Addis Ababa University

College of Education and Behavioral Studies

School of Psychology

Perceived level of Social Accountability and knowledge of Healthcare Workers: The Case of Yeka Sub-city of Addis Ababa

By:-

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A Thesis Submitted to the School of Psychology of Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Social Psychology

By

Lanchisel Amare

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DECLARATION

I, the undersigned, hereby declare that this thesis titled: ***Perceived level of Social Accountability and knowledge of Healthcare Workers: The case of Yeka Sub-city of Addis Ababa*** is my original work and to the best of my knowledge and belief this thesis contains no material previously published by any other person except where proper citation and due acknowledgement has been made. I do further affirm that this thesis has not been presented or being submitted as part of the requirements of any other academic degree or publication, in English or in any other language.

This is a true copy of the thesis.

Lanchisel Amare Demessie

Signature_____ Date_____

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Statement of certification

This is certify that a thesis entitled "***Perceived level of Social Accountability and knowledge of Healthcare Workers: The Case of Yeka Sub-city of Addis Ababa"*** was carried out by Lanchisel Amare under my supervision and supposed to fulfill the minimum requirement for partial fulfillment for the award of Degree of Master of Arts in social Psychology.

Advisor: Belay Tefera (Professor)

Signed---------- **Date----------**

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Certification

This is to certify that the thesis prepared by Lanchisel Amare Demessie titled: ***Perceived level of Social Accountability and knowledge of Healthcare Workers: The Case of Yeka Sub-city of Addis Ababa*** and submitted in partial fulfillment of the requirements of the Degree of Masters in Social Psychology complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

Approved By the Examining Committee

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Examiner	Signature	Date
Advisor	Signature	Date

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Abstract

This study attempted to examine perceived level of social accountability and knowledge of healthcare workers in selected health facilities. It also assesses if the perceived level of social accountability varies by socio- demographic characteristics and identify the factors that affect the perceived level of social accountability of healthcare workers. A mix of qualitative and quantitative survey design was used in the study. A combination of qualitative and quantitative data gathered through semi-structured questionnaires and interviews as a primary source of information for the study. A sample of 212 healthcare workers (59 males and 153 females) was employed as data sources. Quantitative data were collected using self-constructed Likert type rating scale to measure perceived level of social accountability. Key informant interview was also conducted with the facility medical directors to explore factors influencing social accountability. The data that were gathered through the questionnaires was analyzed and interpreted using descriptive statistics like frequency, percentage and mean and was described using tables. A correlation was also worked out if there are any significant relationship between perceived knowledge factor with overall perception of social accountability and the data further examined for difference between perceived level of social accountability with socio demographic characteristics using ANOVA. The qualitative data was summarized in relation to the study questions were presented thematically and discussed in relation to the secondary data of the study. Moreover, the data was triangulated with the quantitative method and presented in line with the research basic questions. Findings indicated that there is a high level of perceived social accountability. Findings also indicated that demographic factors including age and year of service of health care workers have statistically significant difference with their perception of social accountability. It was also shown that there is high level of perceived knowledge among the health care workers which is significantly associated with perceived social accountability. However, there was a clearly indicated gap in health delivery activities in relation to accepting criticism towards health care workers. Recommendations were forward as to how to further promote social accountability among healthcare workers.

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Acronyms and Abbreviations

BoFED - Bureau of Finance and Economic development

CSO - Civic Society Organization

ESAP - Ethiopian Social Accountability Program

IA - Institution of Accountability

FTA - Financial Transparency and Accountability

KAP - Knowledge Attitude and Practice

MMR - Maternal Mortality Ratio

NGO - Non-Government Organization

PBS - Promotion of Basic Social Service

SA - Social Accountability

SDG - Sustainable Development Goal

WDR - World Development Report

CHAPTER ONE

INTRODUCTION

1.1. Background of the study

Social accountability is the obligation of power holders to take responsibility and be answerable for their actions and decision. Social accountability is a concept in governance that denotes "being answerable for" and refers to strategies that employ information and participation to demand fairer, more effective public services, responsive to the people. (Malena, Forster, and Singh 2004).

The 1993 World Development Report (WDR), investing in Health, deemed strengthening accountability as one of the core elements of health sector reform. This ignited a trend to incorporate participation and accountability as part of the planning process for health sectors and has been reinforced by various players in civil society, bilateral and multilateral donors, and governments towards a vision of a more effective, efficient and equitable access to health care.

Presently, studies linking hospital board governance, managerial competencies, and accountability in the health care sector in emerging economies especially in the African context are rare. Most empirical studies have examined board governance with firm performance. (Dunne, 2013; Nkundabanyanga, Ntayi, Ahiauzu, and Sejjaaka, 2014).

The government of Ethiopia implemented public sector reform in a number of ways, for example accruals accounting and performance assessment focusing on key performance indicators since 2013 (Base Line Survey, 2013). These techniques were aimed at improving operational systems and enhancing accountability in the public sector.

Inadequately developed social sectors, weak institutions and marked social inequalities make the implementation of social accountability difficult (Kapiriri and Martin, 2007). Reasons to weak social accountability in public sector confirms due to the following reasons: There is a lack of credible information. This lack of information and transparency is often due to a lack of periodic evaluations of key components in the

public strategy. In general, there is a lack of communication between different levels of government and community. There are also inadequate and inaccurate data from the local level, as well as a lack of planning for evaluating social accountability (Boex, 2008).

In general, the central problems with social accountability in the area of public sector particularly in the health sector tend to be lack of both institutionalization and inclusiveness. The reason for this is unequal power structure. When it comes to getting the voice of the community heard in the public sectors, community priorities are often in competition with other stakeholders' priorities, for example, from the private sector, NGOs or religious institutions. Institutional mechanisms often do not function well and thus do not ensure accountability. The poor management service providers and both participation and institutionalization of social accountability initiatives considered as a threat to some organizations. Therefore, a mechanism needed, which are more institutionalized and grounded in broad-based participation in order for the social accountability system as a whole to flourish.

To sum up, most of the literatures also reviewed are only focuses on specific aspects of social accountability, often as part of a wider analysis. Much of the literature is theoretical in nature, and well-grounded empirical studies of social accountability are still not conducted in this area.

Despite all these, there are limited or no studies are found so far specifically with an objective of assessing the perception of social accountability have in building capacity of healthcare workers in the context of Ethiopia and mainly in Addis Ababa. Thus, this study aimed at finding out the perceived level of social accountability and knowledge of healthcare workers and factors affecting in the health care setting of Addis Ababa.

1.2. Statements of the problem

A number of scholars have emphasized the importance of accountability in improving service delivery outcomes. More importantly, many contemporary efforts seek to improve service performance either through strengthening existing accountability mechanisms or creating new channels of accountability (Ackerman, 2005).

In Ethiopia, while attempts to strengthen accountability in basic services provision are not new, what is new about the current initiatives is the emphasis given to citizen led accountability-termed 'social accountability' to enhance downward accountability of service providers to users of different social services in different sectors including health, education, and the likes. Since the early 2000s, a few publications attempting to conceptualize, describe and assess social accountability initiatives particularly in relation to the health sector.

In Ethiopia, particularly in Addis Ababa social accountability mechanism is not widely practiced, only few non-government organizations attempted to support the health sector in particular selected health facilities in building capacity through training and establishing health care worker-client forums with the objective of improving the quality of health services. This practice is not scaled up. There is no platform where service recipients and service providers meet and discuss their expectations where they create accountability system.

In few of the health facilities where there is the practice of social accountability, the mechanism how it operates, the knowledge level of the health care providers, their perception on the social accountability system, the response of clients towards the service they receive and role of the facility management on creating conducive environment is not documented.

In the majority of health service providing facilities there is no mechanism of accountability of health provider for the beneficiary except in a form of putting complaints in a suggestion box. This is not well supported by client awareness or education strategy. It is not known whether these complaints are collected, analyzed and used to provide feedback or used for service improvement.

Social accountability concept and practice is not incorporated in the medical education curriculum where new graduates can practice accountability system widely. It is only when they get on job trainings that they become aware of how to implement social accountability mechanism in their respective health facilities.

In the Ethiopian health care structure, particularly in the health care facilities the practice of social accountability is not supported by strong human resource structure that is assignment of focal person, reporting mechanism and monitoring mechanism.

In general in Addis Ababa and elsewhere in Ethiopia as far as I know the perceived level of social accountability in the health sector was not studied. Health care workers perception and knowledge of social accountability is not well known in Ethiopia, the relationship between health care workers and the service beneficiaries or clients was not explored, and how this group play role in improving the health service using accountability system was not known. Hence this study fills the gap in the general body of knowledge about understanding of the perceived level of social accountability and knowledge of healthcare workers in Ethiopia.

1.3. Research questions

- What is the knowledge of social accountability of healthcare workers?
- What is the perceived level of social accountability of healthcare workers?
- Is the perceived level of social accountability vary by the socio-demographic characteristics of age, educational qualification and year of service?
- Is the perceived level of social accountability associate with knowledge of healthcare workers?
- What major factors affect the perceived level of social accountability of healthcare workers?

1.4. Objectives of the study

1.4.1. General Objective

The general objective of this study was to explore the perceived level of social accountability and knowledge of healthcare workers in selected woredas in yeka sub-city.

1.4.2. Specific Objectives

This study intended to:

- To assess the perceived level of healthcare workers on social accountability
- To assess the knowledge of healthcare workers on social accountability
- To assess the perceived level of social accountability varies by socio-demographic characteristics of age , educational level and year of services
- To assess the practices of social accountability of health care workers
- To assess the association between the perceived level of social accountability and knowledge of healthcare workers
- To identify the factors that affect the perceived level of social accountability of healthcare workers

1.5. Significance of the study

The understanding of both the nature and the processes of health facilities accountability and their resultant outcomes or consequences is now a key requirement for any health service providing facilities. However, there is no attempt so far in Ethiopia to measure the perceived level of social accountability on healthcare workers. If the quality of health service is to continue to attract service beneficiaries, health care workers must position themselves in such a way as to both obtain and then promote consistently ‘outstanding’ results within all core health care standards. For this perceived level of social accountability must be explored, the knowledge of healthcare workers needs to be measured periodically and factors contributing to the improved social accountability practice need to be examined. Therefore, the quality of health service provision, as determined by the standard with assessment out comes, has become central to the future

health service quality care success of the nation and is therefore, central to governmental policy, irrespective of politics.

This study was undertaken to examine the perceived level of social accountability and knowledge of healthcare workers in Addis Ababa. It explores the various benefits associated with health care system. It investigates the professional drivers for continuous reform policies, providing an insight into their impact upon health service delivery.

As a professional healthcare workers in the health care system and a member and implementer of the Ethiopian social accountability program in the healthcare system, I have first-hand experience of the facilities accountability and the challenges associated with, which have placed upon health care management, health care workers and clients. And I, therefore, have very strong professional reasons for undertaking the study.

This study builds upon the knowledge base on social accountability in health facilities which identifies the perceived level of social accountability and knowledge of healthcare workers.

The study focused on health care worker's perceived level of social accountability and knowledge of healthcare workers and factors affecting social accountability. This study added evidence to the limited work so far on how health professionals and clients operating within differing socio-economic environment actually view the measures of attainment of their services and facilities' performance in relation to their own accountability and how this is related to context.

My conceptualization on the study about perceived level of social accountability and knowledge of healthcare workers will draw together the professional and practical issues connected to the ever changing responsibility and stresses of running a health facility under the umbrella of social accountability within a goal of service improvement.

1.6. Operational definitions

- **Healthcare Workers** - Refers to individual professionals providing public basic service and public basic service delivery centers (health centers) as well. This includes all categories of health workers including Physicians, nurses, midwives, pharmacists, laboratory technologists, etc.
- **Knowledge of Social accountability** – understanding of social accountability regarding to clients right, transparency and accountability. In this study this was measured by using means as indicator. High level of knowledge and low level of knowledge based on the calculated mean.
- **Perceived level of Social Accountability of healthcare workers** – healthcare workers of the facility perception towards service user's or client's capacity, healthcare workers responsibility, responsiveness and commitment for their work. In this study this was measured by using means as indicator. High level of perceived social accountability and low level of perceived social accountability based on the calculated mean taking cut of point at 3.
- **Practices of Social Accountability-** Healthcare workers current practices related to assessment of their performance, responses for clients complaints and experience sharing related to social accountability issues. In this study this was measured by using means as indicator. High level of practice of social accountability and low level of practice of social accountability based on the calculated mean taking cut of point at 3.

1.7. Limitations of the study

There was financial and time limitation in undertaking this study at large scale. Besides, one of the challenges in conducting this research has been absences of adequate national studies in the area of social accountability program in improving quality of health services.

1.8. Delimitation of study

The focus of the study is also delimited to purposively selected participants of social accountability program within specific geographic areas and selected health facilities where the social accountability program is being implemented. The study targeted different categories of health professionals to explore their perceived level and knowledge on social accountability. The study; However, didn't generate any comparative results across professional categories.

CHAPTER TWO

LITRATURE REVIEW

2.1. Accountability definition

Accountability is an assurance that an individual or an organization will be evaluated on their performance or behavior related to something for which they are responsible. Accountability is also defined as the ability to provide answers to higher authorities over the actions of a person/group of people to the wider community within an organization (Rasul & Syahrudin, 2003).

Accountability has evolved from an individual to a collective dimension, namely a concept in which all providers, in concern with health care institutions, work collaboratively to share responsibility for transparency and error prevention. In other words, accountability is the synthesis between credibility and reliability, both of the individual professional, and the institutions and the health care system. An accountability system establishes the processes for monitoring, analyzing, and improving the performance of individuals and institutions, and as such, it is a key mechanism for achieving good governance outcomes. Good governance occurs when systems and the stakeholders who operate in them strive to be "efficient, effective, open, transparent, accountable, responsive, and inclusive". Accountability systems can be both internal (within the government) and external (between government and civil society) (McGee and Gaventa, 2010, Bereket, 2016).

Government leaders play a key role in fostering good governance and accountability by determining the rules and regulations that govern the health system, providing policy leadership and oversight, guiding policy and program implementation, harnessing resources, creating mechanisms for social participation, and answering to their citizens for pledged commitments. Civil society also plays a key role in monitoring how policies are actually rolling out and affecting communities, and they can contribute to government accountability by generating information and feedback, increasing transparency, and mobilizing citizen voices. Strong civil society networks, with the capability and relationships to influence policymaking and implementation, are a key component of the accountability system. (McGee and Gaventa, 2010).

Good governance and accountability, government leaders must establish internal accountability mechanisms and also create space for social participation and systems for responding to civil society. Government should be committed to a culture of efficiency and transparency, routinely make government documents publicly available and accessible, and actively engage and facilitate the participation of a range of stakeholders in policy development and implementation. (McGee and Gaventa, 2010).

The government accountability can improve by civil society groups actively engagement in policy monitoring and utilize established mechanisms for participation, as well as external mechanisms, to hold policymakers accountable. Civil society groups should understand government structures, who is responsible for what; laws and policies that outline citizens' rights and service delivery standards such as right to information legislation, established national standards; and existing redress mechanisms such as compliant procedures, ombudsmen/women). They should be able to mobilize citizen action, analyze problems, and choose the most effective approach to elicit a government response. In many cases, successful accountability activities will require expertise in advocacy, coalition building, and media relations.

According to Goetz there are four types of mechanisms political, fiscal, administrative, and legal by which these oversight authorities hold government institutions accountable. Each mechanism has a different set of associated actors, including parliaments, government auditors, ombudsman offices, and the judiciary. High-performing institutions tasked with ensuring accountability investigate performance problems, uncover cases of inefficiency or corruption, mete out and enforce penalties/punishment, and report those findings to the public (Goetz, 2001).

Glynn and Murphy (1996) argue that accountability is, broadly speaking, the process via which a person or group can be held to account for their conduct. However, the concept of accountability has numerous facets (Sinclair, 1995; Horton, 2006; Caron & Giauque, 2006) and is complex and not easy to define. The essence of accountability, argue Cutt and Murray (2000), has always been the obligation to render an account for a responsibility that has been conferred. Accountability involves the giving and demanding

of reasons for conduct and occurs in various social structures, such as within families, friendship groups, and within and between organizations.

Broadbent and Laughlin (2003) argue that there are, broadly-speaking, and two aspects of accountability: public/political accountability that involves the public as principals and is concerned with issues of democracy and trust; and managerial accountability that is concerned with day-to-day operations of the organization. Under managerial accountability, the provision of detailed information is not directed to being more accountable to the public but rather it is an attempt by the principals or elected representatives to control the agents or managers, and to legitimize past decisions and justify future ones. The provision of annual financial statements is an example of legitimizing past decisions.

Foster (2000) argues that accountability can be achieved best by the use of contracts. This relies on the ability to reduce all accountability relationships to ones of obligation, where there is a principle/agent relationship. So long as the contract is clear then the obligations under the relationship are clear as are the information needs to monitor the performance of the contract. However, principal/agent relationships are complicated by information asymmetry and power differentials (Broadbent and Guthrie, 1992). It is argued that some relationships cannot be accurately defined by a contract and therefore, to define accountability in contractual terms limits our understanding of the concept. Kloot and Martin (2001) suggest that there are also social contracts that are important for accountability and which go beyond the legalistic approach suggested by Foster (2000).

Accountability is being weakened because of the encouragement of a concept of it that highlights accomplishments, progress and performance. Service delivery, according to Funnell, has been changed from a political activity to a technical issue, therefore placing greater emphasis on technical information such as accounting, budgeting, and performance measurement. Further, these predominantly quantitative measures provide information about efficient performance, which is related to the managerial aspect of accountability, rather than effective service delivery, which is related to the public/political aspect of accountability (Funnell, 2003).

The emphasis on efficient service delivery and quantitative information changes the nature of accountability, leading to greater control by the executive rather than increased scrutiny of it (Broadbent and Laughlin, 2003). In the public sector, accountability relationships are hierarchical involving principal and agent relationships. For example, elected councilors are agents for the citizens that elected them and local government managers are agents for the councilors. Rendering of account requires the agent to provide information about decisions and activities to the principal.

The changing nature of accountability is also discussed by Taylor and Rosair (2000), who note that it has broadened from stewardship to managerial accountability. They conclude that the predominance of one aspect of accountability depends upon the intended accountees that is, the participating parties within the structure of government and the public. The results reported by Taylor and Rosair indicate that the main purpose of external reporting is linked to meeting accountability demands of the participating parties and has little to do with providing accountability to those stakeholders who are not local government employees or councilors. To the extent that this is happening that the public is not the focus of accountability has important implications for local government; indeed all levels of government.

As one of the efforts in creating a good governance can be done by utilizing the maximum government resources. In addition to effective, efficient, efficient and effective management of government components. Governments are required to be responsive, participative and professional in carrying out basic tasks and functions for the sustainability of government. The need for information about the implementation of government is actually necessary to ensure public openness about how the process of making, implementation and results achieved by the government in every government activity. Therefore, the principles of transparency, accountability, responsiveness, and professionalism in creating better governance conditions need to be applied consistently and continuously. Therefore, cooperation between the government, the public, and the private sector is required. One of the important things of the existence of such cooperation is the availability of publicly accessible information, which demands the government's role so great in maintaining public trust.

Accountability is one of the steps that must be taken to maintain and increase public confidence in government performance.

Accountability in the context of public administration is always interesting to examine because the center of government administration practice lies precisely in issues surrounding accountability (George, 1997). In European countries, for example, accountability has long been a concern especially in relation to policy-making. Accountability is a concept that is constantly evolving and often used because it provides an image of transparency and trust for those who run it. So, accountability can be interpreted as an evaluation activity of the implementation process of organizational performance to be accountable so that it becomes a feedback for organizational leadership in the future.

In modern public administration, accountability is king, and measurable results are a necessity (Dalam & Graeme, 1993). Then, the question is how to determine precisely the concept of accountability. Appropriate understanding allows determining what aspects are taken into account to assess the accountability of the stakeholders. Therefore, the first problem is the conceptual problem. Conceptually it means that what is meant by accountability. Accountability is often used in a rather broad sense, for example, often equated with the concept of evaluation, but the essence of accountability is a concept that can be synchronized with responsiveness, responsibility, and effectiveness. The next question is related to an analysis that includes a discussion of accountability. When translated from a simple definition, accountability is defined by a series of dimensions to describe the various relationships of accountability and their composition within different domains of governance.

Accountability is a form of liability that refers to who and for what and what is accountable, which is understood as the obligation of the holder of the trust to provide accountability, presenting and reporting all activities that are his responsibility to the party who provides the trust has the authority to hold such accountability. The decision-makers of the government, the private sector, and community organizations are accountable to the public and to the agencies concerned. The form of liability depends on the type of organization concerned. Accountability basically provides a very important

role in creating a good governance activity as a part of improving public confidence in government performance. The conception of accountability can be seen that government officials are not only accountable to higher authorities in the institutional chain of command but also accountable to the general public, non-governmental organizations, mass media, and many other stakeholders. Public accountability consists of two kinds, namely vertical accountability and horizontal accountability. Vertical accountability is accountability for the management of funds to higher authorities, such as accountability of work units to local governments, regional accountability to the central government. And then horizontal accountability is the responsibility that is conveyed to the general community.

The concept of accountability has a long tradition in both political science and financial accounting, but only more recent prominence in public administration and international development. In accounting, the concept's long tradition is strictly limited to financial prudence and accounting in accordance with regulations (Barton, 2006). Yet, the underlying principle of delegating some authority, evaluating performance, and applying sanctions is essentially the same as in its long tradition in political science. Thus, Locke's theory of the superiority of representational democracy built on the notion that accountability is only possible when the governed are separated from the governors (Grant and Keohane, 2005; Locke, 1980).

In the last twenty and years, the concept of accountability has become fashionable. To illustrate this growth: when Schmitter and Karl (1991) reminded us that accountability was central to most definitions of democracy, their claim was met with indifference (Schmitter, 2004). A decade and a half later, a quick search in any of the academic search engines generates a dizzying number of entries. Unfortunately, this proliferation has resulted in a myriad of meanings and dimensions ascribed to the concept of 'accountability'. Donors, their consultants, and their partner governments have picked up on this trend in their focus on 'good governance' and have added peculiarities to the landscape.

A distinction has been made between horizontal and vertical accountability. Vertical accountability is in a well-functioning state, the government is subjected to accountability that is both imposed upon it from outside by citizens, and horizontal accountability imposes upon itself through public institutions empowered to restrain the political executive. Vertical accountability may include citizens acting through the electoral process or indirectly via civic organizations or "civil society" or the news media. Horizontal accountability covers the range of public entities created by the state to check its own abuses and inefficiencies, for example, the judiciary, auditor's general, anti-corruption units and Ombudsmen. Horizontal accountability crucially depends on the degree of autonomy or independence of such Institutions of Accountability (IA). Moreover, governments are more likely to bind themselves through institutions of horizontal accountability under circumstances where they may be punished for failing to do so. (O'Donell, 1999).

Accountability consists of restraining the power of an authority that gives an account of its actions. Since Modernity, the authority embodied by a ruler, or a group started to be connected to the authorization to execute power in the name of the subjects of a territory. In contemporary democracies, the base of authority moved to a form of power that represents the willingness of the people, a power based on the citizenship in order to be legitimate. Nowadays, a ruler or a group of people might take public decisions because they have authority, but the same decisions might lack legitimacy. On the contrary, in democracies, if those decisions are taken considering citizens, either in terms of representation, participation, transparency, and rule of law, it is said that those decisions have more legitimacy before the public (Koppell, 2010). Those ingredients do not define legitimacy, but the presence of them even if one is absent paves the road to a legitimate decision. At the same time, authority is not spontaneous neither is a miraculous practice. Authority takes decisions by normative, cognitive, symbolic and pragmatic considering legitimacy either as a process or as a consequence. In the former case, authority to execute a decision is permeable to the steps of legitimacy during the adoption and implementation of a public decision. In a consequential approach, authority considers legitimacy as result rather than as a mean to take and implement a public decision.

In both cases, accountability restrains authority to promote legitimacy, checking and assessing political decisions by their motivations and results. Thus, the point here is to recognize that authority and legitimacy are two concepts that are bargained to decide and implement a policy.

At the same time, accountability is a concept permeated by several values, practices, and expectations to improve democratic procedures. Nevertheless, accountability restrains authority and enlarges the base of legitimacy by two main dimensions: by soft power or answerability, and by hard power or enforcement. In the first case, an accountant player demands a justification and an assessment of another player in order to enhance responsible actions according to normative, institutional or moral values. In the second case, an accountable player can be forced to demonstrate responsibility but can also be punished or corrected by the rule of law or enforcement as an accountable outcome. In that sense, authority is supposed to be committed to the sources of legitimacy, the citizens, either by being responsible before them or by being enforced or "corrected" by rules of other actors.

In this societal form of accountability, not only procedural forms are called to demand an account of the authority, but also societal values and norms that seek to (re)connect authority with a base of legitimacy. This base relies upon the subjects of the socio-political order, the citizens, and by considering them as real sources of legitimacy, authority turns up (re)establishing trust in its actions. As examples on this quadrant, one can speak of civil society organizations, community representatives, the role of media and other groups that are not inserted in traditional institutions of democracy. As they seek to enlarge the base of legitimacy of a certain authority by demanding accountability by soft means (because they lack authority or veto power to regulate or impose sanctions over their targets), their main instrument is retiring or giving their trust and consent over authority, which in turn are important aspects that sustain authority and promote deeper democratic values. Part of the current crisis of democracies in the last years is due the lack of trust in political authorities and in the socio-political democratic order as a whole, in part because there is a sensation of lack of accountability beyond legal procedures and

because there are new demands of societal groups to enlarge the base of legitimacy beyond representation (Schmitter, 2004; Bovens, Goodin & Schillemans, 2014).

Accountability has become a topic of concern in governance literature. The question of holding politicians and administration accountable in new governance environment, where many traditional means for controlling government no longer fully apply, has gained wide recognition. As a consequence, new types of accountability have been sought and identified. Accountability is increasingly becoming a topic of concern in governance literature. The growing interest in the issue of accountability is largely explained by the rise of new governance models which are seen to challenge the traditional mechanisms of accountability. The problem of holding politicians and administration accountable for their actions in the new governance environment has been widely acknowledged. As the interest in 'accountability' has increased, the definition of the term itself seems to have become more ambiguous. Scholars have argued that the concept is all but well defined and that the definition of the term has moved and expanded (Mulgan, 2000; Dubnick, 2005).

Traditional Types of Accountability

The different definitions of accountability all entail an element of control, which in fact was the term commonly used in the literature before the term accountability took over Some scholars have also used a similar term 'comptrol' especially when referring to hierarchical means of control. (Beck & Larsen, 1987; Hood & Schuppert, 1989). Carol Harlow has argued that the notion of control differs slightly from accountability since the process of calling someone to account is retrospective by nature whereas control can be proactive (Harlow, 2002). Yet both of these terms refer to the same phenomena: authority over those who govern.

However, the blunt definitions of accountability do not take a stand on the mechanisms of calling someone to account. In fact, the range of options in the mechanisms of holding the politicians and administration accountable seem to cause problems in conceptualizing the term consistently. This has left room for various definitions and even misuses of the term. Scholars have argued that different types of accountability apply in different administrative contexts and that there are no universal solutions for organizing

accountability systems (Peters, 1989; Dubnick, 2005; Sinclair, 1995; Romzek, 2000; Mulgan, 2000).

The traditional idea of democratic accountability is based on the institutional environment of a nation state (Reinicke, 1998). However, public administrations throughout Europe have been subjects of a structural change from the late 1980's to the present day. This development has been characterized by redefining the role and scope of public sector and state (Pierre & Peters, 2000). From the point of view of the state, this can be seen to consist of three kinds of outbound shifts in power an upward shift emphasizing the role of international organizations, a downward shift of decentralization granting local government more autonomy and a shift towards private and non-governmental organizations in terms of externalization of government activities (Pierre & Peters 2000).

These shifts have significantly changed the role of state, as it no longer can be seen as single locus of power. Instead, a network of other actors has surfaced alongside the traditional state apparatus. Also, the nature of public administration as an actor has changed. The insertion of market type mechanisms into the public sector has blurred the traditional border between the public and private sector. (Lane, 2000; Kooiman 1993; Pollitt & Bouckaert, 2004).

The concept of accountability is closely tied to concepts of democracy and legitimacy (Mulgan, 2003; Skogstad, 2003). Those who govern have to answer for their actions to a wider public either directly, when politically elected or appointed, or indirectly as subordinates of politically elected bodies. If they fail to do so they can be substituted in democratic elections. This constant threat forces the ruling government to respond to the demands of a constituency, who can thus hold their government to account (Moncrieffe, 1998).

Many scholars have referred to this kind accountability as 'political accountability' or 'political responsibility'. The political accountability is external in nature, since the body in control, a constituency, resides outside the body that is being called to account. (Romzek & Dubnick, 1987; Sinclair, 1995; Skogstad 2003; Behn, 2001).

The Separating administration from politics weakens in the link of accountability between elected and non-elected bodies, which inevitably creates pressures for inventing

other mechanisms of administrative accountability (Peters, 1989). Perhaps the strongest degree of control can be achieved through hierarchy based 'bureaucratic accountability' (Romzek & Dubnick, 1987). There seems to be a wide consensus that bureaucratic accountability is based on a hierarchic relationship between superiors and subordinates, rules and regulations and supervision. These kind of hierarchic relationships and traditional mechanisms of accountability tend to be characteristic for a state bureaucracy (Goodin, 2003; Mulgan, 2003; Beck & Larsen 1987; Harlow 2002 and Peter, 1989).

The idea of internal control as means of accountability is perhaps best captured in so called 'personal accountability' which refers to personal values and ethics as guidelines for acting in the public interest. The personal integrity of an individual is largely shaped by shared values, ethics and beliefs communicated within the organization or within a certain collective. In public administration the mechanisms of personal accountability are closely tied to the prevailing administrative culture and its values and ethics. These normative constraints can, to a certain extent, be seen as complementary to the institutional arrangements enhancing administrative control (Sinclair, 1987, 1995; Grosenick, 1994; Beck & Larsen, 1987; Peters, 1989; Mulgan, 2000).

Administrative culture may provide moral guidelines for acting, sense of involvement, commitment and boundaries for identification, and it can foster self-regulation by deeming certain behavior undesirable. Besides the legal and bureaucratic framework defining duties and responsibilities of public service, that the continuity of public administration is largely based on administrative culture. Thus, shared norms, values and ethics effectively act as a mechanism of accountability. (Grosenick, 1994; Sinclair, 1995; Goodin, 2003; Denhart, 1994).

The public administration tasks through time increase its complexity, because of this public bureaus are more and more becoming expert organizations specialized in executing certain specific tasks. Controlling and supervising kind of expert activity requires 'professional accountability', it is largely based on 'deference to expertise within the organization' (Romzek & Dubnick 1987). Therefore, the key mechanisms of a professional accountability system are peer-review and expert scrutiny. Professional accountability can be seen to have become a more common mechanism of accountability

in policy fields involving complex tasks such as financial management, biotechnology, food safety, and energy and transport policy. Apart from increasing complexity it can also be linked with result-oriented public management agendas, globalization and the increasing importance of international organizations responsible for negotiating international standards and agreements (Skogstad, 2003; Romzek, 2000).

The New Alternatives on Accountability

The Changes in government due to the fragmentation of power and the decline in role and scope of a state have been seen to create situations where the traditional means of accountability no longer fully apply. Therefore, new means of accountability are sought and identified (Kersbergen & Waarden 2004; Mulgan 2003; Behn 2001). The two new alternative types of accountabilities often cited in governance literature, namely 'performance' and deliberation. Performance regards policy outcome and results as a means of holding administration accountable whereas deliberation emphasizes the importance of public debate, openness and transparency. The debate around both of these new alternatives can be linked to the changing conditions for holding politicians and administration accountable. The debate around performance as a type of control can be traced to the late 1980's when the NPM reforms were first introduced to the public sector. The idea of deliberation as means of accountability is more recent and can, to a certain extent, be seen as a critique of performance discourse, since they are usually seen as counterparts or alternatives to each other. Even though both undoubtedly reflect the changes in the conceptualization of accountability.

2.2. Meaning of social accountability

Social accountability is broadly defined as the obligation of power-holders to take responsibility for their actions. "Power-holders" refers to those who hold political, financial or other forms of power and include officials in government, private corporations, international financial institutions and civil society organizations. It describes the dynamics of rights and responsibilities that exist between people and the institutions that have an impact on their lives, in particular the relationship between the duties of the state and the entitlements of citizens. (Malena, Forster & Singh, 2004).

The concept of accountability is at the heart of both democratic, rights-based governance and equitable human development. A democratic and inclusive society is based on a social contract between a responsive and accountable state and responsible and active citizens, in which the interests of the poorest and most marginal are taken into account. Such contracts "have to be constructed over time, through mutual interactions between states and citizens". Over the past decade, many international development actors have used social accountability initiatives as their preferred route for reinforcing this construction. (Kabeer, 2010).

Social accountability has been defined as an approach towards building accountability that relies on civic engagement, in which it is ordinary citizens or civil society organizations who participate directly or indirectly in exacting accountability. There is a growing need for public governance and service delivery to be responsive and accountable to citizens had been widely addressed in development strategies and policy discourses such as World Bank's empowerment framework and the Millennium Development Goals (Malena, Forster, and Singh, 2004).

The World Bank definition of social accountability sums up actions that citizens can use to hold power into account. It defines social accountability as "referring to the broad range of actions and mechanisms beyond voting that citizens can use to hold the state to account, as well as actions on the part of government, civil society, media and other societal actors that promote or facilitate these efforts". (Bellver, Ana, and Daniel, 2005).

Social accountability can allow for civil society to engage meaningfully in public policy and in-turn public good. Organizations including the World Bank and other international NGOs (Non-Government Organization) have contributed greatly to efforts to promote social accountability. (Bell, Delbanco, Anderson-Shaw, Mc Donald and Gallager 2011).

Social accountability refers to a form of civic engagement that builds accountability through the collective efforts of citizens and civil society organizations to hold public officials, service providers and governments to account for their obligations with responsive efforts (Houtzager and Joshi, 2008). It describes the principle of a vibrant, dynamic and accountable relationship between states and citizens underpinning efforts to ensure equitable development. A social accountability initiative is a managed intervention guided by this principle.

Many literatures defining the word accountability in a similar grounds, defining it as 'the obligation of power-holders (those who hold decisive positions in government, private cooperation or civil society organizations) to take responsibility for their actions' (JeCCDO, 2014).Accountability is a crucial element of democratic development approach, which emphasizes the vital relationship between the responsibilities of the state or governing body and the corresponding entitlements of the citizen. Moreover, it is also an indispensable component for concepts such as 'empowerment' and 'poverty reduction' as they request power holders' transparency and responsiveness if they are to be practical and effective (Malena, Forster, & Singh 2004).

Mechanisms of assuring state accountability could be categorized in to two, internal or horizontal accountability and external or vertical accountability. The traditionally prominent internal accountability mechanism focuses on the 'supply side' which is uses the governance methods of political check and balance, administrative rules and procedures, auditing requirements, and formal law enforcement agencies like courts and the police. This internal or horizontal mechanism involves one party holding another accountable and therefore exercising 'superior authority' (Ahmad, 2008).

The external or vertical accountability mechanism refers to the demand side of governance that involves the voices as well as the capacity of citizens to bring their requests and demand responsiveness and accountability from their service providers. Election, public protest, social accountability and the like are expressions of these mechanism of accountability. (Ahmad, 2008)

Social accountability centers on the flow and interactions between three components: information, civil society (citizen) action, and government (state) response. Most obviously, social accountability interventions use information to catalyze civil society action to result in an official government response. However, civil society mobilization and action can also lead to the generation or dissemination of relevant information. The government's response to citizen action can lead to information being released to the public. However, "all information is not equal; all citizen action is not the same and all official responses cannot be seen as accountability enhancing. (Houtzager and Joshi, 2008).

Accountability is an evolving umbrella that encompasses citizens monitoring public and/or private sectors performance, public information access system, public complaint and grievance redress mechanism and citizen participation in resource allocation (Fox, 2014). This mechanism is about affirming and operationalizing direct accountability relationship between citizens and the state (JeCCDO, 2014). It is meant to complement and enhance those conventional mechanisms of accountability, which holds the power holders against their promise, but more importantly and quintessentially the concept of SA underlines the right of citizens to expect and ensure that the government acts in the best interest of the people (Malena, Forster & Singh, 2004).

Studies in India have highlighted that lack of accountability in the health system can lead to maternal inequities and deaths (George, 2007; HRW, 2009; Subha, Sarojini, and Khanna, 2012).

Accountability is basically the obligation of an individual or agency to provide information, explain and justify their conduct to stakeholders, backed up with the imposition of sanctions for non-compliance and/or inappropriate behavior (Schedler, 2009). Accountability problems in the health system such as distorted accountability mechanisms, or unaccountable behavior of health providers and managers result in its failure to guarantee the availability and functioning of obstetric care services at different levels of health facilities and to address factors influencing maternal health behavior and outcomes in an appropriate way. These were among the major factors contributing to the Maternal Mortality Rate (MMR). In the Indian states studied that Social accountability has been highlighted as a potential mechanism to improve the performance of the health system in contributing to better maternal health outcomes (George, 2003; Dasgupta, 2011; Papp, Gogoi, and Campbell, 2013).

Social accountability refers to the mechanisms that citizens can use to hold the state and service providers to account for their actions. It aims to improve service delivery through participatory processes to identify health service gaps and women's needs, and to demand that the health system address these needs. It therefore reinforces and legitimizes these demands through intermediaries such as the media or local elected leaders, leading to

their better understanding and receptiveness to women's concern. (George, 2003; Dasgupta, 2011; Papp, Gogoi, and Campbell, 2013).

2.3. Social accountability in Ethiopia

Governments and development partners had rendered social accountability increased attention in the development dialogue (Boydell and Keesbury, 2014). Because of the remarkable achievements of social accountability (SA) initiatives with regard to promotion of basic service delivery in Africa (Affiliated Network for Social Accountability (2010) as cited in Emiru, 2014). Ethiopia is one of such countries. In 2006 with the support of international partners Ethiopia was able to launch the Promotion of Basic Social Service (PBS), which was previously known to be Protection of Basic Social Services, to tackle poverty with enhanced and decentralized public service delivery to the poor.

The program has supported the delivery of five basic services across Ethiopia; health, education, water and sanitation, agriculture and since 2009 rural roads. While majority of the funding from the international partners (donors) was intended to be spent on basic service, the program also included essential components like public financial management, monitoring and improving accountability (Sandford, 2012). Hence, along with this initiative, the SA (Social Accountability) program better known as Ethiopian Social Accountability Program (ESAP) and Financial Transparency and Accountability (FTA) were introduced aiming to empower and promote the poor Ethiopians' engagement in service delivery and assure accountability. While ESAP deals with promoting the service users' direct involvement in the service provision process, FTA works with the service Providers to create a budgetary system of government open to public scrutiny by disclosing key information.

The First phase of this SA (Social Accountability) program or ESAP1 was the earliest recorded experience of SA approach in Ethiopian government's service delivery. It had tested the SA approach on a smaller scale, method, tools and principles covering 86 woreda and four service providing sectors. The evaluation of the first phase of the SA program (ESAP1) revealed that citizen engagement, i.e. bridging citizen's needs and concerns with the service providing sectors' planning, budgeting, implementation and

monitoring could work and be beneficial to all stakeholders (Pieterse, Debele, Taddesse, and Getahun, 2016).

Henceforth, a more elaborate and effective second phase of the SA program, which covered 232 woredas in the country, was launched as part of the second phase of the PBS in 2012. The Management Agency (MA), a multi-donor trust fund under the World Bank, have been the coordinating organization on this Program. The program had been put in to a nationwide practice through 49 local implementing partners which are local Civic Society Organizations (CSOs) and community members (citizens) with assistance from Management Agency and supervision by Bureau of Finance and Economic development (BoFED). The second phase took place until the end of September 2015. (Bereket, 2016).It is currently ESAP3 implementation started.

2.4. Social accountability in the healthcare system

Health service managers and providers increasingly have to contend with populations demanding answers on the quality of and access to health care services they are entitled to receive. The traditional approach to service delivery has been supply-side or provider driven with little or no input from the demand-side (clients). Moreover, up and until very recently, there has been minimal collaboration with other interested parties such as Civil Society Organizations and other stakeholders in engaging with users to address the challenges of the health sector. (Westband and Ebrahim, 2007).

Demand-side or clients side approaches focus on increasing the 'voice' and capacity of citizens to demand greater accountability from public officials and service providers and to improve responsiveness in service delivery. This can be achieved through active engagement with clients in the whole spectrum of service delivery, planning, implementation and review.

Social accountability has in other countries been shown to result in improvements in governance in the health sector, improvements in performance and empowerment of health care workers and communities and effective development through optimal management of available resources with benefits to service providers and clients as well as other health stakeholders.

Community participation enhances answerability and responsibility towards health service delivery. By engaging with the community, the basis for what, how and whom are benefiting from existing health programs is laid. A key pioneer in theorizing community participation, defined it as "collective efforts to increase and exercise control over resources and institutions on the part of groups and movements of those hitherto excluded from control". (Westergaard, 1986),

In sub-Saharan Africa, concerns have been raised regarding the quality of services delivered and health outcomes Existing health system bottlenecks such as drug shortages, disrespect of patients in public health facilities, health workers' focus on donor funded activities that offer access to per diems and drug and bed net pilfering are among the factors that affect health service functioning in sub-Saharan African countries. (Ashley, Wyss, Shakarishvili, Atun, and Don de Savigny, 2013).

The 2008 Accra Agenda for Action and the 2005 Paris Declaration on aid effectiveness emphasized country ownership for development policies through citizen engagement. Social accountability is a process in which citizens are engaged to hold politicians, policy makers public officials accountable for the services that they provide. It can be defined as "an approach towards building accountability that relies on civic engagement, in which the ordinary citizens and/or civil society organizations who participate directly or indirectly in exacting accountability" (Malena, 2004).

In the context of health care, social accountability is a form of participatory citizen engagement in which citizens are recognized as service users who are ultimately impacted by health care decisions and thereby can affect change in health policies, health services and/or health provider behavior through their collective influence and action (Fox, 2015).

Scholars consider two key aspects of social accountability are answerability and enforceability. Answerability is the obligation of politicians, policy makers, and providers to explain and justify their actions. This includes being answerable for meeting performance objectives, measured against a number of goals or standards in a complex relationship that involves several stakeholders with vested interests and different levels of authority .Enforceability refers to the capacity to ensure an action is taken and can

involve penalties, consequences or remedies for failure to do so. (Ackerman, 2004, George, 2003, Bruen, Brugha, Kageni, and Wafula, 2014).

Social accountability can play an important role in addressing corruption, increasing trust in public servants and government, which is key to accelerating efforts to achieve the Sustainable Development Goals (SDGs), and increasing the power and influence of citizens on agenda-setting (Bratton and Gyimah-Boadi, 2016; Mbachu, Onwujekwe, Ezumah, et al. 2016); McDougall,2016;

Schatz, 2013). Identifying the conditions for implementing successful social accountability initiatives can help community leaders, civil society organizations (CSOs), or non-governmental organizations (NGOs), to increase their leverage. While there have been several studies examining social accountability initiatives on health outcomes in various sub-Saharan African countries, there has been no systematic analysis of these initiatives in aggregate to identify common enabling and limiting factors to success.

Social accountability is a contested concept used in a variety of disciplines, including in the context of professional health education, New Public Management and participatory democracy (Fung and Wright, 2006; World Bank, 2004). In the health sector, social accountability is often viewed as an advanced form of community participation whereby citizens take action to enhance the accountability of politicians, policymakers and service providers.

2.5. Components of social accountability

Social accountability has several core components or building blocks that are common to most social accountability approaches. These include accessing information, making the voice of citizens heard, and engaging citizens in a process of negotiation for change.

2.5.1. Accessing or generating relevant information/ Information Sharing /

Accessing or generating relevant information is one of the components of social accountability. It builds credible evidence that will serve to hold public officials accountable for the community. This involves by obtaining and analyzing both service givers information from government and service providers and service user's information from users of government services, communities and citizens. (Westband and Ebrahim, 2007).

Information sharing and disclosure is meant to increase transparency in the health sector and give citizens information about the services they receive so as to make informed choices and take informed action. The transparency of government and its capacity to produce and provide data and accounts are crucial for accessing service givers information such as policy statements, budget commitments and accounts, records of inputs, outputs and expenditures, and audit findings.

Information sharing created awareness about citizens' rights, the type and quality of services that they should expect, and supported citizens in demanding accountability from service providers. Healthcare providers on the other hand benefitted from feedback shared with them by citizens and were influenced to change their behavior towards them, ultimately influencing decisions by Health Management Teams. Information sharing also influenced the quality of community participation.

The initial focus of social accountability interventions often has been to lobby for enhanced information rights and public transparency. With regard to demand-side information, a wide variety of participatory methods and tools such as community scorecards, citizen report cards, and participatory monitoring and evaluation techniques have been developed to generate data while simultaneously serving to raise awareness and promote local-level mobilization and organization. (Westband and Ebrahim, 2007).

2.5.2. Giving voice to the needs/community participation

Another key component of social accountability is giving voice to the needs, opinions and concerns of citizens. Giving voice to the needs help the government to better understands citizen priorities and how to better serve citizens. Community participation enhances answerability and responsibility towards health service delivery. By engaging with the community, the basis for what, how and whom are benefiting from existing health programs is laid.

Important strategies for strengthening community participation include creating spaces for public debate and platforms for citizen-state dialogue, building citizen confidence and rights awareness, facilitating the development of coalitions and alliances that can speak with a strong, united voice, and making strategic use of (or helping to develop) both modern and traditional forms of media.

2.5.3. Engaging citizens in a process of negotiation for change

Engaging citizens in a process of negotiation processes may be ad hoc or institutionalized. They can take the form of direct citizen-state interaction, for example, community level meetings with government officials or indirect, mediated forms of consultation and negotiation. In negotiating change, citizens groups employ a range of both informal and formal means of persuasion, pressure, reward and sanction.

These include creating public pressure (e.g., media campaigns and public meetings) or when necessary, resorting to formal means of enforcement (e.g., legal and judicial processes). The space and opportunity for negotiation, as well as the possibility of appeal to formal means of sanction, vary greatly from one context to another. (Westband and Ebrahim, 2007).

2.6. Factors influencing perceived social accountability

Age, gender, education, and years of work have significant impacts on organizational commitment (Akintayo and Abu, 2006). Research conducted by Rehman, Yousaf, and Zia (2010) showed that there is a significant relationship between the organizational commitment and job satisfaction with social responsibility. Dan (2010) reported that job satisfaction has a positive effect on social responsibility and employee engagement.

Akintayo & Abu examined demographic factors in relation to corporate social responsibility, corporate reputation and employee engagement. The demographic results indicate that employees who are tied to their job are over 40 years old. It is associated with cognitive and emotional components of own employees perception who have been working in the hospitality industry for a long time. Some respondents said that for those who are older than 40 years no longer desire to get out of the hotel in which they work and they just want to stay put until retirement. Different results are shown for those between the ages of 18-28. The younger ones are less committed due to the long working period at the hotel. So they don't sense the cognitive and emotional commitment to the hotel. Less committed can also come from job enrichment and task accuracy (role fit) that have a positive predictor for meaningfulness that is not perceived by young who have less experience.

The same paper also examined the level of education where they found that it has a significant impact on organizational commitment (Akintayo & Abu, 2006). The results of these studies indicate that workers who have a bachelor's degree have higher commitment to the organization compared to their peers who don't have it. For the category of education, it is almost the same as the category of office/position; a manager has usually a minimum education level equivalent to a bachelor's degree. This is because the manager is not only required to just run the operations of the hotel, but it's also required to teach ethics for its employees. Business ethics stresses that managers and corporations are responsible for implementing ethical principles in their organization and they use moral bases in making decisions, policies and strategies, and dealing with other general issues of the company. In the context of corporate social responsibility, managers act as moral actors and are responsible for the conduct of responsibility (discretion) on their existing management in all aspects of social responsibility to produce results that are socially responsible. Similar to the demographic factors of age, it has been noticed that employee engagement is affected by how long the employee worked at the hotel. Long work affects employee's perceptions of the hotel where they work. How they treat their employees can determine the employees' sustainability commitment to the hotel where they work. Akintayo (2003) reported that the desire of the employee's turnover has a negative correlation with organizational commitment. So it can be said that the larger the organization's commitment to the welfare of employees, the lower the desire to turnover becomes. The potential causes are age, length of work, and career satisfaction.

The existing literature identifies three broad contextual domains that influence health provider responsiveness to societal demands. First, health system factors have a significant impact on responsiveness. These factors include the nature of competition between health providers, the level of provider autonomy, the relative importance of community priorities funder or national priorities and the relative importance of social accountability internal accountability (Gaumer, and Beswick , 2012; Berlan and Shiffman 2012; Wild ,Chamber and King , 2012; Cleary, Molyneux, and Gilson 2013; Batley and Harris 2014). For example, provider responsiveness to the public may be constrained if professional careers depend on the goodwill of direct supervisors or political connections in the recruitment processes (Acosta, Joshi, and Ramshaw, 2013;

Therkildsen, 2014). Second, broader contextual factors have an influence on social accountability and provider responsiveness, including histories of citizen-state engagement and experiences with activism or contestation and conflict (O'Meally, 2013). Third, some authors highlight the local level context of social accountability initiatives, such as the presence and quality of 'voice' of citizens, the local politics of participation, as well as providers' attitudes to and resources for citizen engagement,(McCoy, Hall, and Ridge, 2012; Cleary, Molyneux, and Gilson ,2013).

CHAPTER THREE

RESEARCH METHODOLOGY

This chapter of the paper gives details of the research method used for this study. Accordingly, study design, the study area, the data collection methods, sampling technique, the data analysis and the ethical consideration are discussed.

3.1. Research approach and study design

The major objective of this study was describing the perceived level and factors affecting perceived social accountability of health care providers. To achieve the current study objective the researcher employed the quantitative and qualitative study approach of survey method.

A combination of qualitative and quantitative data gathered through semi-structured questionnaires and interviews as a primary source of information for the study.

3.1. Study setting

This research conducted in three health centers in three woredas (Woreda 1, 8, and 11) of Yeka-Sub-City in Addis Ababa City Administration. According to the 2007 Population and Housing Census Report, Yeka is one of the sub cities located in the central part of Addis Ababa. The sub-city has 13 woreda administrations. Its population is around 212,009 (male= 99,392, female= 112,617), 7.78 % from Addis Ababa total population.

Hiwot Integrated Development organization (HIDO) is a local non-governmental organization implementing social accountability program in the three weredas of Yeka Sub-City of Addis Ababa-Ethiopia. HIDO has been implementing the Social Accountability program in Public Service Delivery including health, education since January 2013. The partner uses Community Score Card and Participatory planning and budgeting as the main Social Accountability tools to implement the program.

3.2. Participants

3.2.1. Study population

McMillan and Schumacher (2006) describe a population as a group of individuals, objects or events that have some common characteristics that comply with certain standards and to which the researcher intends to generalize the results of the research. The target population for this study is all healthcare workers (498) (Nurses, midwives, physicians, pharmacists, laboratory technologists, facility management who are permanent employees of the study facility who are working in the health sector currently working actively in the selected facilities.

3.2.2. Sample size and sampling technique

Based on the obtained information from sub-city health office and woreda health offices Ethiopian social accountability program currently implemented by one of the civil society organization (CSO) on three woredas of the health facilities. The organization is known as Hiwot Integrated development Organization (HIDO).

Based on the obtained information from AA city government health office and woreda health offices all health care workers at Federal government organizations are organized based on their nature of work and the service they deliver for the public. Therefore, in order to conduct a study on the health care workers level of perception on social accountability the researcher considered to include three facilities from three woredas.

Additionally, facility directors of the three facilities were selected in purposive sampling technique for key informant interview with the assumption based on their specific positions, they have had adequate experience and understanding about perception on social accountability.

According to the information obtained from the facilities, the total number of the target population of the study is 498.

In order to determine the sample size according to (Taherdoost 2017) considering the aforementioned factors Yamane (1967) formulate the following simplified formula to calculate sample sizes.

$$n = \frac{P\,(100-P)\,z2}{E^2}$$

n is the required sample size, P is the percentage occurrence of a state or condition which is 50% in this study, E is the percentage maximum error required (5%), Z is the value corresponding to level of confidence required (0.05: Z value equal to 1.96). Therefore, out of the total 498 study population in the three woredas, based the fact sheet with 1.96 confidence interval and 5% precision level the calculated sample size is 217 respondents identified for the quantitative study.

So, then 217 survey questionnaires distributed and 212 collected from the three health centers with response rate of 97.6%.

In this particular study the assumption was made that most health care practitioners in government organizations would apply similar objective and structural operations, due to the similar nature of their work.

Therefore, in this study researcher believes that selected sample, upon which the study was based, would be adequately representative of the health care practitioners in AA health facilities and generalizes the results to an identified population.

Joseph, (2011) explain that there are four issues to consider when deciding whether to use probability or non-probability sampling i.e. purposive of the study, cost versus value, time constraint and amount of acceptable error.

Additionally, facility directors of the three facilities were selected in purposive sampling technique for key informant interview with the assumption based on their specific positions; they have had adequate experience and understanding about perception on social accountability.

3.3. Tools of data collection

3.3.1. Description of the tools

The instrument for data collection used sequentially. Thus the following instruments was developed and employed. Questionnaires are prepared for facility staff, and interviews for facility managing directors.

A. Likert scale questionnaire was employed as instrument of data collection.
B. key informant interview was also used

Likert scale is applied as one of the most fundamental and frequently used psychometric tools in educational and social sciences research. Simultaneously, it is also subjected to a lot of debates and controversies in regards with the analysis and inclusion of points on the scale. With this context, through reviewing the available literature and then clubbing the received information with coherent scientific thinking, this paper attempts to gradually build a construct around Likert scale. This analytical review begins with the necessity of psychometric tools like Likert scale and its variants and focuses on some convoluted issues like validity, reliability and analysis of the scale.

The choice of the key informant interview, as a method, was due to its advantage in helping the researcher understand the issue as explained by very knowledgeable individuals on the subject matter. The key informant interviewees were chosen due to their professional experiences or their prolonged services in relations to the issue understudy. Therefore, key informant interviews were made with medical directors of the four health facilities located in the four woredas of Addis Ababa. Accordingly, a total of key four informants was interviewed.

Since the role of the interviewer is to draw out information from the participants regarding topics of importance to a given research investigation (Berg, 2001), the researcher was responsible for conducting the interview.

3.3.2. Construction of the tools

The questionnaire, which was used as a data collection instrument in this study, consisted of three sections. The first section included demographic expressions designed to collect the demographic characteristics of respondents. The second section contained questions to examine the knowledge, perceived level and current practice of healthcare workers on

social accountability. The items included in the second section were presented using a 5-point Likert scale from 1 (—strongly disagree) to 5 (—strongly agree).

3.3.3. Administration

As far as the procedure of data collection is concerned the questionnaire was distributed to the selected individual respondents and collected physically from the potential respondents at their site by the researcher and the personnel assigned by the researcher for the purpose of data collection.

3.4. Methods of Analysis

3.4.1. Quantitative data analysis

The data that are gathered through the questionnaire are presented in two parts. The first part deals with the presentation related to the socio-demographic characteristics of the respondents while the second section deals with the presentation of all the data gathered based on the basic research questions to get the answer from the respondents to achieve the objective of the study.

The data that were gathered through the questionnaires was analyzed and interpreted using descriptive statistics like frequency, percentage and mean and was described using tables. The data was also coded using scientific statistics data analysis software SPSS version 20, a correlation was also worked out if there are any significant relationship between perceived knowledge factor with overall perception of social accountability and the data further examined for difference between the independent variable which is perceived level of social accountability among healthcare workers with their socio demographic characteristics using ANOVA.

3.4.2. Qualitative data analysis

The method of data analysis for this particular study was thematic analysis. After data was collected, the data was thoroughly verified to check its comprehensiveness and consistency. According to Lacey and Luff (2007), almost all qualitative research studies involve some degree of transcription – the data may be tape recorded or handwritten field notes. For that reason, the recorded data of the study was carefully transcribed.

In this process, the original collected data and the translated/transcribed one was cross-checked to avoid differences that occur in meaning. After this, these sets of data were meticulously organized into easily retrievable sections. Interviews were given a code number. Interviewees were also referred to by a code number. Lacey & Luff (2007) insist that, as with any research, this file is confidential and would usually be destroyed after completion of the project and names and other identifiable materials should be removed from the transcripts.

Following the familiarization through the process of transcribing and organizing the data, the researcher listened to tapes of the interview, read and re-read the data, made memos and summaries before the formal analysis began. Next, repeated reading of the notes was carefully carried out and central points of the data that go in line with the objective and research questions were labeled/coded using color coding method. Then, code reduction through merging (categorizing) similar primary codes was done by giving common titles or codes. Hence, the primary codes were reduced and condensed. After the coding and code reduction process was finished, the condensed codes were categorized into the main research questions. During this process, each of the categorized codes was carefully read and the concept of each code written in a paper. Themes were duly identified to do re-coding to develop better defined categories. Here, the relationships and differences among different themes were explored.

Finally, the concept of the summarized themes in relation to the study questions were presented thematically and discussed in relation to the secondary data of the study. After identifying the major results, the researcher classified the data in a meaningful manner and organized them logically to give meaning to the study questions. As a final point, a discussion and conclusion of the major results vis-a-vis the theoretical and empirical literature studies was employed.

Moreover, the data was triangulated with the quantitative method and presented in line with the research basic questions.

3.5. Ethical considerations

Researchers should respect the research sites and most importantly the research participants in all processes of the research (Cresswell 2003).

This research was therefore, gave due attention to ethical issues while collecting data, analyzing and interpreting as well as during the reporting phases. Since the issue related to health workers perception of social accountability and the implication towards service provision to the needy is sensitive, this research respected and insured confidentiality and anonymity of the participants.

The study protocol was submitted to AAU research ethics committee and ethical approval was obtained. All the health facility management and health offices were notified of the study and permission was obtained by presenting official letter from AAU duly signed and sealed presented.

The study employed all the necessary precautions to protect the study participants from such sort of problematic encounters by applying certain measures. Accordingly, the respondents were notified not to mention their identity, particularly their names while filling questionnaire. Moreover, they were assured that no meaningful damage would be inflicted on them because of their participation in this particular study by boldly explaining to them the apparent purpose of the study (which is actually for academic purpose) and ensuring the confidentiality of their identity and whole part of the information they provided for the purpose of undertaking this study.

CHAPTER FOUR

RESULT AND DISCUSSION

4.1. Result

This chapter deals with the presentation, analysis and discussion of quantitative and qualitative data. Analyses of data is a very important part of any research the quality of data collected matters but what matter more is the interpretation of the data. This chapter deals with presentation of data analyses and interview of the finding. Data of all the respondents to the questioners were compared to provide a better understanding of the situation. The comparison used to achieve the objective of the study.

The researcher has distributed 217 questioners among thus 212 questioners were correctly managed and returned buck but the remaining 8 questioners, some of them were not properly filled and some of them not returned.

The data also included data obtained from interviewees. The first part consists of socio-demographic data and followed by presentation, analysis and discussion of the results on the perceived social accountability of services and associated factors among healthcare workers.

4.1.1. Socio-demographic Data

This section aims at discussing the respondents' profile to help the study establish the extent of judgment one might have in the area of the study. The researched respondents' characteristic included sex, age, educational background, professional status, and services year in the selected facilities.

Table 1: Distribution of respondents by age, educational level, professional category and year of service

Variables	Frequency	Percent
Sex - Male	59	27.8
- Female	153	72.2
Age- 20 - 30	111	52.4
31 - 40	82	38.7
41 - 50	15	7.1
Above 50	4	1.9
Total	212	100
Educational level		
Below college diploma	3	1.4
College diploma	54	25.5
First degree	145	58.4
Second degree	10	4.7
Total	212	100
Professional category of respondents		
Nurse	101	47.6
Health officer	48	22.6
Midwife	31	14.6
Pharmacist	16	7.5
Laboratory technologist	13	6.1
General practitioner	3	1.4
Year of service of respondents		
1 - 5	83	38.2
6 - 10	99	46.7
11- 15	16	7.5
16-20	12	5.7
Above 20 years	2	0.9

As indicated in the table1, the majority 111 (52.4%) of respondents are categorized under the age group of 20 to 30. This is followed by 82 (38.7%) and 15 (7.1%) of respondents are categorized under the age range of 31 to 40 and 41 to 50 respectively. The remaining 4 (1.9%) of respondents are above 50 years old. With regard to the educational level of respondents, the majority 145 (68.4%) of respondents have first degree. 54 (25.5%) and 10 (4.7%) of respondents have college diploma and second degree respectively. Only 3 (1.4%) of respondents have the educational level below college diploma.

As shown in table 1, the majority of the 101 (47.6%) of respondents were nurses. This is followed by 48 (22.6%) of respondents were health officers. 31 (14.6%), 16 (7.5%) and 13 (6.1%) of respondents were midwife, pharmacist and laboratory technologist respectively. The remaining 3 (1.4%) respondents were general practitioner.

Concerning about the sex of respondents, the majority 152 (72.2%) of respondents were female and the remaining 59 (27.8%) of respondents were male. This indicates that females have relatively better level of participation in health care activities. It is encouraging to find females at this level in a country where females are lag behind in different areas of professional activities.

In relation to service year, the majority 99 (46.7%) of respondents have 6 to 10 years of experience. 83 (38.2%), 16 (7.5%) and 12 (5.7) of respondents have 1 to 5, 11 to 15 and 16 to 20 years of experience respectively. The remaining 2 (0.9%) of respondents have above 20 years of service experience. It shows that respondents have relatively longer years of experience in the health sector. This enables to obtain detail data about the perceived level of social accountability in relation of relevant variables among healthcare workers.

4.1.2. Knowledge of social accountability of health care workers

Overall, there is high level of perceived knowledge among the health care workers with a total mean of 4.07. Table 2 showed that the current social accountability knowledge of healthcare workers. The highest mean was 4.37 with standard deviation .752 which is explained by health center clients have the right to demand quality health services. The next highest mean was 4.19 with standard deviation of .900 which is given by active participation of service users improves quality of service. The third highest mean was 4.17 with the standard deviation of .867 that by creating community awareness it is possible to enhance transparency and accountability. The fourth highest mean was 4.04 with the standard deviation of .965 that favors the application of social accountability into health care is beneficial to service users to get quality services. Application of social accountability into health care is beneficial to service users to get quality services were confirmed by the mean of 4.04 with the standard deviation of .965. 4.03 mean with standard deviation .913 was for the explanation of application of social accountability in to health care creates transparency between service giver and service users. The mean of 3.99 with standard deviation of 1.009 accounted for the statement that confirms service users have the right to hold service givers accountable for their performance. The statement that states a social accountability service makes health providers to give inclusive services for vulnerable groups has the mean of 3.94 with standard deviation of .974. The lowest mean was 3.83 with the standard deviation of 1.060 which explained by the existence of enough knowledge about social accountability.

Table 2: knowledge of social accountability of health care workers

	N	Minimum	Maximum	Mean	Std. Deviation
I have enough knowledge about Social accountability.	212	1	5	3.83	1.060
Application of social accountability into health care is beneficial to service users to get quality services.	212	1	5	4.04	.965
Application of social accountability in to health care creates transparency between service giver and service users.	212	1	5	4.03	.913
A social accountability service makes health providers to give inclusive services for vulnerable groups (women, person with disability …..).	212	1	5	3.94	.974
Health center clients have the right to demand quality health services.	212	1	5	4.37	.752
Service users have the right to hold service givers accountable for their performance.	212	1	5	3.99	1.009
By creating community awareness it is possible to enhance transparency and accountability.	212	1	5	4.17	.867
Active participation of service users improves quality of service.	212	1	5	4.19	.900
Total Mean			**4.07**		

4.1.3. Perceived level of social accountability of healthcare workers

Overall, the perceived level of social accountability of health care workers was high with the total mean of 3.61. Table 3 revealed the perceived level of social accountability of healthcare workers. The highest mean was 4.33 with standard deviation 0.810 which states that I am ready to satisfy my clients/service users. This is followed by the mean of 4.31 with the standard deviation of .825 confirms that I believe that service users have the capacity to monitor and assess the quality of service delivery. The mean of 4.13 with standard deviation .761 was indicated by the statement that claims service users should have a voice about the service they are provided. The next mean was 3.90 with standard deviation of 1.194 that agreed on accountability to quality health services is the responsibility of the facility management and staffs. The mean of 3.88 with the standard deviation of 1.017 was for the explanation that confirms I believe that I am responsible to deliver quality health services. The statement that states all health workers in this facility undertake their activity by considering social accountability has the mean of 3.58 with standard deviation 1.101. The mean of 3.57 with standard deviation of 1.089 accounted for the statement that verifies the health center is a pleasant place to work. 3.52 mean with the standard deviation of 1.112 was for the explanation of social accountability empowers citizens to make health workers responsive and committed for their work. The explanation that stated all healthcare workers are accountable for the service they provide to clients was indicated by the mean of 2.80 with the standard deviation of 1.292. The lowest mean was 2.14 with the standard deviation 1.154 for the statement that stated I feel upset of any criticism towards health care workers.

Table 3. Perceived level of social accountability of healthcare workers

	N	Minimum	Maximum	Mean	Std. Deviation
I believe that I am responsible to deliver quality health services	212	1	5	3.88	1.017
All health workers in this facility undertake their activity by considering social accountability	212	1	5	3.58	1.101
Social accountability empowers citizens to make health workers responsive and committed for their work	212	1	5	3.52	1.112
Service users should have a voice about the service they are provided	212	1	5	4.13	.761
Accountability to quality health services is the responsibility of the facility management and staffs	212	1	5	3.90	1.194
I am ready to satisfy my clients/service users	212	1	5	4.33	.810
I believe that service users have the capacity to monitor and assess the quality of service delivery	212	1	5	4.31	.825
The health center is a pleasant place to work	212	1	5	3.57	1.089
All healthcare workers are accountable for the service they provided to clients	212	1	5	2.80	1.292
I feel upset of any criticism towards health care workers	212	1	5	2.14	1.154
Total Mean				**3.61**	

4.1.4. Current practice of healthcare workers in the context of social accountability

Overall, the level of practice of social accountability among the health care workers was high with the total mean of 3.5. As indicated in the table below, the nature of social accountability practice by health centers and health workers, the highest mean was 4.23 with standard deviation of .666 for the statement that explains willingness to attend review meeting with service users. This is followed by the mean of 4.07 with standard deviation of .969 that claims in believe that accountable to their clients for the service they provide. The next highest mean was 3.78 with standard deviation of .915 which explains the health centers have clear structure for feedback for complaints from their clients. The explanation that stated staffs are held accountable for getting work done according to clear performance standard was indicated by a mean of 3.67 with standard deviation of 1.063. The next mean was 3.43 with standard deviation of .998 which asserts that the health center has a mechanism for clients to complain on poor quality of services they received from the health care providers. The lowest mean was 2.88 with standard deviation of 1.256 that affirms the Health center gives an equal opportunity for employees. The findings clearly indicate that there are favorable conditions to work closely with service users. It is also implied that health professionals have considerable level of awareness with regard to their accountability in delivering different health services.

Table 4. Current practice by healthcare workers in the context of social accountability

	N	Minimum	Maximum	Mean	Std. Deviation
I have participated in a training to promote transparency and accountability.	212	1	5	3.00	1.277
The health centers have a clear mechanisms or procedures to assess the performance of health care workers	212	1	5	3.39	1.157
The health center organizes a review meeting for healthcare workers to share their experience and challenges on accountability issues.	212	1	5	3.27	1.135
I am willing to attend review meeting with service users.	212	1	5	4.23	.666
The health center gave enough emphasis on social accountability	212	1	5	3.31	1.210
The health center has a mechanism for a clients to complain on poor quality of services they received	212	1	5	3.43	.998
The health centers have clear structure for feedback for complaints from their clients	212	1	5	3.78	.915
Staff are held accountable for getting work done according to clear performance standard	212	1	5	3.67	1.063
The Health center gives an equal opportunity for employees	212	1	5	2.88	1.256
I believe that I am accountable to my clients for the service I provided.	212	1	5	4.07	.969
Total Mean	**3.5**				

4.1.5. Perceived social accountability varies by socio-demographic characteristics of age, educational qualification and year of service

The ANOVA table below indicates the perceived level of social accountability difference with age, educational level of participants and years of service. In this regard, there is statistically significant difference between the means of the different levels of age of respondents by perceived level of social accountability (F =14.378, P<0.000). There is no significant difference between perceived level of social accountability and educational qualification (F=0.778, P>0.50). Regarding year of services, there is a statistically significant difference between the means of the different years of service of respondents in practicing of social accountability (F =18.981, P>0.000). This indicates that the two important variables have significant difference with perceived level of social accountability.

Table 5: Perceived level of social accountability differences by socio-demographic characteristics age, educational qualification and year of service

ANOVA

	Sum of Squares	df	Mean square	F	Sig.
Age of respondents					
- Between groups	60.232	3	20.077	14.378	.000
- Within groups	290.448	209	1.396		
- Total	350.679	212			
Educational qualification of respondents					
-Between groups	.712	3	.237		
- Within groups	63.495	209	.305	.778	.507
- Total	64.208	212			
Year of Service of respondents					
-Between groups	31.653	3	10.551	18.891	.000
-Within groups	116.172	209	.559		
- Total	147.825	212			

4.1.6. Perceived level of social accountability association by knowledge of social accountability

As indicated in the SPSS output, the relationship between perception level and knowledge is resulted with a significant correlation index (r=0.727**). The more the knowledge level they have the higher perceived level of social accountability indicating the contribution of awareness creation using different mechanisms including trainings, meetings, social accountability system development and engaging the community.

Table 6: Perceived level of social accountability association by knowledge of health care workers

		Perceived Level	Knowledge
Perceived Level	Pearson Correlation	1	.727**
	Sig. (2-tailed)		.000
	N	212	212
Knowledge	Pearson Correlation	.727**	1
	Sig. (2-tailed)	.000	
	N	212	212

**. Correlation is significant at the 0.01 level (2-tailed).

4.1.7. Analysis of key informant interview

The primary goal of key informant interview is to obtain qualitative description of perceptions or experiences, Key Informant Interviews Can Provide: qualitative, descriptive information for decision-making, understanding of motivation, behavior, and perspectives of participants, examples of successes and shortcomings of the activity or program, recommendations or future directions, information to support interpretation of quantitative data collected through other methods and preliminary information needed to design a comprehensive quantitative study (Mountains States Group Inc, 1999).

For this study, key informant interviews were carried out with the medical directors from the selected health facilities; the data was coded, transcribed, analyzed by selected thematic areas and presented below.

Social accountability concepts and principles

Participants were asked social accountability concepts and principles, accordingly one of the participants responded that "*For me Social accountability mean that giving the service for client by considering accountability. This is our health professional responsibility*". The other participant added that "*Providing quality health care service for our beneficiaries without discrimination by considering the professional ethics, transparency and accountability*".

The third participant said "*When we say social accountability, we talk about the responsibility of the service givers. As we know in our facility the health professional is the service giver, so we considered accountability when we undertake the healthcare activity*".

Social accountability is about the responsibility of the service givers. In healthcare facilities the health professional are the service givers. Providing quality health services is the responsibility of a professional, one should give the service for our client with respect, without discrimination, and giving the healthcare service by considering the professional ethics. Especially, for the health professional, social accountability is very important because we strive to work for our community for a better health condition.

Capacity of service users in assessing and monitoring the quality-of-service delivery

Participants were asked about capacity and one of the respondents said "*Most of our clients don't have enough knowledge about how to monitor the heath care workers by considering the service standard. Because most of our clients have not enough information about the health service standard*".

Participant two added that "*By my observation our clients have a knowledge gap about assessment for the service delivery. Because some of our client's expectation were beyond the health center service standard"*.

The third participant also said that "*I can observe that some of our client have the capacity to assess and monitor the quality of the health service delivery. But it needs support from the government to improve the knowledge of our community in a larger scale*".

Clients in general require capacity in terms of measuring the service they received, for this reason health care providers need to build the capacity of service users to compare quality of services against the standard or compared to other similar service givers. The respondents in this study have similar understanding that some of the clients have the capacity to monitor and assess the quality of the service delivery they are getting.

As one of the medical directors said

> *Our facility has the practical experience in this area because we have the service user's representatives in different groups. During our contact I can observe that some of them have the capacity to assess and monitor the quality of the service delivery. But most of our clients don't have enough knowledge about how to monitor the heath care workers by considering the service standard. Because some of our client's expectations were beyond the health center service standard. Our facility used different mechanism to give awareness for the service users on the monitoring issue, but it needs more work and support from the government and concerning body.*

Existing mechanism to build the capacity of the clients/service users to voice their needs and demands

Participant were also asked about existing mechanism to build capacity and one of the respondents said "*Yes, our facility used different mechanisms to capacitate community groups. One of the mechanisms is awareness creation on the morning session for the clients waiting area".*

The other participant added *"We use different mechanism like client's suggestion box and the suggestion format to put freely about their needs, demands and ideas about the service that provided by healthcare workers".*

Participant three also said "*We organize capacity building meetings with community representative and we tried to discuss with them how to promote the clients to exercise to voice their needs and demands".*

In the selected facilities health care providers used different mechanisms to capacitate community groups. One of the mechanisms is awareness creation about importance of community participation in health service. they create awareness among service users through different mechanisms; health related meetings, use of client suggestion box and the suggestion format to voice their needs, demands and ideas about the service that provided by healthcare workers.

It was also mentioned that the support to capacitate the clients are very limited and needs more strategies of building capacity which needs attention from the facility and also from the government to improve the knowledge of the community groups in the larger scale.

Existence of current system to report the service delivery performance and challenges to clients /Service users

Participant were also asked about existing system to report the service delivery performance and challenges and one of the respondents said "*Yes, we reported our performance for different community groups like family health groups, women development group and youth groups".*

Participant two added that *"Yes we have the system. We reported our performance and challenges in quarterly bases for our client's representatives".*

Participant three also said that "*Yes, we met with our clients in quarterly bases and we reported for them the performance of the facility and challenges that we face during the quarter".*

The medical directors in all the facilities revealed the existence of the system in place that the performance and challenges are reported in quarterly bases for the client's representatives. The client's represented by member of facility board and by different community groups. The community groups established by the woredas. Some of the community groups are family health groups, women's development groups, youth groups, and also community structures like Idir's and community associations.

Mechanisms or procedures to assess the performance of service delivery by the health care providers

Participant were also asked about existing mechanism to assess the performance of service delivery and one of the respondents said *"Yes, one of the mechanisms is comparing the performance with plan for each department by the team leader on team meeting".*

Another participant added that "*The team leader asses each healthcare worker performance and scored the result by using one of the assessment cards called the balanced score card (BSC)".*

The other participant also said that "*Yes, one of the mechanisms is organizing review meeting to assess the performance and each department prepared the improvement plan for the poor performed activities".*

All the respondents have similar opinion on this, they have mechanisms to assess their own performance of service delivery. There are different mechanisms including departmental level performance review against plan and target. The other mechanism is departmental meetings in weekly bases to assess the weekly performance and discuss about the well performed and low performed activities, for the poor performance they prepared improvement action plan in monthly bases to work based on plan for a better achievement, then all team leaders conduct meetings on improvement action plans with medical Directors, later after approval by the medical director, the plan posted on each department offices and examination rooms for daily reference to guide as reminder.

The other mechanism is the use of balanced score card (BSC). The balanced score card prepared by sub-city health offices and provided to the facility. This card filled by team leader for each healthcare worker by considering their performance.

The team leader discusses with department staffs on the filled score card individually and each member signed on the card after they reach agreement on the score. The final agreed balanced score card kept in the personal file. The facility considering it during the promotion of staff and any related chances for the individual healthcare workers carrier.

In general, all the facilities selected for this study have mechanisms in place for monitoring of health care worker performance.

Existence of procedures to receive service user's complaints and the reaction of health care workers

Participants were also asked about existing procedures to receive service user's complaints and one of the respondents said *"We have compliance unit to collect the service user complains by formats, and also verbal complains".*

The other participant added that "*We have suggestion registration book and suggestion box for the clients and the facility promotes the clients to use it for their suggestion and complaints".*

The responses of the medical directors shows that there is a procedure where clients submit their complaints on the service they received, there are different procedures which includes the following. There is a compliance unit to collect the service user complains by formats, there is also a mechanism to receive verbal complains directly. The compliance unit has its own governing rule about the resolution of the problem. The unit has team members for investigation and to decide about complains related to service provided by the healthcare workers.

The respondents mentioned that there are challenges during reviewing the complaints related to confirming the case, lack of identifiers, the time of the incident and the likes, one of the medical directors said

> *Some of our clients also write the complaint on suggestion registration book and they put in the suggestion box, during this time the compliance unit face difficulties because there is not any option to investigate more on the issue because most of time they couldn't found the address of the person on the paper. To collect the citizens' complaints in a proper way we need to build the capacity and system of the service users' complaints management by compliance unit and medical director.*

The compliance unit investigates the issue with team and try to solve with clients and health care worker together by organizing a meeting for discussion, but if the case is not solved by the team the medical director manages with management team members.

Regarding healthcare workers reaction towards the complaints against them there is mixed feeling among the respondents, majority mentioned that healthcare workers feel difficult to accept, one of the participants said

> *To frankly speaking almost all healthcare workers, feel bad and they were not ready to accept the client's complaints. They tried to cover the issue, most of our staff interpreted negatively for the complaints. During such times the management of the complaints mostly take longtime to be resolved and needs involvement of other concerning bodies for the decision.*

Participant two added that *"The compliance unit investigate the issue with team and try to solve with clients and health care worker together by organizing the discussion meeting".*

Participant three also said that *"Regarding to their feeling, to frankly speaking almost all healthcare workers feels bad and they were not ready to accept the client's complaints".*

Challenges faced by health care workers related to social accountability

Participant were also asked about challenges faced by healthcare workers and one of the respondents said *"Yes, we faced different challenges. Based on my observation most of our clients don't have enough knowledge about their right and they didn't know how to communicate to healthcare workers".*

Participant two added that *"The other challenge is some of our client expectation is beyond the facility standard delivery".*

Participant three also said that *"One of the great challenges related to social accountability is the shortage of medicine and laboratory reagents because of this most of our free clients complain, and they returned home without medicine".*

All respondents revealed a similar case, existence of different challenges. They mentioned some of the challenges. There are challenges related to their clients, most of

the clients don't have enough knowledge about their right and they don't know how to communicate to healthcare workers, and this leads to conflict between clients and health care workers.

One of the medical director mentioned

> *The other challenge is related to client's expectations where it is beyond the facility standard service delivery, because of this some clients are not willing to accept our referral to hospital for the better investigation and management". Another challenge reported was some of the clients were not interested to participate in the review meeting organized by the facility where everyone can get clearer understanding of the situation.*

The other challenges are related to healthcare workers and system issues like the budget shortage and the budget release time. It causes the shortage of medicine and laboratory reagents because of this most of our free clients complain and they return home without medicine, this is one of the great challenges related to social accountability because they have the right to get the ordered drugs and other services. It was also revealed that there are challenges regarding the staff, as one of the medical directors said, *"There are staff who were not committed to their job, and they are not happy to discuss complaints against them with our clients".*

Suggestion for ensuring social accountability in health services

Participants were also asked if they have any suggestions for ensuring social accountability in healthcare and one of the respondents said, *"We all health care workers should give our service by considering the social accountability because we deal with the life of the human being".*

Participant two added that *"We need to give attention for our vulnerable clients like elders, women and person with disabilities because these clients are our prior targets".*

Participant three also said that *"Finally I suggest that the government and the facility need work hard to capacitate the community to increase the client's involvement and to fulfill clients need".*

All the respondents have a similar response on the issue of implementing social accountability in the health facility for the quality-of-service provision and to make everyone accountable who work against the standard.

One of the medical directors mentioned

> *First, we all health care workers should give our service by considering the social accountability because we deal with the life of the human being. As a health professional we have the responsibility to give care and treatment for our clients without any discrimination"*. the respondent continued saying "*Especially we need to give attention for our vulnerable clients like elders, women and person with disabilities because these clients are our prior targets*.

They all have a similar stand when it comes to government engagement and close working collaboration with the facility to capacitate the community and to increase the client's involvement and to fulfill client's needs. It was also mentioned that the health care workers need capacity building and experience sharing with each other and beyond to give the quality health service for the community they serve.

4.2. Discussion

Socio-demographic factors and their association with perceived social accountability of healthcare workers

Generally, age, educational level and years of services are significant variables to increase health professionals' perceived level of social accountability.

Other researchers also have found age, gender, education, and years of work have significant impacts on organizational commitment though gender was not found to be significant in this study. (Akintayo & Abu, 2006). Research conducted by Rehman and colleagues showed that there is a significant relationship between the organizational commitment and job satisfaction with corporate social responsibility (Yousaf, and Zia 2010).

Research conducted by Akintayo reported that the turnover intention has a negative correlation with age. Ali and colleagues also revealed that there is a significant correlation between organizational commitment to corporate social responsibility and the desire of turnover. Demographic factors with social responsibility, corporate reputation and employee engagement. The demographic results indicate that employees who are tied to their job are over 40 years old. It is associated with cognitive and emotional components of own employees' perception who have been working in the hospitality industry for a long time (Akintayo, 2003, Ali, Rehman; Ali; Yousaf and Zial, (2012).

The level of education has a significant impact on organizational commitment. They stated that graduated workers have a higher commitment to the organization than the non-graduated ones. The level of education has a significant impact on organizational commitment (Akintayo & Abu, 2006). The results of these studies indicate that workers who have a bachelor's degree have higher commitment to the organization compared to their peers who don't have it. For the category of education, it is almost the same as the category of office/position. This is because the manager is not only required to just run the operations of the hotel, but it's also required to teach ethics for its employees. Business ethics stresses that managers and corporations are responsible for implementing ethical principles in their organization and they use moral bases in making decisions, policies and strategies, and dealing with other general issues of the company. In the

context of social responsibility, managers act as moral actors and are responsible for the conduct of responsibility (discretion) on their existing management in all aspects of social responsibility to produce results that are socially responsible. Similar to the demographic factors of age, it has been noticed that employee engagement is affected by how long the employee worked. Long work affects employee's perceptions. How they treat their employees can determine the employees' sustainability commitment to the hotel where they work. Akintayo (2003) reported that the desire of the employee's turnover has a negative correlation with organizational commitment. So it can be said that the larger the organization's commitment to the welfare of employees, the lower the desire to turnover becomes. The potential causes are age, length of work, and career satisfaction.

Perceived knowledge of social accountability by health care workers

The findings of this study imply that by health center clients have the right to demand quality health services. It is also indicated that active participation of service users improves quality of service and creating community awareness enables to enhance transparency and accountability. Hence, healthcare workers have encouraging level of perceived social accountability with regard to the current social accountability practice.

Perception is the process of organizing and interpreting patterns of stimuli in the environment. The study of perception is related to the study of cognitive processes, such as memory and thinking (Atkinson, 1997). Further, perception is like what people see is the concept that people have about themselves and others or other (Back, 1977).

On the key informant interview health facility managers were asked about their perception of social accountability as a concept "What do you mean social accountability for you?" the responses included "When we say social accountability, we talk about the responsibility of the service givers. In our facility the health professionals are the service giver. Providing quality health services is our responsibility and as a professional we should give the service for our client with respect, without discrimination and giving the healthcare service by considering the professional ethics. Especially for the health professional social accountability is very important because we strive to work for our community in a better health condition."

It is possible to conclude that the respondents both in the questionnaire and interview have adequate level of knowledge of social accountability as a concept and principle. This is evidenced from the literature, Jonatan states social accountability (SA) is an evolving umbrella category that includes: citizen monitoring and oversight of public and/or private sector performance, user-centered public information access/dissemination systems, public complaint and grievance redress mechanisms, as well as citizen participation in actual resource allocation decision-making, such as participatory budgeting (Fox, 2016). Grandvoinnet and friends also described social accountability as an approach to building accountability in which citizens are key actors; it refers to 'the extent and capacity of citizens to hold the state and service providers accountable and make them responsive to needs of citizens and beneficiaries' (Grandvoinnet , Helene & Aslam, Ghazia & Raha, Shomikho ,2015).

Perceived social accountability of health care workers

There is high level of perceived social accountability. From the findings it is possible to conclude that respondents believe that they are responsible to deliver quality health services and all health workers in the facility undertake their activity by considering social accountability. It is also clearly indicated that social accountability is vital for efficient management of the health sector and to satisfying the existing higher number of needs in the sector. Hence, social accountability is indispensable for the achievement of the targeted goals of the health sector. It also implied that health professional have acceptable level of perception with regard to maintaining the rights of service users in the health delivery activities. This enables to improve service delivery activities and increase the satisfaction level of the service users.

In general health professionals have encouraging level of awareness of their responsibilities in accomplishing their tasks and thereby improve the quality of health services. It is the basic foundation in the efforts of improving quality of health services throughout the country. Health professionals are well prepared to satisfy service users according to their needs for different types of health services. They are ready enough to accept the feedbacks from service users and to use it for improving the whole processes of providing better quality of health services.

They are not satisfied with the existing amount of salary. Obviously, this condition adversely affects the efforts of providing better quality health care services for large number of people.

In addition, the findings of the study imply that there are confusions with regard to accepting criticism from different areas of the activity. Accepting criticism is one of the vital requirements for achieving the successes of in delivering different services. There is a clearly indicated gap in health delivery activities in relation to accepting criticism towards health care workers. Thus, it requires different capacity building activities to improve the existing narrower willingness with regarding to accepting criticisms. Criticisms can be utilized as input in the increasing the efficiency of delivering health services.

Current practice of social accountability by health care workers

The study revealed that there was an acceptable level of practice of social accountability in the study facilities. In relation to this the finding from the key informant interviewees (facility medical directors) also showed the study facilities had the practical experience in this area because of having the service user's representatives in different groups. The facilities used different mechanism to give awareness for the service users on the monitoring issue, but it needs more work and support from the government and concerning body.

Besides, KII discussants were asked to forward more suggestions on how to better include citizens and community priority needs in service delivery to ensure social accountability. Some of these were interrelated and complementary to each other. Some were more technical like increasing the number of skilled staff. Others, more relevant to SA, were suggested. The suggestion that was forwarded by participants was highly the need for citizen participation in planning and budgeting followed by training/ awareness creation of stakeholders on SA mechanisms, identification of priority needs of community and implementing them, close supervision of service providers and implementing community and government cooperation/good governance.

The responses of the KII respondents also raveled the facility used different mechanisms to capacitate community groups including awareness creation through different meetings

and use of client's suggestion box and the suggestion formats. There is a concern on the support to capacitate clients are very limited and needs more of capacity building and needs attention from the facility and the concerned government body to improve the engagement of the community groups in the larger scale.

Similar responses also documented from other researchers; for instance Hunde & Duressa found out in their study that the low citizens awareness about their right and socio cultural barriers that limit speaking out, absence of access to information guarantees rendering government income and expenditure because beneficiaries lack of their right awareness up to this and service provider's unwillingness to share information were the factors raised by the respondents (Doja, & Duressa, 2019).

The key informant interview respondents also shared that there is reporting mechanism of performance and challenges in quarterly bases for client's representatives. The client's represented by member of facility board and by different community groups which were established by the woreda. Some of the community groups are family health groups, women's development groups, youth groups, and also used the existing community structures like Idir's and community associations.

Francesca and Nicholas in their study in India also noted that "the need for community-level mechanisms in India to adequately address issues of participation and empowerment of community members to be successful in contributing to service improvements in health and nutrition. Notably, in most of these mechanisms' community participation is very weak, with committees largely controlled by the frontline workers who are supposed to be held to account. Despite not having an explicit accountability role, these groups were nevertheless effective in advocating for better service delivery and the broader needs of their members to a level not seen in institutional committees (Francesca and Nicholas 2018).

The summary of KII responses also included the existence of mechanisms to assess performance of service delivery; departmental level review of performance and preparing improvement action plans in monthly bases for the better achievement. The respondents also mentioned that the balanced score card prepared by sub-city health offices and provided for the facility.

The respondents further described different mechanisms to receive the service user's complaints. Establishment of compliance unit to collect the service user complains by formats, and also verbal complains. The compliance unit has its own governing rule about the resolution of the problem. Regarding their feeling, almost all healthcare workers feel bad and they were not ready to accept the client's complaints. They tried to cover the issue. The management of the complaints mostly took longtime and needs involvement to other concerning bodies for the decision".

Cornwall and other researchers also documented that community monitoring can be institutionalized and embedded into government programs, or led by stakeholders other than state institutions, such as civil society groups, community based groups and consumer groups. Key means of involving communities in holding service providers accountable include mechanisms such as monitoring committees, citizen juries, scorecards and social audits (Cornwall, 2003).

Some of the results reported through the initiatives can include increased transparency and participation in decisions concerning service delivery, reduction in corruption practices, improvements in availability and quality of services, and overall changes in power dynamics between citizens and service providers.

Crucial to the impact of these initiatives are factors such as the quality of participation of community members (Cornwall, 2003); the need for these mechanisms to be 'vertically integrated' to address bottlenecks in service delivery at different levels of the supply chain (Fox, Aceron, Isaac, 2016).

At broader level, these types of initiatives should not be seen as technical 'widgets' but rather sustained efforts that engage politically with states and service providers (Joshi, 2012; Fox ,2016) and address power dynamics underpinning service delivery, which make a crucial difference in ensuring access to services for marginalized groups such as women and indigenous people.

At a local level, effective accountability mechanisms require building inclusive spaces for community participation, whether institutional or informally established, which can reduce 'asymmetrical power relations' (Flores, 2011) between local service providers and community members. However if participation is not meaningful, the responsiveness of

providers to accountability demands is significantly weaker (Lodenstein , Dieleman , Gerretsen, and Broerse ,2016).

For this reason, successful accountability activities focus on building awareness, confidence and capacity of community members and ensuring an adequate facilitation of dialogue between citizens and providers (Cornwall, Coelho, 2007; Miller, Veneklasen and Clark, 2005). While bearing in mind the broader literature, and concerns about the need for strategic, comprehensive approaches, this study focuses on accountability initiatives operating at a local level, through institutional spaces for participation aimed at improving the delivery of health and nutrition services (Krishnan & Subramaniam, 2014). KII further revealed challenges related to implementation of social accountability which included client's limited knowledge about their right and ways of communication to healthcare workers which led to conflict between clients and health care workers. Budget shortage and the budget release timeline are also reported as part of the challenges causing the shortage of drugs and supplies like laboratory reagents which hinders particularly free patients to get the comprehensive service.

This study focused on the major factors affecting social accountability, tools or mechanisms and roles of social accountability. In line with the findings and the previous empirical studies strengthening social accountability has emerged as a key strategy for improving public services and making progress towards attaining the millennium development goals (MDGs) through increasing transparency (World Bank, 2004; Deverajan and Widlund, 2007). In contrast to this, there were factors which are hindering not to attain this objective. These hindering factors includes, lack of awareness from beneficiary perspectives, reluctance of the service providers, lack of supervision, absence of access to information, lack of transparency and the overlook of bottom-up approach.

As Eshetu presented on 2011 of United Nations conference held in New York, there are a number of Social Accountability mechanisms that citizens, community groups, and CSOs can use to hold service providers and government officials accountable. These mechanisms mainly include, Citizens Report Card, Community Score Cards, Citizen Participation in public policy making, participatory planning and budgeting, public budget tracking citizen monitoring of public service delivery, lobbying, campaigning and

advocacy, etc. however, paradoxically this finding revealed that except infrequent public meeting and beneficiaries report on the document prepared by the service providers, the other mechanisms were not utilized in the study areas. The citizen-led accountability tactics were not as the culture of these organizations. This finding is similar with study conducted by Tamsin and friends. (Tamsin, Ghazia, & Rasmus, 2017). According to these authors, social accountability mechanisms are rarely appearing as a wider approach to ensure good governance.

Support for social accountability mechanisms in rural Sub-Saharan Africa has increased over the past decade and is becoming firmly anchored in government policies and donor and NGO strategies (Esbern, 2014).

Social accountability mechanisms need to be better institutionalized and linked to existing governance structures. Moreover, NGOs could support the process of building capacity of both staff and community members in drawing up budgets and planning activities.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1. Conclusion

The main purpose of this study was to investigate the perceived level of social accountability of health services among health care workers in four health centers found in Yeka Sub-city. More specifically the study had designed to answer the following research questions: the perceived level of social accountability among healthcare workers, the perceived level of social accountability varies with age, educational qualification and year of service of participants, and what major factors affect the healthcare workers perceived level of social accountability.

In order to achieve the purpose intended, out of the total number of 498 population found in the three health centers 212 health care workers of different categories were made to participate in the study, the data was gathered through a self-constructed Likert scale structured questionnaire and key informant interview from medical directors of the health facility . The questions asked in both the questionnaire and the interview were focused on the perceived level of social accountability, associated factors including socio-demographic and others like knowledge, and current nature of practice of social accountability. The collected data were analyzed using frequency, percentile, mean, standard deviation and further looked for correlation between demographic factors and perception of social accountability. The quantitative finding also triangulated with the findings of the qualitative data from the key informant interview. The major findings were briefly summarized as follows: -

The respondents' characteristic included sex, age, educational background, professional status, and services year in the selected facilities. The majority are young, females, married, and health workers with first degree and have relatively longer years of experience in the health sector.

The study showed significant association between demographic factors and perception of social accountability, Age, level of education and service years positively associated with social accountability, When age, service year and educational level increase the level of perceived social accountability increases indicating capacity building effort among the

young, those with few years of service and the lower educational category showing that facilities continue on providing capacity building trainings, empowering health care providers and ensuring accountability for quality health services.

It was also shown that there is an overall high level of knowledge of social accountability among the health care workers significantly associated with perceived social accountability. There is also high level of perceived level social accountability among healthcare workers which was significantly associated with current practice of the social accountability program. It was also found that health professionals have encouraging understanding of their responsibilities in accomplishing their tasks and thereby improve the quality of health services. It is the basic foundation in the efforts of improving quality of health services throughout the country.

The study found out that there is a clearly indicated gap in health delivery activities in relation to accepting criticism towards health care workers. Thus, it requires different capacity building activities to improve the existing narrower willingness with regarding to accepting criticisms. Criticisms can be utilized as input in the increasing the efficiency of delivering health services.

The findings also clearly indicate that there are conducive conditions to work closely with service users. It is also implied that health professionals have considerable level of readiness and practice with regard to their accountability in delivering different health services.

The assessment of accountability cannot be separated from the vision one has about the components of social accountability, tools and mechanisms to enforce the accountability system, empowering both the health care workers and the beneficiaries in a strong and actively participatory model.

5.2. Recommendations

It was found out that there are significant differences of social accountability perception when examined against sociodemographic characteristics. There are also gaps in implementation of social accountability. Based on the findings the following recommendations were forwarded by the researcher:

- Social accountability implementers together with facility management must be engaged in building the capacity of healthcare workers in SA concepts, tools, mechanisms of participation and monitoring to get them equipped better with the ability to work with beneficiaries to improve the quality of basic health services through integrating social accountability mechanism.
- Community members shall be made aware of their rights to demand and contribute to improvement in quality of basic health services and be able to hold service providers accountable for poor performance. Beneficiaries should have access to adequate information on services provided in the facility, budget allocation and expenditure. They should be consulted on improving basic services and be allowed to have much stronger participation in planning basic services. They should also be effectively reported to, with regard to plan implementation and the challenges faced.
- For the sustainability of social accountability program, it should be owned and implemented by government institutions. Social accountability needs to be integral part of all health service providing institutions in AA and beyond. Social accountability mechanisms need to be implemented regardless of the type of service provided.
- Any future attempts to promote social accountability and to increase the proactive engagement of citizens should take a more diversified approach to citizens and explore the various potentials and limitations of social groups in relation to their structural positions, interests and capability to engage in various types of actions.

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Annex I

Questionnaire

ADDIS ABABA UNIVERSITY

College of Social Psychology,

Department of Psychology

Dear Respondents:

I am a graduate student at Addis Ababa University College of Social Psychology, Department of Psychology. Currently, I am conducting a research titled "**Perceived Level of Social Accountability and knowledge of Healthcare Workers in Yeka Sub-city woreda 1,,8,and 11."** as a partial fulfillment of requirements for the award of Masters of Education in Social Psychology.

The purpose of this questionnaire is to gather data for the proposed study, and hence you are kindly requested to assist the successful completion of the study by providing the necessary information. Your participation is entirely voluntary and the questionnaire is completely anonymous. I confirm you that the information you share will stay confidential and only used for the aforementioned academic purpose only. So, your genuine, frank and timely response is vital for the success of the study. I want to thank you in advance for your kind cooperation and dedication of your precious time to fill this questionnaire.

Sincerely Yours;

Lanchisel Amare

Note:

1. No need of writing your name.

2. Put this _√' or _X' mark on the appropriate block/cell both for multiple choice and Likert scale questions.

3. If you need further explanation you can contact me and discuss the matter freely at (Telephone No. 0911643390, E-mail lanchiamare@gmail.com).

Part I: Socio-demographic characteristics of respondents

Instruction: read the following sentences and put _√‘or _X‘ mark on the appropriate cell/block

Code	Questions	Choices	Skip
001	Client identification Code		
002	Age:	In Years_____	
003	Sex:	1. Male 2. Female	
004	Marital status	1. Single 2. Married 3. Divorced 4. Widowed	
005	Educational Qualification:	1. Below college diploma 2. College diploma 3. First Degree (BSc, BA) 4. Second Degree (MSc, MA)	
006	Professional Category	1. Nurse 2. Midwife 3. Health officer 4. General practitioner 5. Pharmacist 6. Lab technologist	
007	Year of service	In years ……..	

Part – II: Five point Likert scale questions

Please express your level of agreement in the following questions by putting _√‘or _X ‘mark in the appropriate cell.

1= Strongly Disagree, 2= Disagree, 3= Neutral, 4= Agree, 5= Strongly Agree

P Knowledge of Social Accountability						
Level of satisfaction (Likert's 5 point scale)						
Code	**Statement**	**Strongly Agree (5)**	**Agree (4)**	**Neutral (3)**	**Disagree (2)**	**Strongly Disagree (1)**
201	I have enough knowledge about Social accountability					
202	Application of social accountability into health care is beneficial to service users to get quality services					
203	Application of social accountability in to health care creates transparency between service givers and service users					
204	Social accountability services makes health providers to give inclusive services for vulnerable groups (women, person with disability …..)					
205	Health center clients have the right to demand quality health services					
206	Service users have the right to hold service givers accountable for their performance					
207	By creating community awareness it is possible to enhance transparency and accountability					
208	Active participation of service users improves quality of service					
	Perceived Level of Social Accountability					
209	I believe that I am responsible to deliver quality health services					
210	All health workers in this facility undertaken their activity by considering social accountability					
211	Social accountability empower citizens to make health workers responsive and					

	committed for their work					
212	Service users should have a voice about the service they are provided					
213	Accountability to quality health services is the responsibility of the facility management and staffs					
214	I am ready to satisfy my clients/service users					
215	I believe that service users have the capacity to monitor and assess the quality of service delivery					
216	All healthcare workers are accountable for the service they provided to clients					
217	I feel upset of any criticism towards health care workers					
	Current Practices of Social Accountability by Healthcare Workers					
218	I have participated in a training organized for health workers to promote transparency and accountability					
219	Health care workers assess their performance based on standard					
220	Health care workers attend a review meeting organize for health care workers to share their experience and challenges on social accountability issue					
221	I am willing to attend review meeting with service users					
222	I attended a review meeting with clients on service delivery organized by the facility					
223	The health center has a mechanism for the clients to complain on poor quality of services they received from the health care providers					
224	Health care workers use clear structure for feedback for complaints from their clients					
225	Staff are held accountable for getting work done according to clear performance standard					
226	The Health center give an equal opportunity for employees					
227	I believe that I am accountable to my clients for the service I provided					

Part III. Key Informant Interview for Health center Medical Directors

This interview aims to identify the "**perceived level of social accountability and knowledge of healthcare workers: the case of Yeka sub city, Woreda 1,8, and 11**. It focus on factors affecting the perceived level of social accountability that are critical to health workforce practice of quality service provision. That is: Medical doctors; Nurses; pharmacists; midwives and health officers.

Read the informed consent form to the respondent(s) and ask them to sign it.

Name of facility	
Title/Position	
Time interview started	
Time interview ended	
Name of interviewer	

No	Guiding question	Probing questions
1	What do you mean social accountability for you?	
2	How do you express the level of the capacity of your clients in assessing and monitoring the quality of service delivery?	
3	Does your facility have any mechanism to capacitating community groups to voice their needs and demands?	If Yes, in what forms?
4	Does your facility have a system to report the service delivery performance and challenges to beneficiaries/Service users? Do service providers use specific mechanisms or procedures to assess their performance of service delivery?	If yes, what mechanisms/procedures do they use to assess their service delivery performance?

5	Do service providers use specific mechanism or procedures to assess their performance of service delivery?	
6	Are there processes/mechanisms in place to receive citizens' /service users' complaints?	If yes, what mechanisms are in place?
7	How healthcare workers respond to service users' complaints?	Can you say something about their feeling?
8	Are there any challenges faced by health care workers related to social accountability?	If yes? What are the challenges?
9	What is your suggestion for ensuring social accountability in health services?	

Many thanks for your time and useful information

Annex II
Amharic questioner

አዲስ አበባ ዩኒቨርሲቲ

የባህሪ ጥናት ክፍል

የሳይኮሎጂ ትምህርት ክፍል

<u>የጥናቱ ተሳታፊዎች የስምምነት መግለጫ ቅፅ</u>

<u>መግቢያ</u>

ላንቺስል አማረ እባላለሁ በአዲስ አበባ ዩኒቨርስቲ የሶሻል ሳይኮሎጂ የድህረ ምረቃ ተማሪ ስሆን በየካ ክፍለ ከተማ ወረዳ 1, 8 እና 11ጤና ጣቢያ ጥናት ለማድረግ ይህን መጠይቅ አዘጋጅቻለሁ፡የጥናቱ አላማም የጤና ባለሙያዎች በማህበራዊ ተጠያቂነት ዙሪያ ያላቸውን አመለካከት እውቀት እና ተያያዥ የሆኑ ጉዳዮች ለመፈተሽ መረጃ ለመሰብሰብ ነው፡

ስለዚህ እርስዎም በጥናቱ ተሳትፈው ለምጠይቅዎት ጥያቄ መልስ በመስጠት ይተባበሩኝ ዘንድ ፍቃደኝነትዎን እጠይቃለሁ፡ ጥናቱን በመሳተፍዎ የሚያገኙት የግንዘብ ጥቅም የሌለና በሙሉ ፍቃደኝነት ላይ የተመሠረተ መሆኑን ልገልፅልዎ እወዳለሁ። የሚሰጡኝን መረጃ በሚስጥራዊ ቦታ የሚቀመጥና ስሞዎም በጥናቱ ላይ የማይጠቀስ መሆኑን ላረጋግጥልዎ እወዳለሁ። በማንኛውም ሰዓት በጥናቱ ወቅት ጥያቄ ካለዎት መጠየቅ ይችላሉ።

በጥናቱ ለመሳተፍ ሙሉ ፍቃደኛ ከሆኑ ፊርማዎትን ከዚህ በታች በተቀመጠው ቦታ ላይ ያኑሩ። ስለ ትብብርዎ በቅድሚያ አመሠግናለሁ።

ፊርማ .....ቀን .....

<u>መመሪያ</u>

ይህ መጠይቅ ሁለት ክፍሎች አሉት። የመጀመሪያው ክፍል የተሳታፊዎች ግላዊ መረጃዎች ላይ የሚያተኩር ይሆናል፡

ሁለተኛው ክፍል የጤና ባለሙያዎች በማህበራዊ ተጠያቂነት ዙሪያ ላይ ያላቸውን አመለካከት እና ተያያዥነት ያላቸው ጉዳዮች ይመለከታል።

የተዘረዘሩት ጥያቄዎች በሙሉ የሚመለሱ ሲሆን ለጥያቄዎቹ ካለዎት እውቀት አና ልምድ አንፃር ትክክለኛ ነው ብለው የሚያምኑበትን ምላሽ እንዲሰጡ እየጠየኩ በቅድሚያ ለትብብርዎ ልባዊ ምስጋናዬን አቀርባለሁ።

ክፍል አንድ ፦ የግለሰብ እና ማህበራዊ ሕይወት መገለጫዎች

መመሪያ ፦ጥያቄዎችን ካነበቡ በኋላ በተሰጠው ክፍት ቦታ ላይ በመፃፍ እንዲሁም

በምርጫ ከቀረቡት ውስጥ ደግሞ መልስዎ የሆነውን በማክበብ መልስዎን ይስጡ

ኮድ	የመግቢያ ጥያቄዎች	ምርጫዎች	ምርመራ
001	መለያ ቁጥር	---------- (በቢሮ የሚሞላ)	
002	ዕድሜ	----------በቁጥር ይግለፁ	
003	ፆታ	1. ወንድ 2. ሴት	
004	የስራ ድርሻ	----------	
005	የትዳር ሁኔታ	5. ካሁን ቀደም ያላገቡ 6. ያገቡና አብረው ያሉ 7. የተፋቱ 8. ፍቺ ሳይፈፅሙ ተለያይተው የሚገኙ	
006	የትምህርት ደረጃ	1. ከዲፕሎማ በታች 2. ዲፕሎማ 3. የመጀመሪያ ዲግሪ 4. ሁለተኛ ዲግሪ 5. ሶስተኛ ዲግሪ	
007	የሙያ ሁኔታ	1. ነርስ 2. አዋላጅ ነርስ 3. ጤና መኮንን 4. ጠቅላላ ሀኪም 5. ፋርማሲስት 6. ላቦራቶሪ ቴክኖሎጂስት 7. ሌላ ካለ ይግለፁ ----------	
008	የአገልግሎት ዘመን	----------	

ክፍል ሁለት ፦ የተዘረዙትን ሀሳቦች ካነበቡ በኋላ የሚስማሙብትን የምላሽ ደረጃ በተሰጠው ቦታ √ ወይም X ምልክት በማድረግ ምላሽዎን ይስጡ

1= በጣም አልስማማም, 2=አልስማማም, 3=ምንም ሀሣብ የለኝም, 4= እስማማለሁ,

ኮድ	የምላሽ ደረጃ					
	ጥያቄዎች	**በጣም እስማማለሁ**	**እስማማለሁ**	**ምንም ሀሳብ የለኝም**	**አልስማማም**	**በጣም አልስማማም**
201	ስለ ማህበራዊ ተጠያቂነት በቂ ግንዛቤ አለኝ					
202	የማህበራዊ ተጠያቂነትን መተግበር ደንበኞች ጥራት ያለው የጤና ግልጋሎት እንዲያገኙ ያደርጋል					
203	የማህበራዊ ተጠያቂነትን አገልግሎት ሲተገበር በአገልግሎት ሰጪዊችና በአገልግሎት ተቀባዮች መካከል ግልፀኝነት ይፈጠራል					
204	የማህበራዊ ተጠያቂነት አገልግሎት የጤና ባለሙያዎች ለችግር ለተጋለጡ የማህበረሰብ ክፍሎች (ሴቶች፣አካል ጉዳተኞች...) አካታች የሆነ አገልግሎት እንዲሰጡ ያደርጋል					
205	የጤና ጣቢያ ደንበኞች ጥራት ያለው የጤና ግልጋሎት መፈለግ መብታቸው ነው					
206	አገልግሎት ተቀባዮች የጤና ባለሙያዎችን ላገኙት ውጤት ተጠያቂ ማድረግ መብታቸው ነው					
207	ለደንበኞች መሰረታዊ ግንዛቤ በመፍጠር ግልፀኝነትና ጠያቂነትን ማሻሻል ይቻላል					
208	የደንበኞች ተሳትፎ የተቋሙን አገልግሎት ያሻሽላል					
209	ያለው የጤና ግልጋሎት መስጠት የእኔ ሀላፊነት መሆኑን አምናለሁ					
210	ሁሉም የተቋሙ ባለሙያዎች ስራዎችን ሲተገብሩ ማህበራዊ ተጠያቂነትን ታሳቢ ያደርጋሉ					
211	ማህበራዊ ተጠያቂነት የደንበኞችን					

	አቅም በመገንባት የጤና ባለሙያዎች ምላሽ ሰጪና ለስራቸው ተገዢ እንዲሆኑ ያደርጋል					
212	ደንበኞች ስለተሰጣቸው አገልግሎት ያላቸውን አስተያየት መግለፅ አለባቸው					
213	ጥራቱን የጠበቀ የጤና ግልጋሎት አንዲኖር ማድረግ የጤና ጣቢያ አስተዳደር (ሀላፊዎች) እና ሰራተኞች ሀላፊነት ነው					
214	ደንበኞቼን ለማርካት ዝግጁ ነኝ					
215	ደንበኞች የአገልግሎቱ አሰጣጡን ጥራት የመመዘንና የመፈተሽ አቅም እንዳላቸው አምናለሁ					
216	የጤና ጣቢያ ባለሙያዎች ሁሉ አገልግሎት ለሚሰጧቸው ደንበኞች ተጠያቂ ናቸው					
217	በጤና ጣቢያ ባለሙያዎች ላይ በሚሰጥ ማንኛውም ሂስ ጥሩ ስሜት አይሰማኝም					
218	ለጤና ባለሙያዎች ግልፀኝነት እና ተጠያቂነት ላይ ያላቸው ግንዛቤ እንዲጨምር በተዘጋጀ ስልጠና ተሳትፌ አውቃለሁ					
219	የጤና ባለሙያዎች የስራ አፈፃፀማቸውን በተቀመጠለት መስፈርተ መሰረት ይገመግማሉ					
220	ጤና ባለሙያዎች በተጠያቂነት ዙሪያ ያላቸውን ልምድና ያጋጠማቸውን ችግሮች መወያየት እንዲችሉ የሚያደርግ የውይይት መድረኮች ላይ ይሳተፋሉ					
221	አገልግሎት ከምሰጣቸው ደንበኞች ጋር የውይይት መድረክ ለመሳተፍ ፈቃደኛ ነኝ					
222	በጤና ጣቢያው ከደንበኞች ጋር በጤና ግልጋሎት ላይ በተደረገ የውይይት መድረክ ላይ ተሳትፌ አውቃለሁ					
223	ደንበኞች ለተሰጣቸው ዝቅተኛ አገልግሎት የጤና ባለሙያዎችን ተጠያቂ የሚደርጉበት አሰራር አለ					

224	ጤና ባለሙያዎች ደንበኞች ላነሱት ቅሬታ ምላሽ የሚሰጡበት ግልፅ የሆነ አሰራር ይጠቀማሉ					
225	የጤና ባለሙያዎች ለፈፀሙት ተግባር ባለው ግልፅ የሆነ የአፈፃፀም መመዘኛ መሰረት በተግባር ተጠያቂ ናቸው					
226	ጤና ጣቢያው ለሰራተኞች እኩል እድል ይሰጣል					
227	ለደንበኞች በምሰጠው አገልግሎት በተግባር ተጠያቂ እንደሆንኩ አምናለሁ					

5= በጣም እስማማለሁ

አመሰግናለሁ !!

ስጤና ጣቢያ ሀሳፊዎች የተዘጋጀ ቃስ-መጠይቅ

ተ.ቁ	መሪ ጥያቄዎች	ማብራሪያ ጥያቄዎች
1	ማህበራዊ ተጠያቂነት ስንል በእርስዎ እይታ እንዴት ያዩታል?	
2	የጤና ጣቢያ ደንበኞች በአገልግሎት ጥራት ዙሪያ ያለውን የጤና ግልጋሎት የመፈተሽ እና የመከታተል ሁኔታ ደንበኞች ያላቸውን አቅም እንዴት ይገልፁታል ?	
3	ደንበኞች ያላቸውን ፍላጎት እና የሚፈልጉትን ነገር መጠየቅ እንዲችሉ የአቅም ግንባታ ስራዎች ትሰራላችሁ?	.አዎ ከሆነ ምን ምን አይነት የአቅም ግንባታዎችን ትሰራላችሁ?
4	የጤና ጣቢያውን የስራ አፈፃፀምና ያጋጠሙ ችግሮችን ለደንበኞች ሪፖርት የሚያደርግበት አሰራር አለ?	.አዎ ከሆነ ምን ምን አይነት ዘዴዎች ትጠቀማላችሁ ትሰራላችሁ?
5	ጤና ባለሙያዎች የስራ አፈፃፀማቸውን መፈተሽ እንዲችሉ የሚረዳ የተዘጋጀ ሂደት ይጠቀማሉ	አዎ ከሆነ ምን ምን አይነት የአሰራር ሂደቶችን ይጠቀማሉ?
6	ደንበኞች ያላቸውን ቅሬታ የሚገልፁበት መንገድ አለ?	አዎ ካሉ ምን ምን አይነት ዘዴ ትጠቀማላችሁ?
7	ደንበኞች ለሚያቀርቡት ቅሬታ የጤና ባለሙያዎች ምላሽ የሚሰጡት እንዴት ነው ?	ቅሬታ በሚቀርብባቸው ሰአት የጤና ባለሙያዎችን ስሜት እንዴት ይገልፁታል ?
8	በማህበራዊ ተጠያቂነት ዙሪያ የጤና ባለሙያዎች የሚገጥማቸው ችግር ይኖራል?	አዎ ከሆነ ምን ምን አይነት ችግሮች ይገጥማቸዋል?
9	ማህበራዊ ተጠያቂነትን ከማረጋገጥ አኳያ ያለዎት ሀሳብ ምንድን ነው?	