



Mutual-learning at accountability's cutting edge – a practitioners' consultation on improving Health and Nutrition services in South Asia

Online expert discussion on 16th and 17th March 2016

A visual mapping of the online discussion is available here:

<https://prezi.com/a0jyyta7mtng/social-accountability/>

FINAL SUMMARY

The online discussion was attended by 49 participants across India, Bangladesh, Pakistan, UK, USA and the Netherlands. Contributions were received by 31 participants (out of which 5 were from the organizing team) over the two days of discussion, for a total of 134 contributions.

A number of topics were discussed, summarized below. Quotes reported here have not been attributed and permission needs to be sought before re-quoting.

1. Community participation and engagement

To the question 'how do organizations on the ground ensure community members are engaged and lead social accountability efforts?,' participants illustrated how any **social accountability process begins with** raising awareness and informing community members over rights and entitlements.

This step entails **building a 'culture of questioning'** which is crucial to mobilize communities around issues of healthcare and basic services. In this sense, the rights-based framework is essential to provide a framework for social action. Furthermore, this process is not only limited to raising awareness over specific rights and entitlements, but it includes building awareness on wider social and policy structures, the role of democracy, and the way state functions. Some organizations engage with frontline service providers during this stage, both to fill the 'knowledge gap' among health providers and also to ensure shared goals and vision and reduce the risk of tensions between community members and FLWs.

Community participation can rely on a number of **different tools**. Participants mentioned, among others, community scorecards, social audits etc. Beyond more 'traditional' tools (Scorecards), organizations also use of ICT (see below) and pictorial materials/flashcards (to ensure inclusion of illiterate persons).

“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 Anganwadis of their villages through a set of picture cards. They used a ten-point checklist to monitor Anganwadi centres, and conduct neighborhood surveys.” [a participant]

Choice of tools depends on the type of data that needs to be collected, but at times can also be influenced by funders’ requirements. As rightly pointed out, 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.’* Ground experience has shown that while negotiating with service providers, the leverage points that a specific tool can open up for communities is context-specific.

The discussion then shifted to the **factors affecting people’s participation to SA processes**. Motivation, incentives and social recognitions are concepts crucial to ensuring participation of community members. Equally important is setting clear, reachable goals. However, questions remains with regards to sustainability and ‘institutionalization’ of accountability processes.

“When committee members accompany the patients to local health centers they receive recognition from the health system as ‘VHWSC 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 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.” [a participant]

During the community participation process, special attention needs to be placed **towards inclusion of particularly marginalized sections**. For instance, raising women’s voices, especially with regards to sexual and reproductive health and rights, is particularly challenging in contexts where gender, caste and religion hinder people’s participation (e.g. ability to attend community meetings) and ability to address specific issues (e.g. family planning). Here, social accountability processes can be useful to resist oppression and ensure representation of vulnerable groups. Some organizations address intra-community divisions by ensuring each group within the community can participate to community monitoring, and present their views (and needs) about the state of healthcare delivery. In the case of some women groups, solidarity and intercommunity support is essential to collectivize actions, and give the group a stronger voice.

“MSAM women support each other in the group meetings, they listen each other's problems, emotions, miss happenings, threats etc. and show solidarity for it. Then they try 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.) resolved by the group itself but for other issue (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.” [a participant]

In addition, community participation processes can provide a valuable opportunity to engage men in conversations about healthcare, 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).” [a participant]

2. Negotiating with the State

Data collected through community monitoring is then presented to and discussed with government health providers at different levels. In some cases, local service providers also participate to the monitoring process and provide their own data. Most of the participants indicated that the negotiation at local level happens through existing committees or **ad-hoc platforms** set up by local groups. Some of these committees are established under government schemes (like the Village Health and Nutrition Committees in India), but become properly functioning only through Social accountability interventions. In other instances, new platforms or opportunities for dialogues needs to be created ad-hoc.

Some participants **mix collaborative and confrontational approaches** when dealing with health providers. More confrontational approaches, including dharnas and litigation, can be resorted to in particularly serious cases of health rights violations or to advance strategic claims.

It has been pointed out that negotiation is usually easier at community level, where frontline workers and patients live side by side and find ways to collaborate, but it becomes more difficult to **translate local demands into wider changes**. Here, an essential step is the aggregation and analysis of information collected at community level. This data is brought to the attention of District or Province/State level discussion forums (mirroring the community-level committees) between civil society and government representatives. Participants' experience pointed out that when locally-collected data is 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 voice becomes more legitimate.

Lastly, good examples of '**vertical integration**' and continuous exchanges between various levels (community and District/State) come from the work some of the participants have been doing around budget. Budgetary considerations are essential when advocating for improvements of health service delivery. Some of the participants' work focuses on unpacking public health budget, and facilitate communities' inputs on budget allocations. Here, the community participation process leads to the formulation of 'key asks' for the government. This approach has led to the state initiating consultations with communities during the formulation of budgets.

3. Accountability of the private sector

When speaking about ensuring accountability in the delivery of healthcare, the private sector is a crucial piece. Regulation of the private health sector is indeed very critical and urgent task. Lack of regulation means lack of an effective framework for claiming accountability in service delivery.

Moreover, the relations patients-private providers is of an economic nature that doesn't 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. The leverage points community members have are virtually non-existent. This issue can only be addressed by stressing the role of the Government as main responsible for healthcare provision and regulation. This agenda must essentially be pushed at policy level however the decision-making spaces and processes are neither transparent nor accountable to the principle of ensuring access to quality healthcare for all.

4. Defining and Measuring Impact, and issues around M&E

Participants have been encouraged to share about **what impact means and who defines it**. As emerged in the first day of discussion, 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 from a number of other factors, such as the quality and acceptability of the service, and the capacity of service providers to deliver healthcare. Therefore, there seems to be an **excessive focus on service uptake as standard indicator** to measure impact of social accountability.

“Often times, implementers 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 SA. 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?” [a participant]

The issue is strongly linked with who are practitioners doing evaluation for. Participants agreed that evaluations are mostly carried out for funders, and thereby try to abide to project commitments and narrowly indicators that focus largely only services uptake and use. Mainstream approaches to evaluation do not consider the many declinations of social change – other than increase in access to services – that result from social accountability processes, such as empowerment. These approaches also fail to grasp complexities surrounding community's 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 (which can be downloaded from the discussion thread 2). For instance, '**stories of change**' has been identified as a promising method to document 'how' and 'why' change is created rather than only 'what' is the change.

Participants then discussed about the role of community members in monitoring change. Here, a couple of posts discussed the **use of ICT for gathering data**, ranging from SMSs to Interactive Voice Recording (IVR) and multimedia (photo and videos). Overall, it clearly emerged how the use of technology can increase participation of community members, especially women, because it protects anonymity. For instance, patients feel comfortable with reporting corruption in health facilities through the use of SMSs or IVR because they don't fear retaliation from health staff. In addition, the collecting data through technology increases its perceived validity by government authorities.

Wrap up: the need for ‘politicizing’ accountability

Final remarks focused on placing existing social accountability initiatives for health and nutrition within wider pushes for social change. Participants were asked how do localized community-level actions make sense of their goals on the long-run? How do they ally together? Indeed, local-level initiatives need to **sync up with wider movements to pursue long-term goals of addressing supply-side barriers and influencing policymaking**. Also, changes in power-dynamics at local level need to reflect on wider political structures. A classic example of an (initially) localized demand for accountability, which then translated into wider political change, is the Right to Information movement in India. 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 synced up with a state-wide campaign calling for increased wages across the tea industry.

Putting politics and power at the core of the accountability discourse becomes therefore essential to ‘make sense’ of the change we seek to create, and any attempt to understand impact should take into account these considerations.

About the organizers:

The INSTITUTE OF DEVELOPMENT STUDIES (IDS) is a leading global institution for development research, teaching and learning, and impact and communications, based at the University of Sussex, United Kingdom. Our vision is of equal and sustainable societies, locally and globally, where everyone can live secure, fulfilling lives free from poverty and injustice.

<http://www.ids.ac.uk/>

COPASAH is a community where practitioners who share an interest and passion for the field of community monitoring for accountability in health interact regularly and engage in exchanging experiences and lessons. Copasah’s vision is that communities are actively engaged in promoting accountability and transforming health systems towards the realization of social justice.

<http://www.copasah.net/>