SOCIAL ACCOUNTABILITY SERIES
SOUTH ASIA SUSTAINABLE DEVELOPMENT DEPARTMENT

With a weak accountability structure in local service delivery, Satara District Council[1] was not able to target its most relevant populations, despite being considered among the better-developed districts as measured by social and economic indexes. In mid–2007, the district council implemented an innovative social accountability process in 178 villages, combining micro-planning with community scorecards to assess and monitor service delivery at the village level. After one year of implementation, this process had led to a series of behavior changes in service users and service providers and institutional and policy changes at various levels of government. These changes have, in turn, led to development outcomes in child health, maternal health, and water and sanitation. Within one year of the beginning of the accountability initiative, Satara District Council saw a 46 percent increase in normal-nutritional-grade children, a 16 percent increase in immunized children, and successful implementation of a total sanitation campaign leading to a significant decrease in waterborne diseases in all 178 villages.

CASE STUDY 6

Impact of Social Accountability Mechanisms on Achieving Service Delivery and Health Development Outcomes in Satara District, Maharashtra, India

CONTEXT

Satara District Council has an average budget of roughly US$30 million/1,410 million Indian rupees[2] to provide health, nutrition, drinking water, sanitation, and education infrastructure services to its citizens. While social and economic indexes indicate that Satara is one of the better-developed districts in Maharashtra, it still falls short in attaining expected service delivery outcomes. Irregular health services and suboptimal health outcomes—such as malnourishment, unsafe drinking water, and lack of sanitation—remained major challenges in the district because of the absence of community participation in planning and poor accountability on the part of public functionaries. The planning and monitoring of programs was mostly based on physical and financial targets without much reference to key human development outcomes. Satara invested a large portion of this development budget of US$30 million in mass awareness campaigns, infrastructure, and pilot projects. However, these budget allocations were made with little dialogue between the community and service providers and did not translate into improved conditions.

Service Delivery Structure in Satara

Satara District Council is responsible for delivering health services, while the Gram Panchayat (GP), through village-level committees, performs a supervisory role. A three-tier health

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1. The broader goal of the 73rd amendment to the Constitution of India is to encourage a greater role for communities and the Panchayat Raj Institutions in the entire cycle of development programs. India has adopted a three-tier Panchayati Raj model of democratic decentralization under this amendment. The district-level rural local government is known as the Zilla Parishad (ZP) or District Council, the block level is the Panchayat Samiti, while the village-level local government is known as the Gram Panchayat (GP).
2. The size of this budget figure varies from year to year depending on the inflow of grants from the central government for development schemes.

care system functions at the subblock, block, and district levels. Primary health centers (PHCs) are the first level of contact and act as referral centers for the community health centers and public hospitals. Each PHC, staffed by two professionally qualified doctors, is charged with providing preventive, curative, and rehabilitative care. In addition to supervising health services, the GPs in Maharashtra are also responsible for formulating village development plans and implementing the delivery and maintenance of water supply and sanitation services. A Village Water and Sanitation Committee (VWSC), a subcommittee of the GP, looks after the operation and maintenance, quality control, and financial management aspects of water supply at the village level.

Accountability Relationships in Service Delivery

Health service providers are hired by, and upwardly accountable to, their superiors in the district. Before the accountability intervention was introduced, actual users had little to no involvement in health and education service delivery design and implementation. Moreover, the performance of these service providers was measured in a top-down, target-driven manner without assessing service quality or end-user satisfaction. In contrast, the GP is statutorily accountable to the *Gram Sabha*, a village assembly, for the services they deliver. This was the only form of downward accountability within the service delivery structure before this accountability mechanism was introduced (table 1).

Satara District Council Changes Its Strategy

Because the existing supply-driven approach was not delivering expected development outcomes, Satara officials, in close collaboration with the Yashwantrao Chavan Academy of Development Administration (YASHADA), developed a project integrating a social accountability mechanism—community scorecards (CSCs)—into micro-planning (MP).[3] While Maharashtra and UNICEF have been conducting the MP process for more than two decades, this project integrated the CSC process into MP to strengthen accountability relationships for service delivery. The project was carried out in 178 villages in the Khandala and Mahabaleshwar Blocks in Satara, involving 20,000 families and benefiting 136,512 people. Block-level government institutions in these two blocks, along with Nehru Yuva Kendra, a local nongovernmental organization (NGO), took leadership of project implementation. This project was jointly funded by Satara District Council and the World Bank.

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3. Developed as a response to central-level-oriented planning processes, MP is typically a participatory process at the village level to collectively analyze local problems and develop a village action plan. These village-level action plans are then communicated to higher levels of government to inform and guide their planning processes and responsiveness to local needs. Community scorecards are qualitative monitoring tools developed and implemented by service users to monitor and evaluate local-level services, projects, and government administrative units.

Table 1 Service Delivery in Satara

Service	Service delivery agency	Group responsible for appointing staff	Monitoring of service delivery	Degree of accountability to users
Water supply and sanitation	GP, through VWSC	GP/VWSC	Gram Sabha	Medium to high
Primary health care	PHC serving a cluster of villages; subcenters serving 3-4 villages through village-level extension workers	Doctors appointed by state; other staff appointed by district	District Health Officer at district level; Block Development Officer at block level; Village Health Committee at village level (supervisory, no punitive powers)	Low

Source: Authors.

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THE SOCIAL ACCOUNTABILITY PROCESS IN SATARA

The overall objective of this accountability intervention was to improve development outcomes by strengthening the delivery of services by key government departments and programs. The MP aspect of the process allowed communities to set collective priorities and decide on investments while the CSC part allowed regular monitoring, feedback, and dialogue between service users and providers. The following stages describe the accountability process implemented in Satara.

Strengthening of Bureaucratic Will and Local Human Resources

Before introducing this accountability intervention at the village level, YASHADA held **orientation workshops** at the district and block levels to form **district- and block-level task forces** to coordinate the project. These task forces included district- and block-level officials and service providers, YASHADA staff, and local NGOs and community organizations, such as parents and teachers' associations, to assist in process design and improved targeting. The workshops served to consolidate bureaucratic will and support among government functionaries and service providers at all levels of the service-delivery structure. In addition, YASHADA conducted intensive, 20-day **facilitator trainings** for the local youth who would actually lead the process at the village level, building a cadre of trained facilitators. In the initial phase of the project, district and block government functionaries also took part in this intensive training and actually conducted the MP and CSC processes themselves.

Community Ownership of Local Problems through Micro-Planning

The actual MP and CSC processes took place over five days at the village level. The MP process included **participatory data generation and analysis** though household surveys, village surveys, and focus group discussions with vulnerable groups such as women and youth. These surveys and discussions were conducted by village youth with the help of facilitators. Participatory data generation was an integral part of the process because it allowed the community to determine the local understanding of problems and resources as well as to build ownership of the information collected.

Community Monitoring of Service Delivery through Community Scorecards

CSC exercises were conducted for health and *anganwadi*[4] services. The CSC process followed four steps (input tracking, community-generated performance scorecard, self-evaluation scorecard, and interface meeting).[5] Through **input tracking,** the community collectively analyzed supply-side data on services such as budget allocations and official inventories of physical assets. Both the community and providers received information on entitlements related to that service at the community level. This step in itself was empowering because the community often had little awareness of their actual assets and entitlements before this point, thus removing information asymmetry around budgets, expenditures, and entitlements. **Community-generated performance scorecards** and **self-evaluation scorecards** were completed by the service users and the service providers, respectively. Once the scorecards were completed, the two groups came together in an **interface meeting** to discuss differences in the scoring and jointly devise solutions to improve service delivery.

Information from the MP and CSC interactions was compiled and analyzed in village meetings and shared with the entire village community through a *Gram Sabha* on the last day. During the *Gram Sabha*, villagers deliberated the findings of the process, prioritized the problems, and developed **village action plans,** which detailed potential solutions.
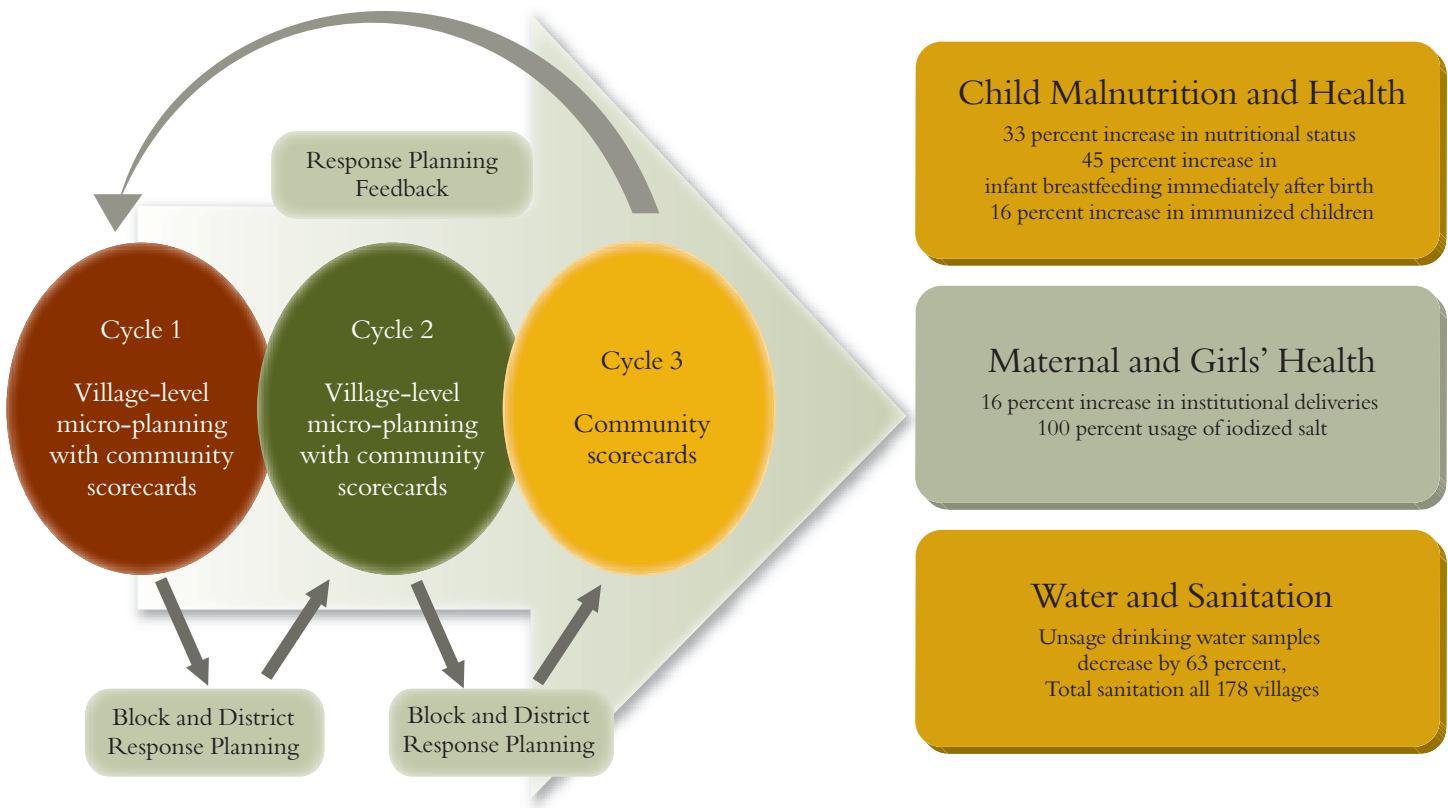
Iterative Feedback and Responsive Planning

To regularly monitor and measure service delivery, Satara carried out two cycles of MP with CSCs and a third cycle of just the CSC process at six-month intervals. These iterations allowed the community to develop accountability-seeking behavior and service providers to develop a culture of public accountability over time. Between each cycle, village action plans were

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4. An anganwadi is a center built under the Integrated Child Development Scheme (ICDS) for children ages 0–6 years to receive supplementary nutrition and preprimary education. ICDS is a flagship program of the government of India for promotion of maternal and child health and nutrition that involves several government departments and is coordinated at the village, block, district, state, and central government levels. The program provides an integrated approach for converging all the basic services for improved child care, early stimulation and learning, health and nutrition, and water and environmental sanitation aimed at young children, expectant and lactating mothers, and other women and adolescent girls in a community.

5. For more details on the CSC methodology, please refer to Singh and Shah (2004) and Murty, Agarwal, and Shah (2007).

Figure 1 Social Accountability Process in Satara

Response Planning Feedback

Cycle 1

Village-level micro-planning with community scorecards

Cycle 2

Village-level micro-planning with community scorecards

Cycle 3

Community scorecards

Block and District Response Planning

Block and District Response Planning

Child Malnutrition and Health

33 percent increase in nutritional status
45 percent increase in
infant breastfeeding immediately after birth
16 percent increase in immunized children

Maternal and Girls' Health

16 percent increase in institutional deliveries
100 percent usage of iodized salt

Water and Sanitation

Unsafe drinking water samples
decrease by 63 percent,
Total sanitation all 178 villages

Source: Authors

compiled and analyzed at the block level by the service providers through **Block Response Planning**. Under Block Response Planning, block-level officials of various departments convened to consolidate the key priorities reflected in the village action plans in that block, took stock of the available resources under various programs, and assessed any gaps between the services demanded by communities and the services actually offered under the various programs. On the basis of this exercise, an effort was made to reorient the programs and reconfigure budgets to address the expressed needs of the communities more effectively. Similarly, block-level plans were also communicated up to inform **District Response Planning**. For the first time, planners in the government had the opportunity to respond to large-scale feedback from the community. The next cycle of the process then assessed and monitored service delivery under modified programming (see figure 1). Block and District Response Planning signify an explicit shift from the supply-driven, distributive planning that was taking place before the accountability intervention to more demand-driven, responsive planning. Key interventions in the process and their effects (see

annex) allowed responsive planning mechanisms to develop and be gradually institutionalized within local government and service providers. The following section presents the impacts and development outcomes of the process over the one-year period of the project.
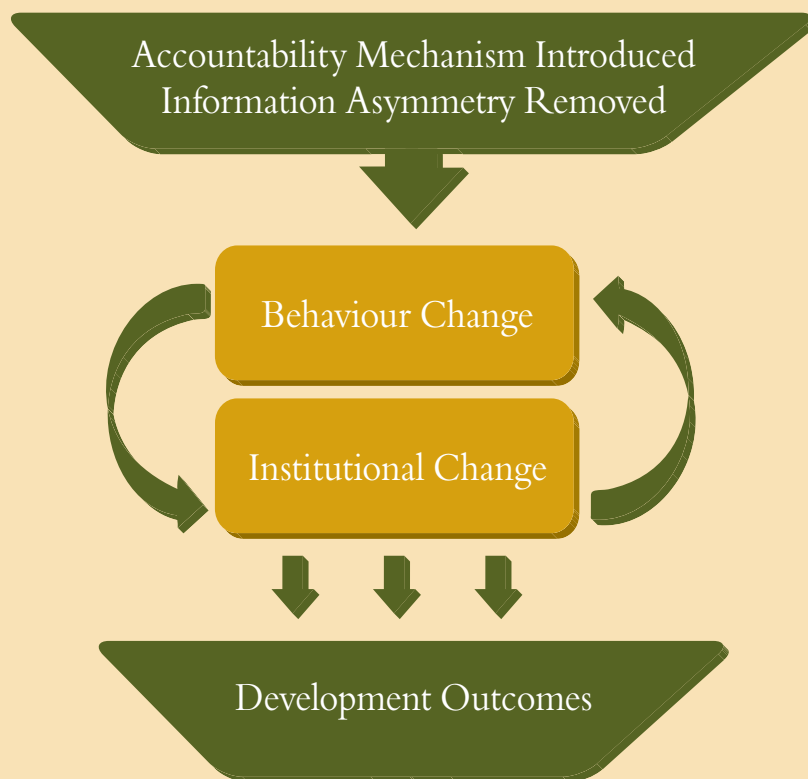
KEY IMPACTS AND DEVELOPMENT OUTCOMES

This accountability intervention has led to a series of (1) **behavior changes** in the community, service providers, and local government; (2) **institutional changes** at various levels of local government and service providers; and ultimately, (3) **development outcomes** in child health, maternal health, and water and sanitation.

First, the introduction of this accountability intervention removed information asymmetry through awareness-raising efforts about community practices and development programs and entitlements. This increase in information established

Assessing Impacts of Accountability Interventions

Behavior changes are changes in the practices of individuals and the community. Specifically, the introduction of an accountability intervention initiates behavior changes that include **information-seeking behavior** (when individuals seek out information that they normally would not), **accountability-seeking behavior** (when individuals begin to question and challenge information, service providers, and government) as well as **development-seeking behavior** (when individuals seek specific development outcomes). Behavior changes that are iterated over a period then inform the practices of local government and service providers, become internalized as norms, and are established as **institutional changes**. Institutional changes include **process changes** (shifts in the functioning of management systems, including how data are received and how decision making takes place) as well as **policy changes** (such as changes in budget allocations and legislation).

Accountability Mechanism Introduced
Information Asymmetry Removed

Behaviour Change

Institutional Change

Development Outcomes

behavior changes at the community and household levels. The accountability mechanism initially opened channels of communication between the community and service providers and altered relationships between them to allow for more constructive dialogue. The community first developed information-seeking behavior, such as questioning service providers and local government functionaries to better understand which development programs and entitlements were available to them. Through this heightened understanding, the community developed a sense of ownership over these resources, then exhibited accountability-seeking behavior in instances when they did not have access to these programs and entitlements. For instance, they learned to question service providers about service-delivery practices and lapses in delivery.

The increase in information – and accountability-seeking behavior, in turn, changed the degree and intensity of other individual and collective behavior. At the household level,

mothers and children developed behavior to seek nutrition, regular immunizations, and better water quality. The accountability intervention also galvanized the community to collectively monitor the delivery of health services and build sanitation infrastructure in the villages. On the supply side, service providers and local government functionaries developed responsive management systems and processes after interfacing with the community to discuss gaps in service delivery.

These behavior changes iteratively informed practices of the local government and service providers and became internalized as norms and established as **institutional changes** over time. Institutional changes include the establishment of a formal platform for continuous dialogue and feedback between community, local government, and frontline service providers to solve service-delivery problems through responsive planning. These institutional changes, in turn, reinforced and deepened the shifting behavioral changes at the community level. For

Table 2 Social Accountability: Key Impacts and Outcomes

Behavior changes	99 percent of children weighed regularly (Khandala)
	45 percent increase in infant breastfeeding immediately after birth, 30 percent increase in infant breastfeeding for first six months (Khandala and Mahabaleshwar)
	23 percent increase in institutional deliveries by trained attendants (Mahabaleshwar)
	All drinking water sources in the villages disinfected and unsafe drinking water samples decreased significantly, by approximately 63 percent at the end of first year
	Local government functionaries and service providers developed sharper understanding of problems in service delivery and responsive management systems and processes
Institutional changes	Institutional platform for continuous dialogue and feedback between community and service providers Cadre of community monitors, including community groups and NGOs, women, and youth, who participate in local problem solving and improved targeting
	Task forces that bring together service users, service providers, and local government to inform program design
Development outcomes	46 percent increase of children in normal nutritional grade (Mahabaleshwar)
	Khandala and Mahabaleshwar blocks both now have total sanitation and have significantly decreased waterborne diseases in all 178 villages
	A 16 percent increase in immunized children within one year, covering 94 percent of the children in the community (Khandala and Mahabaleshwar)
	Program redesign and resource reallocation to improve program effectiveness and public expenditure efficiency (generation of innovative solutions to local problems through interaction of community and service providers)
	Improved quality of service delivery (reduction in mortality rates and malnutrition)

Source: Authors.

instance, after the first cycle of this accountability intervention, local government and service providers were eager to implement the reforms in service delivery after receiving feedback from the community. As a response, in the later cycles, the community sought more accountability from service providers as well as better health outcomes in the community. Over time, this combination of accountability and increased information led to behavior and institutional changes within the community, service providers, and local government, and ultimately, to development outcomes in child nutrition and health, maternal health, and water and sanitation. See table 2 for a summary of results of the intervention.

Child Nutrition and Health

One year after beginning this planning and accountability intervention, both Khandala and Mahabaleshwar Blocks made significant progress in addressing health issues related to children and women.

Increased information and accountability led to ownership by mothers and decreased child malnutrition. Through the household surveys and focus group discussions, community concerns emerged about child nutrition, the absence of immunizations, and the high incidence of measles and intestinal worm infestations. The surveys and discussions also revealed many information gaps in community knowledge. For instance, most parents did not know the healthy weight for a child or that children from birth to six years old needed a supplementary diet to avoid malnutrition.

To improve the nutritional status of the children, local government and villagers first conducted an information campaign to increase parents' awareness of childhood nutrition

and encourage weighing of the children. After this information campaign, mothers started to regularly weigh and track the growth of their children as well as to compare the weight of their children with that of same-age children in the village through growth charts that were painted on *anganwadi* floors. This practice led mothers of lower-weight children to take action to be sure that their children did not fall behind. The children themselves also learned to compare their weight with that of other children and often encouraged their mothers to give them healthier food. Because the weighing was iterative, mothers learned to track the progress of their children's growth over time and adopted this practice as a habit. Weighing the children in a public place in the presence of other mothers and children was another form of social accountability. As a result of this practice, farmers in some villages donated soy supplements to serve the children in the *anganwadis* to improve their nutrition.

This combination of individual behavior changes of mothers and children as well as collective behavioral changes—such as on the part of the farmers—has led to improved child health and nutrition outcomes. Instances of parents having their children weighed regularly increased from 88 percent to 99 percent in Khandala within one year. The percentage of fully nourished, normal grade[6] children increased from 68 percent

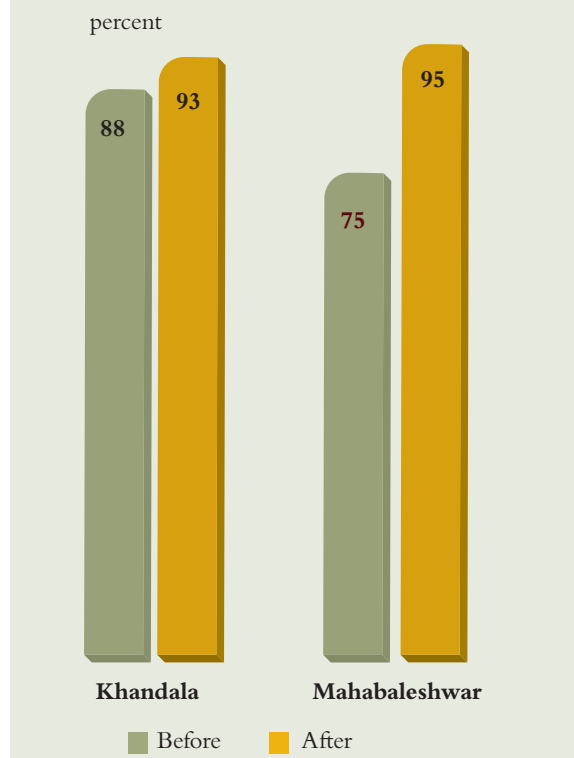**Figure 2: Increase in Normal Grade Children**

percent

	Khandala	Mahabaleshwar
Before	68	55
After	81	80

■ Before   ■ After

Figure 3: More Than 90 Percent of Children were Fully Immunized within One Year

percent

	Khandala	Mahabaleshwar
Before	88	75
After	93	95

■ Before   ■ After

Source: YASHADA's calculations

to 81 percent in Khandala and from 55 percent to 80 percent in Mahabaleshwar, a significant improvement in just one year (see figure 2). In addition, because pregnant women were also part of this information campaign and accountability process, there was a 45 percent increase in infant breastfeeding immediately after birth, which contributed to a significant decrease in the infant mortality rate as well as a decrease in certain child diseases. Instances of infant breastfeeding for the first six months increased by 30 percent within the same year. The changes can be directly attributed to this social accountability intervention.

Information availability altered immunization outcomes. Information increased the rate of immunization and directly lowered disease prevalence in Satara by the end of the one-year period. After gaining an understanding of the importance of immunizations, the community began to give regular input on the immunization schedule and rigorously monitor the schedule. In instances of a lapse in service delivery, the community appealed directly to the PHC to address the problem. The health service providers consciously integrated iron supplements for pregnant women and vitamin

6. Under ICDS, children are classified into five grades according to their degree of nourishment: normal, Grade 1, Grade 2, Grade 3, and Grade 4. Normal grade refers to fully nourished children and those ranking from Grade 1 to Grade 4 are increasingly malnourished.

supplements for children into the immunization schedule, which has greatly helped in improving the overall health of children and women.

A range of visible improvements were seen in typhoid, measles, and intestinal worm infestations—which further improved the nutritional status of the children. Increased immunizations also reduced the incidence of blindness acquired as a result of vitamin A deficiency. Khandala and Mahabaleshwar together saw a 16 percent increase in immunized children within one year, covering 94 percent of the children in the two communities at the end of the year (figure 3).

Maternal and Girls' Health

The accountability intervention also increased community awareness of acute health problems, especially among women and girls. Initial conversations with the women during the focus group discussions raised concerns on a range of health-related issues such as irregular health check-ups and house visits by health officials for pregnant mothers, shortages of health staff, absence of institutional deliveries, high prevalence of anemic mothers, lack of nutritious food deliveries to pregnant mothers, lack of hemoglobin testing, and lack of information dissemination on health, specifically family planning.

The accountability mechanism introduced specific interventions to identify and document in detail the service-delivery problems and to encourage the communities and local NGOs to work together with health officers to mitigate these issues. Health committees consisting of villagers, especially village women, were formed in every village to follow up on the health-related components in the village action plan and to monitor the delivery of health care services. As a result, the process has led to a 16 percent increase in institutional deliveries by trained attendants. Health workers' visits have increased to two per household every week, leading to a drop in the maternal mortality rate.

By the end of the project, pregnant women better understood the importance of prenatal care and regularly registered for health check-ups and referral services. Prenatal care registration by pregnant mothers increased by 12.5 percent after one year. Pregnant mothers are also now taking daily iron tablets and maintaining healthy diets.

The process also led to full participation of women and adolescent girls in regular, biannual health meetings and hemoglobin testing for girls. At the end of the year, 90 percent of women and girls were aware of their hemoglobin percentages and have adopted measures to monitor and maintain the desired levels. These practices have reduced anemia among women, particularly among mothers. Health workers regularly distribute dietary supplements and communicate the importance of iodized salt in daily meals. This effort increased the usage of iodized salt to 100 percent in all the villages. All villagers, most importantly expectant mothers, are using iodized salt at every meal and the availability of iodized salt in local shops has increased. Village development officers and workers at *anganwadi* centers have also started to monitor, track, and document health service delivery and impacts on women's health on a regular basis.

Water and Sanitation

Irregular water supply and poor-quality drinking water were raised as issues by the villagers through this social accountability intervention. Before this intervention, the community was generally not aware of how to get clean water and did not regularly chlorinate the water supply. Because of this, conversations were initiated with women's groups and local youth to convey information about the importance of clean drinking water and its links with health. Women learned how to use a simple test to check the water quality in their homes and learned to do so on a weekly basis. Children also learned how to disinfect drinking water in the schools with chlorination drops. By the end of the process, all drinking water sources in the villages were disinfected regularly and unsafe drinking water samples decreased significantly, by approximately 63 percent at the end of the first year.

Khandala and Mahabaleshwar Blocks both now have total sanitation and have significantly decreased waterborne diseases in all 178 villages. The Total Sanitation Campaign (TSC), initiated and supported by the block administration, has made significant steps in decreasing open defecation by involving local masons, facilitators, and villagers in building toilets during the five-day process. Although the materials were funded by the village local body, facilitators and women's groups in the villages volunteered their time to construct soak-pits to better manage wastewater disposal and domestic waste. Household members and facilitators volunteered to construct
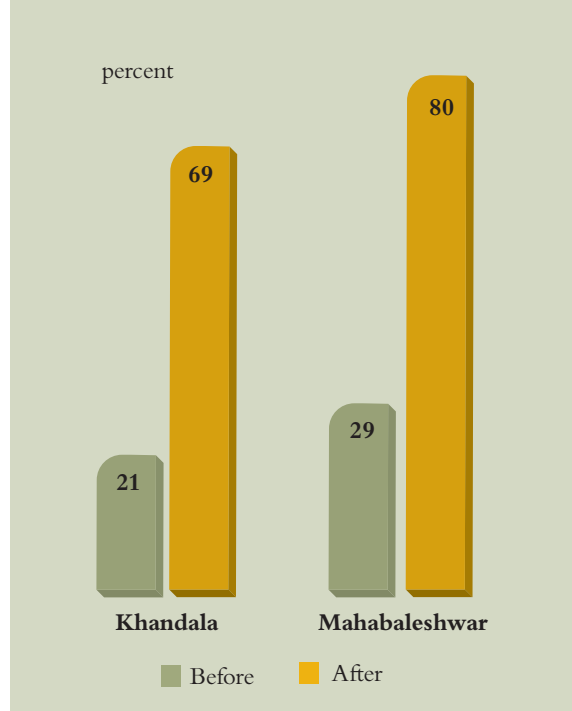
individual toilets in 90 percent of the households and common toilets in the locality.

The TSC received the national *Nirmal Taluka* award for its efforts. Pride in the TSC program and the award further encouraged the communities to continue their efforts for village cleanliness, as reflected in various community initiatives and daily practices. Women regularly organized cleanliness drives to clean common areas in the village and often started in front of the homes of those who did not participate to motivate them to join. The community also played an active role in sanctioning open defecation, gradually building a strong deterrent against this practice. Other behavioral changes were also reflected in improved cleanliness and hygiene routines, such as hand washing, use of low-cost sanitary toilets (figure 4), and acquiring drinking water from safe water sources. Basic facilities for personal hygiene and cleanliness have been made available in all *anganwadi* and the *anganwadi* workers understand the importance of cleanliness and general hygiene. Local youth and women's groups especially play an important role in facilitating these behavioral changes within each household as well as at the village level.

Institutionalization of Accountability Systems in Satara District Council

In addition to the behavioral changes described above, local government functionaries and service providers developed a sharper understanding of problems in service delivery at the village level. In all villages in the project, local government functionaries took active part in the five-day process, and in some instances, they even underwent the intensive training process and joined as facilitators to conduct household surveys and focus group discussions. Additionally, through the interface meetings in the CSC process, both service users and service providers came together face-to-face to discuss gaps in the scoring to jointly devise solutions. This part of the process prioritized constructive conversation rather than confrontation but without diffusing the real problems that the community and frontline service providers face. The trained facilitators played a role in making sure the CSC process was a meaningful conversation between two groups who rarely get to meet in such a space. Active participation in the accountability process has established responsiveness and responsibility among local government functionaries and service providers. This shift has, in turn, strengthened relationships between local government functionaries, service providers, and the community.

The behavioral changes produced institutional changes at the district, block, and village levels. Foremost, the process created an institutionalized platform for continuous dialogue among the community, local government, and frontline service providers to solve basic problems with health, nutrition, and water and sanitation. Using this platform, the process generated innovative solutions to local problems through interaction of community and service providers at the village level. These local concerns and solutions were communicated up to the block level and again to the district level. As well, block- and district-level task forces that were formed through this accountability intervention have become established groups to inform higher levels of planning. Because the task forces also comprise community members and NGOs, community input not only comes up from the village action plan but also from within these high-level task forces.

The project introduced a new process that generated rapid improvement of key health indicators affecting the poor and showed excellent progress in all 10 indicators monitored by the

Figure 4: Total Sanitation Campaign Leads to Increase in Sanitary Toilets among Participating Families in One Year

percent

Khandala: Before 21, After 69
Mahabaleshwar: Before 29, After 80

Before ■ After ■

Source: YASHADA's calculations

project. On average, Khandala saw an 18 percent improvement in key indicators and an 82 percent decrease in samples of unsafe drinking water. Mahabaleshwar, which started from a more disadvantaged position, saw an average 35 percent increase in the key indicators and a 46 percent decrease in unsafe drinking water samples (see table 3).

Table 3 Percentage Change in Key Development Indicators in the Mahabaleshwar Block (after One Year)

Indicator	Before process (%)	After process (%)	Change (%)
Children weighed regularly	85	98	15
Children in normal nutritional grade	55	80	46
Children being breastfed within one hour of birth	60	92	53
Children being breastfed for 6 months after birth	65	90	39
Fully immunized children	75	95	27
Villagers using iodized salt	65	100	54
Pregnant women registered for antenatal care	84	99	18
Institutional deliveries	61	75	23
Water samples found *unsafe* for drinking	66	36	–46
Families with individual toilets	52	73	41

Source: YASHADA's calculations.

SCALING UP TO IMPROVE HEALTH OUTCOMES

The social accountability mechanism introduced in Satara established community management and ownership of development programs through MP and a transparent and participatory system of auditing district-level development programs through the CSC. As a result, this accountability mechanism has precipitated a series of impacts over a period of just one year.

In all development programs, behavior change is a sought-after impact but usually takes well over 10 years to achieve. Slow change is especially true in conventional development programs that focus solely on supply-side interventions. In contrast, the accountability mechanism introduced in Satara has catalyzed a series of behavior changes in the community and supply side alike within one year. This process of accountable planning has not only facilitated more effective infrastructure utilization and service delivery but also improved key indicators of human development in major sectors such as health, nutrition, and water and sanitation.

Implementation and replication of this process requires a few crucial enabling factors. First, on the supply side, bureaucratic will and the leadership of local-level functionaries and service providers as well as a dedicated budget are necessary for building initial support for the process. Second, strategic alliances between the supply side and organizations such as YASHADA and other NGOs allow for an institutional platform at the community level for social accountability interventions to take place. Finally, a core group of well-trained people is integral for replication and scaling up of the process. With these factors in place, this accountability intervention could be implemented in other blocks and villages in India.

Malnutrition is a severe problem in India—among the worst in the world—and poor service delivery and targeting play a large role in the problem. Although expenditure on public health is low, even committed financing for child nutrition programs remains unspent. And even a state such as Maharashtra, which has had high economic growth compared with most states in India, has high rates of malnutrition. This accountability intervention costs approximately Rs. 7,000/US$150 per village. For a district the size of Satara, which has 1,727 villages the total cost would be approximately Rs. 12 million/ US$0.26 million a year), representing less than 1 percent of the total district budget. This investment, while not relatively large, promises to lead to significant behavior and institutional changes as well as to deliver concrete development outcomes.
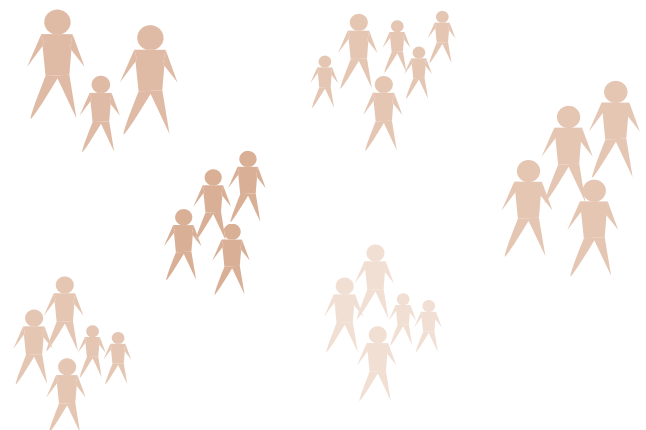
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ANNEX: KEY SOCIAL ACCOUNTABILITY INTERVENTIONS

Stage	Key interventions	Effects
Before MP and CSC	**Orientation workshops** for local government officials, PHC officers, and NGOs Task forces formed (district and block level)	Bureaucratic will and support of the process
	20-day **training of facilitators** for local youth and district and block-level functionaries	Cadre of trained facilitators
Micro-planning	**Participatory data generation and analysis** (household and village surveys, and focus group discussions)	Raised awareness and local ownership of data
	Develop **village action plans**	Collectively prioritized problems and action plan for solutions and ownership of outcomes
Community scorecard	**Input tracking**	Removed information asymmetry of assets and entitlements
	Performance Scorecard conducted by service users **Self-Evaluation Scorecard** conducted by service providers	Active performance monitoring by users
	Interface meetings between service providers and community	Constructive dialogue between users and frontline service providers
After MP and CSC	Village action plans analyzed at the block level for **Block Response Planning** and communicated up to **District Response Planning**	Responsive planning Convergence of service providers and agencies at the block and district levels

↕ Concurrent during five-day process ↕

Source: Authors.