Unpicking Power and Politics for Transformative Change:

Towards Accountability for Health Equity





Workshop Report

Institute of Development Studies, Brighton, Sussex
19 to 21 July 2017

IDS Institute of Development Studies

Our partners in convening this workshop, as part of a new IDS programme on "Accountability for Health Equity" were the Unequal Voices project, Future Health Systems, the Open Society Foundations, the Impact Initiative and Health Systems Global.

The Institute of Development Studies (IDS)

The Institute of Development Studies (IDS) is a leading global institution for development research, teaching and learning, and impact and communications, based at the University of Sussex. Our vision is of equal and sustainable societies, locally and globally, where everyone can live secure, fulfilling lives free from poverty and injustice. We believe passionately that cutting-edge research, knowledge and evidence are crucial in shaping the changes needed for our broader vision to be realised, and to support people, societies and institutions to navigate the challenges ahead.

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Our mission is to increase the uptake and impact of research from two major research programmes jointly funded by the UK's Economic and Social Research Council (ESRC) and the Department for International Development (DFID): the Joint Fund for Poverty Alleviation Research and the Raising Learning Outcomes in Education Systems Research Programme. The Initiative will achieve this through a process of identifying synergies between the programmes and grant holders, and supporting them collectively and individually to exploit influencing and engagement opportunities.

Future Health Systems

The purpose of Future Health Systems consortium is to generate knowledge that shapes health systems to benefit the world's poor. Future Health Systems addresses fundamental questions about the design of health systems and works closely with people who are leading the transformation of health systems in their own countries

Health Systems Global

The mission of Health Systems Global is to convene researchers, policy-makers and implementers from around the world to develop the field of health systems research and unleash their collective capacity to create, share and apply knowledge to strengthen health systems.

Unequal Voices (ESRC/DFID)

The Unequal Voices project - Vozes Desiguais in Portuguese - aims to strengthen the evidence base on the politics of accountability via multi-level case studies in health systems in Brazil and Mozambique, exploring how accountability can be strengthened to deliver better health services for citizens everywhere. Led by Alex Shankland (Principle Investigator), with Gerry Bloom (IDS), Denise Namburete (N'weti Comunicação e Saúde), and Vera Schattan Coelho (CEBRAP), this project will compare the dimensions of accountability politics across Brazil and Mozambique and between different areas within each country

Acknowledgements

This workshop was funded by Open Society Foundations, Unequal Voices, Future Health Systems, the Impact Initiative and Health Systems Global. The organising committee included: Alex Shankland, Gerry Bloom, Tom Barker, Erica Nelson, Karine Gatellier and Jennifer Constantine, with logistics support from Miles Bagnall.

We would like to thank our funders for their support of this event, and to all the participants who took the time to travel to Brighton and join us for three days of debate and dialogue. The exchange of ideas across geographic contexts, areas of experience, and technical know-how was truly vibrant. We would like to thank those who helped to convene the thematic sessions and chair the plenaries, in collaboration with our organising committee: **Walter Flores** (CEGSS / COPASAH, Guatemala); **Vera Schattan Coelho** (Cebrap, Brazil); **Denise Namburete** (N'Weti Communication and Health, Mozambique); **Asha George** (University of the Western Cape, South Africa); **Sara Bennett** (Johns Hopkins Bloomberg School of Public Health, USA); **Hilary Standing**, IDS Emeritus Fellow; **John Gaventa**, IDS Director of Research; **Cynthia Ngwalo Lungu** of the Open Society Initiative for Southern Africa (OSISA); and **Melissa Leach,** Director of IDS.

We would also like to thank all those who played a formal speaking role at this workshop, whether in thematic sessions or in plenaries: **Susanne Kiwanuka** (Makerere University School of Public Health, Uganda); **Erika López Franco** (IDS, UK); **Shaila Mahmood** (ICDDR,B, Bangladesh); **Donald Mogeni** (World Vision, UK); **Paula Monjane** (CESC, Mozambique); **Erika Placella** (SDC, Switzerland); **Courtney Tolmie** (R4D, USA); **Luiz Eduardo Fonseca** (Fiocruz, Brazil); **Jonathan Fox** (American University, USA), **Brendan Halloran** (International Budget Partnership, USA); **Anuradha Joshi** (IDS, UK); **José Luiz Telles** (Fiocruz, Brazil); **Priya Balasubramanian** (Public Health Foundation of India); **Lijie Fang** (CASS Institute of Sociology, China); **Meenakshi Gautham** (LSHTM, UK); **Abhay Shukla** (SATHI, India); **Uranchimeg Tsevelvaanchig** (University of Queensland, Australia); **Fatima Adamu** (Women for Health Initiative, Nigeria), **Heather McMullen** (IPPF, UK); **Godelieve Van Heteren** (RGHI, Netherlands and WHO-Health Systems Governance Collaborative, Switzerland); **Renu Khanna** (SAHAJ/COPASAH, India), **Matthias Leicht-Miran**da (Swiss Development Cooperation, Moldova); **E. Premdas Pinto** (CHSJ, India); **Faruque Ahmed** (BRAC International, Bangladesh); **Joanna Chataway** (SPRU, Sussex University, UK); **Lewis Husain** (ITAD/IDS, China); **Maureen Mackintosh** (Open University, UK), **Julius Mugwagwa** (Open University, UK); **Rômulo Paes de Sousa** (RIO+ World Centre for Sustainable Development, Brazil); **Anna Roemer-Mahler** (University of Sussex Centre for Global Health, UK); **Yunping Wang** (National Health Development Research Center, China); **Anne Buffardi** (ODI, UK); **Ian Harper** (Edinburgh University, UK); **Desta Lakew** (AMREF, Kenya); **Pedro Prieto Martin** (IDS, UK); **Justin Parkhurst** (LSE, UK); **Daniela Rodriguez** (Johns Hopkins Bloomberg School of Public Health, USA); **Rosie McGee** (IDS, UK) and **David Peters** (Johns Hopkins Bloomberg School of Public Health, USA).

This workshop report was drafted by EN with editorial contributions from GB, AS, TB and KG. Support in the form of copy-editing, formatting, video production and photographic contributions was provided by Sophie Marsden, Sarah King, George Graham and Gary Edwards. A team of rapporteurs contributed to note-taking and documentation of the event, including: Tanvir Ahmed, Brandon Bollinger, Alexandre Calandrini, Natalia Herbst, Tabitha Hrynick, Alessandra Ipince, Ruhil Iyer and Rhea John. For a full list of participants, please see Annex 1.

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Executive Summary

While "accountability" has become an increasingly popular buzzword in health systems debates and health service delivery, it has multiple – and contested – meanings. This workshop was conceived as an opportunity to convene key thinkers, activists and health practitioners in the emerging field of "accountability for health equity," to push the boundaries of our collective knowledge and to strengthen our ability to mobilise for positive change. We, at IDS, are particularly interested in how accountability practices and mechanisms can be used to achieve better health for the less powerful and least served people of the world. The people we gathered for this event all share this goal, though the expression of their commitment varies widely across country-specific contexts, academic disciplines, and fields of professional activity and expertise. The ethos of the event was one of mutual learning. We asked participants to set aside any preconceived notions on what accountability means to them in the context in which they work, and to be open to hearing what it means to others. Our starting point for analysis and action is that we must try to better understand the different dimensions of accountability relationships, the distinct levels at which accountability for health equity can be promoted, and the influence of factors that lie beyond a government-led organisation of health services.

From 19-21 July 2017, we brought together 80-plus activists, researchers, public health practitioners and policy makers to examine critically the forces that shape accountability in health systems, from local to global levels. Our partners in convening this workshop, as part of a new IDS programme on "Accountability for Health Equity" were the Unequal Voices project, Future Health Systems, the Open Society Foundations, the Impact Initiative and Health Systems Global.

We designed this workshop to bring together diverse voices from the health sector and beyond, and to encourage fresh connections and unexpected conversations among researchers studying a range of different areas and practitioners working in distinct regional and political contexts. The event sought to catalyse innovative thinking and partnerships to strengthen national and international efforts to tackle health inequities and secure universal health coverage.

The workshop itself was structured around **thematic discussion sessions** jointly convened by IDS researchers and partners from Africa, Asia, Latin America, the UK and the US. These thematic discussions were combined with **plenary exchanges and debates**. The plenaries brought together emerging insights from the thematic discussion sessions with 'provocations' from guest speakers, and addressed the following themes:

- ***Accountability for health equity: reflections on an emerging framework***
- ***Health accountability politics in time***
- ***New actors, future accountabilities***
- ***Making accountability real: implementing UHC in Africa***
- ***Transforming health accountabilities***

The thematic sessions provided opportunities for the presentation of cutting-edge findings from research and practice, combined with experience-sharing and group discussion. Their aim was to explore in greater depth the specific challenges in making health systems more accountable when it comes to meeting the needs of marginalised populations in complex and rapidly changing contexts, in addition to identifying promising innovations that have emerged from efforts to address these challenges.

The workshop centred on these core objectives:

- To examine practices and politics that shape accountability in health systems from the local to global levels to inform interventions for improving equity;

- To bring together diverse voices in terms of geography, positions in the health accountability ecosystem and areas of expertise to build a more realistic understanding of challenges and emergent approaches for improving health system performance;

- To build links between complementary networks on accountability and health for greater impact.

One outcome of this event, for the team at IDS, has been a strengthening of our commitment to key areas of future work that we believe are crucial to the success of accountability for health equity efforts. These key areas are:

- Creating enabling environments for mutual learning between key actors and "action strategists" working in different country contexts, not just on "what works" to strengthen accountability for health equity, but also on what doesn't.

- Analysing the interconnection of local, national and global relationships of power and their influence on particular accountability interventions.

- Taking the long view of accountability change processes, both in the methods we develop to share with action-strategists and health practitioners, and the in multi-disciplinary approach we take to understanding the challenges and barriers to positive change.

- Creating new alliances and strengthening existing partnerships with our fellow "accountability for health equity" travellers, and building on the possibilities that new media create for reaching out to global and national-level citizen activists, policy-makers, health professionals and business leaders. This includes building broader and more diverse coalitions of support for multi-level, pro-accountability for health equity initiatives.

What follows in this report is a record of the presentations and discussions that occurred over the course of these three days, in July. It is by no means exhaustive, but we have tried to represent accurately the debates that emerged. For a complete programme of events, see Annex 2.

Reflections on Accountability Meanings and Futures: A Short Film

In our effort to share with a broader audience the kinds of cutting edge thinking and debates that took place during the workshop, we asked select workshop participants to speak to us on camera about their understandings of accountability, the potential for mutual learning, and priorities for future accountability for health equity work. Included in this short film are: **Fatima Adamu; Aggrey Aluso; Walter Flores; Luis Eduardo Fonseca; Asha George; Ian Harper; Elizabeth Ekirapo Kiracho; Desta Lakew; Vera Schattan Coelho;** and, **Abhay Shukla.**

https://www.youtube.com/watch?v=ZFWoVvOFfBA

STORIFY of the Workshop: #IDSAHE2017

During the course of the event, the social-media savvy amongst the group live-tweeted their reactions and reflections, collated here in Storify form.

https://storify.com/IDS_UK/idsahe2017-unpicking-power-and-politics-for-transf?utm_source=embed_header

Workshop Record

Day One – 19 July, 2017

Plenary 1: Accountability for health equity: reflections on an emerging framework

Chair: John Gaventa, IDS Director of Research**; Speakers: Melissa Leach**, IDS Director**; Gerry Bloom,** IDS Health and Nutrition Co-Convenor**; Erica Nelson,** IDS Research Officer; and, **Alex Shankland,** IDS Research Fellow.

In this opening plenary, members of the "Accountability for Health Equity" programme and leading figures at IDS set the stage for three days of engaged, mutual learning. **Melissa Leach**, provided the institutional background of IDS's work on health systems, social justice and equity, and grounded the event in a longer history of IDS' work on accountability, governance, citizenship rights, power and popular politics. *"The inclusivity challenge,"* Leach explained, *"is fundamentally about accountability and people being able to hold governments, or indeed new actors, to account to deliver what they need for their wellbeing."* Although the work on accountability had been fragmented within the institution, this workshop served as an exemplar of a shift towards joined up ways of thinking and work on accountability across sectors of development, including health. **John Gaventa** furthered Leach's argument about the relevance of the workshop to current research and action both within and beyond IDS, stating *"We can't really talk about accountability meaningfully without talking about accountability for what? While much of the debate on accountability in the aid context has focussed on efficiency, that is to get the dollars out there more quickly, or effective implementation – in the context of growing and multiple inequalities we can't really talk about it without talking about the other key word in the title of this conference, equity."*

Following on from Gaventa and Leach's overarching comments on accountability at IDS, **Gerry Bloom** began a presentation on the AHE team's emerging accountability for health equity framework by asking *why accountability and why now?* He briefly traced an institutional and political history of health system development, where, in spite of global commitments to achieve "health for all", and national-level commitments to invest resources into health worker training, infrastructure, and equipping facilities, we nonetheless find ourselves living in a world where glaring gaps in health services continue to exist. Bloom spoke about the influence of power and politics in health systems and in accountability relationships, and in an increasingly globalised world where new configurations of power shape what is possible to achieve in terms of regulatory arrangements, political commitments and agenda-setting. He asked workshop participants to take up the challenge of changing thinking on accountability, which remains rooted in older models of health system management and service delivery: "*The thinking in health is often as if the communications of the 21st century still look like they did in 1978."*

Taking our understanding of accountability for health equity in future-oriented direction, **Erica Nelson** shared the AHE programme's developing framework for accountability analysis and action (Fig. 1). The first step, Nelson suggested, is to refract what we currently understand as accountability relationships and practices through an analytical lens that produces distinct "accountability wavelengths": Social Accountability (grassroots, citizen engagement), Market Accountability (financial transactions, supply chains, market-based regulation of health providers), Political Accountability (formal and informal political processes and health policy negotiation) and Bureaucratic Accountability (managerial dimensions of health systems and regulation). She argued that each of these categories or wavelengths of accountability are loosely understood by people working towards accountability for health equity, but often

without reference to the other wavelengths or to their blurred boundaries and overlaps. Rather than see them as mutually exclusive, Nelson argued that the recognition of these broad categories can help us to think about where workshop participants sit on the accountability spectrum and whether it would be to their benefit to engage with other "wavelengths" of accountability thought and practice.

Fig. 1 Accountability Prism of Analysis

Following on from the refraction of accountability into its distinct wavelengths, Nelson encouraged workshop participants to think about the next step, that by taking into account the broad spectrum of accountability relationships and focusing our actions on the interconnection of relationships (versus working on accountability in disconnected and disparate silos), it would become possible to generate greater health equity.

Fig. 2 Accountability Action

Finally**, Alex Shankland** presented on the organisational ethos of the workshop, helping to bring together a diverse set of people with distinct experiences of accountability for health equity work. He mapped out the breakdown of thematic sessions, followed by plenary discussions, before opening up to workshop participants for initial reactions to the framework-in-development.

Walter Flores, (COPASAH, Guatemala): *"Lenses don't have equal value. What is missing is the power relations. Some have more value than others, and who is deciding about those lenses? Just*

by having different lenses does not change the essential question which is who has the power to decide when equity has a priority?"

Priya Balasubramaniam, (Public Health Foundation of India) *"Is the prism really as neat as it looks? If you approach it from a different perspective where there are multiple markets and multiple sectors juggling for space, the lenses that kind of emerge from this might be quite shattered by the end of it."*

Rosie McGee, (IDS*) "Market accountability is a massive outlier…Market accountability is about reigning in the excesses of the market which isn't there for accountability to more marginalized people, or poorer people or weaker members of society or weaker parts of the private sector. It's about profit and it is about regulating that and reigning it in. So, for me, it is the one that stands out as fundamentally different, but is increasingly encroaching on all the others and we really need to wrap our heads around it and understand it and it's one that I'm really hoping to explore more of while we're here."*

Ligia Paina, (John Hopkins Bloomberg School of Public Health) also wrote about her reflections on the opening plenary and the discussions that emerged over the course of the workshop in a blog titled "Onions, elephants and lenses: reflections on the accountability for health equity workshop."

Chair, **John Gaventa**, in his final plenary remarks, flagged six key issues for workshop participants to consider both in terms of the debates and dialogues of this IDS event, and also with reference to their own work in the future: 1) the challenge of not only using a lens of history to understand the contexts in which accountability struggles to play out, but also a lens of the future to begin to carve out pathways to a more just and equal world; 2) the nature of power is changing, and we need to develop new understandings about these new dynamics to succeed; 3) markets have the power to trump our efforts at accountability, but also; 4) power is positive, there is power TO, power WITHIN and power WITH, including the power to build coalitions; 5) we need to embrace a diversity of perspectives by having not only multiple forms of accountability, but also multiple starting points; and finally, 6) we need to change our lens to think about scale and think about accountability not only at a micro level but at both national and global levels.

On this note, John Gaventa handed over to **Tom Barker** to introduce the first set of thematic sessions, described in the next section.

Theme 1: Accountability Politics at the Local Level and Beyond

Theme convenor: Alex Shankland (IDS); **Speakers: Susanne Kiwanuka** (Makerere University School of Public Health, Uganda); **Erika López Franco** (IDS); **Shaila Mahmood** (ICCDR, B, Bangladesh); **Donald Mogeni** (World Vision, UK); **Paula Monjane** (CESC, Mozambique); **Erika Placella** (SDC, Switzerland); and **Courtney Tolmie** (R4D, USA).

Overview: The recent boom in social accountability (SAcc) interventions has stimulated an impressive wave of innovation in local accountability practice, often centred on the use of tools such as community scorecards. However, such interventions have also attracted criticism for being insufficiently attuned to the social, political and power relations shaping local accountability outcomes: for failing to achieve a sustainable fit with formal accountability structures within health systems and for ignoring the higher-level constraints affecting the ability of local-level providers to respond to community feedback. The sessions under this theme combined a discussion of emerging innovations in the use of local accountability tools – including the different ways that technology can enable citizen voice – with an exploration of strategies for institutionalising accountability through health councils, community health committees and other mechanisms at the local level and beyond.

Session One: Social Accountability Tools in the Local Context

In this session, contributors presented on the experience of doing social accountability work to improve health services in four distinct country contexts: Mozambique, Tanzania, Indonesia and Bangladesh. The session focused on strategies for achieving a good fit between social accountability initiatives based on tools such as Community Scorecards and the local context, including considerations of the potential role played by local and national civil society organisations (CSOs).

Paula Monjane began by sharing the rapid learning process through which her organisation, the Centre for Civil Society Capacity Building (CESC), has been going over the last few years in which it has been at the forefront of the adoption of Community Scorecards in Mozambique, highlighting the increasing emphasis by CESC and other Mozambican CSOs on "vertically integrated" initiatives that link local SAcc processes with national policy engagement in a politically challenging environment. Building on this overview, **Erika López Franco** continued the exploration of experience from Mozambique by sharing some lessons from work with the Citizen Engagement Programme (CEP), highlighting in particular the challenges that micro- and macro-level exclusions and power asymmetries raise for efforts to turn SAcc processes into a "bridge" between citizens and states.

Courtney Tolmie then moved the geographical focus to Tanzania and Indonesia, where R4D and its partners have been developing a major initiative to strengthen transparency for accountability that is designed to respond to different contexts, emphasising the importance of reflecting locally-determined priorities rather than imposing a single-issue framework. Finally, **Shaila Mahmood** shared ICDDR,B's experience of local stakeholder engagement and developing an initial "accountability matrix" to guide implementation of a Community Scorecard intervention, highlighting the complexity of local accountability relations that this mapping process has revealed.

Shared challenges that the group identified included: 1) how best to engage community groups and encourage a "culture of Social Accountability" at the community level; 2)

mitigating the "unintended consequences" of a social accountability intervention which can include creating unnecessary tensions and mistrust between providers and the users of health services, or which can involve the influence of agendas unrelated to the goals of the SAcc process; 3) the challenge of monitoring and evaluation of a SAcc process; 4) the importance of first identifying the relevant contextual factors – political, historical, socio-cultural – that will influence a Community Scorecard process before engaging in action.

In discussion, participants identified the absence of common understandings of the concepts, indicators and related processes for Community Scorecard interventions at a broader level and suggested that there might be scope for the development of shared guidelines and recommendations in the future. Participants also highlighted the crucial importance of generating greater understanding of health rights and citizenship rights at the local level as part and parcel of any public health intervention, mitigating the risk of SAcc interventions becoming too tool-focused.

Session Two: Institutionalising and Sustaining Local-Level Accountability
This session focused on issues of scale and sustainability. Contributors explored different ways to strengthen links between social accountability interventions (often time-bound and externally supported) and longer-term accountability processes, including formal structures such as government mandated community health committees.

Susanne Kiwanuka began by presenting some contrasting experiences from Uganda, including a dialogue with local health system stakeholders designed to promote institutionalisation and strengthen the sustainability of SAcc initiatives and a top-down intervention by the Presidency that had brought about immediate changes in personnel but little in the way of long-term impact on service quality. **Donald Mogeni** then introduced the thinking behind Everyone Counts, an ICT-enabled initiative intended to promote a common platform for data from local Community Scorecard processes in multiple countries in order to support higher-level advocacy strategies. Finally, **Erika Placella** shared the experience of the Swiss Agency for Development and Cooperation (SDC) with attempting to institutionalise inclusion, equity and accountability via a "learning trajectory" designed to clarify understandings of key concepts and link these understandings to health sector programme design, monitoring and evaluation in a way that takes account of political dynamics and patterns of inclusion/exclusion at different levels.

Participants and speakers discussed the key factors for successful institutionalisation which include: 1) an enabling political environment; 2) context-driven social accountability approaches that seek legitimacy, feasibility, ownership and embeddedness; 3) agreed common understandings of accountability meanings and concepts; 4) proper risk analysis of SAcc interventions; and 5) pro-inclusion strategies. With reference to the potential for technological innovation in SAcc, this session also considered what kinds of citizen action could be achieved or strengthened if aggregated citizen data is compiled and communicated meaningfully to allies within civil society and across other formal and informal political spaces.

Related to the debates and discussions of this first thematic session, **Denise Namburete, Vera Coelho, Alexander Shankland** and **Gerald Bloom** - members of the Unequal Voices research

initiative – argue for greater coordination of pro-accountability actors and actions in a blog titled "Towards Accountability for Health Equity."

Theme 2: (Re)Building Accountability

Theme convenors/speakers: Walter Flores (CEGSS/COPASAH; Guatemala) and **Erica Nelson** (IDS); **Speakers**: **Luiz Eduardo Fonseca** (Fiocruz, Brazil); **Jonathan Fox** (American University, USA), **Brendan Halloran** (International Budget Partnership, USA); **Anuradha Joshi** (IDS, UK); **José Luiz Telles** (Fiocruz, Brazil).

Overview: The process of change in health systems and accountability politics has reached a velocity where it has outpaced our ability to grasp it. In the drive to create a forward-looking accountability for health equity agenda, we argue that historical perspectives should not be lost. The first session in this theme presented case studies from different regions where distinct democratisation and citizen-state engagement played out over the latter half of the 20th century in ways that challenge the notion that pro-accountability activism and good governance agendas are something entirely new. The second session offered a chance to examine how the language of accountability has been translated and reworked (or has evolved different meanings altogether) within the contexts of different countries.

Session One: Putting Accountability Processes into Historical Context

In this first session, contributors **Walter Flores**, **José Luiz Telles,** and **Anuradha Joshi** presented on different historical trajectories that shaped contemporary accountability agendas and possibilities of mobilisation for greater health equity. Flores introduced the session by framing accountability work as necessarily engendering negotiation and conflict. These conflicts, which in turn shape accountability for health equity, did not first emerge 10-15 years ago when the term "accountability" first gained prominence in global health and development circles. As a case study, Flores spoke of his work with civil society organisations in Guatemala, a country that experienced profound human rights abuses under the military dictatorship that began in the late 1960s and continued through to the mid-1990s. He challenged session participants to think about how both language and historical trajectories shape what people think is possible in terms of citizen rights and entitlements in a contemporary context. In the case of Guatemala, there emerged parallel strands of accountability engagement – at the level of "the street" (civil society organisations pushing for social justice and rights-based accountability) and "the suits" (a technocratic approach to accountability, limited to English-speakers).

Following on from Walter's probing questions, **José Luiz Telles** told the story of the historical development of the Sistema Único de Saúde (Unified Health System or SUS) in Brazil, beginning with its establishment in the wake of the 8th National Health Conference in 1986. Although the origins of community engagement in health service delivery were progressive and innovative at the time, recent political developments have revealed fragile and conflicting arrangements between health actors and citizen groups. He spoke about the recent amendment to the Brazilian constitution that will limit the expansion of health spending, and growing uncertainty about the potential damage of this law. "Without social participation and accountability on behalf of the grassroots, our current programmes will be eliminated," Telles warned.

Finally, **Anuradha Joshi** reflected on what the case of India can bring to our understanding of historical trajectories and accountability practices. She traced state-citizen engagement beginning with India's independence in 1947, through the rise of new social movements in the 1980s (focusing on issues such as indigenous rights and the environment). By the 2000s, partially in response to market-based policies and deregulation, social rights came into being (right to information, health, education and employment). The point, Joshi emphasised, is that these trajectories meant that *"expectations of the state and its institutions are very much framed in this historical context,"* which in turn opens up and closes down different kinds of accountability relationships depending on the accepted social contract at any given point in time.

In the group discussion, **Hilary Standing** raised the question of how to confront the challenges we are now witnessing in relation to globalisation and rising populations that are not linked to the state, or are linked to more than one state, *''where entitlements are vague or fluid or not there.''* She suggested that national citizenship may no longer be the cornerstone for a basic understanding of accountability because citizenship is being reframed and reformulated in a globalised world.

Marta Schaaf noted that one issue, not brought up in the "streets" versus "suits" dichotomy described by Flores, is the fact that in health care there is the issue of what constitutes biomedical language and how this closes space for who can and cannot participate in certain dialogues. The issue of accountability languages, in this sense, is not just about multilingualism but also about technical languages and lay languages.

Session Two: Accountability – a Multilingual Approach
In the second session, contributors **Erica Nelson**, **Luiz Eduardo Fonseca, Jonathan Fox** and **Brendan Halloran** spoke on the historical origins of distinct languages and understandings of accountability, and on the diversity of accountability framings in contemporary contexts.

Erica Nelson introduced the session with reference to the role of collective memory and symbolism in post-military dictatorship contexts in Latin America's Southern Cone region. She suggested that whether or not historic abuses of power are recognised in contemporary political debates, they can nonetheless be present in collective memory and social movements and inform current accountability demands.

Luiz Eduardo Fonseca offered reflections on the history of accountability language in Portuguese, which translates into a range of terms used to describe different aspects of accountability relationships and practice (e.g. transparency, participation, social responsibility, and feedback mechanisms). He argued that in Brazil, the re-constitution of democracy and citizenship in post-military dictatorship Brazil provided the foundations for contemporary accountability mechanisms. The challenge now, some decades after the foundation of accountability structures such as health councils, is whether or not participation in such structures is truly participatory or unduly influenced by competing political interests.

Brendan Halloran talked about the ways in which accountability travels and gets used in a range of spaces, as well as across linguistic divides. He asked session participants to think about the use of the term "citizen voice" in accountability discourse: who is listening? Why would they listen? The accountability ecosystems approach, he suggested, enables a recognition of the diversity of actors, pathways and mechanisms implicit in the term

"accountability." However, if this approach is considered alongside relationships of power and the political dimensions of specific contexts, it becomes possible to navigate the ecosystem more effectively, with the maximum potential for impacting on health equity.

Jonathan Fox spoke, broadly, about the links between history, memory and accountability in a Latin American context, from formal political accountability structures in Colombia with colonial roots, to the grassroots practice of the 1970s and 1980s of "*análisis de coyuntura*" which roughly translates as the "*naming of the political moment, of the conjuncture*." He critiqued the mainstream approach to social accountability interventions which do not invest sufficiently in the training of organisers, or in what he referred to as "cadre formation."

In discussion, **Martha Schaaf** warned against the romanticisation of "the grassroots" and to take the complexity and opacity of health policy seriously, both at national and transnational levels. If these issues are not taken seriously, she argued, it could potentially lead to communities being excluded from participation because the issue of accountability becomes overly technical or specialised.

Theme 3: Accountability Responses to the Spread of Health markets

Theme convenors/speakers: Gerry Bloom (IDS) and **Vera Schattan Coelho** (Cebrap, Brazil); **Speakers: Priya Balasubramanian** (Public Health Foundation of India); **Lijie Fang** (CASS Institute of Sociology, China); **Meenakshi Gautham** (LSHTM, UK), **Abhay Shukla** (SATHI, India); **Uranchimeg Tsevelvaanchig** (University of Queensland, Australia).

Overview: Many low- and middle-income countries have experienced rapid growth in markets for health-related goods and services, resulting in pluralistic health systems with a wide variety of providers in terms of their ownership, their relationship to the regulatory system and their sources of finance. Subsequently, the boundaries between the public and private sectors have become blurred. These sessions explored emerging approaches for building effective accountability mechanisms and the role of local and national citizen groups, professional and business associations, governments and global governance agreements. Both sessions included the sharing of relevant experiences and research findings, followed by discussions addressing a range of questions to better develop strategies for improving pluralistic health markets (session A) and the changing relationships between government and non-government providers in the cities of the BRICS countries (session B).

Session One: Strategies for Improving Pluralistic Health Markets

By way of introduction, **Gerry Bloom** began the session discussing some of the challenges posed by pluralistic health systems and the fact that there is no single "private sector" to regulate.

Uranchimeg Tsevelvaanchig presented on the particular problems of regulating and financing the for-profit private health care sector in Mongolia. She explained that in a country characterised by the Soviet-Semashko model of health service delivery, the expansion of private in-patient care from the 1990s onwards has contributed to a situation where the majority of current users are economically-disadvantaged and also vulnerable. Based on qualitative research carried out with private health care providers, policy makers, regulators and health insurance officers, she found that the lack of political will to ensure equity is in part due to the design of social insurance schemes that make it much easier for urban populations

to access government hospitals at virtually no cost, while rural residents rely on private insurance to meet their health needs. The main lesson to be drawn from the Mongolian case is the importance of regulation as part of strategic planning, and the need to ensure that schemes such as health insurance keep with equity goals.

Meenakshi Gautham presented on the overuse of antibiotics by informal providers in West Bengal, India, asking session participants to consider the relationships of accountability involved. In South Asia generally, and in this region of India specifically, there are high levels of informal health providers and services that exist outside regulatory systems. The results of an ongoing study suggest that providing increased training on the appropriate use of antibiotics may have little impact on prescribing practices. Rather, an effective strategy would need to (1) provide information to the general public aimed at altering a prevalent belief in the need for antibiotics to address almost all health problems, (2) foster agreements with pharmaceutical companies, whose reputation is an element of their business model, to provide training in the appropriate use of antibiotics, reduce the supply of inappropriate products and end the offer of inducements that encourage drug sellers to supply high volumes of antibiotics and (3) seek agreements with senior doctors to provide public support for measures to improve antibiotic use by licensed doctors; and 4) create and enforce an appropriate government regulatory framework.

One session participant, **Alexandre Calandrini** of the Unequal Voices research initiative, reflected on this challenge of antibiotic regulation in pluralistic health systems in his blog, "Is Accountability for Health Equity a Blaming Dance?"

Finally, in this session, **Abhay Shukla** gave a presentation on "Combining accountability of private medical sector from within and without: ethical doctors' voices and patients' rights campaigns in India." Shukla spoke about the issue of "irrational care" in India and the work he carried out in collaboration with **Arun Gadre** to break the silence about these "irrational" practices. This work resulted in the book *Dissenting Diagnosis* and in the emergence of a national alliance on ethics and of rational doctors seeking alternatives to the commercialisation of health care. He suggested that to encourage further progress on accountability and on regulation (which he termed *"accountability at large"*), a social compact would be needed between senior leaders in the medical profession, active consumers and members of the government. He encouraged session participants to take seriously the potential of "social regulation" as an approach to address this complex problem. "Social regulation" is defined here as state-supported legal regulations plus participatory monitoring and the proactive self-regulation of medical professionals.

As the characteristics of pluralistic health systems vary greatly across national and geographic contexts, so too do the strategies that national governments employ to make private health care services more affordable and equitable. **Uranchimeg Tsevelvaanchig, Priya Balasubramaniam and Meenakshi Gautham** – all members of the Health Systems Global Private Sector in Health Thematic Working Group – share their thoughts in a blog based on this thematic session.

Session Two: The Changing Relationship between Government and Non-Government Providers

In this second session, **Vera Schattan Coelho** kicked off the discussion on the changing relationship between public and private health providers with a presentation on public-private

partnerships in urban Brazil. She explored the São Paulo municipal government's decision to sign contracts with private, not-for-profit, organizations to provide health services to defined populations. This led to improvements in the distribution of health-workers and improved service access. The presentation particularly emphasized the ways in which this strategy mitigated the previously intractable issue of medical professional shortages in services covering poor and hard-to-reach populations within the city.

Fang Lijie presented on the emergence of new kinds of social organisations to provide social services to rapidly growing urban populations in China. These include providers of welfare services to the elderly, the deployment of a new cadre of social workers to mobilise residents to express their needs and the emergence of new ICT platforms that enable people to make better use of available services. She argued that new kinds of partnerships are emerging between city governments and these social organisations in response to the complex needs of an ageing population in rapidly growing cities.

The last presentation, by **Priya Balasubramaniam**, focused on urban health governance and changing health provider dynamics in India's "mega-cities." In this case study, she outlined a complex and rapidly evolving pluralistic health system with vastly divided economic tiers and opportunities for access to health care services, whether informal, formal, local, national or international. She asked session participants to think about the reasons why markets exist and thrive, and suggested that systemic failures and traditional capacity gaps contribute to the proliferation of markets. How cities are managed and governed, she argued, is why challenges are emerging. In strong states in India there has been wiser spending on better outcomes and better facilities for health. States without this level of management or resources make do with private systems. This becomes complicated as urban patients have to navigate various channels to seek care. She concluded that while cities are viewed as individual agents of change, they don't have the fiscal autonomy to invest in the sectoral changes that are needed.

The session concluded with a lively debate about the case studies presented and which opportunities exist to strengthen accountability in such complex and rapidly-evolving pluralistic health systems as those discussed. **Dhananjay Kakade** asked, "why does political economy makes privatization so attractive to the state?" He referred to a report that showed all public-private partnerships (PPPS) are by definition a conflict of interest, therefore what role is the state thinking about? **Gerry Bloom** suggested that it wasn't a coincidence that the case studies under consideration involve strong states, but also that within these cases there are multiple pathways and relationships, for example in Brazil, the municipal government relationship with private, not-for-profit, social organisations (versus private for-profit health providers). **Duncan Wilson** stated that the perhaps we need to be thinking about new roles and new models, given these changing relationships between state, private and social sectors.

Plenary 2: Health Accountability Politics in Time

Chair: Hilary Standing (IDS Emeritus Fellow) **Speakers: Jonathan Fox** (American University, USA); **Asha George** (University of the Western Cape, South Africa); and, **Rômulo Paes de Sousa** (RIO+ World Centre for Sustainable Development, Brazil).

This plenary offered a fresh look at the role of history and memory in shaping the politics, languages, and possibilities of accountability for health equity. Chair Hilary Standing asked

presenters to reflect on the question: to what extent does history shape relationships of accountability for health equity?

Jonathan Fox argued that we need to aware of how accountability languages have been politically constructed in the past, as well as the opportunities for creating accountability terms in the present that can better communicate pathways to greater equity. He presented a history of concepts and suggested that the language of accountability isn't specifically technocratic (though it can be) but that it has the capacity for ambiguity, fluidity and creative deployment. In a Latin American context, he spoke about an example from twenty-years ago of grassroots organizers in Mexico who *"deliberately tweaked the term transparencia"* (transparency) to "*trasparencia*" (to get behind appearances") for a series of nested reasons, both pragmatic and political. Fox also offered examples of terms that have been invented out of particular political contexts *("whistleblower"*) and terms created to deceive *("open-washing"*). He concluded with a call for *"action strategists,"* such as those present at the workshop, to think about re-appropriating existing terms and creating new discourses based on their relevance to accountability for health equity, common sense and the potential to *"go viral."*

For a more complete account of his presentation, see Jonathan Fox's post-workshop blog, "History and language: keywords for health and accountability."

Following on from Fox's presentation, **Rômulo Paes de Sousa** gave a talk on transparency and public memory**,** in which he outlined the case of Brazil's *Bolsa Familia* conditional cash-transfer programme, first initiated under President Lula in 2003. As someone directly involved in the creation of this policy and programme, he spoke about his memories of this process. He talked specifically about the aspects of transparency that defined the conditional cash-transfer programme and proved the existence of both strengths and weaknesses in the face of powerful opposing interests. Ultimately, he argued, even though the commitment to transparency meant that they (government actors such as himself) made themselves vulnerable to critique when it was revealed that certain recipients were double-claiming or making false claims on the cash-transfers (for non-existent children, for example, or on the basis of false claims of low income), it was nonetheless a positive approach to take as it helped to build strong public support over its first years of the programme's existence.

Asha George then spoke about history as present influence**,** reflecting on "things that have been happening around me" in this past year living and working in South Africa as a starting point for a conversation about history and accountability. She suggested three overarching reflections 1) First, that "*history matters because it informs the current context,*"; 2) Second, that it isn't just in the past, *"it is history making in the everyday,"* and finally, 3) that there are *"multiple periods of history happening at any given moment in time…how people engage with the state varies dramatically"* dependent on the historical processes at play in distinct contexts. For example, the history of apartheid in South Africa is reflected in the memory and the ideal of anti-apartheid activists, who suggest that the South African government of today is not the *"state they fought for."* With regard to legislation, and sexual and reproductive health rights, activists are now witness to regressive legislation and a turning back of the clocks on gains made in the past. In this moment, George argued, we are also witnessing a closing of space for feminist activism and women's health activists broadly speaking (not just in South Africa), in part because while accountability debates and claims have progressed, there hasn't been a concomitant shift of social norms. She also argued that the professionalization of the field of sexual and reproductive health rights has resulted in a step back in terms of funding and civil

society involvement, despite all the problematic issues which remain (e.g. poor adolescent sexual health, HIV transmission rates, safe abortion). In South Africa specifically, and on the issue of public health, George spoke about processes for direct policy engagement that currently exist alongside an increasingly technocratic sphere, a strong private sphere with media engagement, and the influence of fake news. This combination of factors, she argued, is hindering progressive change.

Following on from questions posed by workshop participants, which ranged from concerns about how to bridge gaps between oppositional groups when strengthening accountability mechanisms, to questions about the role of legal accountabilities, to questions specific to the Brazil case study presented, **Hilary Standing** asked panel members to give their reflections.

Rômulo Paes de Sousa took up the issue of accountability in moments of economic crisis, such as that currently affecting Brazil, and suggested that this issue is broadly Latin American. He argued that the economic crisis has become *"the main topic when you talk about politics"* which then has implications for social spending. *"What is happening in Brazil is changing many things, in terms of health, it is stagnating…but internal allocation of resources can change. This is the main issue of public policy: how do you allocate the resources?"*

Asha George offered this reflection on legal accountability: *"For me, rights are not just legal accountability. In SRH, sometimes we have progressive legislation, but making it real and implementable in people's lives is difficult."* With reference to work she had undertaken with fellow workshop participant **Renu Khanna**, George pushed the idea that *"maybe our expectations of what social accountability is meant to achieve – maybe we aren't looking the right direction? We are expecting shifts in allocation of health workers but that happens at a higher level."* However, in working on this project in Gujarat, George said that she had learned that the extensive amount of work put into just talking to women about health entitlements had resulted in a conscientization process that proved to be a crucial shift.

Jonathan Fox, in response to a question about "what do we do now?", asked the workshop to think about who this "we" is? He said that *"finding the right language to communicate accountability claims involves going into a listening mode, it entails working closely with action strategists instead of just imagining the next big thing… what is the difference between a fuzzy concept and a contested concept? What if that fuzziness allows for a subtle contestation? It is important to take advantage of the fuzziness…the term isn't going to be neutral."* Finally, on the question of polarisation, he suggested that people look at *"where are the swing constituencies and try to engage with them."*

Day Two – 20 July, 2017

Plenary 3: New Actors, Future Accountabilities

Chair: Gerry Bloom (IDS) **Speakers: Faruque Ahmed** (BRAC International, Bangladesh); **Rosie McGee** (IDS); and, **Yunping Wang** (National Health Development Research Centre, China)

The discussion in this plenary focused on the ways in which new opportunities and challenges for thinking on health and accountability are being created by new actors – both state and non-state – from rising powers such as China and emerging development leaders such as Bangladesh, and by new technologies.

Gerry Bloom began the plenary with a recap of the previous day. He offered three major reflections on the content of the workshop: Firstly, that accountability is not simply reduced to a set of interventions but that it requires the "*construction of a social contract between stakeholders*, *all whom agree on accountability relationships and recognizes their respective responsibilities*"; Secondly, that accountability has different meanings, and this multiplicity of accountability meanings demand reflexive thinking on our part and a recognition of complexity. Thirdly, that *accountability relationships are constructed over time* and in particular, in historical contexts.

Bloom then shifted the focus to looking towards the future, to moving beyond Alma Ata and thinking about the meaning of accountability in a 21st Century context. A move that takes into account new technologies and new actors – such as BRAC international, set up and run by Bangladeshis with the potential to be a major development actor by 2020. In addition, the increasing importance of China and its new foreign policy of global engagement for global health must be considered; and finally, the rapid spread of mobile phones and internet access coupled with the growth of the IT industry and increased relevance of tech actors in global health.

The first speaker, **Faruque Ahmed**, of BRAC International, presented on the history of the organization, its models of operation and programmatic priorities and practices. Founded in 1972 in a newly independent Bangladesh, BRAC has since grown to the point that its services reach every village in the country, in addition to having now expanded into ten additional countries where it works in partnership with national actors. The BRAC approach is one of mutual cross-country-programme learning and mutual accountability practices.

Second, **Rosie McGee**, of IDS, spoke about the emerging results from the Making All Voices Count programme on tech-enabled approaches to citizen engagement and accountability. She outlined a new set of actors that have emerged over the last 6-7 years, including tech developers, data scientists, civic tech activists and hackers. Where this relates to accountability for health equity, McGee shared some *"qualified good news"* as well as both simple and complex concerns. The good news, according to McGee, is that the *"tech offers possibilities of accelerating communication and aggregating information which can lower the costs of claiming accountability, and increase the policy-maker's capacity to respond to these claims, enhancing the chances of success."* However, this requires political will and willingness on the part of accountability-givers.

McGee's simple concern about these developments, based on what has come out of the MAVC project, is that there is *"little evidence for the impact of 'tech' solutions in Transparency and Accountability initiatives."* She then outlined five complex concerns about actors and power: 1) Tech actors do not come from an accountability culture, but rather from a profit-driven innovation culture; 2) In the changing nature of authority, tech actors are a challenging sub-set of corporate actors; 3) Unaccountability of algorithms and bots – how can the faceless be held accountable? 4) tech-induced individuation undermines collective action; and lastly, 5) will tech make all voices count, or exacerbate the existing fault lines of exclusion and inequality of voice?

Lastly, **Wang Yunping**, of the China Health Development Research Center, presented on the Silk Road Economic Belt and the 21st Century Maritime Silk Road (Belt and Road) development initiative, initiated in 2013. This initiative aims for policy coordination, facilitates connectivity, unimpeded trade, financial integration and a *"people-to-people bond."* The idea behind this tremendous financial investment (8.7 billion over the next three years) in infrastructure development and new cooperation mechanisms, is to build a global community of *"shared interests, destiny and responsibility based on political trust, economic integration and cultural inclusiveness…and to pursue the common ideas of mankind, create new models of governing the world, uphold the fundamental interests of the international community and help build a long, peaceful and harmonious world that is safe and prosperous for all."* Wang explained that China's effort to improve global health is a key to building the *"people-to-people bond"* and will include the prioritization of strengthening cooperation on epidemic info-sharing, training medical professionals, improving the capacity to respond to public health emergencies, as well as the provision of medical assistance and cooperation on major global health issues more generally.

Following this panel, participants moved into the parallel thematic sessions of Day 2.

Theme 4: Accountability for Equity, Universality and Inclusion

Theme convenor: Asha George (University of the Western Cape, South Africa); **Speakers**: **Heather McMullen** (International Planned Parenthood Federation, UK); **E. Premdas Pinto** (Centre for Health and Social Justice, India); **Matthias Leicht-Miranda** (Swiss Development Cooperation); **Renu Khanna** (Society for Health Alternatives, India); **Fatima Adamu** (Women for Health Initiative, Nigeria); and **Godelieve Van Heteren** (Rotterdam Global Health Institute and WHO Health Systems Governance Collaborative).

Overview: Accountability is increasingly being instrumentalised as an intervention to improve health sector performance and improve health outcomes. Yet, at its heart, accountability is about how power relations are mediated in dynamic health systems that carry transformative potential. Accountability initiatives, like community participation, imply an advance of equity and social justice, but if they do not explicitly address power relations they may inadvertently replicate existing social hierarchies. The discussions in these sessions considered how power relations intersect across class, gender, ethnicity/race and sexuality, among other forms of marginalisation, to shape initiatives that seek to affirm health equity and accountability. This thematic session asked participants to think about the following question: *How does viewing power from an intersectionality lens affect how accountability initiatives frame issues, enable their visibility and the terms of engagement and alliances required to support progressive change?*

Session One: Universality, Power and Marginalisation
In the first session, **Heather McMullen** began with a presentation of IPPF's collaborative social accountability study on family planning and reproductive health programmes in Uganda. Through a method they developed entitled, "Remedy and Redress", they sought to track processes of change at the community level. The results of this work brought up some key issues for consideration. Firstly, McMullen, suggested, the framing of the "family" in family planning is problematic. Who is included in this category and who isn't? Secondly, the community scorecard process revealed that family planning was not necessarily a priority for community participants, as the study had assumed it might be. Thirdly, the attribution of change and success can be misplaced. One of the challenges of the community scorecard method is the issue of "elite capture" whereby the most powerful members of a given community control the process and distort its aims. This raises the question of who is excluded.

E. Premdas Pinto, of the Centre for Health and Social Justice in India, was unable to physically attend the workshop, but provided a video presentation to be included in this session. Pinto's presentation focused on two distinct pathways towards accountability in India: Firstly, a focus on engaging men for gender equity (a focus of the CHSJ's work) and secondly, a focus on engaging the judiciary and legal actors for maternal and reproductive health.

Matthias Leicht-Miranda, of the Swiss Agency for Development and Cooperation's Moldova office, spoke about accountability and intersectionality from a donor perspective. He reported on results of research on inequality of access to health services and information, which identified a need for greater civil-society support. He suggested that there is a need to distinguish between watchdog NGOs which can be critical and hold governments accountable, and service NGOs which have less financial independence from government authorities. Taking note of this distinction, he argued that we need to promote more watchdog NGOs.

In discussion, participants raised issues such as the challenge of raising one's individual voice to flag up accountability issues when there isn't a sufficiently supportive or enabling environment. Thematic session participants did not agree on how to categorise the power relationships that define global health and national-level health systems – is it a question of oppressor and oppressed or is this too simplistic? What kind of relationships and alliances are needed to achieve both "voice" and "teeth" in accountability claims? What range of strategies are possible to achieve pathways to accountability? The group came out in favour of generating more collaborative relationships between service providers and citizens (both as individuals and as collectives), and the need for more resources to promote those civil society actors that can play a "watchdog" role. The group also concluded that in terms of future research, more effort needs to be put towards understanding the "middle ground" of oppression, not just in terms of this oppressor/oppressed binary.

Session Two: Empowering Marginalised Communities
To begin the second session, **Renu Khanna** presented on recent work done by the Society for Health Alternatives in Gujarat, Western India, to improve health outcomes for adolescents. What emerged over the life-cycle of the project, which initially focussed on girls' empowerment with regards to gender-based harassment and sexual health, was the need to engage boys and young men. As part of their programmatic work, SHA included an

educational component that spoke to both girls' and boys' entitlements and vulnerabilities, as well as their sense of worth, with parents and community leaders.

Fatima Adamu then spoke about the work of the 'Women for Health Initiative' in Northern Nigeria. The programme's mandate is to increase the number of female health workers in this historically underserved region of the country. Their approach encourages women from communities facing acute health worker shortages to receive midwifery training with the understanding that they will return back to their communities of origin for a minimum of three years-service. One of the biggest challenges they have faced is that the fathers of some of these young women, want to "claim" them back, in order to marry them off, therefore denying them the opportunity to provide an essential service to their communities. Through focusing their efforts on building a strong connection with the communities where they work, and in fostering relationships between communities and higher government authorities, the Women's Health Initiative has been able to move forward with their training and expansion of the health workforce.

In the last presentation, **Godelieve Van Heteren,** of the Rotterdam Global Health Institute and the WHO's Health Systems Governance Collaborative, proposed to shine a light on the *"elephant in the room,"* in these discussions on accountability and intersectionality: the role we all play in maintaining the very power relations that contribute to health inequity. "*We need to talk more openly about what we do ourselves to stay in power,"* and as part of this, *"we need to look more closely at where the money is coming from"* that sustains global health efforts.

The content of Van Heteren's presentation was later expanded, in collaboration with **David Clarke** and **Maryam Bigdeli**, into a thought-provoking blog. As members of the Health Systems Governance Collaborative, Van Heteren, Clarke and Bigdeli suggest that to truly transform accountability for health equity, we need to consider the power dynamics that influence our own work. They also argue in favour of greater inclusivity where debates about power and accountability are concerned, in effect, arguing for an expanded "we" in terms of the "we" who are acting to foster better governance.

This challenge to look at power relationships as not only being located in communities that are "out there", but also to look at them within our own networks of research, policy-making, activism and health service delivery, has provoked a wide-ranging debate. One point of contention was the categorisation of communities as "marginalised", which doesn't allow for a more nuanced understanding of the multiple levels of deprivation that exist within communities and the potential for positive change. In this sense, technical experts, brought in to catalogue and categorise a group of people and their health needs, should be aware of the power they are assuming in doing so. Another issue raised was the question of where the money is coming from that allows much of this work to be financed and supported? The group discussed how it is possible to be aware of these market realities while at the same time challenging those practices that undermine health rights. Finally, the group talked about what is possible in terms of new measurements of success that go beyond the typical impact indicators.

Theme 5: New opportunities and new challenges: mutual learning for effective accountability

Theme convenors/speakers: Gerry Bloom (IDS); **Jennifer Constantine** (IDS); **Speakers**: **Joanna Chataway** (University of Sussex, UK); **Maureen Mackintosh** (Open University, UK);

Julius Mugwagwa (Open University, UK); **Faruque Ahmed** (BRAC International, Bangladesh); **Wang Yunping** (China National Health Development Research Center); and **Rômulo Paes de Sousa** (RIO+ World Centre for Sustainable Development, Brazil).

Overview: A number of factors have led to big changes in the health accountability ecosystem. These include: the growing importance of national and transnational non-state providers of health-related goods and services; the increasing influence of the governments and private companies from several large and rapidly developing countries; the emergence of a wide variety of citizen organizations and political movements. At the same time, a number of rapid interconnected changes in technology, communications, demography and ecology have opened up new opportunities for action, and also led to new accountability challenges. It is becoming increasingly clear that major efforts to strengthen accountability arrangements for health equity in this rapidly changing context, will require effort to build mutual understanding between stakeholders with very different positions, economic interests and historical legacies about basic rules of engagement for public health. In that spirit, this thematic session tackled both the challenge of transnational actors for building accountability, and the challenge of encouraging mutual learning between countries and distinct stakeholder groups.

Session One: The Challenge of Transnational Actors
In this session, speakers focused on the changing nature of health systems delivery mechanisms in the African continent, and the influence of external, transnational actors on this shift. In the first presentation on complex accountabilities in product development partnerships, **Joanna Chataway** spoke about market and development failures in the production of medicines that meet the disease burdens of the world's poor. The drivers of change in global health, she argued, include a growing awareness of inequalities in health and that the achievement of good health is a global effort. In this push towards reaching global health objectives, Product Development Partnerships (PDPs) have become a new social technology that is shifting the terrain. They involve working with new partners in the arena of global health, such as venture capitalists. Chataway argued that they have thus far been successful in stimulating the creation of effective partnerships to develop specific vaccines or treatments of neglected tropical diseases, however, new approaches are now needed to build substantial capacity for ongoing R&D of new therapies. She asked participants to think whether, as a project-based model, the PDP is a sustainable approach in this new era?

In the second presentation, on the inter-relationships between Indian and African pharmaceutical companies, **Maureen Mackintosh** talked about the major changes that are currently taking place in the African pharmaceutical sector. Primarily, the issue at stake is the emergence of a small number of large foreign-owned companies that are displacing the national production of commonly used products. Indian companies have been especially active. Mackintosh suggests that the rapid reduction in local production could have a significant impact on the availability of these products in local contexts, which raises important accountability issues regarding the influence of policies in India, China and other countries on the development of the African pharmaceutical sector.

Julius Mugwagwa then presented on local accountability in a globalised health innovation context: the case of regulation and standards in developing country health systems. In his talk, he focused on what accountability looks like *"for the regular person."* In an ideal accountable health system, he suggested, expertise should be combined with compassion, and

the delivery of drugs at the local health service level should be without judgment. From a governance and regulatory view, the question is how to get products to the people who most need them? Indian and Chinese firms have become increasingly active in Africa, consequently, Mugwagwa argued, African Governments and regional bodies such as the African Union will need to build their capacity to negotiate the establishment and enforcement of quality standards for drugs, diagnostic equipment and so forth. The politics of decision-making in this context is key and cannot be ignored.

The discussion in this thematic session centred on the question of who is in a position to demand greater accountability in these shifting contexts, and who is being held accountable? For example, **Desta Lakew** pointed out that pharmaceutical companies are only too willing to reduce costs and sell drugs to the public. **Rosie McGee** asked which social actors are demanding greater accountability when it comes to medical treatment and prescribing practices? **Joanna Chataway** added that there is an inherent tension between advocacy and procurement (of medicines) in the context of different countries. **Faruque Ahmed** offered the BRAC case of trying to do preventative care in Bangladesh but going against the challenge of a national drug policy, which required BRAC to push for a legal framework that allowed for the local production of high quality, low-cost drugs. On the question of the potential for pandemic preparedness in these contexts of substantial transnational actor influence, Julius Mugwawa, argues that the local agenda is in a better position to deal with pandemics than outside actors. Ultimately, the discussants reached the conclusion that the identification of strategic alliances would be one way to move forward towards greater accountability where transnational actors – like pharmaceutical companies – are concerned. As Joanna Chataway, pointed out, the private sector is not *"one entity, but is in fact diverse and responding to different contexts and incentives."*

Session Two: Building Mutual Learning for Reform and Global Regulation
This session began with a case study of China's recent efforts in global health and development funding and cooperation with a presentation by **Wang Yunping**. **Gerry Bloom** raised the question of who specifically should be accountable for health equity with regards to China-Africa cooperation. **Wang Yunping**, suggested that in order to build a cooperative relationship, the first step would be the identification of key stakeholders, for example, identifying actors in the China-Africa forum, or through development assistance activities. **Alex Shankland** asked what the role of civil society might be in the Belt and Road initiative, and which organisations have already achieved positive outcomes? **Priya Balasubramanian** wondered what kind of partnership would be possible between China and India where global health and development cooperation is concerned given the tenuous nature of their geopolitical relationship. **Wang Yunping**, said that while India has not yet expressed interest in collaboration, governments in Latin America have expressed interest in joining the Belt and Road initiative. In response to a question about health resources funding and health worker training as part of China's global health work, **Wang Yunping** explained that there are no special earmarked funds, South-South collaboration between governments could involve dedicated efforts to improve health workforce training.

Bridging into the afternoon session presentations, Jennifer Constantine reiterated the importance of mutual learning in South-South collaborations to improve health equity. With this goal of mutual learning in mind, **Faruque Ahmed** presented on BRAC's experience, shifting from Bangladesh-specific development projects and community-based work to a

model of mutual learning and cooperative partnerships across a range of countries. He gave the example of BRAC's Bangladesh-focused efforts in the 1980s which involved collaborating with a range of policy makers and development donors to develop multi-dimensional policies with accountability dimensions at all levels. This was a factor, he argued, in achieving impressive health outcomes during that time. Now that BRAC International is moving into partnerships in a range of different countries, with different policy and legislative contexts, Ahmed suggested that the one key element to future success will be the kind of space given to civil society in these debates and in policy development.

Lastly, **Rômulo Paes de Sousa** spoke about contemporary challenges to the existing public health system model in Brazil (the SUS) and, in particular, the changing legal frameworks that have led to a decline of 10% in investment to this sector. South-South cooperation between Brazil and other development and health partners has been "erratic" for many years, Paes de Sousa argued, but the potential of Brazil remains to be a leader in mutual learning via sharing human resources.

In the light of these presentations, participants raised questions about the feasibility of civil society involvement in accountability processes when, and where, health systems are no longer strictly divided between public and private actors. There was discussion about the levels of public health accountability, from local to global, particularly in countries where there is a complex mix of donor and development actors. **Lewis Hussain** pointed out the distinction between 21st century issues versus yesterday's issues, and urged session participants to acknowledge the big transformations that are coming, and the negotiations which will be required to develop new models and mechanisms for global health cooperation. **Jennifer Constantine** suggested that there is a lot to be gained in sharing learning, particularly because a lot of the learning has been an active, "learn by doing" knowledge production versus codified knowledge. **Priya Balasubramanian** concluded the discussion stating that there are distinct cultures of accountability, some more developed and institutionalized than others, so the question becomes how to integrate cultures of accountability into the fabric of institutional effectiveness?

Theme 6: Brokering, metrics and the politics of evidence

Theme convenors: Tom Barker (IDS) and **Sara Bennett** (Bloomberg School of Public Health, Johns Hopkins University, USA); **Speakers**: **Anne Buffardi** (Overseas Development Institute, UK); **Ian Harper** (University of Edinburgh, UK); **Justin Parkhurst** (London School of Economics, UK); **Daniela Rodriguez** (Bloomberg School of Public Health, Johns Hopkins University, USA; **Pedro Prieto Martin** (IDS) and **Desta Lakew** (AMREF Health Africa, Kenya).

Overview: While evidence and metrics may be derived through independent, rigorous and unbiased processes, the way in which it enters the policy and decision-making process is rarely neutral. Instead different actors may seek to shape debate by bringing different types of evidence to the policy sphere. The nature of the scientific rigor that underlies the evidence is typically not fully understood by policy actors, and thus issues of trust and the perceived credibility of the agent bringing evidence, become key. These two sessions asked participants to consider the politics of evidence creation and evidence use, broadly speaking, as well as the role of knowledge brokers and knowledge translators more specifically.

Session One: The Politics of Evidence and the Accountabilities of Policymaking
Sara Bennett began by framing the session as a critical reflection on the use and generation of evidence in global health at the national level, particularly given the shift in emphasis on the importance of evidence to health decision-making over the past two-decades. How, for example, do you move from a systematic review to policy dialogue? Each speaker gave examples from their own work about the politics of evidence use and the pragmatic considerations of policy makers when turning to certain kinds of evidence to make decisions. **Ian Harper** gave the example of pharmaceutical markets in India and Nepal and the conduct of pharmaceutical trials that take place at the interface between development and health, in addition to the case of the brokering and outsourcing of Maternal Neonatal and Child Health (MNCH) services in Nepal. **Justin Parkhurst** spoke about his recent monograph, *The Politics of Evidence,* which includes case studies of distortions of evidence in policy making, highlighting that it is not just a question of the quality of evidence produced, but the ways in which evidence ultimately gets used to make certain political arguments. **Daniela Rodriguez** spoke about the types of evidence used by health-service middle managers versus the types of evidence that makes its way into global policy debates. She asked session participants to think about whose interests are being served and about the role of power in knowledge use. **Pedro Pietro Martin** gave examples from his work on digital transformations in evidence generation and evidence sharing and civil society led accountability struggles in Spain. **Anne Buffardi** spoke about the power asymmetries and political considerations that lead to the privileging of certain kinds of evidence in policy-making circles, based on her research on complexity-informed development approaches and impact-oriented monitoring and evaluation systems.

These examples led to a lively discussion on the nature of power at all levels of evidence creation, co-construction and mobilization. The conversation between both roundtable speakers and session participants was wide ranging, but centred on the following key issues:

- Power shapes how knowledge is produced and how it gets used at all levels of health decision-making.
- The role of knowledge translators and knowledge brokers is key to evidence-based policy making.
- There is validity in multi-disciplinary approaches to generating evidence on what works in global and national health, but this requires a commitment by scholars of different disciplines to go beyond their comfort zones and it requires the creation of new networks and "communities of knowledge."
- Global health commitments, such as Millennium Development Goals 4 & 5, drive action towards "what gets measured" (which can leave out valuable approaches or ignore more complex health issues), but can also generate political will and greater accountability of governments to implement change.
- We need to think about how to include the kind of evidence generated by social participation-focused projects and interventions, which does not fit with the biomedical bias of global health, in a more efficient manner.
- There needs to be more work done to build collaborations to help sustain research and programmes, and to increase the demand for good evidence.
- There needs to be more explicit goal clarification before research begins, to avoid producing incoherent policies. We have not sufficiently looked at implementation contexts and adaptation strategies (e.g. the problem of 'pilotitis').

- We need to build local capacity to generate scientific evidence in many contexts and address information gaps.

Session Two: The Role of Knowledge Translation Organizations in Brokering Evidence
In the second session, the topic shifted from the original stated focus due to planned contributors not being able to travel to IDS. Instead, the second session aimed to examine more closely not only hierarchies of knowledge, but also hierarchies of data. Session chair **Sara Bennett** asked the panel to reflect on what kinds of collaboration might be possible between differently positioned actors. Given that there are different kinds of evidence required to understand the challenges of accountability for health equity and for developing solutions, why aren't different types of evidence brought to bear more equally on health systems debates, both within research and policy circles? Bennett spoke about the issue of non-scalability of pilot studies and the pressure within biomedical research towards the monetization of certain kinds of technical solutions.

Justin Parkhurst framed the problem as one of identifying 'appropriate evidence' depending on the type of research question being asked, for example: is there a problem? What intervention works? How do we implement it? How do we evaluate it? For each set of questions, different types of research strategies are required. This led to a discussion within the group about how to measure certain kinds of desired outcomes, like 'empowerment' – if it isn't as easy to measure as other kinds of intervention outcomes, this impacts on what types of action are more dominant. The group also discussed how to integrate non-biomedical ways of knowing and systems of healing.

Sara Bennett guided the group to think about researcher accountabilities, in the sense of being accountable to funders as well as to their own research communities. **Ian Harper** commented on the pressure on researchers to demonstrate impact to funders, as potentially leading to distortion of evidence and narratives of success. **Desta Lakew** added that there is the added pressure of not being sufficiently funded by donors to ensure robust research, whilst being held accountable for the production of certain kinds of evidence. **Daniela Rodriguez** raised the issue of access to evidence and paywall restrictions on journal articles or barriers of access to disaggregated data. **Ian Harper** added that the challenge of securing research funding and the pressure to write proposals that are attractive to funders leads to risk-averse funding strategies. This discussion of researcher accountability ended with a debate on the role of a researcher versus the role of an advocate, and to what extent these roles should be conflated. Participants agreed that there is a trade-off between policy influence and research neutrality that must be acknowledged.

On the challenge of translating evidence of policy and influencing change processes at the level of national health systems, **Desta Lakew** suggested that what we need to do is strengthen institutions of knowledge creation and gather more evidence about practice (rather than abstract intellectual inquiry). Furthermore, we need to promote the collaboration of research institutions, because issues such as Ebola don't have borders.

The session concluded with a discussion on the transformative potential of research. Part of the response to these shared challenges might involve a shift in the way that researchers work and a more flexible approach to working with policymakers. Both evidence and political action are "forms of accountability", **Daniela Rodriguez** argued, and we (researchers and knowledge

brokers) should work towards "being okay with the discomfort" of working together. Discussants agreed that we (researchers) need to be more aware of our own power as agenda-setting actors, and as such move towards generating evidence that can influence intellectual trends and shift public attention, among other strategic interests.

Plenary 4: Making Accountability Real: Implementing UHC in Africa

Chair: Cynthia Ngwalo Lungu (Open Society Initiative for Southern Africa, OSISA) **Speakers: Elizabeth Ekirapa Kiracho** (Makere University School of Public Health, Uganda) and **Fatima Adamu** (HPI/DAI Women's Health Initiative, Nigeria).

This plenary session brought together two leading figures working to improve access to health services for marginalised groups in Uganda and Nigeria. The Chair, **Cynthia Ngwalo Lungu,** began the session by asking the panel participants to speak about the accountability challenges they have witnessed, and that will need to be overcome, in order to realise Universal Health Coverage (UHC) in Africa.

Elizabeth Ekirapa Kiracho reframed the question slightly, saying that she wanted to talk about "how accountability can help us achieve our UHC objectives." Reflecting on a personal story of being held to account by her daughter for coming home late, she remarked that the people who hold others accountable do not always have the moral authority to do so. This is an overarching challenge, in addition to issues such as a lack of resources, a lack of coordination or dialogue with private sector actors, and a lack of clarity regarding which individuals or which institutions are in a position to hold power to account. This is addition to a reliance on "western methods of accountability" that may not work in an African context, particularly given the shifting nature of power held by local leaders such as sub-county chiefs in relation to communities.

Fatima Adamu spoke about the challenge that her organisation faces, which is that "of the dying mother; a mother wants to have access to care." In the face of health system failures, which result in women receiving no care, or poor care, or being held hostage in hospital waiting areas until their care has been paid for, Adamu argued that the Nigerian government is making promises that it isn't keeping. "How can you get services to the people who need it most?" she asked. The response of the Women's Health Initiative to the government's accountability failures has been to focus on developing and training a health workforce deriving from the villages and communities with the greatest shortages. She urged workshop participants to think about Universal Health Coverage in terms of dignity, not simply access to services.

In post-presentation discussion, one point that emerged was the challenge of how to reinforce the value of the right to health when the push towards UHC creates an opening for the private sector to move into the spaces where the public sector is seen to be failing (a point made by **Duncan Wilson**)**.** In response, **Ekirapa Kiracho** stated, *"We need both, but in different countries they have different roles to play. We need to sit down and talk about how we are working together, so that together that we are able to achieve these goals."*

The second overarching question posed to the panel by **Ngwalo Lungu** was: "what are the new opportunities for achieving real change at scale in Africa?" **Adamu** responded that in Nigeria there are certain civil society groups doing great work in this area, and that perhaps a more localised approach is what is needed if tackling federal government accountability is

"too big an elephant to deal with." She gave the example of hospital infrastructure – easy to build, but less easy to staff. In this sense, UHC provides an opportunity to mobilise citizens to demand change, for example, better service provision.

Ekirapa Kiracho outlined areas of opportunity to achieve improved accountability with this idea of achieving real change at scale, including: multi-sectoral collaborations; innovation in approaches used at the local level; the role of technology; allocation of adequate resources; and meaningful sanctions.

Day Three – 21 July, 2017

Plenary 5: Transforming Health Accountabilities

Chair: Melissa Leach (IDS); **Speakers: Walter Flores** (CEGSS, COPASAH, Guatemala); **Anuradha Joshi** (IDS) and **David Peters** (John Hopkins Bloomberg School of Public Health, USA).

This plenary discussion brought together three specialists from different fields of accountability research and practice to reflect on possible pathways to transformative change in accountability for health equity.

In the first set of reflections, **Anuradha Joshi** spoke about the ways in which the world has changed in the past two decades and the implications of these changes for accountability practices and possibilities. There are now *"multiple actors, both state and non-state, that are involved in the production of public goods and we need to tackle them at multiple sites simultaneously."* She urged participants in the workshop to expand their attention beyond the usual binary of citizens and providers and take seriously the larger accountability ecosystem that exists, and the politics of evidence that plays a role in shaping our understanding and in delegitimizing certain kinds of accountability claims. This requires thinking more strategically about *"where power lies and how it is used*," including within the realm of market actors and non-state actors. Joshi highlighted the role of ideology and religion and how this shapes social contracts. The rise of certain fundamentalisms poses challenges for collective action as societies fragment along religious or ideological lines. Finally, she drew attention to the issue of fragmented, fragile and conflict-affected states. *"What does empowerment look like to people living in these contexts?"* she asked.

Following on from these reflections, **Walter Flores**, told the story of his work with marginalized indigenous communities in Guatemala over the last several decades, and what accountability meant to him in light of these experiences. He challenged the concept of an "accountability intervention" and the idea that tools such as community scorecards or training workshops could achieve greater accountability for marginalized populations. *"To me,"* Flores argued, *"an accountability intervention or process is different cycles of challenging and engaging with power…We dialogue, negotiate, have setbacks and tensions."* If we accept that building accountability is an ongoing process, then the question becomes, *"what do we need to do to make those cycles better?"* This involves strengthening networks of solidarity, and creating spaces of negotiation and dialogue.

On the topic of institutionalization of social accountability in health systems, **David Peters** set forth a research proposition for workshop participants. He suggested that if we assume that "accountability is required to ensure fairness and change determinants of ill-health and health inequities," then our role as researchers is to 1) better understand how accountability changes

across contexts and time; 2) understand what it means to different stakeholders, health interventions and outcomes; and finally, 3) be part of the process of catalysing change, expending, amending or sustaining strategies for health equity.

Key research questions, Peters suggested, include the following: 1) are we building scalable and sustainable strategies that are feasible? 2) are we building scalable and sustainable strategies that have the potential for adoption and institutionalization? 3) are these strategies achieving the overall purpose?

In response to the presentations, **John Gaventa**, remarked that there is a sense of equity *"missing from our discussion."* Within health systems, it isn't just a question of routes to service delivery, but also the quality of the treatment that citizens receive within health systems in terms of dignity, respect and fairness. *"Empowerment has been considered a means to accountability,"* he said*, "but it could also be considered as a valuable outcome of accountability."*

Sara Bennett commented that it was striking how different speakers talk about outcomes in this shared field of work, in terms of trust, resolution, equity, and action. *"People have different aims and objectives in mind. We do not always have clarity as to which pathways lead to what in these processes. I would like to know more about the risks of these interventions (potential for reprisals in the case of scorecards). Can it increase distrust for the state or people in supporting these types of intervention? We need to explore the positive effects as well as the potentially less positive and unexpected effects".*

David Peters reiterated the importance of language, discussed on Day 1 of the workshop. *"Sometimes we need common terms, sometimes you don't get there," he reflected, but, "the important part is to bridge understanding. If we continue to have multiple terms and understandings, the more interaction we have, the more helpful. We need more of these spaces."*

Plenary 6: Summing up and Ways Forward

Speaker/Facilitator: Alex Shankland

For the final plenary, Alex Shankland summarised the crucial findings and debates that had emerged over the course of the three-day workshop. For *accountability analysis*, he identified the following key points for consideration:

1) **History Matters** – for example, Alma Ata and the legacy of previous efforts to secure health for all matters to our contemporary understandings of accountability for health equity. However, there is also the risk that history becomes a dead weight and that we ignore shifting roles and the emergence of new non-state and state actors.
2) **Language Matters** – there are multiple languages that need to be taken into account, both in the sense of different national languages of accountability, local understandings and meanings of accountability, and new languages for challenging accountability failures.
3) **Technology Matters** – technology is important but it is not a magic bullet; there is a lack of accountability of those who control technological developments and data use.
4) **Context Matters** – tools and strategies have to be adapted to fit local contexts, but we also have to look at power relations across different levels and the cultures of institutions as well as locations.

5) **Power Matters** – it is not only the poor who are "unruly," but corporations and transnational actors as well. Communities must also be held accountable if there is to be "mutual accountability", but we should remember that power ensures that "mutual" does not always mean "equal".
6) **Brokers and Translators Matter** – making the knowledge translatable is a key step.

Shankland suggested that while we realize analysis and action need to be interactive and interacting, we don't yet clearly see where the path is. We need to make sure we are asking the right questions and that we understand causal pathways, but we must also recognise that our "lens" is normative and not value-free. In measuring outcomes, there are opportunities to expand what gets counted, to include outcomes such as "human dignity." Strengthening *accountability action* requires us to push towards a greater convergence and mutual support among interventions operating on different "accountability wavelengths". He remarked on John Gaventa's cautionary thought that emerged from buzz discussions at tables, that when people speak truth to power, harassment, violence and hard power will follow. In that sense, the collective group of workshop participants was asked to reflect on whether – when pushing for greater accountability – we are prepared to support those individuals and groups who are raising their voices and challenging existing power dynamics?

In the final discussion, there were calls from participants to continue to meet – whether in person or in virtual spaces – and to open up these discussions to a broader group of civil society and health systems actors. Some challenged the idea that any solution could come in the short term, and encouraged the group to think about long-term institution building rather than quick projects and interventions to improve health equity.

For a closing reflection, **Gerry Bloom,** emphasized the importance of inclusion, and expanding our partnerships and alliances to include new actors, particularly those implementing health systems changes in country-specific contexts. He argued that we need to look beyond holding public health system actors to account and start to think more seriously about how to hold private health system actors to account. He acknowledged that the history of politics matters and that research is a long process. Without mapping the accountability and power relations, interventions will not be able to drive change. On a final note, he encouraged workshop participants to take seriously this moment in time and the possibilities it brings for a renewed push towards health equity.

What next for IDS work on Accountability for Health Equity?

At IDS, our shared vision is one of equal and sustainable societies, locally and globally, where everyone can live safe, fulfilling lives free from poverty and injustice. As should be clear from the content of this workshop and the types of participants we invited to join us, we believe that cutting-edge knowledge and evidence are crucial in shaping the changes needed for our broader vision to be realized, and to support people, societies and institutions to navigate the challenges ahead, in highly dynamic global contexts. The IDS approach, one which we feel was illustrated by the discussion and debates that emerged over these three days, is one of "engaged excellence." We, the IDS Accountability for Health Equity programme team, along with other colleagues at the Institute, think that knowledge should be generated by sound methodology and in partnership with other development and non-development actors. Engaged excellence is the ability to produce and promote rigorous and relevant research whilst

understanding the policy, power and knowledge context in order to communicate and apply that knowledge effectively, to bring about change.

The specific aim of this workshop was to convene and facilitate the exchange of practical ideas, cutting edge research, and to engender new collaborations between health equity actors. The overarching aims of the Accountability for Health Equity programme were reflected in the organisation and the implementation of the event itself, namely to *make health systems more accountable to meet the needs of all population groups* by: (i) bringing together practical experiences with health rights advocacy and analytical studies of politics, power and the management of health system change; (ii) learning from initiatives in Mozambique, Bangladesh, Uganda, Brazil and other countries that are seeking to strengthen accountability for health equity; (iii) co-constructing innovative methodological and conceptual approaches to understanding power and accountability in health systems; and (iv) creating a platform to facilitate ongoing links between researchers, practitioners, advocacy groups and policy actors.

Through this workshop we sought to achieve: (i) an increased understanding of the nature of power, and enhanced knowledge and capacity to navigate it, across research and practice in the fields of health equity and accountability; (ii) strengthened links between research and knowledge mobilisation communities, thus increasing the potential of evidence being mobilised to inform decision making and action in the health sector and (iii) a catalytic convening of actors from different backgrounds around a shared interest in understanding and learning how to influence and inform change processes, to enhance health equity in rapidly-changing and politically challenging environments.

Reflecting on the outcome of the workshop, we have identified – in dialogue with our partners - core strengths and principles that will guide our future work on accountability for health equity. These include the following:

- The IDS Accountability for Health Equity programme envisions itself as both a catalytic convenor and a co-producer of knowledge on change processes. This involves parallel efforts to, on the one hand, bring together strategic actors and analysts to build knowledge about what works, and what doesn't, and how best to push the accountability for health equity agenda forward in different political spaces, and on the other hand, to broaden our engagement on the topic of accountability for health equity so that it reaches new actors and generates new alliances.

- Our focus will be on new approaches to accountability for health equity that are emerging in different country contexts, such as those presented by participants in this workshop. Our focus on "the new" will be developed alongside a longitudinal approach to accountability for health equity that grapples with how accountability relationships develop and change over time. We are less interested in the short-term impact of interventions, and more interested in shifts that occur at the level of social contracts, social norms, and the institutionalisation of accountability mechanisms that are pro-equity.

- We will continue to work with “action strategists,” such as those who attended the workshop, as well as those looking to develop new collaborations with key action strategists in the contexts where they work.

- We will continue to place a high value on the creation of opportunities for mutual learning between countries, and to strengthening those networks and platforms that enable linkages between action strategists and change agents in governments, civil society, and within the medical professions.

- Our work will continue to focus on marginalised and excluded communities, co-generating knowledge on accountability gaps, failures and strategies for positive change.

- Finally, we will push ourselves to be innovative in our use of both “old” media and new forms of communication and engagement, in order to reach a broader collective of action strategists. Instead of “reporting” on what is happening “on the ground,” we aim to co-produce new types of content that can shift dialogue and action within accountability eco-systems.

Annexes

1. Full Participant List
2. Workshop Programme
3. Bibliography of Selected Authors
4. Blogs and Web Links

Annex 1 Workshop Participant List

Participant first name	Participant last name	Organisation	Country
Alise	Abadie	OSF	USA
Luidina Hailu	Abebe	International Institute for Primary Health Care	Ethiopia
Sebkewengel Lemma	Abreham	International Institute for Primary Health Care	Ethiopia
Fatima	Adamu	HPI/DAI, Women's Health Initiative	Nigeria
Mengesha	Admassu	International Institute for Primary Health Care	Ethiopia
Faruque	Ahmed	BRAC International	Bangladesh
Elena	Ahmed	DFID	UK
Olakunle	Alonge	Bloomberg School of Public Health, Johns Hopkins University	USA
Aggrey	Aluso	OSIEA (OSF Eastern Africa)	Kenya
Rachel	Apolot	Makerere University	Uganda
Miles	Bagnall	IDS	UK
Priya	Balasubramaniam	Public Health Foundation of India	India
Lola	Banjoko	NHS Brighton & Hove Clinical Commissioning Group	Nigeria / UK
Tom	Barker	IDS	UK
Sara	Bennett	Bloomberg School of Public Health, Johns Hopkins University	USA
Abbas Uddin	Bhuiya	ICDDRb	Bangladesh
Gerry	Bloom	IDS	UK
Victoria	Boydell	IPPF Evidence Project	UK
Anne	Buffardi	ODI	UK
Alexandre	Calandrini	Escola Paulista de Medicina da Universidade Federal de São Paulo	Brazil
Joanna	Chataway	Sussex University	UK
Andes	Chivangue	N'weti Communication and Health	Mozambique
David	Clarke	WHO	Switzerland
Ernestina	Coast	LSE	UK
Jennifer	Constantine	IDS	Brazil/UK
Ayako	Ebata	IDS	UK
Duncan	Edwards	IDS	UK
Elizabeth	Ekirapo Kiracho	Makerere University	Uganda
Lijie	Fang	CASS	China
Francesca	Feruglio	IDS	UK
Walter	Flores	Center for the Study of Equity & Governance in Health Systems (CEGSS)	Guatemala
Luiz Eduardo	Fonseca	Fiocruz	Brazil

Jonathan	Fox	American University	Mexico/USA
Karine	Gatellier	IDS	UK
Meenakshi	Gautham	LSHTM	India
John	Gaventa	IDS	UK
Asha	George	University of the Western Cape	India
Brendan	Halloran	International Budget Partership	USA
Ian	Harper	University of Edinburgh	UK
Mike	Holdgate	NHS Brighton & Hove Clinical Commissioning Group	UK
Mohammed Shahidul	Hoque	ICDDRb	Bangladesh
Peter	Houtzager	IDS	UK
Lewis	Husain	IDS	China
Mohammad	Iqbal	ICDDRb	Bangladesh
Anuradha	Joshi	IDS	UK
Dhananjay	Kakade	OSF	USA
Jeremy	Kanthor	DAI	USA
Renu	Khanna	SAHAJ-Society for Health Alternatives	India
Desta	Lakew	AMREF	Kenya
Matthias	Leicht-Miranda	Swiss Development Cooperation (Moldova)	Switzerland
Erika	Lopez Franco	IDS	UK
Maureen	Mackintosh	Open University	India/UK
Shehrin Shaila	Mahmood	ICDDRb	Bangladesh
Rosie	McGee	IDS	UK
Heather	McMullen	IPPF	UK
Donald	Mogeni	World Vision	UK
Paula	Monjane	CESC	Mozambique
Rosemary	Morgan	Bloomberg School of Public Health, Johns Hopkins University	USA
Julius	Mugwagwa	Open University	UK
Sarah	Mukasa	Open Society Institute East Africa (OSIEA)	Kenya
Denise	Namburete	N'weti	Mozambique
Suzanne	Namusoke Kiwanuka	Makerere University	Uganda
Erica	Nelson	IDS	UK
Cynthia	Ngwalo-Lungu	OSISA (OSF Southern Africa)	South Africa
Rômulo	Paes de Sousa	RIO+ World Centre for Sustainability	Brazil
Ligia	Paina	Bloomberg School of Public Health, Johns Hopkins University	USA
Justin	Parkhurst	LSE	UK
David	Peters	Bloomberg School of Public Health, Johns Hopkins University	USA
Erika	Placella	Swiss Development Cooperation	Switzerland

Pedro	Prieto Martin	IDS	UK
Daniela	Rodriguez	Bloomberg School of Public Health, Johns Hopkins University	USA
Amina	Salihu	MacArthur Foundation	Nigeria
Vera	Schattan Coelho	Cebrap/CEM	Brazil
Alex	Shankland	IDS	UK
Abhay	Shukla	Support for Advocacy and Training to Health Initiatives (SATHI)	India
Hilary	Standing	IDS	UK
Dolf	Te Lintelo	IDS	UK
José Luiz	Telles	Fiocruz	Brazil
Courtney	Toulmie	R4D	USA
Uranchimeg	Tsevelvaanchig	University of Queensland	Australia
Godelieve	Van Heteren	Rotterdam Global Health Initiative, WHO Global Health Governance Initiative	Netherlands
Peter	Waiswa	Makerere University	Uganda
Linda	Waldman	IDS	UK
Yunping	Wang	China National Health Development Research Center	China
Duncan	Wilson	Open Society Foundations (OSF)	USA

Annex 2 Workshop Programme

Day 1 – Wednesday, 19th July 2017	
09.00–09.30	**Registration** *[Refreshments will be available in Room 120-121]*
09.30–11.00	**Introductions and welcome** *Plenary:* **Accountability for Health Equity: Reflections on an Emerging Framework**
11.00–12.30	**Parallel thematic session A** *[Tea/Coffee will be available]* **Theme 1A:** Social Accountability Tools in the Local Context *[Room 127]* **Theme 2A:** Putting Accountability Processes into Historical Context *[Room 221]* **Theme 3A:** Strategies for Improving Pluralistic Health Markets *[Room 220]*
12.30–14.00	*Lunch, IDS Upper Common Room [by Reception]*
14.00–15.30	**Parallel thematic session B** **Theme 1B:** Institutionalising and Sustaining Local-Level Accountability *[Room 127]* **Theme 2B:** Accountability – A Multilingual Approach *[Room 221]* **Theme 3B:** The Changing Relationships between Government and Non-Government Providers in the Cities of the BRICS *[Room 220]*
15.30–16.00	*Tea/coffee break [Room 120-121]*
16.00–17.30	*Plenary:* **Health Accountability Politics in Time**
18.00-20:00	*Welcome drinks and dinner – Attenborough Centre, University of Sussex*
Day 2 – Thursday, 20th July 2017	
09.00–09.30	Feedback from Day 1: **What have we learnt?**
09.30–11.00	*Plenary:* **New Actors, Future Accountabilities**
11.00–11.30	*Tea/coffee break [Room 120-121]*
11.30–13.00	**Parallel thematic session A** **Theme 4A:** Universality, Power and Marginalisation *[Room 127]* **Theme 5A:** The Challenge of Transnational Actors *[Room 221]* **Theme 6A:** Politics, Evidence and the Accountabilities of Policymaking *[Room 220]*
13.00–14.30	*Lunch, IDS Upper Common Room [by Reception]*
14.30–16.00	**Parallel thematic session B** **Theme 4B:** Empowering Marginalised Communities *[Room 127]* **Theme 5B:** Building Mutual Learning for Reform and Global Regulation *[Room 221]* **Theme 6B:** The Role of Knowledge Translation Organizations in Brokering Evidence *[Room 220]*

16.00–16.30	*Tea/coffee break [Room 120-121]*
16.30–18.00	*Plenary:* **Making Accountability Real: Implementing UHC in Africa**
18.30–21.00	*Dinner – Stanmer House, Stanmer Park [This is a very pleasant 20 min walk from IDS]*
Day 3 – Friday, 21st July 2017	
09.30–11.00	*Closing Plenary:* **Transforming Health Accountabilities**
11.00–11.30	*Tea/coffee break [Room 120-121]*
11.30–13.00	*Reflections on the AHE Workshop, Summing Up, and Ways Forward*
13.00–14.30	*Lunch, IDS Upper Common Room (by Reception) and Close*

Annex 3 Bibliography

This bibliography includes key publications by speakers and participants in the Accountability for Health Equity Workshop that directly relate to the issues and debates that emerged over the three days of our meeting. It is by no means exhaustive, but rather is offered a starting point of reference for readers of this report who are interested in finding out more about the work that was presented and discussed, as well as key pieces of literature that informed the discussions.

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Annex 4 Blogs and Web Links

- **Has politics shaped the terms 'accountability' and 'participation'?**

  Author: Luis Eduardo Fonseca

  Luis Eduardo Fonseca discusses the changes he has observed during his lifetime in terms and meanings of words within the political arena. Political parties, international agencies and public institutions often absorb words and expressions born from social movements or among leftist academics.

  http://www.ids.ac.uk/opinion/has-politics-shaped-the-terms-accountability-and-participation

- **Towards accountability for health equity**

  Authors: Denise Namburete, Vera Coelho, Alexander Shankland, Gerald Bloom

  Denise Namburete, Vera Coelho, Alexander Shankland, and Gerald Bloom from the Unequal Voices project – Vozes Desiguais in Portuguese- talk about the importance of partnerships between actors working in accountability practice, policy and research, and local accountability politics - a key component of the project.
  http://www.theimpactinitiative.net/blog/blog-towards-accountability-health-equity

- **Transforming accountabilities for health**

  Authors: Tom Barker, Karine Gatellier

  Tom Barker and Karine Gatellier share the Accountability for Health Equity team's reflections post-workshop around the themes discussed and the important dimensions shaping accountability that were identified, namely: history, language, knowledge and evidence, technology, context, institutions, interest and ideology, and power and politics.

  http://www.ids.ac.uk/opinion/transforming-accountabilities-for-health

- **Is accountability for health equity a blaming dance?**

  Author: Alexandre Calandrini

  Alexandre Calandrini, from the ESRC-DFID funded "Unequal Voices" project, shares reflections on the first day of the workshop. He writes about a presentation on health care providers in India, and asks who is to blame for these providers over-prescribing antibiotics to patients. He also reflects on the meaning of accountability for health equity.

  vozesdesiguais.org/2017/08/02/is-accountability-for-health-equity-a-blaming-dance/

- **History and language: keywords for health and accountability**

  Author: Jonathan Fox

Jonathan Fox, Director of the newly-established Accountability Research Center at the School of International Service, American University, shares notes from his presentation on languages of accountability. He argues for a greater awareness of how accountability terms are politically constructed, and encourages us to search for terms that do a better job of communicating the key steps on the path to accountability-building.

http://www.ids.ac.uk/opinion/history-and-language-keywords-for-health-and-accountability

- **Onions, elephants and lenses; reflections on the accountability for health equity workshop**

  Author: Ligia Paina

  Ligia Paina, an assistant professor at the Johns Hopkins Bloomberg School of Public Health and affiliated researcher with the Future Health Systems programme, shares some reflections on the event and on the FHS team's contributions to the sessions. Topics covered included community scorecards, the politics of evidence and considerations around whose knowledge counts and the role of knowledge translation among others.

  http://www.futurehealthsystems.org/blog/2017/8/4/onions-elephants-and-lenses-reflections-on-the-accountability-for-health-equity-workshop

- **Accountability responses to the spread of health markets**

  Authors: Uranchimeg Tsevelvaanchig, Priya Balasubramaniam and Meenakshi Gautham In this blog, Uranchimeg Tsevelvaanchig, Priya Balasubramaniam and Meenakshi Gautham, from the Health Systems Global "Private Sector in Health Thematic Working Group," share their reflections from the workshop focusing on accountability responses to the spread of health markets. They focus their comments on national and transnational challenges and responses to the spread of health markets in Mongolia, China, India, and Brazil.

  http://www.healthsystemsglobal.org/blog/218/Accountability-responses-to-the-spread-of-health-markets.html

- **Tweaking or transforming: Dancing around power and accountability**

  Authors: Godelieve van Heteren, David Clarke, Maryam Bigdeli

  Godelieve van Heteren, David Clarke, Maryam Bigdeli are all active in the newly founded Health Systems Governance Collaborative. In this blog, they suggest that to truly transform accountability for health equity we need to consider the power dynamics that influence our own work. They also argue in favour of greater inclusivity where debates about power and accountability are concerned, in effect, for an expanded interpretation of the "we" that is acting to foster better governance.

https://www.ids.ac.uk/opinion/tweaking-or-transforming-dancing-around-power-and-accountability

- **Seven challenges for accountability 2.0**

  Author: Anuradha Joshi

  Anuradha Joshi, from the Institute of Development Studies, remarks that building accountability from below is going to be a slow and long-term process in which addressing the following challenges will be key to progress: Merely thinking about "states" and "citizens" is too limiting. We need to think more strategically about where public power (actually) lies. Current political ideologies and religion are increasingly fracturing shared moral norms. Closing of civic spaces by governments afraid of citizen voice is a real problem. One must be aware of the politics of (competing sources of) evidence. There seem to be two parallel worlds of accountability (the BRICS and the MICS versus the rest of the world). Finally, accountability work faces the challenge of impact: how will we assess whether any of our efforts have made a difference?

  https://www.ids.ac.uk/opinion/seven-challenges-for-accountability-2-0

- ***Storify: Unpicking Power and Politics for Transformative Change: Towards Accountability for Health Equity #IDSAHE2017***

  https://storify.com/IDS_UK/idsahe2017-unpicking-power-and-politics-for-transf?utm_source=embed_header

- **Video: Accountability for Health Equity: Power, Politics and Transformative Change**

  https://www.youtube.com/watch?v=ZFWoVvOFfBA