Accountability in health and nutrition in South Asia – a conceptual and practical review of lessons from the global literature and from India, Pakistan and Bangladesh

Nabeela Ahmed, Shilpa Deshpande, Francesca Feruglio and Nicholas Nisbett
Authors
Nicholas Nisbett is Research Fellow and Cluster Leader, Health and Nutrition Cluster, Institute of Development Studies at the University of Sussex.

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

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

Francesca Feruglio is Research Officer at the Institute of Development Studies, where on the MAVC programme and is co-founder of the legal empowerment organisation Nazdeek.

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1. Introduction: current issues and concepts in accountability

Social and community accountability initiatives in health and nutrition have been associated with the potential for significant improvements in outcomes when applied to relevant services. As one recent review concludes, such forms of community engagement can lead to:

... significantly larger reductions in maternal and infant mortality, larger improvements in health-related behaviors, and greater use of health facilities than investments in health inputs alone can deliver. Interestingly, successful programs are often located within larger government health delivery systems.

(Mansuri and Rao 2013: 8)

Such initiatives are increasingly diverse, both within and outside of the health and nutrition sectors, while the definitions of what constitutes accountability – social, community or otherwise – have likewise expanded. Despite the positive potential and assessments noted above, the evidence on actual impacts and the pathways to achieving impact is also considerably mixed. Fortunately, several recent reviews have attempted to convey greater conceptual clarity (Joshi and Houtzager 2012; Gaventa and McGee 2013; Joshi 2013b; Grandvoinnet, Aslam and Raha 2015; Fox 2015; Bukenya, Hickey and King 2012). They also review the evidence on impacts and, most importantly, attempt to summarise the factors behind the success and failure of particular approaches, in which contexts and whether they are part of wider processes. We make extensive use of these reviews here to help define the field and then to consider some of the key conceptual issues that have emerged from critical analysis and which have relevance to better service provision in health and nutrition.

1.1 Definitions

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

Grandvoinnet et al. (2015), in a further recent conceptualisation of accountability, identify five key constituent elements of social accountability. These are: citizen action, state action, the citizen-state interface, information and civic mobilisation. They postulate that social accountability is a result of the interplay between citizen action and state action, influenced by the levers of interface, information and civic mobilisation. In their view, accountability can be led by state action or citizen action, and either may initiate any of the three levers. In this way, information may be made available by the state or generated/collected through citizen action or civic mobilisation. Information may lead to mobilisation and/or vice versa. The state-citizen interface may be the starting point or the end point of the accountability action. Grandvoinnet et al. (2015) further emphasise the iterative nature of social accountability.
processes, pointing out that neither state nor civil society is an exclusive or homogenous category.

Widening the definition of accountability initiatives to such citizen-led action and ‘community-driven development’ does tend towards a very broad definition, and expands the number of related literatures on, for example, participatory development, political movements and civil society more generally. Commentary in wider political science has, therefore, noted the ubiquity of the concept of accountability and how it has become tantamount to good governance (Dubnick and Yang 2011). Within development, others have commented on the danger that accountability becomes just another development ‘fuzzword’ (Cornwall 2007) – ‘full of euphemism and normative resonances but emptied of their original meaning’ (Gaventa and McGee 2012: s4); some have recommended narrower definitions (such as that used here) as focusing on ‘that of ensuring the implementation of existing state obligations’ (Joshi and Houtzager 2012: 151).

There are other directions, discussions and divisions in the literature (see Box 1). At its core, however, scholars agree that ‘accountability’ is about ‘calling to account’ (Bovens 2007; Bovens, Schillemans and Goodin 2014; Lindberg 2013; Mulgan 2000). Typically this involves an actor who is required to give account in an area or domain for which s/he is answerable, and another actor or actors or a forum to whom that person is required to give account. Usually, these other actors or forums have the requisite authority and the power to impose sanctions. Additionally, accountability involves a process – of calling to account, seeking information and explanations, and passing judgements and sanctions (Bovens 2007; Bovens et al. 2014; Lindberg 2013; Mulgan 2000). When applied in the development literature, the prefixes ‘social’, ‘community’, ‘political’ and ‘administrative’ simply describe the means of engaging such a calling to account; and/or the locus of activities (e.g. social, community, political or bureaucratic processes and contexts).

This review, therefore, is designed to look specifically at this ‘calling to account’ process in the case of health and nutrition services and outcomes for poor people in low- and middle-income countries. It considers processes and interventions that are conceived and implemented at the frontline interface between people and services (whether those services exist or are lacking). While we focus primarily on processes originating in the community or on local political processes, the review follows Joshi and Houtzager (2012) in tracing the background and origins of such activities to the limitations of existing political and administrative systems. It also starts from Joshi and Houtzager’s premise that reaching an understanding of each domain (political, administrative, social, etc.) is necessary to take into account the full range of ‘calling to account’ activities available to poor people, how they interrelate, and where they succeed and fail (including as a result of this interrelation).

<table>
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<th>Box 1: Variations in defining social accountability – orientation, scope, directionality, leadership, process and outcomes</th>
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<td>In terms of definition, social accountability is a contested concept and there is little consensus in the literature about what it means. This is largely because social accountability initiatives (SAIs) vary widely in key aspects such as the following.</td>
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<td>• <strong>Ideological orientation</strong>: Some SAIs such as citizen charters and complaint hotlines are ideologically rooted in new public management (NPM) and attempt to change accountability relations by framing citizens as users and consumers (Joshi and Houtzager 2012). Whereas those that emphasise citizen participation in policymaking and service delivery such as</td>
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advisory/consultative groups and user committees respectively emerge from the ‘democratic deepening’ school (Gaventa and McGee 2013).

- **Scope:** Joshi (2008) argues for an analytical distinction between initiatives that involve citizen participation in governance and those that focus on monitoring and evaluating the use of public authority. The latter, she contends, perform better on the dimension of accountability than the former, which raise concerns about co-option by the state. Malena and McNeil (2010), on the other hand, hold that mechanisms in which ordinary citizens are involved in decision-making are a new generation of social accountability practices.

- **Direction of control:** Peruzzotti and Smulovitz (2006) characterise social accountability as a non-electoral vertical accountability mechanism that can activate horizontal accountability mechanisms. Horizontal mechanisms represent the conventional internal systems of government accountability – legal, fiscal, administrative and political – whereas vertical mechanisms represent more ‘bottom-up’ external checks by non-state actors (i.e. citizens) (Bukenya et al. 2012). Goetz and Jenkins (2001), on the other hand, describe conditions when social accountability can also be diagonal – i.e. when vertical accountability activities engage with horizontal mechanisms such as in participatory budgeting.

- **Leadership:** SAIs are by definition citizen-led, but they can even be state-led when institutionalised by the state (Malena and McNeil 2010).

- **Process:** Some SAIs (such as community monitoring, social audits, public demonstrations, protests, advocacy campaigns and public interest litigations) are confrontational whereas others (such as participatory budgeting and citizen scorecards) are more collaborative in their approach to the state (Joshi and Houtzager 2012).

- **Outcomes:** Whereas some SAIs aim to improve service delivery, others focus on empowering the citizen vis-à-vis the state (Gaventa and McGee 2013).

### 1.2 The ‘standard model’ of political and administrative accountability

Accountability is both a central ideal of representative democracy and a crucial process in the democratic system. Conceptually, citizens – the principals in a democracy – delegate their sovereignty to representatives or agents to govern on their behalf and can call such agents to account regarding their use of public power (Bovens 2007). In terms of process, accountability in a representative democracy can be conceived of as a chain of principal agent relationships in which power is delegated from voter to representative, representative to minister, and minister to civil servants and bureaucrats, whereas accountability works in the reverse direction (Bovens 2007; Mulgan 2000). Representatives are accountable to voters, and bureaucrats are accountable to representatives. These two systems of accountability – political and administrative respectively – constitute the standard model of accountability in a representative democracy (Joshi and Houtzager 2012).

In the standard model, political accountability is ensured through regular, competitive elections. Voters make electoral choices based on ‘programmatic politics’ – that is, voters have policy preferences and vote for those parties or coalition of parties whose manifesto matches their preferences and whose credibility and electability they are convinced about. Victorious parties are expected to implement their promises by making relevant laws and policy, and monitoring implementation through the bureaucratic machinery. Voters evaluate the performance of elected representatives based on their everyday interaction with the state machinery as well as the overall performance of the government, and reward or punish them in subsequent elections (Kitschelt and Wilkinson 2007). Administrative or bureaucratic accountability is thus inextricably linked to political accountability.

Public officials at all levels are accountable to their political and administrative superiors for their compliance with supervisory directives, rules and standard operating procedures as well as their use of the authority and discretion available to them. Internal mechanisms to
ensure their accountability include formal ones (such as budgeting, personnel management, performance evaluation and audits) as well as informal ones (such as ethics, professionalism, commitment and the expectations of superiors) (Mashaw 2006; Romzek and Dubnick 2000). External accountability mechanisms for bureaucracies include judicial and legislative reviews, ombudsman offices, evaluation research, and freedom of information laws. The media, peers, interest groups, political parties and other politicians and bureaucrats represent other external but more informal systems of bureaucratic accountability (Smith 1991).

In the standard model, the roles of voter-citizens, politician-representatives and bureaucrats are assumed to be fairly distinct: voters elect politicians based on programmatic politics, elected politicians make policy, and bureaucrats design and implement programmes based on that policy. In wider policy processes there may be further interactions than this suggests (when citizens lobby to get issues onto the policy agenda) (see Schmitter 2004, cited in Joshi and Houtzager 2012: 148). However, in many democracies, voters, politicians and bureaucrats have significantly reshaped and blurred the distinctions between their roles assumed by the standard model – in the process, redefining democratic accountability. These are contexts where ‘clientelistic’ and/or ‘patronage’ politics predominate: voters exchange their political support for individual material gain, politicians distribute state resources among their supporters, and bureaucrats operate not on the basis of rules and regulations but to manage political demands.

1.3 Social accountability interventions as addressing failures in the standard model

Even relatively well-functioning bureaucracies can become too large and complex to act within the average citizen’s comprehension (and thus amenability to accountability). This, combined with the existence of the more nefarious aspects of clientelism and patronage in denying reliable accountability and service provision to poor people, has provided fertile ground for alternatives to the standard model. Social accountability initiatives (SAIs) have therefore been seen as emerging as a specific response to the failure of the more traditional mechanisms of political and bureaucratic accountability in holding the state to account (Gaventa and McGee 2013; Joshi and Houtzager 2012; Peruzzotti and Smulovitz 2006). In particular, SAIs have been highlighted as an effective way to redress the grievances of poor people in developing country contexts, where transparency, accountability and participation are limited, if not lacking altogether.

In contrast to the standard model, SAIs refer to citizens’ attempts to demand accountability from the state through processes which do not involve elections or intra-state checks and balances, although particular social accountability mechanisms may trigger the functioning of these more traditional systems (Gaventa and McGee 2013; Peruzzotti and Smulovitz 2006). Instead, citizen collectives monitor the working of the state, expose wrongs and demand action. SAIs differ from the standard model of accountability in that they can be activated on demand and can focus on specific issues and policies (Peruzzotti and Smulovitz 2006).

Joshi (2008) identifies several distinctions between social accountability approaches and traditional (usually formal) approaches: (1) SAIs incorporate both institutional and non-institutional (formal and non-formal) mechanisms; (2) they take place continuously rather than being limited to election timeframes; and (3) unlike lobby groups and civil society organisations (CSOs), social accountability movements are based on collective actors (or communities) who seek to create new spaces for engagement and institutionalise sustainable control over policies by enabling ‘voice’ in accountability processes rather than
promoting particularistic agendas. Social accountability processes also often operate within existing legal spaces and are conducted transparently in the public domain (Cornwall and Gaventa 2001; Joshi 2008). It can be said that such approaches are more favourable to developing country contexts, where service delivery routinely fails poor and marginalised people (Joshi 2008).

Since participatory approaches to development have become mainstream as an alternative to top-down bureaucratic systems, academics and practitioners alike have emphasised the linkages between pro-poor development, participation, accountability (Chambers 1995) and a dominant discourse stresses the relationship between ‘good governance’ and economic development (Ackerman 2004; Rose-Ackerman 1999; World Bank 1997). The rise of SAIs is in some way simply an extension of such a trend.

However, Joshi and Houtzager (2012: 149) have cautioned that bracketing all accountability initiatives together hides the fact that SAIs emerge from distinct traditions (see also Box 1). These include in one stream a managerialist and World Bank-driven agenda, which emerged from a wider concern in the NPM literature with governance (over politics). This supports a view of citizens as exercising rational or consumer choice over the services they receive. In another stream, this includes wider developments in the right to information and broader transparency movements (Gaventa and McGee 2013). Finally, we see a third stream, which includes activities associated with participatory or ‘deepening’ democracy and the issue of basic rights to services (Joshi and Houtzager 2012: 150; Gaventa and McGee 2013: s5–s7).

1.4 The importance of context

This third stream, of participation and deepening democracy, is accompanied by a rich literature in development studies that has much relevance here. While it is beyond the scope of this paper to fully review the overlap between accountability and participation, there is value in looking at some of the broad critiques of that field, which might apply equally to the role of the community in accountability initiatives. Such critiques (Cooke and Kothari 2001; Falus, Meessen, Ndayishimiye and Bossuyt 2012; Mosse 2001; Cornwall 2003) have reported how, in many cases, a participatory approach can only reveal or reinforce underlying local hierarchies of power and decision-making according to local norms regarding social status, gender, ethnicity and caste. Such critiques apply equally, then, when extending participatory approaches to ‘community’ accountability and, indeed, lead to questioning any idea of community as a single, homogenous identity in accountability initiatives.

Contemporary discourse on community participation in accountability argues that citizens should engage with the state as ‘makers and shapers’ of policies that affect their daily lives and locate themselves at the centre of accountability processes and targeted outcomes (Cornwall and Gaventa 2001). The problem with a wide variety of these approaches, however, is that although they emphasise citizen action, they tend to emerge through a number of external ‘initiatives’ and ‘interventions’, which can carry the same relationships of power as made visible by the critiques of participation. As noted earlier, though, the scholarly interest in accountability has also arisen simply as a way of documenting wider emergent forms of citizen action and community-driven development. Paying closer attention to such extant forms of citizen-led action is consistent with Joshi and Houtzager’s proposal for ‘a conceptualization of social accountability that focuses on ongoing political engagement by social actors with the state as a part of a long-term pattern of interaction shaped both by historical forces and the current context’ (Joshi and Houtzager 2012: 146). Such activities might include forms of long-term struggle over the spoils of the state and of growth by
particular groups (see, for example, Srinivasan 2014; Harriss-White 2003: 47 for diverging views as to whether these benefits accrue to the elite or to the poor); they may also include populist politics (ibid.) or forms of ‘rude accountability’ (Hossain 2010) and public shaming (Unsworth 2010). In this latter form, accountability may lack formal sanctions but tactics such as public shaming of providers can impose reputational and political costs and, in some cases, trigger formal accountability mechanisms (for instance, through the courts or an ombudsman office).

Many studies on the effectiveness and impact of SAIs have similarly emphasised the critical nature of context, decrying purely technocratic framings as depoliticising and ‘widget-like’ (Joshi and Houtzager 2012). The latter two authors argue that available research tends to take a ‘snapshot’ approach, which ignores a range of contextual and process factors – most importantly the political processes within which social accountability mechanisms are embedded and which they believe are crucial for success. Gaventa and McGee (2013) similarly highlight how context is central in determining actors, objectives, design, the way an intervention unfolds, and its ultimate impact. The case studies looking at the Right to Food movement in India and the Narripokkho (women’s rights) movement in Bangladesh further illustrate how context – political, legal and social – can shape and interact with community actions. Bukenya et al. (2012) reviewed 90 studies on social accountability and concluded that political context shapes SAIs in multiple and complex ways. They emphasise the role of political will, formal and informal political institutions, capacity and commitment of civil society actors, levels of inequality and exclusion, and overall state–society relations. Building on this work, Grandvoinnet et al. (2015) posit that social accountability is shaped by the two institutional spheres of civil and political society and their interactions (state–society and intra-society), influenced by cultural norms, global factors and the prevailing political settlement (inter-elite relations). The conceptual frameworks which result from these two important reviews are produced below (Figure 1 and Figure 2 respectively).
While the recent literature has seen an increase in such conceptual work on the importance of context in social accountability, this has not been matched by empirical research conducted at the community level. For instance, while many studies accord centrality to the role of political processes in determining the success of SAIs, they mostly interpret these processes in terms of the capacity and willingness of politicians, political parties and bureaucrats to foster social accountability (O’Meally 2013). What is missing is something we wish to note as a further and final area of overlap with regard to existing literature, which has been explored earlier but which is poorly examined in the empirical evidence on accountability initiatives – that of the social and political embeddedness or everyday ‘sightings’ of the state and political actors in their administrative and political capacities.

1.5 Everyday embedded accountability and the political mediation of the state

A significant conceptual and empirical contribution to this body of literature exists in the form of Corbridge and colleagues’ work (2005) on accountability programmes for education and work-based relief in three Indian states (West Bengal, Jharkhand and Bihar) in the late 1990s and early 2000s. This draws on related bodies of literature concerned with the everyday workings of the state as experienced by poor people, as well as wider concerns derived from the Foucauldian analytical framing of governmentality (i.e. the ways in which the state and other actors construct bodies of knowledge about their subjects – in this case,
poor people – in order to exert administration and control).¹ Important in the analysis of Corbridge et al. is the care they take to locate these everyday ‘sightings’ of the state within the existing social and political relations that precede any programmatic conception and implementation. This is, to some extent, an extension of the concerns with context and process noted above, but it is more explicit in outlining how new initiatives only complicate the existing sociopolitical mix further, in ways that can be unexpected, though not always negative in the long run (Corbridge, Williams, Srivastava and Véron 2005: 261–2).

Corbridge and colleagues’ work therefore fits within a wider genre that considers how the everyday functioning of the government machinery is determined not by impartial bureaucrats but by the compulsions of local politics (Berenschot 2010; Witsoe 2012, 2011). Elected representatives, their brokers, political party leaders and workers determine people’s access to information on public services and programmes, their participation and benefits, and can even subvert programme objectives, sometimes defeating them altogether (Berenschot 2010; Corbridge et al. 2005; Sharma 2011; Witsoe 2012). Such practices of rent seeking and/or political control of bureaucratic functioning results from limited state capacity and a cascade effect of rent seeking from the political top to the street-level bureaucracy (Berenschot 2010; Witsoe 2012). Further political control can be exerted in some countries via the transfer system, whereby politicians also manipulate the working of bureaucrats through threats of punishment, ‘bad’ postings, or promises of favourable ones (Berenschot 2010; Witsoe 2012).

¹ Governmentality has famously been defined as concerned more with the governance of conduct rather than the conduct of governance (Dean 2010).
As with the lessons from the literature on participatory development noted above, this raises questions about supporting external ‘interventionist’ approaches to accountability versus the wider scholarly process of simply documenting and conceptualising extant initiatives. There is a danger that external initiatives shoehorned into community contexts without proper assessment of existing social and political structures simply work to shore up the position and power of those able to respond best to the kinds of processes, documents and procedures entailed by accountability initiatives. Worse, they may act to ‘depoliticise development’ in a manner that has been described by several classic ethnographies of development projects (most famously Ferguson 1994). As Corbridge and colleagues write of ‘the mainstream agenda of participatory development’ but which may again be applied to any accountability initiative, ‘[it] presumes what it must demonstrate: that strong individuals flourish in strong civil societies, and that distinct centres of bureaucratic power (or
governance) can be brought under their control. Politics gets lost in this mix, along with accounts of the structuring of local political societies.²

Understanding the context of accountability necessarily returns us to a critical re-examination of the forms of political and administrative accountability seen hitherto as failures. We have outlined how several scholars regard patronage and clientelism as evidence of political failure—a politics of poverty that transforms democracy into a messy sphere of informality, brokerage, desperation and greed (Piliavsky 2014). However, understanding how clientelism and patronage function as mediators of representative democracy or of administrative state schemes and programmes is a critical part of understanding: (a) the operation of accountability under the standard model; and (b) the context in which accountability interventions originating externally will also operate in nearly every situation—i.e. those situations in which the poor are interacting with the everyday politics of the state. Box 2, therefore, provides a further explanation of the functioning of clientelism and patronage, which draw on ethnographic and other critical insights into the everyday functioning of state institutions and their interface with ‘political society’ (Chatterjee 2004).

Finally, such analysis begs a further set of questions: if all these citizen–state or bureaucratic processes can be considered as accountability acts, then what are the processes triggered by specific development interventions (intervention-accountability) that introduce additional and specific instruments into this already complex mix? This is made even more complex by interventions that (following the accountability literature recommendations) may move beyond feedback loop mechanisms to wider demands on the state structured along the lines of collective action and advocacy and which may therefore carry intervention-accountability actions into the same domains as state or national-level party politics. This is interesting terrain for development actors in particular, where even very technocratic intervention-accountability cannot but play a role in these wider politics whether at the state or community level. Beyond the moral questions this raises (particularly for external actors), it reinforces the conclusion that a better understanding of the hidden politics of intervention-accountability is necessary for an understanding of why initiatives should ultimately succeed or fail on their own terms at any political level.

The complexities of these interactions mean perhaps that it would be better to understand intervention-accountability outside of a framing of success or failure. But we do not view this as a reason not to try to promote accountability in health and nutrition in South Asia given its current dire situation. The rest of the report is therefore intended for the cautious activist or development actor wanting to recognise this complexity and yet still ‘intervene’.

**Box 2: Understanding the everyday personal accountabilities of clientelism/patronage**

The barter of political support for direct individual profit is studied as ‘clientelism’ in political science and ‘patronage’ in anthropological and sociological literature. Early scholarship of clientelism emphasised direct, face-to-face interactions and transactions between the patron and the client (Hicken 2011; Kitschelt and Wilkinson 2007; Piliavsky 2014). Later research recognised that democratic electoral competition, especially at the national level, scales up clientelistic networks,

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² Corbridge and colleagues note this as a caveat to work in this field, not a barrier—in fact, they conclude that despite the criticisms that may be levelled at such policies or the need for loftier projects overcoming the functioning of political accountability (citing Harris-White 2003: ‘it is not obvious’ that practice would look so very different to NGO, government and international agendas that are promoting such themes of participation and accountability (Corbridge et al. 2005: 273).
introducing brokers and mediators between the patron and the client (Kitschelt and Wilkinson 2007). Yet, even extensive pyramidal hierarchies of brokerage rely on personal relationships between individuals – the patron and high-level brokers, high- and low-level brokers, and finally low-level brokers and the clients (Hicken 2011).

The clientelist exchange is direct and conditional. In democratic systems, politicians target benefits to specific constituencies on ethnic, regional, religious, class or caste lines. Within the programme politics frame, benefits are directed towards groups that are most likely to profit and therefore more likely to vote for the party or politician who provided the gains. However, there is no monitoring or enforcement of the same. In clientelistic politics, on the other hand, voters vote only for those politicians who promise to benefit them individually (through private rather than public goods) or in groups (through club goods) and politicians seek to benefit only those voters who assure them of their vote. The main criterion for giving and receiving resources is political support and not just membership of the target constituency. Accordingly, politicians in clientelist linkages set up elaborate devices and mechanisms to monitor the voting behaviour of clients and ensure their accountability. These include: (a) strategic mechanisms such as targeting benefits to constituencies that are more likely to respond favourably, rather than those that would support them anyway; (b) performative mechanisms such as demanding that voters publicly declare their support; by ferrying voters to and from polling stations, distributing food and drink to them and having party workers help voters cast their vote or exchange ballot papers with pre-marked ones; (c) organisational or relational mechanisms such as an extensive network of party workers, mediators and brokers who canvas door-to-door and/or enroll voters in a web of exchange, obligation and reciprocity over a period of time; (d) statistical mechanisms by tracking voting returns and opinion polls; and finally (e) illegal mechanisms such as violating the secrecy of the ballot or giving the impression that they can.(Hicken 2011; Kitschelt and Wilkinson 2007; Stokes 2007).

The political study of the links between elected representatives and their constituents tends to focus on its transactional nature whereas a more anthropological approach stresses the relational aspect. Anthropological literature rejects the clientelist conception of ‘elections as auctions’ with millions of profit-seeking voters ‘wielding the abacus of rational choice’ and instead focuses on why the patronal relation takes the form it does (Piliavsky 2014). Berenschot (2014, 2010) and Corbridge et al. (2005) find that voters want politicians who will do their work. Constituents often need political mediation to access public services and want representatives who will help them negotiate the local bureaucracy. Piliavsky (2014) argues that while this partiality is interpreted as corruption by the advocates of good governance, it is merely a representative working on behalf of the people s/he represents. She contends that the analytical lens needs to shift from the notion of a contract between politician and voter to the idea of representation. Conceptualising the patron–client linkage as a social relation, she highlights that politicians as representatives stand in and for their constituents and consequently work for their benefit. Patronage, for her, is a social institution that ‘ . . . involves entitlements and obligations, which are politically constitutive in their own right, and which oblige politicians to understand, convey and respond to their constituents needs’. A good patron is effective, resourceful and generous. S/he keeps their promises and shares gains with his/her constituents, unlike fixers, who transact only for their private gain. However, patronal generosity requires power and pelf, which powerful patrons extract from the state (Witsoe 2012).

Piliavsky’s notion of patronage, despite emphasising representation, remains a vertical relationship, with the patron looking after his/her clients as a part of a social responsibility. In contrast, Witsoe (2011) finds that in contexts of intense political competition between different social groups for dominance over the state, the political leader is supported to attain power to ensure the control of a particular social group over the state. The politician, in turn, works for the social upliftment of ‘his/her’ people. Patronage here is conceived ‘horizontally’: the patron and clients identify with each other such that the patron’s rise to power represents the clients’ ascent and vice versa.
1.6 Summary: conceptualising context for accountability at the community level in health and nutrition services

Much of the preceding review has covered ground that has been well explained in earlier reviews. But these reviews also expand in many directions beyond the context of community delivery of services in health and nutrition we would like to consider here. These wider concerns are inseparable from what happens at the community level and we are not suggesting that they are ignored. But the frameworks in Figure 1 and Figure 2 are also ambitious in their undertaking to consider issues ranging from examining the historical development of state–society relations and political settlements to assessing the capacity of civil society and political interlocutors. It might be useful at times to draw on a narrower subset of considerations when the locus of political or programmatic activity is at the community level, and it is these considerations we summarise here in preparation for further parts of this review.

The first set of considerations surrounds assumptions around community itself. Drawing from earlier critiques of participation and the wider literature on the embeddedness of the state in extant social and political structures, we note that no assumptions can be made about the community as a single, homogenous entity expressing any awareness or desire towards levels of service provision and service quality. Different parts of the community will serve their own needs through government and other private sector provision to varying extents or not at all. One part of the community might not welcome another part of the community’s increased access to a service, and both this existing service provision and likely disputes over future provision are likely to fragment along existing lines of social exclusion relating to caste, ethnicity, age, gender, sexuality, disability, and many other factors. This understanding of community also precludes ready divisions between the community and service providers. Frontline workers and low- to mid-level bureaucrats serving communities will be drawn from various parts of that community or different communities. Their identity (e.g. caste or kinship) may also affect the level of service they are willing to, or feel obliged to, provide.

The second set of considerations focuses on coercion and collective action. This is intended to reflect the actions of individuals and groups of community members operating to demand, incentivise and coerce action from service providers. As already flagged here, it has long been a contention in the accountability literature that overly technocratic interventions tend to ignore not only local politics but also any potential for translating community voice, demands and action into wider change. The importance of collective action is repeatedly highlighted in the literature as the key ingredient behind successful advocacy for better services – sometimes in conjunction with but at other times without the aid of accountability initiatives (Gaventa and Barrett 2010). But there are also many other low-level instances of coercion between community members and service providers (including ‘rude accountability’), which may realise dividends in terms of provision of services but which are not always preceded by larger-scale collective action.

The third set of considerations is to do with cooperation, capacity and commitment. This suggests that successful interventions involve work on both sides of the supply and demand divide. It also flags issues of the capacity of community-based frontline workers to meet any ‘demand side’ expectations that emerge from extant or interventionist accountability actions at the community level. But it also plays into wider concerns around capacity and commitment on behalf of local political actors to ‘forge and maintain synergistic relations with different social actors’ (vom Hau 2012, cited in Bukenya et al. 2012: 47), and the ability of
individuals or particular community groups to shape these same interests around their own. Commitment underlines the fact that service providers need to champion – or be prepared to respond to others’ championing of – particular aspects of services that require improvement or have yet to be delivered at all (a particular duty of a frontline worker for home visits, for example). This echoes other concerns in the wider literature stressing the need for wider state responsiveness (Fox 2015: 353; see also Joshi 2013b: s42-s43) and ‘sandwich strategies’, which place pincer pressure on such responsiveness from above and below (Fox 2015: 355–6).

The final set of considerations suggests a reappraisal of clientelism or patronage in all the nuanced ways suggested by Box 2 and the preceding section. The reference to clientelism stands therefore for all those further dimensions of interactions between existing community social relationships, agents of the state and political actors. This is not invoked to suggest a positive reappraisal of clientelism or patronage, but simply to imply that how these institutions function is critical to understanding how poor people and groups of poor people usually experience the everyday workings of the state prior to, during and after the existence of an accountability intervention.
2. Accountability initiatives in health and nutrition in South Asia

2.1 Health systems in South Asia and the standard model of accountability

The three countries chosen for this study share a common political past (shared until independence from colonial rule in 1947; and from Bangladesh’s independence from Pakistan, in 1971). They exhibit common problems, some of which affect all post-colonial contexts while others are specific to the region, reflecting wider problems of governance failures, accountability deficits and failures to implement adequate service delivery discussed so far in more general terms. These states also all face specific challenges in terms of equitable health and nutrition service delivery.

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

Broad indicators of health outcomes and access have shown some moderate improvement (e.g. in maternal mortality in Pakistan – Nishtar, Boerma, Amjad, Alam, Khalid, Ul Haq and Mirza 2013) or even substantial improvement (e.g. infant, child and maternal mortality in Bangladesh – Chowdhury, Bhuiya, Chowdhury, Rasheed, Hussain and Chen 2013) but are generally still poor by international comparison (Figure 3). Indicators of health systems and outputs are also poor (Table 1) and explained, in recent analyses, as relating directly to aspects of poor governance, including endemic corruption and accountability gaps (e.g. Nishtar et al. 2013: 2198–2200). A recent paper on South Asia summarised ‘bad governance, inadequate monitoring, weaker health institutions, and poor accountability… as factors inhibiting progress in the region [on child and maternal health and nutrition]’ (Rajan, Gangbar and Gayithri 2014).

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

In Pakistan, the least densely populated of the three states, similar drives of militarisation and authoritarianism have affected the state’s political trajectory and its relation with citizens. The government mandated a process of devolution in services such as health care and education in 2000 that followed the Indian three-tier model. However, while community meetings and public hearings have played a key role in several social accountability movements in India at the grassroots level, and have also been used in Bangladesh, they have been largely absent from the literature on Pakistani social accountability initiatives (SAIs).
Finally, India is the largest of the three in terms of population, size and gross domestic product (GDP), and is characterised by a highly heterogeneous population (in terms of social, cultural and economic factors) and complex relations between central and state party politics.

While divisions drawn based on judgements on the ‘standard’ or ‘quality’ of democracy between the three states can ring hollow and appear reductive (Jalal 1995), the nature of political processes between the centre and state in each country varies according to paths taken; the case studies illustrate the ways in which differing political contexts have shaped both formal service delivery and community movements, particularly in health care and nutrition.

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

<table>
<thead>
<tr>
<th>Health systems</th>
<th>Health outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public expenditure in health (as percentage of GDP)</td>
</tr>
<tr>
<td>South Asia</td>
<td></td>
</tr>
<tr>
<td>Bangladesh</td>
<td>3.7</td>
</tr>
<tr>
<td>Pakistan</td>
<td>2.5</td>
</tr>
<tr>
<td>Nepal</td>
<td>5.4</td>
</tr>
<tr>
<td>India</td>
<td>3.9</td>
</tr>
<tr>
<td>West Bengal</td>
<td>NA</td>
</tr>
<tr>
<td>Southeast Asia</td>
<td></td>
</tr>
<tr>
<td>Cambodia</td>
<td>5.7</td>
</tr>
<tr>
<td>Laos</td>
<td>2.8</td>
</tr>
<tr>
<td>Burma</td>
<td>2.0</td>
</tr>
</tbody>
</table>

EPI=expanded programme of immunisation. NA=not available.
Source: Chowdhury et al. 2013

Considering how such contexts provide a setting for accountability, it is easy to see why there may be specific failures in addressing poor health and nutrition performance and inequities under the ‘standard model’. Standard governance models work on the assumption that representative democratic systems will direct resources towards pressing health problems and that where they fail, citizens can engage with the system via the principal agents (local leaders, politicians, etc.) described above. However, in both the regional and global literature, a great deal has been written about the need for the existence of political will (Rajan et al. 2014), commitment (Heaver 2005) and attention (Shiffman and Smith 2007; Shiffman 2010; Shiffman, Quissell, Schmitz, Pelletier, Smith, Berlan, Gneiting, Van Slyke, Mergel, Rodriguez and Walt 2016) in order to direct policy attention towards pressing health issues. Without this, many health issues remain both invisible (whether to the political system or to communities themselves) and ignored within the standard model.

Even where policy has been directed to specific health problems, without further political attention the system bears a huge risk of rent-seeking individuals overriding any public good. Rajan and colleagues, for example, comment on the way in which India’s community for nutrition delivery (the Integrated Child Development Services) ‘has continued to emphasize political returns over beneficiary impact; whereas Sri Lanka has been able to create a
political environment where beneficiary improvement breeds political returns… the result of bottom-up demand for quality service provision and top-down accountability for effective implementation’ (Rajan et al. 2014: 6). Such calls for greater accountability and transparency are repeated in other reviews of health systems in the region (Nishtar et al. 2013: 2199), but have yet to be realised.

**Figure 3: Selected health indicators in South Asia and China**

![Figure 3: Selected health indicators in South Asia and China](Image)

Source: WHO 2016

### 2.2 What are the lessons from the global literature?

The preceding findings have relevance to most sectors to which accountability initiatives might be applied and it should be noted that these reviews have also included findings on health and nutrition as part of their scope. Fox’s meta-review of 25 ‘large N’ quantitative studies, for example, includes two interventions with positive health impacts (lowered infant mortality via participatory budgeting in Brazil and improved health outcomes via participatory monitoring in Uganda – discussed below). Mansuri and Rao’s (2013) study of over a decade of World Bank-funded ‘community-driven development’ projects, quoted at the beginning of this paper, noted significant improvements in health outcomes, behaviours and service use.

Other studies have systematically reviewed the evidence in terms of the impact of accountability (in health in particular) on:

- care quality for consumers (Berlan and Shiffman 2012);
• the functioning of ‘peripheral health facilities’ (i.e. clinics, dispensaries, excluding hospitals and district facilities) (Molyneux, Atela, Angwenyi and Goodman 2012);
• health facility committees (McCoy, Hall and Ridge 2012);
• community monitoring (Flores 2011);
• contextual factors influencing health committees (George, Mehra, Scott and Sriram 2015a);
• awareness raising (of rights) and utilisation of maternity care services (George, Branchini and Portela 2015b);
• the influence of resources, attitudes and culture on the functioning of accountability mechanisms in primary health-care settings (Cleary, Molyneux and Gilson 2013).

In several cases the evidence is found to be ‘weak’ (Berlan and Shiffman 2012: 277; Molyneux et al. 2012: 552), largely due to the lack of rigorous quantitative studies. However, intervention design may be an issue, given that one review found studies overwhelmingly reporting committee/group-based interventions (ibid.; 19 out of 21 studies3). While noting this lack of rigorous quantitative evidence, authors also stress the need to move beyond the assumed gold standard of randomised controlled trials (RCTs), given that it is equally important to understand how and why particular outcomes are being achieved in different situations – something that is addressed better by longitudinal and qualitative studies (McCoy et al. 2012: 460). Mixed methods are also advocated to combine more rigorous assessment of impacts with explanations of why such impacts were reached (ibid.; see also Lodenstein, Dieleman, Gerretsen and Broerse 2016: 3, arguing for a realist perspective).

Several of the findings are consistent with the wider literature on social accountability, including: the need to pay attention to user needs for appropriate information (rather than information for information’s sake) (Berlan and Shiffman 2012: 278); the importance of not assuming community homogeneity (Molyneux et al. 2012: 552); the importance of political context (ibid.: 553; McCoy et al. 2012: 458–9) and therefore of ensuring adequate representation of the community (George et al. 2015a: 162), including addressing economic barriers (McCoy et al. 2012: 457); understanding how interventions play out on the supply side in terms of ‘provider norms’ (Berlan and Shiffman 2012: 277); and finding the right links to collective action, civil society and other institutions (ibid.: 278; Molyneux et al. 2012: 552–3; McCoy et al. 2012: 458; Lodenstein et al. 2016: 10).

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

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3 This appears to reflect the dominant choice of committee/group-based interventions for accountability approaches within the health sector – another two of the above reviews deal primarily with committees. Because of the lack of clear evidence it cannot be concluded that this approach is therefore not effective in health contexts – but this weaker ‘gene pool’ of approaches within health does potentially limit the opportunities to learn from experimenting with a range of approaches in different contexts.
Our review below classified studies according to a broader terminology that has been emerging for some years in the wider accountability literature (see e.g. Joshi 2013b) according to specific approaches (user-centred information access, complaint/grievance redress, citizen report cards, public hearings, community scorecards, community monitoring, participatory budgeting). Another review classifies such actions under dialogic and advocacy approaches focusing on different stages of accountability processes (Table 2).

### Table 2: Dialogic and advocacy approaches to accountability

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

Source: adapted from Lodenstein et al. 2016

In addition to highlighting the difference between process impacts (such as improved governance reforms) and service quality outcomes, Joshi argues that in the case of health accountability initiatives, it is hard to separate positive outcomes resulting from increased uptake and improvements caused by improved accountability in the service itself (Joshi 2013: s32–33). This is not necessarily a negative outcome, but it does make it difficult to draw lessons that can inform the design of future approaches. Another study of accountability in São Paulo underlines these differences in showing how levels of social accountability are much higher for health than for social services, reflecting the different institutional models that have been adopted. Service delivery in health requires physical points of contact between citizens and agents of the state, including local health posts and participatory councils, and coordinating bodies at local levels of government. Programmes such as cash transfer schemes, however, entail fewer physical or organisational contact points around which people can mobilise (Unsworth 2010). On the other hand, health delivery – more broadly conceptualised as including public health and preventive rather than

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4 Joshi’s broader argument here is that poor people often ‘opt out’ of health and education services when not provided adequately by the state – either by going to private/informal providers or by not using services at all.
purely curative services – is likely to suffer in contexts in which citizens and providers see delivery largely in terms of the logistics and receipt of medical products such as drugs.

While these meta-reviews point to positive outcomes, understanding how these outcomes came about is consistently related to context (Molyneux et al. 2012: 553; Bukenya et al. 2012; Fox 2015; Joshi 2013). In the next section, we discuss some of the key studies from our literature search that illustrate the thematic ‘lessons’ emerging on accountability in health and nutrition.
3. Summary of current practices drawn from the literature

3.1 Methodology of review

The review took as its starting point a broad view on what constitutes evidence on impact and practice, considering both qualitative and quantitative evidence. The review methodology consisted of a two-step search process. In the first step, keywords were generated from a rapid review of the definitions offered in the theoretical literature on social accountability, particularly those with a focus on community-based initiatives. These keywords were used to create search strings within the date range 2000–2015 and restricted to sources focused on developing countries. These search strings were applied to indexes in cross-disciplinary databases in the social and medical sciences: JSTOR, Scopus, IBSS, Google Scholar, MEDLINE and PubMed.

Each database searches across thousands of online journals. Based on a title review, and following removal of duplicates, an initial total of 131 articles were yielded. Following a review of the abstracts of these initial findings, and including findings snowballed from reference scans, the results were narrowed down to 25 relevant articles.

The second step entailed a search of the existing grey literature for the same date range, sectoral and geographic parameters, and using the same keywords. An initial list of key ‘catalyst’ websites and search engines was devised, and references were snowballed from these websites and search engine results. Following the same initial elimination process, a list of 65 sources was identified.

Using these findings from the original multi-sectoral literature search results (from both academic and grey literature) as a starting point, the references were used as a basis for the snowball method. In addition, a rapid review was conducted to capture any more recent publications. A broader review of recent critical reviews and meta-reviews was also consulted to identify any important missed findings and wider conclusions.

Finally, 29 studies focusing on the health and nutrition sectors were identified following an abstract review process. Following an in-depth text review of this subset and narrowing down on cases from India, Bangladesh and Pakistan, 26 studies were finally selected according to the following criteria: an evidence-based approach (i.e. some basic description of qualitative or quantitative methodology pursued); a focus on health and/or nutrition and relevant determinants such as sanitation; and a specific focus on community-based accountability.

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A broad view of nutrition determinants was employed here to capture activities at a community level likely to be of relevance to nutrition outcomes. We followed the UNICEF (1990) framework, which outlines how underlying factors in the community such as care practices, health, and water and sanitation environments can have a collective impact on nutritional outcomes for children and mothers as well as food intake. Likewise, more basic determinants, including income, can also be strongly linked to nutritional outcomes, hence the inclusion of relevant social protection schemes targeting the poor.
3.2 Social audits/public hearings

Social audits and public hearings are terms which often overlap in the literature. They are commonly used to describe accountability tools where public expenditure or service delivery outcomes are shared with communities in a public meeting (Joshi 2013b). They enable the dissemination and transparency of information and provide a platform for communities’ voice in a multi-stakeholder forum. In the health and nutrition sectors, they have been used as a direct and timely mechanism for exercising voice-based accountability – either in rallying for rights and reform or for redress of grievances.

While community meetings and public hearings have played a key role in several social and community-led accountability movements in health and nutrition in India at the grassroots level, and have also been used in Bangladesh at higher levels of governance and in more formalised mechanisms, they have been largely absent from the literature on SAIs in Pakistan.

In India, a widely cited study by Papp, Gogoi and Campbell (2013) highlights the importance of awareness as an imperative for communities to make demands for better health services, following findings from a series of interviews and focus groups from programme participants in Odisha (formerly Orissa). Public hearings designed to bring women together on the issue of maternal health were organised by an alliance of CSOs as part of a trio of accountability tools to address gaps in government maternal health programmes. Local village committees (Jaanch committees), women’s self-help groups and mothers’ committees were given specific responsibilities to supervise and monitor the nutrition components of the Integrated Child Development Services (ICDS) scheme. A social audit suggested a prescribed menu (designed to protect against malnutrition) and observed an increase in children’s attendance at anganwadi (Ahuja 2014). An improvement was also seen in the nutritional composition and dietary diversity reflected in the menu. The reported findings also state that an emphasis on locally sourced, fresh ingredients led to increased food production locally, thus boosting income multiplier effects. Increased community participation in AWCs and increased community-based management of acute malnutrition (CMAM) and growth monitoring of children was also observed (Ahuja 2014).

The civil society alliance developed these mechanisms in response to low awareness among women – most acutely in tribal communities – of available maternal health-care services and public entitlements, and of childbirth-related risks, all compounded by economic, geographic and social indicators. In addition to public hearings, the alliance of civil society groups also made use of maternal death audits via verbal autopsies and health facility checklists.

The public hearings were shown to be effective as a ‘one-size-fits-all tool meant to target several audiences simultaneously’ (Papp et al. 2013: 454). Grievances could be discussed openly in a forum designed to be accessible to participants on both the supply and demand side, with a particular focus on marginalised women. Accessibility was encouraged through the choice of the physical space itself – an open space located where participants could be seen publicly in discussion by all, thus enabling several different audiences to be targeted.

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6 Papp et al. draw from George’s (2003) approach to accountability, based on the idea that information, dialogue and negotiation are all crucial in ensuring non-homogenous community participation. These three factors should form the basis of any accountability mechanism at the community level to ensure support for marginalised groups to exercise voice in unequal power relations; the identification of structural causes of unaccountability and feasible resolutions and helping to ‘transform’ the way in which both marginalised participants and those in power view their positions in accountability relationships (Papp et al. 2013: 452).
The space for public hearings was also supported by intermediaries such as the civil society alliance, media and public officials, with the aim of building responsiveness to women’s needs. The hearings were initiated in many cases with a public rally generating crowds of up to thousands (WRA 2010 and Futures Group 2010, cited in Papp et al. 2013).

A recent study of social audits in Karnataka, South India, under the Mahatma Gandhi National Rural Employment Guarantee Scheme (MGNREGS) attempts to observe the links between citizen participation and the role of politics and accountability outcomes (Lakha, Rajasekhar and Manjula 2015). The social audits adopt a multi-stakeholder approach and belong to the category of accountability mechanisms designed to broadcast voice (Paul 1998).

Findings were gathered from focus group discussions with local women, including expectant/new mothers and women of childbearing age and village maternal health-care workers. Key informant interviews were also held with local health providers, policymakers and government officials, as well as CSOs. The main findings suggest that public hearings and rallies enabled local CSOs to engage directly with women when educating them about maternal health and entitlements. Links were forged between existing women’s self-help groups to train group leaders and spread information among group members about the public hearing as well as maternal health and entitlements. The hearings and rallies were held regularly and were thus embedded into the daily lives of the community rather than isolated as stand-alone projects.

Tempering these positive findings, however – and linking back to the earlier reference to the importance of extant political context – Lakha et al. 2015 conclude that ‘co-option and collusion’ between local governance members and their kinship networks are widespread; there is a conflict of interest in much of the role allocation and the social audit mechanisms themselves are mediated through dominant actors and arbiters of elitism. The study authors argue that elite capture of both resources and power can be the result of social processes and structures regardless of level of hierarchy, as elites exist at every level of governance (DiCaprio 2012).

While the examples from social audits in India have been led or mediated by CSOs, they have been held mainly at the grassroots level. A comparison with the available literature suggests that social audits have been used in Bangladesh to build the capacities of Union Parishad (UP) members, civil society representatives and communities to monitor the working of the Local Government Support Project II (LGSP II). The project aims to strengthen local government to manage public services and resources (although it does not have a strong health or nutrition focus, the sanitation elements have warranted its inclusion here). Under LGSP II, grants are provided to local government to be used for public projects, such as the building of roads, toilets and tube-wells, which are to be selected and implemented by the community. Three committees were set up to facilitate these processes: a three-member committee comprising the UP chairperson, secretary and one member for fund management; the ward committee to plan and implement projects; and a scheme selection committee for monitoring the implementation of projects.

The Citizens Making Governance Effective project was undertaken by Democracy Watch under the supervision of Manusher Jonno Foundation (MJF) and Partnership for Transparency Fund to strengthen the working of LGSP II in selected areas. Democracy Watch selected and trained citizen group committees (CGs) to review and support the functioning of the ward and scheme selection committees. The CGs collected information on the use of grants received

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7 A nationwide public works and wage labour guarantee scheme, which came into law in 2005. More information can be found here: www.nrega.nic.in/netnrega/home.aspx
under LGSP II, which was verified through focus group discussions with the ward and scheme selection committees as well as community members. These data were then analysed to identify problems and issues. These were presented in a public hearing attended by community members, UP representatives, various committee members and civil society representatives to solicit their suggestions and feedback. The social audit process improved awareness among UP members regarding their annual budgets as well as development plans. It also improved the participation of all committee members who gained confidence about executing their roles. UP functioning became more transparent, with the quotation method rather than open procurement being preferred for obtaining materials. Yet scheme selection continued to be influenced by the elected representatives’ personal interests (Democracy Watch 2014).

3.3 Community monitoring and committees
Community monitoring mechanisms aim to oversee ongoing activities of service providers and are often used as a way of ensuring that an accepted standard of performance (as defined by the community) is maintained. This usually involves measuring easily observable features such as staff attendance, quality of construction in facilities, or adherence to appropriate procedures (Joshi 2013b). Community monitoring processes can often force the ‘supply’ and ‘demand’ sides of accountability relationships to come together; they can also be used to expose corruption among service providers and public officials (ibid.).

Community monitoring can often form an integral part of participatory and community-based development efforts and its use has been widespread across sectors and contexts. In the majority of health and nutrition examples reviewed, such monitoring took place through the work of committees comprised of users, community, political and/or service provider representatives. Alternatives exist, however, in the form of a smaller number of examples of mechanisms that overlap with wider participatory initiatives, such as those described in Box 3.

In Bangladesh, this review identified a range of cases of community monitoring in the health sector. Their approaches ranged from rights-based social mobilisation – in the case of Naripokkho (Taking women’s side) and Nijera Kori (We do it ourselves) – to research-based community analysis carried out by the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B).

Naripokkho’s Women’s Health Rights and Advocacy Partnership (WHRAP) project (2003 onwards) attempts to work through multiple levels – from the village to the state – to strengthen health system accountability. At the village level, Naripokkho has set up women’s groups or Nari Dals to create awareness about health rights and entitlements and demand quality health services from public facilities. Nari Dal members protest instances of rent-seeking and denial of services by health service providers through confrontation, argument and shouting slogans. They also conduct regular monitoring visits to their local Union health and family welfare centres. Their awareness of entitlements and group strength forces the health system to respond to their demands. At the district and sub-district levels, the 16 NGO partners of WHRAP each monitor a health centre for cleanliness, staff attendance and staff behaviour towards women patients, sharing their observations with the hospital management committee of the facility and at the district and sub-district level NGO coordination committee meetings. Their intervention is reported to have led to improvements in the cleanliness of facilities, ambulance availability, power supply, availability of patient beds and reduced rent-seeking. WHRAP also works to activate the largely non-functional hospital management committees, which every public hospital is expected to have. Chaired by the local Member of Parliament (MP) and including stakeholder representatives such as hospital employees, health
department and local government officials as well as civil society members, this committee has the ability to identify and solve local problems. Activating these committees involves convincing MPs to convene meetings and convincing members to attend those meetings. Active hospital management committees have been reported as effective in reducing private practice by doctors during hospital hours, rent-seeking, and in improving the quality of inpatient meals (Barpanda, Afrin and Das 2013).

In contrast to Naripokkho’s movement towards health service accountability, Nijera Kori’s (NK) health watch committees were set up as part of the Bangladesh government’s invited institutional spaces for people’s participation in 1998. The government proposed health watch committees of community members from different professional and social groups to monitor the functioning of local health facilities at the UP and upazilla parishad (sub-district) levels. Nijera Kori was one of four NGOs tasked with forming these committees. Based on its experience and approach, NK modified the government guidelines and set up two health watch committees for each union, comprising 50 per cent female members. A female member of the UP chaired the committee with an NK worker as secretary and members drawn from NK’s landless groups, professionals and service holders. Members actively resisted the inclusion of public health staff in the committee, fearing a conflict of interest, although local health facility doctors were eager to participate. The upazilla parishad committee comprised nine members from different professions, an NGO representative, a woman, a UP member, and two members from union health watch committees (Johnston 2009; Mahmud 2009, 2007; Schurmann and Mahmud 2009).

Mahmud (2009, 2007) found that while selection to the NK committees was conducted in a transparent and participatory manner, most members selected were associated with NK’s other social mobilisation activities in some way. As a result, union committee membership was quite homogenous; most members were neighbours. However, this also meant that many villagers who were not a part of NK were not aware either of the existence of the health watch committees or their purpose. On the other hand, women were more active and vocal in the union-level committees due to the absence of elite and male domination. In the upazilla level committees, where membership was more varied (with many members neither poor nor related to NK), women were not able to express their opinions as freely. Elite and non-elite members were also found to have different but complementary modes of participation. Whereas elite members were more comfortable and effective in dialogue with health service providers, non-elite members led and participated in confrontation and loud and noisy protest.

The health watch committees were effective in raising awareness about nutrition, sanitation and hygiene, and increasing the utilisation of health services (Mahmud 2009). However, their ability to influence the working of health service staff was limited as they lacked official recognition and authority (Johnston 2009; Mahmud 2009, 2007; Schurmann and Mahmud 2009; Thomas, Sarker, Khondker, Ahmed and Hossain 2003). In the absence of the promised legal basis for their activities and identity cards by the Ministry of Health, public health doctors who were openly hostile towards the health watch committees were able to ignore their demands (Mahmud 2007). Backed by a powerful medical association and the absence of any laws to regulate their performance, doctors continued to collect illegal payments despite, in one instance, being confronted by the chairman of the upazilla parishad committee, a college professor (Thomas et al. 2003).

In 2004, Bangladesh’s health watch committees were disbanded under the government’s health policy reforms, but those mobilised by NK continued. Mahmud (2009) attributes the survival of NK’s health watch committees to their roots in rights-based mobilisation. In her view, citizens need to be politically aware and active to effectively exploit the potential of
participatory spaces created by the state. However, Thomas et al. (2003) argue that NK’s confrontational approach – especially the use of satirical folk songs and drama – severely limited its impact as it was never able to create a platform for dialogue with local public health staff.

Elsewhere in Bangladesh, ICDDR,B set up health monitoring committees as part of a community health project trial in Chakaria, a remote coastal area. The objective was to develop a strategy to empower the community in three stages. Stage one involved rapport-building and community needs assessment; stage two involved the development of a monitoring plan; and stage three involved analysis and interpretation of findings and their dissemination among the community. Stages two and three were the main components of the project and were repeated in four-monthly cycles. Community monitoring teams comprising 6–8 people (males and females of different ages) were set up to collect, analyse and interpret data. A progress review committee of 3-4 leaders was set up to guide them. Both types of committees were trained in sampling techniques and data collection methods. The monitoring teams conducted exit interviews at UP and upazilla-level health facilities to identify barriers to health care and community surveys using the lot quality assurance sampling (LQAS) technique on topics of their choice – immunisation status, sanitary facilities and the use of iodised salt. After every round of data collection, committee members received training on data analysis and interpretation techniques. Dissemination meetings were organised at the community level at which the teams shared key messages they had identified. Dissemination meetings at the union level were organised annually, where the data collected and analysed were shared in various forms. These events formed the basis of a dialogue between service providers and communities, which led to improvements in health staff performance – for instance, attendance of doctors increased by 56 per cent, whereas the comparison area registered an increase of only 12 per cent (Aziz, Bhuiya, Hanifi, Iqbal, Looman, Costello and Prost 2009).

Box 3: Overlaps between participatory and accountability programmes in community health – two examples from India

While the specific evidence-based literature on social and community accountability initiatives in health and nutrition in India is relatively scarce, there is a rich tradition of participatory and civic engagement initiatives strongly linked with the context of a democratic system and activist-judicial nexus. While the cases below do not fall within the definitional framework for community and social accountability as discussed in this review, there are overlaps with existing accountability initiatives that can in some ways offer insights into the functioning of effective initiatives.

Houweling, Tripathy, Nair, Rath, Rath, Gope, Sinha, Looman, Costello and Prost (2013) conducted a three-year quasi-experimental study to measure the impact of a community participatory mechanism, the ‘Ekjut’ trial, on the neonatal mortality rate (NMR). The cluster-randomised study took place across three districts in Jharkhand and Odisha – two of India’s poorest states with a high proportion of marginalised tribal communities. The findings showed that the participatory initiative was effective in reducing the NMR among the most marginalised communities. While the Ekjut initiative is more broadly focused on stimulating community participation rather than specific accountability mechanisms, the study shows encouraging results in terms of the impacts of community participation on maternal health care.

The mechanism was based on a ‘participatory learning and action cycle’ where maternal and infant health problems were identified and prioritised. These problems were then addressed using strategies developed, implemented and evaluated on a community-wide scale. The groups were designed to be as accessible and open as possible in both social and physical terms. They were open to non-members, used accessible language, and overcame widespread illiteracy by using picture cards, games and stories relevant to women’s experiences. Group meetings were held in remote areas such as hamlets, as well as the main villages, and the members themselves were in charge of setting the dates and times of each meeting. The facilitators were of the same tribal status.
as many of the community members, thus bridging across any potential social divisions or deterrents for participants.

The findings of the study in the intervention group showed that between baseline and endline, the NMR declined by 50% among lower socio-economic groups and by 71% among the most marginalised groups. There was also a decline (although of a lesser proportion) among higher socio-economic groups. In the control areas, the NMR remained stable or increased across all social groups. Impacts were also observed on maternal health behaviours such as hygiene practices in home deliveries; attendance at the women’s groups also increased significantly over time. The effectiveness of the intervention was not only attributed to its participatory and accessible design but also to how simple the interventions were. Houweling et al. observed potential ‘spin-off’ effects where one risk factor was addressed and in turn led to addressing another – e.g. addressing infection led to greater survival benefits for babies of low birth weight.

Elsewhere in India, the Mitanin programme – a community health intervention in Chhattisgarh – has been deemed an effective form of ‘integrated governance’ in terms of both sectors and levels of governance, and exemplifies a multi-level approach to community accountability of health care similar to the Naripokkho model. The model is designed to address both upward and downward chains of accountability (Kalita and Mondal 2012). A case study of the programme shows the link between integrated governance and a reported improvement in maternal and child health care, as well as an increase in community participation and higher prioritisation of health care within local government agendas. The case study is based on data collected using qualitative and quantitative methods.8

The intervention mobilised communities via women health workers at the hamlet, village and village-cluster levels. The communities integrated as clusters at a higher level to include panchayats (village governments). Key findings include: an increase in referrals of pregnant women and children; an increase in interaction in common forums; and also increased frequency of meetings. Post-intervention, 78.6% of gram sabhas (village meetings) prioritised health and nutrition issues on their agendas.9 Community awareness of entitlements to food subsidy schemes increased in intervention villages to 63.6%, compared with 44% in non-intervention villages. Other positive impacts were found in ante-natal care, immunisations, counselling of mothers and children about health and nutrition, institutional deliveries, and growth monitoring and advice about child weight. Overall, this suggests that where collective actors are involved during significant moments of public reform, they are more likely to influence the design of institutional mechanisms and thus remain engaged in monitoring activities (Kalita and Mondal 2012).

Partnership defined quality (PDQ) is an approach to community accountability used by the international NGO Save the Children. In Pakistan, it used this approach to encourage community involvement in defining, implementing and monitoring the quality improvement process of service delivery.10 The process was facilitated by district-level teams who held community workshops. Community representatives and health workers were brought together to form ‘quality improvement teams’: producing action plans, mobilising communities and ensuring sustained dialogue between communities and providers (Green 2011).

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8 Primary document analysis, interviews and groups discussions are combined with survey data on impact of integrated governance on service delivery, conducted on a randomly selected sample across intervention villages matched with non-intervention villages for comparative analysis. The qualitative data were analysed according to pre-determined themes to study the State Health Resource Centre (SHRC) and integration as processes in organisational management. The quantitative data were gathered through surveys and compared with comparison areas (matched geographies without focused interventions). Regression analysis was then conducted to detect significant differences between services and human resources in the two areas, if any, at 0.05 confidence interval.

9 The State Health Resource Centre (SHRC) – a joint initiative of ActionAid India and the government of Chhattisgarh – was used by the researchers as a resource to help build evidence through document analysis for this case study. The documents included internally published reports as well as unpublished material in the form of proposals and concept notes. Further information can be found here: www.shsrc.org.

While the outcomes were reported as mainly positive, they were part of a project framework rather than being implemented on a transformative community-wide scale. The communities’ capacity to participate in quality improvement as taught by the local implementation teams was enhanced and infrastructural and procurement gains were made (improvements in water supply and the introduction of an ambulance). However, the challenges reported indicate flaws in design reflecting those commonly found in top-down approaches to community mobilisation and community-led accountability movements: the programme demanded a 'high level' of participation and it was also difficult to encourage participation from those in the most marginalised groups (Green 2011).

The Tawana Pakistan Project (TPP) (2002–2005) was implemented by the Pakistan government with funding from the United States Agency for International Development (USAID). The project aimed to address malnutrition among girls and was implemented in 4,000 schools. Citing primary evaluation data from Badruddin, Agha, PeerMohamed, Rafique, Khan and Pappas (2008) and Pappas, Ghaffar, Masud, Hyder and Siddiqi (2009), Khan, Rafique and Ali Bawani (2013) argue that the project functioned effectively as an accountability mechanism but ultimately failed due to a hostile political context. The project targeted the structural causes of malnutrition by taking a participatory approach to implementation and accountability. It aimed to provide sustainable nutrition solutions by mobilising communities around malnutrition, and establishing a transparent information system for monitoring (Khan et al. 2013). Women in the community were given the chance to learn about the importance of nutrition, and of education for girls. They collectively managed the procurement, preparation and delivery of daily nutritional meals for schoolchildren. Village-based nutritional committees raised self-managed funds through member contributions, with self-monitoring and accountability procedures in place. Data gathered from growth monitoring, attendance records, pre- and post-intervention community-based surveys, focus group discussions and a KAP (knowledge, attitudes and practices) survey suggest a reduction in all forms of malnutrition in the community and improvement in caregivers’ nutritional awareness (Badruddin et al. 2008; Pappas et al. 2009).

However, the project was closed after three years, which Khan attributes to the ‘politics of nutrition’ (Khan et al. 2013: 81) – the overriding political context of corruption among local and central government actors. The TPP’s financial mechanism prevented the diversion of funds, and helped to introduce financial transparency at community and district levels up to central government level, and subsequently became a ‘source of tension’ (ibid.) for state decision-makers. Khan et al. cite the example of changes made to the model for contracts concerning the provision of food, which created opportunities for leakage and diversion. That the community themselves lacked capacity to challenge the cancellation of the TPP is indicative of the power imbalance between communities and the state, even for mechanisms explicitly designed to resolve this.

Following a series of nationwide health sector reforms, Primary Care Management Committees (PCMCs) – formed of community volunteers and health-care providers – were set up in the Khyber Pakhtunkhwa province of Pakistan (Khan and Ahmad 2016). The committees are an example of community-based practices that become formalised under government reforms. Key functions include generating awareness, ensuring gender inclusiveness and development of health facilities. The PCMCs also function as community accountability mechanisms in the sense that they are tasked with ensuring financial transparency and are bound to share information in upward accountability processes, although no information is reported on downward accountability processes. The provision of ‘public information boards’
to expose staff absenteeism, corruption such as overcharging, lack of available medicines and test facilities in public areas is designed to share information with communities at an accessible level. Finally, the installation of a ‘complaint management system’ to act as a grievance redress system has been reported, although there is little information on the outcome of this mechanism (Khan and Ahmad 2016).

3.4 Citizen report cards

Citizen report cards are user-led assessments of the performance of public services on parameters such as availability, access, quality and reliability, which are combined with publicity and advocacy strategies to extract social accountability from the state (Wagle, Singh and Shah 2004). Recognised as a powerful voice mechanism (Thampi and Sekhar 2006), the methodology was pioneered in Bangalore, India, in 1993 and has since been used extensively in countries such as the Philippines, Uganda, Ghana, Malawi, Kenya, Tanzania and Ukraine, with varying degrees of success (Ahmad 2008; Ampratwum, Armah-Attoh and Agyei Ashon 2014; Browne 2014; Wagle et al. 2004).

According to available literature on the health and nutrition sectors in India, citizen report cards have been used extensively as part of the community monitoring process of the National Rural Health Mission, which was launched in 2005 to revitalise the public health system. The community-based monitoring programme began in 2007 on a pilot basis in select districts of nine states in partnership with reputed and experienced NGOs. An Advisory Group on Community Action (AGCA) was constituted by the Ministry of Health and Family Welfare, comprising NGOs, health experts and government representatives. Its mandate was to pilot and streamline an accountability structure to strengthen local service delivery. Part of this structure entailed community-level planning and monitoring carried out through village health and sanitation committees (VHSCs), with citizen report cards being the first step in the community monitoring process. Members of these committees were trained and supported to fill out village health report cards, which included indicators on the availability of various services at the village level as well as quality of care at the primary health centre (PHC), the utilisation of untied funds, and health outcomes. More importantly, committees receive an untied fund of 10,000 rupees per year to conduct activities to improve sanitation, health and nutrition services in the respective hamlets.

However, a study found significant gaps in the training and awareness of committee members, hampering their ability to use the committees for planning and monitoring purposes (Pandey and Singh 2012). Nevertheless, other studies note how the report cards were displayed in a prominent place in the village and a copy sent to the PHC monitoring committee for further dialogue and action. Selected community members along with block facilitators were also trained and supported to fill out facility report cards on indicators relating to infrastructure, human resources and supplies as well as quality of care. According to Shukla, Scott and Kakde (2011), the citizen report cards helped create awareness about public health services.

Committees are a top-down structure, with funding coming from the Health Department and activities led by government frontline workers, who act as convenors and record-keepers. Decision making over budget allocation and expenditure is taken upon inputs provided by frontline workers and medical officers. Community awareness of committees is primarily linked to the existence of the untied fund, which allows the committee to employ community members to carry out works and repairs at village levels. Funds are also utilised to support access to health services by providing financial assistance to the poorest individuals. In this sense, committees are intended to fill gaps in service delivery and facilitate decentralised service delivery rather than serving as a platform to hold service providers accountable.
entitlements among communities and concretised their sense of being wronged, which in turn fuelled mobilisation for demanding action.

In Bangladesh, citizen report cards have been used in very different ways by CSOs and the state. While Transparency International, Bangladesh (TIB) has used citizen report cards as part of a larger effort to create a social movement against corruption, the Bangladesh Rural Water Supply and Sanitation Programme of the Ministry of Local Government, Rural Development and Cooperation has used them as a data collection tool to obtain feedback on the programme.

TIB set up community watchdog forums called committees of concerned citizens, to promote accountability and transparency at the local level. Supported by volunteer youth groups, these committees survey local communities to produce report cards on key public services – health, education, land administration and local government – that highlight the nature, process and implications of corruption at the local level. The findings are widely disseminated to the public, press and authorities through fact sheets, theatre/cultural shows, local campaigns, community meetings and meetings with service providers. Advice and information desks were set up to ensure that people have basic information about key public services and can resist demands for rent. Knox (2009) found that while prior to the intervention there was widespread dissatisfaction with public health services due to lack of facilities and hygiene, rent-seeking by medical staff for services and private practice by doctors, after the report cards and the associated publicity, the situation improved considerably. Information on the fees for various services (including diagnostics, availability of medicines and the schedule of doctors and nurses) was displayed prominently. Additionally, notices warning patients not to pay any extra money were posted. Moreover, the availability of doctors and cleanliness of the facilities improved. Finally, public health staff became more transparent in their functioning and helpful in their approach to patients. TIB plans to sustain this intervention through the concepts of ‘islands of integrity’ at the micro level and ‘integrity pacts’ at the macro level. In the former, individual institutions such as a school or hospital publicly commit to function without indulging in corruption and are monitored by the committees of concerned citizens, whereas in the latter, all stakeholders of a public body – governments, corporates and citizens – commit to not abuse power and engage in corruption. However, Knox (2009) remains sceptical of the future of the anti-corruption drive in Bangladesh in general, arguing that corruption is entrenched in the workings of both major political parties of the country.

The Bangladesh Rural Water Supply and Sanitation Programme commissioned a citizen report card survey in 2014 to provide feedback to the Department of Public Health Engineering on the quality and outcomes of their social mobilisation processes for completed and current projects. The survey, implemented by the Resource Integration Centre (RIC) and technically supported by Manusher Jonno Foundation and the Partnership for Transparency Fund, was followed up by key informant interviews and focus group discussions. It was found that a majority of respondents in completed project areas were not aware of the details of the water supply schemes – such as criteria for selection of beneficiaries, provisions for the poor, and membership and functioning of the water user committee – highlighting the weakness of the social mobilisation component of completed projects. Additionally, community satisfaction with the completed projects was low. Most respondents claimed that they received insufficient water for their needs, complained about the illegal storage of water by affluent families, and did not know if water quality checks were conducted regularly. Awareness levels in newer project areas were comparatively higher, but needed to be enhanced to ensure that communities knew the requirements for connecting to piped water supply and decision-making processes regarding charges and location of pumps. Subsequently, community scorecards
were used to build the capacity of users and providers for monitoring water supply services in completed piped water schemes (Resource Integration Centre 2015).

3.5 Community scorecards

Community scorecards are a hybrid of the processes that make up citizen report cards and social audits. They involve a combination of user feedback on service performance, provider self-evaluation and user-provider interface meetings in which the performance assessments are discussed along with remedial action (Babajanian 2014). The literature suggests that they are a popular tool for exercising community accountability and promoting civic engagement in India but have yet to take off to a wide extent in Bangladesh. Most models consist of producing a report based on primary data (including that collected by community members or community-based organisations) or existing secondary data (e.g. service reach or quality), with a view to allowing communities to reflect on local service provision and, in some cases, allowing the ranking of service provision between communities.

A pilot of community scorecards in rural Maharashtra illustrates how India’s three-tier model of democratic decentralisation fosters social and community accountability (Murty 2007). The mechanism for the scorecards entailed input-tracking, community-generated performance scorecards, self-evaluation scorecards and interface meetings between community patients. Health committees consisting of villagers, and inclusive of women, were established in each village to follow up on the health-related components of the action plan and to monitor the delivery of health-care services. Based on the findings of the community scorecards, village-based committees and village governance council meetings (gram sabha) activated a series of community-based solutions in health care and WASH (water, sanitation and health), leading to a reported reduction in child malnutrition, and broadening into improvements in governance and transparency of information. The findings suggest that the mechanism had a broad-ranging and effective impact on behaviour at both the individual and community levels, which in turn led to an overall improvement in children’s health and nutritional status. Increased information and accountability was cited as the main cause of increased ownership of services and outcomes by mothers and a decrease in rates of child malnutrition. In terms of maternal and girl health, the accountability mechanism introduced specific interventions to identify and document service delivery problems and to encourage communities and local NGOs to work together with health officers to mitigate these issues. In terms of policy implications, the community scorecards boosted a revival in village-led committees and the voluntary sharing of information encouraged greater transparency (Murty 2007).

The primarily qualitative evaluation of the community scorecard intervention consisted of focus group discussions across 14 villages, the findings of which provided the basis for indicators for assessing various service sectors. The same indicators were used for users and providers in their self-evaluations. Engaging with providers as well as users served to mitigate tensions between them and helped improve communication and coordination among frontline workers and patients, while identifying supply-side gaps that hindered local access to services. Changes attributed to the scorecard findings were evident in a combination of sectors. For example, one community mobilised their local school to lobby the local health department to provide health check-ups for students, thus impacting both education and health service delivery. The implementation of regular monitoring for child malnutrition and sensitisation of parents and villagers to the need to pay attention to their children’s health was said to be linked to the reported reduction in malnutrition. Community resources were also mobilised: monthly contributions from parents of children attending nursery crèches (anganwadis) enabled the creation of a corpus fund to combat malnutrition (Murty 2007).
The quantitative findings were based on the figures collected as part of regular *anganwadi* centre monitoring and thus are not likely to be particularly reliable, nor were they compared to a counterfactual. However, they indicate that the percentage of ‘normal grade’ children increased from 56 per cent to 69 per cent in one primary health care (PHC) centre, and from 67 per cent to 73 per cent in another over a six-month period. In both PHCs, the number of severely malnourished children was eliminated in six months. In another district, the proportion of normal grade children rose from 59 per cent to 66 per cent over a period of 11 months. The number of severely malnourished children (grade 3 and 4) fell from 399 to 58 (Murty 2007). A 45 per cent increase in infant breastfeeding immediately after birth was also observed, leading to a significant decrease in the infant mortality rate and in certain child diseases. Increases in child immunisation, institutional deliveries by trained attendants and positive impacts on WASH were also observed.

Murty (2007) reports that the institutionalisation of the accountability process in this case indicates the effectiveness and sustainability of the mechanism, most visibly with the establishment of an institutionalised platform for dialogue between community, local government, and frontline service providers to solve basic problems with health, nutrition and WASH. Communities were able to generate innovative solutions to local problems through interaction of community members and service providers at the village level. Upward chains of accountability were also utilised as these local concerns and solutions were communicated up to block and then district level.

The use of community scorecards on primary health care service provision in the Indian state of Andhra Pradesh exposed discrepancies between the perceptions of service providers and users (Misra 2007). The findings led to collaboration between both parties. A joint action plan was devised where providers agreed to: undergo training to improve their interactions with users; change health centre opening hours to better meet community needs; institutionalise a better grievance redress system; and to publicly display medicine stocks. The process facilitated a dialogue between users and providers, which allowed a better understanding of community needs and of the constraints faced by providers, and eventually led to increased satisfaction ratings by service users (Misra 2007).

The Bangladesh Rural Water Supply and Sanitation Programme used community scorecards to improve the monitoring of water supply services in completed piped water schemes. Two rounds of community scorecards were conducted with user groups, water user committee members, CSOs responsible for social mobilisation in the project, and central and local Department of Public Health Engineering staff participating. Initially, the participants scored service performance based on their own perception and experience. Subsequently, they reviewed the differences in user and provider scores and developed an action plan to reduce related service gaps. Public hearings were also conducted to share the findings of the citizen report cards and community scorecards and enable communities to present their problems.

There was a wide gap between user and provider scores in the first community scorecard process, with users scoring service performance much lower than providers. On indicators such as inclusion of community members in decisions about connection charges and monthly bills, inclusion of women members and poorest representatives in water user committees, community involvement in formation and functioning of water user committees and ease of lodging complaints, user scores were 1 out of 10 or even lower. In the second scorecard

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12 Under the Indian government’s Integrated Child Development Scheme (ICDS), children are classified into five grades according to their degree of malnourishment: normal, grade 1, grade 2, grade 3, grade 4, and grade 5, with normal being the optimal grade and grade 5 children being the most malnourished (Murty 2007: 7).
process, user scores improved across indicators and the user–provider score gap narrowed considerably. However, for three of the four indicators, the score remained low (less than 5). Water user committees were dominated by local elite and politically influential persons, which was difficult to challenge and change (Resource Integration Centre 2015).

While the evidence base for community scorecards in Pakistan is relatively thin, what little is available is along similar lines to that of Bangladesh, where it operates within a local governmental framework. The Empowerment, Voice and Accountability for Better Health and Nutrition (EVA-BHN), with funding from the UK Department for International Development (DFID), has reported on the piloting of community scorecards as part of a family planning initiative in the Peshawar region. The scorecards were used to solicit feedback from community members at local government health centres as part of the planning and implementation process of establishing citizen ‘joint monitoring committees’. Following the feedback, committees were set up and a joint action plan was established. The following outcomes were reported: improvement in health centre infrastructure; procurement of equipment and facilities; community outreach and awareness building in family planning; establishment of funding for plan to revitalise referral systems and inbuilt monitoring procedures for family planning initiatives (Khan and Ahmad 2016).14

3.6 Budget tracking and advocacy

This methodology involves CSOs tracking the implementation of public budgets to understand the use of public resources and identify problems such as leakages, lack of expenditure and other budgetary irregularities (Boydell and Keesbury 2014).

In India, budget tracking by civil society has been institutionalised through the setting up of the Centre for Budget and Governance Accountability (CBGA) in New Delhi in 2003. It analyses the annual union government budget and conducts a trend analysis of major economic indicators, including allocations to sectors such as education, health and agriculture. It also tracks expenditure, verifying whether funds have been released as per the budget and the extent of any time lag. CBGA also undertakes research on the utilisation of special allocations such as the funds allocated to MPs for their constituency and the funds earmarked for specific disasters, etc. Its main objective is to demystify the budget and enable people to understand its implications and advocate for change (Public Affairs Foundation, Bangalore, Sirker and Cosic 2007).

In Bangladesh, budget tracking and advocacy have been used in the WASH sector largely to ensure that local WASH budgets reflect community needs and are implemented. These budgets are to be spent by local governments who are required to consult communities in formulating WASH plans and share details of final allocations by the central government. However, this is rarely done. To address this gap, the NGO Forum for Public Health, working in remote areas of western Bangladesh, supported communities to identify their water and sanitation needs using a variety of participatory situation analysis methods. Selected representatives then presented community demands to local officials. In parallel, the NGO Forum for Public Health sensitised officials and communities regarding the open budgetary

13 Inclusion of community members in decisions about connection charges and monthly bills, inclusion of women members and poorest representatives in water user committees, community involvement in formation and functioning of water user committees
14 Further information on this initiative can be accessed here: http://hanif.futuresgroup.com
provisions of the Local Government Act 2009. Their campaign led to 21 of 67 local authorities publishing their annual budgets and increasing WASH allocations. An active chairperson was even inspired to initiate participatory budgeting and organise open budget sharing programmes. To sustain these processes and continue dialogue between public health officials, communities and CSOs, committees known as CSO forums were set up at local and district levels. A significant achievement of this process was that 20 per cent of sub-district funds for WASH services were allocated to sanitation for the poorest families (NGO Forum for Public Health and Freshwater Action Network South Asia n.d.)

In a similar endeavour, the organisation Simavi tracked WASH budgets in six UPs while sensitising communities about WASH policies and the Right to Information Act, under which communities can demand information from the government about WASH strategies, activities and budgets. WASH budget hearing meetings were then facilitated between local governments and communities in which people expressed their needs. Simavi’s efforts led to significant increases in the annual WASH budgets of these UPs (Simavi 2015).

In Odisha, the Odisha Budget and Accountability Centre (OBAC) run by the Centre for Youth and Social Development has been working towards pro-poor budgeting and policy practices in the state (Mishra 2014). To achieve this, OBAC’s own reports note how they have been carrying out policy and budget analysis in conjunction with the promotion of social accountability tools such as citizen report cards, community scorecards and expenditure tracking (the latter in health, education, water and sanitation, community nutrition, and agriculture and food security). The initiative aims to promote an informed debate and citizen participation towards inclusive and participatory budgeting in the state. OBAC has facilitated budget watch groups at state level and in five tribal-dominated districts of Odisha. As a result, the state has started pre-budget consultation for the past three years. OBAC claims that the process has been instrumental in driving greater transparency, accountability and participation in the state budgeting process, and that this has created new opportunities for citizens to engage with the institutions of governance.

Finally, in 2000, the government of Pakistan mandated a process of devolution stating the aims to strengthen local government and foster community participation and accountability. The process of devolution was in some ways similar to that of India’s, bringing in a three-tier system of local governance. The scope of district-level governments was increased through the devolution of services, including education and health care (Mohmand and Cheema 2007). However, evaluative evidence available in the literature suggests that results were mixed (Ahmed and Talib 2013; Mohmand and Cheema 2007).

Under such devolution initiatives, ‘citizen community boards’ (CCBs) were established to encourage community participation as a way of mobilising resources and improving local service delivery. Marginalised communities were to be empowered through applying their local knowledge and resources to project development and participating in ‘self-development initiatives’. Community participation was mandated via compulsory contributions and cost-sharing of projects, with local governments providing 80 per cent of funds and the communities themselves covering 20 per cent (Ahmad and Talib 2013). The project proposals included improvement of health facilities such as the number of community health-care workers and primary hygiene health-care programmes (ibid.; Kurosaki 2006).

The findings from the literature suggest mixed outcomes overall and specifically in terms of
health care. CCBs were more effective under strong leadership and NGO support, according to findings from a regression analysis-based study. However, less successful outcomes were observed in rural and more remote areas, partly reflecting an insufficient ‘pro-poor’ approach in the design of CCBs (Kurosaki 2006). The majority of project proposals were for infrastructure rather than health care, and deficiencies in health-care indicators such as number of available community health workers were not shown to be a driver for CCB project proposals (ibid.; Ahmed and Talib 2013).

Rural populations showed low literacy levels and low levels of awareness and this also inhibited participation. The lack of information and awareness about the CCB processes and benefits themselves were a key impediment to participation. The required financial contribution was also seen as an impediment to community participation, in that many of the rural population had precarious livelihoods, so the requirement to bear a proportion of the costs was not realistic (Ahmad and Talib 2013).

Finally, the nature of decentralisation itself in the Pakistan context is also an underlying factor in the limited effectiveness of CCBs. The CCBs were also vulnerable to elite capture and lack a reliable accountability structure. Local officials themselves – under the newly devolved structure of government and with no clear autonomy over community-based activities – have few incentives to be accountable for their performance when further away from the hold of central authorities (Ahmad and Talib 2013).
4. Mutual learning at accountability’s cutting edge – findings from the online consultation

As part of this project, an online discussion was held to complement the literature review and attempt to capture some of the undocumented ‘cutting edge’ thinking and practice from the field. Participants were selected via a variety of methods: membership of the partner network of Community of Practitioners on Accountability and Social Action in Health; mention in the published and grey literature reviewed above; other local partners or recommended participants; and ‘snowballed’ invitations. The consultation, hosted on the Eldis community discussion platform, was eventually attended by 49 participants from India, Bangladesh, Pakistan, the UK, the USA and the Netherlands. The discussion took place on 16 and 17 March 2016. Active posts were received by 31 participants (of which 5 were from the organising team) over the two days of discussion, for a total of 134 contributions. A number of topics were discussed, which are summarised below. Meta-themes drew on topics pre-selected by the consultation lead partners (informed by this review) and prior consultation with participants, but in some cases broadened in the actual discussion, as reported here.\(^\text{16}\)

4.1 Community participation and engagement

To the question ‘how do organisations on the ground ensure that community members are engaged and lead social accountability efforts?’, participants illustrated how any social accountability process begins with raising awareness and informing community members of their rights and entitlements. This step entails building a ‘culture of questioning’, which is crucial to mobilising communities around issues of health care 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 of specific rights and entitlements, but it includes building awareness of wider social and policy structures, the role of democracy, and the way the state functions. Some organisations engage with frontline service providers during this stage, both to fill the ‘knowledge gap’ among health providers and to ensure shared goals and vision, and to reduce the risk of tensions between community members and frontline workers.

Community participation can rely on a number of different tools. Participants mentioned the full range of activities noted in the earlier literature review, including tools such as community scorecards and social audits. Beyond more ‘traditional’ tools (scorecards), organisations also mentioned innovative uses of information and communications technology (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.

\(^{16}\) Quotes from participants in this section are provided anonymously but with participants’ permission, to protect the ‘closed’ and free-ranging nature of the discussion.
Participants were keen to underline that the effectiveness of social accountability tools does not depend on the type of tool chosen, but on the strategy built around it: ‘tools are just a medium to create an environment in the community so that people can sit together and start talking about the issues’. Experience on the ground has shown that while negotiating with service providers, the leverage points that a specific tool can open up for communities is context-specific. Often, in reality, the choice of tools depends on pragmatic decisions based on the type of data that need to be collected; but at times it can also be influenced by funder requirements.

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

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

During the community participation process, practitioners underlined how special attention needs to be paid towards inclusion of particularly marginalised groups in society. For instance, raising women’s voices, especially with regard to sexual and reproductive health and rights, is particularly challenging in contexts where gender, caste and religion hinder participation (e.g. ability to attend community meetings). These factors can also affect women’s ability to address controversial issues such as, for example, family planning. Here, social accountability processes can be useful to resist oppression and ensure representation of vulnerable groups. Some organisations address intra-community divisions by ensuring that each group within the community can participate in community monitoring and present their views (and needs) about the state of health-care delivery. For some women’s groups, solidarity and inter-community support is essential to collectivise actions, and give the group a stronger voice.

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

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

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

4.2 Negotiating with the state

In the standard process outlined by several of the participants, the next stage of an accountability initiative often involves data that were collected through community monitoring being presented to and discussed with government health providers at different levels. In some cases, local service providers also participate in the monitoring process and provide their own data. Most of the participants indicated that this local-level negotiation happens through existing committees or ad hoc platforms set up by local groups. Some of these committees are established under government schemes (such as the village health and nutrition committees in India), but become properly functioning only through social accountability interventions. In other instances, new platforms or opportunities for dialogue need to be created ad hoc.

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

It was pointed out that negotiation is usually easier at community level, where frontline workers and patients live side by side and find ways to collaborate, 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. These data are brought to the attention of district or province/state-level discussion forums between civil society and government representatives. In participants’ experience, when locally collected data are used to push for better service delivery at ‘higher’ levels, this also supports the way in which community members come to be seen as legitimate sources of information and enhances their voice.

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

4.3 Accountability of the private sector

When speaking about ensuring accountability in the delivery of health care, many participants felt that the private sector was a crucial piece of the accountability picture. Regulation of the private health sector was seen as a critical and urgent task. Lack of regulation can result in the lack of an effective framework for claiming accountability in service delivery. Moreover, the relations between patients and private providers are of an economic nature that does not follow the paradigm of rights and duties.
With the exception of one example from Pakistan, in most of the contexts where participants work, there is a lack of effective channels for dialogue and grievance redressal. Participants therefore felt that accountability could only be realised by reaffirming the government’s role as having primary responsibility for health-care provision and regulation. This agenda must essentially be pushed at policy level. However, these decision-making spaces and processes were felt to be neither transparent nor accountable to the principle of ensuring access to quality health care for all.

4.4 Defining and measuring impact, and issues around M&E

Participants were encouraged to share their thoughts on defining impact. As emerged during 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 on a number of other factors, such as the quality and acceptability of the service, and the capacity of service providers to deliver health care. Therefore, there seems to be an excessive focus on service uptake as a standard indicator to measure impact of social accountability.

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 social accountability. But is this really sufficient? The dynamics illustrated [in the consultation] show an empowered community constantly negotiating and asserting its rights, while services per se may not be improving. Is this not a marker of change?

This issue is strongly linked with another which is, for whom are the practitioners carrying out the evaluation? Participants agreed that evaluations are mostly carried out for funders, and thereby try to abide by project commitments and narrow indicators that focus largely on service uptake and use. Participants felt that mainstream approaches to evaluation do not consider the many instances 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 the complexities surrounding community choices around access to and usage of services.

Participants shared examples of recent efforts by civil society and researchers to counter this ‘technocratic’ approach to impact assessment, pointing out some relevant resource materials (which can be downloaded from the discussion thread 2). For instance, ‘stories of change’ have been identified as a promising method to document ‘how’ and ‘why’ change is created rather than just ‘what’ the change is.

Participants then discussed the role of community members in monitoring change. Here, a couple of posts discussed the use of ICT for gathering data, ranging from SMS to interactive voice recording (IVR) and multimedia (photo and videos). Overall, participants strongly highlighted 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 using SMS or IVR because they do not fear retaliation from health staff. In addition, collecting data though technology increases its perceived validity by government authorities.

4.5 Wrap-up: the need for ‘politicising’ accountability
Final remarks focused on placing existing SAlS for health and nutrition within wider efforts to achieve social change. Participants were asked, how do localised community-level actions make sense of their goals in the long run? How do they become allies? Indeed, it was felt that local-level initiatives need to align 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) localised demand for accountability, which then translated into wider political change, is the Right to Information / Right to Food movement in India (see case studies below). 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 contributed to a state-wide campaign calling for increased wages across the tea industry (Dhital and Feruglio 2016; The Times of India 2015).

Overall, to sum up the rich contribution of participant discussions and contributions over the two days, putting politics and power at the core of the accountability discourse becomes essential to ‘make sense’ of the change we seek to create, and any attempt to understand impact should take into account these considerations.
5. Summary and conclusions

Earlier, we summarised those community-specific factors, drawn from recent literature, which are likely to be of interest to researchers and practitioners in the field of health and nutrition delivery, stressing the importance of context in understanding accountability initiatives. Here we bring together some of the findings of the practice review and practitioner consultation, linking back to that earlier summary.

Several of the studies have reiterated the importance of questioning assumptions around community homogeneity, and understanding how social relations function within the community in question. These studies highlight familiar themes of the dangers of exclusion or elite capture (e.g. DiCaprio 2012; Green 2011; Resource Integration Centre 2015), or simply the fact that committee selection may be biased towards those members of the community already most engaged in similar activities (Mahmud 2007, 2009). But other studies reveal that careful planning and consideration of community contexts - and paying careful attention to inclusion - can have positive results (Papp et al. 2013). The practitioner consultation also highlighted similar issues with inclusion and recognising particular voices - notably (but not exclusively) women's voices - whether via general mobilisation or specific and separate consultation of sub-communities that would otherwise be unlikely to be given a voice.

Collective action and coercion were seen to be a significant factor in a number of the cases reviewed, whether as a deliberate result of the design of a given SAI (e.g. Democracy Watch 2014) or as a result of community-level accountability activities that were able to leverage existing collectives or rights-based movements. One useful example reveals how participation in such endeavours (e.g. Mahmud 2009) can be dependent on participants' backgrounds, with the types of collaborative dialogue described below an option for some, while 'noisy protest' is an alternative for groups who feel less able to engage in constructive dialogue (whether because of social position and/or level of education).

The practitioner consultation confirmed this range of engagement options available to communities and provides further examples of ways in which people might shout louder (e.g. dharnas) on the one hand, or pursue litigation on the other, in order to achieve a response. The consultation highlighted how choice of action might depend on both formal and informal styles or registers of communication but also whether the action aims for change at the local or national level. Participants highlighted the need for multi-level action or 'vertical integration' between actions at the various administrative levels of government, from village to district to state. The two extended case studies that follow this summary (on the Right to Food movement in India and Naripokkho in Bangladesh) also provide useful examples of community accountability joining forces with wider civic and legal action and national-level political movements to pursue change simultaneously at these multiple levels.

Cooperation, capacity and commitment relates primarily to the interface between service providers and the community/clients, and to service providers' ability and willingness to respond to new demands (and in a way which acknowledges the demands of the micro-politics of communities and bureaucracies). There are many examples of the importance of bringing service providers into community mechanisms, including, for example, studies from Bangladesh on monitoring of health centres and health provision (Barpanda et al. 2013; Johnston 2009; Mahmud 2007, 2009; Schurmann and Mahmud 2009); other examples (e.g. Green 2011) focus on mixed committees involving community members and service providers; while others still follow the community score approach, where this type of dialogue is a central part of the intervention philosophy. Likewise, in the cases cited by practitioners in
the consultation, rather than being a threat, deliberate involvement in accountability has been part of the story of empowering frontline workers or lower-level officials to contribute to local movements for change.

Our stress on clientelism in the earlier summary of existing evidence acts as an antidote to any over-optimism on what such initiatives might achieve. We have seen here mentions of rent-seeking in clinical practice (Barpanda et al. 2013; Mahmud 2007; Thomas et al. 2003), which illustrate the potential limits to accountability actions, alongside ‘co-option and collusion’ between those parts of local political structures coming into contact with social audits (Lakha et al. 2015). Khan et al.’s study (2013) of the everyday politics of local and central government operating behind the failure of a significant project in Pakistan is also salutary in this regard.

That there are not more of such reports may reflect the fact that some of the literature reviewed – particularly the grey literature – is written from a perspective advocating for greater accountability, which may cloud reporting of failure and/or the messy everyday reality in which these cases occur. For similar reasons, perhaps, this review has fallen short of our ambition of being able to provide some more nuanced accounts of how external interventions might interact with existing political structures in ways that are not always anticipated by the originators of accountability interventions. But we maintain that such nuances may be important in gaining a greater understanding of why accountability initiatives succeed or fail.
Case study 1: Multi-dimensional movements in social accountability - the Right to Food movement (India)

Introduction

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

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

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

Background and legal action

The RtF campaign is based on an ‘informal national network’ of CSOs, academics and activists.17 The movement was triggered in 2001 by a decade-long Public Interest Litigation (PIL) in the Supreme Court to petition the state to address inadequate drought and hunger relief in Rajasthan, despite the existence of nine nationwide government programmes on hunger prevention and food security (Khera 2013).18 While the Indian Constitution at the time did not explicitly guarantee a ‘right to food’, this was petitioned under the constitutional ‘right to life’. Despite the existence of state programmes to address hunger and malnutrition such as the Public Distribution Scheme (PDS) (a nationwide food subsidy scheme), they had failed in terms of local implementation and lacked operational accountability mechanisms (Saxena 2010).

The RtF movement gathered pace and pursued legal recourse (pursuing legal orders at a Supreme Court level, which led to state-level mandates). These forms of legal advocacy became a tool for holding state institutions accountable for wide-scale malnutrition, hunger and failed state food subsidy programming. By taking action at the local and national levels,

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17 Definition drawn from the Right to Food campaign website, http://www.righttofoodcampaign.in
18 The case was brought about by the People’s Union for Civil Liberties (in Rajasthan) vs the Union of India and others, Civil Writ Petition 196/2001
the campaign was effective in securing legal accountability mechanisms from state institutions (Krishnan and Subramanian 2014). The overall context of a democratic (and increasingly decentralised) system of governance facilitated a series of political opportunities for the campaign. Protest activities served to open ‘spaces for dialogue’ in the move toward accountability (Krishnan and Subramanian 2014: 109).

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

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

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

Accountability tools

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

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

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

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

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

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

Finally, an example of a movement under the RtF banner on a nationwide scale: the Supreme Court orders regarding the Midday Meal Scheme were used as a platform to urge state-driven reform. Activists under the RtF movement mobilised the media and were able to use a combination of public pressure and legal orders to bring about nationwide implementation of a scheme that guarantees one cooked meal per day for school-going children (Khera 2013).
Case study 2: *Naripokkho* – from community activism and accountability to state-level action on women’s rights and development in Bangladesh

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

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

As reported in the review above, *Naripokkho*’s primary community-level work on maternal health services involved a multi-level community monitoring approach, which operated in 5 districts and 14 sub-districts of southern Bangladesh in partnership with 16 local women’s NGOs. The women’s groups or *Nari Dals* set up at a village level were key in catalysing awareness about health rights and entitlements and demanding quality health services from public facilities. But the ‘noisy protest’ (Hossain 2010) was also critical in highlighting issues of rent-seeking and denial of services. Work with local union health and family welfare centres forced the health system to respond to their well-informed demands regarding health entitlements.

At the district and sub-district levels, the 16 NGO partners each monitored a health centre for cleanliness, staff attendance and staff behaviour towards women patients, sharing their observations with the hospital management committee of the facility and at the district and sub-district level NGO coordination committee meetings. Their intervention led to improvements in the cleanliness of facilities, ambulance availability, power supply, number of patient beds, and reduced rent-seeking. *Naripokkho* and its partners also worked to activate the largely non-functional hospital management committees, which every public hospital is expected to have. Chaired by the local MP and including stakeholder representatives such as hospital employees, health department and local government officials as well as civil society members, this committee has the ability to identify and solve local problems. Activating these committees involved convincing MPs to convene meetings and members to attend the same. Active hospital management committees were effective in reducing private practice by doctors during hospital hours, and reducing rent-seeking, as well as improving the quality of inpatient meals (Barpanda *et al.* 2013).
In the area of violence against women, Naripokkho’s accountability focus translated into monitoring of state interventions to combat such violence. Begun in 1999 as part of their campaign against acid violence, initially this included regular monitoring of 22 police stations in the Dhaka metropolitan area, the emergency, gynaecology, burns and forensic medicine departments of two major public hospitals and the special court for all cases of violence against women (COPASAH n.d.; Huq 2003). Gradually, Naripokkho activists negotiated with the police to set up regular reporting of violence against women incidents and follow-up action from all 460 police stations in the country. In this way, a special cell for monitoring violence against women was set up in Dhaka police headquarters (UNIFEM 2003).

The objective of all such monitoring was to identify loopholes in the system and report back to the relevant agencies for action. Quarterly meetings were organised with all service providers and the findings of the monitoring presented as action research in a ‘spirit of dialogue’ (Huq 2003). The resulting discussion led to explanations and a self-review by officials with representatives from the agencies and Naripokkho jointly preparing recommendations for action (UNIFEM 2003). Huq (2003) highlighted that while most service providers identified lack of resources as a major problem, Naripokkho emphasised the role of the behaviour and attitudes of staff providing services, which many survivors of violence had highlighted. For instance, male doctors’ attitudes and behaviour towards victims led to high rates of refusal for post-rape examinations. After Naripokkho’s intervention, the rate of refusal fell significantly (UNIFEM 2003). Huq (2003) clarified that such constructive engagement was possible because of an understanding that Naripokkho would not publicise or release the findings of their monitoring to the media or public.

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

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