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MAKING ALL
VOICES COUNT

RESEARCH REPORT

A GRAND CHALLENGE
FOR DEVELOPMENT

Social accountability initiatives in health and nutrition: lessons from India, Pakistan and Bangladesh



Nicholas Nisbett, Nabeela Ahmed, Shilpa Deshpande
and Francesca Feruglio

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IDS Institute of
Development Studies

Authors

Nicholas Nisbett is a Research Fellow and Cluster Leader in the Health and Nutrition Cluster, Institute of Development Studies at the University of Sussex.

Nabeela Ahmed is a Doctoral Candidate in Human Geography in the School of Global Studies, University of Sussex.

Shilpa Deshpande is a Doctoral Candidate in Development Studies at the Institute of Development Studies at the University of Sussex.

Francesca Feruglio is a Research Officer at the Institute of Development Studies, where she works on the Making All Voices Count programme; she is also co-founder of the legal empowerment organisation Nazdeek.

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Summary

South Asia is home to nearly a quarter of the world's population and is a region of dynamic economic growth, yet it performs relatively poorly on health and nutrition indicators. As a potential route towards addressing this poor performance, a range of accountability initiatives has been implemented to improve service delivery in the health and nutrition sectors. These initiatives can be categorised as techno-managerial, transparency oriented, participatory, and collective or social accountability (based on the typology developed by Joshi and Houtzager 2012). This is a rich and vibrant field, with a great deal to offer in terms of best practice; but there is little work that focuses on South Asian innovation and practice generally, and takes a comparative and theoretical perspective to ground existing and future accountability initiatives in health and nutrition specifically.

The project synthesised in this report started from the overall premise that studies of accountability initiatives should be rooted in an understanding that the state is not distinct from society but is embedded in prevailing power dynamics and social relations. We therefore looked to the existing critical accountability literature to understand the socio-political processes within which different types of accountability initiatives and movements emerge, are shaped, unfold and influence socio-political change.

The report first summarises current concepts and issues in accountability thinking and practice, focusing on practices commonly referred to as 'social accountability'. It goes on to contrast these with the 'standard model' of political and administrative accountability, which is prevalent in the literature, and points to ways in which reality often deviates from this standard model.

Against this general conceptual and theoretical backdrop, the report examines health systems in South Asia in the light of assumptions underpinning the standard model of accountability. Viewed from this perspective, these health systems face considerable accountability challenges and gaps, some of which are now being addressed using social accountability approaches.

We then identify a series of contemporary critical issues arising in social accountability literature and practice. Some of these came to light in recent studies seeking to ascertain the factors that influence the effectiveness and impact of these approaches, and offer useful pointers for how to design and implement initiatives for maximum impact. Others have been on the agenda for some time, and include the importance of context (particularly socio-political context) in shaping accountability initiatives and how they unfold. They also include clientelist or patronage political cultures, which pose particular challenges for social accountability as they do for bureaucratic and political accountability – but which nevertheless operate according to their own logics and rationality, which researchers and practitioners must seek to understand.

Having identified key issues and lessons from the global literature on social accountability, the report sketches some of the accountability issues facing the health and nutrition sectors in India, Pakistan and Bangladesh, before homing in on social accountability practice in the three countries. We present findings from a more focused review of academic and ‘grey’ literature on health and nutrition accountability initiatives in India, Bangladesh and Pakistan, followed by a summary of an online consultation with practitioners involved in these fields in each country, alongside two case studies.

Overall findings are then summarised to reflect the structure of our conceptual review, which, for pragmatic purposes, we narrow down to the micro-level political processes at play within community-based interventions and actions. This proves useful in drawing out some of the key considerations for the design and analysis of such programmes. The framework highlights four factors:

- the need to understand **community** heterogeneity (rather than assuming homogeneity, as many interventions do);
- the role of community **collective action** and/or its role in **coercion** or ‘noisy protest’ in effecting change;
- the ways in which **cooperation, capacity and commitment** affect the community and frontline provider relationship, and the ability and willingness to deliver to meet demands;
- the ways in which **clientelism** and other such extant local political structures form the backdrop against which accountability actions play out.

About this report: background and objectives

South Asia is home to nearly a quarter of the world's population and is a region of dynamic economic growth, yet it performs relatively poorly on health and nutrition indicators. A range of accountability initiatives has been implemented to improve service delivery in the health and nutrition sectors. These initiatives can be categorised as techno-managerial, transparency oriented, participatory, and collective or social accountability initiatives (based on the typology developed by Joshi and Houtzager 2012). This is a rich and vibrant field, with a great deal to offer in terms of best practice. However, there is as yet little work that focuses on South Asian innovation and practice, and takes a comparative and theoretical perspective to ground existing and future accountability initiatives in health and nutrition specifically.

This report presents the synthesised findings of a research project¹ that aims to fill this gap by addressing the following questions:

- What are the salient theoretical developments in the field of social accountability and how are they relevant to the pursuit of improved accountability and outcomes in the delivery of health and nutrition services in South Asia?
- What can be learnt from comparing current practices in the field, drawing on the literature and the experience of practitioners at the cutting edge of accountability work?

We intend the report to be useful principally to scholars and practitioners of health and nutrition

in South Asia who encounter challenges around weak accountability and poor governance. It should help them relate their experiences – of accountability challenges in service delivery and innovative practical responses to those challenges – to current scholarship and practice in the thematically broader field of transparency and accountability at the global level. We hope this will enable them to learn from this broader field and use developments therein to address the challenges they encounter and refine their own practices and responses, all with a view to making health and nutrition service delivery more effective and accountable.

We began by reviewing the general social accountability literature and that pertaining to the health sector (section 1). We then conducted a more focused review of academic and 'grey' literature on health and nutrition accountability initiatives in India, Bangladesh and Pakistan (section 2).² Because the scope of such a review is limited to what has been documented and published, this was complemented with an online consultation intended to capture some of the undocumented cutting edge thinking and practice from the field, engaging a range of participants through a variety of methods (section 3).³ Finally, two case studies were commissioned (involving purposively selected accountability initiatives in the countries of interest) to provide more insights into how accountability initiatives operate at multiple levels, both within local communities and at interfaces between communities and the state (section 4).

¹ The full report on the research project is available online at www.transformnutrition.org/2017/03/accountability-in-health-and-nutrition-in-south-asia/

² Twenty nine studies focusing on the health and nutrition sectors were identified following an abstract review process. Following an in-depth text review of a subset, and narrowing down on cases from the three countries involved, 26 studies were finally selected according to the following criteria: an evidence-based approach (i.e. some basic description of qualitative or quantitative methodology pursued); a focus on health and/or nutrition and relevant determinants such as sanitation; and a specific focus on community-based accountability.

³ Participants in the online consultation were selected via several means: membership of the partner network of Community of Practitioners on Accountability and Social Action in Health (COPASAH); mention in the published and grey literature reviewed above; other local partners or recommended participants; and 'snowballed' invitations. The consultation, hosted on the Eldis community discussion platform, was eventually attended by 49 participants from India, Bangladesh, Pakistan, the UK, the USA and the Netherlands. The discussion took place on 16 and 17 March 2016. Active posts were received by 31 participants (out of which five were from the organising team) over the two days of discussion, for a total of 134 contributions.

1. Conceptual and practical review of relevant lessons from the literature

Accountability initiatives in health and nutrition, whether led by citizens' groups, community members or non-governmental organisations (NGOs), have been associated with significant improvements in health and nutrition outcomes when applied to relevant services. Such initiatives are increasingly diverse, both within and beyond the health and nutrition sectors.

Definitions of the different ways of claiming and securing accountability have likewise expanded. One prominent review defines social accountability as 'the ongoing and collective effort to hold public officials to account for the provision of public goods which are existing state obligations' (Houtzager and Joshi 2008: 3, cited in Joshi and Houtzager 2012: 152). The authors place accountability initiatives within a wider context of the failure of traditional models of political accountability and poor service provision and outcomes for poor people. A wider definition of 'transparency and accountability initiatives' follows from this definition, and considers 'demand-side' initiatives [which] are led by citizens and social actors who engage with more powerful actors... across a range of interfaces, which are social rather than political, institutional or bureaucratic' (Gaventa and McGee 2013: s4).

Further directions, discussions and divisions in the literature exist (see Box 1 on page 8). Essentially, however, scholars agree that accountability is about 'calling to account' (Bovens 2007; Bovens, Schillemans and Goodin 2014; Lindberg 2013; Mulgan 2000). When applied in the development literature, the prefixes 'social', 'community', 'political' and 'administrative' describe the means of engaging such processes of calling to account, and/or the locus of their activities (e.g. social, community, political or bureaucratic processes and contexts).

Our review looked specifically at these calling to account processes in the case of health and nutrition services and outcomes for poor people

in low- and middle-income countries, focusing on India, Bangladesh and Pakistan. It considered processes and interventions that are conceived and implemented at the front line or interface between people and services (or in the absence of such services). Focusing primarily on processes originating in communities or local political processes, the review followed the approach developed by Joshi and Houtzager (2012), which locates the background and origins of such activities in the limitations of existing political and administrative systems. We also started from their premise that to understand accountability issues from the perspective of poor people it is important to look across the full range of calling to account processes (political, administrative, social, etc.) available to them, as well as to explore how these are interrelated and identify where and why they succeed or fail. Nonetheless, as our focus is on accountability-seeking processes originating in communities or at local interfaces between community members and political processes – loosely referred to as 'social accountability' – we start by setting out some definitions (Box 1).

1.1 The 'standard model' of political and administrative accountability

Accountability is both a central ideal of representative democracy and a crucial process in the democratic system. According to this concept, citizens – the 'principals' in a democracy – delegate their sovereignty to representatives or 'agents' to govern on their behalf and can call such agents to account regarding their use of public power (Bovens 2007). In terms of process, accountability in a representative democracy can be conceived of as a chain of principal-agent relationships in which power is delegated from voter to representative, representative to minister, and minister to civil servants and bureaucrats; whereas accountability works in the reverse direction – representatives are accountable to voters, and civil servants and bureaucrats are

Box 1: Defining social accountability – orientation, scope, directionality, leadership, process and outcomes

Social accountability is a contested concept and there is little consensus in the literature about what it means. This is largely because social accountability initiatives (SAIs) represent a wide range of actions that vary in key aspects, as follows.

- *Ideological orientation:* Some SAIs such as citizen charters and complaint hotlines are ideologically rooted in new public management and attempt to change accountability relations by framing citizens as users and consumers (Joshi and Houtzager 2012). Those that emphasise citizen participation in policy-making and service delivery (such as advisory/consultative groups and user committees respectively) emerge from the ‘deepening democracy’ school (Gaventa and McGee 2013).
- *Scope:* Joshi (2008) argues for an analytical distinction between SAIs that involve citizen participation in governance and those that focus on monitoring and evaluating the use of public authority. The latter, she contends, perform better than the former, which raises concerns about co-option by the state. Malena and McNeil (2010), on the other hand, contend that mechanisms in which ordinary citizens are involved in decision-making are a new generation of ‘social accountability practices’.
- *Direction of control:* Peruzzotti and Smulovitz (2006) characterise social accountability as a non-electoral vertical accountability mechanism that can activate the operation of horizontal accountability mechanisms. Horizontal mechanisms represent the conventional internal systems of government accountability – legal, fiscal, administrative and political – whereas vertical mechanisms represent more ‘bottom-up’ external checks by non-state actors (i.e. citizens) (Bukonya, Hickey and King 2012). Goetz and Jenkins (2001), on the other hand, describe conditions when social accountability can also be diagonal – i.e. when vertical accountability activities engage with horizontal mechanisms, such as in participatory budgeting.
- *Leadership:* SAIs are, by definition, citizen-led, but can become state-led when institutionalised by the state (Malena and McNeil 2010).
- *Process:* Some SAIs (such as community monitoring, social audits, public demonstrations, protests, advocacy campaigns and public interest litigations) tend to be confrontational, whereas others (such as participatory budgeting and citizen scorecards) tend to be more collaborative in their approach to the state (Joshi and Houtzager 2012).
- *Outcomes:* Whereas some SAIs aim to improve service delivery, others focus on empowering the citizen vis-à-vis the state, and others still focus on deepening the democratic process and system (Gaventa and McGee 2013).

accountable to representatives (Bovens 2007; Mulgan 2000). These two systems of accountability – political and administrative respectively – constitute the standard model of accountability in a representative democracy (Joshi and Houtzager 2012).

In the standard model, the roles of voter-citizens, politician-representatives and bureaucrats are assumed to be fairly distinct: voters elect politicians based on their political manifestos; elected politicians make policy; and bureaucrats design and implement programmes based on that policy. In the wider policy process there may be further interactions when citizens lobby to get issues onto the policy agenda (see Schmitter 2004, cited in Joshi and Houtzager 2012: 148).

However, in many democracies, voters, politicians and bureaucrats have significantly reshaped and blurred the distinctions between their assumed roles within the standard model, redefining democratic accountability in the process. This happens in many ways, some of which serve to enhance state accountability to citizens. One prevalent way in which this happens (which does not enhance accountability to all citizens equitably) is ‘clientelistic’ or ‘patronage’ politics, in which voters give political support for individual material gain, politicians distribute state resources among their supporters, and bureaucrats operate not on the basis of rules and regulations but in response to (often highly localised) social and political demands.

1.2 Health systems in South Asia and the ‘standard model’ of accountability

The three countries chosen for this study share a common political past until independence from colonial rule in 1947; and, in the case of Bangladesh, independence from Pakistan, in 1971. Some of the problems they face are common to all post-colonial contexts while others are specific to the region, reflecting broader issues such as governance failures, accountability deficits and failures to implement adequate service delivery. The three states also face their own specific challenges in terms of equitable health and nutrition service delivery.

Despite these similarities, the three states have taken divergent paths in terms of governance, development and, consequently, health systems. Implementation of their chosen health system has been determined by contextual factors such as population size, geography and centre–state relations, thus rendering these ‘analogous’ states (Jalal 1995: 4) useful cases for comparison. Relations between the state and citizens and communities in all three countries also differ along the axes of class, community and caste (*Ibid.*), and this is strongly linked to the political trajectory undertaken by each state.

Broad indicators of health outcomes and access have shown some moderate improvement (e.g. maternal

mortality in Pakistan; see Nishtar, Boerma, Amjad, Alam, Khalid, Ul Haq and Mirza 2013) or even substantial improvement (e.g. infant, child and maternal mortality in Bangladesh; see Chowdhury, Bhuiya, Chowdhury, Rasheed, Hussain and Chen 2013) but are generally still poor by international comparison (Figure 1). Indicators of health systems and outputs are also poor (Table 1), with recent analyses citing poor governance as a reason, including endemic corruption and accountability gaps (e.g. Nishtar *et al.* 2013: 2198–2200). A recent paper on South Asia highlighted ‘bad governance, inadequate monitoring, weaker health institutions, and poor accountability ... as factors inhibiting progress [on child and maternal health and nutrition] in the region’ (Rajan, Gangbar and Gayithri 2014).

Bangladesh is the youngest independent country and the smallest of the three in terms of size and population, though the largest in terms of population density. While its process of democratisation has been disrupted by military coups and routine periods of authoritarianism, it has a vibrant, wide-reaching and influential civil society (particularly in health and education) and an activist judiciary comparable with India’s.

In Pakistan – the least densely populated of the three states – similar drives of militarisation and authoritarianism have affected the state’s political trajectory and its relation with citizens. The government mandated a process of devolution in

Table 1 Health system indicators and health outputs in Bangladesh and neighbouring countries and regions

	Health systems			Health outputs					
	Health expenditure (% of GDP)	Public expenditure in health (% of total health expenditure)	Per head health expenditure (US\$)	Doctors (per 1,000 population)	Nurses (per 1,000 population)	EPI (%)	Diarrhoeal episodes that receive oral rehydration therapy (%)	Skilled attendance at delivery (%)	Facility delivery (%)
South Asia									
Bangladesh	3.7	36.6	27	0.3	0.3	82.0	83.4	31.7	26.9
Pakistan	2.5	27.0	30	0.8	0.5	47.3	48.0	42.1	37.4
Nepal	5.4	39.3	33	0.2	0.5	82.8	40.7	49.0	40.6
India	3.9	31.0	59	0.6	1.3	44.0	61.2	48.9	40.4
West Bengal	NA	NA	NA	NA	NA	64.0	69.4	60.2	42.0
South East Asia									
Cambodia	5.7	22.4	51	0.2	0.9	78.0	58.4	75.1	61.8
Laos	2.8	49.0	37	0.4	1.0	NA	NA	41.5	37.5
Burma	2.0	13.0	23	0.4	1.0	NA	NA	63.9	NA

EPI= expanded programme of immunisation. GDP= gross domestic product. NA=not available.

Source: Chowdhury *et al.* 2013

services such as health care and education in 2000 that followed the Indian three-tier model. However, while SAIs – prolific in the shape of community meetings and public hearings – have played a key role in India at the grassroots level, and have also been used in Bangladesh, they are largely absent from the literature on service delivery in Pakistan.

Finally, India – the largest of the three countries in terms of population, size and gross domestic product (GDP) – is characterised by a highly heterogeneous population (in terms of social, cultural and economic factors) and complex relations between central and state party politics.

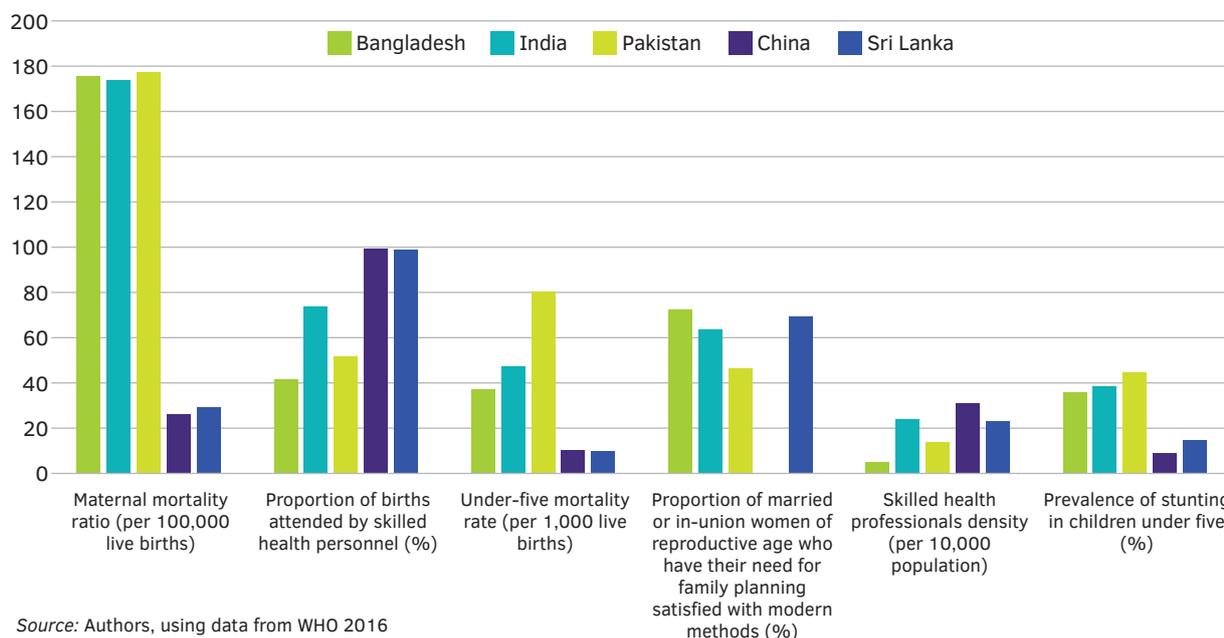
While divisions drawn based on judgements on the ‘standard’ or ‘quality’ of democracy between the three states can ring hollow and reductive (Jalal 1995), the nature of political processes between the centre and state in each country varies according to the different path each has taken. The case studies (section 4), drawn from India and Bangladesh, illustrate how differing political contexts have shaped both formal service delivery and community movements, particularly in health care and nutrition. Table 1 illustrates comparisons between the three countries with data on health system indicators and outputs for South Asia and South East Asia.

In the light of even these very brief contextual sketches, it is easy to foresee obstacles to addressing poor health and nutrition performance and inequities under the ‘standard model’ of accountability. Standard governance models work

on the assumption that representative democratic systems will direct resources towards pressing health problems and that where such systems fail, citizens or service users as ‘principals’ can engage with the system via their ‘agents’ (local leaders, politicians, etc.) as described earlier. However, in both the regional and global literature, a great deal has been written about the need for political will (Rajan *et al.* 2014), commitment (Heaver 2005) and attention (Shiffman and Smith 2007; Shiffman 2010, 2016) in order for pressing health issues to become a policy focus. Without these, many health issues remain both invisible (to the political system or to communities themselves) and ignored within the standard model.

Even where policy attention has been directed to specific health problems, without further political attention, the system bears a huge risk of rent-seeking individuals overriding any public good. Rajan and colleagues, for example, comment on the way in which India’s community-level nutrition delivery (the Integrated Child Development Services) ‘has continued to emphasize ... political returns over beneficiary impact’ (Rajan *et al.* 2014: 6). However, this does not have to be so: conversely, ‘Sri Lanka has been able to create a political environment where beneficiary improvement breeds political returns ... the result of bottom-up demand for quality service provision and top-down accountability for effective implementation’ (*Ibid.*). This is reflected in significantly better health indicators (as shown in Figure 1). Such calls for greater accountability and transparency are repeated in other reviews of health systems in the region (Nishtar *et al.* 2013: 2199), but have yet to be realised.

Figure 1 Selected health indicators in South Asia and China



Source: Authors, using data from WHO 2016

1.3 Social accountability initiatives addressing failures in the ‘standard model’

SAIs have emerged as a specific response to the failure of the more traditional mechanisms of political and bureaucratic accountability in holding the state to account (Gaventa and McGee 2013; Joshi and Houtzager 2012; Peruzzotti and Smulovitz 2006). In particular, they have been highlighted as an effective way to redress the grievances of poor people in developing country contexts, where transparency, accountability and participation are limited, if not lacking altogether.

Joshi and Houtzager have noted that SAIs, while often bracketed together, emerge from distinct traditions (2012: 149; see also Box 1). One stream reflects a managerialist and World Bank-driven agenda, emerging from a wider concern in the ‘new public management’ literature with governance (over politics). This supports a view of citizens as exercising rational choice over the services they receive, and is an explicit extension of the principal–agent approach to accountability described earlier, rather than an alternative as such. Another stream characterises wider developments within right to information and broader transparency movements (see also Gaventa and McGee 2013). Finally, a third stream includes activities associated with participatory or ‘deepening’ democracy and the issue of basic rights to services (Joshi and Houtzager 2012: 150; Gaventa and McGee 2013: s5-s7).

The distinct traditions outlined above can also be traced in accountability initiatives in the health and

nutrition sectors, notwithstanding differences in the origins of specific initiatives. Some have emerged as governance-focused interventions (primarily externally driven or conceived) or as field trials drawing on the World Bank conception (McCoy, Hall and Ridge 2012: 251). Others form part of health-centred claims to the right to information, focusing on health budgeting (for instance). Others still arise in the context of either external or more organic, endogenous movements focused on participation and rights (George, Scott, Garimella, Mondal, Ved and Sheikh 2015a: 164; George, Branchini and Portela 2015b; McCoy *et al.* 2012: 450) or are part of broader movements for democratisation and wider political reform (George *et al.* 2015a: 164).

A number of recent reviews have summarised the field of health accountability and helpfully describe the state-of-the-art in terms of types of activities and broad categories of social accountability or transparency initiatives (Cleary, Molyneux and Gilson 2013; Molyneux, Atela, Angwenyi and Goodman 2012; Berlan and Shiffman 2012; Lodenstein, Dieleman, Gerretsen and Broerse 2016; McCoy *et al.* 2012; Asha *et al.* 2015a, 2015b; Flores 2011). In the review below we classify initiatives according to a broad typology of approaches that has been emerging for some years in the wider accountability literature (see, for example, Joshi 2013b) (user-centred information access, complaint/grievance redress, citizen report cards, public hearings, community scorecards, community monitoring, participatory budgeting). Another review classifies such actions under dialogic and advocacy approaches, focusing on different stages of accountability processes (Table 2).

Table 2 Dialogic and advocacy approaches to accountability

Steps in accountability	Approach: dialogue	Approach: advocacy
Information collection	Facility co-management meetings Monitoring in health centres/specific services Scoring/evaluation in groups Collection of user complaints	Large-scale surveys Maternal death audits Collection of testimonies
Presentation/ negotiation	Training of health providers Joint problem analysis with providers and other stakeholders Joint planning with providers and other stakeholders	Independent analysis – formulation of statements and claims Radio broadcasting Presentation in public hearings, demonstrations, protests, media reports
Follow-up/enforcement	-	Involvement in political or administrative parties
Other characteristics	Initiator: community groups/committees Locus: health facility Target: frontline service providers	Initiator: civil society organisation (CSO)/NGO Locus: sub-national Target: providers, policy-makers, politicians

Source: Adapted from Lodenstein *et al.* 2016

1.4 Current critical issues in accountability

The accountability literature has been expanding rapidly over the past decade, a development which some trace to the specific influence of the World Bank-inspired stream of initiatives identified by Joshi and Houtzager (2012). Of late, there have been several reviews within development studies that have either attempted a meta-analysis of impacts and /or have taken a more critical qualitative approach to assessing current issues (e.g. Gaventa and McGee 2013; Joshi 2013a; Joshi and Houtzager 2012).

The most recent of these is by Fox (2015), which purposefully re-examined evidence covered by previous reviews with a view to understanding its unevenness and providing a finer-grained analysis of differences between approaches and their outcomes. Fox criticises the ‘import’ of deductive concepts from outside of the empirical field of social accountability, such as the principal–agent approach inherent in some of the World Bank-inspired work (*Ibid.*: 352). From his analysis of empirical work and critical literature, he explores which characteristics of SAIs are associated with which degrees of effectiveness and impact, and lists 11 emergent analytical propositions that sum up the key current critical issues in this field. These are summarised in Box 2.

Referring back to the three ‘traditions’ of social accountability described earlier, the third – participatory and ‘deeper’ democracy – is the subject of a rich literature within development studies, which has raised many critical perspectives. Here, a number of sources (Cooke and Kothari 2001; Falisse, Meessen, Ndayishimiye and Bossuyt 2012; Mosse 2001; Cornwall 2003) critique participatory approaches, highlighting that, unless used with care, they can at best reveal (and at worse reinforce) underlying local hierarchies of power in decision-making, aligned with local norms regarding social status, gender, ethnicity and caste. Such critiques apply equally, then, when extending participatory approaches to ‘community’ accountability struggles and, indeed, should lead to questioning any idea of ‘community’ as a single, homogenous identity in accountability initiatives.

Contemporary discourse on community participation in accountability argues that citizens should engage with the state as ‘makers and shapers’ of policies that affect their daily lives and locate themselves at the centre of accountability processes and targeted outcomes (Cornwall and Gaventa 2001). The problem with a wide variety of these approaches, however, is that although they emphasise citizen action, they tend to emerge through a number of external ‘initiatives’ and ‘interventions’, which can carry the same relationships of power as those made visible by the critiques of participation.

Box 2: Social accountability propositions for discussion

- a. Information needs to be user-centred to empower
- b. ‘Voice’ needs representation as well as aggregation
- c. Recognise that voice can be constrained by the ‘fear factor’
- d. Unpack accountability goals in terms of reactive versus preventive approaches
- e. ‘Teeth’ for public accountability refers to the state’s capacity to respond to citizen voice – a process that includes both negative sanctions and proactive reforms
- f. Bring vertical accountability back in
- g. ‘Voice’ and ‘teeth’ need each other
- h. Social accountability strategies need to address the ‘squeezing the balloon’ problem
- i. As a result, civil society policy monitoring and advocacy needs vertical integration
- j. ‘Sandwich strategies’ can shift power with state–society synergy
- k. Because context matters, the subnational comparative method is necessary to capture variation

(Fox 2015: 352–6)

As noted earlier, the scholarly interest in accountability forms part of a recent tendency to document wider emergent forms of citizen action and community-driven development. Paying closer attention to such extant forms of citizen-led action is consistent with Fox's (2015) enjoinder to distinguish 'tactical' from longer term, more complex 'strategic' approaches and recognise the greater chances of success of the latter. It is also consistent with Joshi and Houtzager's proposal for 'a conceptualization of social accountability that focuses on ongoing political engagement by social actors with the state as a part of a long-term pattern of interaction shaped both by historical forces and the current context' (2012: 146). Such activities might include forms of long-term struggle over the spoils of the state and of growth by particular groups (see, for example, Srinivasan 2014 and Harriss-White 2003: 47 for diverging views as to whether these benefits accrue to the elite or to poor people); they may also include populist politics (*Ibid.*) or forms of 'rude accountability' (Hossain 2010) and public shaming (Unsworth 2010). In this latter form, accountability may lack formal sanctions, but tactics such as public shaming of providers can impose reputational and political costs, in some cases triggering formal accountability mechanisms – for instance, through the courts or an ombudsman's office.

1.5 The importance of context

Many studies on the effectiveness and impact of SAIs have emphasised the criticality of context in their working, decrying as depoliticising and 'widget-like' (Joshi and Houtzager 2012) the purely technocratic framings. Bukenya *et al.* (2012) and Gaventa and McGee (2013) highlight how context is central in determining actors, objectives, design, the way an intervention unfolds, and its ultimate impact. Building on this work, Grandvoinet, Aslam and Raha (2015) posit that social accountability is shaped by the two institutional spheres of civil and political society and their interactions (state–society and intra-society), influenced by cultural norms, global factors and the prevailing political settlement (inter-elite relations). This is summed up in Figure 2.

Corbridge and colleagues' work on accountability programmes for education and work-based relief in three Indian states (West Bengal, Jharkhand and Bihar) represents a significant conceptual and empirical contribution to this body of literature.

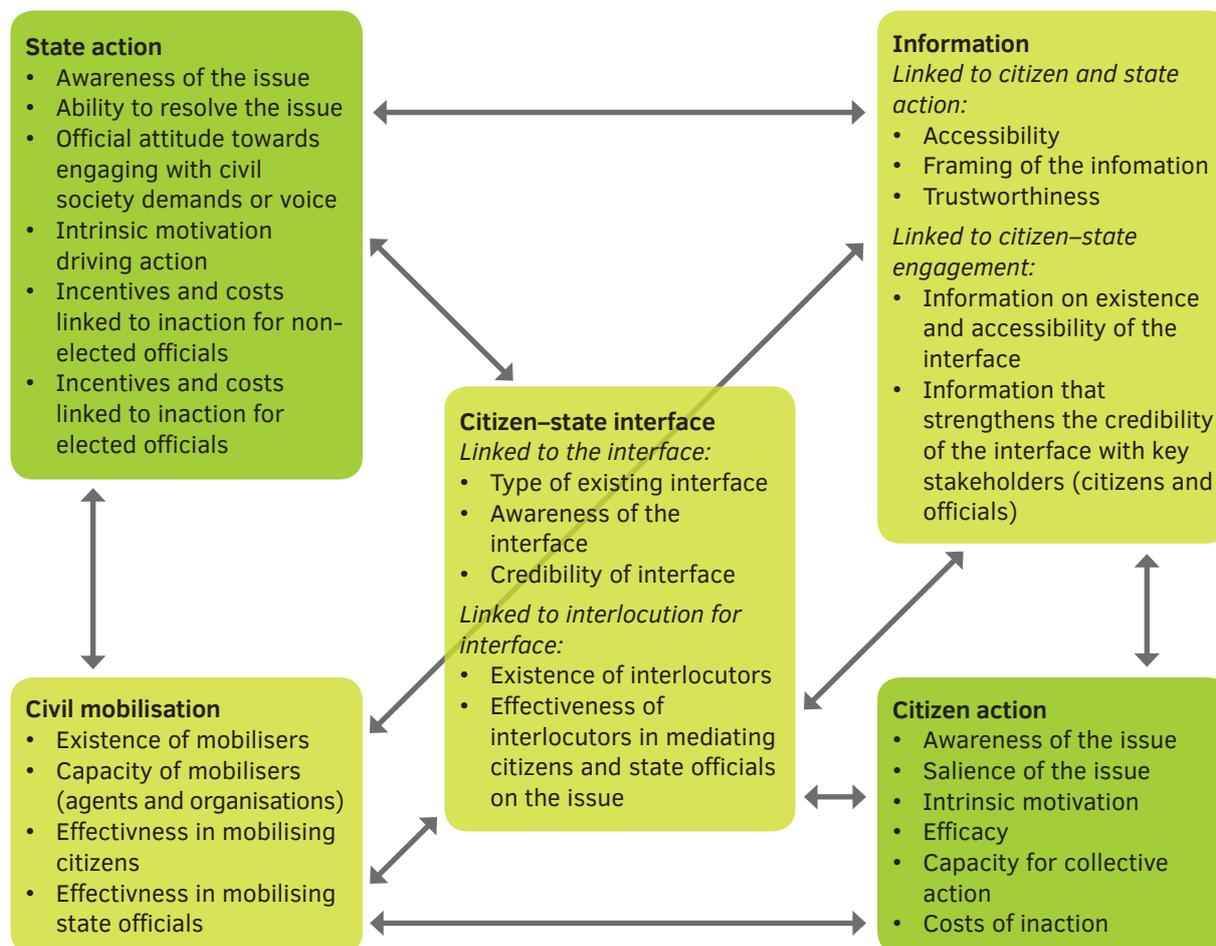
It draws on related bodies of literature concerned with the everyday workings of the state as experienced by poor people, as well as wider concerns derived from the Foucauldian analytical framing of governmentality (i.e. the ways in which the state and other actors construct bodies of knowledge about their subjects – in this case, poor people – in order to exert administration and control).⁴ The authors locate these everyday 'sightings' of the state within the existing social and political relations that precede any programmatic conception and implementation. This is, to some extent, an extension of the concerns with context and process, but is more explicit in outlining how new initiatives only complicate the existing socio-political mix further, in ways that can be unexpected though not always negative in the long run (Corbridge, Williams, Srivastava and Véron 2005: 261–2).

These contextual approaches to accountability fit, therefore, within a wider genre that considers how the everyday functioning of the government machinery is determined, not by impartial bureaucrats, but by the compulsions of local politics (Berenschot 2010; Witsoe 2012, 2011). Elected representatives, their brokers, political party leaders and workers determine people's access to information on public services and programmes, their participation and benefits, and can even subvert programme objectives, sometimes defeating them altogether (Berenschot 2010; Corbridge *et al.* 2005; Sharma 2011; Witsoe 2012). In this respect, SAIs often take place, not in the absence of the 'standard model' of bureaucratic and political accountability, but among its ruins and/or in the gaps it leaves.

A crucial part of understanding context is understanding the everyday personal accountabilities of clientelism and patronage. The barter of political support for direct individual profit is studied as 'clientelism' in political science and 'patronage' in anthropological and sociological literature. Early scholarship of clientelism emphasised direct, face to face interactions and transactions between the patron and client (Hicken 2011; Kitschelt and Wilkinson 2007; Piliavsky 2014). Later research recognised that democratic electoral competition, especially at the national level, scales up clientelist networks, introducing brokers and mediators between patron and client (Kitschelt and Wilkinson 2007). Yet, even extensive pyramidal hierarchies of brokerage rely on personal relationships between individuals – the

⁴ Governmentality has famously been defined as concerned more with the governance of conduct rather than the conduct of governance (Dean 2010: 10).

Figure 2 Contextual drivers framework



Source: Grandvoinnet *et al.* 2015: 119

patron and high-level brokers, high- and low-level brokers, and then low-level brokers and clients (Hicken 2011).

The clientelist exchange is direct and conditional. In democratic systems, politicians target benefits to specific constituencies on ethnic, regional, religious, class or caste lines. In clientelist politics, voters vote only for those politicians who promise to benefit them individually (through private rather than public goods) or in groups (through club goods), while politicians seek to benefit only those voters who assure them of their vote. The main criterion for giving and receiving resources is political support, not just membership of the target constituency. Accordingly, politicians in clientelist linkages set up elaborate devices and mechanisms to monitor the voting behaviour of clients and to ensure their accountability.

The political study of the links between elected representatives and their constituents tends to focus on their transactional nature, whereas a more anthropological approach stresses the

relational aspect. Anthropological literature rejects the clientelist conception of 'elections as auctions' with millions of profit-seeking voters 'wielding the abacus of rational choice', instead focusing on why the patronage relations take the form they do (Piliavsky 2014). Berenschot (2014, 2010) and Corbridge *et al.* (2005) find that voters want politicians who will do their work. Constituents often need political mediation to access public services and want representatives who will help them negotiate the local bureaucracy. Conceptualising the patron-client linkage as a social relation, Piliavsky (2014) highlights that politicians as representatives stand for the interests of their constituents and consequently work for their benefit. Patronage, for her, is a social institution that 'involves entitlements and obligations, which are politically constitutive in their own right, and which oblige politicians to understand, convey and respond to their constituents' needs'. In contrast, Witsoe (2011) finds that in contexts of intense political competition between different social groups for

dominance over the state, the political leader is supported to attain power to ensure the control of a particular social group over the state. The politician, in turn, works for the social upliftment of 'his/her' people. Patronage here is conceived 'horizontally': the patron and clients identify with each other such that the patron's rise to power represents the clients' ascent and vice versa.

1.6 What are the lessons from the global literature for SAIs in health and nutrition?⁵

The preceding findings are largely drawn from several recent meta-reviews or synthetic reviews of the literature, and the themes summarised so far are therefore similarly broad. Notably, however, some of these reviews also contain specific findings from SAIs in the health and nutrition sectors, and we now focus on these in more detail. Fox's meta-review of 25 'large *n*' quantitative studies, for example, (2015: 350–1) includes two interventions with positive health impacts (lowered infant mortality via participatory budgeting in Brazil and improved health outcomes via participatory monitoring in Uganda – discussed in this section). Mansuri and Rao's (2013) study of over a decade of World Bank-funded 'community-driven development' projects (which included a number of accountability initiatives) summarised some significant improvements in health outcomes, behaviours and service use.

Other studies have systematically reviewed the evidence on the impact of SAIs in health, in particular on:

- care quality for consumers (Berlan and Shiffman 2012);
- the functioning of 'peripheral health facilities' (i.e. clinics, dispensaries, excluding hospitals and district facilities) (Molyneux *et al.* 2012);
- health facility committees (McCoy *et al.* 2012);
- community monitoring (Flores 2011);
- contextual factors influencing health committees (George *et al.* 2015a);
- awareness-raising (of rights) and maternity care service use (George *et al.* 2015b);
- how resources, attitudes and culture influence the functioning of accountability mechanisms in primary health-care settings (Cleary *et al.* 2013).

In several cases, the evidence on the impact of SAIs is found to be 'weak' (Berlan and Shiffman 2012: 277; Molyneux *et al.* 2012: 552). This is often attributed to the lack of rigorous quantitative studies, though intervention design may also be an issue: one review found studies overwhelmingly reporting committee/group-based interventions (*Ibid.*; 19 out of 21 studies⁶). While noting this lack of rigorous quantitative evidence, authors also stress the need to move beyond the assumed 'gold standard' approach to impact assessment – i.e. randomised controlled trials – given that longitudinal and qualitative studies are better for understanding how and why particular outcomes are being achieved in different situations (McCoy *et al.* 2012: 460). Mixed methods are also advocated to combine more rigorous assessment of the impacts with explanations of why such impacts were reached (*Ibid.*; see also Lodenstein *et al.* 2016: 3, arguing for a realist perspective).

Several of the findings are consistent with the wider literature on social accountability. They include: the need to pay attention to user needs for appropriate information (rather than information for information's sake) (Berlan and Shiffman 2012: 278); the importance of not assuming community homogeneity (Molyneux *et al.* 2012: 552); the importance of political context (*Ibid.*: 553; McCoy *et al.* 2012: 458–9) and therefore of ensuring adequate representation of the community (George *et al.* 2015a: 162), including addressing economic barriers (McCoy *et al.* 2012: 457); understanding how interventions play out on the supply side in terms of 'provider norms' (Berlan and Shiffman 2012: 277); and finding the right links to collective action, civil society and other institutions (*Ibid.*: 278; Molyneux *et al.* 2012: 552–3; McCoy *et al.* 2012: 458; Lodenstein *et al.* 2016: 10). One of the studies (Berlan and Shiffman 2012: 276) highlights a critical characteristic of health provider accountability – 'consumer power'. It observes that there are strong information asymmetries between health service providers and users, which prevent the latter from demanding accountability, based on market forces. The review stresses the need for accountability interventions to address these information and power asymmetries. Another study (McCoy *et al.* 2012) highlights how information

⁵ This section is adapted from an earlier review in Ahmed, Feruglio and Nisbett (forthcoming 2017).

⁶ This appears to reflect the dominant choice of committee/group-based interventions for accountability approaches within the health sector (another two of the above reviews deal primarily with committees). Because of the lack of clear evidence, it cannot be concluded that this approach is therefore not effective in health contexts – but this weaker 'gene pool' of approaches within health does potentially limit the opportunities to learn from experimenting with a range of approaches in different contexts.

asymmetry prevented an otherwise successful SAI from influencing the actual running of clinics.

Two reviews highlight the interaction of externally driven accountability mechanisms with internal bureaucratic functioning (Cleary *et al.* 2013); or the interaction between formal and informal forms of participation (McCoy *et al.* 2012: 450). Four reviews highlight relevant contextual factors in communities or among service providers – e.g. community and provider values and attitudes (Cleary *et al.* 2013; Lodenstein *et al.* 2016) – while considering wider issues of resources and capacities (Cleary *et al.* 2013; George *et al.* 2015a: 163; Lodenstein *et al.* 2016: 10; McCoy *et al.* 2012: 457); community awareness and scepticism towards initiatives (George *et al.* 2015a: 161–2); and similar health provider perceptions and orientations towards initiatives and their wider incentives to serve communities. The latter include fear of negative sanctions and more positive incentives such as a sense of moral duty (Lodenstein *et al.* 2016).

In addition to highlighting the difference between ‘process impacts’ such as improved governance reforms and service quality outcomes, Joshi argues that in the case of SAIs in health, it is hard

to separate positive outcomes that result from increased uptake from improvements caused by greater accountability in the service itself (Joshi 2013b: s32–33⁷). This is not necessarily a negative outcome, but it does make it difficult to draw lessons that can inform the design of future approaches. Another study of accountability in São Paulo underlines these differences in showing how opportunities for social accountability may actually occur more naturally for health than for social services in some instances, reflecting the different institutional models that have been adopted. This is because service delivery in health requires physical points of contact between citizens and agents of the state, including local health posts and participatory councils, and coordinating bodies at local levels of government. Programmes such as cash transfer schemes, however, entail fewer physical or organisational contact points around which people can mobilise (Unsworth 2010). On the other hand, health service delivery – more broadly conceptualised as including public health and more preventive rather than purely curative services – is likely to suffer in contexts in which citizens and providers see it largely in terms of the logistics and receipt of medical products such as drugs.

2. Summary findings from review of current social accountability practice in the health and nutrition sectors in India, Pakistan and Bangladesh

Having identified key issues and lessons from the global and South Asian literature on social accountability and the literature on accountability in the health and nutrition sectors, we now focus on current practice in the three South Asian countries of interest. Besides our review of the general social accountability literature and that pertaining to the health sector, we undertook a more focused review of health and nutrition

accountability initiatives in India, Bangladesh and Pakistan.⁸

Table 3 summarises the five types of social accountability initiative identified in our earlier review, and gives a brief description of the form, scope and experience with each, as well as highlighting relevant information sources. Further findings are summarised in the conclusion, section 5, and in the main report.⁹

⁷ Joshi’s broader argument here is that poor people often ‘opt out’ of health and education services when not provided adequately by the state – either by going to private/informal providers or by not using services at all.

⁸ See footnote 2 for a description of the methodology.

⁹ The main report, available at www.transformnutrition.org/2017/03/accountability-in-health-and-nutrition-in-south-asia/, includes a discussion of each of the five types of social accountability initiative encountered in the focused review.

Table 3 Social accountability approaches in use in the health and nutrition sectors in India, Pakistan and Bangladesh

Social accountability approach	Description	Sources
Social audits and public hearings	<ul style="list-style-type: none"> Public expenditure on health and nutrition provision or service delivery outcomes are shared and discussed with community members in a public meeting Serve an information dissemination and transparency function and provide platform for community members' voices in multi-stakeholder forum Can act as direct, timely mechanism for voicing accountability claims, within a framework of rights or of redressing grievances Frequently mentioned in literature on India and Bangladesh but scarce in literature on Pakistan 	Joshi 2013b; Papp, Gogoi and Campbell 2013; Ahuja 2014; WRA 2010; Lakha, Rajasekhar and Manjula 2015; DiCaprio 2012; Democracy Watch 2014
Community monitoring initiatives and committees	<ul style="list-style-type: none"> Ongoing community oversight of service providers' activities, used to establish and maintain community-defined performance standards Easily observable features used as indicators (e.g. staff attendance, physical quality of facilities, adherence to due procedures) Can bring 'supply' and 'demand' sides of accountability relationships together Can shed light on corruption among service providers and public officials Usually done by committees intended to represent users, service providers and political representatives 	Joshi 2013b; Barpanda, Afrin and Das 2013; Johnston 2009; Mahmud 2007, 2009; Schurmann and Mahmud 2009; Thomas, Sarker, Khondker, Ahmed and Hossain 2003; Aziz, Bhuiya, Hanifi, Iqbal and Hoque 2009; Houweling, Tripathy, Nair, Rath, Rath, Gope, Sinha, Looman, Costello and Prost 2013; Kalita and Mondal 2012; Green 2011; Khan <i>et al.</i> 2013; Khan and Ahmad 2016
Citizen report cards	<ul style="list-style-type: none"> User surveys of public service performance using availability, access, quality and reliability parameters, usually combined with advocacy and publicity efforts to exact accountability from state Pioneered in Bangalore, India, and now used extensively around the world 	Ahmad 2008; Ampratwum, Armah-Attoh and Agyei Ashon 2014; Browne 2014; Wagle, Singh and Shah 2004; Pandey and Singh 2012; Shukla, Scott and Kakde 2011; Knox 2009; Resource Integration Centre 2015
Community scorecards	<ul style="list-style-type: none"> Hybrid comprised of citizen report cards + social audits; combine user feedback on service performance, provider self-assessment and user-provider interface meetings to discuss performance assessments and agree remedial actions Usually produce report based on primary or secondary data as input to community reflection on local service provision, sometimes including ranking of services provided in different communities 	Babajanian 2014; Murty 2007; Misra 2007; Resource Integration Centre 2015; Khan and Ahmad 2016
Budget tracking and advocacy	<ul style="list-style-type: none"> Civil society actors track implementation of public budgets to understand use of public resources and identify leakages, lack of expenditure and other irregularities 	Boydell and Keesbury 2014; Public Affairs Foundation Bangalore, Sirker and Cosic 2007; NGO Forum for Public Health and Freshwater Action Network South Asia, n.d.; Simavi 2015; Mishra 2014; Mohmand and Cheema 2007; Ahmad and Talib 2013; Kurosaki 2006

3. Mutual learning at accountability's cutting edge: findings from an online consultation

The third part of this project consisted of an online discussion to complement the literature review and attempt to capture some of the undocumented cutting edge thinking and practice from the field. Participants were selected via a variety of methods: membership of the partner network of the Community of Practitioners on Accountability and Social Action in Health (COPASAH); mention in the published and grey literature reviewed earlier; other local partners or recommended participants; and 'snowballed' invitations.¹⁰

The discussion centred on four topics as summarised here. The topics were pre-selected by the partners leading the consultation (IDS and COPASAH), based on their engagement with the literature and practice review and on some prior consultation with participants. In some cases the topics broadened in the course of the discussion. This is reflected in the present write-up, where the length of each topical section reflects both the different degrees of engagement on different themes, and the degree of broadening of or exploration around the topic initially set.

3.1 Community participation and engagement

This discussion started by focusing on the question:

- **How do organisations on the ground ensure that community members are engaged and lead social accountability efforts?**

Participants illustrated how all social accountability processes begin with raising awareness and informing community members of their rights and

entitlements. This step entails building a 'culture of questioning' that is crucial to mobilise communities around issues of health care and basic services. In this sense, a rights-based approach provides the framework for social action. The awareness-raising aspect is not limited to specific rights and entitlements, but includes building awareness on wider social and policy structures, the role of democracy, and the way the state functions. Some organisations engage with frontline service providers during this stage, both to fill the 'knowledge gap' among health providers and to ensure shared goals and vision, thus reducing the risk of tensions between community members and frontline workers.

Community participation can deploy a range of tools. Participants mentioned the full range of activities noted in the earlier literature review (community scorecards, social audits, etc.). Beyond more 'traditional' tools like scorecards, organisations also mentioned innovative uses of information and communication technologies (ICTs) (see page 21) and pictorial materials/flashcards as ways to ensure inclusion of illiterate people.

During capacity-building workshops, picture materials depict the problems to start discussion and then explain entitlements. Women's group leaders use these flashcards to inform other women during local village meetings. The illustrations are simplified as tools and checklists to enable the women's groups to monitor those entitlements. Women learned which services should be provided in the Anganwadis¹¹ of their villages through a set of picture cards. They used a ten-point checklist to monitor Anganwadi centres, and conduct neighbourhood surveys.

¹⁰ The consultation, hosted on the Eldis community discussion platform (www.eldis.org), was eventually attended by 49 participants across India, Bangladesh, Pakistan, the UK, the USA and the Netherlands. The discussion took place on 16–17 March 2016. Over the two days, 31 participants posted contributions to the discussion (five of whom were from the organising team) for a total of 134 contributions.

¹¹ *Anganwadis* are local-level delivery units in Indian villages, providing basic health care, including contraceptive counselling and supply, nutrition education and supplementation and pre-school activities. They were started by the Indian government in 1975 as part of the Integrated Child Development Services programme to combat child hunger and malnutrition.

Participants were keen to underline that the effectiveness of social accountability tools does not depend on the type of tool chosen, but on the strategy built around it: *'tools are just medium to create environment in the community so that people can sit together and start talking about the issues'*. Experience on the ground has shown that while negotiating with service providers, the leverage that a given tool can open up for communities is context-specific. However, the choice of tool is often a pragmatic decision driven by the type of data that needs to be collected (or at times also influenced by funder requirements).

The discussion then shifted to the factors affecting people's participation within social accountability processes. Motivation, incentives and social recognition are vital to ensure the participation of community members. Equally important is setting clear, reachable goals. However, questions arise with regard to sustainability and 'institutionalisation' of accountability processes.

When committee members accompany the patients to local health centres they receive recognition from the health system as 'VHWSC [village health, water and sanitation committee] members' and this motivates them to work more. In a primary meeting place of the village, the names of the committee members were written on the walls, which also brought recognition to them among the community, which is another motivating factor. The big trigger was when the community-led monitoring exercise started. Other than committee members, many of the villagers got interest into the accountability process and showed their willingness to join the group.

Practitioners underlined how, during the community participation process, attention needs to be paid towards inclusion of marginalised people. For instance, raising women's voices, especially with regard to sexual and reproductive health and rights, is particularly challenging in contexts where gender, caste and religion hinder people's participation (including their ability to attend community meetings). It can also affect their ability to address such issues as family planning. Here, social accountability processes can have broader uses in resisting oppression and ensuring representation of vulnerable groups. Some organisations address intra-community divisions by ensuring that each group within

the community can participate in community monitoring and present their needs and views on the state of health care delivery. In the case of some women's groups, solidarity and inter-community support is essential to collectivise actions, and give the group a stronger voice.

[W]omen support each other in the group meetings, they listen to each other's problems, emotions, mishaps, threats, etc. and show solidarity for it. Then they try to identify the reasons behind these problems and make a collective plan of action against the issues. Most of the family issues (i.e. domestic violence, their mobility, etc.) are resolved by the group itself but for other issues (i.e. entitlements/schemes by the government), trained women motivate other women to negotiate their rights with service providers and become active claimants from passive beneficiaries.

In addition, community participation processes can provide a valuable opportunity to engage men in conversations about health care, particularly family planning, and in turn counter those gender dynamics that affect women negatively.

If communities can demand accountability from the state, they also have to look within and address gender inequality in that domain – this requires giving up privilege, which is no doubt a challenge, but necessary. In interventions like these where we want the community to reflect on both aspects, we always lay the foundation with an understanding of gender/caste/class inequalities, before speaking about entitlements. Secondly, with respect to family planning, we find that in addition to speaking to women about their right to use contraceptives, it is equally important to talk about family planning entitlements (from the state).

3.2 Negotiating with the state

In the standard process outlined by several of the participants, the next stage of an accountability initiative often involves data collected through community monitoring being presented to, and discussed with, government health providers at different levels. Therefore, the next question we focused on was this:

- **How are community members involved in negotiating with the state?**

Most of the participants indicated that the negotiation at a local level happens through existing committees or *ad hoc* platforms set up by local groups. Some of these committees are established under government schemes (such as the village health and nutrition committees in India), but become properly functioning only through SAIs. In other instances, new platforms or opportunities for dialogue need to be created *ad hoc*. In some cases, local service providers participate in the monitoring process alongside community members and provide their own data.

Some participants mix collaborative and confrontational approaches when dealing with health providers. More confrontational approaches, including *dharnas* (non-violent sit-in protests) and litigation, are resorted to in particularly serious cases of health rights violations, or to advance strategic claims.

It was pointed out that negotiation is usually easier at community level, where frontline workers and patients live side by side and find ways to collaborate. It becomes more difficult at higher levels, because of the difficulty of translating local demands into wider changes. Here, an essential step is the aggregation and analysis of information collected at community level. These data are brought to the attention of district or province/state-level discussion forums between civil society and government representatives. In participants' experience, when locally collected data are used to push for better service delivery at 'higher' levels (such as district or state), community members are seen as legitimate sources of information, and their voices become legitimate ingredients in decision-making processes.

Lastly, there are some good examples of 'vertical integration' and continuous exchanges between various administrative levels (community and district/state) in the work some participants have been doing on health budgets. Budgetary considerations are essential when advocating for improvements in health service delivery. Some of the participants' work focuses on unpacking public health budgets, and facilitating community input on budget allocations. Here, the community participation process can lead to the formulation of 'key asks' for the government. This approach has led to cases where the state actually initiates consultations with communities during the formulation of budgets.

3.3 Accountability of the private sector

When speaking about ensuring accountability in the delivery of health care, many participants saw the private sector as a crucial piece of the picture. Key questions are:

- **What are the different ways of promoting accountability of private providers?**
- **What should be done when patient rights are violated through private sector actions?**
- **What are the ways of ensuring rational and ethical practice that has the potential to safeguard patients' rights?**

Regulation of the private health sector was seen as a critical and urgent task. Lack of regulation can result in the lack of an effective framework for claiming accountability in service delivery. Moreover, the relations between patients and private providers are of an economic nature, and do not follow the paradigm of rights and duties.

With the exception of one example from Pakistan, in most of the contexts where participants work, there is a lack of effective channels for dialogue and grievance redressal. Participants felt therefore that accountability can only be realised by reaffirming the role of the government as having primary responsibility for health-care provision and regulation. This agenda must essentially be pushed at policy level.

However, these decision-making spaces and processes were felt to be neither transparent nor accountable to the principle of ensuring access to quality health care for all.

3.4 Defining and measuring impact, and issues around monitoring and evaluation

Participants were encouraged to share their thoughts on the following questions:

- **How do standard ways of understanding the impact of social accountability initiatives look, when viewed from community members' and practitioners' perspectives?**
- **What roles can community members play in monitoring change?**

During the first day of discussion, it emerged that the first and foremost focus of social accountability processes is to build capacity and awareness of community members to demand their rights. However, even if community members become more empowered, access to services may not necessarily improve. Indeed, service uptake depends on a number of other factors, such as the quality and acceptability of the service and the capacity of service providers to deliver health care. Therefore, there seems to be an excessive focus on service uptake as a standard indicator to measure impact of social accountability.

[I]mplementers of social accountability as well as those who study them, tend to look at improvement in services and increase in uptake as indicators of effectiveness of social accountability [initiatives]. But is this really sufficient? The dynamics illustrated [in the consultation] show an empowered community constantly negotiating and asserting its rights, while services per se may not be improving. Is this not a marker of change?

This is strongly linked with the question of for whom the practitioners are carrying out the monitoring or evaluation of health provision. Participants agreed that evaluations are mostly carried out for funders, and therefore tend to be framed by project commitments and narrow indicators focused largely on service uptake and use. Participants felt that mainstream approaches to evaluation do not consider the many other forms of social change – beyond increased access to services – that can result from social accountability processes, such as empowerment. Narrow approaches also fail to grasp the complexities surrounding community choices over service access and usage.

Participants shared examples of recent efforts by civil society and researchers to counter this ‘technocratic’ approach to impact assessment, pointing out some resource materials produced on this issue (Das 2015). For instance, ‘stories of change’ have been identified as a promising method to document ‘how’ and ‘why’ change is created rather than just ‘what’ the change is.

Participants then discussed the role of community members in monitoring change. Here, a couple of posts discussed the use of ICTs for gathering

data, ranging from short message service (SMS) to interactive voice recording (IVR) and multimedia (photo and videos). Overall, participants strongly highlighted how the scope of technologies to enable anonymous participation can increase the participation of community members, especially women. Patients feel comfortable reporting corruption in health facilities through the use of SMS or IVR because they do not fear retaliation from health staff. An additional bonus of using technologies to collect data is that it increases the perceived validity of the data on the part of government authorities.

3.5 Wrapping up the discussion: the need to politicise social accountability

Final remarks focused on situating existing SAIs for health and nutrition within wider pushes for social change. Participants were asked how localised community-level actions make sense of their goals in the long run, and how they form alliances with each other. It was felt that local-level initiatives need to link up and synchronise with wider movements to pursue long-term goals of addressing supply-side barriers and influencing policy-making. Attempts to change power dynamics at local levels need to reflect on wider political structures.

A classic example of an (initially) localised demand for accountability, which then translated into wider political change, is the Right to Information / Right to Food movement in India (see case study on page 27). A more recent and smaller-scale example comes from the state of Assam, where efforts to expose gaps in the delivery of maternal and infant health services for tea workers have allied with a state-wide campaign calling for increased wages across the tea industry (Dhital and Feruglio 2016; *The Times of India* 2015).

To sum up the rich contributions of participants over the two days of online discussion, we can say that the main message might be that putting politics and power at the core of the accountability discourse is essential to ‘make sense’ of the change we seek to create, and any attempt to understand impact should take into account these considerations.

4. Case studies

4.1 Case study 1: Multi-dimensional movements in social accountability – the Right to Food movement (India)

Introduction

The Right to Food (RtF) movement in India took a multi-stranded and strategic approach, drawing together several stakeholders at local and state levels of governance with civil society and activist communities to enact several accountability mechanisms, both formal and social (Hertel 2015). The movement gathered momentum over the course of a series of Supreme Court orders on nutrition and food policy, and has also been characterised by 'micro-level' grassroots activities (Krishnan and Subramanian 2014).

The RtF movement began in the early 2000s and contributed to the passing of the National Food Security Act in 2014 as well as a number of other achievements. Along with linked and similar campaigns for transparency (Right to Information) and public works-based social protection (the Mahatma Gandhi National Rural Employment Guarantee Act 2005), the RtF movement exemplifies how a combination of public pressure (from social mobilisation and the media) and Supreme Court interventions can instigate formal accountability mechanisms (Khera 2013; Pande 2008).

The importance of social mobilisation through generating awareness of rights and via various forms of public scrutiny enacted by communities has been highlighted by Dreze (2001) among others. At the community level, citizens can exert pressure through voice-based accountability practices and collective action. The key role of intermediaries such as CSOs, the judiciary and activists in catalysing processes of accountability at all levels of governance is highlighted in the case of the RtF movement (Pande 2008). Khera (2013) refers to these as the 'non-party politics' players and invokes the idea of combining 'self-assertion' and 'solidarity' to enact social change and accountability (Dreze and Sen 2002).

Background and legal action

The RtF campaign is based on an 'informal national network' of CSOs, academics and activists.¹² The movement was triggered in 2001 by a decade-long Public Interest Litigation in the Supreme Court to petition the state to address inadequate drought and hunger relief in Rajasthan, despite the existence of nine nationwide government programmes on hunger prevention and food security (Khera 2013).¹³ While the Indian Constitution at the time did not explicitly guarantee a 'right to food', this was petitioned under the constitutional 'right to life'. Despite the existence of state programmes to address hunger and malnutrition such as the Public Distribution Scheme (PDS) (a nationwide food subsidy scheme), they had failed in terms of local implementation and lacked operational accountability mechanisms (Saxena 2010).

The RtF movement gathered pace and pursued legal recourse as a tool for holding state institutions accountable for wide-scale malnutrition, hunger and failed state food subsidy programming. By taking action at the local and national levels, the campaign was effective in securing legal accountability mechanisms from state institutions (Krishnan and Subramanian 2014). The overall context of a democratic (and increasingly decentralised) system of governance facilitated a series of political opportunities for the campaign. Protest activities served to open 'spaces for dialogue' in the move towards accountability (Krishnan and Subramanian 2014: 109).

The Supreme Court ruled 'right to food' as a legal entitlement, thus making state institutions formally accountable. This ruling converted 'state welfare measures into legal rights', therefore easing the way for demand and public action in local and state contexts (Krishnan and Subramanian 2014: 110). In 2002, an order was issued mandating states to refrain from diverting central funds meant for food and employment schemes to other purposes. The gram sabha (village councils) were authorised to conduct social audits of all schemes implemented in their local areas.

¹² Definition drawn from the Right to Food campaign website, <http://www.righttofoodcampaign.in>

¹³ The case was brought about by the People's Union for Civil Liberties (in Rajasthan) versus the Union of India and others, Civil Writ Petition 196/2001

Commissioners were appointed by the Supreme Court to monitor the implementation of these schemes; their report confirmed the shortcomings in state delivery of the PDS. However, both the public and the commissioners' investigation teams were consistently denied access to documents linked with food and employment schemes and a series of bureaucratic hurdles signified a lack of political will. In 2003, the Supreme Court converted existing directives concerning famine and hunger management into binding codes for state-level governments to follow. This provided enforceability and sanction powers to state governments – including, for example, the ability to cancel the licences of grain shop owners (operating under the PDS) if they did not open on time or made false entries on beneficiary entitlement amounts. Action was also taken against certain states that had failed to implement the government's Midday Meal Scheme in schools, and the programme was made mandatory at a national level (Mahabal 2004).

Against this background of legal activity, the RtF movement emerged with a coherent goal of realising the core right for Indians to be free from hunger and malnutrition. Achieving this goal required a holistic approach that incorporated sustainable and equitable food security systems but also guaranteed rights to work, land and social security (Mahabal 2004). Eventually the RtF movement brought together their goals to call for a rights-based social welfare system for vulnerable groups.

Accountability tools

The RtF was catalysed through legal mechanisms and mobilisation of communities and organisations at a national scale. These played out in multi-level dynamics at state, local and nationwide levels to enable a widespread and escalating movement.

In addition to deploying existing legal accountability mechanisms at the state and national levels of governance, the RtF movement can be seen as a series of scattered actions taking place across India using more informal and grassroots-based accountability tools. Social audits, public hearings and community monitoring were among the key tools used in the movement (Hertal 2014). The citizen-led accountability tactics could be conceived as a combination of both 'confrontational' and 'collaborative' actions (Krishnan and Subramanian 2014: 106). The role of the media and CSOs (and individual

activists and academics) in mediating social mobilisation was also central to the enactment of accountability processes in the RtF movement.

One example of an approach that combined both 'confrontational' and 'collaborative' tactics is from Delhi, where public hearings were organised by a local citizen group Parivatan to expose corruption among officials involved in the PDS (Pande 2008). This case shows how the existing Right to Information legal mechanism was used to voice calls for transparency and accountability in providing grains to beneficiaries according to their entitlements under the PDS. The campaign began with individual cases of beneficiaries who had not received their correct entitlements petitioning for the Right to Information with the help of Parivatan. Such moves gathered momentum through social mobilisation, the attention of the media and response from state governments. Public hearings (or *jan sunwais*) were held as the final part of a strategy where information that had been collectively gathered and analysed was presented to the public and verified. The public hearings involved government and community members and were overseen by an independent committee, exemplifying the collaborative aspect of the approach (Pande 2008).

Despite attempts at reprisal from targeted public officials, including violent attacks on the members of Parivatan, the movement escalated quickly and the state responded: public scrutiny processes were introduced in several areas of Delhi; the public could access food grain records and air grievances on a twice-monthly basis. The supply of food was also scaled up in areas where Parivatan had campaigned. While the movement did not lead to a transformation of the entire system in Delhi, it demonstrates how direct actions can enable citizen groups to enter into negotiations with the state and how two separate movements (for transparent information and food security in this case) can be linked in accountability approaches (Pande 2008).

An example of a state-wide movement to guarantee nutrition and maternal health-care as a result of the RtF movement is also provided by the Mitadin programme in Chhattisgarh (Krishnan and Subramanian 2014). The Mitadin model is an example of a grassroots primary health-care model with inbuilt community accountability mechanisms. The model provided key primary health services (such as weighing children in a village and collecting nutrition data) and effectively created a

'social safety net' for women and children (Nandi and Schneider 2014).

Mitanin workers were found to be both 'agents of change' within the community and representative advocates for accountability to the community (Nandi and Schneider 2014). The effectiveness of the model has been attributed to the fact that accountability was linked to the community rather than to a government department. The community health workers were unpaid, which could also reinforce autonomy, although Nandi and Schneider question the structures of payment in determining accountability outcomes.

Finally, an example of a movement under the RtF banner on a nationwide scale: the Supreme Court orders regarding the Midday Meal Scheme were used as a platform to urge state-driven reform. Activists under the RtF movement mobilised the media and were able to use a combination of public pressure and legal orders to bring about nationwide implementation of a scheme that guarantees one cooked meal per day for school-going children (Khera 2013).

4.2 Case study 2: *Naripokkho* – from community activism and accountability to state-level action on women's rights and development in Bangladesh

Naripokkho (meaning pro-women) is a membership-based activist organisation that strives for women's rights and development in Bangladesh. Its efforts are focused on four themes: (a) violence against women and human rights; (b) reproductive rights and women's health; (c) gender issues in the environment and development; and (d) representation of women in media and cultural politics (Azim 2001). *Naripokkho* works in all 64 districts of Bangladesh through partnerships and networks. It has built, supported and strengthened 37 community-based organisations in 29 districts to work directly with women on reproductive rights and health and issues of violence. It has also partnered with Doorbar, a women's network that focuses on preventing violence against women and enabling their political empowerment.

Naripokkho's work in the area of women's reproductive rights and health has included activism and advocacy against target-oriented and coercive population control policies and programmes as well as the rights of sex workers. In the late 1990s, it expanded its focus to the quality of public health services available to women and, in collaboration with the government and district hospitals, sought to make public hospitals more accessible to women. This experience highlighted the criticality of accountability in ensuring that women patients received the services they needed.

In 2003, *Naripokkho* began an initiative on community monitoring of maternal health services in five districts and 14 sub-districts of southern Bangladesh in partnership with 16 local women's NGOs. This initiative worked through multiple levels – from the village to the state – to strengthen health system accountability. At the village level, it set up women's groups or *Nari Dals* to create awareness about health rights and entitlements and demand quality health services from public facilities. *Nari Dal* members protested instances of rent-seeking and denial of services by health service providers through confrontation, argument and shouting slogans. They also conducted regular monitoring visits to their local union health and family welfare centres. Their awareness of entitlements and group strength forced the health system to respond to their demands.

At the district and sub-district levels, the 16 NGO partners each monitored a health centre for cleanliness, staff attendance and staff behaviour towards women patients, sharing their observations with the hospital management committee of the facility and at the district and sub-district-level NGO coordination committee meetings. Their intervention led to improvements in the cleanliness of facilities, ambulance availability, power supply, number of patient beds, and reduced rent-seeking. *Naripokkho* and its partners also worked to activate the largely non-functional hospital management committees, which every public hospital is expected to have. Chaired by the local Member of Parliament (MP) and including stakeholder representatives such as hospital employees, health department and local government officials as well as civil society members, this committee has the ability to identify and solve local problems. Activating these committees involved convincing MPs to convene meetings and members to attend the same.

Active hospital management committees were effective in reducing private practice by doctors during hospital hours, and reducing rent-seeking, as well as improving the quality of inpatient meals (Barpanda *et al.* 2013).

In the area of violence against women, *Naripokkho's* accountability focus translated into monitoring of state interventions to combat such violence. Begun in 1999 as part of their campaign against acid violence, initially this included regular monitoring of 22 police stations in the Dhaka metropolitan area, the emergency, gynaecology, burns and forensic medicine departments of two major public hospitals and the special court for all cases of violence against women (COPASAH no date; Huq 2003). Gradually, *Naripokkho* activists negotiated with the police to set up regular reporting of violence against women incidents and follow-up action from all 460 police stations in the country. In this way, a special cell for monitoring violence against women was set up in Dhaka police headquarters (UNIFEM 2003).

The objective of all such monitoring was to identify loopholes in the system and report back to the relevant agencies for action. Quarterly meetings were organised with all service providers and the findings of the monitoring presented as action research in a 'spirit of dialogue' (Huq 2003). The resulting discussion led to explanations and a self-review by officials with representatives from the agencies and *Naripokkho* jointly preparing recommendations for action (UNIFEM 2003). Huq (2003) highlighted that while most service providers identified lack of resources as a major problem, *Naripokkho* emphasised the role of the behaviour and attitudes of staff providing services, which many survivors of violence had highlighted. For instance, male doctors' attitudes and behaviour towards victims led to high rates of refusal for post-rape examinations. After *Naripokkho's*

intervention, the rate of refusal fell significantly (UNIFEM 2003). Huq (2003) clarified that such constructive engagement was possible because of an understanding that *Naripokkho* would not publicise or release the findings of their monitoring to the media or public.

Nazneen and Sultan (2010) highlighted the role of personal networks in *Naripokkho's* negotiations with the state, like several other women's organisations in Bangladesh. According to them, *Naripokkho* relied on personal connections to obtain permission, overcome resistance and manage disagreements while monitoring state interventions. They consciously avoided engaging with any political party because of the partisan nature of Bangladesh politics, striving hard to maintain a neutral stance and fighting off any labels applied from time to time. Local politicians were approached for redressal of specific issues in their constituencies but there was no engagement with national-level political parties.

Naripokkho's success in other domains, including its well-publicised role in the setting up of the Acid Survivors Foundation to support victims of domestic and sexual violence, has received criticism for aligning itself too well with global donor priorities and approaches rather than the physical and structural violence of gender inequities as experienced by Bangladeshi women wholesale (i.e. beyond high-profile attacks on young women; Chowdhury 2011). However, this needs to be countered by *Naripokkho's* own stated approach to support affected young women to move from being victims to activists working against acid violence (Nazneen and Sultan 2010) alongside their wider rights-based activism; attention to addressing structural inequities in services such as health; and their willingness to take on government and donor policies (such as coercive population control) directly.

5. Conclusion

The cases highlighted, both in the literature reviews and the online consultation, show that there are a range of approaches taken or ‘tools’ employed to strengthen accountability, including social audits, community scorecards, user committees, community report cards and expenditure tracking. The consultation in particular raised some new possibilities and innovations stemming from the use of ICTs directed towards a range of accountability goals, from awareness-raising to real-time user monitoring of service quality and grievance redressal. By way of a conclusion, we present here the most salient considerations arising from our overarching analysis of the material. We frame these as wider themes that emerge from the rich insights the material offers on community-level and intra-community accountability dynamics, and which are pertinent to broader accountability debates.

Community

The first set of considerations surround assumptions about **community** itself. Drawing from the literatures and practices discussed in this report – including earlier critiques of participation, wider synthetic or critical work on accountability and the wider literature on the embeddedness of the state in extant social and political structures – we note that no assumptions should be made about the community as a single, homogenous entity expressing any awareness or desire towards levels of service provision and service quality for health and nutrition. Different parts of the community will serve their own needs through government and other private sector provision to varying extents or not at all. One section of the community might not welcome another section securing increased access to a given service, and both this existing service provision and likely disputes over future provision are likely to occur along existing fault lines of social exclusion relating to caste, ethnicity, age, gender, sexuality, (dis)ability and so on. This understanding of community also precludes ready divisions between ‘the community’ and ‘service providers’. Frontline workers and low- or mid-level bureaucrats serving communities will be drawn

from various parts of the community or different communities. Their identity (e.g. caste or kinship) may also affect the level of service they are willing to (or feel obliged to) provide.

The literature on Pakistan, India and Bangladesh highlights familiar themes of the dangers of exclusion or elite capture occurring in health and nutrition or related programmes (e.g. DiCaprio 2012; Green 2011; Resource Integration Centre 2015) as well as the fact that committee selection may be biased towards those members of the community already most engaged in similar activities (Mahmud 2007, 2009). However, other studies reveal that careful planning and consideration of community contexts – and paying careful attention to inclusion – can have positive results (Papp *et al.* 2013). The practitioner consultation highlighted similar issues with inclusion, recognising the need to listen to particular voices – especially (but not exclusively) women’s voices – whether via general mobilisation or specific and separate consultation with groups who are unlikely to otherwise be given a voice. The consultation also stressed the need to mobilise and sensitise communities around specific issues – something that resonates with the wider literature on the need to highlight the less visible and lower-profile community issues such as chronic undernutrition, for example (Gillespie, Haddad, Mannar, Menon and Nisbett 2013).

Collective action and coercion

The second set of considerations focus on **collective action and coercion**,¹⁴ by which we mean the actions of individuals and groups operating to demand, incentivise and coerce action from service providers. As already flagged here, it has long been a contention in the accountability literature that overly technocratic interventions tend to ignore, not only local politics, but also any potential for translating community voice, demands and action into wider change. People coming together collectively to demand action or rights has been associated with successful advocacy for better services – sometimes in

¹⁴ We apply the term ‘coercion’ to refer to the way in which the community might coerce provision from reluctant service providers. However, we note that the term has also been employed in the wider literature to refer to the way that communities might be coerced by higher status / more powerful state employees (McCoy *et al.* 2012: 450).

conjunction with, but at other times without the aid of, accountability initiatives (Gaventa and Barrett 2010). But there are also many other low-level instances of coercion between community members and service providers (including 'rude accountability', Hossain 2010), which may realise dividends in terms of provision of services, but which are not always preceded by larger scale collective action.

In the cases reviewed or noted within the consultation, collective action was highlighted sometimes as a deliberate result of the design of a particular SAI (e.g. Democracy Watch 2014) and sometimes as a result of community-level accountability activities that were able to leverage or 'piggyback' on existing collectives or rights-based movements. One useful example reveals how participation in collective action (e.g. Mahmud 2009) can be dependent on participants' backgrounds, with the types of collaborative dialogue described in this section an option for some, while 'noisy protest' is an alternative for those groups who feel less able to engage in constructive dialogue (whether due to social position and /or lack of education). Others, however, have noted that this inability to engage formally can still limit effectiveness (Thomas *et al.* 2003). The practitioner consultation confirmed this range of engagement options available and provided further examples of ways in which people might shout louder (e.g. *dharnas*) on the one hand, or pursue litigation on the other, in order to coerce a response. The consultation highlighted how choice of action might depend on both formal and informal styles or registers of communication but also whether the action aims to secure change at the local or national level. Participants highlighted the need for multi-level action or 'vertical integration' between actions at the various administrative levels of government, from village to district to state. The two extended case studies in section 4 (Right to Food in India and *Naripokkho* in Bangladesh) provide useful examples of community accountability joining with wider civic and legal action and national-level political movements to pursue effective change simultaneously at these multiple levels.

Cooperation, capacity and commitment

The third set of considerations is to do with **cooperation, capacity and commitment**. Successful interventions usually involve work on both sides of the supply and demand divide.

The capacity of community-based frontline workers to meet any 'demand-side' expectations that emerge from extant or interventionist accountability actions at the community level is also a factor that shapes outcomes. But the capacity and commitment of local political actors to 'forge and maintain synergistic relations with different social actors' (vom Hau 2012, cited in Bukonya *et al.* 2012: 47) is also relevant, as is the ability of individuals or particular community groups to shape these same interests around their own. The notion of commitment denotes the fact that service providers need to champion – or be prepared to respond to others' championing of – particular aspects of services that require improvement or have yet to be delivered at all (a frontline worker's duty to make home visits, for example). This follows other concerns in the wider literature stressing the need for broader state responsiveness (Fox 2015: 353; see also Joshi 2013b: s42–s43) and 'sandwich strategies' that place pincer pressure on such responsiveness from above and below (Fox 2015: 355–6).

We found many examples of the importance of bringing service providers into community mechanisms, including (for example) work cited from Bangladesh in terms of health centre and health provision monitoring (Barpanda *et al.* 2013; Johnston 2009; Mahmud 2007, 2009; Schurmann and Mahmud 2009); other examples involve mixed community–service provider committees (e.g. Green 2011); and several cited examples follow the community score approach, where this type of dialogue is a central part of the intervention philosophy. Likewise, in the cases cited by practitioners in the online consultation, deliberate involvement in accountability – rather than being a threat – has been part of the story of empowering frontline workers or lower-level functionaries to contribute to local movements for positive change. Online contributors highlighted cases where the presence of civil society was necessary to activate or harness more formal mechanisms, which had recently been built into government services. However, such institutionalisation of accountability has come with a loss of momentum, or of 'teeth' (Fox 2015), in a number of cases already described, highlighting the very real concerns about co-option, including by health professional elites such as doctors (Mahmud 2009, 2007).

Clientelism

The final set of considerations suggests that a reappraisal of **clientelism** or patronage is

in order in all the nuanced ways suggested by Box 2 and our preceding discussion. Clientelism therefore stands for all those further dimensions of interactions between existing community social relationships, agents of the state and political actors. This is not invoked to suggest a positive reappraisal of clientelism or patronage, but simply to imply that how these institutions function is critical to understanding how poor people and groups of poor people usually experience the everyday workings of the state prior to, during, and after the existence of an accountability intervention. We have seen here mentions of rent-seeking in clinical practice (Barpanda *et al.* 2013; Mahmud 2007, Thomas *et al.* 2003) which begin to hint at such practices and the limits to accountability actions; or 'co-option and collusion' between those parts of local political structures coming into contact with social audits (Lakha *et al.* 2015). Khan's reports of the everyday politics of local and central government operating behind the failure of a significant project in Pakistan are also salutary in this regard (Khan 2013).

Such references were fewer than we had expected. The wider health accountability literature we referenced earlier includes a revealing reference from Nepal, in which it is explained that, 'While on paper the service was argued to be about the provision of patient care, in practice the service was seen to exist to pay salaries to workers irrespective of whether any care was provided' (Cleary *et al.* 2013: 220; see also George 2009 for a further case in India). McCoy and colleagues provide several other examples 'of local politics affecting the functioning of Health Facility Committees, especially in relation to local politicians or elites asserting control over committees for

their own gain' (2012: 458, citing cases from La Forgia 1985 (Panama); Ramiro *et al.* 2001 (the Philippines) and Soahani 2005 (Kenya). Other references in the wider literature highlight how, in some cases, processes of democratisation and decentralisation or wider legal reforms have served as a more positive national background against which local politics are then shaped, with positive examples from Kerala (George *et al.* 2015b: 164, citing a number of references including Heller *et al.* 2007, Elamon *et al.* 2004) and Brazil (George *Ibid.* citing Cornwall 2008).¹⁵

5.1 A closing word

The fact that there were not more reports of such interaction of accountability approaches with real, messy, micro-politics may reflect the fact that some of the literature reviewed – particularly the grey literature – is written from a normative perspective advocating for greater accountability (see Gaventa and McGee 2013: s11), which may cloud reporting of failure and /or the messy everyday reality in which these cases occur.

For similar reasons, in this project we have struggled to meet our ambition of providing further and more nuanced accounts of how external interventions might interact with existing political structures in ways that are not always anticipated by the originators of accountability interventions (as in the case of classic development ethnographies, including Corbridge *et al.* 2015). In future, a more nuanced assessment will be important in gaining a greater understanding of the factors that determine whether accountability initiatives succeed, fail, have unintended consequences and /or are sustained beyond external intervention and momentum.

¹⁵ Though notably, the wider evidence in both the Indian and Brazilian contexts – when balancing the opportunities posed by wider political reform with extant local politics – is actually also rather mixed.

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About Making All Voices Count

Making All Voices Count is a programme working towards a world in which open, effective and participatory governance is the norm and not the exception. It focuses global attention on creative and cutting edge solutions to transform the relationship between citizens and their governments. The programme is inspired by and supports the goals of the Open Government Partnership.

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Research, Evidence and Learning component

The programme's Research, Evidence and Learning component, managed by IDS, contributes to improving performance and practice, and builds an evidence base in the field of citizen voice, government responsiveness, transparency and accountability (T&A) and technology for T&A (Tech4T&A).

Web www.makingallvoicescount.org

Email info@makingallvoicescount.org

Twitter [@allvoicescount](https://twitter.com/allvoicescount)

About Transform Nutrition

Transform Nutrition is a consortium of five international research and development partners funded by the UK Department for International Development. Its aim is to transform how people think about nutrition and how they act to improve it in South Asia and sub-Saharan Africa – the two regions with the highest burden of undernutrition. We aim to help stakeholders in the most-affected countries – policy-makers, civil society and business leaders – to use quality research to address undernutrition. For more information see www.transformnutrition.org

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