors join values, meaning and resources (knowledge, power and authority, capacities, institutional and financial assets, engagement) towards addressing common problems”. See Schommer, P. and M. Guertzovich. Forthcoming. Collaborative Governance. In List, R. Anheier, H. Toepler S., eds. International Encyclopedia of Civil Society, 2nd edition. Springer. Bevir, Mark. (2009) Collaborative Governance In Bevir, Mark, et. Key concepts in Governance. Los Angeles, CA, London: SAGE.

ⁱⁱⁱ World Development Report (2017).

^{iv} M. Poli and F. Guertzovich (2016a). The Global Partnership for Social Accountability’s Capacity Building Work. Portfolio Review. The Global Partnership for Social Accountability. Internal Document.

Review of sample of 1100+ applications for GPSA funding Poli, M. and F. Guertzovich. 2014. Supporting Politically Smart Social Accountability. Dissemination Note. The Global Partnership for Social Accountability.

^v New generation social accountability refers to collaborative social accountability interventions and processes that do not focus only the provision of information, but seek to contribute to governance and collective action that supports policy-making and implementation through problem-solving as prescribed by the WDR 2017. The processes

supported by the GPSA are focused on the intermediate governance and managerial levels through which policies are implemented and services delivered (see, Levy, Brian and Walton, Michael, *Institutions, Incentives and Service Provision: Bringing Politics Back In* (February 1, 2013). ESID Working Paper No 18)

^{vi} On discussion of GPSA's projects see e.g. Westhorp, Gill and Ball, Daniel (2018), 'Citizen Voice and Action for Government Accountability and Improved Services: Maternal, Newborn, Infant and Child Health Services: Final Evaluation Report.' Community Matters Pty Ltd.

^{vii} See endnote ii.

^{viii} M. Poli and F. Guertzovich (2016). *The Global Partnership for Social Accountability's Capacity Building Work*. Portfolio Review. The Global Partnership for Social Accountability. Unpublished Manuscript.

^{ix} Guertzovich, Maria F. and Poli, Maria, *How does Social Accountability Contribute to 21st Century Quality Health Delivery?* (January 15, 2019). Available at SSRN: <https://ssrn.com/abstract=3420279>. Guertzovich, F. et al (2018), 'How does social accountability help resolve the learning crisis?', GPSA Discussion Note, Global Partnership for Social Accountability, World Bank.

^x The first generation of social accountability, and research associated with it building on the World Development Report of 2004, assumes that the main contribution of these processes is for citizen-led interventions to produce information to hold providers to account, improving outcomes. The second generation of transparency and accountability work was identified in Carrothers, Tom. (2014). *Ideas for Future Work on Transparency and Accountability*. Transparency and Accountability Initiative and the Carnegie Endowment for International Peace, <https://carnegieendowment.org/2016/05/02/ideas-for-future-work-on-transparency-and-accountability-pub-63318>.

^{xi} Schommer, et.al. (2019). *Collaborative Social Accountability for development at scale*. Unpublished Proposal

^{xii} Tsai, L. and F. Guertzovich. 2014. *Results Framework*. Washington, DC. The Global Partnership for Social Accountability. Portfolio Review M. Poli and F. Guertzovich (2016a). *The Global Partnership for Social Accountability's Capacity Building Work*. Portfolio Review. The Global Partnership for Social Accountability. Internal Document. Poli, M. and F. Guertzovich. 2014. *Supporting Politically Smart Social Accountability*. Dissemination Note. The Global Partnership for Social Accountability.

^{xiii} Teskey, G. 2017. *Thinking and Working Politically: Are we Seeing the Emergence of a Second Orthodoxy?* Governance Working Paper Series: Issue 1. Abt Associates: Canberra. On the GPSA see Poli, M. and F. Guertzovich (2016b). *The Global Partnership for Social Accountability: Adaptive Learning with the Grain*. Draft Technical Note. The Global Partnership for Social Accountability. For internal use.

^{xiv} Portfolio Review M. Poli and F. Guertzovich (2016a). *The Global Partnership for Social Accountability's Capacity Building Work*. Portfolio Review. The Global Partnership for Social Accountability. Internal Document building on Raynor, J., Cardona, C, Knowlton, T., Mittenthal, R., and Simpson, J. 2017. "Capacity Building: 3.0: How To Strengthen the Social Eco-System" A Briefing Paper of The Conservation Company accessible online: http://www.tccgrp.com/pubs/capacity_building_3.php. Also see, Wenger-Trayner, B and Wenger Trayner, E. 2014. "Chapter 6: Systems Conveners in Complex Landscapes." In Wenger-Trayner, E., Fenton-O'Creavy, M, Hutchinson, S, Kubiak, C, and Wenger-Trayner, B., (Eds). *Learning in Landscapes of Practice Boundaries, Identity, and Knowledge ability in Practice-Based Learning*. Routledge Taylor and Francis Group: London and New York. Guertzovich, F. et.al. (2017). *Beyond Fundamentals: Learning About Social Accountability Monitoring Capacities and Action in Southern Africa*. Grahamstown: Public Service Accountability Monitor / Rhodes University.