Social Accountability in Health in East and Southern Africa

Practitioners Perspectives of Trends, Strengths, Challenges and Opportunities in the Field

Giulietta Luul Balestra, E. Premdas Pinto

COPASAH

CENTRE FOR HEALTH AND SOCIAL JUSTICE

Foreword

The field of International Development is a rapidly growing and challenging field. While the idea of poverty alleviation and economic growth has for remained a central concern for economists, concerns like income inequality, social inclusion, participation, transparency and accountability have become increasingly common ideas in many development for a including the World Bank. As these ideas are embraced and become integrated in practical development interventions, it is also necessary to review and understand how these ideas emerged or were first articulated. While some ideas came from academics and universities, many ideas and concepts became accepted as a result of the persistent struggles of practitioners in the field. COPASAH (Community of Practitioners on Accountability and Social Action in Health) is a collective of practitioners who have been developing these ideas and applying these principles in the field of health governance in different places around the world. In these Issue Papers COPASAH members have deliberated over some of their key concerns to draw lessons for future practice.

Health care is a contested area of governance and public policy action. It is also an area of immediate concern being featured prominently in the erstwhile MDGs and in the contemporary SDGs. In this series of Issue Papers, COPASAH members share their insights in critical issues especially related to the inclusion and participation of the poor and marginalised communities and how these may be negotiated or kept centre stage within contemporary development practice. The Issue Papers draw upon the years of practice of COPASAH members and are practical and insightful at the same time. We are sure these will provide important pointers for practice for any development practitioner in the field of heath governance. On behalf of COPASAH we look forward to your feedback and suggestions to continue the discussions and sharpen our practice

About Authors

Giulietta Luul Balestra is a researcher and practitioner with a passion for social accountability and community action for the right to health. For the past ten years, she has alternated operational roles and research on community engagement for health, focusing primarily on issues including migrants' health, access to food, maternal health and infectious diseases. She worked for various NGOs and Research Centres holding posts in Italy, Brazil, the USA, Pakistan, India, South Sudan, Cameroon, the UK and Papua New Guinea. She holds an MA in Cultural Anthropology and Ethnology from the University of Bologna and an MSc in Health Community and Development from the London School of Economics and Political Science. She can be contacted at luul.balestra@hotmail.com

E. Premdas Pinto is the Global Secretariat Coordinator for COPASAH and the Director-Advocacy and Research at the Centre for Health and Social Justice (CHSJ),India. He facilitates the thematic area of social accountability with a special focus on processes of community monitoring and accountability in health. He is a Human Rights lawyer with expertise in public health and law and he conducted his doctoral research in healthcare jurisprudence. He is actively engaged in processes and social justice issues of the communities of Dalit women, rural unorganised labourers and other disadvantaged communities for the last two decades. He can be reached at e.premdas@chsj.org

Acknowledgements

Cite as: Balestra G. L. and Pinto E. P. (2018), *Social Accountability in Health in East and Southern Africa. Practitioners' Perspectives of Trends, Strengths, Challenges and Opportunities in the Field.* New Delhi: CHSJ and COPASAH

Abbreviations

AGHA	Action Group for Health, Human Rights and HIV/AIDS
ART	Anti-Retroviral Treatment
CBO	Community Based Organisation
CBM	Community Based Monitoring/ Community Based Monitor
CCB	Community Capacity Building
CBMES	Community Based Monitoring and Evaluation System
CEHURD	Center for Health Human Rights and Development
CHRO	Community Human Rights Observer
CHSB	Council Health Service Board
CHSJ	Centre for Health and Social Justice
CHW	Community Health Worker
CoP	Community of Practice
COPASAH	Community of Practitioners for Accountability and Social Action for Health
COPSAM	Community of Practice for Social Accountability Monitoring
CRC	Citizens Reports Cards
CSC	Community Score Cards
CSO	Civil Society Organisation
CWGH	Community Working Group on Health
DFID	Department for International Development (UK)
DoH	Department of Health
EQUINET	Regional Network for Equity in Health in East and Southern Africa
ESA	East and Southern Africa/ East and Southern African
FLE	Facilitated Learning Exchange
GBV	Gender Based Violence
GPSA	Global Partnership for Social Accountability
HCC	Health Clinic/ Centre Committee
HFC	Health Facility Committee
HUMC	Health Unit Management Committee
HENNET	Health NGOs Network
HEPS	Coalition for Health Promotion and Social Development
HERAF	Health Rights Advocacy Forum
HFGC	Health Facilities Governing Committee
HSSF	Health Sector Service Funds
IBP	International Budget Partnership
ICT	Information and Communication Technology
IHI	Ifakara Health Institute
IHRCV	Institute for Human Rights and Civil Values
ISER	Initiative for Social and Economic Rights
MoH	Ministry of Health

MoHCC	Minister of Health and Child Care
LC	Local Council
NHC	Neighbourhood Health Committee
NGO	Non-Governmental Organisation
NRHM	National Rural Health Mission
NTA	National Taxpayers Association
OSIEA	Open Society Initiative for East Africa
OSF	Open Society Foundations
PAR	Participatory Action Research
PETS	Public Expenditure Track Survey
PHAB	Public Health Advisory Board
PHM	People's Health Movement
PRA	Participatory Reflection and Action
RCT	Randomized Control Trial
SAHRC	South African Human Rights Commission
SAM	Social Accountability Monitoring
TAC	Treatment Action Campaign
TARSC	Training and Research Support Centre
UDN	Uganda Debt Network
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNHCO	Uganda National Health Consumers/ Users Organisation
VHR	Voices for Health Rights
WB	World Bank
ZADHR	Zimbabwe Association of Doctors for Human Rights
ZNNP+	Zimbabwe National Network for People Living with HIV
WHO	Word Health Organisation

EXECUTIVE SUMMARY

1. Introduction

This report summarises the findings of research undertaken with the aim of mapping the field of social accountability in health in East and Southern Africa (ESA) from a practitioners' perspective. The research was conducted on behalf of the Community of Practitioners for Accountability and Social Action in Health (COPASAH), a global network of organisations that focuses on promoting mutual learning and sharing among practitioners to advance the field.

2. Methodology

The research was conducted by an independent consultant. 26 social accountability practitioners based in Kenya, South Africa, Tanzania, Uganda, Zambia, Zimbabwe and the USA were interviewed face-to-face, over Skype and in one instance by email. Questions focused on their organisations' work, their views on the field of social accountability in health in their country and region and their opinion on COPASAH. The consultant also conducted field visits of two projects to promote social accountability in health in Uganda and attended a COPASAH ESA regional meeting where she presented preliminary findings on COPASAH. Validation of findings was obtained through a webinar which included a presentation of the results and input by participants, as well as through an open call to comment on the draft report.

3. Characteristics of social accountability in health in ESA

We explored the main characteristics of the field of social accountability in health in ESA, through investigating: a. the practices of organisations involved in the study; and b. participants' perceptions of the field.

3.1. Practices of the organisations interviewed

Most of the organisations involved in the study have an exclusive focus on health, while a minority also tackle issues related to other publicly funded services. Some organisations have moved to a systemic approach to monitoring all public provisioning functions as a way to increase effectiveness. Organisations share several focus areas. Those most commonly reflect common shortfalls in health sectors in the region (such as health funding and spending; access to essential medicines; the availability and distribution of health workers; the state of public health facilities and infrastructures; and health services and systems management) as well as major health issues (maternal health and HIV/AIDS especially). Work done on social determinants of health was overall less evident.

Strategy-wise, most organisations use a mix of health policy monitoring/ advocacy and community empowerment to generate social change. Collaboration with duty-bearers is

said to be more common than confrontation in ESA, although practitioners use both means of engagement whenever necessary. Approaches and tools to enhance social accountability in health are broadly similar across the region, with an overall predominance of Community Score Cards (CSCs).

Most organisations involved in the study have governments as their main target. However, effectiveness is higher at the local level, while influencing change at the national level is a common challenge. Organisations are highly dependent on international donors who have a deep influence on focus areas, strategy and approaches adopted. Donors' practices were also said to have important consequences on the ability of practitioners to learn from mistakes and foster genuine community ownership of social accountability processes. Future priorities of the organisations involved commonly include enhancing effectiveness at the national level and increased documentation and networking.

3.2. Practitioners' perspectives on social accountability in health in ESA

Social accountability in health is generally perceived as an expanding field by practitioners, with more organisations using it and increasing credibility among different stakeholders. On the other side, there is a trend among some donors to move away from social accountability approaches due to uncertainties over its effectiveness.

National policies enable community participation in the health sector in all countries involved. However, implementation of such policies is problematic and effective participation often hindered by political interference, lack of resources and limited responsiveness of service providers and duty-bearers. Civil society is increasingly called to interact with technical spaces for participation and needs to strengthen its ability to do so effectively, especially to advocate for more meaningful institutional spaces for participation. Communities' ownership of the goals and processes promoted by CSOs is generally seen as lacking. Concerns

were voiced that social accountability in health is often treated as a set of tools rather than as a process aiming at community empowerment in ESA. Governments' repression of NGOs and the shrinking of spaces for political participation were identified as challenges in certain countries, and this was said to hinder the ability of civil society to demand structural change.

Partnerships among practitioners are common and most frequently revolve around loose national coalitions on specific health issues. However, rivalry is seen as limiting the extent of partnership working in the region, particularly in platforms which are donor dependent. A general lack of coordination of initiatives for social accountability in health at the national level is seen as a challenge, leading to a missed opportunity to consolidate evidence and voices as well as to struggles for legitimacy among duty-bearers. Formal spaces dedicated to sharing and mutual learning are also seen as insufficient. Moreover, a lack of resources for research and documentation limits the chances of learning from practitioners' own and others' challenges.

3.3. What needs and opportunities for social accountability in health in ESA?

This section critically reviews the findings of *Chapter 3* and outlines major needs to be addressed/opportunities to be pursued to enhance the way practitioners are supported. These include:

a. Increase capacity building of practitioners to promote change at the national level and strengthen the relationships between downwards and upwards approaches to social accountability in health in ESA. This is especially important considering donors tendency to move away from this approach due to ineffectiveness at this level.

b. Promote coordinating platforms for social accountability in health at the national and regional level without sacrificing the support given to individual organisations, and with a

view to linking the local and global dimensions of health accountability.

c. Analyse the contributing factors to the lack of community ownership and possible solutions in ESA. The latter include identifying entry points for capacity building in specific contexts; brainstorming on alternative funding practices; and combating the decrease of spaces political participation;

d. Promote clarity on the nature and conditions of sustainability in social accountability practice in different contexts, especially considering the perceived disconnection between opposite requirements from donors;

e. Promote mutual learning and coordination of efforts to strengthen institutional mechanism for community participation in the health sector. This is to address issues in implementation of otherwise enabling policies as well as a more effective collaboration between institutions and civil society.

f. Multiply spaces for genuine, practitioners-led learning on social accountability in health, taking into account that this was identified as an important gap by practitioners in ESA.

4. Perspectives of practitioners on COPASAH

We explored the perceptions of practitioners on COPASAH and in particular: 1. its relevance and added value in the ESA region; and 2. the challenges that COPASAH experiences in the region and ideas for the way forward.

4.1. Contribution and value addition of COPASAH in ESA

COPASAH was said to fill an important gap by providing occasions for sharing and mutual learning in the region which are otherwise lacking. COPASAH enjoys a good reputation as a network that is genuinely committed to advancing the field rather than the interests of individuals and organisations. Some informants expressed appreciation for the work COPASAH has done so far in terms of promoting the role of practitioners in generating knowledge on social accountability in health. Members who have taken part in continuous improvement programs - especially Facilitated Learning Exchanges (FLE), Technical Assistance (TA), face-to-face regional and global meetings - consider activities for capacity building valuable. Online communication from the Secretariat is appreciated and said to be source of inspiration and resources.

4.2. Challenges and ideas to strengthen COPASAH in ESA

COPASAH seems to lack clarity and/or widespread agreement on its nature as a 'network' or a 'movement'. Important questions about the autonomy of the regional hubs to set their own objectives and the flexibility of COPASAH with regards to unexpected outcomes of engagement of practitioners remain unanswered. Clarity is also lacking with respect to the overall purpose of COPASAH, and most interviewees would like to expand the role of COPASAH in facilitating joint advocacy, as well as increase documentation of practice. To some, clarity is also needed with regards to what values are shared by ESA members, especially in the context of the broader debate about social accountability in health in the spectrum of technical/ expert-led intervention *versus* political/ community-driven process.

There is a general agreement that COPASAH does not have enough visibility or reach in the region. The uneven coverage of different countries and sub-regions is also seen as problematic. Activities carried out by COPASAH are generally seen as insufficient to maintain interest among participants. It is also felt that the regional focus and members' ownership of online communication should increase. Overall, there was a strong call for more participatory structures and mechanisms to promote ownership of COPASAH by ESA members. The relationships between the regional hub and the Secretariat should also be clarified and strengthened with a view to giving more ownership to local members.

4.3. What needs and opportunities for COPASAH in ESA?

Here we critically connect findings on social accountability in health in ESA and on COPASAH with a view to laying the ground for recommendations to COPASAH in ESA. Needs/opportunities include:

a. Build on COPASAH strength of filling a gap by providing specific and genuine learning, an important stepping stone to all efforts to strengthen COPASAH in ESA.

b. Anchor activities to practical needs of practitioners in ESA, both for learning and action, with a view to promoting an enabling environment to social accountability practice in ESA.

c. Proactively promote practitioners views and demands through increased dialogue with other stakeholders. This include dialogue with duty-bearers on how to strengthen institutional platforms for participation in health and support coordination of efforts at the national level, and with donors on how to promote funding practices that are conducive of sustainability and community ownership, coordination of efforts, learning and networking.

d. Find a balance between focus on theory versus practice and local versus global level, keeping in mind the desire of practitioners to address the specific challenges faced by ESA practitioners without losing sight of the overall issues and debate on social accountability;

e. Promote participatory mechanisms of engagement in and members' ownership of COPASAH in ESA as a way to reflect the very values that the CoP seeks to promote.

5.   Recommendations to strengthen COPASAH in ESA

The way forward for COPASAH in ESA should be determined through an open and inclusive consultation with members. Based on our findings we make the following recommendations:

1. *Nature and organisational principles of COPASAH*- Clarify through an inclusive dialogue the nature and organisational principles of COPASAH; the relationships between global and regional levels; the role of the Secretariat; the autonomy of regional hubs to set up their own objectives and the degree of flexibility of processes promoted by COPASAH.

2. *Purpose and scope of COPASAH*- Promote an inclusive discussion on the purpose and scope of COPASAH, including by clarifying the purpose and the content of learning; the role of knowledge generation in COPASAH; as well as the role of COPASAH in advocacy and coordination.

3. *Organisational structure and mechanisms for engagement*- Encourage full ownership of COPASAH by ESA members through clarity about structural set-up and the role of regional coordination and the Secretariat; sound mechanisms for an effective engagement at the strategic level; open and regular feed-back; inclusiveness and representativeness across the region; and transparency on all decisions taken.

4. *Reach and visibility of COPASAH*- Increase the reach of COPASAH across different countries through increased partnership with existing networks; the active involvement of members in recruiting and engaging members; and increased occasions for face-to-face interactions.

5. *Activities and communications*- Increase and diversify activities carried out in ESA, especially face-to-face interactions and documentation; increase frequency and relevance of online communications for the ESA region; and promote ownership of communications by members.

6. Conclusion

Social accountability in health has a huge growing potential in ESA. However, practitioners on the ground are still facing important challenges which get in the way to promoting sustainable, community-centred social accountability in health and systemic change. In this context, it is crucial that a debate between practitioners and between practitioners and other stakeholders is adequately promoted. Strong networks have an important role in making this happen. Their use by practitioners should be maximised while interconnections between networks are also promoted.

Other stakeholders also have a pivotal role in supporting social accountability practice. Researchers should pay increasing attention to exploring practitioners' views on social accountability in health. More attention should also be paid to exploring the role of context and of

the process of social accountability interventions. Duty-bearers have a pivotal role in promoting conversations among institutions representatives and service providers on the value of social accountability in health. In addition, duty-bearers can provide crucial support for the coordination of social accountability practitioners at the national level. Donors should also consider addressing crucial questions through increased dialogue with practitioners and networks of practitioners. These include the role of specific funding practices in determining trends in the field including a limited ownership by communities in ESA of social accountability processes. Moreover, the lack of funds for research, learning and follow up, as well as for networking and coordination of efforts should also be addressed. Social accountability has a huge potential in ESA and occasions for cross-fertilisation of knowledge should be multiplied to capitalise on experience.

Table of Contents

1

INTRODUCTION

This chapter introduces 1. the concept of social accountability and its application in the health sector; and 2. the Community of Practitioners for Accountability and Social Action in Health (COPASAH) and its rationale for conducting a study on social accountability in health in ESA from the perspectives of practitioners.

1.1. Social accountability in health

Too many populations around the globe still struggle to see their rights to health and health care satisfied. Limited resources, systemic shortfalls, widespread corruption and lack of political commitment are common obstacles on the way to building healthier and more just societies. Where these challenges occur, policies and/or their implementation often fail to place the neediest in society at the centre (Berlan & Shiffman, 2011).

Traditional mechanisms for fostering governments' accountability in protecting and promoting people's health have proved limited in similar contexts (Dasgupta, 2011). Crucial as they are for good governance, accountability mechanisms internal to the state – the various political, fiscal, administrative and legal mechanisms for parts of the state machine to check and oversee others (Goetz & Gaventa, 2001) – are easily undermined by corruption and opacity of governmental processes. On the other side, traditional mechanisms for citizens to demand accountability such as political vote or litigation ('vertical' forms of accountability as opposed to 'horizontal' accountability internal to the state, Schedler, 1999) are often too indirect, slow or inaccessible and therefore not sufficient for fostering time-sensitive and sustainable social change processes.

One response to such a state of affairs has been the rise - in the last decade - of the concept and practice of social accountability (Joshi, 2010). Social accountability has been defined as "an approach towards building accountability that relies on civic engagement" (Malena, Forster & Singh, 2004:3). Social accountability is considered by some an umbrella term for a number of approaches to facilitating citizens' monitoring of public policies, processes and services (Joshi, 2010) for the purpose of generating advocacy, improving services and deepening democracy (Fox, 2007). As such, social accountability is meant to complement internal accountability systems as well as established mechanisms for interaction with the democratic state such as through elections (Schedler, 1999). The outcomes of social accountability initiatives have increasingly been the subject of research. This tends to highlight the potential for this approach under certain conditions to positively influence change in policies and services provision as well as to foster participation and inclusive citizenship (Gaventa & Barret, 2010; Rocha Menocal & Sharma, 2008).

As the concept of social accountability gains traction, initiatives inspired by it multiply. Civil society all over the world is increasingly working to render public acts more reflective of communities' needs and desires through community engagement. Aided by donors' recent embrace of social accountability for good governance (Gaventa, 2002), civic engagement is increasingly used to enhance the accountability of governments in their function of fulfilling people's right to health and health care (Croke, 2012). As experimentation in this area accumulates, much important, localised but comparable knowledge is being generated (and too often retained) by Non-Governmental Organisations (NGOs), Civil Society Organisations (CSOs) and Community Based Organisations (CBOs) alike. In this expanding phase, it is hugely important to create the opportunity for practitioners to share their experiences and learn from each other so as to maximise the potential of social accountability approaches to improve health services and foster inclusive citizenship.

1.2. Introducing COPASAH and this study

COPASAH is a community where practitioners who share an interest in and passion for the field of civic engagement and community monitoring for accountability in health interact regularly and engage in exchanging experiences and lessons; sharing resources, capacities and methods; in the production and dissemination of conceptual, methodological and practical output towards strengthening the field; and in networking and capacity building among member organisations.

The Community of Practice (CoP) was established following a three-day event entitled Practitioners Convening on Community Monitoring for Accountability in Health, organised by the Accountability and Monitoring in Health Initiative of the Open Society's Public Health Program in July 2011 in Johannesburg, South Africa. The creation of the CoP was a response to the need for increased South-South networking and support in a context marked by strong and unequal relationships with Northern entities. At the same time, COPASAH was envisioned as a platform from which to strengthen the legitimacy of practitioners in the global arena and in the social accountability discourse. To this end, COPASAH focused on developing knowledge products such as issue papers, case studies and newsletters, while also developing a model for practitioners' capacity building that includes formal training, Facilitated Learning Exchanges (FLE), peer-to-peer Technical Assistance (TA), and regional networking meetings[1].

COPASAH has expanded considerably since its foundation and today has a membership of nearly 300 with a listserv of close to 600 subscribers from all over the word. Regional hubs were formed in South Asia, Latin America and East and Southern Africa (ESA) reflecting trends in the membership base, and are now represented in the Steering Group. At the time of writing, COPASAH had just entered its third funding cycle[2] with the intention of reassessing its strategy and maximising its relevance among practitioners locally as well as in the global arena. To this end, the Global Consultation on COPASAH's strategic future directions was convened in Vancouver in November 2016[3]. As part of this process COPASAH is also making efforts to reach out to regional hubs to understand their particular perspectives on the matter.

Several factors indicate that the CoP has a particularly weak presence in the ESA region. In the context of the broad self-reflexive process described above, COPASAH wants to understand the reasons for this and act in response, with the goal of increasing its reach and relevance in that specific context. With this in mind, COPASAH embarked on a research project to elicit the perspectives of practitioners on major trends, strengths, challenges and opportunities in the field of social accountability in health, specifically in the ESA region.

This report summarises the findings of that study. Its main objective is to provide COPASAH with recommendations on ways to strengthen its presence and better support ESA practitioners through South-South networking. However, we believe that the potential contribution of this paper goes beyond this purpose. In mapping the field of social accountability in health from ESA practitioners' perspectives, in fact, we also hope to provide various readers with an interest in the subject with a tool to improve understanding of this context and how it can be better supported. Above all, what we wished for was the views of local social accountability practitioners to find the space and acknowledgement they deserve. This report is a humble contribution in that direction.

---

1 For more information on COPASAH and its approach to capacity building see: http://www.copasah.net/uploads/1/2/6/4/12642634/synthesis_report_copasah_capacity_building.pdf

2 All three funding cycles have been granted by the Open Society Foundation (OSF).

3 For more information on the event see: http://www.copasah.net/uploads/1/2/6/4/12642634/copasah__strategic_meeting__draft.pdf

2

METHODOLOGY

The research was conducted by an independent consultant between June 2016 and May 2017.

The focus of the study arose from the specific goal of the CoP to enhance its relevance and strengthen its presence in ESA. The main research question was collaboratively developed by the consultant, the COPASAH Secretariat, Steering Group and ESA regional coordinators as focusing on the views of ESA practitioners on the role of networking to strengthen the field of social accountability in health in their region. Two sub-questions break this down, namely:

1. What are the main characteristics of the field of social accountability in health in ESA according to local practitioners' experiences and perspectives?; and

2. What are the perceptions of local social accountability practitioners on COPASAH?

The first sub-question elicits contextual information needed to better understand the actual and possible role of networking in strengthening the field through influencing trends, building on strengths, and opposing challenges which are specific to the region. The second mirrors COPASAH's need to evaluate its own practice in order to increase its relevance in ESA.

In the first phase, a non-exhaustive literature review was conducted to provide background knowledge and inform the specific research questions. This included both formal research and grey literature on civil society-led initiatives for social accountability in health as well as policy frameworks for participation in the health sectors in the ESA region. The review also highlighted the scarcity of knowledge products aimed at portraying practitioners' views of the strengths and challenges of their practice in an honest, non-promotional way.

The methodology was decided collaboratively and revolved around in-depth interviews with key informants among active practitioners or experts in the field of social accountability in health in ESA. Key informants were initially identified from

within the COPASAH membership. 'Snowballing' was subsequently used to expand the list of informants, with interviewees advising on further contacts within and beyond the COPASAH membership. The inclusion of a number of practitioners that were not yet involved in COPASAH had the aim of gathering 'new' perspectives as well as to understand the reason for not being involved. While the recruitment of these informants proved more challenging (possibly due to the lack of incentive to participate when COPASAH was not known and no personal connection was involved), some practitioners with no or minimal involvement in COPASAH were also interviewed.

Finally, the research involved 26 practitioners based in Uganda, Kenya, Tanzania, Zambia, Zimbabwe, South Africa and the United States[4]. Interviewees represented 18 different organisations working on social accountability in health in ESA and two were freelance.

Table 1: Profile of Interviewees

Organisational Affiliation	
Local NGO/ CSO staff	14
Coalition/ membership organisation staff	5
International NGO staff	1
Network staff	1
Foundation staff	3
Freelancer	2
Involvement with COPASAH	#
Yes	21
No	5
Country of activity	#
Uganda	11
Kenya	5
Tanzania	1
Zambia	1
Zimbabwe	4
South Africa	3
United States	1
TOTAL INDIVIDUALS INTERVIEWED	26

---

4   The only non ESA based informant is a senior staff from the Open Society Public Health Program which has supported COPASAH since its inception, and a Special Invitee of the COPASAH Steering Group.

Data were collected through 20 in-depth interviews[5] done face-to-face during field visits to organisations based in Uganda and Kenya, and via Skype to informants based elsewhere. Only one interview was done through email exchanges. Interviews were recorded with the verbal consent of the participants and/or notes were taken to summarise points made. A loose topic guide oriented the interviews with questions revolving around the following axes:

The organisational practice with regards to the use of social accountability for health;

1. The interviewees' perceptions of the field of social accountability in health in the region, including major trends, strengths, challenges and opportunities; and

2. The interviewees' perceptions of COPASAH and suggestions to enhance its relevance in ESA.

Data collected through interviews were complemented by field visits to two projects using a social accountability approach to influence health services and policies in Uganda (the Empowering Citizens to Demand for a Health Sector that is Accountable and Relevant project by UNHCO and the Reproductive Stock Outs project by HEPS Uganda). In addition, the researcher took part in the COPASAH ESA Regional Strengthening Meeting held in Kampala in July 2016. The agenda of the meeting included various participatory sessions on topics relevant to the study. Moreover, on this occasion the researcher delivered a presentation of the preliminary findings of the study with a focus on practitioners' views on COPASAH, followed by a facilitated focus group discussion on the way forward for the CoP in ESA[6]. The discussions held in the various sessions of the meeting were recorded and summarised in notes and included in the corpus of data.

Qualitative data collected were analysed through a thematic approach. Validation of the findings was sought through an open call to all participants and other experts in the field to review drafts of the present report. Several comments were made by the readers and incorporated into the final version. Moreover, an interactive webinar entitled Mapping Social Accountability in Health in East and Southern Africa was held on April 24th, 2017 to present the findings and stimulate feedback and discussion with interviewees other ESA practitioners. A draft of the report was also reviewed by the COPASAH Secretariat and Steering Committee with the goal of providing input on its structure. To avoid conflicts of interest, the Secretariat and Steering Committee did not comment on its content or the overall findings.

---

5   Some interviews were conducted with more than one informant from the same organisation.

6   Find the report of the event at: http://www.copasah.net/uploads/1/2/6/4/12642634/report_on_the_copasah_esa_regional_strengthening_meeting_july2016.pdf

3

CHARACTERISTICS OF SOCIAL ACCOUNTABILITY IN HEALTH IN ESA

To gain a better understanding of social accountability in health in ESA, we inquired about 1) the specific practices of the organisations involved in the study; and 2) the perceptions of the interviewees on the field. Emerging from these two components (depth and breadth), an analysis of the needs and opportunities of the field of social accountability in health in ESA is provided at the end of the chapter.

3.1. Practices of the organisations interviewed

All the organisations involved in the study have considerable experience and expertise in the field of social accountability in health. In this section, we explore the main characteristics of their practice to gain an insight of common trends as well as the peculiarities existing in the field.

3.1.1. Mission is commonly health-specific and includes community participation

Most organisations involved in this study have a specific mission to improve the accountability of their country's health sector. Some were created as health advocacy organisations and embraced social accountability when the concept gained traction in the beginning of the 2000s. Others emerged from collective mobilisations around specific topics of concern and then found in social accountability a framework for ongoing efforts to improve health sectors.

A minority of the organisations involved work on a broader range of topics. Most of these organisations were created to fight corruption and/or improve the effectiveness of tax revenue and use, and tackle health as the sector consuming the biggest bulk of public money alongside education.

Overall governance processes and mechanisms are tackled by some as part of a broader approach to social accountability. For some organisations (see Box 1: A systemic approach to social accountability in health), these entered the work program as a result of realizing the intrinsic limitations of their approach in tackling the structural determinants of poor health services. On the other hand, some organisations started from a good-governance agenda and began focusing on health per se at a later time, sometimes as a result of sector specific funds being made available by international donors.

The expansion of spaces for the participation of citizens in the health sector is explicitly part of the mission of most organisations, and is implicit in the work of all of them. This often takes the form of creating spaces or mechanisms for communities to participate in demanding accountability; facilitating the participation of communities in those spaces through information or capacity building; and/or advocating for strengthening institutional mechanisms and platforms for community participation (more in Box 5: The role of civil society in promoting enabling policies for participation).

3.1.2. Focus areas reflect common health system challenges and major health issues

Several focus areas recur across practitioners from the same or different ESA countries. Not surprisingly, these mostly mirror common challenges faced by health sectors in the region. Recurrent issues tackled through social accountability approaches include health funding and health spending; access to essential medicines; the availability and distribution of health workers; the state of public health facilities and infrastructures; and health services and systems management. While few organisations focus on one of these elements (for instance HEPS Uganda has a specific focus on availability of essential medicines), the majority work on all or several of them at the time. Several interviewees thought that such commonality makes it easier for practitioners in the social accountability field to relate to each other's experiences, learn from one another and engage in common actions.

Maternal and child health, sexual and reproductive health and HIV/AIDS are the health issues that are most commonly tackled through social accountability approaches by participating organisations. These issues are most often tackled through dedicated projects and funds from international donors, reflecting prioritisation in the global arena. Urban health, rural health and health education/ information were also mentioned as specific focuses of social accountability programs. A few organisations have programs that seek to improve services for specific at risk groups (for instance the Ugandan AGHA has the mission to improve service provision with particular consideration of vulnerable populations including People Living with HIV/AIDS- PLHIV).

Work on the social determinants of health was also mentioned or was implicit in some accounts. However, this was overall less prominent than work on health systems' components, possibly due to less obvious platforms for engagement on social determinants at the local level as well as at the global level where root causes are often located. Some informants were of the opinion that this particular focus should be strengthened.

BOX 1: A SYSTEMIC APPROACH TO SOCIAL ACCOUNTABILITY IN HEALTH

Influencing the health sector at the structural level is often challenging for organisations using a social accountability approach, especially when shortfalls in services are attributed to lack of resources. This led some practitioners to adopt a systemic approach to monitoring government functions linked to publicly funded health facilities. For instance, the Tanzanian organisation **Sikika** started a **Public Finances Monitoring** programme in 2016 to support its main health accountability programme. In this programme Sikika use the PSAM approach to monitoring public services accountability (more in Box 10: Networks working on social accountability in health in ESA) and implements it at the local government level in nine stages. In stage 1, a task force of selected organisation staff is created with the goal of developing a Social Accountability Monitoring (SAM) concept note and an implementation guide. Key documents for analyses with basic information on services to be monitored are also collected in this phase. Meetings are then organised with communities and councillors (stage 2), and representatives of both are elected to take part in the SAM team. In stage 3, the SAM framework is introduced at Health Stakeholders' meetings and Full Council (the supreme organ for oversight at local government level and a key decision-making organ in Tanzania). A SAM team of around 15/20 members is then formed including CSOs staff, local government, community members, health centre governing committees, health district board and executive officers. Training is conducted with the team (stage 4) on the PSAM model, with focus on key questions for analysing documents related to health planning and resource allocation, health expenditure management, health performance management, public health integrity management and health oversight management. After analyses, teams composed of 3/4 SAM members proceed to monitor health facilities for verification of observable components such as health commodities and human resources (stage 5) through comparison with official documentation. A draft report is produced that compiles analyses of documents and evidence collected through verification. Internal meetings are then organised to get explanations from service providers on discrepancies that were found (stage 6). If no satisfactory explanation is given or resolution is beyond the responsibility of the local level, the item is escalated to the Health Stakeholders' meeting (stage 7). An agreed action plan is formulated (stage 8) and taken on by the SAM team to monitor (stage 9) throughout the next financial year.

3.1.3. Mixed strategies of health policy advocacy and community empowerment

Most organisations involved in our study seek to enhance social accountability in health in their country and/or region through a mix of health policy monitoring/ advocacy, and community empowerment.

Most commonly, the health policy monitoring/ advocacy component involves research; representation of civil society/ service users in high level technical groups or committees; and campaigning work through coalitions and partnerships.

Community empowerment is realised through capacity building of communities and/ or civil society, typically defined as NGOs/CBOs. Health literacy/ health rights awareness generation is most often promoted for community empowerment irrespective of the specific social accountability approach adopted. Interviewees often include in this work-stream training delivered to members of health centres committees, health professionals, and government representatives on health rights and participation theories/ methods/ policies.

While not all organisations directly facilitate communities' engagement in demanding health accountability, community empowerment is nonetheless often tackled indirectly through providing learning opportunities or partnering up with grassroots organisations (for instance by using their evidence to reinforce high level advocacy). In this sense, the links between the two levels are central to all of our informants irrespective of their main strategic inclination with respect to the policy/ top-down and community empowerment / bottom-up continuum.

3.1.4. Community engagement through lay-monitors and community groups

Community engagement most often involves training and supporting volunteer monitors/ advocates/paralegals to monitor health sector components and act on the basis of the findings. This is at times scaled up through a cascade system, with monitors training other monitors. The selection of monitors was often said to be left to communities, however many organisations had set criteria such as literacy or numeracy, and many organisations prefer volunteers who cover certain roles in the community, such as members of health centre committees or Community Health Workers (CHWs). Common challenges with community monitors are high rates of drop outs; time and resources needed for training and support; and the disparity between the number of issues raised and the resources available for follow-up.

Some organisations prefer developing the capacities of existing community groups or encouraging the formation of new groups that in time become autonomous in identifying themes and indicators for monitoring and action (for example the Ugandan UDN, see Box 7: Capacity building for community empowerment). The type of support provided in this case depends hugely on the approach being adopted and the specific outcomes of the process being encouraged, but most often involves technical assistance, support with stakeholders' identification and escalation of issues to the national level for follow up through dialogue, advocacy or litigation.

3.1.5. Greatest effectiveness is at the local level

Without fail, all organisations participating in the study have governments as the main targets of their social accountability initiatives.

Local governments created through processes of decentralisation/ devolution were identified as particularly crucial targets. Indeed, decentralisation/ devolution were often referred to as crucial in enabling a more effective dialogue between civil society and the government.

Although most of the organisations involved strived to make a difference at both local and national levels, many thought that the benefits of social accountability initiatives including their own were more obvious at the local level (health facility/ dispensary, sub-districts/ sub-counties and districts/ counties). Concurrently, influencing change at the national level was said to be more challenging and not as effective as they wished.

"At the local level we see the results, you see, like improvements in the relationships between the health service providers and the community, improvements in infrastructures, or availability of medicines... but if you don't tackle the national level it is very difficult to sustain this, and that – influencing the system - is very challenging".

– Key Informant from Uganda

The exact target of social accountability initiatives within government structures varies. Some organisations prefer tackling political leaders due to the direct nature of their accountability to citizens/ electors, as well as for their being in the position to influence technical leaders. Others usually target technical leaders, as they tend to stay in post longer than political leaders and have a more tangible influence at the operational level. Oversight bodies are also often involved by our informants, and some mentioned being increasingly called to provide evidence on patient experiences of services during high level investigations (more in 3.2.6. Need to strengthen interface with institutional forms of participation).

Some informants reported advocating for increasing and enhancing their government's role and responsibility to regulate the private sector. A minority of our interviewees directly targeted the private sector also. One example is the Ugandan

CEHURD that – after warnings by community monitors – occasionally denounces misbehaving private health workers to medical councils for them to act on their licence.

3.1.6. Collaborative approaches are more common than confrontation

Overall, the majority of our interviewees mentioned preferring a collaborative approach to advocating for health accountability in their country – especially through the creation of 'dialogues' between communities and duty-bearers/ service providers for constructive criticism and mutual commitment – and to use confrontation as a last recourse. Some thought that collaboration was more popular in ESA as it tends to work better in the field. Others pointed to the role of governmental repression of NGOs in their countries and/or to donors' preferences for non-confrontational organisations in determining the predominance of a collaborative approach, implying that little space is left to other options. Some interviewees also referred to the role of culture and history in certain countries in shaping environments that are resistant to confrontation. This was deemed partly responsible for a general difficulty in engaging communities in social accountability initiatives that include more confrontational approaches.

Relatedly, only a minority of organisations involved in our research use strategic litigation as a central strategy, and mostly in combination with other 'dialogue based' approaches (more in 3.1.7. Approaches and tools are similar across organisations and countries). Strategic litigation is mostly used to increase public access to information; to increase specific allocations; and to demand compliance with legal and constitutional obligations. Some organisations use strategic litigation in combination with legal empowerment approaches (for instance the Ugandan CEHURD, more in Box 3: Tool for social accountability in health: examples from ESA). In these instances, community health advocates are able to refer cases that need legal interventions to the

organisation, but most of the cases are settled through redressal mechanisms at community level. Other organisations are not directly involved in promoting litigation but on occasion refer cases reported by community paralegals to organisations with that specific remit (for instance, the UNHCO to CEHURD).

3.1.7. Approaches and tools are similar across organisations and countries

Approaches and tools for social accountability in health tend to be similar across organisations involved in the study and in different ESA countries. Several interviewees remarked on this similarity of tools. However, some thought that how approaches are deployed differs based on context or different 'national' traditions. In their opinion, the combination of similarity of tools and variation of use increases the ability to relate to others' practices as well as the incentive to engage

in mutual learning. At the same time, concerns were expressed that some tools are being used without innovation or consideration of the role of context and process to generate change (more in 3.2.8. Tool-based versus process-based approach).

"At the local level we see the results [...] but if you don't tackle the national level it is very difficult to sustain, and that is very challenging".
– Key Informant from Uganda

Community Score Cards (CSCs) were the most common tool among organisations involved. To many informants, this reflects a trend in ESA. Based on interviews, documentation and observation, the CSC process is fairly standard and follows quite closely the model originally developed by CARE in Malawi[7] to foster discussion and action on the quality of services offered at a particular health facility (in Box 3: Tools for social

---

7   http://www.care.org/sites/default/files/documents/FP-2013-CARE_CommunityScoreCardToolkit.pdf

accountability health: examples from ESA and 3.2.8. Tool-based versus process-based approach).

Various versions of community monitoring/ sentinels surveillance were also frequently found among organisations involved in the study. These normally involve community volunteers in gathering data on publicly funded services/ projects, which often result in reports being developed for advocacy with the facilitation of the implementing NGO/CSO.

Other common approaches include social audits; participatory budgeting (in isolation or as part of the CSC process) and budget monitoring; Public Expenditures Tracking Surveys (PETS); Participatory Action Research (PAR) approaches including community photography; Participatory Reflection and Action (PRA); legal empowerment and litigation; and Information Communication and Technology (ICT) mechanisms, such as tool free alert SMS, community radio (for awareness or to gather community feedback on services)

BOX 3: TOOLS FOR SOCIAL ACCOUNTABILITY IN HEALTH: EXAMPLES FROM ESA

Community Score Cards (CSCs) are an accountability process for assessing the quality of service delivery, improving local health services through feedback from service users and enhancing collaboration between communities and service providers. The Health Rights Advocacy Forum (HERAF) approach to CSCs is articulated in three phases. In the first phase, health facilities are selected through the advice of the District Medical Offices for Health. The organisation meets health workers, the health facility committee and the community to introduce the project, gather data and mobilise. In the second phase, communities are encouraged to select the community monitoring steering team which is to be trained on the right to health, the Constitution, health services provision and community based monitoring. Input tracking scorecards are generated to collect information on the supply side of services, including amount of decentralised funds disbursed and received; services offered; expected standards and variety of services delivery as compared to national guidelines and targets. Independent focus group discussions with service providers and service users are then run by community monitors at the facility level. Citizens' evaluation of services and service providers' self-evaluation are then presented at joint interface meetings where performance cards and action plans are generated through consensus. In the third phase, CSCs are disseminated through films, local radio, roadshows, and public forums such as chiefs' barazas. Advocacy is done during public hearings, citizens' juries and dialogue forums in which commitment is sought from stakeholders and progress in worst scoring areas is followed up.

The Coalition for Health Promotion and Social Development (HEPS Uganda) used a similar approach to CSCs alongside other tools in a project aimed at monitoring family planning services and raising community awareness of the importance of contraceptive choice in public health facilities. Baseline studies were conducted in 16 health facilities in Kamuli and Mbarara districts on availability of services and commodities, through assessing for instance the methods on offer, point in time stock-outs, and the timeliness of procurement orders. CSCs were then run every six months for a total of eighteen months by volunteer monitors trained by HEPS. During these exercises, communities were engaged in conversations on different aspects of family planning service with the goal of creating awareness and identifying gaps through scoring and prioritisation. These were then discussed at an interface meeting with service providers and duty-bearers, leading to the formulation of action plans to be implemented in the following six months. Evidence was then collated by HEPS and used as a basis to advocate for structural improvements in a national stakeholders' engagement meeting. The project was closed in September 2016 and HEPS and its partners are currently following up on commitments taken up by duty-bearers at the national level.

Community Based Monitoring (CBM) is a form of public oversight driven by data collected by communities with the goal of increasing the accountability and quality of public services. It is a broad term that includes different approaches. The Kenyan National Taxpayers Association (NTA) uses Citizens' Report Cards (CRCs) to enable citizens to engage in the management of devolved funds and government service delivery. During the process, citizens review the performance of service providers and devolved fund managers, agree on collective demands, and articulate their priorities to the duty-bearers. A report is then developed to document local development processes, and to provide a source of information for citizens as well as a tool to hold leaders accountable. In the fiscal year 2014/15, NTA commissioned to CBOs a total of 199 county projects to be monitored and engaged residents of five counties in various activities including development of data collection tools, partnership building with respective counties, training of community-based data collectors, field-based project assessment, constructive engagement with county officials, and dissemination of the report at the county and national level. The following year was dedicated to follow up on action plans created collaboratively by NTA and Country Governments. In this phase, 119 projects which were either badly implemented, ongoing, abandoned, delayed or ghost projects were assessed. Among these was the completion of an X-ray laboratory at Mosoriot sub-county hospital. The project was assessed in October 2015, when the monitors found out that the project had stalled since 2014 due to insufficient funds allocated. The issues were presented to the implementing agency during the constructive engagement meeting in December 2015 and the County government committed to completing the project in the Fiscal Yeay 2016/17. In March 2016 during a monitoring visit, the NTA community monitor found that the project was awarded more funds for completion and construction of the project was ongoing.

Participatory Reflection and Action (PRA) was used by the Zimbabwe Association of Doctors for Human Rights (ZADHR) and the Zimbabwe National Network for People Living with HIV/AIDS (ZNNP+) with training and technical input from the Training Research and Support Centre (TARSC). This initiative aimed to support residents of the informal settlement of Cassa Banana in their efforts to build active citizenship and public and private accountability for water and sanitation. A series of community meetings were initially organised to analyse concerns regarding health and develop a strategy to tackle major problems. In addition, nine community photographers were trained in Photo Voice, a participatory approach that uses pictures as triggers for reflection and action on issues affecting communities. The process led to the formation of a Community Health Committee with the remit to coordinate action on the priorities identified, namely 1) strengthening relationships with service providers; 2) water and sanitation; and 3) HIV/AIDS. Among other activities, the CHC gathers evidence of services on a regular basis through CSCs and escalates recurring problems to platforms that engage with the council. Moreover, the HIV/AIDS work stream eventuated in a separate project led by ZADRH, the Coalition for Youth Community and Accountability.

Several social accountability tools are designed to engage citizens in monitoring and influencing how public money is allocated and spent by their local governments. The Kenyan Institute for Human Rights and Civic Values (IHRCV) regularly uses budget monitoring to empower Busia country's residents to influence the budgeting process. To this end, IHRCV trains community facilitators on budget literacy and public expenditure monitoring, and equips them with knowledge of relevant laws, policies, resources and relationships. After training, IHRCV works with the facilitators to initiate a citizen budget and oversee the District Health Committee with regards to decision-making processes on budgets and supply allocations. Then, IHRCV identifies four community health units per constituency for monitoring of allocated public funds through **Public Expenditure Tracking Survey (PETSs)**. PETSs results in a survey being released three times a year which volunteers help disseminating at the same time as they mobilise community members to build a concerted movement. Facilitators also help IHRCV to identify and train community members and groups.

IHRCV facilitates the establishment of committed grassroots groups in the Sub-Counties (known as 'chapters' or 'outposts') to monitor public expenditure and demand participation in governance processes. All trained community members directly participate in local government dialogue where duty-bearers commitment to improve services is pledged.

Legal empowerment has the primary goal of strengthening the capacity of individuals and communities to exercise their rights by knowing how to identify and address their violation, and by creating awareness of the processes of the law, including both judicial and administrative redress processes. This approach has recently gained traction in ESA where it is mostly used in combination with approaches that seek to facilitate the engagement of communities in monitoring public functions and services. For instance, legal empowerment is deployed by the Center for Health, Human Rights and Development (CEHURD) in 7 districts in Uganda. The organisation trains both community health advocates and community paralegals. Community health advocates help individuals, families and the community navigate the health care system with free information, advice, and advocacy. Community health advocates are able to settle some cases at the community level, especially through dialogue between communities and the health care services. Moreover, they collect evidence that is used by CEHURD for advocacy at the national level. Community paralegals, on the other hand, are trained to know health rights and to understand the process of asking for redressal in case of their violation. The advantage of this approach is that CEHURD have the option to support communities by acting on what is being reported through pro-bono litigation or dialogue/ advocacy, depending on the issue. This is especially useful to restore the credibility of the intervention as well as communities' motivation to engage in situations in which dialogue approaches are not always effective.

and social media (for example used by community monitors to inform fellow community members of shortcomings in services or joint actions).

Several strengths and limitations of specific tools and approaches emerged during our interviews. For instance, CSCs were deemed to be quite effective in promoting improvement at the facility level. However, despite their popularity, CSCs were said to be limited in tackling structural problems in the health sector, particularly when used in isolation and in projects of relatively brief duration. It was also said that because of their popularity in the region, CSCs tend to induce a 'dialogue fatigue' in communities. This was also said with regard to social audits and particularly in those contexts where community participation is not yet well accepted by public officials who therefore do not contribute in making those spaces effective. On the other side, PAR and PRA were said to be particularly useful to elicit reflection over power dynamics. This led not only to demanding accountability of the system as it is but also to

questioning how the system came to be in the first place and how it can be changed.

Public Expenditures Tracking Surveys (PETS) are also very common in the region. However, the process of conducting PETSs is complex and there is a risk that PETSs do not go beyond providing information on expenditure. Some of our informants recalled moving on from them as in isolation they provide limited insight on what precedes (budget formulation) and follows (quality of services) the expenditure, as well as on how to demand answerability from authorities based on the information collected. Legal empowerment was also said to be useful in growing community confidence to take action as well as to act as a deterrent for service providers and public officials who might misbehave. On the other hand, legal empowerment was also said to share the difficulties of strategic litigation and in particular the risk of alienating communities who are not comfortable with confrontation.

Overall, many critiques of specific tools seem to imply that social accountability interventions cannot rely on one single tool but require the simultaneous deployment of multiple strategies. The timeframe of the interventions is another important factor as many of the tools and approaches described appear ill equipped to produce sustainable change with no appropriate follow up. This is also crucial for fostering genuine community empowerment, which is at the core of the effectiveness of any tool deployed.

3.1.8. Reliance on international donors and unfavourable funding practices

International donors represent the major sources of funding for the organisations involved in the study. Some interviewees said - and others implied - that this creates a situation of over-dependency from donors. This was illustrated by smaller organisations' struggles to survive when donors rapidly change their focus. Such a situation creates special concern among practitioners as some donors are redirecting their attentions away from social accountability in health (more in 3.2.3. Shrinking funds and donors' uncertainties over effectiveness).

Donors' practices were often said to have a major influence on the organisational strategy and approach to social accountability in health. This is well exemplified by the difficulties for organisations to being funded when using a confrontational approach (as reported in 3.1.6. Collaborative approaches are more common than confrontation) as well as by the predominance of certain social accountability tools (for instance CSCs, more in 3.2.8. Tool-based versus process-based approach). Moreover, donors' funding practices were often referred to as being unfavourable to the effectiveness and sustainability of social accountability initiatives. Common challenges include the disbursement of grants that are too brief in duration (very rarely longer than one year). To many, this timeframe does not allow the generation and evaluation of

meaningful change and even less the promotion of community ownership of social accountability processes. Moreover, one informant added that the dependency of civil society on international donors was in itself detrimental to the promotion of community empowerment, as interventions are ultimately identified with external stakeholders.

The lack of specific grants for follow up, research and documentation was also mentioned as hindering the ability of practitioners in the social accountability field to pursue effective and sustainable change as well as organisational learning. Similarly, the insufficiency of dedicated funds for promoting opportunities for mutual learning and networking in general was said to be a challenge and to hinder practitioners' efforts to align their strategies and promote joint action.

"With this project we wanted to influence our national policy on disbursement of funds for deliveries, but the timeframe does not allow for that. Recommendations take time to follow up. But there are no funds for that."

– Key Informant from Kenya

3.1.9. Future priorities include national focus, more partnership and coordination

We asked research participants what their future priorities were. Some of the responses imply a change or innovation in organisational strategy, for instance by exploring the interface between social accountability and strategic litigation (especially in Uganda, possibly due to the influence of Petition 16, see Box 5: The role of civil society in promoting enabling policies for participation) or between social accountability and political elections (in Kenya). Some organisations plan to strengthen their work on overall governance mechanisms and financing mechanisms, especially to tackle the impasse they experience when making recommendations that involve budgets. Several interviewees said they were currently focusing on increasing their effectiveness at the national level and/or on strengthening the connections between

their work at the community and at the national levels.

Other answers revolved around including new approaches and tools, including budget analyses, participatory budgeting and community radio. Some organisations wanted to focus on improving their training/ communication tools (such as developing CSC manuals and material to disseminate simplified information on the budgeting process) as well as tools used to monitor public functions and services. Many wanted to increase documentation of their work, but complained about the lack of funds and resources to do so. One organisation mentioned improving the quality of community participation within their social accountability initiatives through strengthening their dedicated research program (more in Box 2: Researching the dynamics of participation). Finally, many interviewees mentioned further networking with other ESA practitioners, including for joint advocacy purposes and mutual learning.

Some interviewees planned to add specific issues to the work programme beside those already tackled. Some examples include the effectiveness of reimbursements to health facilities for maternal health care, domestic resource mobilisation for Primary Health Care, tax justice (all three in Kenya), and the role of globalisation/ global health governance on health and health sectors.

Some responses seemed to imply that certain priorities came from donors and did not always mirror practitioners' priorities or their perceived capabilities to make a contribution. For instance, OSF and OSIEA wanted to bring their focus to the global level as a countermeasure to the loss of public accountability in global institutions such as the WHO, following the increase of ring-fenced funds by private entities. Some practitioners, however, saw this change in focus as being at odds with the difficulties of influencing even the national level (see 3.1.5. Greatest effectiveness is at the local level) and the fact that initiatives in the region are mostly effective at the local level. Far

from rejecting the importance of going upstream, more coordination and capacity building were said to be needed for practitioners to be able to contribute at this level.

3.2. Practitioners' perspectives on social accountability in health in ESA

In spite of the fact that research on social accountability is multiplying, literature exploring the perceptions of practitioners of their field is rare. With this in mind, in this section we explore our informants' perspectives on the main characteristics of social accountability in health in ESA, with a view on identifying ways to advance the field through South-South networking.

3.2.1. Social accountability in health is a growing field

Social accountability in health is generally seen as a growing field in ESA. To some interviewees, the region is particularly advanced and is leading the way for other countries in the African continent. For this reason, networking is being increasingly encouraged by donors (for instance USAID) between practitioners from ESA and West African organisations.

Key informants from Uganda, Kenya, Zimbabwe, Tanzania and South Africa see the field as expanding in their countries. This was linked to the fact that many more organisations are now using a social accountability approach in the health sector, and/or that their prominence is increasing over organisations working in service delivery, and/or that organisations are now using it more explicitly than in the past. On the contrary, social accountability in health was said to be in its infancy in Zambia by our only local informant, a former MoH Health Promotion Officer who, while promoting a social accountability initiative, was surprised by the lack of experimentations in other districts as well as of NGOs/CSOs to partner with.

3.2.2. Gaining credibility among institutions, but more sensitisation is needed

According to many interviewees, social accountability in health is also gaining increasing credibility among governmental institutions. In this view, this is due to the progressive realisation of the value of feedback from service users, especially for performance management and value for money. For this reason, governments in the region are increasingly promoting policies that integrate social accountability approaches and especially CSCs as a tool for monitoring health services performance (more in 3.2.4. Enabling policies for participation).

Social accountability processes were also said to be increasingly well accepted by health care workers as they make communities realise the structural nature of many shortfalls in health services. This decreases the blame communities put on health care workers which in turn increases collaboration. A similar outcome is obtained through promoting health literacy, which leads to increased awareness of the responsibility of service users to respect health workers as fundamental to health rights.

Despite this, most interviewees also thought that the concept of social accountability is still very new in their country and that much more needs to be done to communicate its importance to both institutions and communities. In particular, a lot of resistance is still coming from government representatives at the national level, especially when faced with approaches that 'follow the budget'. Health workers are also said to be very resistant at times, especially as they tend to be ill equipped to appreciate the importance of community voice and to deal with the dynamics of dialogue and participation. At the same time, most informants agreed that communities in the region are not yet fully aware of their possible role in improving health sectors through social accountability and participation (more in 3.2.6. Scarce community ownership of social accountability processes).

In other words, despite the general success of the concept of social accountability and the progressive gaining of credibility among different stakeholders in recent years, much needs to be done to overcome resistance and provide the right tools to effectively promote participation. On this note, it was said that both CSOs and institutions should increase efforts and resources dedicated to educating all sectors of society on the importance of community participation and social accountability.

3.2.3. Shrinking funds and donors' uncertainties over effectiveness

Despite the growing trend seen above, there were also concerns about a general decrease in funding in favour of other – possibly more top-down - approaches to social accountability. Some informants thought that an ongoing debate exists on how to best promote social accountability between these two poles, which leads to fundamental questions but also to instability in the field.

"There is still a lot of discussions on whether accountability is better promoted through top-down or bottom-up approaches. And this can also lead to fluctuations in availability of funds."
– Key Informant from Zimbabwe

According to our informants from the donor community, some of the reasons for the decrease in funding stem from:

a. the lack of innovation in most approaches to social accountability;

b. their failure to generate a multiplier effect; and

c. unclear relationships between downstream and upstream approaches.

In this view, a general lack of innovation characterises the region, where the same tools tend to be applied repeatedly with minimal adaptation. This is a challenge for donors due the impossibility of repeatedly funding the same activity. On the other side, the lack of a multiplier

effect leads to concerns with regard to the sustainability of social accountability intervention, as exemplified by the many instances in which performance indicators fall back down when NGOs stop focusing on a specific health facility.

Moreover, in this view unclear relationships between downstream (the community/ facility/ county/ district level) and upstream approaches (the national/ regional/ global level) are also limiting the potential of social accountability interventions to influence structural change, and as a consequence push donors away from them. The consolidation of civil society's voice and the coordination of efforts to influence change at the national/ regional and global level is seen as a way to strengthen those links and, therefore, as a high priority for donors going forward.

BOX 4: MERGING SOCIAL ACCOUNTABILITY AND PEOPLE CENTRED ADVOCACY

Social accountability and advocacy are intimately linked and often used in combination to push for improvements in the public health system. A common challenge of advocacy beyond the local level of services is ensuring that the communities that would benefit from the change retain ownership of the process. Mindful of this, **GOAL Uganda** uses People Centred Advocacy (PCA) in their **Accountability Can Transform (ACT) Health** programme, which was started in 2014 in consortium with four Ugandan NGOs and communities with the goal of assessing health services and documenting proposed improvements in their quality and use. Initially, the programme aimed at proving the efficacy of community engagements by increasing direct dialogue between community and service providers through the so called 'short route to accountability' (Malena et al., 2004). After some reviews, it was found that pivotal issues could not be resolved at that level and required engagement with duty-bearers along the 'long route to accountability'. For instance, common problems like tardiness and absenteeism among health workers remained unresolved after several engagements between service providers and members of the community, yet quicker improvements were reported when community advocates engaged with district level actors/duty-bearers. PCA was identified as the best approach for keeping the community members as the principle owners and leaders of the engagements at that level. PCA is defined as a systematic process owned and led by those affected by an issue, who use evidence to influence change at different levels in practice, policies, laws, social norms and values. Capacity building is essential to this process. For this reason, PCA invests a great deal in participatory problem analysis to ensure that communities are empowered to question the status-quo, including the fears and perceptions that impinge on their ability to question shortfalls in health service delivery and their determination to influence reforms in service delivery. From this basis, community advocates are prepared to develop proactive advocacy strategies to guide district level engagements between duty-bearers and representatives of the affected communities. These engagements derive their power from organic processes of evidence generation by those affected, culminating in Participatory Data Analysis (PDA). PDA is the collective process of making sense of the data collected and is considered an essential part of the empowerment process for the community's understanding of the magnitude and complexity of the health problems in their area, thus enabling informed action. This approach endows these stakeholders with the job of generating meaning out of the information collected, and designing responses that enhance their contribution towards the bigger advocacy objective. ACT Health programme is currently focusing on developing people-centred engagements beyond the district level to tackle chronic systemic deadlocks in health service delivery. In this light, the organisation is now investing in improving its understanding of what support is necessary to enable the affected people to own and lead a people-centred advocacy process at the national level.

3.2.4. Enabling policies for participation

National policies promoting community participation in health are in place in all countries involved in the study. This is a strength in the region and a major enabler of the work of civil society to promote social accountability in the health sector and beyond. In the view of our informants, the development of the field was greatly enhanced by explicit policies on community participation through:

a. providing a legal framework for civil society attempts to promote participation and enhance accountability;

b. supplying a conceptual tool to work towards a change in the dominant mindset regarding power relationships in society; and

c. stimulating an increase in funds made available to practitioners on the ground in some cases (for instance during the development of the 2010 Kenyan Constitution).

Decentralisation/ devolution processes are commonly considered the main enablers of civil society efforts to strengthen social accountability. In many cases, in fact, the principles of community participation and/or social accountability were explicitly stated for the first time by policies guiding these processes (for instance, constitutions or local government reform policies).

Some national development plans also touch on community participation and social accountability in the health sector, for example the South African National Development Plan 2030 which was said to be more explicit than ever on the role of community participation in health. This is seen as a great opportunity for civil society to advocate for improved mechanisms for social accountability, as provinces are currently working to produce local versions of the plan. Community participation and social accountability are also often included in health sector strategic plans. Examples in ESA include the Ugandan Integrated Reproductive, Maternal, New-born and Child Health (RMNCH) Sharpened Plan and the Tanzanian Health Sector Strategic Plan 2015-2020. Both policies

include measures to strengthen the participation of communities in monitoring health services, including by institutionalising the use of CSCs for performance monitoring at the district level[8].

The mainstreaming of social accountability mechanisms is regarded by many interviewees as a favourable development which creates a stronger platform for civil society to interact with institutional mechanisms for health accountability. However, it was also pointed out that the linking of social accountability and performance management brings the risk of overemphasising the aspect of data collection while sacrificing the potential of these approaches to foster community empowerment and action. With this in mind, it was suggested that civil society has a pivotal role in making sure that the two dimensions reinforce rather than weaken each other, for instance by ensuring that communities are not merely involved in providing feedback but also in making sense of and using data for promoting action.

Institutional processes and structures for participation vary across countries. The creation of management committees at the health centre or dispensary level, however, is a constant and a major trend in the region[9]. These are supposed to include representation of different stakeholders including local government representatives, health service providers, CSOs/ CBOs and community members (often community leaders and Community Health Workers- CHW). Their functions usually include services planning and monitoring and sometimes planning and raising their own resources. Moreover,

---

8   In Uganda, the plan was developed through the engagement of international stakeholders including the WHO, UNICEF and UNFPA, as well as the civil society. The latter was also pivotal during the piloting phase of the CSCs, which was led by UNHCO. In Tanzania, the 2015-20 plan introduced the term 'social accountability' for the first time in the national policy landscape, and made provisions to strengthen participatory structures created in the 90s such as the Council Health Service Boards (CHSBs) and the Health Facilities Governing Committees (HFGCs).

9   For an analysis of this platform across the region, see: http://www.equinetafrica.org/sites/default/files/uploads/documents/EQUINET_HCC_Diss_paper_101_FINAL.pdf

Civil society has an important role in promoting policies that enable the participation of communities in demanding greater health accountability. Several examples of this can be found in the ESA region.

In **Zimbabwe**, for instance, civil society was deeply involved in the **review of the 1924 Public Health Act**. That process led to the drafting of a new Public Health Act Bill which is likely to be finalised, gazetted and ultimately brought to Parliament for debate soon. The reviewing process was initiated by the Minister of Health and Child Care (MoHCC) in 2010 and co-led by the Public Health Advisory Board (PHAB, with TARSC and CWGH as Chair and Vice-chair) and the MoHCC. The review sought to: rationalise past piecemeal revisions and fragmentation; address the need to apply the law to new hazards; address gaps, including in the rights and principles promoted by the act; provide for affirmative actions as well as promote a proactive, partnership approach in public health; ensure coherence with other laws; comply with international obligations; and review the roles and powers needed to implement duties and functions. The review process provided for opportunities for change in a number of areas including health governance, as it provided for the first time legal recognition and, likely, resourcing (from the newly introduced Public Health Fund) to participatory platforms such as Health Facility Committees (HFCs). Civil society was instrumental in promoting wide discussion about how those platforms should be set up and sustained, for instance through facilitating stakeholders' forums and systematic community consultations to gain insight on community priorities. According to our informants, the variety of actors involved in the process was exceptional and contributed greatly to informing the principles that guided the review process. This is exemplified, for instance, by the active participation of labor unions (representing a change from the focus on occupational Health and Safety to Public Health as a whole) as well as of organisations working from other sectors, such as housing and private business. Such variety resulted in important lessons being incorporated in the Bill, such as the need to establish a Public Health Fund to pool additional domestic financial resources to fund specific areas of public health. The process also highlighted the importance for civil society to have a coordinated approach when advocating with the government and parliament, for instance to help parliament make the requisite follow-up to the executive. Moreover, this broad engagement increased collaborations in public health and public health consciousness in a number of sectors. At the time of writing, the draft Bill had not been officially finalised by the Ministry of Justice and Legal Affairs and gazetted to allow for public debate. The Zimbabwean civil society has been calling for an acceleration of the process that would lead to its adoption into new law .

In **Kenya**, the MoH recently adopted an **implementing manual/ guidelines for integrating social accountability activities in the health sector**. This was developed through a multi-stakeholders engagement process started in 2015 and led by the World Bank. According to a key informant, the development of the manual was also a response to CSOs' demands for a tool to legitimise and harmonise social accountability efforts. Moreover, CSOs such as NTA, Transparency International (TI) and TISA among others collaborated in the development of the tool, making sure that important lessons from the field had been incorporated. The guideline is envisioned as a resource for both institutional implementers and civil society practitioners. This is regarded by civil society as having great potential for mainstreaming social accountability in the health sector as well as in formalizing the engagement process between civil society and the government. The process is still new and, while the government is working to cascade it down to counties, civil society has the opportunity to advocate for its adoption at the local level.

In **Uganda**, UNHCO led the development of a **Patient's Charter** which provides an overall framework for patients' rights to demand for quality healthcare and health accountability. The charter was embraced by the MoH in 2009 and is currently being adopted across the health sector. As the Patient's charter is not legally enforceable in court, though, a motion to draft the Patient Rights and Responsibilities Bill was initiated by UNHCO in 2015 under a project titled Empowering Citizens to Demand for a Health Sector that is Accountable and Relevant funded by the Open Society Initiative for East Africa (OSIEA). UNHCO was able to popularise and intensify advocacy for the right to health, with increasing interest and involvement of civil society actors and other stakeholders including parliamentarians, the Uganda Human Rights Commission and the Ministry of Justice and Constitutional Affairs in Uganda. The intervention strengthened community and facility level health service monitoring mechanisms, including Community Monitors, Health Unit Management Committees (HUMCs), and suggestion boxes. These mechanisms are integral in engendering sustained participation of health users and providers in mutual accountability processes. The Bill is especially relevant in Uganda, where the right to health is not included in the substantive parts of the 1995 Constitution but rather in the national objectives and directive principles of state policy.

This gap in the law of Uganda is also being tackled through mobilisation around **Constitutional Petition 16**, a landmark case demanding state accountability for shortcomings in maternal health care. The Petition was filed by CEHURD in 2011 following the death of two expectant mothers in Arua and Mityana for lack of basic maternal health commodities in government-owned health facilities. The filing of the case saw formation of a coalition to stop maternal mortality in Uganda. The case raises several issues, including whether the death of women in government health facilities for lack of basic necessities is a violation of their right to health. The petition was initially dismissed by the Attorney General and the Constitutional Court on the basis of the 'political question doctrine' or doctrine of separation of powers, in other words on the basis of the fact that the issue was considered political in nature and therefore not relevant to the judiciary. However, after an appeal by CEHURD to the Supreme Court in 2015, this decision was overturned and the Constitutional Court was ordered to re-hear the matter on its merits . This case opened the way to a number of other cases which civil society has rallied behind, which in turn has created good jurisprudence and policies around maternal health care. For example, access to emergency obstetric care was declared a right in Uganda in the case of CEHURD and others vs Nakaseke District local government, Civil suit No. 111 of 2012, in which an expectant mother died for lack of care .

Health Centre Committees (HCCs)[10] should have a central role in involving communities in health services, for instance through facilitating their participation in identifying health needs, by acting as a channel of information for the community, and by representing them in health service issues at the sub-country/ sub-district or county/district level. Platforms including community members at levels other than the facility (like the Neighbourhood Health Committees in Zambia) appear to be rarer or less utilised by social accountability practitioners in the region[11].

---

10   Governing/ management committees at the health centre level are called with slightly different names in the countries involved in the study. We here use HCC to refer to these institutions in general.

11   The NHCs were created in the 1990s with a brief to: a. identify community needs and integrate these into health centre action plans; b. be the linkage between community and health centre staff; c. initiate and participate actively in health related activities at household and community level; d. develop mechanism for sustainability of community based health care initiatives; e. link initiatives with local development in other sectors such as education, agriculture, housing, social welfare etc; f. identify training needs for and support community based health care volunteers (CBDs and TBAs); g. collect relevant community based data; h. implement community based diseases control programmes; and i. ensure accountability of local resources (Zulu et el., 2015).

Also linked to social accountability in health are policies on community health strategies, and particularly Community Health Workers (CHWs). CHWs are present in all countries involved in the study, and often engaged by civil society-led initiatives for social accountability in health by virtue of their ability to link communities and the system (especially as they are also usually HCC members). Advocacy to strengthen their role in inclusively facilitating community engagement and activism is gaining momentum in the region, thanks to the work of networks (for instance the People's Health Movement Africa, more in Box 10: Networks working on social accountability in health in ESA) and of organisations who have engaged in reviewing community health strategies in their countries (recent examples being Kenya and Uganda).

Lastly, the inclusion of the right to health and health care in national policies has important – although indirect – consequences for social accountability. For instance, the absence of such a right in the constitution represents an important challenge in Uganda according to some informants, as it not only limits the possibility of tackling its violations through legal processes, but also decreases the incentive for communities to engage in demanding accountability. At the same time, this is also creating synergies among practitioners in the country, who are advocating for the recognition of the right to health and health care following the blueprint of initiatives such as the Patient's Rights and Responsibilities Bill and Petition 16 (more in Box 5: The role of civil society in promoting enabling policies for participation).

3.2.5. Problematic implementation of policies for participation

If the existence of enabling policies for participation and social accountability is a strength in the region, their implementation was seen as a challenge by virtually all respondents.

Existing platforms for public participation in the health sector are regarded by many interviewees as being only semi-functional. This was often linked to scarce political commitment to promoting genuine participation. Political interferences were said to be common, for instance leading to 'non-threatening' community representatives being elected to be part of HCCs. Furthermore, participatory platforms and processes are often limited by a lack of dedicated resources, insufficient capacity building and absence of independent facilitation. Minimal transparency was also said to be common, resulting in the inadequate advertisement of public meetings or in minutes not being produced or published. The lack of appropriate 'vulgarisation' of the topics being addressed also hinders the effective participation of communities in these spaces, the most typical example being the use of English rather than local languages to disseminate information.

All of this contributes to creating mistrust of institutional spaces for participation among communities, according to several informants. This is aggravated by the diffuse perception of participation in institutional spaces as a tick box exercise where agendas are already set and communities' concerns are not seriously considered or responded to. Fear of retaliation was also said to be a major obstacle to community participation. In many instances, this happens in contexts where the relationship between citizens and the state is not one of trust due to historical and political reasons.

The need to strengthen institutional spaces and mechanisms for participation was felt by all our respondents. Some thought that practitioners in their countries were engaging in this debate

with clear demands to their governments. For instance, at the time of writing CSOs in Uganda were involved in a campaign led by HEPS Uganda for reviewing and amending the MoH Health Unit Management Committees' (HUMCs) Guidelines through approving a HUMCs Act of Parliament that would mandate and recognise their operations. Other informants, however, felt that social accountability practitioners were not active or coordinated enough in advocating for improved institutional participation. This was attributed to the facts that practitioners are mostly busy implementing their projects and that no strong platforms exist to consolidate voices around this topic at the national as well as regional level.

The development of guidelines on participation was regarded as pivotal to improving its quality, standardizing local government practice and legitimizing social accountability within institutions. Relevant policies are fairly new in most countries and their dissemination to local governments is still ongoing. This is the case in Kenya, where most counties are yet to develop a local Public Participation Act with general guidelines for community participation in institutional processes. This means that, in many cases, the most effective efforts to promote public participation in institutional spaces are still CSO-led. On the other hand, our informants presented several examples of collaboration between civil society and duty-bearers to produce guidelines, manuals and tools for participation in those spaces, for instance the Supporting the role of HCC Training Manual by the Zimbabwean TARSC and the Kenyan Implementing manual/ guidelines for integrating social accountability activities in the health sector (see Trends in focus 2- Civil society participation in promoting enabling policies in ESA).

Many of our interviewees thought that there is a need for more sensitisation of both institutions and communities around the dynamics of participation within institutional spaces. This was seen as one of the main roles of CSOs in the region, although the collaboration of duty-bearers and service providers

in sensitizing communities is essential given the widespread fear of retaliation. On the other hand, some practitioners thought that effective platforms to coordinate social accountability efforts in the health sector at the national level would help the cause as they would reduce time and resources invested in engaging with changing government representatives from scratch. In this view, coordinating platforms could be especially effective when promoted from within the institutions, possibly even through specific funds.

"Structures are there but they are not working at their full potential. Why? Communities are not aware of their role, the system is also not sensitised enough."
– Key Informant from Uganda

3.2.6. Need to strengthen interface with institutional forms of participation

Most organisations involved in the study work in connection with institutional platforms for participation to some extent, for instance by training HCCs members on health rights and participation policies/ processes, by recruiting health advocates/ monitors among CHWs, or by using institutional platforms for community participation to promote social accountability in health (for instance village meetings, health district meetings, budget cycle meetings etc). However, this was said to be challenging due to the insufficiencies of those platforms and mechanisms analysed above.

According to many practitioners, there is an urgent need to redefine and refine what is happening at the interface between CSOs and institutional spaces for community participation. This was said with regards to the national level as well as to the regional level, especially since policies, challenges and opportunities tend to be quite similar across countries. For instance, some respondents said that practitioners should collectively look at HCCs in the ESA region and define a common advocacy strategy which also includes a clear role for civil society.

The interaction of civil society-led and institutional spaces for participation is seen by many informants as particularly important. In fact, such interaction has the potential to promote a balance between effectiveness (change is more likely since the process is embraced by institutions) and community ownership (capacity building as well as independence of processes are facilitated by involvement of civil society). To this aim, however, there is a need to clearly define what kind of interactions and formalised mechanisms should link civil society-led and institutional spaces for participation. The Zimbabwean **Community Working Group on Health (CWGH)** considers this aspect to be of particular importance. In the **Tendai project**, volunteers were recruited and trained to monitor availability of essential medicines in rural health facilities. Monitors collected information on a quarterly basis using different tools, such as a questionnaire and structured interviews to investigate service users' experiences of access to essential medicines; a medicine availability form for recording observation at health facilities; pictures to document availability and storage; and mobile phones messaging to provide prompt warning of stock-outs. This information was compiled in a monthly report card indicating average stock levels at each facility and featuring community experiences in accessing medicines. The report card was then used as a tool for advocacy and engagement with district and national level authorities. Monitors regularly took part in the meetings of the Health Centre Committees (HCCs) they monitored, where they provided feedback based on the results of the data collection and made constructive suggestions for improvement. Individual reports were also collated into a data analysis report and brought to district level forums such as the District Health Executive, the Rural District Council and the District Stakeholders meetings. This way, monitors were able, for instance, to influence discussions on the health budget at the district level. The active engagement of communities with authorities and policy makers on increasing access to medicines at rural health centre level was promoted through anchoring social accountability practices to existing institutional spaces for community participation.

Moreover, social accountability practitioners in the region have increasingly been invited to be part of strategic committees at the national level as well as to interact with oversight and other constitutional bodies. This is obviously a welcome development. However, some respondents believed that more attention is needed to avoid 'elitist' forms of representation of communities by NGOs/CSOs, as well as to maximise effectiveness of participation in these spaces. This was particularly the case in contexts where community ownership of social accountability processes was regarded as low, possibly due to historical, political and cultural reasons.

Some respondents also thought that CSOs need to improve the way they engage with institutions. This includes learning how to better consolidate their 'own' evidence as well as evidence collected by different organisations. Moreover, it also implies strengthening the role of CSOs in advising/advocating for more sensitive institutional forms of participation based on evidence of what works and how communities 'feel' about certain spaces. According to some of our interviewees, one challenge to this is the lack of dedicated time and resources to do the 'background' work of consolidating the evidence and doing research. Some informants also thought that practitioners in the field have a poor understanding of the dynamics of participation in their countries and in the region. In this view, civil society should focus on improving the understanding of what makes sense for communities to interact with and how, and then transferring this information to institutions. This was seen as particularly relevant in so far as public resources are also used for

participation and therefore represent a government function to be monitored in itself.

Conversely, institutions also need to be sensitised on how to better engage with social accountability practitioners. This is particularly important, according to our interviewees, to avoid having institutions assuming that CSOs will always know what is best for communities, even when no specific engagement of actual communities has been done yet. Similarly, duty-bearers were said to be sometimes 'using' CSOs as 'community representatives' in what is perceived as tick-box exercises.

3.2.7. Scarce community ownership of social accountability processes

According to several informants, there is a lot of scope to expand the community ownership

of initiatives and processes to enhance social accountability in health in ESA. Among or informants, some felt that NGOs/CSOs – rather than communities - are determining the agenda in the field. Possibly because of proximity through COPASAH, some interviewees contrasted this situation to India where social accountability processes started from below and were then institutionalised[12] based on learning from the field, and where the development of social accountability frameworks was strongly influenced by social movements such as the People's Health Movement (PHM).

According to many interviewees, participation is often tokenistic is ESA. The 'incentives mentality' - fuelled by the widespread habit of compensating

---

12   For instance with the introduction of Community Based Monitoring under the National Rural Health Mission (NRHM).

BOX 7: CAPACITY BUILDING FOR COMMUNITY EMPOWERMENT

Scarce community ownership of processes to enhance social accountability in the health sector was identified as a challenge in the ESA region. Best practice to tackle this issue includes a variety of approaches to community empowerment, including Community Capacity Building (CCB). CCB aims to facilitate communities in the process of identifying and dealing with issues of concern, while also building their capabilities to lead similar processes in the long run. The **Uganda Debt Network (UDN)** incorporates CCB in their **Community Based Monitoring and Evaluation System (CBMES)** model, developed in 2006 and since then implemented in more than 26 Ugandan districts. The focus of CBMES is broader than health and also includes water and sanitation, agriculture, roads and education. This allows communities more choice on what they wish to monitor and facilitates the process of making links between different issues. The backbone of the CBMES programme are Community Based Monitors (CBM) who are recruited, trained and supported by UDN to facilitate their communities in identifying issues for monitoring and in generating and implementing action plans. Up to three follow up meetings are organised by UDN to facilitate implementation and pick up issues to be escalated at the district and national level. CBM groups are usually formed and supported by trained CBMs who also act as the link with UDN for reporting and assistance. Monitoring approaches and activities are unique since they are generated by each group. Some examples include local community radio programs; Sub County and district dialogue meetings; an SMS platform that helps connect communities to duty-bearers through instant communication; media engagements; and partnering/ alliance with like-minded organisations.

To facilitate the process, UDN supports willing groups to register as CBOs and provides continued technical assistance, including by linking them to external support if needed. As an approach for improving coordination and local advocacy, UDN sub-contracts and provides operational contribution to CBOs so as to become advocates for local accountability and quality service delivery.

community members for their participation in projects' activities – was said to be particularly strong in some countries. Although most of the participants in our study were personally against this practice, its predominance was seen as setting an expectation that was difficult to overcome and that was therefore sometimes accepted. Some interviewees also believed that communities are not empowered enough to speak for themselves, which sometimes lead to 'elitist' forms of representation of communities by NGOs/CSOs, particularly in high level committees at the national level.

"The representation of civil society by NGOs is problematic, we need to raise the voice of citizens to be able to speak by themselves. And we are definitely not doing that enough"

– Key Informant from Uganda

The general lack of community ownership in the region was linked by some informants to the predominance of approaches that envisage initiatives to foster social accountability in health as 'projects' with pre-defined methodologies, outcomes and timeframes. In this view, this creates a situation where social accountability is mainly shaped from above – as well as clearly 'branded' - by donors and implementing NGOs/ CSOs. In contrast to this, many informants stressed the importance of sacrificing organisations' own visibility and handing power to people. In this view, this also include adopting more flexible approaches and being prepared to support unexpected outcomes of social accountability processes that reflect the experience and wills of communities.

The lack of community ownership was also said to have big implications for sustainability, as communities tend to not continue work initiated by CSOs in this context. As noted above, this is also one reason for a donor to retreat from funding social accountability initiatives. This made some of our respondents feel constrained by contrasting requirements: on one side, to handle interventions as projects with tights timeframes and pre-determined outcomes; and, on the other, to generate sustainability based on community

ownership. With this in mind, some informants thought that more discussion is needed between different stakeholders about the expectations with regards to sustainability, what is meant by it, and how to foster it. Moreover, some felt that resources should be dedicated to better understanding the capacity building needs of communities and civil society alike, particularly to sustain community ownership, in different contexts in ESA.

3.2.8 Tool-based versus process-based approach

Some respondents expressed concern for what they perceived as a tendency to approach social accountability in health as a set of tools replicated without consideration of the context as opposed to a process to empower communities to stand up for their right to health. This was said to happen everywhere in the field but particularly in ESA. For instance, CSCs were said to be predominant in the region but to be often used without a proper structural analysis or an appropriate consideration of the power dynamics leading to community empowerment.

"We are concerned about how [CSCs] are used here, with no structural analysis. We want to promote long term and sustained interactions and see services structured in a way that serve the poor"

– Key Informant from Zimbabwe

When asked about possible reasons for this, many interviewees mentioned the role of donors and international organisations in promoting specific tools and mainly CSCs. This was linked by some respondents to the simple existence of trends or fashions in the field. Others associated this tendency with an agenda – championed by the World Bank - to de-politicise social accountability and render it a technical intervention, particularly as the tools in question reflect a 'managerial' version of social accountability in which communities provide feedback on service performance rather than leading political processes for change.

Moreover, some of our informants attributed this to academics' hegemony in generating knowledge on social accountability through Randomized Control Trials (RCTs) which focus on measuring pre-determined outcomes and often leave out the role of the process in fostering social accountability as well as community empowerment. This was said to be particularly true in the region also due to the inheritance of pioneering and influential studies conducted there (for instance, Bjorkman & Svensson, 2009 study of a CBM project in Uganda). Such trend was seen as particularly concerning since spaces to promote alternative narratives on social accountability are limited in the region.

BOX 8: IMPROVING ACCESS TO SERVICES FOR VULNERABLE POPULATIONS

Improving access to services for vulnerable groups often requires working at different levels to address obstacles created by social disadvantage as well as shortfalls in the provision of services. The **Action Group for HIV/AIDS (AGHA)** adopted this approach in their project **Promoting and Protecting Human Rights in relation to GBV**. The project aims at reducing Gender Based Violence (GBV) in 5 sub-counties in Dokolo district by: a. addressing the knowledge and capacity gaps in Local Council (LC) III courts and other community structures; b. facilitating access to redress by using community oriented approaches; and c. scaling up monitoring, documentation and reporting of human rights violations. Central to the project is the recruitment and training of Community Human Rights Observers (CHROs) selected from each sub-county to monitor, document and report GBV cases. Training includes gender power relations, legal provisions for justice for GBV survivors, judicial processes for GBV cases and response mechanisms/structures, as well as how to use of various tools to classify and monitor cases. After training, CHROs are responsible for promoting community awareness through sensitisation meetings. These are usually highly participatory to give an opportunity to community members to share their experiences as the CHRO guide them on how to address GBV issues. After the meetings, CHROs follow up with home visits to community members that reported being victims of GBV to ensure that they access health and psycho-social services and redress. Community radio talks are also organised to sensitise the public as well as the duty-bearers, for instance by eliciting testimonies of community members and advocating for additional funds for redress and justice structures, psycho-social support for survivors, sensitisation activities and programs to promote women's empowerment through job generation to reduce the risk of GBV. These activities were credited for the increase in reporting of GBV cases and of cases handled in LC III courts. LC III courts were created in 2016 to handle court cases in villages, parishes and sub-counties but are not yet allocated funds for their operation. AGHA has directly addressed issues of capacity at these courts through providing court leaders with training and assorted country laws and procedures for handling GBV cases in local languages, as well as through mediating court sessions. Moreover, AGHA has facilitated advocacy to obtain more resources and capacity building for these institutions. Outcomes of the programme include the integration of the LC III courts' activities into local government plans and the institutionalisation of their functioning in broader local government reports. However, there is still need to enhance the community redress structures to ensure timely quality justice for all. An adequate provision of health and psycho-social services to victims of GBV is also lacking, despite the development of a referral system for survivors through partner organisations by AGHA. Moreover, AGHA believes that responses to GBV must be holistic and tackle the intersectional components of women's vulnerability to violence. For this reason, AGHA conducts high level advocacy to address the need to promote gender equality, in partnership with the Uganda Women's Network (UWONET) umbrella. Demands at this level include investing in economic opportunities for women, strengthening accountability mechanisms for women's economic empowerment, addressing the needs of women who experience intersecting forms of inequalities and addressing the social norms that contribute to keeping women in poverty.

However, some informants thought that this situation is gradually changing, particularly as practitioners have the increasing desire to overcome a 'tool-based' approach and focus on using tools strategically to generate change.

3.2.9. Repression of NGOs and shrinking of political space for engagement

When asked about challenges faced, many informants talked about various forms of repression experienced by NGOs/CSOs using a social accountability approach in their country. This was said to be true particularly for organisations working at the national level and to coincide with the progressive closure of spaces for political participation of civil society.

Some forms of repression are embedded in national policies regulating the sector. For instance, the 2016 NGO Act prevents Ugandan NGOs/CSOs from aligning with any specific political agendas. This was said to be often used by the government to repress any political stance that it opposed, for instance by threatening not to renew organisations' licences. In certain contexts (for instance Kenya), governments also have the ability to limit the amount of funds NGOs can receive and have used it to threaten them in the past. This kind of policies was said to act as a deterrent for practitioners in tackling some of the root causes of health injustice or in organizing communities and forming alliances with other, more 'political' stakeholders (for instance unions, social movements etc.) which actively oppose or challenge the government.

"Practitioners do not want to get involved in politics, because of the power dynamics with government and the donors. But the problem is the confusion between politics and partisanism, the reality is that everything we do is political."

– Key Informant from Uganda

NGOs/CSOs accused of being political have experienced 'a wave' of office break-ins in different countries involved in the research, and the consequent loss of material and resources to conduct their work. These instances are regarded by civil society as very likely to be government-led. Some of the organisations that took part in our research were personally involved in similar episodes. For instance in Kenya - where government repression of human rights organisations is particularly strong - IHRCV is currently appealing against an aggression to their office that resulted in the loss of important material and in the inability to make use of the space.

More subtle forms of ostracism are also used by governments to penalise organisations perceived as 'troublesome'. For instance, the Kenyan Public Participation Bill and NGO Coordination Act state that the facilitation of certain activities linked to community participation is to be contracted out to CSOs. However, according to some of our informants these kinds of contracts tend not to be assigned to organisations known to be vocal in denouncing - for instance - acts of corruption. This is particularly true as public funds dedicated to participatory processes are also often misused or misappropriated.

In response to this challenge, many interviewees have pointed to the need to better coordinate at the regional and global level to jointly condemn these practices and sustain - also practically - organisations hit by acts of repression. On the other side, a long term effort is needed to identify spaces at the national and regional level where more space for political engagement of civil society and communities can be advocated (more in Box 10: Networks working on social accountability in health in ESA).

3.2.10. Topic-based or action-driven partnerships

A main objective of this research is to gain a better understanding of the needs for networking in ESA. With this in mind, we asked our respondents what sorts of collaborations currently exist between practitioners in their countries and in their region,

what the strengths and challenges of these collaborations are, and what gaps they perceive.

Most of our respondents thought that partnership is a widespread practice among NGOs/CSOs advocating for health justice in their countries. In some cases, partnership is facilitated by umbrella bodies that coordinate health organisations at the national level, some examples being the Kenyan Health NGOs Network (HENNET)[13] or

---

13   HENNET was established in 2007 to give voice to Kenyan civil society in developing health policies and reviewing health programs. It carries out several activities including mapping health initiatives in the country, advocating for civil society participation in the sector planning process, and overseeing the management of the Health Services Sector Funds (HSSF). In this sense, HENNET encompasses social accountability issues despite not being explicitly dedicated to this approach.

the Tanzanian Policy Forum[14]. Fairly structured networks also exist with a focus on specific health topics, especially maternal and new-born health and HIV/AIDS. On the other side, loose coalitions were considered the most common form of partnership in the region by our informants. These are usually characterised by a light structure and only occasional coming together for events, activities, and discussions over specific cases or policies. A number of networks of this kind were said to exist at the national and regional levels, ready to be activated when a need for joint campaigning arose.

Many interviewees pointed out that networks and coalitions are usually donor dependent. This was seen as hindering real collaboration as practitioners are rivals competing for funds in those contexts. An informant also expressed the idea that networks in the region are mostly funded, managed and therefore perceived as projects. This results in a lack of ownership by members, who perceive the organisation administering funds as ultimately setting the agenda.

"The mistake is to pretend that networks work as an organisation. A network requires a bottom up approach, so flexibility in funding mechanisms and deciding objectives and strategies. If not you struggle to keep legitimacy with both donors and membership."

– Key Informant from South Africa

Moreover, some practitioners expressed concern about the perception that donors were increasingly funding networks with the assumption that this will reduce the need for funding organisations. This was said to be potentially more relevant for Africa than for any other region.

3.2.11. Lack of coordination of social accountability efforts

Many interviewees expressed the feeling that not enough coordination exists among practitioners who promote social accountability in health at the national and regional levels.

Specific platforms for social accountability in health at the country level were said to be either non-existent or semi-functional. For instance, the Governance Monitoring Platform[15] and the Social Accountability Platform[16] (initiated by the Uganda National NGO Forum) organise Ugandan practitioners around issues of common interest, facilitate mailing exchanges, organise yearly events and mobilise CSOs around joint action. However, not many informants mentioned them when asked about existing platforms, while other comments suggest a lack of resources and support which negatively influences continuity, publicity and also effectiveness.

Networking among social accountability practitioners from different countries in the region was also said to be lacking. Most interviewees were not aware of any platform with this specific goal in ESA, while others mentioned and commended the work of the Regional Network for Equity in Health in East and Southern Africa (EQUINET) in generating knowledge and advocacy on social accountability in the area (more in Box 10: Networks working on social accountability in health in ESA). Overall, occasions for social accountability practitioners to come together at the regional level were generally considered insufficient. This was seen as an important gap, especially considering the increasing role of the regional and global levels in influencing the health of populations in ESA as well as in enabling action in the field.

The absence of effective platforms for coordination was said to possibly create problems of duplication of efforts, as well as to leave important gaps in the

---

14   Since 2003 the Tanzanian Policy Forum (PF) regularly gathers more than 100 CSOs to discuss and coordinate matters of national policy with a specific focus on public money accountability at both local and national levels. The Forum is structured around thematic sub-groups, including health. Sub-groups meet monthly to discuss, identify gaps and formulate action plans, which are then championed by member organisations in government-led committees.

15   http://ngoforum.or.ug/uganda-governance-monitoring-plaform/
16   http://ngoforum.or.ug/anti-corruption-conviction-report-communiques/

promotion of social accountability in health at the national and regional level. Moreover, the lack of structured interactions with this specific focus was seen as a missed opportunity to collate evidence gathered through community engagement and to strengthen civil society's voice. According to some informants, this also exacerbates the challenges faced by practitioners who aim to go beyond the facility and local levels and tackle national and regional issues through a social accountability approach.

The need to form national platforms specifically on social accountability in health was also linked to opportunities to gain legitimacy and enhance continuity with government representatives. For example, an informant thought that such a platform would help Tanzanian practitioners enormously by creating a base from which to engage with institutions rather than with individual institutional representatives. This was said to be particularly important given the high level of turnover among political as well as technical leaders, including due to changes in political scenarios.

"There is a need to coordinate civil society. This is mainly done by national platforms so they should be strengthened."

– Key Informant from Uganda

3.2.12. Lack of occasions for mutual learning

Our data suggest that existing networks in the region tend to be focused on generating joint action around specific issues. According to our informants, important informal learning takes place in such spaces. An example is the South African Treatment Action Campaign (TAC) which created several occasions for learning about HIV and advocacy as a by-product of coordinating campaigns on access to Anti-Retroviral Treatment (ART). However, many practitioners expressed the idea that more spaces dedicated to learning about social accountability are needed, adding that networks of this kind are absent or semi-functional

at both the national and regional levels. Some informants also thought that there is currently not enough interaction with other continents for mutual learning. This was seen as an important gap, as some regions were seen as particularly advanced on social accountability (for instance South Asia) and a potential source of inspiration.

Several interviewees commented that genuine learning and sharing were somehow hindered by the need to hide challenges to showcase to donors. This was also linked to the challenge of not being able to produce documentation that really serves the purpose of fostering personal and mutual learning, as documentation is most often produced with donors in mind, which reduces the chances of honestly reflecting on what works and what doesn't. The lack of dedicated resources to document organisations' own practices also contributes to this. Documentation produced by and for practitioners in the region remains extremely rare.

"In the field it feels like we are doing the same mistakes over and over. There is a lot of documentation in the sector but not much learning about the practice itself."

– Key Informant from South Africa

3.3. What needs and opportunities for social accountability in health in ESA?

Chapter 3- Characteristics of social accountability in health in ESA has so far provided an insight into the variety of practices of our informants to promote social accountability in health in ESA and has outlined the main characteristics of the field from the perspective of practitioners. This section critically reviews the findings of the chapter and outlines some of the major needs to be addressed and opportunities to be pursued to enhance the way practitioners are supported in their efforts to advance health equity in ESA.

Increase efforts for capacity building of practitioners to promote change at the national

level- Initiatives to improve social accountability in health in ESA have so far been especially effective in bringing about improvements in the provision of health care at the facility and local levels, while there are persistent challenges in influencing structural change at the national level. This is a missed opportunity as well as a potential challenge to the stability of the sector, as the lack of a multiplier effect is driving donors away from social accountability approaches. There is a general agreement between practitioners and donors over the need to effectively strengthen the relationships between downwards and upwards approaches to social accountability in health in ESA and enhance effectiveness of efforts at the national, regional and global level. This convergence in practitioners' and donors' perspectives is in itself an advantage and it should lead to an increased dialogue to analyse capacity building needs rather than to a decrease in resources and support.

Promote coordinating platforms for social accountability in health at the national and regional level- Collaborations between organisations with different orientations and expertise are commonly pursued by practitioners, including those that aim to connect evidence coming from the ground with policy demands. However, well-structured platforms for coordinating social accountability efforts at the national and regional level are mostly absent or semi-functional. This is an important gap according to both practitioners and donors, who agree that the establishment of sound mechanisms for consolidating evidence and strengthening civil society' voice in the policy arena is a key priority. Once again, such a fortunate convergence of perspectives has a huge potential to strengthen social accountability in health in ESA. However, it should be noted that support given to coordinating efforts for social accountability in health should not substitute funding to individual organisations, as this would risk weakening the very base of the structure. Support and capacity building is needed at all levels to allow for the right balance of community ownership/ empowerment and effectiveness through leverage upwards. This should also be kept in mind by donors who

seek to increase their focus on strengthening accountability at the global level.

Analyse the contributing factors to the lack of community ownership and explore ways to address this in ESA- Social accountability in health has a relatively long and rich tradition in ESA. It is a common perception that the field has expanded considerably over the past decade in the region in terms of number and leverage of organisations using social accountability approaches and acceptance/ support by institutions. However, several concerns were expressed over what kind of social accountability is really being promoted between expert-led/ technical interventions versus community-led/ empowering processes. Community ownership of accountability processes was said to be lacking in several ESA countries. This was linked to various factors including the role of historical and socio-political processes in discouraging engagement of communities and especially confrontation with institutions; the management of accountability interventions as projects; the reliance on elitist forms of representation of community by CSOs; and the overall dependency of the sector on international donors with the possible consequent disempowerment of local actors. An analysis of the specific factors at play as well as of the entry points for capacity building in specific contexts is urgently needed to address this issue. Moreover, pivotal to this process is the promotion of alternative funding practices and the identification of mechanisms to combat the decrease in spaces for the political participation of civil society.

Promote dialogue and clarity on the nature and conditions of sustainability in social accountability practice in different contexts- Community ownership is commonly seen as linked to the likelihood that social accountability efforts will be sustained after withdrawal of the implementing CSO/ NGO. In turn, sustainability is crucial in bringing about improvements in the health sector and in determining allocation of funding (sustainability being increasingly a crucial requirement of grants). Community

Networks of practitioners have a pivotal role to play in ESA and more attention should be devoted to understanding how their capacity can be built to be up to the task. Our study participants suggested that there is scope to expand their role and/or practitioners' engagement in them. At the same time, a few examples emerged during the study which suggests a great potential to tap into.

The **Regional Network for Equity in Health in East and Southern Africa (EQUINET)**, for instance, is a network of professionals, civil society members, policy makers, state officials and others in the region who share an interest in promoting and realising equity and social justice in health. To this purpose, it promotes networking through bottom-up approaches to building a forum for dialogue, learning, sharing of information and experience and critical analysis. EQUINET is governed by a steering committee with representatives from 16 institutions in East and Southern Africa with its secretariat at the Training and Research Support Centre (TARSC) in Zimbabwe. Areas of work are organised into five clusters, namely a. equity analysis; b. health rights and the law; c. engaging globally; d. fairly resourcing health systems; and e. social empowerment for health. Selected organisations lead the work in different areas of focus according to expertise. For instance, work around social empowerment for health is led by the Zimbabwean Community Working Group on Health (CWGH), while health rights work is coordinated by CEHURD. All clusters work on social power in health as a central concept in equity. In the past 12 years, EQUINET with the lead of TARSC has used Participatory Action Research (PAR) to build analysis and action in local health systems and ultimately strengthen people-centred Primary Health Care approaches to health. Since 2006, the pra4equity learning network within EQUINET has produced over twenty PAR studies in nine countries in the region as well as cross-regional comparative analyses of – for instance – health rights, the role of Health Centre Committees (HCCs) and participatory health governance mechanisms at the district level. This has allowed them to claim the expertise to dialogue with duty-bearers in the region and formulate recommendations on participatory strategies. These included issues such as greater community participation in budget and planning processes, improved communication and joint decision-making between health workers and community stakeholders, and building community skills to interact with local authorities.

Promoting widespread dialogue on social accountability in health is also central for the South African **Public Service Accountability Monitor (PSAM)**. PSAM was initially founded in 1999 as a project to monitor incidents of corruption within the East Cape government, a focus that was later broadened to systematically strengthening public resource management by key East Cape government departments. From 2007 PSAM added a training and academic component better known as the Regional Learning Programme and the Advocacy Impact Programme. Regional Learning activities aim to equip and engage Sub-Saharan Africa civic actors and interest groups on effective evidence-based social accountability monitoring and advocacy tools. Main activities include delivering the Fundamentals of Social Accountability Monitoring course and developing country partnership agreements for context-specific understanding and analysis of social accountability. The training includes the rights-based approach to social accountability monitoring originally developed by PSAM in the East Cape for systematically monitoring governance financial functions and particularly a. planning and resources allocation; b. expenditures management; c. performance management; d. public integrity management; and e. oversight functions. The Advocacy Impact work draws on information from PSAM, its partners, social accountability practitioners and academics to contribute to the conceptual framework for social accountability and enhance the effectiveness of social accountability initiatives. Research on the work of PSAM and its partners is shared among partners with the aim of influencing African and global discourses in the field. This is

achieved through case study research, the hosting of a biennial conference (the Pan African Social Accountability Learning Lab), management of the Community of Practice for Social Accountability Monitoring (COPSAM), conference and seminar presentations, and fostering organisational learning. The COPSAM seeks to identify the most effective ways to link Sub-Saharan Africa social accountability practitioners and other stakeholders in a network for shared learning and improved practice in the field of social accountability. Social accountability practitioners are encouraged to participate in the CoP by participating in discussion forums and writing on the blog as well as sharing content.

The **People's Health Movement (PHM)** is a global network of health professionals, activists, academics and researchers, campaigners and people's organisations who promote the re-endorsement of the Health for All principles of the Alma Ata Declaration and the importance of social determinants of health and health care. PHM has developed considerably since its inception globally, although slower in Africa due to a general fragmentation of civil society efforts towards health activism and advocacy. Since 2009 PHM has however experienced a strong push in Africa, which has translated into an interest in initiating PHM circles in various African countries. With time, PHM Africa developed into East and Southern Africa and West and Central Africa regional nodes. Each region has a steering committee that communicates frequently. In ESA, Tanzania, Kenya, Burundi, Uganda, Rwanda, Zambia, Zimbabwe and South Africa have country PHM circles. Country circles are composed of volunteers from local organisations who take the lead or collaborate on specific work streams including advocating for enhancements in health systems or social determinants. While themes for advocacy often reflect country contexts, human resources for health was prioritised by the network as a common theme in ESA, for instance through collectively supporting doctors' strikes in Zimbabwe and Kenya with statements which advocate for better working conditions. Moreover, PHM strongly advocated for the full recognition of the role of Community Health Workers (CHWs) in resource-limited health sectors in the region, including through negotiating for increased resources and training, for instance in South Africa and Tanzania. Recently, PHM has concentrated on producing an analysis of what national platforms can help enlarge civil society spaces to demand health for all in ESA. This is considered especially relevant in a region where several countries are experiencing a closure of political spaces for engagement and where repression of civil society is common. In this light, a regional workshop was recently organised to present the results of a research study done across DRC, South Africa, India, Colombia, Italy and Brazil to explore different countries' experiences with health governance through policy dialogue; movement building; campaign and advocacy; knowledge generation and dissemination and capacity building of civil society. On the wave of interest created by such a work stream, the network is planning to bring it to the regional level with the goal of gaining a better understanding of how to engage in regional spaces to advocate for more space for civil society engagement in health policy.

ownership is therefore a declared priority for both practitioners and donors. However, the extent to which that is promoted by specific practices of both stakeholders is debatable. Practitioners often feel that they are being set up for failure by funding practices that do not allow for sustained community empowerment. At the same time, some donors perceive an overall lack of innovation and technical approaches as a set-back to investing into social accountability initiatives to improve the health sector. There is here a disconnection in the way sustainability is framed that needs to be addressed by increased and improved dialogue among all stakeholders. This includes fundamental questions over the nature of sustainability itself, how it is best promoted and what enabling conditions need to be put in place in a more systematic and coordinated way.

Promote mutual learning and coordination of efforts to strengthen institutional mechanisms for community participation in the health sector- On the other side, sustainability is also linked to the extent to which the concept and mechanisms of social accountability are incorporated in the institutional culture and processes in a certain country and region. While the policy environment is favourable to social accountability in health in ESA, there is a need to address issues in implementation, through

strengthening institutional mechanisms for community participation in and beyond the health sector as well as the interfaces between those and civil society/community-led processes for social accountability. In some ESA countries, effective collaboration between institutions and civil society is increasingly translating into policies and guidelines to enhance community participation effectiveness in generating social accountability in health. A wide divulgation of these experiences is desirable as is the increased coordination of the demands of civil society in this area.

Multiply spaces for genuine, practitioners-led learning on social accountability in health- Lastly, the need for sharing and learning about social accountability in health specifically is not adequately met in ESA. While much informal learning takes place through partnerships in various forms, there is a lack of formal, specific, and sustained spaces for genuine cross-pollination and debate. Honest debate about challenges and steps to improve practice is hardly promoted by an environment strongly marked by the need to showcase to donors and survive despite competition, and a lack of funds for partnerships and learning is contributing negatively to this. As this section shows, such a debate is much needed in ESA.

4

PERSPECTIVES OF PRACTITIONERS ON COPASAH

In this chapter, we analyse the perspectives of our informants on COPASAH, including its contribution and value addition to the field as well as its challenges and ideas to strengthen it in ESA. The focus, is on the functioning and relevance of the CoP in ESA. However, the global level of COPASAH is also involved as far as its role in ESA is concerned.

4.1. Contribution and value addition of COPASAH in ESA

This study has the goal of identifying ways to strengthen COPASAH in ESA by increasing its relevance to the specific needs of local practitioners. Such an exercise has its starting point in the increased understanding of what has so far been valued by practitioners who have, to various extents, crossed paths with the CoP. With this in mind, in this section we review findings related to the perceived contribution and value addition of COPASAH to the practice of organisations involved in the study as well as to the development of the field of social accountability in health in ESA.

4.1.1. Filling a gap for learning on social accountability in health

As mentioned in Chapter 3- Characteristics of social accountability in health in ESA, several informants thought that spaces and funds for learning and sharing specifically about social accountability in health are insufficient. National and regional networks specifically dedicated to this purpose were said to be scarce or non-existent. In this context, COPASAH was said to fill a gap by providing practitioners with spaces and occasions for sharing and mutual learning with a specific focus on social accountability in health.

"As a network to share and learn on social accountability in health, COPASAH has no competitors in ESA"

– Key Informant from Uganda

This was considered a valuable objective by virtually all respondents. There was a strong agreement over the added value of sharing ideas

and approaches through face-to-face interactions and/or online exchanges promoted by COPASAH, particularly in terms of sharing specific tools and approaches as well as thinking strategically of how to use tools or approaches to effectively influence change. In this, the broad similarity of approaches and tools used commonly across the region was seen as facilitating the process of sharing experiences within COPASAH, as well as increasing the motivation of practitioners to engage with into its activities.

4.1.2. Genuine environment for learning

According to many interviewees, COPASAH enjoys a good reputation among its members. Generally speaking, COPASAH is described as genuinely devoted to advancing the field rather than the individual interests of the network or of member organisations. In this, COPASAH was perceived as different from other networks which are driven by practitioners' interest in gaining visibility and/ or by donors' interest in showcasing their partners. Moreover, members were said to generally approach COPASAH with no rivalry and ulterior motives. This was seen as essential to genuine sharing and learning, which requires openness, honesty and trust. In this sense, COPASAH is perceived as opening up 'safe spaces' where practitioners are able to share challenges with no interferences by other interests brought about by competition for funds.

Some of our informants also expressed the idea that COPASAH is more robust and transparent than other networks and coalitions. This was particularly linked to communication around activities, and the availability of records of activities and discussions held.

4.1.3. Promoting the role of practitioners in knowledge generation

Since its inception, COPASAH has strived to create a platform that could not only encourage mutual learning but also promote the visibility and recognition of practitioners. In particular, an

important objective for COPASAH was to affirm the role of practitioners in advancing the debate about social accountability in health through grounded knowledge.

This area of work was acknowledged by some interviewees as relevant to the specific needs of the practitioners' community in ESA. Knowledge generation through case studies and issue papers was seen as an important objective of COPASAH, and as a particularly successful area of activities that contributed to promoting practitioners' credibility in a debate otherwise strongly led by academic research. This was in turn instrumental, in this view, in promoting the case for process-based and community-led versions of social accountability in health.

4.1.4. Capacity building activities are generally valuable

Informants who participated in capacity building activities organised by COPASAH perceived them as very valuable. Generally speaking, activities that involved face-to-face interaction were especially appreciated, also due to the fact that mutual trust is more easily created through personal knowledge. Moreover, in-person interactions were said to work better in ESA compared to online exchanges.

Special mentions were made with regards to Technical Assistance (TA), Facilitated Learning Exchanges (FLEs) and annual regional meetings. TA was mentioned as having been instrumental in identifying and addressing specific organisational needs. FLEs were also mentioned by some as extremely valuable, especially as they exposed participants to different ways of using similar approaches and tools for social accountability in health. Annual regional meetings were also praised for their potential for mutual learning and for the networking opportunities it opened up across the region.

Documentation of case studies promoted by COPASAH was also often mentioned as an especially valuable activity, particularly when less

known and used approaches and tools for social accountability in health are involved.

4.1.5. Online communication is inspiring and channels opportunities

Online communication among COPASAH members was considered very important. In particularly, several interviewees said that email exchanges and website content have been instrumental in channelling opportunities for learning and getting inspired by other practitioners' work.

The role of the Secretariat in facilitating and sharing information through online communication was appreciated by many respondents. One member praised the regularity of online communications by the COPASAH Secretariat, which in her view increased members' interest in getting involved and remaining engaged. Funding and training opportunities were mentioned as a particularly welcome subject for online communication.

4.2. Challenges and ideas to strengthen COPASAH in ESA

In this section, we explore our informants' perspectives on the challenges faced by COPASAH in ESA and ways to overcome them. During the study, many ideas to strengthen the CoP in ESA in the near future were shared. This in itself and along with the findings of the previous section shows an appreciation of the CoP and a desire to continue its work in ESA. Such ideas are both summarised here and re-elaborated into our final recommendations for COPASAH.

4.2.1. Lack of clarity on shared values

Some interviewees thought that COPASAH lacks clarity about what common values are keeping members together. In particular, a more explicit conversation was considered necessary with regards to what interpretation of social accountability in health COPASAH and

the organisations that compose it are seeking to promote or promoting in practice, in the spectrum of technical interventions versus political processes. This is considered particularly relevant in ESA considering the lack of both a shared understanding of and an enabling environment towards community-led social accountability (see 3.3. Analytical conclusions: needs and opportunities in social accountability in health in ESA).

Moreover, the role of international institutions such as the World Bank in determining current trends in the region is considered a matter of concern by some. Here, concerns are related to both its effects on the field and to COPASAH, as involved organisations have different points of view and stances with regards to collaborating with such institutions. These comments reflect a concern that the diversity present in the network - a positive feature in itself – also risks creating confusion and disincentives to engage. In this view, clarity on common values will not necessarily translate into a common position. However such diversity, if assumed, needs to become explicit.

4.2.2. Lack of clear purpose

During the interviews as well as at the COPASAH ESA Regional Meeting, different members expressed the opinion that COPASAH lacks a clear purpose and/or that no clarity or agreement exists over what should be its overall purpose. This was considered a pivotal reason for the lack of strength in the region and therefore an important area for collective reflection.

Some informants thought that more clarity is needed on the content and purpose of the learning. Somebody suggested anchoring the learning to a few health topics which are relevant for the whole region, adding that this might raise the interest of practitioners as well as make it easier to justify time and resources spent in COPASAH's activities. Other learning priorities which were mentioned include best practices in social accountability in health; effectively producing change at the national level; working

models for promoting coordination among practitioners and joint advocacy; harmonisation/ standardisation of tools across practitioners; using approaches and tools strategically according to context and to promote community ownership; and scaling up interventions to promote social accountability in the health sector.

On the other side, several interviewees aspired to use COPASAH for purposes beyond learning, and especially for joint advocacy. In fact, there appeared to be no clarity or agreement among members over whether advocacy was one of COPASAH's original objectives. Despite this, it was clear that many thought that advocacy should be considered as a possible outcome of networking through COPASAH (more in 4.2.6. Possible role in advocacy and coordination).

"I think we need a balance between learning and advocacy. We should be asking ourselves what is the relationship between the two and how we want COPASAH to act on that."
– Key Informant from South Africa

On the other side, some of COPASAH's original goals did not appear to be unanimously embraced. For instance, knowledge generation was not considered a priority by everybody. Some participants at the COPASAH ESA meeting were 'uncomfortable' with the idea, unless knowledge generation was clearly tied to the learning objectives of practitioners. Some of our interviewees thought that the objective of knowledge generation came from the global level of COPASAH but did not reflect the interests of the ESA members.

4.2.3. Need to map other networks and analyse gaps

According to some informants, COPASAH's efforts to maximise its relevance in ESA should be supported by an analysis of the needs and existing gaps in the region. In this sense, discussions among members should build on a comprehensive mapping of the work of other networks in the area.

In this view, such an effort to map the work of other networks in the area should also promote the quantity and quality of the interactions of COPASAH with realities that already operate on the ground. This would in itself ensure the maximisation of COPASAH's relevance in the region, as it would increase cooperation and avoid competition. Moreover, enhanced understanding of and collaboration with other networks in the region was considered to have the potential to improve COPASAH's visibility and reach among practitioners (more in 4.2.11. Insufficient reach and visibility).

4.2.4. Possible role on advocacy and coordination

To many interviewees, COPASAH should go beyond mutual learning and provide a platform for advocacy. This was envisioned as promoting collective analytic work and ultimately practitioners' collective voice, for instance through position papers and joint actions. Suggestions for possible advocacy objectives include increases in sector budgets; access to essential medicines; strengthened statutory platforms for community participation in the health sector (for instance through increased budget/ training/ facilitation/ transparency/ independence for HCCs or national platforms for coordinating initiatives to enhance social accountability in health); and support for NGOs subjected to governmental repression in various countries of the region.

Moreover, some members thought that COPASAH could also assume a direct role in coordinating social accountability practitioners at the country level. In this line, it was suggested that COPASAH focuses on creating stronger national networks to stimulate a collective analysis of local gaps and advocacy needs. This was also said to be important in strengthening the voice of practitioners when convening through COPASAH at the regional and global level.

4.2.5. Extending the debate to other stakeholders

In this line, some respondents also expressed the desire to expand the scope of COPASAH to promoting debate with other stakeholders, including duty-bearers and donors.

"The views of practitioners are not taken seriously, the debate tends to happen in spaces created and allowed by donors. Coalitions are there just because of funds. And power dynamics are unequal in those forums. COPASAH is already working to rebalance those power dynamics but more could be done."
– Key Informant from Uganda

Comments of this kind build on the existing objective to promote practitioners' voice and legitimacy but expand it to include the proactive engagement of other stakeholders. This was implied for instance by an interviewee who, while a staff member at the MoH of his country, was inspired by COPASAH to design and implement a social accountability program. Reflecting on this experience, he suggested that COPASAH involve more people from within the system (for instance health promotion officer at the district level) with a view to generating change from within. Similarly, other respondents thought that exposing government representatives to social accountability approaches from other countries and continents through COPASAH could inspire them and lead to innovation at the national and regional level.

In this line, some members thought that COPASAH could also do more to promote dialogue with donors and legitimise their views with these important stakeholders. In this view, particular efforts should be put into advocating for more favourable funding practices, including longer funding cycles and dedicated funds for research and follow up (see 3.1.8. Reliance from international donors and unfavourable funding practices).

4.2.6. Considering broadening the health focus

Some comments were made about the possibility of expanding the focus of COPASAH beyond social accountability in health to include other thematic areas. This was deemed to potentially promote an exchange with what is happening in other sectors, as well as with actors who are using approaches to influence overall governance practices or community participation in public functions and structures in itself. On the contrary, such a dialogue could be lost if the single-focus is maintained, as organisations working with a broader focus might not feel motivated to engage. For other respondents, this broadened focus would highlight the interactions between social accountability work done around health and its determinants.

However, there was a general sense that broadening the scope too much would bring a risk of losing the focus. This was said to be particularly relevant as other networks are already working on a global scale on social accountability as a whole – for instance the Global Partnership for Social Accountability (GPSA). Instead, it was suggested that more exchange and collaboration is sought with networks that focus on the application of social accountability approaches to a broader range of topics. Some members also said that if the scope is indeed broadened, then thematic sub-groups could be established in order to keep the health focus.

4.2.7. Insufficient activities in ESA

There was widespread agreement among our informants that activities carried out by COPASAH in ESA are not enough in number and frequency. This was attributed to a general scarcity of funds, and said to be partly responsible for the weakness of COPASAH in the region. On the contrary, more activities would sustain the interest of existing members and attract organisations that are not yet involved.

In particular, our informants expressed a desire to increase the number and frequency of FLE and TA, as those are generally considered very valuable (see 4.1.4. Capacity building activities are generally valuable). More face-to-face regional meetings are also needed to connect and create an environment of trust better built through personal knowledge and proximity. There was also a sense that the network was not facilitated beyond and between the meetings, possibly for lack of specific funds to do so, and this was also discouraging participation.

In addition, many respondents expressed an interest in expanding documentation of programs to foster social accountability in health in the ESA region. Several members pointed out that COPASAH could be instrumental in linking practitioners with academics as well as in advocating for the disbursement of funds dedicated to documenting and researching social accountability practice.

4.2.8. Online communications not effective, owned or specific enough

While respondents generally appreciated online communications from the CoP, communications from and for the region were perceived by many as ineffective and insufficient. There appeared to be some gaps with regards to communication around COPASAH activities, resulting for instance in some members not receiving communication or being contacted late about the upcoming regional meeting. Mostly, however, comments around communication revolved around the lack of facilitation of COPASAH ESA in between meetings, as well as to a general apathy of ESA members with respect to COPASAH, which hinders the likelihood of them contributing through case studies or news of common interests.

Several comments were also made about the role of existing platforms in hindering effective communication in the region. In particular, some informants felt the need for a platform which is able to facilitate sharing of content by members

themselves without intermediation. Others thought that the COPASAH website itself should be more accessible for members to post directly with minimal intervention by the Secretariat. In these views, increased accessibility could translate into more ownership by members and relevance to the ESA context. Moreover, it would also multiply occasions for learning currently channelled by quarterly newsletters, foster a more continuous communication, and facilitate sharing of time-sensitive information such as latest news and calls for action. Practical suggestions in this sense included an ESA regional blog and an ESA-specific newsletter.

4.2.9. Insufficient reach and visibility

Respondents generally agreed that the network is not very strong in the region. This was often referred to as lack of visibility of COPASAH among practitioners, including both members and organisations that are not yet involved.

Various possible reasons were identified for this. These include the lack of clarity and/or agreement over the values and purpose of COPASAH seen above. In this line, one informant thought that including advocacy could increase the motivation of more experienced members, who could otherwise disengage in the long run if the CoP was to exclusively focus on mutual learning. Other comments pointed at the lack of a strong strategy for recruitment and engagement, particularly through appropriate engagement with other networks in the region. Some interviewees talked about the vicious circle produced by the lack of a broad membership in discouraging others to join.

"If you start seeing that many interesting people are involved you are more likely to involve too. There should be a big effort for recruiting new members, for engaging new organisations".
– Key Informant from Zimbabwe

Moreover, as mentioned above several informants attribute the disengagement of current members to the scarcity of communication and activities

carried out by COPASAH in ESA. On the other side, members often struggle to guarantee time for participating in activities organised by COPASAH. Continuity is also a serious challenge to the reach of COPASAH as engaged individuals change over time and in many cases there is no effective cascade of information on COPASAH among colleagues. This was apparent in many accounts of interviewees who discovered COPASAH through various channels (for instance google search or a conference) in spite of the fact that their organisation had being formally involved for years.

4.2.10. Uneven coverage across the region

Our informants generally agreed that COPASAH is stronger in certain ESA countries and especially in Uganda, Kenya and Zimbabwe. This is reflected by the COPASAH membership as well as by patterns of engagement in activities carried out so far. According to some interviewees, several other ESA countries (for example South Africa and Tanzania) play host to very interesting initiatives for social accountability in health but are not sufficiently represented in COPASAH. This was seen as a lost opportunity to create synergies and cross-pollination of ideas and practices across the region. An interviewee also thought that the under-representation of some countries also creates disincentives to participate as it decreased the ability of organisations from those countries to engage meaningfully.

This challenge was linked to different factors. Clearly, the fact that the regional coordination was based in Uganda at the time of the research (although the role was vacant at the time of writing due to the stepping down of UNHCO) was mentioned as a factor contributing to the strength of COPASAH in this country as well as in neighbouring Kenya. Conversely, the absence of coordination in Southern Africa at present (contrary to the initial set-up of two coordinators for East and Southern Africa) – is seen as hindering the reach of COPASAH in that region. This was seen as particularly relevant considering the

vastness and the diversity that characterises the region. Once again, the lack of dedicated strategy and resources for 'recruiting' across the continent was considered a challenge in the way of being able to attract representatives from different countries in ESA.

4.2.11. Low ownership of members and need for strategic engagement

The COPASAH structure and mechanisms for engagement of members in ESA was identified as an aspect in need of rethinking by many participants to our study as well as at the COPASAH ESA Regional Meeting. A common thread across comments in this area is the desire for a broader and deeper involvement of the regional members in determining the way forward of the CoP.

Several respondents reported being unaware of the strategy, work plan and budget for the region, as well as of how these are determined. This could have various reasons, including – it was suggested - the challenges of ensuring continuity or cascading information on COPASAH within individual organisations. However, it was also pointed out that no structured platform or mechanisms exist to share the decision making process with regional members. For this reason, COPASAH's operations in the region are generally identified with regional coordination (sitting with UNHCO at the time of the research). This leads to a lack of ownership of the process by members. Other members actually thought that no strategy or work plan exists at all, and believed that this would change if more organisations were actively involved in the process.

Most respondents thought that broader involvement is needed at the strategic level in order to promote the relevance and effectiveness of COPASAH, and some interviewees expressed a desire to be more personally involved at this level. Moreover, broader involvement was said to be needed to increase the internal transparency and accountability of the CoP in the region. Particularly felt was the need to create spaces to constructively

rethink and criticise the functioning of COPASAH in the region on a regular basis.

The country level was identified by many informants as a potential starting point for broader and more effective engagement. Several suggestions were advanced in this direction, including having one focal organisation per country or establishing country level committees (where membership numbers allow it) with responsibilities to develop and implement a work plan. Other suggestions include the establishment of a regional committee including representatives from different countries.

On the other side, some members were concerned about adding extra layers and making the structure too complex. This was suggested also in light of the existence of other networks that could be strengthened in the region as an alternative to creating specific COPASAH structures. It was also highlighted that more clarity on the general purpose of COPASAH is needed before any determination on its structure is made.

4.2.12. Unclear relationships with COPASAH global and overall nature of the CoP

The relationship between the ESA hub and COPASAH as a global network was also discussed by many interviewees as well as at the COPASAH ESA Regional Meeting. Such comments imply a general sense of disconnection of active ESA members with regards to the global level, and highlight the need to work at this level to improve ownership by members.

Some interviewees thought that the region was relatively isolated with respect to the global discourse, both outside and inside COPASAH, and expressed the desire to see more global events being organised by the CoP in the ESA territory. Other informants had the feeling that the region was marginalised with regards to budget allocated by COPASAH to the ESA hub. Overall, a few comments implied a lack of clarity over how the

general COPASAH budget was allocated to the regional hubs.

Several comments made at this level revolved around the relationship between the ESA hub and the Secretariat. There was a sense that the Secretariat is somehow lacking legitimacy in the region. This was linked by some to a lack of clarity on its role in relation to the regional hubs, and particularly of whether it should be one of management or support. Some comments implied that the latter had been mostly put in practice, but that the former should be preferred and increased.

This argument was also developed by participants at the COPASAH ESA Regional Meeting. Several discussions held at the meeting implied that the general direction was somehow identified with the Secretariat. On the contrary, a fundamental question was raised regarding what space should be left to regions to develop their own strategies and objectives within COPASAH. In this line, there appeared to be different interpretations of whether COPASAH should be considered a 'network' or a 'movement', with diverging consequences for its functioning, the role and level of engagement of its members, and the appropriate degree of flexibility to embrace the unexpected outcomes of engagement in different regional hubs.

"Social movements should be an example; there is no leading organisation there. We should do like them"

– Key Informant from Uganda

4.3. What needs and opportunities for COPASAH in ESA?

Chapter 4: Perspectives of practitioners on COPASAH analysed the perceptions of our informants with regards to the added value and challenges of COPASAH in ESA. This conclusion summarises and critically connects its main points with the findings about social accountability in health in ESA summarised in Chapter 3- Characteristics of social accountability practice in health in ESA. This is done with a view to

understanding our informants' perceptions of COPASAH and the way forward in the broader context of the specific assets and needs of social accountability practitioners in the ESA context. This link is necessary to lay the ground for the recommendations for strengthening COPASAH in ESA which will be developed in the next chapter (Chapter 5- Recommendations to strengthening COPASAH in ESA).

Build on COPASAH strength of filling a gap by providing specific and genuine learning - Our analysis suggests that there is a general appreciation of COPASAH as a space that promotes genuine learning and sharing among practitioners. This is especially relevant in a context where sharing and mutual learning specifically on social accountability in health is said to be insufficiently promoted and funded, or to be sometimes hindered by competition between practitioners. This constitutes an important stepping stone to all efforts to strengthen COPASAH in ESA, including when seeking for funding.

Anchor activities to practical needs of practitioners in ESA, including for action- On the other side, there is an obvious call to clarify and rethink the purpose of the CoP in ESA. In different ways, these calls talk about a desire for COPASAH to be more and more explicitly focused on supporting and enhancing practice in the region. To many informants, for instance, learning channelled by COPASAH should be clearly targeted to specific issues of common interest and of relevance for ESA members. There is also a common desire to increase and strengthen those activities that are more obviously directed towards sharing practical knowledge on how to use tools and approaches effectively. Moreover, increased advocacy and coordination among social accountability practitioners working on health in the region (identified as lacking in Chapter 3: XXX) should also be promoted, including by COPASAH, with a view to promoting an enabling environment to social accountability practice in ESA. The objective of knowledge generation, on the other side, is

controversial and many ESA practitioners see it as valuable in so far as it is serving the practice rather than advancing the theory on social accountability.

Proactively promote practitioners' views and demands through increased dialogue with other stakeholders- COPASAH is appreciated by many as a dedicated and therefore safe space for practitioners to reflect on their practice in the context of sharing and mutual learning. On the other side, there is an overall sense that practitioners lack a platform that can bring forward their aggregated views and demands in important matters. Networks in the region are most often focused on specific health topics and more rarely on the practice in itself. This means that there is huge scope to further support practitioners in the region in their efforts to create more enabling contexts for social accountability in health, particularly with regards to institutions' and donors' practices. Possibly for this reason, some explicit calls and several arguments emerged throughout the study to expand the scope of COPASAH in ESA to actively promote dialogue with other stakeholders. Examples of themes for engagement with duty-bearers include strengthening institutional platforms for community participation in the health sector and supporting coordination of efforts at the national level. On the other hand, donors should be engaged in conversations over funding practices that are more conducive of sustainability and community ownership, as well as supporting coordination of efforts, research and documentation, and networking.

Find a balance between theory/ practice and local/ global level- Generally, there is a desire to determine specific objectives for COPASAH in ESA which will be directed towards strengthening the field by addressing some of the challenges faced by practitioners in the region. These include a tendency towards enacting tools-based versus process-based versions of social accountability; a lack of community ownership of the process in some ESA countries; the problematic implementation of otherwise enabling policies for community participation in the health sector; and a repressive environment in some countries with a general decrease of the spaces for political participation. The promotion of practitioners-led assessments of challenges and opportunities in the field needs to marry with practical direction and action to overcome them in ESA. On the other hand, some of these challenges relate to broader issues that encompass the global politics of social accountability. The global level of COPASAH has a pivotal role here in facilitating processes able to link contextual analysis and action to overall issues of health policy and governance, as well as to the broader theoretical debate on social accountability. With this in mind, a balance is needed between enhancing relevance at the local and global level, as well as between attention to practice and theory.

Promote participatory mechanisms of engagement and members' ownership in COPASAH in ESA- Concurrently, there is an obvious need for rethinking the form and mechanisms of engagement of COPASAH, on the 'network' versus 'movement' spectrum. As is evident in this study, important calls are being made for increasing the ownership of members and relevance to the specific ESA context. This is important not only – and crucially - to ensure the effective functioning of COPASAH, but also to effectively advance the very principles COPASAH is seeking to promote - participation/ empowerment, local relevance and grounded knowledge, representativeness/ inclusiveness and transparency. An agreement over common values is needed not only to better position COPASAH in the social accountability debate but to also guide its very existence. This is a pivotal enabler for strengthening COPASAH in ESA.

5

RECOMMENDATIONS TO STRENGTHEN COPASAH IN ESA

In this chapter, we build on our informants' views to provide recommendations for the way forward of COPASAH in ESA. In doing so, we do not intend to be exhaustive but rather lay the groundwork for in-depth discussions to be taken forward by COPASAH members. Recommendations are provided with reference to some key dimensions of COPASAH including a. nature and organisational principles; b. purpose and scope; c. organisational structure and mechanisms for engagement; d. reach and visibility; and e. activities and communications.

5.1. Nature and organisational principles

Our analysis highlighted the need to promote a conversation on the very nature of COPASAH. This is to be considered a pivotal starting point for any discussions on the way forward as its consequences are relevant to all other dimensions of COPASAH's functioning in the region, as well as to its very legitimacy.

This debate should take into account a strong call for more bottom-up structures and processes and

for enhanced relevance of COPASAH to the field in ESA. With this is mind, it should be clarified whether COPASAH is to be considered a 'network' or a 'movement'. This entails rethinking the degree of fluidity of the form and mechanisms of the decision-making as much as redirecting efforts towards including common action. While we tackle the latter point later in 5.2 Purpose ad scope of COPASAH, the former includes: defining what relationships should exist between the global and regional levels; the degree of autonomy of regional hubs to define their own objectives to address local needs; as well as the degree of flexibility with regards to set objectives and the unexpected outcomes of engagement (especially in light of participatory, time-sensitive advocacy).

As emerged in this study, moreover, this tension is not exclusive to COPASAH but concerns other networks in the region and globally which – it was suggested - also struggle to find an alternative model to that of a 'project' with set recipients of funds and disputed ownership. The necessary debate concerning the nature of COPASAH could

---

BOX 11: RECOMMENDATIONS ON NATURE AND ORGANISATIONAL PRINCIPLES

General recommendation

Clarify through an inclusive dialogue the nature and organisational principles of COPASAH; the relationships between global and regional levels; the role of the Secretariat; the autonomy of regional hubs to set up their own objectives and the degree of flexibility of processes promoted by COPASAH.

Practical recommendations

Organise a global COPASAH meeting to be possibly held in ESA. This should be highly participatory and directed towards discussing and clarifying the above issues.

Facilitate an exchange on the way specific objectives have been identified and pursued by different COPASAH regional hubs in the past with a view to increasing exchange between continents and learning about networking processes.

Facilitate the process of identifying specific objectives for the COPASAH ESA regional hubs as well as how those link with the overall purpose of COPASAH and the global debate on social accountability

Facilitate the dissemination and translation of decisions taken at the ESA level through online mechanisms such as conference calls, forums and shared development of key documents to guide practice.

Promote an exchange with other networks in the region and globally on alternative models of running networks to avoid framing them as 'projects' and maximise collaboration among practitioners.

connect with and encourage a broader dialogue on this topic.

5.2. Purpose and scope

There is scope to clarify the content as well as the purpose of learning promoted by COPASAH. Moreover, learning has to be adapted to the needs of practitioners in specific contexts. For instance, this review has highlighted the need to focus on promoting citizen-led forms of social accountability in health by encouraging community ownership, using tools strategically and influencing change at the national level in ESA. Learning priorities should be determined collectively with a view to promoting localised discussion and innovation.

On a similar line, this study has suggested that there is a need to rethink the role of knowledge generation in COPASAH, as conflicting views exist with regards to its relevance and purpose. In particular, this should be directed towards reaching a balance between a general desire to anchor the generation of knowledge to the practical learning and documenting needs of ESA practitioners and

---

BOX 12: RECOMMENDATIONS ON PURPOSE AND SCOPE

General recommendation

Promote an inclusive discussion on the purpose and scope of COPASAH, including by clarifying the purpose and the content of learning; the role of knowledge generation in COPASAH; as well as the role of COPASAH in advocacy and coordination of social accountability efforts.

Practical recommendations

Facilitate an inclusive discussion on the general purpose of COPASAH through global networking meeting. This should include reflections on the role of knowledge generation.

Replicate this study in other regions to gain a comprehensive picture of the relevance of COPASAH across its various hubs and of local perspectives on the way forward.

Conduct a mapping exercise of existing ESA networks to identify gaps and promote collaboration through making use of the specific strengths of the region, for example in promoting health topic-based and action-driven networking.

Conduct an analysis of the existing learning needs among ESA members followed by the collective development of a learning strategy. The strategy should also analyse and make full use of both internal and external expertise to increase members' ownership and maximise cooperation.

Encourage learning opportunities with a link with the identified advocacy goals (recommendation below) or link members with learning opportunities that are already available.

Conduct an analysis of the existing advocacy needs according to ESA members, followed by the collective development of an advocacy strategy.

Aim to link members with relevant stakeholders for advocacy purposes and/or actively coordinate advocacy if an advocacy gap is identified.

Promote reflection on how to enhance coordination of practitioners at the national and regional levels, for instance by developing case studies/ review of best practices or by organizing events to promote discussion and/or advocacy for crucial enablers, including public or private funding for national platforms.

Proactively open up spaces for dialogue with other stakeholders on the basis of specific advocacy objectives, for instance through events on the role of funding practices or on strengthening institutional forms of participation in the health sector.

the advancement of the theoretical discussion on social accountability in health (more in 5.5. Activities and Communications).

On the other side, there should be a balance between learning and engaging in common action. The role of COPASAH in promoting advocacy in ESA should be discussed and promoted, through a strategy that links learning opportunities and advocacy goals as much as possible while also maximizing the use of existing platforms to avoid duplication of efforts.

A need for increased coordination among social accountability organisations has also emerged. An active role for COPASAH in this sense is unlikely if we take into account its present lack of strength in the region. However, COPASAH could contribute by promoting analysis and/or advocacy for enabling the expansion of this pivotal function.

Practitioners appreciate the 'safe space' created by COPASAH but strive to increase dialogue with other stakeholders such as duty-bearers and donors. In light of this, COPASAH should organise its ESA activities around two axes: one dedicated to practitioners' learning and action; and the other revolving around dialogue with other stakeholders on the basis of specific advocacy objectives.

5.3. Organisational structure and mechanisms for engagement

Fundamental clarifications on the nature and purpose of COPASAH will have to be sought before any determination is made on its future structure. However, there is an obvious need for boosting members' feeling of owning the process which is being promoted by COPASAH in ESA. Active participation of members at the strategic and operating levels has been lacking and should therefore be strengthened through sound and diversified mechanisms which are agreed among active members. Strategic engagement needs to be perceived and experienced as a regular process. This must also allow for reflective engagement with possibilities for open and constructive criticism of the functioning of COPASAH at all levels.

In a context of limited reach of the CoP in the ESA region, there is a need to maximise representation from different countries as well as to ensure a balance between voices from East and Southern Africa at the strategic level (with flexibility for accommodating different levels of involvement among countries in the region).

The roles and engagement mechanisms between the global and the local levels are unclear and this affects relationships and confidence in the process. This should be tackled through promoting an open conversation among members aimed at discussing and clarifying the roles and responsibilities of each level. This conversation should also include a clarification over the role of the Secretariat between supervision, facilitation and support and the mechanisms to be expected for each function.

Considering the perceived disadvantage of the region in terms of resources and activities promoted, maximum transparency on the decision-making process and budgetary choices should also be ensured.

General recommendation

Encourage full ownership of COPASAH by ESA members through clarity about structural set-up and the role of regional coordination and the Secretariat; sound mechanisms for an effective engagement at the strategic level; open and regular feed-back; inclusiveness and representativeness across the region; and transparency on all decisions taken.

Practical recommendations

Facilitate an open conversation on the structure of COPASAH and mechanisms to promote the participation of members at the strategic level through a global networking meeting.

Follow up through regional or online meetings to adapt general deliberations to the ESA context, including by considering creating a regional committee; identifying focal organisations at the country level; and/or giving members the lead on different activities/themes.

Promote a balance between East and Southern Africa at the strategic level by re-instating a Southern Africa sub-regional coordinator and electing a new East Africa coordinator.

Facilitate participatory deliberation about the role of regional and sub-regional coordinators, including their responsibilities towards regional members and mechanisms to promote their accountability.

Ensure that sound mechanisms for support of regional hubs by the Secretariat are established in a participatory manner and then widely shared with members.

Establish sound mechanisms for open feed-back and constructive criticism of the functioning of COPASAH at all levels, including regular surveys and externally facilitated focused discussions.

Publish all decision-making processes and budgetary choices on the COPASAH website and disseminate them through the COPASAH contact lists, with request for input and feedback when needed.

5.4. Reach and visibility

There is a general agreement that the reach of COPASAH in the region is limited and this decreases the incentive for organisations to engage. For this reason - once fundamental questions over the nature, the purpose and the structure of the CoP have been clarified - COPASAH should seek to increase its membership base in ESA to strengthen its role and enhance credibility.

The insufficiency of activities carried out by COPASAH in ESA was deemed to be partly responsible for the lack of visibility and engagement among practitioners. With this in mind, COPASAH should multiply the occasions for interaction not only to enhance its relevance but also to attract new members and increase the engagement of the existing ones. In a region where activities and membership have so far concentrated in few countries, it is crucial to also increase the accessibility of the occasions for interaction promoted by COPASAH.

Moreover, COPASAH is ESA should address issues of continuity of engagement within member organisations, particularly as active members tend to change within organisations and there is a weak internal transmission of information on COPASAH's existence, purpose and activities. This is reflective of low ownership of the process promoted by the CoP, as well as of the often individual – as opposed to organisational - nature of the engagement with COPASAH.

General recommendation

Increase the reach of COPASAH across different countries through increased partnership with existing networks; the active involvement of members in recruiting and engaging members; and increased occasions for face-to-face interactions, including at the country level.

Practical recommendations

Lead a mapping exercise of initiatives and networks for social accountability in health as a starting point for conducting outreach. This should ideally be led by members at a country level and seen as a work in progress, with organisations 'referring' others and information flowing in an interactive mapping tool to be hosted by the COPASAH website to promote connections.

Plan and budget for a 'recruitment phase', starting from existing networks and concentrating on countries and sub-regions that are currently under-represented. An outreach officer could be hired for a short time to this purpose or the regional coordinator(s) could be facilitated to do this.

Facilitate more occasions for face-to-face interactions and enhance accessibility, for instance through 'piggy-backing' events in the region, facilitating smaller meetings at the national level where number of members allows it, and/or rotating the location of the COPASAH meetings in different ESA countries.

Establish volunteer national focal organisations to recruit other members at the national level and/or act as 'passive' promoters of COPASAH by featuring it in their websites and spreading information.

Tackle issues of continuity through focusing on the organisational component of engaging with COPASAH, for instance through featuring the COPASAH website in organisations' websites, promoting internal recruitment of new members and cascading information on COPASAH to colleagues.

5.5. Activities and communications

Activities carried out by COPASAH have been widely appreciated by members in ESA, but their insufficiency was said to limit the level of interest and active engagement of existing and potential members. To strengthen its presence and relevance, therefore, COPASAH should seek to increase and diversify activities carried out in the region, and especially face-to-face interactions which are considered to work better for networking in ESA.

Documentation of initiatives for social accountability in the health sector should be strengthened with a view to stimulating discussion and action on the specific challenges in the ESA context. This study has suggested that there is a need to increase contextualised innovation to promote citizen-led processes to influence change beyond the local level in ESA. This might result in efforts to document less known or used social accountability approaches or providing analysis of the broader contexts of the interventions.

Operational communications regarding COPASAH activities lack effectiveness at times and seem not to reach all members within an appropriate timeframe. On the other side, online interactions lack in frequency and relevance to the ESA region. Members are discouraged by the lack of facilitation and follow up in between meetings and by the difficulties in sharing action-bound and time-sensitive content with minimal effort. The ownership of member organisations with regards to activities and online communications should be especially strengthened in ESA.

BOX 15: RECOMMENDATIONS ON ACTIVITIES AND COMMUNICATIONS

General recommendation

Increase and diversify activities carried out in ESA, especially face-to-face interactions and documentation; increase frequency and relevance of online communications for the ESA region; and promote ownership of communications by members.

Practical recommendations

Increase number and frequency of FLE, TA and regional and global networking meetings, and piggy-back on external events in the region to increase face-to-face interactions.

Promote documentation of initiatives through partnerships with academics and between practitioners. This could focus on innovative approaches and national case studies to map contexts of social accountability in health, and should promote links between documentation/ learning and advocacy objectives.

Establish sound mechanisms to ensure an effective, inclusive and timeless communication of all operational issues surrounding COPASAH in ESA, including of a comprehensive contact list with recording of history of and preferences for engagement, as well as agreed timeframes for specific communications.

Promote regular online meetings and focused webinars specifically for follow up, learning and common action in ESA.

Increase the ownership of member organisations with regards to online communications through an ESA blog, ESA topic forums hosted on the COPASAH website or other channels which allow for time-sensitive content sharing.

6

CONCLUSION

Social accountability in health is an expanding field in ESA as well as globally. Recent years have witnessed an increase in the quantity and diversity of initiatives to enhance health sectors' accountability in the region through community engagement. Practitioners in the field are progressively becoming more and more explicit in their approach to social accountability in health. At the same time, national policies are increasingly incorporating concepts and establishing practices for the participation of communities in the health sector. This is contributing towards a progressive legitimisation of the concept and practice of social accountability in health among civil society and institutions alike.

At the same time, practitioners in the region still face important challenges. Some of these are linked to the fact that social accountability in health is fairly new in some ESA countries. Duty-bearers and service providers are far from unanimously embracing social accountability concepts and practices, and unequal power dynamics represent a huge obstacle to the work of practitioners in the region. At the same time, communities are not yet fully aware of their possible role in demanding improved health sectors and their ownership of social accountability processes is often weak. While outcomes of social accountability interventions are often visible at the local level, influencing change at the national level is especially challenging. This is aggravated by a general lack of coordination of efforts which leads to missed opportunities to collate local evidence and voices.

Maybe most importantly, the field is not unanimous with regards to what kind of practice to promote in ESA, in the spectrum between communities-centred/ citizen-led practice versus tool-based, instrumentalist and funder driven accountability. The tension between these two versions of social accountability is part of a broader dynamic in the field (Joshi, 2010), although its effects are perhaps more obvious in ESA (IHI, 2015). As our study suggests, there are concerns among practitioners that the latter version of

social accountability is somehow stronger in the region. Moreover, even when practitioners are supportive of a community centred framework, they often encounter numerous challenges to promote it in practice. Many of those challenges are linked to the high degree of dependency of social accountability programs on external funding. Others are linked to the progressive closure of spaces for political (as opposed to technical) participation in several countries in the region. In this context, there is an urgent need to promote a debate among practitioners in ESA to reach a common understandings of the kind of accountability practice they aim to promote and how, as well as to coordinate voices to promote it among stakeholders.

Strong networks of practitioners are vital to encourage this kind of debate. Our study suggests that there is scope to expand and strengthen the connections currently existing among ESA practitioners as well as between existing networks of practitioners. But networking should be targeted to the specific needs of practitioners in the region to be effective. As this study highlights, a mix of learning, documentation and advocacy opportunities is needed to promote a discussion grounded on and oriented towards practice.

COPASAH has a great opportunity to rethink its strategy and become more relevant to the needs and desires of ESA practitioners along these three axes (learning, documentation and advocacy), including by better linking with the work of other networks. This study contributes to this by outlining local practitioners' perspectives on the characteristics of the field in ESA and the way forward for COPASAH. But this is only the beginning of a process to determine the way forward for COPASAH in ESA that has members at its centre. Perhaps above all, this study highlighted a strong commitment among practitioners to engage in self-reflection as well as a real appetite for a strengthened CoP in ESA. These and other assets that emerged during the study are reasons for optimism on the way forward.

Although the main goal of this study was to provide recommendations for the way forward of COPASAH in ESA, we also hoped for this study to be useful to other stakeholders such as practitioners and networks not yet involved in COPASAH, academics, duty-bearers and donors.

In particular, we wished to induce practitioners to reflect on their own needs and desires by identifying (or not) with our analyses, while also helping them to gain an honest understanding of the potential of COPASAH to promote a dialogue and support the field. Similarly, by promoting a conversation about social accountability in ESA, we hoped to encourage the convergence of networks towards the common goal of meeting practitioners' needs and advancing the field.

The legitimisation of practitioners' views vis-à-vis academics is one of COPASAH's original goals. This report contributes to this by exploring the views of a number of practitioners on their own field. There is a paucity of research produced with this specific purpose, which should be addressed in the first place. Moreover, this study also calls for researchers to pay more in-depth consideration to the role of context and the process of social accountability interventions in particular settings. This is especially needed in ESA to support a shift towards more nuanced and process-oriented initiatives for citizen-led health accountability. Strong partnerships between researchers and practitioners/ networks of practitioners are needed to this purpose.

Duty-bearers have a pivotal role in promoting conversations among institutional representatives and service providers on the need for social accountability in health. As this study suggest, this

is especially needed in ESA. Moreover, institutions should provide crucial support –including through funding – to promote the coordination of practitioners at the national level. Once again, this is especially needed in ESA to ensure consolidation of evidence and strengthening voices, as well as to facilitate the legitimisation of the concept and practice of social accountability in health vis-à-vis the same institutions. Lastly, this paper voices important views held by practitioners on how to improve working relationship with institutions, for instance by understanding the need to avoid elitist forms of representation and tick-box exercises.

Last but not least, donors can find here an indication of some crucial questions that should be addressed from the perspectives of practitioners. These include the over-dependency on international donors and the consequent vulnerability of practitioners to oscillations in funding; the impact of specific funding practices in pushing versions of social accountability in health that do not promote community ownership nor the sustainability required for accessing grants; the need for longer funding cycles and for funds dedicated to research and follow up, networking and mutual learning, and the coordination of practitioners at the national level.

Social accountability in health is an expanding field in the ESA region with plenty of existing expertise as well as a huge potential for growth. In this phase, it is crucial that networking is encouraged and supported by all stakeholders. The potential of the field to reach its maturity lies in each and every opportunity to promote cross-fertilisation of knowledge.
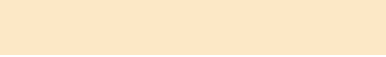
REFERENCES

Berlan, D, Schiffman, J. (2011). Holding health providers in developing countries accountable to consumers: a synthesis of relevant scholarship, Health Policy and Planning, 27(4), 271-280

Bjorkman, M., & Svensson, J. (2009). Power to the People: evidence from a randomised field experiment on community-based monitoring in Uganda. The Quarterly Journal of Economics, 124(2), 735-769

Commonwealth Foundation (1999). The Way Forward: Citizens, Civil Society and Governance in the new Millennium. London, Commonwealth Foundation

Croke, K. (2012). Community-Based Monitoring Programs in the Health Sector. A Literature Review. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc

Fox, J. (2007). The Uncertain Relationship between Transparency and Accountability, Development in Practice, 17 (4), 663-71.

Dasgupta, J. (2011). Ten years of negotiating rights around maternal health in Uttar Pradesh. India BMC International Health and Human Rights, 11(3):S4

Gaventa, J. (2002). Introduction: Exploring Citizenship, Participation and Accountability. IDS Bulletin, 3(2). Brighton: Institute of Development Studies

Gaventa, J., & Barrett, G. (2010). So What Difference Does it Make? Mapping the Outcomes of Citizen Engagement (Working Paper No. 347). Brighton: Institute of Development Studies

Goetz, A.M., & Gaventa, J. (2001). Bringing Citizen Voice and Client Focus into Service Delivery (Working Paper No. 138). Brighton: Institute of Development Studies

Joshi, A. (2010, October). Review of impacts and effectiveness of transparency and accountability initiatives: service delivery', Annex 1 Service Delivery. Prepared for the Transparency and Accountability Initiative Workshop, Brighton, UK.

Ifakara Health Institute (2015), Social Accountability in Tanzania: Social Accountability experiments, results and lessons in the social sectors. Retrieved at www.policyforum-tz.org/sites/default/files/SAMLESSONSLEARNED.pdf

Malena, C. M., Forster, R., Singh, J., (2004). Social Accountability: An Introduction to the Concept and Emerging Practice. Washington, D.C.: World Bank.

Rocha Menocal, A. and Sharma, B. (2008) 'Joint Evaluation of Citizen's Voice and Accountability Report', London: Department for International Development.

Schedler, A. (1999) 'Conceptualizing Accountability', in Schedler, A., Diamond, L. and Plattner, M. (eds) The Self Restraining State: Power and Accountability in New Democracies, Boulder CO: Lynne Rienner.

Zulu, J. M., Hurtig, A. K., Kinsman, J., and Michelo, C. (2015) Innovation in health service delivery: integrating community health assistants into the health system at district level in Zambia, BMC Health Services Research, 15:38