What Makes Local Authorities Responsive? Lessons from Two Social Accountability Projects in Cambodia

Social accountability as a good governance concept and procedure has been introduced in transitional societies to close the gap between state and society. It is a "nonelectoral yet vertical mechanism of control of political authorities that rests on the actions of an array of citizens' associations and movements and the media" (Peruzzotti and Smulovitz 2006, 10). A stocktaking of social accountability experience in developing countries has generated valuable insights into the impacts of social accountability initiatives by identifying the enabling conditions under which social accountability practices can induce positive result. These include the functioning of democratic institutions, political will and citizen actions (see Arroyo and Sirker 2005; McNeil and Malena 2010).

In Cambodia social accountability was pioneered by the World Bank jointly with the Ministry of Interior (MOI) to ride the successive waves of decentralisation beginning in 2002. Under the banner Demand for Good Governance (DFGG), civil society organisations were trained in relevant concepts and skills followed by piloting and implementation of social accountability initiatives to coordinate citizen demands to improve the quality of basic public services. At the core of DFGG's approach is the shift in relationship from confrontation to constructivism – from "shouting" to "counting", in the words of the World Bank – between civil society and government in finding mutually acceptable solutions to local service problems (Rodan and Hughes 2013). This mode of working eclipses the more common approaches of imposing reputational cost or public shaming because of the optimism in the promise of political will or political opening. Further, Cambodia's political system holds little hope for interventions from independent institutions to improve political and bureaucratic responsiveness. As the findings show, the political opening approach is not without effectiveness and particularly fits the context where formal systems of accountability are weak or unreliable.

This article assesses two cases of social accountability implementation, one "successful" and the other "unsuccessful", by focusing on the supply side of social accountability practice to tease out the factors that shape the emergence or the lack thereof of government responsiveness. The discussion is expected to enrich understanding of what makes social accountability initiatives work in Cambodia.

Community score cards in primary health care

A major plank of DFGG focused on promoting social accountability in social sectors such as health and education. These areas were seen as less politically contentious and thus were more likely to gain cooperation from the state for reform actions. This section examines the case of community scorecards in primary health care implemented by Takeo-based NGO Buddhism for Health (BfH). The Community Scorecards for Health Services Project (CSHSP) was implemented in 2012, targeting 20 health centres in Takeo's Kirivong operational district (OD). The Chi Khmar health centre, which provides primary health care services for more than 160,000 villagers, was selected for this case study.

Since 2008 the Ministry of Health has instituted an accountability structure to engage citizens in the health sector. For each health centre, this includes the simple institutional procedure of a complaints box and more organised institutions such as the village health support group and the health centre management committee. These institutions were designed to promote accountability from below, but in practice there exist multiple defects. The official view from the OD chief is that these institutional arrangements assume that citizens engage with public officials and service providers. But most of the time villagers do not feel comfortable

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doing so as they are very concerned about the consequences of public criticism, justified or not.[1] Community scorecards, a social accountability tool, are intended to fill this institutional gap. Unlike existing accountability mechanisms, the community scorecard process is led by NGOs. The advantage of this stewardship, according to the OD chief, is that NGOs are generally perceived as impartial and trustworthy, so citizens are more likely to express opinions with their presence.

Designed primarily to enhance the quality of health services through citizen feedback, the CSHSP largely achieved its objective. BfH's monitoring reports show that the health centre's performance deficits, including issues of staff attitude, hygiene, prescribing practice and working hours, were measurably improved upon: a new pump and pipe system to provide water in the health centre toilets was installed; and complaints over attitude, working hours and prescriptions were addressed through internal meetings leading to friendlier behaviour, more regular working hours and more diligent prescribing practice. That this new accountability procedure generated responsiveness is a significant accomplishment that warrants explanation.

A critical explanatory factor concerns state preparedness. The Program to Enhance Capacity in Social Accountability (PECSA), DFGG's predecessor, was formally launched in 2007, five years before the CSHSP was implemented. This afforded government agencies ample time to familiarise themselves with the concept and practice of community scorecards and anticipate possible ramifications. The fact that a joint initiative was ever formed foretold the government's willingness to listen and act.

The government was selective of the NGOs to be engaged in the social accountability program and distinguished between two main categories – advocacy and development NGOs (Rodan and Hughes 2013). Development NGOs are considered supportive of the government's ongoing poverty reduction efforts which makes them preferred partners in social accountability implementation.

BfH is a typical development NGO. Its more than 10-year presence in Kirivong administering health equity funds and community-based health insurance has culminated in strong reciprocal relationships between BfH, health officials and local politicians, laying the groundwork for new ways of working. Further bureaucratic clearance came with a national workshop held before starting the CSHSP to showcase ministerial commitment to community scorecards as a means to strengthen health systems performance and improve outcomes. The workshop led to the publication of a community scorecard guideline stamped by the Ministry of Health, thereby publicly underpinning social accountability practice in the sector. It was vital because endorsement from the ministry was imperative to form and induce collaboration from its subnational agencies and local politicians.

Finally, a decisive determinant of state action was practicality. Chi Khmar health centre was adequately equipped to address the issues identified by scorecard reporting. The tasks required to address those issues largely fell within the scope of local capacity and discretion. That meant no ministerial actions or substantial funding were needed which would have complicated and delayed the solution process and thus undermined the quality of that responsiveness. Policywise, the standardised list of indicators used to garner collective feedback broadly mirrored existing ministerial policy actions. Put differently, the resultant improvements may have been achieved, with or without DFGG. The OD chief stated the current approach:

> Our focus is to ensure that service providers follow provisions in the ministry's guidelines, for example, attitude, 24-hour operation, responsibility and hygiene. This is the leadership's main role. We are not yet in a situation where we spend the energy to find out if people are satisfied with us or not. This has to be done by a third party. (Interview, Takeo, 13 November 2014)

Social accountability's added value, therefore, was in providing administrative support for the chosen policy objectives by complementing the consistency and completeness of information flows in the health sector.

Citizen report cards in urban water and sanitation

This section examines another social accountability project that received a different degree of responsiveness from local government and service

1 Interviews with health centre chief, commune authorities and project facilitator, Takeo, 9–10 September 2014, OD chief, Takeo, 13 November 2014 and BfH, Phnom Penh, 14 August 2014.

providers.[2] The Deepening Local Democratic Governance through Social Accountability in Asia Project (DLDGP) was implemented by Phnom Penh-based NGO Silaka from 2011 to 2013 with financial support from the United Nations Democracy Fund. The project derived from successful social accountability experience in India and advocated for expanding access to piped drinking water and solid waste collection for the urban poor. Two of the six sangkats in Takmao – a municipality 12 km south of Phnom Penh – that are the poorest and with least access to safe water and basic sanitation were chosen as study sites. DLDGP's strategies combined elements of advocacy and conventional social accountability tactics. Two small and low-profile motorcycle parades were held to restate citizens' rights for water and sanitation. These events were followed by the more innovative citizen report cards, which collected citizens' views on the current status of water and sanitation services. The results were then communicated to the service providers and subnational government at a public meeting.

Final project evaluation shows that more than one year after the project ended, access to the services remains fundamentally unchanged. Several factors can be ascribed to this apparent inertia. First was the project's failure to achieve a political breakthrough by obtaining formal commitment from powerful central state actors. Unlike primary health care in Kirivong, piped water and solid waste collection in Takmao have a more complex institutional setup. The provision of clean water in Phnom Penh and its adjacent areas including Takmao is the responsibility of the Phnom Penh Water Supply Authority (PPWSA). The PPWSA is an autonomous state enterprise, meaning its executive director has the prerogative over all aspects of the firm's operation. To some extent, local governments are involved to evaluate prospective users' income status to determine if they qualify for subsidy, a social program to help low-income households that has been running since 1999.[3] Solid waste collection, on the other hand, is a mandate of the Ministry of Environment (MOE) but is outsourced to a private company who has a contractual agreement with another ministry – the Ministry of Economy and Finance (MEF).

Water supply and waste collection have not been incorporated into the decentralisation of service delivery.[4] Decisions on service delivery are therefore either highly centralised or determined by private business interests. But in implementing the project, Silaka adopted a demand-side tactic of prompting the sangkat councils to address villagers' demand for services, an approach that frustrated the councils. Although the project was approved by the MOI, which gave the municipal government and sangkat councils the go-ahead to work with Silaka, the apparent lack of power of these state actors and corresponding pressure from the project implementer contributed to an antagonistic relationship and a sense of futility.

Similarly, the nature of public service outsourcing did not incorporate a workable accountability procedure, as the owner of the waste collection firm asserted: "I don't think Silaka has the right to demand that I respond. I hear them but it's up to me and the government whether we can or will respond to their demand."[5]

Silaka's approach had a number of disadvantages compared to DFGG. Unlike DFGG, which cultivated years of habituation before substantive implementation was set in train, the DLDGP was a case of local implantation inspired by a foreign success story. It lacked a patient workaround with the political aspects of social accountability that permit the relaxation of state scepticism and resistance. Organisationally, Silaka lacks the local knowledge and hands-on experience in public services that BfH has. Silaka's work has a thematic focus on capacity building, gender equality and good governance without specific geographic concentrations. Consequently, the organisation could not build a local footprint where it wanted to have an impact. While Silaka's work may categorise it as an advocacy NGO, it was not obvious that the status predetermined the government's attitude towards the DLDPG. Indeed, it was observed that Silaka deliberately took an apolitical stance to avoid affecting MOI's endorsement of the project.

2 This section draws on fieldwork data collected by Eng Netra in Eng, Vong and Hort (2015).

3 In spite of the program, according to Silaka's survey in 2012, only 29 percent of 150 poor households in Takmao have access to piped clean water.

4 At the time of writing, the MOE had begun piloting the decentralisation of waste collection in a number of districts.

5 Interview with owner, Takmao, 20 August 2014.

Last, the lack of service coverage was complicated by the commercial nature of these services. For both services, expansion is possible only if there is adequate capital to finance the needed infrastructure and enough fee-paying users to generate profit. For example, the owner of the waste collection firm explained that the company's current capacity can only serve the city centre and its main roads. Expanding to remote areas with fewer users would mean lower profits. Also the company was not under pressure from the MEF, its contractor, to expand its coverage in rural areas. The only obligation is that the company spends USD20,000 annually to renovate the city's roads. The PPWSA faces similar feasibility considerations. By 2014, PPWSA's supply capacity covered the entire four khans of central Phnom Penh, but just 60 percent of the remaining seven poorer suburban khans spanning new areas annexed from the surrounding provinces in a recent enlargement of the capital. This is a reason why coverage in these places is relatively lower. By including new households, both fee-paying and subsidised, PPWSA faces the challenges of capacity scale-up and resource mobilisation. These factors will have a bearing on the priorities of its expansion plan and subsidy program.

Conclusion

The case study findings suggest that responsiveness was a product of issue-specific political decision making that has to be continuously negotiated between state and non-state actors. The case of primary health care was considered a responsive one because issues confronting the commune health system were mostly successfully addressed by the responsible health centre chief and staff in a fairly straightforward manner. Crucially, a decisive factor of responsiveness was that the response load was commensurate with the health centre's budget and scope of responsibility. In fact, many problems such as poor behaviour or absenteeism were resolved without needing financial inputs. In contrast, the case of urban water and sanitation was much more resistant. The providers of these two services are an autonomous state enterprise and a private contractor, respectively, who operate on market principles. Broadening service coverage to poor communities would put considerable strain on their existing capacity and consequently be less practical. Further, these services, unlike primary health care, fall outside the scope of decentralisation, meaning local governments are essentially powerless to be responsive.

DFGG and its subsidiary projects had worked around central ministries and subnational governments to elicit official endorsement of the change to the existing mode of operation. This was aided by Buddhism for Health's long history working in the local health sector allowing it to mesh with bureaucratic ranks and thus quell resistance to the change it had to introduce. The case of Silaka's social accountability project, on the other hand, did not have that advantage. It was primarily inspired by the success of social accountability elsewhere, but a lack of local footprint and relation building limited its potential. In sum, evidence from the case studies indicates that a unique combination of practicality, state preparedness and NGO embeddedness drive local authorities to be responsive in the provision of public goods and services.

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