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Strategies and Institutions in
Delhi and São Paulo**

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Summary

There are signs that public services can improve in big cities when the urban poor hold providers directly accountable – what we now call social accountability. We do not know, however, to what extent the urban poor, through their civil society groups, engage in forms of social accountability nor what strategies they use. We do not know what factors lead the poor to choose accountability as a way to secure access to essential services, rather than clientelism, electing representatives to public office or simply self-provisioning. We need to answer these questions in order to develop programmes that support accountability initiatives and understand the potential social accountability has to improve the basic public services.

We designed a unique comparative study to take a step in this direction. The study compares activism by the urban poor to improve two essential types of services in the cities of Delhi and São Paulo, primary healthcare and social assistance. The unusual comparison between a South Asian and Latin American city, and across two very different types of services, gives us greater capacity to sort through different possible causes of accountability activism by the urban poor and explanations for the different types of strategies people use.

In the two cities, we find, a substantial share of civil society groups attempt to improve health and welfare services by holding providers accountable. They seek to establish greater accountability as one of several types of engagement strategies with the state – that is, accountability is a part of a larger repertoire of activism. There is large variation, however, in the level of activity and type of strategies in the two cities, and across the two services. Surprisingly, accountability activism is most robust in health in São Paulo and welfare (Public Distribution System, PDS) in Delhi; and least in welfare (Family Minimum Income Guarantee) in São Paulo and health in Delhi. Understanding the sources of this variation is one of the challenges of our paper. We look at whether the type of organisation and sources of funding influence accountability activity, and whether it matters whether civil society groups are local or translocal, or active in several areas of the city. We look at whether the type of service, or how services are provided, shapes activism. And we explore whether institutional factors, such as the right to information legislation in India and participatory governance councils in Brazil, which create different kinds of incentives or opportunities for civil society actors, impact levels of activity and what strategies are adopted.

Keywords: social accountability; primary health care; Public Distribution System; Renda Mínima; minimum income programme; civil society; urban poor.

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1 Introduction

To what extent do the urban poor in large cities attempt to improve public services by holding providers directly accountable? And how do they combine different aspects of such forms of social accountability – that is, creating common standards against which to measure performance, monitoring services, requesting information on budgets and staffing levels, and pressuring service providers to do better? Research hereto has focused on the impact of particular accountability tools, such as community scorecards or public audits, on services.¹ While the jury is still out, there are signs that this form of accountability from below can be effective.

As research on impact advances it becomes more urgent that we know more about social accountability efforts by the poor in large cities, where an ever-larger share of the world's population lives. If we are to develop a stronger framework for understanding when and where social accountability can improve public services, how to scale-up so that impact is systemic, and the ways in which international development actors can foster and support such efforts, then we need to identify which types of civil society groups take on this challenge, and the strategies they pursue – what actions are most common, who do they target, and how does accountability activity sit alongside other types of efforts to improve services.² In some contexts it's entirely possible that the urban poor find it more effective to lobby city assemblies or support the election of committed political leaders, or rely on clientelist relations, rather than direct action focused on providers. They may have given up on the state altogether for some public services and begun to self-provision services such as security through neighbourhood watches.

In this paper we try to provide both a rich descriptive portrait of civil society accountability efforts and a view into the main causal factors that lie behind which groups take up this challenge and the strategies they pursue. Given the tremendous differences in civil societies across the world and the many dimensions of social accountability – shared standard against which to measure services, information about performance, justification of official decision-making, and compliance with accepted standards – we chose an unusual comparative approach. We decided to compare, in as rigorously a way as possible, civil society groups engaged in accountability of providers in two very different large urban centres, Delhi and São Paulo. We then decided to deepen the comparison by looking at two distinct types of services: primary healthcare and welfare benefits (cash transfers in São Paulo and the Public Distribution System – PDS – in Delhi). Common patterns and trends we find in the two cities and/or sectors, despite their great differences, we believe, provide the bases for generalisation. The resulting four-way comparison is meant to help us sort through possible causal factors that can explain the levels and forms of social accountability we find. The differences across city and service help filter causal factors such as the type and/or funding sources of civil society organisations, the nature of the service and how it is delivered, the local or translocal nature of activism, and the broader institutional setting of accountability activism.

¹ Farzana and Iversen 2014, Banerjee et al. 2010; Bjorkman and Svensson 2009; Gaventa and Barrett 2010; Gaventa and McGee 2010; Mansuri and Rao 2013; O'Neil et al. 2007; Olken 2007. Cf. Joshi and Houtzager 2012.

² Such collective efforts to hold providers accountability contrast to new public management (NPM) inspired efforts to make individual citizens agents of accountability by providing mechanisms such as easy to use complaint procedures and citizen charters, NPM-inspired policies bet that the accumulation of individual pinpricks (complaints) will trigger administrative accountability mechanisms, in particular sanction of managers and front-line workers. Social accountability acknowledges the power disparities between poor individuals and public officials, and the poor and non-government service providers, in most social contexts. Cf. Schedler (1999); Mainwaring (2003); Fox (2007; 2015); Peruzzotti and Smulovitz (2006).

The paper makes a particular effort to explore social accountability in the context of the multi-dimensional web of relations civil society groups have to each other, to the providers and to the state agencies with responsibility for overseeing delivery of services. Groups that engage in accountability efforts have relationships with many other organisations and may engage in many other kinds of activities, such that any single act of social accountability must be understood as part of a broader set of interactions. The actors engaged in social accountability activities in particular are also likely to be engaged in many other kinds of strategies to interact with the state and its service providers.

What we find is that civil society groups of the urban poor in Delhi and São Paulo are investing heavily in accountability activities. We also find that accountability activity is not ring-fenced from other efforts to improve public services but often is part of multi-scalar strategies by civil society actors that engaged with front-line providers, as well as with state agencies at the city and even federal levels.³ But actors in the two cities pursue strategies that differ substantially. There is also significant variation in accountability activity between the types of services we examine. In both cities civil society groups monitor, publicise, and pressure public officials and providers to improve coverage and quality in public services. In Delhi, however, we find that groups are more likely to monitor service providers, use the right to information, and bring administrative cases to pressure for better performance. In contrast, in São Paulo they combined the use of formal participatory institutions (e.g. health councils) and public contention such as protests and petitions to inflict reputational costs on providers and officials.

What causal factors explain the varying levels of accountability activity we find, which groups engage in accountability and what strategies do they adopt? Some of the usual suspects appear not to matter. The type of organisation or sources of funding have little impact on levels or forms of activity. The type of service (universal such as health or targeted such as welfare benefits) and form of delivery (using public or private providers) may play some role but they matter less than the two main causes. First, groups that are part of translocal movements had higher and more robust levels of activity than organisations of the urban poor that worked exclusively in one locality.⁴ Such translocal actors are part of the legacy of larger social movements – the right to information and right to food in Delhi and the popular health movement in São Paulo that brought urban poor and middle-class professionals in broad alliances across the city. Such movements also played a critical role in the creation of a favourable or enabling environment for accountability action – the right to information (RTI) (Delhi) and participatory councils (São Paulo). The lesson for both theory and practice is that localism, and isolation of local actors in particular, reduces rather than increases accountability activity. Conversely, translocalism and involvement in broader civil society movements increases activity. Second, the broader institutional setting within which activism occurs, such as the right to information legislation in India and participatory governance councils in Brazil, have a substantial impact on accountability strategies. Such institutional arrangements create different kinds of opportunities for civil society and help steer on what dimensions of accountability actors will focus and what strategies they pursue. In the case of Delhi and São Paulo, the institutional arrangements that had a particularly strong influence on accountability efforts are themselves the legacy of earlier civil society activism.

³ Skocpol (1992); Evans (1996).

⁴ The greater capacity for action, existing literature suggests, is likely the result from access to level of resources, skills, and influential social networks that more isolated local actors cannot achieve. Much of the work on social accountability, while concerned with elite capture of local associations, takes as a given that exclusively local actors are closer to, and more authentic representatives of, low-income communities. Larger (translocal) movements are seen as external actors with weak ties to local communities, and likely to distort and compromise the interests of these. Historically, however, some of the most influential social actors have been broad movements with local chapters or branches that reach deep into communities —the Movement of the Landless in Brazil, labor movements and peasant federations across regions of the globe, and important parts of U.S. civil society. Skocpol (2003), Fox (2007).

Our study surveyed local civil society leaders in approximately 40 localities in each of the two cities. We did not have an *a priori* focus on a particular type of local group or specific accountability instruments, common in impact studies. Instead, the research relied on a framework of broad types of accountability activity that we might encounter, types of institutional arenas in which this activity might take place, and different types of actors that might be targeted – service providers, private organisations that manage public sector providers, state agencies at different levels of government, elected officials, and others. The localities we selected are defined by the catchment areas of local healthcare centres, as these are small administrative units for which maps and other data is available. This purposeful sampling is meant to raise the best-case scenario, where the eco-system of civil society is rich/dense and accountability activity is likely, and control for explanatory factors common in the literature. We added to these sample areas that were similar where we searched for presence of civil society activity.

The paper starts by introducing a more relational approach to understanding social accountability. It places civil society actors' strategic decision-making about whether and how to engage in accountability in the context of a broader set of relations to the state and political institutions. It then presents the empirical foundations of the study, and describes the local civil society organisations that engage in accountability activity in the two cities. It characterises their activities and the institutional spheres in which these are pursued. Finally we offer an explanation for the variation we find in types of actors and activities between the cities and sectors and what lessons these hold for both policy and research.

2 A more relational approach to civil society accountability activity

Social accountability in our view is a type of relationship between citizen groups and the actors responsible for providing services.⁵ These actors include both the front-line *private* or *public* service providers, and the state agencies with broad responsibility for public services. A more relational approach to social accountability places social accountability in a context of a broader and ongoing set of ties, which can include but usually extend well beyond accountability. Civil society groups, providers, and public authorities, as earlier state-society synergy approaches suggest, adjust to each other over successive encounters, in different institutional settings.⁶ What types of activity citizen groups are willing and able to take depends in part on what capabilities they and their government developed in previous encounters, and what (if any) institutions emerged from these encounters.

The state is increasingly only one of an array of legitimate actors who exercise public authority and shape services. Most thinking on social accountability focuses on action that targets state providers.⁷ This, however, is too narrow a focus with the growing fragmentation of the state through decentralisation, contracting out and privatisation, public/private partnership and providers of public services that are non-state actors.⁸ We do not know how these changes affect the ability of the poor to hold providers accountable for service delivery.

⁵ Accountability activity is not the same as social accountability, in the same way that democratic activity, such as voting, is not the same as democracy, a particular outcome or state of affairs. Our ambitions in this paper are therefore limited. We focus on accountability activity, not whether there is a state of affairs or process we could call social accountability.

⁶ Evans (1996).

⁷ Ackerman (2005), Malena, Forster and Singh (2004); and O'Neil et al. (2007).

⁸ Dowbor and Houtzager (2014); Scott (2000).

Activity that aims to increase social accountability is that undertaken by civil society groups such as neighbourhood or community associations, social movements, or NGOs, to hold providers and state agencies directly accountable for public services.⁹ The core strategy of social accountability is to make *public* state failures in meeting existing legal obligations. Its power to improve services comes from the ability to impose *reputational costs* on providers and public officials, or to trigger other (classic) forms of accountability that have formal enforcement power.¹⁰ Publicity can trigger forms of what O'Donnell has called horizontal accountability, by other state institutions such as the judiciary, legislature, independent or quasi-independent regulatory bodies, such as the public prosecutors (*Ministerio Público*) in Brazil and public interest litigation in India.¹¹

A more relational approach to social accountability recognises that civil society groups pursue multiple goals and use a variety of strategies to improve the public services. Social accountability activities are almost always part of broader strategies that traverse multiple institutional or non-institutional public arenas, and take place at multiple levels of government. Our approach therefore starts with the idea that whether local actors attempt to build social accountability into their relations with providers and state agencies depends on a willingness to divert resources from other activities that have potential for success. Whether collective actors veer towards heightening social accountability action depends on how committed they are to other strategies, such as policy advocacy, co-production of services, or even campaigning for new policies or programmes. Social accountability activity, for example, might be difficult if collective actors are engaged in other forms of engagement with the state (e.g. holding contracts for service provision). Alternatively, other forms of engagement might give them a strategic advantage, with privileged access to information and policy makers. Local groups in Latin America and South Asia's urban centres may attempt to influence several moments of the policy process, for example by lobbying legislative bodies or engaging in media campaigns. At the same time, they may also use local participatory institutions or informal governance institutions to hold public sector managers or providers accountable for full execution of the very policies they seek to modify through their lobbying campaign.

Civil society groups combine specific accountability activities in different ways, at different points in time. These strategies evolve and change over time but include some combination of gathering information on public services, insisting on public justification on how these have been allocated, and public sanction where these fall short.¹² It is the ongoing and more precisely targeted nature of social accountability that can make it a more effective tool than 'throwing the rascals out' in periodic elections. Elections, Manin, Przeworski and Stokes also note, are often a vote on the future, rather than a holding to account for past performance.¹³ And Jalal observes further that accountability activity 'catalyses on demand as and when the situation requires.'¹⁴

⁹ Social accountability, we should be clear, is different from such individual problem-solving, as well as from social movement demands for new positive rights or services. Instead, social accountability focuses on collective efforts to gain access to services that are legal entitlements

¹⁰ Scholars such as Mainwaring (2003) and Olken (2007) argue that social accountability has limited potential to improve public services because, in contrast to political or administrative forms of accountability, it cannot impose formal sanctions and force compliance. Civil society groups, for example, cannot levy fines, remove officials from public office, or cut agency budgets. But by making state failure public these groups create nontrivial reputational and political costs, and thereby threaten loss of public standing and political support, and possibly removal from office, cuts in budgets, or even loss of contracts. The reputational strategy, Schedler (1999:16) points out, is not restricted to civil society activism. 'In the world of politics, the destruction of reputation through public exposure represents one of the main [means to achieve] accountability.'

¹¹ O'Donnell (1998).

¹² Peruzzotti and Smulovitz (2006).

¹³ Manin, Przeworski, and Stokes (1999). This, of course, does not preclude the fact that clear evidence of under-performance or corrupt practices cannot play a role in election results even in poor communities as we find in Banerjee, Kumar, Pande and Su (2011).

¹⁴ Jalal (2008):106.

Creating institutionalisation of mechanisms for social accountability over the medium to long run is often one of the goals of social accountability action. Sometimes this succeeds, such as in the case of the social audits in India (which emerged from informal public hearings) that have been incorporated into the national rural employment guarantee law (NREGA), after much pressure from the National Campaign for the Right to Information.¹⁵

3 Many dimensions of social accountability

Preliminary research in São Paulo and Delhi showed that civil society groups use a diversity of accountability strategies and, therefore, that we need to think more carefully about the different dimensions of social accountability. If there is no monitoring or if there is no public shaming, can we still have social accountability? Does reliance on informal accountability mechanisms such as those in professional, political party or other social networks constitute social accountability?

We are inclined to believe that engagement in accountability is an inventory of activities that have overlapping characteristics much like family resemblance. Different components have different costs to local actors and different impacts on service delivery. Such activity — making demands through regular formal channels, demonstrating or engaging in contention, collecting data on services provision, bringing legal or administrative cases — requires that local groups choose in which activities to invest and to consider the trade-offs.¹⁶ The variable costs might explain why in different contexts some forms of accountability activity prevail over others.

It is therefore useful to disaggregate social accountability activity. A lot of the research conceives social accountability as including most forms of citizen participation, such as participation in policy-making or campaigning for new rights and services. While there is a connection between different types of citizen participation, social accountability has a distinct set of dynamics on service provision from other types of participation.¹⁷ In contrast to participation in deliberative processes, in which policy is negotiated and service delivery standards are set, accountability is a process of ensuring state power is used to achieve these policies and standards. If we want to understand how delivery of public services such as healthcare or education interacts with accountability activities, then we have to isolate these activities from other related actions, such as being engaged in deliberative processes that help shape legislation.

Schedler makes the important point that the components of accountability do not all have to be present in equal measure.¹⁸ This raises the question, if some dimension(s) is entirely absent, can we still talk of social accountability? Breaking the idea of social accountability into different dimensions, as we do below, also leads to the critical question, how do these dimensions interact in practice, in different types of social accountability initiatives and different contexts? Can progress in one dimension undermine progress along another, or are they tightly linked and one depends on the other?

Public accountability is a type of control over the exercise of power by public authorities, and over those to whom this authority has been delegated (such as private service providers).

¹⁵ Pande (2014).

¹⁶ This is similar to what Verba, Scholzman, and Brady (1995) observe in relation to forms of political participation, where the costs vary for voting, volunteering in electoral campaigns, and contributing money.

¹⁷ Lavalle and Vera (2011).

¹⁸ Schedler (1999: 17-18).

There is basic agreement on the 'package' of accountability relationships: i) an agreed standard of what government sets out to provide and how, against which performance can be assessed; ii) information about that performance – what is actually being provided; iii) justification of the decisions made by providers; and iv) demanding compliance with standards and sanctions.

Clear and knowable standards of services provide the metric by which public officials and organisations can be held accountable.¹⁹ The services to which citizens are entitled, and how these should be provided, are generally set out in legislation, public policies, and administrative rules. But these can be ambiguous and subject to interpretation. Conflicts over what standards apply are a central dimension of accountability initiatives. Often entitlements to basic services are not widely known by recipients and that is why social accountability initiatives often include information campaigns that generate collective knowledge of what services residents *ought* to receive. National and international civil society organisations, as well as donors, can play an important role in accessing and making these standards public.

Information on service delivery – what is actually being provided – such as budgets, number and location of points of delivery, staff size, and so forth, is the raw data of accountability initiatives. Are staffing levels in schools and health posts adequate? Are providers keeping to scheduled opening hours? Answering these types of front-line questions requires detailed information on what services are being delivered (and how). This information is usually obtained from a combination of accessing official records and direct monitoring of service provision.

Demanding compliance and imposing sanctions seek to close the gap between what has been promised (standards) and delivered. Social accountability involves rendering judgment on the extent and nature of this gap. Communities may demand more doctors in a health post if it has not met the mandated ratio of doctors to the population served. This dimension of accountability has two separate components that can take place simultaneously. One is a demand for compliance. This demand is prior to any sanctions and gives state agencies opportunities to remedy the situation. If agencies do not make substantial progress towards narrowing the gap between promises and delivery, sanctions follow. Sanctions can create reputational costs, disrupt normal functioning of services, and trigger formal sanctions through administrative or political channels of accountability. Civil society groups may engage in contentious collective action and media campaigns to publicise the gap and name and shame poor providers, and simultaneously bring collective cases in administrative tribunals. These activities are on-going, rather than one-offs.

4 Empirical foundations

The study combined a non-random survey of local accountability actors in low-income areas of each city and detailed case studies of the evolution and institutional architecture of each of the health and welfare services. The case studies, which are not presented here but help in the interpretation of the data, included accounts of the role civil society activism had in shaping each of the services and the relevant institutions.

In this paper we answer four basic questions about accountability activity in the two cities: (i) how pervasive are actors who engage in social accountability activities; (ii) are certain types of actors more likely to under-take such activities; (iii) what kind of activities do they undertake; and (iv) which institutional spheres are these actors most likely to use? Our

¹⁹ Schedler (1999: 14) and others address standards and public officials 'rule-guided' behaviour as background conditions, but these are the very basis of accountability and should be part of its explicit conceptualisation.

answers to these questions cannot be generalised to the entire city because the sample is not representative. In the low-income regions of each city that we surveyed – that is, those with an average low household income or, in Delhi, a legally recognised slum area – we did find clear patterns. Given the sampling procedure we used, described below, we feel confident generalising these patterns to the cities low-income areas.

There is little research comparing São Paulo and Delhi. It is in many ways an unusual comparison. They differ greatly in local civil society, in the administrative organisation of the city, and in city politics. While São Paulo is Brazil's longstanding financial and industrial centre, Delhi has lost much of its manufacturing and is the centre of India's politics – it is the national capital. These contrasts, however, allow us to use a 'most different case' design and identify underlying explanations for social accountability activity. Most importantly for us, the cities differ markedly on many factors that we believed might shape social accountability activity such as level of political competition, presence of private service delivery or participatory institutions. If we found similar types of actors, accountability activities, or other dynamics, these would jump out at us and indicate some basic element of social accountability.

Conducting research on civil society is difficult, as organisations and the types of relations they have can be hard to identify. It requires a lot of contextual knowledge and researchers in the field who are well-versed with the areas explored. The cities of São Paulo and Delhi were also a good choice for us because of extensive previous research on citizen-state relations in both, and therefore deep quantitative and qualitative knowledge of low-income regions of each city, and an established network of researchers to work with.

Because local accountability actors are a difficult population to survey, we decided to keep our sample small – between 40-45 micro-regions. We defined these regions by the only criteria for which data exists for the entire city – the catchment area of the local health post. These generally coincide with several neighbourhoods and it was possible to map electoral data (by voting district) onto these areas. The regions are relatively homogenous in terms of household income and levels of urban development and access to public services. For a small non-random sample, careful selection of the regions of each city and the services to compare plays a critical role in testing or controlling for different factors that might shape the presence of social accountability actors, the types of activities that are undertaken, and the institutional spheres that are used.

A variety of factors might influence social accountability. Running through different literatures, from that on collective action to electoral politics and historical institutionalism, we came up with the following set of factors that influenced our case selection:

- 1) Location — regions of the cities:
 - Level of urban development – greater urban infrastructure, such as presence of government offices, security, and transportation networks, can substantially lower the costs of accountability activity.
 - Political party competition – heightened competition, the literature suggests, would make local officials and party activists more responsive; dominance of governing party or coalition could give activists greater access to public officials and more favourable treatment.
- 2) Nature of the service:
 - Primary healthcare is a private good but universal and used by all households, whereas social assistance is narrowly targeted at the very lowest income groups. Both differ from services such as policing, which are public goods.

- Institutional arrangements through which services are provided—centralised/decentralised management, delivery through private/public entities, or presence of participatory governance institutions to co-manage or regulate services.

The surveys of the more local actors in the two cities took place in 2007. Our sampling in the two cities was meant to help identify the possible impact of level of urban development and party competition on local actors' social accountability activity. We chose the Eastern and Southern zones of São Paulo and the East and Northeast of Delhi.²⁰ We first chose a region that was low-income but had good urban infrastructure, reflecting an older settlement pattern, and a region that was more recently settled and with considerable less infrastructure, including the presence of government offices. Within each of these areas we selected micro-regions that had (i) high electoral competition or (ii) were firmly in the hands of the governing party.

It is likely that a substantial share of our sample of 40-plus catchment areas has local associations that actively seek to improve services in their communities, and might therefore engage in social accountability activity. We introduce some bias by selecting on health post catchment area; our strategy was to ask a number of activists who were engaged citywide which areas of the city they thought had the most active associations in local communities. Within the vast cityscapes of Delhi and São Paulo the recommendations of known activists did not entail (1) that the civil society groups were actually present or (2) when found that they engaged in accountability activities. By triangulating the lists we obtained, and then filtering these by the micro-region criteria (high-low development regions of the city, high political competition or governing party dominance) we came up with a list of around 15 catchment areas in each city. We used matching techniques for urban development and electoral competition to ensure that these 35-plus areas matched the first 15 areas we selected.

Primary care in São Paulo is provisioned by both publicly-managed health posts (roughly 60 per cent) and privately-managed ones (about 40 per cent). A large share of primary healthcare is therefore in private hands. By law the entire health system had become more decentralised and, critically for us, had established a system of participatory governance that was meant to give citizens greater voice in service delivery.²¹ The city government's Health Secretariat has five regional Supervisions that supervise 31 Health Coordinators. Each Coordinator was responsible for an area with approximately 300,000 people, including a range of healthcare units.

In Delhi primary care is centralised in Directorate of Health Services (DHS) of Government NCT of Delhi, with 11 district offices responsible for managing publicly run health posts; there are also federally run targeted schemes for particular illnesses and groups and mandated reservations for the poor in private hospitals for receiving land concession. The schemes are intended to serve the eligible poor, some linking back to health posts and some more centrally operated. The poor also seek care from a large private sector operated by both qualified and unqualified providers. In contrast to São Paulo, there is no participatory system providing opportunity for citizen voice. Although some changes have been made since 2007 in Indian health policy for the poor, not much has changed in Delhi as it has not participated in the recent major national initiatives to reach the poor.

We selected social assistance, and specifically Delhi's Public Distribution System (PDS) and São Paulo's Renda Mínima (minimum income programme), because the nature of the good

²⁰ In Delhi low-income areas were identified through location of legally recognised slum areas. In São Paulo we used average household income to identify these areas.

²¹ Tatagiba (2004); Schattan and Pedroso (2002).

differed substantially from health, and the type of assistance differed from Delhi and São Paulo. PDS and Renda Mínima contrast in terms of the debate on how best to provide help to families rise out of poverty – by providing basic necessities or by providing cash. In addition, Renda Mínima is highly centralised, run by a special office within the municipal Secretariat for Social Development. Beneficiaries receive bankcards and withdraw their payments from bank cash machines, but otherwise have no direct contact with the banks. PDS is a federal programme that, in contrast to Renda Mínima, is delivered in a very decentralised way by hundreds of small (privately owned but government licensed) shops located across Delhi. It provides subsidised food grains (mainly rice and wheat), sugar, and cooking fuel (kerosene) in a fixed quantity to ration cardholders.

4.1 The survey

There are few surveys of the type we conducted, because identifying civil society is a complex and costly undertaking. Organisations are difficult to locate and much of their activity leaves no formal record. A part of the influence such organisations wield is based on informal relations and subtle forms of power (in contrast to direct lobbying of legislatures or campaign contributions).

In the absence of reliable and detailed information on local civil society we developed a process for selecting interviewees – the community leaders most active in improving healthcare and social assistance delivery. This process is far from ideal, yet it generated valuable data and a reasonable basis for selecting interviewees. We relied on a set of key informants in area micro-regions to identify the community leaders, and their organisations, who were most active on health and social assistance issues. After a walk around to inspect a micro-region, we identified prominent local residents who could act as key informants. We then sat down and discussed local health and social assistance activism with a sub-set of these prominent individuals. Discussions covered partisan affiliation of community leaders, interpersonal disputes, type and age of their organisations, and inter-organisational competition. The informants were, in general, a shopkeeper, priest, police officer, health post director, and one community leader. In some cases we went back to city-level activists to help identify community leaders. We triangulated the resulting lists for each catchment. In some cases we were unable to identify any active associations or even activists.

The selection of interviewee is, therefore, not based on a snowball sample. Community leaders in each region were selected independently of each other.

The interview used a structured questionnaire, which was divided into three sections. The first gathered basic information about the interviewee (profession, education, age, and gender) and the organisation (budget, focus of activities, and representation in participatory institutions). The second part focused on social accountability activities in health and social services, and PDS and Renda Mínima specifically. We explored acquiring access to information by asking about community leaders' efforts to obtain information such as budgets, levels, and quality of services being provided, from providers and other levels of the state; and making compliance demands to enforce legal standards that are not currently being met. For sanctions we asked first whether they had organised public protest, petitions, and other forms of public contention. We then asked whether they had invoked any formal grievance procedures, such as administrative complaint mechanisms, ombudsmen, or bringing legal cases against a provider or government department.

The third part uses social network analysis questions to map organisations' relations to other local civil society organisations working on neighbourhood and beyond. This section also asks ties to political leaders or public officials, social movements, and finally 'Other'. All the questions asked interviewees to recall their activities over the past two years.

Our survey allows us to depict the associations we found and the breadth of accountability activities they undertake. It does not allow us to say how pervasive these activities are across the entire city.

5 Civil society in low-income areas of São Paulo and Delhi

The local civil society we examined in the two cities is worlds apart. The interviewees led a wide-range of associations in each of the cities but there are broad differences between the two. A majority of activists worked exclusively at the neighbourhood level (58 per cent) in São Paulo but only a third did so in Delhi. In the latter city more than half worked in the city at large or at a wider region of the city. The Delhi associations were considerably richer on average than their São Paulo counterparts. In the latter, half reported having no budget at all, about a third under US\$6,000, and the remaining between US\$6,000 and US\$57,000. Only half the organisations in Delhi (16 of 32) were willing to report their budget but of those the average was \$71,000 a year.²² We know from secondary sources that the associations that did not report budgets tend to be among the more affluent and the largest budget we found was \$185,000, more than three-times that of the best funded association in São Paulo.

In the two cities almost half of the associations reported involvement in government programmes, albeit in different ways. In São Paulo they delivered social programmes, primarily the São Paulo state government's milk distribution programme *Viva Leite* and the city government's day-care and literacy (*MOVA*) programmes. In Delhi the most common were the identification of potential beneficiaries on behalf of federal social programmes—that is, people below the poverty line—and for tuberculosis and HIV/AIDS-related programmes.

And whereas government was a substantial source of funds for associations in São Paulo, it was foreign donors who played this role in the case of health-care in Delhi. Forty-four per cent of associations (14 of 32) in Delhi reported funds from foreign donors and for nine this covered over half of their budgets.²³ While half of Delhi's associations said they worked on government programmes, only 16 per cent reported receiving government funding. The discrepancy is made up by the foreign donors' role in funding many government programmes in low-income areas. No associations reported foreign funding in São Paulo but the ten with the largest budgets drew most of their money from government. Contrary to expectations, funding by religious groups was immaterial in both cities.²⁴

Overall, the leaders of local associations in São Paulo were older and had less formal education than their younger and better educated Delhi counterparts. If the Latin American city's leaders were largely middle aged (60 per cent were 50 years or older, and 25 per cent were in their 40s) and almost half had education below the secondary level, the South Asian leaders averaged 43 years and almost half of them had some post-graduate education (only 15 per cent had less than secondary education).²⁵ Only the gender balance was close in the two cities, with women representing 40 and 30 per cent of leaders in São Paulo and Delhi respectively.

²² Exchange rate in 2008 were for Brazil R\$1 = US\$0.567 and for India INR1 = US\$0.024.

²³ Donor funding was especially prominent among richer organisations; ten organisations reported having a budget of more than US\$71,000 (3.1 million INR) of which eight received donor contribution.

²⁴ One association in each city drew most of its budget from a religious institution but the others received no such funding (with one exception in Delhi).

²⁵ In São Paulo 40 per cent had completed secondary school, 12 per cent were professionals in health or social services, and 20 per cent were industrial workers.

Surprisingly then, the São Paulo leaders were active in a larger number of associations, movements and participatory spaces than the Delhi leaders. Almost half participated in five or more (in addition to their own), and 70 per cent were active in the city’s participatory health councils (a formal institution with government representation). Delhi has no comparable system of participatory councils but these aside, most activists and NGO leaders participated in roughly two or three associations, movements or campaigns.

Table 5.1 summarises the study’s fieldwork by city. Collective actors were more prevalent and a greater proportion took part in social accountability activities in the Brazilian city. In both cities all actors engaged in social accountability activities took part in activities centred on health; a fewer number were active in both types of services.

Table 5.1 Fieldwork in São Paulo and Delhi

	Delhi	São Paulo
Sites Visited	40	45
Civil Society Actors Identified	32	42
Number engaged in social accountability	28	42
Number engaged in accountability of health and social services	16	23

Most actors were neighbourhood specific organisations; a share acted within a city region and some also had citywide links; the latter two groups we call translocal. In both cities the translocal actors were more active than those who worked in single neighbourhoods.

In São Paulo, 86 per cent of the 16 actors with a regional base met with communities, and 77 per cent of the neighbourhood specific organisations did. For social assistance numbers are far lower, 44 and 22 per cent. Similar observations hold for Delhi as well. For health, from those we could identify as neighbourhood-base actors, 63 per cent of the 11 actors met with communities on health issues while for the translocal actors it was 75 per cent of the 16 actors. For social assistance there were very few organisations that could be seen as only neighbourhood actors; we identified only 2 of the 4 neighbourhood specific actors participated with community activities. For the translocal actors, community meetings seem to be a norm: 83 per cent of the 12 actors held community meetings.

5.1 Social accountability by city and service

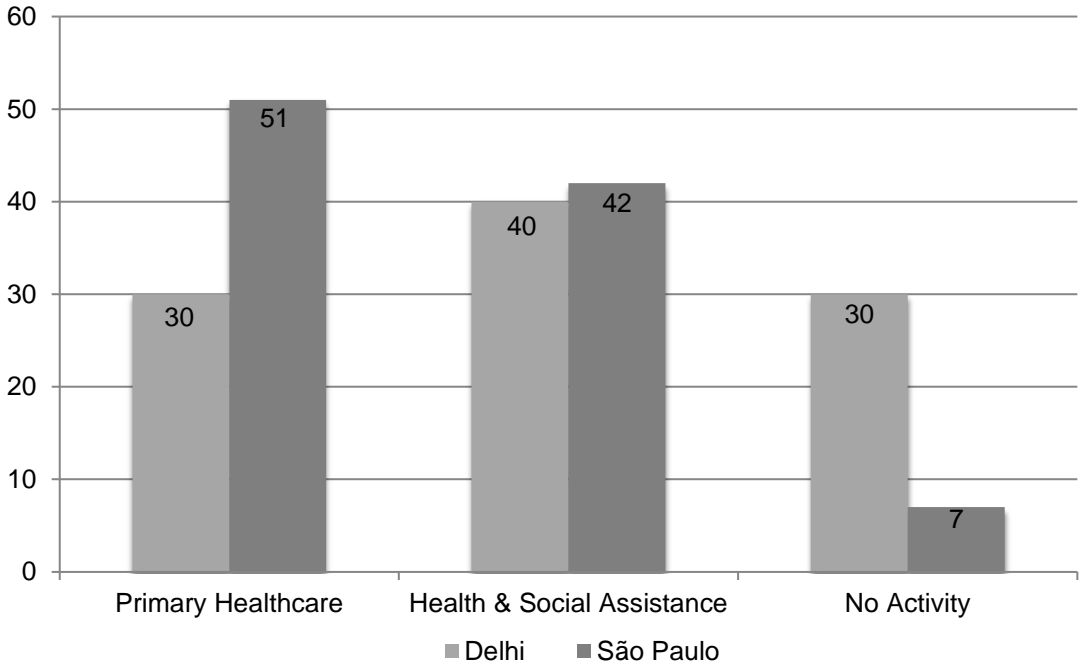
Social accountability of the local health post and social assistance programmes by local actors in Delhi and São Paulo is widespread. Even in the poorest and most vulnerable regions we selected communities engaged with the providers of health and social assistance, PDS and RM, to improve services. Figure 5.1 shows such activity in 70 and 93 per cent of catchment areas we surveyed in Delhi and São Paulo respectively. The figure puts Table 5.1 into percentage terms to tell us how widespread accountability activity was across regions of the city. It does not portray the extent of social accountability activity in each region, which in some instances was high and in others low. It tells us, however, that large segments of the urban poor are able, and have sought, to establish some degree of accountability over

service provision. We show later that the most pervasive form of activity among all collective actors engaged in social accountability was *demand* for better and/or more services (more than 90 per cent) in both cities.

Accountability of the provision primary healthcare was more widespread than for social assistance in both cities, and we did not find any region where local actors engaged exclusively with providers of social assistance. Figure 5.1 shows that we found health accountability in 70 per cent of the Delhi regions we surveyed and 93 per cent in São Paulo, whereas 40 and 42 per cent of the regions has actors engaged with the provision of assistance.

Coverage of social accountability appears to be related in part to the nature of the service being provided. The widespread activity around healthcare likely reflects that health needs are widespread and for more serious health issues people commonly seek treatment by medical professionals – doctors, nurses, dentists, and so forth – though reliance on quacks (unregistered medical practitioners) is common in Delhi. In addition, residents have easy access to health centres, which are located in all of the sample communities.

Figure 5.1 Regions with social accountability in Delhi and São Paulo (percentage of regions)



In contrast, the populations that are beneficiaries of PDS and Renda Mínima is far more restricted than for health and tend to be the poorest and most vulnerable. While all families in a community have health needs at one point in time or another, a smaller share will be enrolled in the social assistance programmes. In the case of social assistance, even serious needs tend to be ‘treated’ through social networks (family, neighbours and friends) and many needs will not be defined as requiring social assistance professionals. Furthermore, PDS is subcontracted to hundreds of small privately owned shops. The shops are small and serve only a small clientele. This creates a coordination problem for PDS beneficiaries, not least because the service problems will vary in nature and intensity by shop, and targeting many small shop owners simultaneously is difficult. The shops are also private and subject to different standards of public access and scrutiny, if not in law certainly in practice. Renda

Mínima has little administrative structure below the municipal administration (city hall), while the rest of social assistance in São Paulo is provided through a patchwork of not-for-profit organisations.

The substantial levels of activism involving PDS and Renda Mínima in fact defy expectations. How is it that the poorest urban residents of these mega-cities are able to mobilise to hold fragmented and/or weakly present local providers to account? Irrespective of their relative success at improving services, this appears on the face of it no small accomplishment. There is no single explanation. In Delhi, specialised activist NGOs such as Parivatan, organised by middle-class activists, worked with local groups in informal settlements to combat corruption and abuses within the PDS. São Paulo's neighbourhood associations, which address a wide range of community issues, have in a number of instances taken on social assistance activity. Renda Mínima is far from frictionless as various problems – lack of addresses for mailing bankcards, loss or demagnetisation of cards, changes or cancellation of benefits without notice – all result in beneficiaries calling on local leaders to demand information and better coverage.

In roughly a third of the surveyed areas in Delhi we were unable to identify any local collective actors who engaged in accountability activity of either the local health post or the PDS shops. These areas were distributed relatively evenly across the regions of the city in which we worked.

The difference in accountability activity between Delhi and São Paulo reflects the more common health activity in the Brazilian city. Why would there be a gap in accountability of health services between the two cities, especially when there is no such gap for social assistance? The gap is not an artifice of the sample, given that it used health catchment areas as the sampling unit and hence it is not the case that there are less health posts in the 40 regions of Delhi than in São Paulo's 45. One possible explanation for the gap is the high prevalence of neighbourhood and other community associations in São Paulo, and their capacity to engage with the health system. Moreover, features of the health system further facilitate civil society engagement – in particular, the presence of participatory governance councils that stretch from local health post, hospitals, region of the city, and the city itself. It is possible that accountability levels differ in health also because Brazil spends about 4.4 per cent of GDP in public funding on healthcare and India less than 1 per cent, one of the lowest in the world.²⁶

5.2 Social accountability activity

Here we examine in which types of accountability activity collective actors invested. In practice several may occur simultaneously. In particular, public protests and petitions were used at various moments – to obtain access to public records, to force providers to sit down at the table to discuss shortcomings in provision, or to sanction.

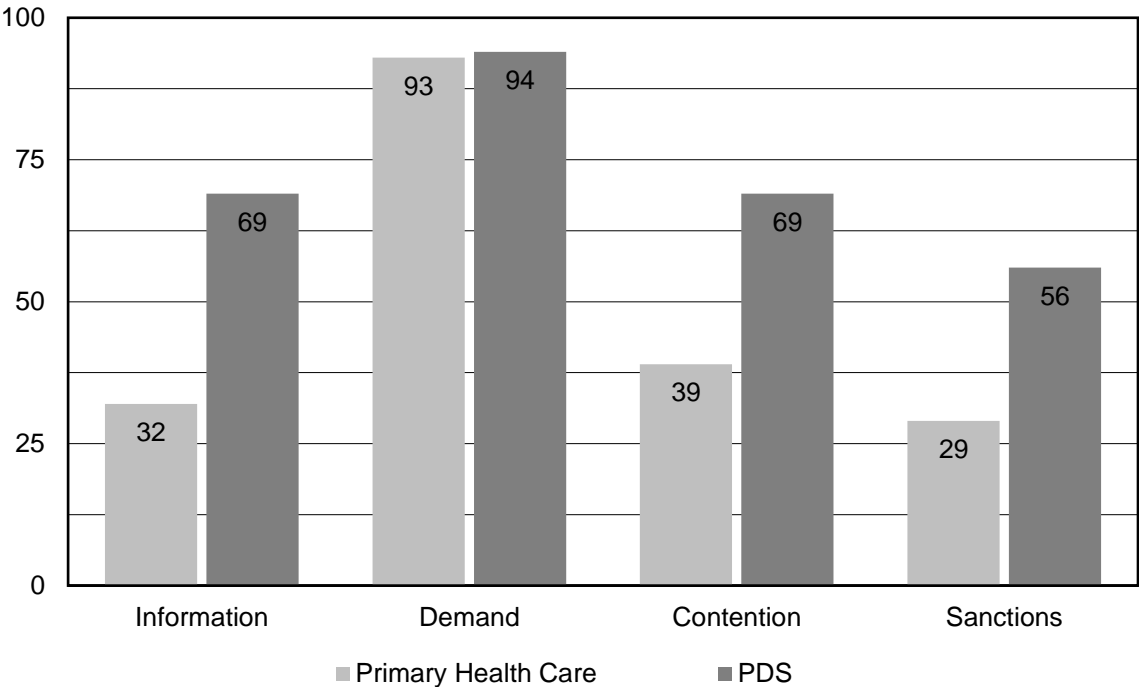
Local actors active in accountability of social services in the two cities were far more concerned with obtaining information about the provision of PDS and Renda Mínima than of primary healthcare (Figures 5.2 and 5.3). In Delhi 69 per cent of actors engaged in social accountability activity to improve social assistance sought information about PDS delivery, twice as much as those engaged in accountability of health centres. In São Paulo 64 per cent of actors involved in social assistance sought information about the delivery of Renda Mínima, while 48 per cent did for health. The information sought about PDS provision included documentation of storeowner's allocation of PDS goods, registration of beneficiaries and how much supply they had received, and even opening hours. For Renda Mínima, along

²⁶ Gragnolati, Lindelow, and Couttonlec (2013).

with other social services in Brazil, it included information about the benefits and requirements of the programme, the registration process, as well as explanations for changes in benefit size and termination.

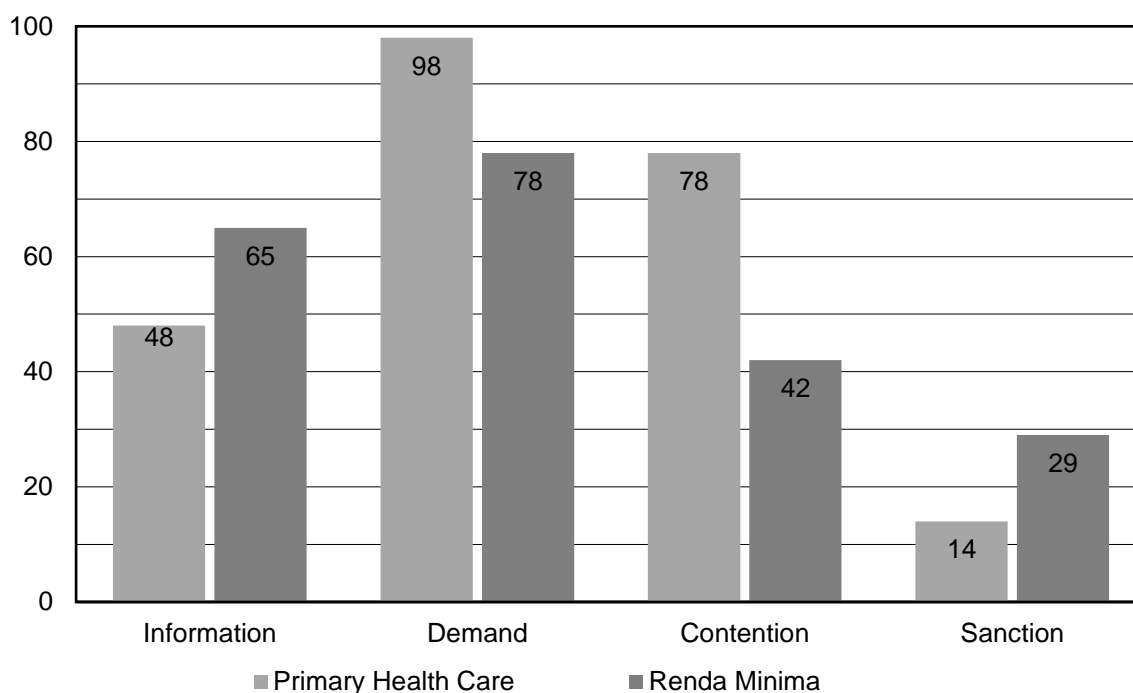
This gap between health and social assistance reflects in part the difference in the nature of health and social assistances as public services. PDS, Renda Mínima and social assistance programmes in general are targeted and some beneficiaries may only receive benefits temporarily, whereas health posts provide universal coverage. Information about who is entitled to services or benefits, and to some extent the nature of this entitlement, is less of a concern. This cannot be the whole story however. Accountability in health requires access to information about the type and level of service to which the community is entitled and about the actual levels of provision, including budgets, staff levels, and opening hours. And the similarity of information seeking activity for social assistance, despite the programmes being significantly different in the two cities, suggests that the nature of the public service influences the types of social accountability activity that is undertaken.

Figure 5.2 Social accountability activity, Delhi (percentages of actors)



In São Paulo, however, the actors engaged in social accountability have far greater access to information for health services than for assistance, because of the system of health participatory governance institutions. Accountability of health provision in São Paulo is greatly facilitated by the health post councils and other participatory bodies that make available/public information about both decision-making and performance of health service delivery. Of the four programmes we look at, only in São Paulo’s healthcare system do local actors face a relatively accessible and open state apparatus.

Figure 5.3 Social accountability activity, São Paulo (percentage of actors)



The outlier in this case is accountability of healthcare in Delhi. Without easy access to information about service provision, but with the pervasive presence of health centres in the regions we surveyed, it is reasonable to expect high levels of activity to secure this type of information. Yet it has the lowest level of the four services. Furthermore, the most prominent type of activity was demand making. We believe that citizens of Delhi do not expect the public health system to be highly responsive. There are several reasons for this: (i) the perception that private health care is usually better fosters lack of demand for improving public care; (ii) multiple numbers of government schemes to address health issues; and (iii) the lack of resources for the public sector.²⁷ Thus citizens in Delhi may care more about getting access to discounted private care through personal action. In addition, those needing special care such as for tuberculosis or HIV/AIDS may make demands on well-known federal schemes rather than the health posts, which are not equipped to handle these diseases.

Furthermore, Delhi has not had a social movement that helped transform what is seen as a private issue into a major public issue, politicising the issue and mobilising citizens to demand better services.²⁸ It also lacks fora that facilitate activism on health issues, such as a public system that oversees all basic care.

Demanding that providers' bridge the gap between the services promised by legislation and those actually provided is the most common accountability activity, across the two cities and in all of the four programmes we examined. It is the moment when providers can respond to local grievances and close the gap before being sanctioned. Over 90 per cent of the local actors made demands for better services, with the one exception of the social assistance programme Renda Mínima in São Paulo (80 per cent).

²⁷ Cf. Das and Hammer (2007); La Forgia and Nagpal (2012).

²⁸ There is health care advocacy in Delhi, often as part of national campaigns, but it is sectoral: women and child health; nutrition; reproductive and child health; and so forth. There has been no high profile public campaign around universal healthcare.

Imposing sanctions by engaging in contentious action such as protests come at a relatively high cost to local groups, as it involves not only opportunity costs (lost days of work and family care) but also possible reprisals and repression. On the other hand, it capitalises on the resources such groups have available – numbers and the skills and local networks that make organising possible. Our findings for contentious sanctions differ sharply across the four cases but not in ways we might expect – that is, by city or by service. Contentious activity is the highest for accountability of primary healthcare in São Paulo and for social assistance (PDS) in Delhi. A surprising 78 per cent of the actors in São Paulo engaged in contention for healthcare, while only 42 per cent of actors involved in social assistance accountability did. In Delhi 69 per cent did for social assistance (PDS) and only 39 per cent for healthcare. Neither city nor service is therefore the common denominator for contentious sanctions.

Contentious action is the hallmark of social movements and advocacy campaigns and in Delhi it appears to reflect the prominent role of the Parivatan cohort of organisations in PDS accountability and in São Paulo the popular health movement in healthcare accountability. These movements span many local communities, have strong middle-class allies, and a normative commitment to not only citizens' access to public services but eliminating poverty and inequality more generally. The far lower levels in the cases of health in Delhi and RM in São Paulo reflect the absence of such more substantial collective actors and the more politicised social movement or campaign approach to accountability.

Formally sanctioning providers through administrative and court cases, or by rallying ombudsman, is a far less used strategy by most of the accountability actors, with one startling exception. We would expect formal sanction to be relatively rare because of the specialised knowledge and high resource required, and given the slow turning of the wheels of justice. PDS is exceptional among the four cases with a high number of actors using administrative-legal procedures – 56 per cent. That is close to double that of health actors in Delhi and almost four times higher than the share of the highly active health actors in São Paulo.

The PDS exception tells us something important about the importance of a relational approach. The high use of formal quasi-judicial procedures reflects in part the strategy of Delhi actors' focus of making public official records of service delivery. The Delhi RTI law allows citizens to bring cases before the Public Grievance Commission, a formal and quasi-judicial body, and argue that the disclosure of information related to PDS is in the public interest. The law has played a critical role in motivating large numbers of people to file applications.²⁹ In addition, and as a last resort, activists could bring related complaints and grievances to the Right to Food Commissioners office. Parivatan and its cohort of activist NGOs are led by middle class activists with the needed skills and resources to navigate formal administrative and legal institutions. Local groups would have difficulty using these channels without the support of these city or region-wide actors.

Only a very small share of São Paulo actors on healthcare have used formal administrative or legal procedures (14 per cent), and even less than for RM. This may seem surprising given the overall high levels of accountability activism in the city's health services. We believe, however, that it points to, on the one hand, the conservative and inaccessible nature of the city's judiciary and, on the other, the importance of its elaborate and legally mandated participatory governance structure. Local actors have ready and institutionalised access to local providers through the local health post's governance council and to city government health officials through a legally mandated system of health councils, as well as civil society

²⁹ The Commission by law can mandate that public officials and private providers, the shopkeepers, make public their records within a set timeframe -- 30 working days for regular applications and 48 hours for some cases where life or liberty is at stake. In practice a lot depends on how Commissioners use their discretion and the state bureaucracy is becoming more adept at evading orders and denying information.

forums. Every community we surveyed has a local health council for its health post. This institutionalised access is far easier – i.e. less costly – to use and far more flexible and responsive than formal administrative or legal procedures.³⁰ Such a well-developed participatory structure, and its civil society counterpart, does not exist for social assistance, which has only a single city-wide participatory governance council and civil society forum (dominated by providers). In the absence of institutionalised access to providers and policy makers, administrative and court cases are twice as likely in social assistance (in absolute numbers there are about as many actors using this form of sanction in health and assistance.)

In both Delhi and São Paulo actors combined non-institutional collective action and engagement with institutional channels like the Public Grievances Commission and the participatory health council system. In Delhi for example, activists conducted surveys of residents ration cards, the records of shop owners, and official government documents to prove corruption. This evidence was corroborated by testimonies from residents at informal public hearings. Together these activities helped mobilised people to file RTI applications and support social audits.

The movement literature is full of examples of actors simultaneously engaging in formal institutionalised and informal contentious processes. Labour movements engage in strike action to strengthen their position in collective bargaining. Advocacy groups organise large public demonstrations when legislative bodies are considering legislation that is crucial to their campaign. And Parivatan and the popular health movement, among others, organise protest events to put pressure on the parties involved in institutionalised dialogue or negotiations, as well as to get such negotiations started and to ensure subsequent implementation of agreements. In short, an important share of the power actors of the urban poor can exercise in institutionalised processes comes from what they do outside of those processes, such as inflicting reputational costs. Giving up contentious action, which takes advantage of the greater numbers and public support for the justness of their claims, is in effect giving up movements' greatest source of power.

5.3 Institutional spheres for social accountability

Local accountability actors have a range of institutional spheres within which they can request information, make demands, and impose sanctions. These channels vary by city, as well as by public service. Our expectation at the start of the study was that local actors would use different institutional spheres depending on the city and service. We also expected that actors with strong local networks, and ties to city-level organisations, would engage with more institutional spheres.

The leaders of the local actors we interviewed proved us wrong and right. The large majority said they focused their activities on government executive agencies – that is, public officials at different levels of government. Figures 5.4 and 5.5 show that this holds true despite the different institutional spheres available in the two cities, as well as across the two types of services. It is all the more surprising given that private entities, for and not-for profit, play an important role in provisioning the services we looked at. Public officials in government agencies with legal responsibility for services, however, remain the single most common target of social accountability activity.

In contrast, providers themselves – private or public – are less likely to be targeted (Figure 5.4 and 5.5), although only slightly less in the case of primary healthcare in São Paulo.

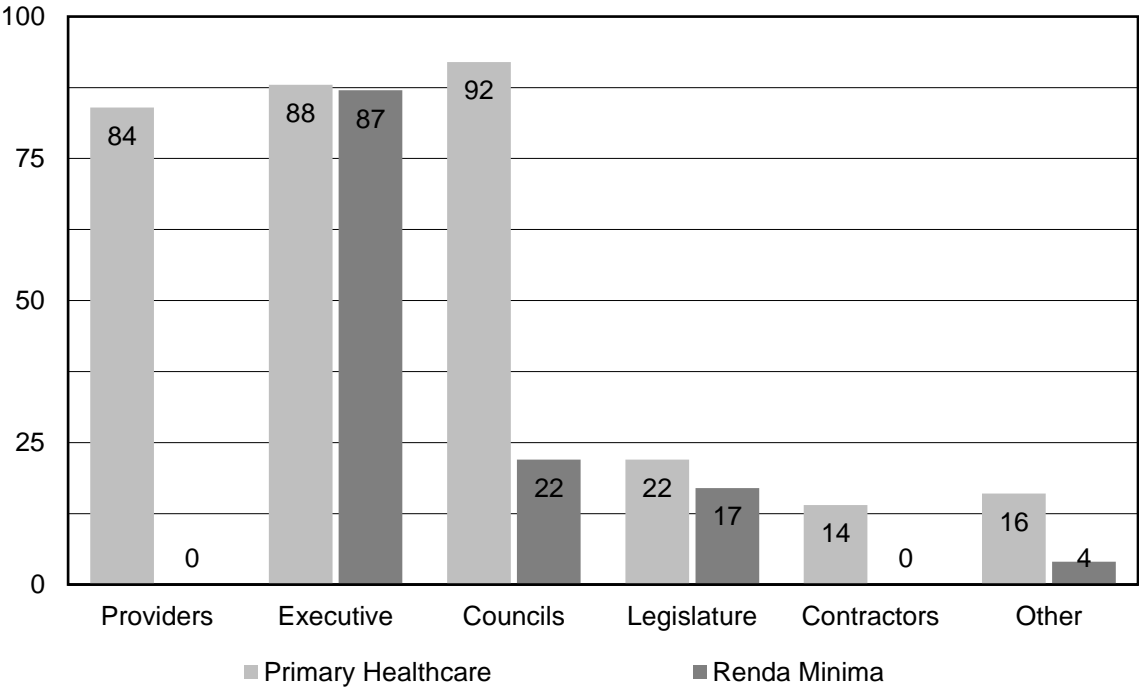
³⁰ The system of participatory health councils stretches from local provider units (health posts and hospitals), to the city, the state, and a national council. At each level except the provider unit, the councils are composed of representatives from civil society, government health officials, and providers. Councils of local health unit are made up of representatives of local civil society and the provider.

Delhi’s PDS is delivered entirely by small private shops licensed by the government, yet 94 per cent of accountability actors in social services sought out the executive, while *half* targeted providers (Figure 5.5). In São Paulo the share of actors engaging directly with providers is high (84 per cent), though still lower than with government agencies (92 per cent). This may be because in the Brazilian city large religious entities such as Santa Marcelina and private hospitals manage many of the local health posts that we covered in our survey. These contractors are large entities and, while they are private, targeting them may have a larger pay-off than engaging with the multitude of small shopkeepers PDS actors face.

Actors seeking greater accountability of services that are entirely provided by public sector providers – health centres in Delhi and Renda Mínima in São Paulo – were twice as likely to target government departments rather than the providers themselves – that is, local units delivering the services (Figure 5.5).

The PDS shops are not only a small and disperse target, but they are run by lower-middle class shopkeepers who see their interest in protecting a small profit margin as being threatened by accountability efforts.³¹ In contrast, the state government agency responsible for PDS offers a larger target and it has jurisdiction over large numbers of shops. For local groups working with middle-class activist organisations such as Parivatan, the cost of engagement is therefore far lower and the potential impact far higher when engaging directly with government. In addition, there are sympathetic public officials who share their interest in reducing corruption and enhancing public accountability.³² This shared interest is far from widespread within the executive but it creates the possibility of better access to information about budgets, distribution of services, and who is making what decisions.

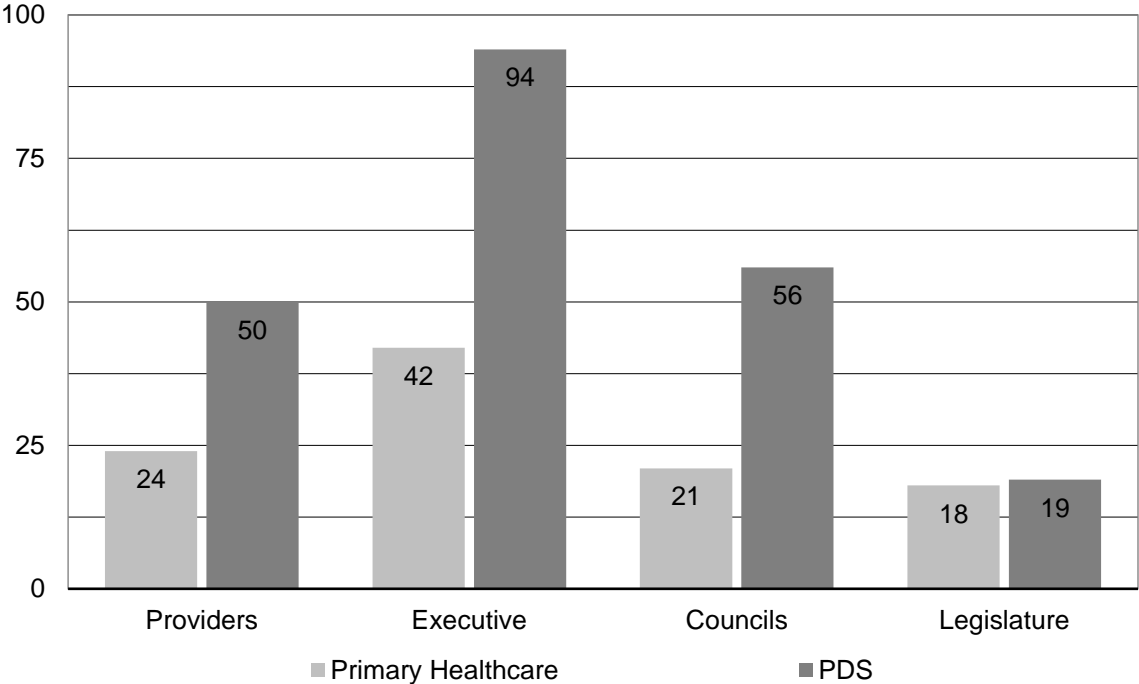
Figure 5.4 Institutional channels used to engage in social accountability, São Paulo (per cent of actors)



³¹ Pande (2008), Pande and Houtzager (2016).

³² Pande (2008).

Figure 5.5 Institutional channels used to engage in social accountability, Delhi (per cent of actors)



The accountability actors did confirm our hypothesis that institutional opportunities matter and shape what dimensions of accountability are pursued. In São Paulo those working to improve healthcare made extensive use of participatory governance institutions, an option of only limited value for Renda Mínima and not available in Delhi.³³ The presence of the popular health movement among our interviewees helps explain this heavy use of the councils – the movement played a central role in the creation of the participatory council system in the 1980s and 1990s. They represented 11 of 49 interviewees, however, only a quarter of the sample. It appears that other types of actors have seized on the opportunity the councils represent. They are readily accessible spheres for local civil society as the health posts councils in the community and civil society have legally guaranteed seats. The relatively high-level of access to the director of the health post (the provider) in São Paulo likely reflects that the relations established in the health unit’s councils are spilling over into other spheres.

The PDS actors lack the participatory governance council option but instead have the institutional space created by the Right to Information Act. The use of the Right to Information Commission was discussed in the previous section, but to recap, all of the 16 PDS actors filed right to information cases with the Commission. This option is not available in São Paulo.³⁴ It is no surprise that the actors are all filing cases because actors such as Parivatan were part of a broad campaign to pass the RTI Act and which was designed in part to facilitate their access.

³³ Renda Mínima has only three limited institutional spheres: the Municipal Council for Social Assistance, city government’s Department for Social Development, six regional Social Assistance Reference Centres. The three spheres are distant from the urban poor: the reference centres cover upward of a million people each and do not have anyone responsible for Renda Mínima. The municipal council covers the entire metropolis and is dominated by service providers. Our analysis of its records show that over the years it has not played any role in relation to Renda Mínima. The councils that actors do engage with are likely those for the Rights of the Child and Adolescent and even Health, which are more likely to be responsive. Dowbor and Houtzager (2014).

³⁴ Filing right to information cases represents both a form of sanction, and the use of a particular institutional sphere – that of the Commission.

Actors in healthcare in São Paulo and PDS in Delhi were far more active than those in the other services, despite being very different services and the institutional spheres available for activism are sharply different. Virtually all of the health actors in São Paulo and the PDS ones in Delhi were active in two or more institutional spheres.³⁵ In contrast, those involved in Renda Mínima and in Delhi's primary care on average were active in only one sphere.³⁶ The higher-level and diversity of accountability activity, in our view, reflects the regional (translocal) and social movement nature of the Brazilian health movement and India's PDS actors. These two movements have played an important role in creating new legislation for their respective areas, protections for users, and institutional spheres for accountability (and other) activity.

6 Some lessons

The take away from these findings for policy and research on social accountability is that in large urban centres like São Paulo and Delhi there are substantial local actors with existing accountability relations. These actors pursue a variety of strategies to improve services, of which social accountability is only one. We need to develop a far richer and more nuanced understanding of these strategies and the relations to providers and state agencies on which they depend.

There is a strong bias among international development actors to see local groups – those based in a single locality – as more authentic representatives of residents' needs. This may or may not be the case, but our study suggests that translocal actors may be more embedded in local communities and engage in higher levels of accountability activity. Furthermore, associations that work in a single locality are also more likely to engage in service provision for government programmes or international donors. There is also research that suggests local efforts to distribute public resources are susceptible to elite capture; collective actors exclusive to local areas may be undermined by local elitism.³⁷

External actors such as large national, international NGOs, and the various bi- and multi-lateral aid agencies need to calibrate their support for civil society, and for social accountability activity in particular, to reflect rather than disrupt the existing ecology of civil society actors in large urban centres and the strategies these actors pursue.

External actors can play a critical role in social accountability. Our finding that translocal actors are more engaged in social accountability suggests that networking local actors to overcome barriers to accountability may foster the rise of such translocal actors. The most active agents of accountability are associations with a citywide or within city-regions (i.e. translocal) reach, rather than those working exclusively in one locality. The former group often enjoyed the support of middle class organisations, professional groups such as doctors or nurses, and sometimes that of sympathetic public officials. They can shift the local balance of power more in favour poorer residents in ways purely local actors find difficult. There is some evidence that such translocal actors have had greater success at increasing accountability and improving service delivery accountability.

To understand and work with local actors, our study suggests, we need to understand the strategic choices they make about which relations to invest in to improve coverage of public

³⁵ In Delhi all 16 use multiple channels (the 33 in health tend to use only one) – all but one target the executive, over half use providers and the legislature, and all use the RTI Commission.

³⁶ In health there is also little overlap between those who use the Executive and those who rely on Providers or the Legislature. Less than half used the executive, and less than a quarter providers, legislature or other.

³⁷ Bardhan and Mookherjee 2005.

service. These choices are shaped through broad and ongoing relations such as those with government units, providers, legislative bodies, courts, and other civil society groups. Studies increasingly stress that context matters for how accountability tools work and interventions need to be adjusted to local conditions. The more relational approach we take in this paper helps to identify how existing relations and the institutional spheres in which they occur induce and constrain the choices of local actors. It shapes what dimensions of accountability they focus on, which specific activities they undertake, and with whom in government they engage. Institutional opportunities such as those provided by the participatory governance councils in São Paulo and the Right to Information Commission in Delhi have a significant influence on what types of accountability activities the actors undertake.

These opportunity structures for accountability, over the medium term at least, are not static and herein lies an important opportunity for civil society support and interventions. Institutional spheres favourable to social accountability, such as the RTI and participatory governance councils, emerge out of previous engagements of civil society with government. For example, at the time of our survey, São Paulo's health movement, neighbourhood associations, and other actors faced a health system that had a variety of institutional access points, including 500 health post councils, linked up to city, state, and federal health councils. These councils are the product of activism by the health movement in the late 1970s and 1980s to expand health services and create a more transparent and accountable system. Many of its ideas and positions were incorporated into the 1988 Constitution, including articles calling for a universal and free access to healthcare (primary through tertiary) and citizen participation. In São Paulo the health movement was particularly strong, producing robust councils, and ultimately contributing to the rapid expansion of coverage of primary healthcare.³⁸

In Delhi PDS activists faced a favourable judiciary with a high degree of legitimacy and a right to information structure that was the product of earlier iterations of civil society engagement with the state. The relatively progressive nature of the judiciary dates back to the anti-colonial struggles, which culminated with independence in 1947. RTI emerged out of a national movement – National Campaign for the Right to Information³⁹ – and actors such as Parivatan have brought critical issues related to targeting errors and corruption in the implementation of the PDS into the public domain through the use of RTI, along with media and other strategies.

These experiences suggest that international support can contribute importantly to social accountability by supporting civil society campaigns and activities that are *not*, in any direct or obvious way, linked to social accountability. Supporting new legislation and public institutions for the provision of public services, or of their regulation, can create enabling environments for social accountability activity. Critically however, such support is more likely to foster accountability when it is delivered in the context of strong civil society campaigns. It is the presence of civil society movements that help forge legislation and institutions that well reflect local context and help ensure take-up in the medium-term.

³⁸ Escorel (1998); Dowbor (2008). The institutional context of Renda Mínima was less favourable and reflects a different trajectory of civil society actors' engagement with the state. Reformist social assistance professionals in the 1980s sought to expand coverage and composition of assistance services through their professional associations and networks. They did not attempt to build a broad movement to push for reforms. They were opposed by a powerful network of private non-profit social assistance providers, who saw their access to financial support from the State threatened by social workers' efforts to replicate the health systems structure. While social assistance, like health, became a social right and duty of the state in the Constitution of 1988, the needed reforms stalled and by the mid-2000s social assistance still lacked a well-developed public infrastructure and a system of participatory councils. Houtzager and Lavalle (2010).

³⁹ Pande (2014).

Our data does not explore impact but other studies of PDS and primary health care in São Paulo suggest that accountability activity have extended and improved services and decreased corruption/fraud. There is compelling, if uneven, evidence that social accountability activities can improve public services for the poor.⁴⁰ We know that, among the urban poor in cities like Delhi and São Paulo, there is an effective demand for such accountability. Here we have argued that how local and translocal actors can use accountability tools to inflict reputational costs on officials and providers, or to pressure power holders into triggering classic channels of accountability, depends on a series of broader relations with government and the institutions in which these unfold. This suggests that external actors and researchers can make a real contribution by supporting such actors and their efforts to create institutions that facilitate accountability.

⁴⁰ Schattan and Pedroso (2002); Pande (2008).

References

- Ackerman, J. (2005) *Social Accountability in the Public Sector: A Conceptual Discussion*, Social Development Papers 82, Washington DC: World Bank
- Banerjee, A.; Duflo, E.; Glennerster, R.; Banerji, R. and Khemani, S. (2010) 'Pitfalls of Participatory Programs: Evidence from a Randomized Evaluation of Education in India,' *American Economic Journal: Economic Policy* 2.1: 1–30
- Banerjee, A.; Kumar, S.; Pande, R. and Su, F. (2011) *Do Informed Voters Make Better Choices: Experimental Evidence from Urban India*, Economics Dept. Working Paper, Boston: Massachusetts Institute of Technology
- Bardhan, P.K. and Mookherjee, D. (2005) 'Decentralizing Antipoverty Program Delivery in Developing Countries,' *Journal of Public Economics* 89.4: 675–704
- Bjorkman, M. and Svensson, J. (2009) 'Power to the People: Evidence from a Randomized Field Experiment on Community-based Monitoring in Uganda,' *Quarterly Journal of Economics* 124.2: 735–69
- Das, J. and Hammer, J. (2007) 'Money for Nothing: The Dire Straits of Medical Practice in Delhi, India,' *Journal of Development Economics* 83.1: 1–36
- Dowbor, M. (2008) 'Origins of Successful Health Sector Reform: Public Health Professionals and Institutional Opportunities in Brazil,' *IDS Bulletin* 38.6: 73–80, Brighton: IDS, <http://bulletin.ids.ac.uk/idsbo/article/view/808> (accessed 19 July 2016)
- Dowbor, M. and Houtzager, P.P. (2014) 'The Role of Professional in Policy Reform: Cases from the City-Level, São Paulo,' *Latin American Politics and Society* 56.3
- Scorel, S. (1998) *Reviravolta na saúde: origem e articulação do movimento sanitário*, Rio de Janeiro: FIOCRUZ
- Evans, P. (1996) 'Government Action, Social Capital and Development: Reviewing the Evidence on Synergy,' *World Development* 24.6: 1119–32
- Farzana, A. and Iversen, V. (2014) 'Social Audit and MGNREGA Delivery: Lessons from Andhra Pradesh,' *India Policy Forum* 10: 297–331
- Fox, J. (2015) 'Social Accountability: What Does the Evidence Really Say?', *World Development* 72: 346–61
- Fox, J. (2007) 'The Uncertain Relationship between Transparency and Accountability,' *Development in Practice* 17.4: 663–71
- Gaventa, J. and Barrett, G. (2010) *So What Difference Does It Make? Mapping the Outcomes of Citizen Engagement*, IDS Working Paper 347, Brighton: IDS
- Gaventa, J. and McGee, R. (2010) *Citizen Action and National Policy Reform. Making Change Happen*, London: Zed Books
- Gragnotati, M.; Lindelow, M. and Couttonlec, B. (2013) *Twenty Years of Health System Reform in Brazil, An Assessment of the Sistema Único de Saúde*, Washington DC: World Bank

- Houtzager, P.P. and Lavallo, A.G. (2010) 'Civil Society's Claims to Political Representation in Brazil,' *Studies in Comparative International Development* 45.1: 1–29
- Jalal, N.G. (2008) 'New Directions in Theorising Social Accountability?', *IDS Bulletin* 38.6: 106–10, Brighton: IDS, <http://bulletin.ids.ac.uk/idsbo/article/view/812> (accessed 19 July 2016)
- Joshi, A. and Houtzager, P.P. (2012) 'Widgets or Watchdogs? Conceptual Explorations in Social Accountability,' *Public Management Review* 14.2: 145–62
- Lavallo, A.G. and Vera, E.I. (2011) 'A Trama da Crítica Democrática: Da Participação e à Accountability,' *Lua Nova* 84: 353-3642
- La Forgia, G. and Nagpal, S. (2012) *Government Sponsored Health Insurance in India: Are You Covered?*, Washington DC: World Bank
- Mainwaring, S. (2003) 'Introduction: Democratic Accountability in Latin America' in S. Mainwaring and C. Welna (eds), *Democratic Accountability in Latin America*, Oxford: Oxford University Press
- Malena, C.; Forster, R. and Singh, J. (2004) *Social Accountability: An Introduction to the Concept and Emerging Practice*, Social Development Paper 76, Washington DC: World Bank
- Manin, B.; Przeworski, A. and Stokes, S.C. (1999) 'Elections and Representation', in A. Przeworski, S.C. Stokes and B. Manin, *Democracy, Accountability, and Representation*, Cambridge MA: Cambridge University Press
- Mansuri, G. and Rao, V. (2013) *Localizing Development: Does Participation Work*, Washington DC: World Bank
- O'Donnell, G. A. (1998) 'Horizontal Accountability in New Democracies,' *Journal of Democracy* 9.3: 112–26
- O'Neil, T.; Foresti, M. and Hudson, A. (2007) *Evaluation of Citizens' Voice and Accountability: Review of the Literature and Donor Approaches*, London: Department for International Development
- Olken, B.A. (2007) 'Monitoring Corruption: Evidence from a Field Experiment in Indonesia,' *Journal of Political Economy* 115.2: 200–49
- Pande, S. (2014) 'The Right to Know, The Right to Live: Grassroots Struggle for Information and Work in India,' Ph.D. diss., University of Sussex, United Kingdom
- Pande, S. (2008) 'The Right to Information and Societal Accountability: The Case of the Delhi PDS Campaign,' *IDS Bulletin* 38.6: 47–55, Brighton: IDS, <http://bulletin.ids.ac.uk/idsbo/article/view/805> (accessed 19 July 2016)
- Pande, S. and Houtzager, P.P. (2016) *Food Fight: Civil Society Innovation and Resilience in the Struggle for the Right to Food in India*, IDS Working Paper, Brighton: IDS
- Peruzzotti, E. and Smulovitz, C. (2006) 'Social Accountability: An Introduction,' in E. Peruzzotti and C. Smulovitz (eds.) *Enforcing the Rule of Law: Social Accountability in the New Latin American Democracies*, Pittsburgh: University of Pittsburgh Press

- Schattan, V.C. and Pedroso, M. (2002) 'Distribuição de Serviços Públicos de Saúde no Município de São Paulo,' *Novos Estudos* 64
- Schedler, A. (1999) 'Conceptualizing Accountability,' in A. Schedler, L. Diamond and M.F. Plattner (eds), *The Self Restraining State: Power and Accountability in New Democracies*, Boulder CO.: Lynne Rienner
- Scott, C. (2000) 'Accountability in the Regulatory State,' *Journal of Law and Society* 27.1: 38–60
- Skocpol, T. (2003) *Civic Engagement in American Democracy: From Membership to Management in American Civic Life*, University of Oklahoma Press
- Skocpol, T. (1992) *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States*, Cambridge MA: Belknap Press/Harvard University Press
- Tatagiba, L. (2004) 'A institucionalização da participação: Os conselhos municipais de políticas públicas na cidade de São Paulo,' in L. Avritzer (ed.) *A Participação em São Paulo*, São Paulo: Editora UNESP
- Verba, S.; Schlozman, K.L. and Brady, H.E. (1995) *Voice and Equality: Civic Voluntarism in American Democracy*, Cambridge MA: Harvard University Press