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Legal Empowerment and Social Accountability: Complementary Strategies Toward Rights-based Development in Health?

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Summary. — Citizen-based accountability strategies to improve the lives of the poor and marginalized groups are increasingly being used in efforts to improve basic public services. The latest thinking suggests that broader, multi-pronged, multi-level, strategic approaches that may overcome the limitations of narrow, localized successes, hold more promise. This paper examines the challenges and opportunities, in theory and practice, posed by the integration of two such citizen-based accountability strategies—social accountability and legal empowerment. It traces the foundations of each of these approaches to highlight the potential benefits of integration. Consequently it examines whether these benefits have been realized in practice, by drawing upon five cases of organizations pursuing integration of social accountability and legal empowerment for health accountability in Macedonia, Guatemala, Uganda, and India. The cases highlight that while integration offers some promise in advancing the cause of social change, it also poses challenges for organizations in terms of strategies they pursue.

Key words — accountability, legal empowerment, health, rights-based approaches, service delivery, governance

1. INTRODUCTION

Recent debates about transparency, accountability, and responsiveness of governments to citizens have been focusing on ways in which citizen-led accountability strategies can work to improve services for the poor and marginalized. Early reviews of existing evidence on the success of citizen-led accountability were mixed: similar approaches in different settings seemed to sometimes be successful and at other times not (Gaventa & McGee, 2013; Joshi, 2013a). Contextual conditions clearly mattered—and several reviews pointed to the limited generalizations that could be made from existing studies (Lodenstein, Dieleman, Gerretsen, & Broerse, 2013). More recently, a rethink of the evidence suggests that a more systemic perspective is needed, that goes beyond narrow tool-based, "tactical" approaches to broader, multi-pronged, multi-level, "strategic" approaches (Fox, 2015; Halloran, 2015). The rationale for this is clear: public accountability failures are not accidental—they occur due to embedded power structures and political dynamics that are systemically anti-accountability. To address these, "countervailing power" is required: rooted in pro-accountability coalitions that cut across states and social groups; that bridge different levels; and that integrate efforts across several domains.

While there is now some agreement about the need, there is little documentation about how such integrated approaches might operate in practice. What are the drivers of multi-pronged, multi-level strategies? What are the practical and conceptual issues they raise for civil society organizations and social movements that adopt them? What prongs appear to be key, and why? What challenges and opportunities do they pose? When do they work and how? Do the different approaches reinforce each other, if so, under what conditions?

This paper seeks to answer one piece of the puzzle of understanding multi-pronged approaches—by a close examination of the combination of two specific "prongs" that can work across levels—the combination of social accountability (SA) and legal empowerment (LE) approaches. The two approaches have much in common—a strategy of awareness-raising and mobilization, an orientation toward state-granted rights, and a concern with improving services, creating active citizens, and establishing sustainable changes in governance structures. A number of organizations are employing the strategies implicit in these approaches to shape their ongoing work. There is now a nascent literature that aims to assess and understand the relevance of these approaches, albeit separately (Fox, 2015; Goodwin & Maru, 2014). More recently, a small number of organizations are explicitly combining these approaches in an attempt to increase the scale and traction of their work (Open Society Foundation [OSF], 2014). As an exemplar of the recent interest in multi-level, multi-pronged approaches, these recent and relatively few experiences of integration of SA and LE require a closer examination. With this task in mind, this paper aims to build our understandings of how

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these two approaches relate to one another—in what ways are they complementary and where are the challenges? When does the combination lead to one approach bolstering the other?

The task is approached here through two distinct starting points. On the one hand, I trace the theoretical roots of both SA and LE, specifically to unpack areas of commonality and difference. On the other hand, I analyze the evolution and strategies of organizations that are attempting to implement these approaches on the ground, to understand what challenges and opportunities the combination offers in specific contexts. Thus, the paper attempts to combine thinking about the conceptualization, evolution, practice of the integration of SA and LE approaches with empirical evidence from the field. Further, while the ideas presented in this paper are broadly applicable to a range of public goods, the focus of this paper is healthcare. The advantages of such a focus are twofold: it allows us to ground the discussion in the specific characteristics of a sector; and it also allows us to draw on the areas where experimentation has been the most prolific.

The empirical evidence underpinning the paper comes mainly from five organizations in four countries that are among the very small number of organizations using a hybrid approach—Association for Emancipation, Solidarity and Equality of Women (ESE) and Health Education and Research Organization (HERA) in Macedonia; Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud (CEGSS) in Guatemala; Center for Health Human Rights and Development (CEHURD) in Uganda; and Nazdeek in India.[1] The author visited all the organizations (with the exception of Nazdeek), reviewed written documentation, interviewed staff, government officials, and personnel from other relevant organizations, and conducted field visits in country. This was not by any means an evaluation of the work of these organizations—rather it aimed to explore the process of integration and raise some key issues that are relevant to understanding how two particular prongs of a multipronged approach might work in tandem.

The paper is structured as follows. The second section, which follows this introduction, lays out the evolution, conceptual underpinnings, and core features of each of these approaches. In the third section, I take up the issue of integration, showing the commonalities and challenges of SA and LE and highlight potential synergies and expectations. The fourth section then shifts focus to look at the empirical evidence, and briefly describes the work of the five organizations that are implementing an integrated strategy. This sets the stage for highlighting some of the key issues that emerge from a review of the experience, which are laid out in the fifth section. In the sixth and final section, I conclude with some observations on what such an integrated approach might mean for both theory and practice.

Before proceeding however, it is essential to clarify terminology: what is meant in this paper by "integrated" approaches?[2] By integrated approaches, I mean integration in two dimensions: approaches that could involve vertical integration—strategies that link efforts across local, subnational, national, or international levels (Fox, Montero, & Aceron, 2016); as well as being multi-pronged in the sense of simultaneously coordinating across different spheres of action—community mobilization, litigation, media work, political advocacy, etc. Clearly initiatives combining SA and LE are integrated in the sense of being multi-pronged as they use legal systems as well as mobilization. It is important to note however, that not all such SA and LE initiatives are necessarily multi-level. In fact, the cases reported here are unusual in that they represent integration in both dimensions.

2. EVOLUTION OF THE APPROACHES

The past two decades have seen the rise of SA and LE approaches independently as a means of improving governance and achieving developmental outcomes (Joshi & Abdikeeva, 2014).[3] Both SA and LE have huge definitional ambiguities—and have been used in a variety of ways. Occasionally social accountability is viewed as a part of, or blending into a world of legal empowerment approaches (Golub, 2010; Goodwin, 2014). Sometimes it is the reverse, legal empowerment is viewed as one of the strategies of grievance redress within social accountability approaches (Peruzotti & Smulovitz, 2006). To set the stage, I discuss where these approaches are coming from, their key features, and their expected impacts (Table 1).

(a) *Social accountability*

The term "social accountability" came into use in the early 2000s to refer to citizen-led processes that demanded accountability from governments outside of formal electoral systems.[4] The term itself appears to have two different origins. One strand, led by international donors attempted to conceptualize and label emerging approaches to improving services and empowering citizens through organic structured bottom-up accountability demands (Malena, Forster, & Singh, 2004). A second strand of analysis came from observations of citizen protests against the lack of political accountability in Latin America (Mainwaring & Welna, 2003; Peruzotti & Smulovitz, 2006). Initially termed "societal accountability" by scholars, these efforts were redefining the relationship between citizens and the state (Peruzotti & Smulovitz, 2006).

By the late 2000s, these two strands had merged in the discourse.[5] The World Development Report of 2004, identified lack of accountability as a key reason for failures of public services, and suggested direct accountability relationships between providers and citizens (World Bank, 2004).[6] Overwhelmingly, the focus of SA practice shifted to non-confrontational "widgets" such as community scorecards, rather than organic political processes of community deliberation, mobilization and action (Joshi & Houtzager, 2012). In this paper I use SA ideally to mean citizens efforts at ongoing meaningful collective engagement with public institutions for accountability in the provision of public goods, rather than projectized, superficial tools that mainly attempt to close the feedback loop.

At the heart of this broader idealistic definition of social accountability there are common elements. First, although social accountability initiatives can originate in state or social action, they require an active citizenry, which is informed, mobilized, and ready to engage with public institutions. Second, the processes of social accountability incorporate both collaborative and confrontational strategies—from deliberation and problem solving around accountability, to protest and naming and shaming (Fung & Kosack, 2014). Third, although focused specifically on accountability, policy advocacy is also a part of social accountability strategies. Fourth, social accountability approaches draw on both formal institutions of engagement and grievance redress to work, but also on informal institutions such as reputational costs and social embeddedness. Finally, social accountability mechanisms do not focus on individual grievances, but aim to fix collective problems faced by communities through collective action.

Recent research on social accountability has increasingly focused on issues of outcomes, and the expectations have been quite wide-ranging (Grandvionnet, Aslam, & Raha, 2015;

Table 1. *Integration of SA and LE—synergies and challenges*

Element	SA	LE	SA and LE integration	
			Synergies	Challenges
Awareness Raising	Legal rights and processes, existing service levels	Legal rights and processes, rights violations, grievance redress processes	Similar work, efficiencies	Confusion regarding roles
Mobilization	Active mobilization intermediaries	Active mobilization paralegals	Mobilization easier with successful LE cases	Credibility of intermediaries
Alliance Building	Whole community, around public goods using collaborative strategies	Sections of community around individual violations, using confrontational strategies	Homogenous groups and common concerns make alliances easier	Social cleavages can constrain alliance building especially if exclusion is socially based
Media	Aggregate numbers can impose political and reputational costs	Individual narratives of rights violations can lead to formal sanctions	Combination of narratives with aggregate statistics	Focus only on marginalized groups could lead to lack of publicity
Community Monitoring	Systemic problems highlighted	Violations of individual rights	Combination of systemic problems with individual rights violations can show patterns across communities	Different kinds of capacities needed
Litigation	Collective, public interest litigation	Strategic, precedence setting litigation	Broader systemic changes possible	Time and resource consuming, diverts from other activities
Grievance Redress	Local, collective	Individual case support	Potential for success higher as legal and administrative remedies sought explicitly	Lack of success can lead to the use of 'exit' options as well as demoralization
Intermediaries	Mobilizers and facilitators	Mobilizers and paralegals	Same staff could do both kinds of work	Different skill sets required
Policy Advocacy	Focused on upstream policy changes for services	Focused on additional legal structural obstacles	Easier than legal reforms	Policy changes might miss concerns of marginalized groups
Documentation	Systematic collective data	Individual cases	Robust evidence through aggregation	Resources are required for both kinds of documentation

Joshi, 2014). As one recent paper put it, "expected results of social accountability include a reduction in corruption, better governance and policy design, enhanced voice, empowerment and citizenship of marginalized groups, responsiveness of service providers and policy makers to citizens demands and ultimately the achievement of rights, health and developmental outcomes" (Lodenstein *et al.*, 2013). These outcomes are expected to unfold from immediate short-term improvements in public services, to more durable long-term changes in states and societies.

Studies of actual impacts of social accountability interventions are now quite advanced, although assessment tends to be dominated by quantitative studies and assessment of more immediate instrumental outcomes such as improvements in services (Gaventa, 2013; Lynch *et al.*, 2013; Westhorp *et al.*, 2013). A meta-analysis of the impact of community-monitoring initiatives (including information campaigns, community scorecards/citizen report cards, social audits, and grievance redress mechanisms) included 10 completed evaluations and found that they had a positive and significant effect on outcomes such as test scores and health status improvements as well as perceived satisfaction with the program (Molina, Pacheco, Gasparini, Cruces, & Ruis, 2013). This systematic review and other research points to the importance of intermediaries facilitating citizen participation (Barr, Mugisha, Serneels, & Zeitlin, 2012). In his evidence review, Fox (2015) show that community monitoring from below by itself is not enough. Citizen action needs to be combined with other accountability mechanisms, to have the desired effects. [7] Overall the evidence shows that success in SA has been limited, local, and not always sustainable, largely due to the prevalence of tool based, apolitical, and decontextualized approaches over strategic ones.

(b) *Legal empowerment*

Legal empowerment has evolved in recent years as a reaction against the perceived limitations of the "rule of law" approaches that sought to reform state institutions and make justice more accessible through legal aid-type strategies that subsidized the costs of litigation, without challenging its basic premises. The legal empowerment approach recognizes "law as a source of economic, social, and political power" (Nielsen, 2013: 112). Consequently, the road to making justice real for the marginalized has to involve confronting power—and empowering people with information about their legal rights and available avenues to seek justice for rights violations, with the help of legal intermediaries, especially *vis-à-vis* the state (Robb-Jackson, 2013). [8]

Along with its growing popularity, legal empowerment, like social accountability, has been used in a variety of different ways. [9] It overlaps with approaches such as legal services for the poor, public interest law, alternative lawyering, developmental lawyering, social justice, access to justice, and social accountability (Golub, 2010). Legal empowerment aims to overcome the limitations of the earlier generation of legal aid: namely a shortage of lawyers, limited resources, and the prevalence of pluralistic legal systems. A most basic definition that has received some consensus is, "the use of rights and laws, specifically to increase disadvantaged populations' control over their lives" (Golub, 2013: 5). The idea was to transfer power from the usual gatekeepers of the law—lawyers, judges,

police, and state officials to ordinary people, with the help of trained community-based paralegals, and thus make law meaningful for people's lives (Joshi, 2014). As one recent paper noted, legal empowerment enables social justice by "opening new avenues for advocacy and action; providing concrete mechanisms for remedial action and redress for rights violations; and setting precedence and standards that can subsequently be reflected in laws, policies and practices, thus offering opportunities for replication and scale" (OSF, 2014). Legal empowerment approaches usually rely on five categories of tools: legal awareness raising, legal service provision, dispute resolution, law reform initiatives, and litigation. In this paper, I use legal empowerment to mean approaches that use at least the first three of these tools with the help of paralegals with a view toward achieving social justice. Strategic litigation is included only to the extent that the litigated cases arise directly from the grassroots mobilization work.

Five principles seem to characterize legal empowerment approaches (Maru, 2010).[10] First, they attempt to demonstrate that even in environments marked by unfairness and arbitrariness, justice is possible. Here justice is viewed not simply *vis-à-vis* the state, but also in relation to intra community disputes, traditional authorities, and between citizens and private firms. In fact, more recently, those working within the legal empowerment frame have moved away from formal litigation, to working with people to access services by understanding the administrative rules and procedures that offer them rights (Maru & Moy, 2013). Second, grassroots-based legal empowerment approaches may be used in combination with strategic litigation and high-level advocacy thus bridging different levels. Third, they offer a pragmatic approach to plural legal systems focusing on respect for traditional institutions, seeking solutions that combine the positive aspects of both. Fourth, legal empowerment is a step forward from the limitations of legal aid—that tended to treat people mainly as clients—toward strengthening people's own agency. Finally, (although somewhat less emphasized) legal empowerment focuses both on rights of people, but equally on their responsibilities as citizens.

In the field of legal empowerment too, expected outcomes are quite diverse. For marginalized groups, legal empowerment strategies are expected to tackle three key problems: (a) lack of awareness among groups about their rights, (b) structural problems such as legal provisions that constrain access, or lack of official identity papers and documentation proving entitlements, and (c) redress in individual cases of rights violations (Gauri, 2013). Thus expected outcomes are also located within these realms, empowering people to confirm and extend their rights, reducing rights violations on an everyday basis, enhancing accountability, improving service access, and removing structural barriers through improved laws and policies (Domingo & O'Neil, 2014). Improved health outcomes are an important part of the expected impacts, with many legal empowerment strategies looking at other types of rights violations that impact health.

Legal empowerment has lagged behind social accountability in terms of assessing impact and there are few relevant documented studies.[11] An exception is the pioneering impact assessment of the Initiative on Legal Advocacy for Roma Health Rights launched by LAHI and RHP which started with a baseline study (OSF, 2010), with a follow up assessment expected later this year. In the absence of official data for quantitative analysis, an innovative qualitative assessment methodology was developed (Abdikeeva, 2013; Abdikeeva, Ezer, & Covaci, 2013).[12] In addition, a recent systematic assessment of legal empowerment interventions examining 199 studies concludes that there is "substantial evidence on the impact of legal empowerment interventions" (Goodwin, 2014).[13] The most commonly reported impact was an increase in the agency of participants. The authors also point to evidence of behavior changes on the part of governments and other institutions; this was anecdotal evidence of respect, attempts to improve responsiveness, etc. based on observations. However, the study used very broad definitions of impact—from increases in legal knowledge, agency, ability to gain remedies, contributions to dignity, and social inclusion, to governance outcomes including reduced corruption, improved public services and institutional changes. The study concludes that while LE approaches have had positive impacts in many of these fields, these are still nascent findings and much more research is needed particularly on the work of paralegals, long-term impacts of LE on individuals and the community, and the links of LE approaches with the work of ombudsman institutions, human rights commissions, etc.

3. THE INTEGRATED APPROACH

The two approaches detailed above have much in common. Both start from the perspective that communities need to be empowered to be able to tackle failures of the state in protecting and promoting their rights. Such empowerment includes raising awareness about their rights (or what they ought to expect in terms of health services), mobilizing communities to act in monitoring instances of breaches of these rights, and following up in terms of demanding better performance from state officials. Both approaches see bureaucratic institutions, and related rules and regulations, as the first port of call in attempting to remedy failures and increasingly much like social accountability, legal empowerment works closely with the administrative state. Both approaches seek to invest in ongoing and long-term processes of the creation of more "active citizens", rather than just tackling specific instances of poor services. In fact, the objectives of both approaches go beyond the narrow instrumental ones of improving services, to deepening democracy and developing environments of accountability and legitimacy where LE and SA processes are only fully used on rare occasions.

Yet, legal empowerment contrasts with social accountability on several counts (Maru, 2010). First, legal empowerment is concerned primarily with situations where there have been violations of rights or where laws and policies can be used in order to ensure access to rights and services (for individuals or communities); social accountability on the other hand is concerned with a broader range of issues that affect service delivery such as resource distribution/shortages, governance, etc. Thus, while redress and justice is at the heart of legal empowerment approaches, it is the weakest part of social accountability, which for the most part lacks "teeth." Grievance redress has been inadequately addressed and not closely tied to other parts of social accountability such as transparency or mobilization. By contrast, legal empowerment professionals "specialize in squeezing justice out of dysfunctional systems" (Maru, 2010: 88). Legal empowerment approaches are strong, in using legal frameworks as a basis for action and in sometimes setting precedents or combining with strategic litigation to attain systemic change, which is not a route that traditionally SA has taken. Second, legal empowerment approaches (drawing on their legal aid roots) enable remedies in both individual cases and occasionally collective action if collective rights are breached, as opposed to the largely collective social processes with which social accountability works,

which might go beyond rights violations in the narrow sense. Thus, one part of legal empowerment work is reactive, having to wait till aggrieved clients are willing to take on unresponsive administrative and legal systems. Social accountability does not depend upon aggrieved individuals to initiate action—widespread dissatisfaction (or external activation) can result in collective action. Finally, and following from the last point, legal empowerment is better at directly addressing social inclusion as it tends to focus on the most marginalized in the system, ensuring that their rights are upheld. By contrast, social accountability work assumes that because such approaches are usually implemented in disadvantaged geographic areas or communities, they address the needs of the marginalized, without actually addressing questions of diversity within communities. This issue of social inclusion (both in terms of process as well as outcomes) is one of the weakest aspects of social accountability (Joshi, 2013a, 2013b).

Thus, despite having much common ground, SA and LE "run up" against each other as the limitations of one approach seems to be complemented by the other. LE—while trying to keep track of patterns in rights violations that are often systemic deficiencies in provision mechanisms—does not always focus on the underlying issues of governance that causes those systemic deficiencies. Social accountability faces challenges in sustaining and scaling up successes achieved at local levels. Together they offer opportunities to improve transparency accountability and inclusion, but as we see below, there are also challenges that they pose. Critically, a combined approach has potential to address structural challenges that limit the possibilities of each approach individually.

4. SA AND LE INTEGRATION—EXPERIENCES FROM THE FIELD

Given the conceptual underpinnings outlined above, and the potential for synergies, the question is: how is the integration working on the ground? Since the early 2000s, several organizations have been supporting SA and LE work by working with grassroots groups to grantees in different countries. [14] More recently, there has been a realization that there is a lot of overlap of this work, and some organizations are already combining elements of these two approaches (Abdikeeva, 2016; Feinglass, Gomes, & Maru, 2016). In this section, I review five organizations that have operationalized integration and provide thumbnail descriptions with particular attention paid to "turning points" that drove integration, and the strategies organizations adopted.

(a) Guatemala: Centro de Estudios para la Equidad y Gobernanza en los Sistemas de Salud (CEGSS)

CEGSS was started informally in 2006 as a group of young health professionals intending to use participatory monitoring approaches to improve the healthcare of the indigenous population in rural municipalities in Guatemala. Years of armed conflict and a history of discrimination against the indigenous population had created an atmosphere in which people did not trust health providers. The result was that indigenous groups faced a lack of access to healthcare, disrespect and abuse, and poor health outcomes despite the constitutional framework assuring a free and universal right to healthcare for all citizens (Flores, 2014). Despite the progressive constitution, even at present there is no clear overarching national vision for health, and health policy has depended upon the preferences of the specific Minister holding the post. Since the return of democracy in 1983, not a single Minister of Health has lasted the full four-year term; the most recent government had four different ministers of health.

Details of the specificities of the CEGSS approach have been elaborated elsewhere (Abdikeeva, 2016; Flores, 2014; CEGSS 2014). Here I recount several key turning points, which led CEGSS to incorporate legal empowerment in its work. [15] First, initially CEGSS aimed at working with both communities as well as municipal authorities with the intention of encouraging engagement between them, and the earliest attempts were to work in ten municipalities whose officials had expressed interest in trying out this new approach to improving healthcare in their communities. However, it soon became clear that dialog on an equal footing would be impossible given the level of disempowerment of communities. This led to a decision to mainly work with communities on awareness raising, empowerment, and capacity building for monitoring and advocacy so that they could themselves engage with health care providers. Second, to begin an assessment of available services at community level, CEGSS had started with the standard approach to community monitoring by collecting information from facilities through surveys and presenting it to public health care officials in reports and policy briefs which highlighted the severe problems with the quality of health care. It soon became clear to leadership within CEGSS that such reports, while useful to quantify the scale of the problem, did not have much traction as government officials rejected the findings on grounds of methodology or inadequate data. In an attempt to address government's critique, CEGSS extended the survey tool and expanded the number of facilities being surveyed. Despite this, authorities still rejected the findings. Moreover, the data collection tool had become too cumbersome and demanded a lot more time from community volunteers. As a result, CEGSS implemented two major changes: (a) reducing the survey tool to a simple one that focused on the services that were largely of interest to the communities (e.g., a few key medicines, appointments, presence of staff as per entitlements, availability of ambulances etc.) and (b) gathering narratives: cases where denial of health care had resulted in serious consequences, particularly death or permanent damage. Third, the obvious next step for CEGSS was to take these cases of rights violations in health through the formal grievance and legal processes available. To do this, community mobilizers (called community health defenders) were trained to lead collective deliberation, prepare detailed documentation of the cases, and CEGSS helped take these cases to the four specialized authorities that deal with human rights violations—the CODISRA (dealing with discrimination); "Defensoría de la Mujer Indígena" (DEMI) which deals with the rights of indigenous women; the Presidential Commission for Human Rights (Comisión Presidencial de Derechos Humanos-COPREDEH), which generally deals with human rights violations; and the Ombudsman's office. Finally, over time, as the work spread, the number of cases that were brought up increased—and CEGSS evolved an innovative SMS platform to gather, record, and follow up on health-related human rights violations. People bring their complaints to the community health defenders, who act as a filter for inputting complaints into the SMS system. The platform achieves several things: its geographic markers enable one to identify the locations where the majority of complaints are recorded, enabling the aggrieved to complain without making them vulnerable, enabling staff to separate the complaints received into those that can be dealt with locally through addressing the administration versus those that need to be pursued legally, and taking up the most grave cases to

national human rights bodies for redress. They have also collected data which, when analyzed, can reveal patterns of state responsiveness. As a strategy then, CEGSS had turned the community health defenders into paralegals, in effect, using a SA- and LE-integrated approach. Despite this integration, there have been limited (largely localized) responses to CEGSS—a result that can be explained partly by the overall unfavorable political climate in Guatemala.

(b) *Uganda: Center for health human rights and Development (CEHURD)*

Founded in 2007, CEHURD is an indigenous, nonprofit, research, and advocacy organization aimed at the enforcement of human rights and the justiciability of the right to health in Eastern Africa.[16] Started by a group of recent law graduates, the organization is well known among health rights advocates for its success in calling the government to account for poor maternal health services within government health facilities through its leadership of Constitutional Petition 16 of 2011.[17]

The case draws upon the "The National Objectives and Directives of State Policy" within the constitution of 1995, as well as other progressive articles relating to women's rights given the natural maternal functional roles they play in society. The Ugandan Constitution lacks a substantive provision on the right to health. Consequently, the case cites regional and international instruments which the state has ratified and whose implementation is deficient. Based on these provisions and Directives, Petition 16 claims that the "non-provision of basic indispensable maternal health commodities in government health facilities and the imprudent and unethical behavior of health workers towards expectant mothers are inconsistent with the constitution and a violation of the right to health" (CEHURD, 2011: 34).

The case brought together a coalition of over 40 civil society- and community-based organizations working in the area of health and human rights. The Coalition (Coalition to Stop Maternal Mortality in Uganda) enabled scaled up advocacy for maternal health, massive community mobilization, media reporting on maternal health, attendance at court hearings, and peaceful demonstrations especially when the Court dragged its feet.[18] The case, recently ruled upon by the Supreme Court, overturns a ruling by the Constitutional court that claimed it had no mandate to hear the case (Kavuma, 2015). Activists note that the decision offers a landmark for jurisprudence on the right to health in Uganda.[19] Overall, at present the government is sensitive to CEHURD's work due to its potential legal "clout".

The initial instinct of CEHURD was to "view every issue through a legal lens" and attempt improvements through litigation. However, Petition 16, litigation had limited success in terms of forcing the government to accept health as a right or improving maternal care in hospitals.[20] Consequently, CEHURD made several strategic shifts. First, it tried lobbying parliamentarians as an alternative strategy to get policy reform through. Indeed the Parliament picked up this idea, and in 2012 passed a strong maternal health resolution with specific requests directed to the state aimed at improving maternal health in the country.[21] Although this appeared to be a success, implementation lagged behind. CEHURD has now limited its work with parliament to monitoring of the health budget and building its capacities in human rights-based approaches to maternal health. Subsequently, CEHURD realized that their initial approach—to work mainly at the national level—had to be reoriented.[22] It was not enough to simply carry out high-level advocacy, there was a "need to get the community voices" into the debates.[23] As a result, five years ago, CEHURD's community empowerment program started with support from OSF, in three districts, training community health advocates (CHAs) to "bridge the gap between duty bearers and rights holders."[24] The CHAs have since become an intermediary between national–local advocacy and community-led advocacy. They feed the national advocacy team with first-hand information, as well as strengthening communities to demand their rights. The community empowerment started by working with existing community structures and followed the classic social accountability traditions—awareness raising, mobilization, monitoring, and engagement with health providers. Second, it was clear that the new orientation required new skills and alliances. CEHURD therefore expanded its team to 20, incorporating new skills by including social scientists, evaluators, and media experts among others. From being a team of lawyers they are now a mix of disciplinary backgrounds, while keeping a strong legal focus. Third, the broader range of work also required new coalitions—working with the media, with parliamentarians, and other civil society organizations as well as local governments. From a starting point of litigating for health rights, CEHURD is now working through an integrated approach of strategic litigation, community empowerment and research, documentation, and advocacy.

(c) *Macedonia: Association for Emancipation, Solidarity and Equality of women (ESE) with Kham, Roma resource Center (RRC) and CDRIM; and health education and research organization (HERA)*

Access to healthcare in Macedonia is a significant issue for the Roma population, which represents a relatively marginalized and discriminated minority community. On average the health status of the Roma is worse than the rest of the population, mainly due to discrimination and exclusion, lack of access to health care and poor social determinants of health. Although the Constitution guarantees universal rights to healthcare, this is mainly through the Health Insurance Fund. The Roma have difficulties accessing health care often due to lack of documentation, lack of resources to pay for services and medicines and also because of distance and lack of transportation.

ESE's main focus is as an advocacy organization that also provides technical assistance to other civil society organizations. It has been implementing a legal assistance program with local partners since 2011 in the municipalities of Delchevo and Shuto Orizari. The paralegal work was initiated through consultation and close collaboration with communities. Besides awareness raising and case documentation, paralegals also advocate patient rights with health care professionals. ESE's social accountability work has mainly centered on budget monitoring and community monitoring, through community empowerment, education and awareness raising, conducting community information gathering, community-led advocacy, and presentation of community score cards, both at local and national levels. Since gaining some experience, it is in the process of merging both work streams in an effort to better leverage the virtues of each approach. ESE's national-level accountability efforts on budget monitoring initially faced problems as it was difficult to get official data from the health institutions; and even when the data were obtained, it was of poor quality and often contradictory between time periods or institutions. Because of this, it was difficult to assess the extent of real program implementation on the ground. It was the paralegal work along with

the community monitoring that enabled ESE to highlight the mismatch with ground reality in its advocacy efforts. The government response has been more promising at the local level than the national level—with better treatment of Roma communities at the local health centers, but without the major reforms of the overall systems.

The other organization, HERA, is a sexual health and reproductive rights organization and had been implementing both social accountability, through community scorecards (started in 2013) and legal empowerment approaches (started in 2012) in the same communities, but as separate projects. The social accountability work was geared to monitoring the delivery of antenatal health and gynecological services to women (particularly Roma communities). Under legal empowerment, HERA was helping provide legal assistance around reproductive rights through community paralegals. Prior to integration, community monitors from the social accountability work were identifying cases of rights violations but initially referred to the paralegals and lawyers. HERA's process of integration therefore involved literally training the same people to be skilled in community-monitoring strategies as well as legal empowerment work at the grassroots. The overall strategy is to "bombard" relevant health institutions through different channels (legal cases and community monitoring as well as media), thus creating multiple accountability pressures. The institutional response to this onslaught has been mixed—while authorities have given in and improved access to maternal health in Shuto Orizari, these have been one off measures, leaving the larger systemic problems untouched.

(d) *India: Nazdeek*

Founded in 2012, Nazdeek is a legal capacity building organization that works with communities, activists, and lawyers to seek justice for human rights violations in India (Feruglio, 2015). Using a legal empowerment approach, a part of its work is focused on the delivery of basic services, in particular maternal and infant healthcare, housing, and food. Its maternal health work is based in one of the north east states of India, Assam, which has some of the highest infant and maternal mortality rates in the country. Nazdeek operates at the national level in legal advocacy and reforms, while working with grassroots groups on SA and LE.

Although India has enacted policies and programs aimed at improving women's health, these are often poorly implemented. The main health scheme is the National Rural Health Mission launched in 2005, which aims to put in place a structure of health care for all—with basic entitlements such as free medical checkups, supplementary nutrition, and post delivery cash-benefits clearly defined.

Nazdeek initially explored maternal and infant health issues and later expanded their work to include labor rights, based on priorities of local groups and workers. The strategy of combining approaches seems to have evolved through an organic process.[25] The most marginalized women in Assam were the tea workers, who depend upon tea plantations for all their needs. Tea plantations were not fulfilling their obligations to provide adequate and free healthcare required under both the national Plantation Labor Act and state government MoUs with specific plantations. At the same time, even with some awareness of rights, it was difficult for tea workers to raise voices against their employers. In 2014, Nazdeek partnered with a local organization in Assam (PAJHRA)[26] to start a pilot, "End Maternal Mortality Now" which comprised of a mobile text-based community-reporting platform to document failures of maternal healthcare in the plantations. PAJHRA had already been using social accountability elements such as awareness raising, collective deliberation, and community mobilizing among the *adivasi* (tribal minority) population. Nazdeek brought expertise in the law and legal empowerment approaches. Around 30 paralegals were trained to identify and report violations via SMS. Together the crowd-sourcing approach to documenting cases enabled an integration of SA and LE by simultaneously enabling broader data collection as well as follow-up involving detailed documentation of particularly serious cases of rights violations. Several complaints have been filed by the aggrieved with the help of PAJHA, using grievance redress mechanisms, and advocacy with local health authorities using accumulated documentation appears to have led to some results. The data provided through this platform will also be used to support a case filed earlier in the state High Court about a preventable maternal death.[27] Since this early work there have been two strategic shifts in Nazdeek's work—first, expanding the work from maternal mortality to issues of labor and wages, and second, going beyond the initial geographic area covered by PAJHRA to working with other organizations and directly with communities.

5. SA AND LE INTEGRATION—ISSUES AND THEMES

The brief description of experiences of organizations in these four countries clearly shows the synergies between the two approaches. On the one hand, legal empowerment can "enhance social accountability interventions by opening new avenues for advocacy and action, providing concrete mechanisms for redress for rights violations" (OSF, 2014: 2). In addition, strategic litigation arising from grassroots LE work can be precedent setting, and lead to strengthening of the legal and policy framework. On the other hand, social accountability can "enhance legal empowerment approaches by focusing on system problems in service delivery including resource distribution; providing mechanisms for community participation in the initiation, development and implementation of policies; promoting identification of patterns in human rights violations in health care settings; and highlighting state failures in the realm of socio economic rights" (OSF, 2014: 2). Social accountability also relies on collective deliberation thus building shared understandings of problems.

The experiences in combining issues raise several issues relating to challenges or opportunities. The issues outlined below are not particular to only SA or LE, but relevant to the broader field of governance, transparency, and accountability and the potential of integrated approaches.

(a) *Impacts of the combined approach*

Although the integrated approach applied by the organizations described above appears to have had some success (and perhaps more than organizations using a single-pronged strategy), the successes have been limited.[28] Organizations recognize that the reason for this limited success relates to the structural roots of the problems with the health system. These are beyond the capacities of small organizations, and require broader alliances with other organizations at the national and international levels.

What has been successful almost universally in these efforts is a perceptible rise in awareness and confidence of the communities, and empowerment of the trained community paralegals. In Guatemala, the author witnessed community health defenders confronting health officials in a public meeting in a manner that was unexpected, given the decades of oppres-

sion of indigenous groups. In Macedonia, Roma communities are more aware of their rights, and better able to seek services and demand accountability with the support of ESE and HERA. In Uganda, CEHURD-supported communities are documenting cases of denial of services, or neglect, in a manner that could be used in strategic litigation if required. Particularly in contexts where communities had little belief in their own efficacy, or little trust in government institutions, or suffered from "mobilization fatigue" as the case of Uganda, the combination of SA and LE seems to have contributed in a small part to restoring trust, by providing some immediate relief, as well as attempting to tackle the systemic roots of the problems. These efforts, with some exceptions are inevitably organization led, and the question of the sustainability of such empowerment, if the organizations leave is an open one.

In terms of health service outcomes, CEGSS was able to help some communities get improvements at the local level—e.g., ambulance services, access to free medicines, and a new health service facility in the municipality of San Marcos in the Province of Solola. San Marco's success is partly due to the fact that it is relatively stable (less conflict and social polarization) community, with a group of very active and experienced community defenders that have been effective in influencing the allocation of municipal resources. A progressive mayor combined with an empowered community has played a significant part in San Marco's achievements. Similarly, HERA was able to ensure that the services of a gynecologist were provided (albeit part time) in the Roma municipality of Shuto Orizari. In Uganda, CEHURD revived formerly defunct, community-led Health Unit Management Committees, enabling effective oversight over Health Centers.

Work on the litigation front has had some success. CEHURD has been able to get compensation for victims in a few cases, and the recent decision on Petition 16 opens the door for more cases on the right to health.[29] CEGSS reports that despite documentation of several cases, they have not been able to push the prosecution of a single human rights violation case—due to reluctance of petitioners to appear in court, the lack of adequate documentation, and overloaded case-loads of the relevant human rights organizations. ESE has helped with over 100 cases on health rights violations and its own assessment suggests that over 70% of the clients are satisfied with the legal assistance they received.

Policy changes have been harder to achieve. While all the organizations reviewed here had achieved some changes to processes at the local levels, national-level achievements were still a distant goal, despite using an integrated approach. What this suggests is that additional "prongs" need to be strengthened (e.g., working with legislators, the media, international human rights organizations). Most organizations are doing this to some extent, but without strong support, such engagement is difficult to sustain. The extent to which these other relevant stakeholders are receptive to such engagement of course depends upon the country context.

Albeit limited, these early successes have strong mobilizational effects. Nazdeek found (not surprisingly) that it was easier to mobilize communities for SA when LE was in place and had delivered concrete results in terms of grievance redress. On the other hand strong SA activity in terms of success in community demands (as in the case of a few municipalities in Guatemala) can help build confidence in individuals to overcome the "fear factor" and be prepared to press charges for a rights violation.

What we noticed (but not yet systematically documented) is that the combination of community mobilization and monitoring through SA, and legal rights awareness and litigation through LE has created an atmosphere in areas where these organizations work, in which health professionals and local government officials seem to have changed their behavior. As a staff member of CEHURD put it, "as soon as you file a case, practice changes."[30] Similarly, Nazdeek found that the power to go to court often works as a strategy to increase accountability by state actors.[31] One might conclude that if the background of law shapes social interactions, then increased awareness can lead to both claim-making on the basis of rights as well as enforcement of existing rights by public officials in fear of invocation of the law.

In the end, achieving lasting systematic change, these examples show, is a long-term process. Short-term quick wins can sustain momentum and keep public officials involved, and thus be a first step in reaching for the longer term goals that can be achieved through multi-pronged approaches.

(b) *The individual and the collective*

SA and LE start with different perspectives on issues of service delivery failures for individuals and the collective. The starting point for LE is individual rights violations (although systemic problems also may be addressed)—particularly as these are prevalent among the most marginalized groups within communities, and communities themselves might be a part of silently sanctioning discrimination (e.g., HIV/AIDS patients, or the mentally ill). For SA, the starting point is collective failures in service delivery, rather than individual grievances and the strategy is public deliberation and building a collective consensus through a shared understanding of problems. The experiences from the field are insightful in relation to this question of individual versus community.

On the one hand, the LE strategy in several countries is limited by the peculiarities of the legal process and requirements. While in many situations, administrative routes to grievance redress are more likely to yield success, sometimes there is a need to seek legal redress. In Guatemala, the legal process is mostly conducted through correspondence, leaving the courts overloaded with cases, and legal representatives struggling to provide all the case arguments through thorough written briefs.[32] In Uganda, the legal system mandates mediation prior to cases being filed in court. While understandable as a strategy to reduce the burdens on the court, mediation in certain kinds of cases is time consuming and often unhelpful. These peculiarities of the legal framework are complicated by the need for individuals to document their cases, press charges (individuals are often reluctant to confront power in this fashion) and find representation in court for cases that often take years to be resolved. In Guatemala, the Procuraduria de la Derechos Humanos (Human Rights Defenders) office highlighted that of the 800 cases of rights violations that appear, "only 20 may ever get to the courts, of these only half might reach the sentencing stage, and even then sentences are typically too light."[33] As many observers in the sociology of law point out, a litigation strategy, even when well justified, has limited potential to ameliorate individual wrongs and strengthen the claims of others (De Souza Santos, 2002; McCann, 1994). Rather litigation can atomize social struggles, leading activists to focus on cases at the expense of broader collective strategies to advance their cause. SA then, helps in mobilizing collective claims, through surfacing systemic shortcomings that are manifested in individual cases of rights violations.

On the other hand, several organizations raised the issue of limits of the reliance on collective data of the SA approach. CEGSS highlighted how it had started its community-monitoring work by collecting aggregated data on

community-level shortcomings in health care (including medicine stock outs, etc.) that were presented in the form of a report to the municipal-level authorities. However, they realized the limits of this as officials reluctant to act, questioned the methodology of the reports, or requested more data. CEGSS then moved to collecting narratives and case histories of serious health rights violations as a way to grab the attention of politicians and the media, which in turn put pressure on the health administration. Similarly ESE found that collective data depersonalize experiences, and can conceal serious cases of rights violations.[34] The value of well-documented individual cases, that are the core of legal empowerment work thus contribute beyond being the basis for grievance redress or litigation, by providing the evocative elements and human stories which serve to raise the indignation and support of a broader population, including the middle classes, politicians, and the media. In this respect, health care failures, because of their serious and often irrevocable consequences, are more powerful than failures in other basic services such as education or sanitation.

(c) *Linking the local with the national*

While there has been a lot of work using SA in the past five years, the SA approach has been critiqued for being mainly successful at the local level—without generating impact at scale (Fox *et al.*, 2016). LE has been somewhat better at having broader impact, largely through pursuing legal cases including collaborating on strategic litigation. It is worth pointing out that all the LE work mentioned here is multi-level, which is not always the case for LE in general. One of the opportunities presented by the integrated approach is to leverage both SA and LE to work across levels. Some of the organizations reviewed here are managing to do just that.

Organizations that are primarily oriented to legal remedies, recognize that they have to gain support and build alliances with a wide array of social and political actors in order to influence action in the legal arena. As one interviewee from CEHURD noted—as half the legal battle is fought in the "court of public opinion."[35] SA strategies then help with the collective mobilization, coalition building, and advocacy outside legal processes. Simultaneously, to the extent that litigation contributes to changing the way substantive issues are conceived and discussed (thus legitimizing certain claims) they can have broader social impacts (McCann, 1994). Thus the indirect effects of employing the law are critical, as the use of law can force the state to recognize civil society organizations as having equal standing and recognizing claims. As the Guatemalan case indicates, having the shadow of the law in the background, makes accountability work at the local level somewhat easier.

ESE offered an interesting example of how combining national advocacy with local-level mobilization would work. When ESE worked on national-level advocacy, it brought local Roma community members to confront politicians about poor policy implementation. For example, in 2011, the Macedonian government allocated money for additional visits from nurses for Roma women. While the official reports showed that the program was being well implemented, local-level monitoring indicated there was no implementation. The collective data from the local level, along with individual cases of rights violations, enabled ESE to challenge the official account and raise questions about where money was being spent.

In all of the cases reviewed here, the key organizations (whether focused on SA or LE) have significant national presence, and collaborate closely with local grassroots organizations, for the combined approach to have greater traction. Whether such national–local collaboration is likely to succeed partly seems to depend upon the nature of decentralization in health care and governance. In most countries, despite decentralization laws, many of the problems in provision of health care relate to higher levels of government—e.g., medicine stock outs, allocation of doctors to health posts, adequate funding, etc. Understanding where responsibility for problems in access lie, and how to use national or local power to resolve them seems to be a critical aspect of success. Underlying these issues is a larger problem, that many of the issues in health care are structural ones (e.g., regulation of drugs or number of health professionals), related to the overall health system. To the extent that organizations aim to bridge national and local levels, they would be in a better position to address systemic challenges.

(d) *Confrontational vs. collaborative strategies*

At first glance, SA and LE are contrasting in terms of their approach to state institutions—most SA approaches being more collaborative, whereas with its focus on grievance redress and litigation, LE represents a more confrontational approach. What stance would organizations attempting the hybrid approach take? All the five organizations considered here saw the value of both strategies, but at different times and levels. It seemed important, particularly in repressive contexts with limited civic space to not been seen as directly confrontational, especially at the local level, due the vulnerability of local groups. It also seemed unfair to target local health officials when the problems may be systemic lying at higher levels. Thus CEGSS in Guatemala, emphasized negotiation and dialog with local authorities, with attempts to understand their constraints and bring them onside as allies. In Macedonia, ESE with Kham and CDRIM were mainly using a collaboration-oriented strategy at the local level, with some confrontation at the national levels.[36] However, some grassroots mobilizers noted that there needed to be a threat of confrontation for collaboration to work and authorities to take their work seriously.[37]

Other organizations emphasized confrontation at the national level. CEHURD for example, has been undertaking strategic litigation with a view to changing policy—taking the Ministry of Health head on. CEGSS has taken out protest marches to bring rural indigenous people to the capital, Guatemala City, in order to present demands to politicians in a show of strength. The threat of confrontation nationally may also provide incentives for the government to collaborate. Within coalitions of accountability actors, some actors may take on an adversarial stance, leaving others to collaborate. Confrontational tactics on the outside might shift the terms of the debate, enabling broader collaboration within. The experiences here show that the confrontation/collaboration choice also depends upon timing—when initial attempts at collaboration fail, confrontation might be the only viable option. In sum, while integrated approaches combine confrontation with collaboration, successful organizations seem to use confrontation more as a threat, largely at the national level, and often collaborate in coalitions with other organizations that specialize in one or the other strategy. Confrontation seems to be a last resort option, which is held in reserve for when other strategies fail.

(e) *Staffing issues*

One of the important practical issues that arise from organizations using an integrated approach relates to the skills and

capacities of staff. Almost universally, these five organizations have staff with mixed skill sets, which are the result of a felt need for the expertise from other disciplines. Although CEGSS started with mainly a team of public health specialists, they now have anthropologists, political scientists, social workers, lawyers, and media professionals. CEHURD, which started as a group of fresh law school graduates, now has social science specialists and monitoring and evaluation experts. ESE along with KHAM and CDRIM, has teams with experts in budget analysis, community mobilization, and legal skills, in addition to public health specialists. Across all organizations, the teams were relatively young and willing to work across disciplines, less embedded in their professions' organizations with their entrenched ways of working, and brought fresh perspectives and problem-solving attitudes to the work.

At the local level, there is almost no distinction between staff involved in the SA and LE work, with the same staff working on both programs. On occasion, frontline workers separate the tasks involved (documenting right violations vs. mobilizing) by time of day, or day of week.[38] There is a proliferation of terms used for these frontline workers—community health advocates, community health defenders, paralegals, etc. Some organizations reported cost savings involved in integration.

In contexts where the problems are large and the potential for success limited, there is a looming problem of "burnout" where motivation levels of frontline workers drop. Finding ways to address this, and retain a high level of worker motivation is important for combined approaches to succeed. HERA has explicitly recognized this problem, and institutionalized regular reflection meetings between paralegals and community monitors to collectively identify issues and troubleshoot at the earliest signs of problems. Establishing networks of peer support across locations, and perhaps even across regions, seems an important step, both for sharing lessons across contexts, and for sustaining morale.

6. CONCLUSIONS

The challenges of improving healthcare are vast and largely structural: the chronic underfunding of health care, skills and capacity constraints, compromised procurement and regulation processes, corruption, politicization of the deployment of human resources, and the lack of a multi-faceted approach to health that looks at determinants of health that might not be the responsibilities of the health system. The multi-pronged, multi-level approaches described here begin to move from "end of the pipe" delivery issues to upstream bottlenecks. Tackling of systemic problems in health systems will no doubt also require reform drivers from within the government and private sectors that can ally with accountability focused organizations as well as additional prongs and levels (e.g., working with media, politicians, etc. and also at additional supra and sub-national levels).

Yet, even the limited examination of recent experiences of integrating social accountability and legal empowerment approaches as part of a multi-pronged strategy to realizing rights in health offers some broad lessons.

First, it is clear from the diverse paths presented above, that organizations using a mix of SA and LE approaches, come to them through various routes—and organizational history matters.[39] These various routes to integration suggest that there is no one optimal route, and the integration is appropriate when it fits within the overall organizational strategy and evolves in response to the environment. We need to understand how organizational evolution affects outcomes.

Second, of significance is that the quick success that is possible through pursuing individual cases under the LE approach enabled organizations working with communities in the field to build credibility that is necessary for both SA and LE and to avoid participation fatigue. For organizations working in this arena, a key element is establishing trust with communities, so that they invest in empowerment and accountability processes. Early wins through a few key cases help establish the efficacy of the overall approach. The key question then is: does the integrated approach contribute to a more robust process of trust building?

Third, it is important to note that in this paper, only two specific "prongs" were examined. The organizations discussed here combine a diversity of other prongs—including media campaigns, coalition building with other organizations, and finding champions within government, all of which contributed to the overall outcomes. Moreover, these cases were unusual in that organizations were influential at both national and local levels, either through bridging levels themselves, or by forming coalitions with other organizations. Through a combination of individual narratives and collective data, the linking of national policy advocacy and technical support organizations with grassroots groups, and the escalating of problems (and potential solutions) from the local to higher levels, these organization combined SA and LE with some success to achieve substantive service changes at the local level, as well as small but promising possibilities for policy reforms at national levels, using a mix of collaborative and confrontational approaches. Given the current consensus about integrated approaches—both multi-pronged and multi-level—the observations reported here offer partial glimpses. How does the multi-faceted approach work in practice—what challenges does it pose for organizations?

Finally, how these approaches evolve and merge depends upon the context within which organizations work—as they are attempting to influence and change complex socio-political relationships and processes within the health sector. Specific legal and governance frameworks set the standard and can clarify responsibilities and accountabilities for various stakeholders. There is a gap in our understandings of why public authorities respond constructively in some contexts and not others—the structural incentives and individual motivations which drive public officials. The form of integrated approach required will depend on features such the capacity of civic organizations, the nature of the bureaucracy, public expectations, the role of the media, and opportunity structures offered by the overall legal and governance frameworks.

Given the importance of context, the big leap then is the move from understanding what works and related "best practices", to understanding how organizations can adjust and integrate different approaches as their work evolves. Organizations need particular kinds of capacities to respond including: ability to work with local grassroots organizations; combine collaborative and confrontational modes of action; work through mixed disciplinary teams; manage frontline staff and potential burnout; and the ability to be backstage when engaging with local governments, and placing community representatives at the forefront. These capacities can no doubt be developed as needed. The overarching feature which seems to matter then, is the flexibility to learn and adapt iteratively rather than implementing "best practices" from elsewhere (even though knowledge of best practice can help expand the menu of options and what is possible). How is such flexibility nurtured in different types of organizations?

Both social accountability and legal empowerment strategies are being increasingly used by organizations to increase

the effectiveness of their work. Practice is racing ahead of conceptualization and reflection. Yet, a deeper exploration of the issues and questions raised in this paper through a thorough analysis of evolving practice can help capture lessons and the implications of experience for organizational strategies and capacities to achieve stronger accountability relationships between states and citizens and contribute to social change.

NOTES

1. Field visits were made to Macedonia (November 2014); Guatemala (May 2015); and Uganda (October 2015). These are all organizations that have been supported by the Open Society Foundation through their Public Health Program.

2. I am grateful to Jonathan Fox for pushing me to clarify what I mean by integrated. Some groups have used integrated to indicate multi-level and also approaches that trigger checks and balances institutions. See Fox & Halloran, 2015.

3. The conceptual section draws heavily on Joshi & Abdikeeva, 2014.

4. Prior to the early 2000s "social accountability" referred to auditable social certification standards for decent workplaces, across all industrial sectors codified in the SA8000.

5. "Social accountability" had come to mean any citizen-led action addressed to the state that might lead to improved public responsiveness. Soon it was being loosely interpreted and used interchangeably with other similar terms such as "voice and accountability," "citizen action," "transparency and accountability," and "citizen engagement" (Malena & Forster, 2004; O'Neil, Foresti, & Hudson, 2007; Rocha Menocal & Sharma, 2008).

6. Note that the World Development Report itself did not specifically use the term "social accountability."

7. Fox identifies several propositions that merit further examination: that campaigns are more strategic than tactical interventions; targeted transparency is useful in mobilizing people; voice needs representation as well as aggregation; institutional capacity is necessary for responsiveness with accompanying incentives and sanctions; vertical accountability and links to electoral politics is essential; corruption and poor performance if improved at one level can mean they simply shift to another level unless one thinks of accountabilities of scale and vertical integration of oversight; and finally, an alliance of pro-accountability actors within the state to pro accountability groups in society can overcome forces opposed to accountability through a "sandwich strategy" (Fox, 2014).

8. Legal empowerment assumes that the law is empowering; this idea is contested by many as the law can be technocratic and disempowering.

9. For a review of various definitions, see Golub, 2010: 10–11.

10. This section draws on Joshi & Abdikeeva, 2014.

11. For further exploration on how legal empowerment can be used for health justice see: https://www.opensocietyfoundations.org/reports/bringing-justice-health.

12. The methodology assesses progress, made against the baseline benchmarks, across four main advocacy strategies: (1) legal empowerment, (2) documentation and advocacy, (3) media advocacy, and (4) strategic litigation. For each strategy, four measurements are proposed: (a) NGO capacity, (b) accountability for Roma rights violations, (c) law and practice, and (d) impact on communities. The methodology table is available in full here: http://www.opensocietyfoundations.org/reports/roma-health-rights-macedonia-romania-and-serbia-baseline-legal-advocacy.

13. However the study used a very wide definition of legal empowerment initiatives, "those that seek to increase the capacity of people to exercise their rights and to participate in the processes of governing" (Goodwin, 2014: 3). Thus they include interventions such as community monitoring, citizen scorecards, citizen audits, right to information, etc, which we would normally consider as social accountability initiatives.

14. Most prominently the Open Society Foundation through its Public Health Program; as well as Namati.

15. This section is based on interviews with the Director and other members of staff at CEGSS, April 6–9, 2015.

16. For details of CEHURD's approach and work see Abdikeeva, 2016. The strategy reported here is based on interviews and field visits conducted with CEHURD staff, October 20–23, 2015.

17. CEHURD and Others vs. Attorney General, available at http://www.ulii.org/ug/judgment/constitutional-court/2012/4/.

18. http://www.monitor.co.ug/News/National/Judiciary-apologises-over-delayed-maternal-health-ruling/-/688334/1411606/-/1q6h0h/-/index.html.

19. The Supreme Court was emphatic on the role of the Constitutional Courts on adjudicating matters concerning the interpretation of the Constitution. It actually ordered the Constitutional court to hear the matter on its merits as the cited political question doctrine, or the doctrine of separation of powers, could not bar it from this Constitutional mandate.

20. In the first judgement, the judges themselves suggested that they start with smaller cases—cases related to enforcement of rights, than cases that relate to interpretation (CEHURD has since filed and achieved victories in a maternal health-related cases filled in the High Court of Uganda. See http://www.cehurd.org/2016/01/civil-suit-revamps-maternal-health-service-provision-in-nakaseke/).

21. http://www.cehurd.org/wp-content/uploads/downloads/2012/06/maternal-motion-factsheet.pdf.

22. Moses Mulumba, interview CEHURD offices, Kampala. October 20, 2015.

23. ibid.

24. ibid.

25. Personal communication, Sukti Dhital, November 2015.

26. ICAAD is the International Center for Advocates Against Discrimination. PAJHRA is the Promotion and Advancement of Justice, Harmony and Rights of Adivasis.

27. See details in Feruglio (2015), regarding Rajesh Bohra vs. Union of India and Ors. WP (C) 5184/2014 (2014).

28. Based on reflections by the organizations themselves during interviews.

29. One successful case that CEHURD pursued concerned a petitioner, FK, who received compensation for the death of his wife in childbirth due to neglect. Interview FK, Kampala, October 22, 2015.

30. Meeting at CEHURD office, Kampala, October 20, 2015.

31. Draft report, Sukti Dhital, 2015.

32. There are also oral debates, but those need to be supported by written arguments.

33. Personal Interview, PDH representative, 9 April 2015, Guatemala City.

34. Comments made by Borjan Pavlovski, ESE in Roma Reflection Meeting, February 2015, Strumica, Macedonia.

35. Moses Mulumba, interview CEHURD offices, Kampala, October 20, 2015.

36. For example in municipality of Shuto Orizari, the patronage nurse could not meet demands for visits, because in reality there was only one nurse for the whole municipality, initially even without a vehicle. Thus, ESE collaborated with local-level providers to demand the needed staff and equipment. At the same time they used a confrontation strategy with the national-level institutions (Ministry of Health) by showing publicly that the program was not reaching those in need because of systemic failures (lack of oversight mechanisms, lack of staff, etc.).

37. Zoran Bivovski, Kham. Interview at Roma reflection meeting, Strumica, Macedonia, February 2015.

38. For example in Kham, Macedonia, paralegals sat in the office when working on the LE side to receive cases, and worked on different days in the community on SA programs. Field visit, Delchevo, 2014.

39. Some organizations, (e.g., CEGGS) started with social mobilization and community monitoring, i.e. social accountability and came to recognize the value of legal empowerment. Others, (e.g., CEHURD) saw the limits of legal empowerment and moved toward social accountability to complement their work. Yet others, (e.g., Nazdeek) brought legal expertise to local, community-based organizations that were already working on awareness raising and mobilization, and together developed an innovative integrated approach through the use of technology. Finally, some (e.g., ESE, HERA) found that they were simultaneously implementing separate SA and LE programs and the merger was natural choice, for improving efficiencies and outcomes.

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