Concept Note for Learning Exchange:

Transparency/accountability strategies & reproductive health delivery systems

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Conveners:
Accountability Research Center, School of International Service, American University
The Evidence Project
International Planned Parenthood Federation
Reproductive Health Supplies Coalition, Advocacy and Accountability Working Group

Problem Statement:

Systemic weaknesses, vulnerabilities or biases at different points in health systems are often the reasons why reproductive health (RH) supplies fail to reach that all-important 'last mile' of women wanting to use modern contraceptives. These issues, sometimes called "wicked problems" because they lack both technical certainty and political agreement, are well known but are often complex and difficult to address (Hope and Hill, 2009). Global, national, and regional stakeholders undertake valiant efforts to coordinate and build local capacity for public sector RH supply forecasting, distribution, and monitoring; however, these technical approaches may not address the full range of underlying causes that limit citizens' choices—including inefficiency, corruption, vested interests, stock-outs, informal fees, as well as social exclusion and bias. These larger systemic issues have been acknowledged by the public health community, but have been under-addressed due to their complexity, controversial nature, and the limited capacity of technical problem-solving approaches to address deeper governance challenges. Moreover, at least in development agencies and government ministries, "sectoral" divisions tend to separate public health issues (usually framed as technical) from governance agendas (which address how the public sector is organized, including public oversight institutions and citizen engagement). In this context, disentangling the symptoms from the causes of service delivery and supply problems is easier said than done.

What do we mean by independent monitoring?

Development organizations and government agencies have developed a range of monitoring systems to identify and address bottlenecks and challenges in the public sector supply chain – these can be large scale routine systems, project performance systems, grassroots monitoring etc. However, the scope of what these systems

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actually monitor is often limited, which means the 'wicked' challenges are not addressed. Accountability systems can bolster monitoring, by helping to reduce abuse, assure compliance with existing procedures and standards, as well as improve performance by providing a systems wide perspective and connecting a range of initiatives (Brinkerhoff 2004).

This workshop will situate practical questions involving monitoring systems in the broader context of the potential for strategic citizen oversight initiatives to encourage more accountable health systems. The discussion will address both the strengths and limitations of existing systems for monitoring reproductive health delivery systems, including what is monitored and what is not, as well as the possible relevance of lessons from a diverse array of independent civil society policy monitoring initiatives in other sectors. The discussion will address different approaches to the possible *scope* of independent monitoring, ranging from the effectiveness of supply chains at delivering contraceptives, but also including the health system's capacity to provide full choice in terms of method mix and the challenge of ensuring respectful treatment by frontline providers.

One of the most important features of any monitoring system – rarely recognized explicitly – involves their key target constituency. Most monitoring systems are intended to inform senior decision-makers, to help them to target problem-solving efforts. Yet they are usually inward-facing; the findings from these kinds of governmental monitoring systems are rarely publicly disclosed, so most stakeholders lack access to the findings. Stakeholders therefore lack the opportunity to act in real time to encourage service quality improvements. In contrast, the growing field of transparency, participation and accountability in international development has experimented with a wide range of public-facing policy monitoring and citizen voice initiatives. Their goal is to provide real time, actionable data about public sector performance in order to inform oversight efforts by citizens and public interest groups intended to improve public sector performance.

This workshop is based on the proposition that civil society actors can contribute to improving access to appropriate contraceptive commodities and services by identifying quality control problems.[2] This discussion will inform ideas about how to build civil society capacity for independent oversight of the full "supply chain" of public sector decision-making that ultimately shapes "who gets what." First, however, in order to facilitate this discussion across sectors and silos, key definitions should be made explicit:

- "Independent oversight" of the public sector is understood here as potentially including *both* monitoring and advocacy. The emphasis on independence addresses the risk of conflicts of interest, as well as the need for potential capacity to "speak truth to power."
- Policy monitoring is defined here broadly, including classic "follow the money" efforts that seek to identify leakages, "chain of custody" monitoring intended

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[2] We use the term 'contraceptive services' rather than 'family planning' services. As Khanna and Sundari Ravindran (2015) notes the term 'family planning' is biased as it only refer to services that serve those within the context of a family or a married couple. The implication being those outside of the 'family' (e.g. unmarried adolescents and young people, sex-workers, etc.) are not legitimate clients. As Khanna and Sundari Ravindran (2015) state 'contraceptive services' better captures the desire to support sexually active adolescents and young people, women and men of all ages and diverse sexualities as clients of contraceptive services.

to assure quality through to the point of delivery, rights-based approaches that can document patterns of bias, the use of open government/freedom of information (FOI) reforms, as well more systemic, independent assessments of the performance of public sector agencies throughout their service delivery process.

- Public interest advocacy is defined here as a spectrum of possible efforts to influence the policy process in favor of the public interest, ranging from agenda-setting to policy-making and implementation.
- In contrast to the conventional usage of the term advocacy to refer exclusively to policy formulation and resource allocation from above, this definition of advocacy can include a broad menu of possible citizen actions, ranging from focused problem-solving at multiple levels to broader agenda-setting.

One key proposition for discussion involves how to identify opportunities to trigger "virtuous circles," in which monitoring can inform problem-solving and policy advocacy, while problem-solving or advocacy can in turn inform monitoring strategies.

The process of identifying and addressing challenges in reproductive health supply chain and service provision raises some interesting questions:

- Where and what are the strengths and the gaps in existing monitoring systems for public sector RH supplies?
- What elements of public sector contraceptive provision are actually monitored in practice? Who decides? Who are the constituencies for the monitoring data? Who sees it? Who uses it?
- From citizens' perspectives, do we even know what should be monitored? How do governments and CSOs make decisions made about what needs to be monitored? How can we bring citizens' perspectives into the monitoring?
- To what degree are monitoring systems capable of providing independent, third party assessments (e.g. external and independent of public sector systems)? How can the findings be disclosed in ways that are perceived as relevant and actionable by stakeholders?
- What lessons from efforts to build independent monitoring capacity in other health and non-health sectors might be relevant for contraceptive provision?
- What lessons can emerge from exchanging experiences in implementing commodity logistics systems or implementing/monitoring strategies designed to address different kinds of institutional problems- namely inefficiency, corruption and abuse? Might lessons from one set of efforts (say, anti-corruption) turn out to also be relevant for others (e.g., improved efficiency)?

What does the emerging TPA field bring to the monitoring agenda?

Conventional approaches to monitoring tend to serve policymakers' and programmers' institutional agendas. As a result, they may not adequately address whether and how access to and quality of contraceptive choices is actually experienced in practice by citizens or front line service providers. [3] This is why recent

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[3] As Marta Schaaf of Columbia University pointed out in her feedback: "This is somewhat similar to discussions in RMNH about coverage versus quality. The focus has been on ensuring "coverage" of services, but recognition is growing that quality and patient

research in the growing field of Transparency, Participation and Accountability (TPA) underscores the key distinction between "upwards accountability" (from frontline workers to managers, and from line agencies to donors or national ministries, for example) and "downwards accountability" (from the public sector to citizens) (Peixoto and Fox 2016). A wide range of donors, governments and civil society organizations are experimenting with diverse TPA strategies to encourage independent oversight of public policy and programs, including numerous community-based monitoring efforts and multi-stakeholder partnerships that are setting standards while encouraging citizen voice in order to meet them.[4]

For example, if policy monitoring identifies very specific points in the supply chain that are especially vulnerable to leakage or inefficiency, that can inform a policy reform agenda that is targeted to break those bottlenecks. This was the case in Textbook Count in the Philippines, where a simple change in budgeting for how book distribution costs were funded improved administrators' incentives to actually deliver books to schools (Aceron and Fox, forthcoming). For another example of the relevance of independent policy monitoring, if reform advocates are successful in campaigning for a "policy win" that that involves numerous decision points and service delivery units – as in the case of rural clinics - then how will they know whether or not the promised changes were actually implemented? Independent monitoring/oversight capacity is needed to determine whether and where promised policy reforms actually reach the "last mile."

The growing TPA field can contribute insights to the field of reproductive health commodity security, in order to inform new initiatives to diagnose and address both supply chain issues and implementation challenges that limit citizen's contraceptive choice. In the process, new kinds of monitoring partnerships -- both between civil society and governments, and across different constituencies within civil society -- may be able to bring together complementary skills, capacities and priorities in order to address both symptoms and underlying causes of citizens' lack of access to contraceptive choice.

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perception/experience of those services (downwards accountability for things patients can monitor) is key."

[4] Consider, for example, the Medicines Transparency Alliance, Global Partnership for Social Accountability, Open Government Partnership, and Transparency and Accountability Initiative. Workshop co-convener Fox has collaborated with three of these four. National governments that have promoted elements of the TPA agenda on a large scale include India, Brazil, Philippines and Indonesia, among others. For an example of how one international donor in the TPA field frames the issues see Hewlett Foundation (2015).

***Box 1: Practitioner perspective: The RH movement needs to go beyond
"business as usual"***

*Sarah Shaw (Marie Stopes International), Co-chair, Reproductive Health Supplies
Coalition Advocacy and Accountability Working Group*

*The RHCS movement has achieved a lot, in terms of influencing the debates around
access, quality and choice, and developed tools to increase awareness and
knowledge of these things. However, not a lot has changed, women still show up at
facilities hoping to leave with a contraceptive method of their choice and all too often
leave empty handed. We aren't   sure of the incidence of this because we only actually
started to track this using standardised metrics in 2015.*

*Clearly we need to change what we are doing, business as usual is not working in any
meaningful way. It's time to turn things upside down, and look to other sectors to see
what has worked and what we can learn - to do things differently. We need to look at
the directionality in the supplies advocacy agenda, although it is founded on principles
of country ownership, it is ultimately very donor driven. So donors and INGOs drive
what is supplied; where it is supplied; how it is monitored; and who accesses and uses
the information. The women and communities have very little say, and are in many
cases reduced to passive recipients.*

*Looking to governance approaches to better secure access to essential medicines is
critical as it offers a chance of a paradigm shift, where access to FP supplies is driven
by those who use them - women, not those who supply them. What information do
communities need to have to mobilise to address stockouts or other institutional
problems? We have learnt how to mobilise the community to focus on stuff, but what
have we missed? People. We need to learn how to do include people, what
approaches work and what don't.*

*We also need to look at why it has taken us so long to have this conversation and be
cognizant that at first we may have challenges talking to each other. We each have
our own jargon and certain words come with different connotations. Before we can
start to apply TPA approaches in the RH supplies world we have to learn the TPA
language and approaches.*

Goals of the Learning Exchange:

The Accountability Research Center (ARC) at American University, the Evidence Project, the International Planned Parenthood Federation, and the Reproductive Health Supplies Coalition and Advocacy and Accountability Working Group are co-hosting a learning exchange that brings together governance and RH supplies researchers and practitioners to develop a learning agenda. This learning agenda will explore the relevance and prospects for applying systemic approaches to monitoring the full in-country reproductive health commodity supply chain, from quantification and procurement to products in the pipeline, arriving in the facilities and getting into the hands of women. The goal is to inform practical strategies to identify and address un-named or unmeasured bottlenecks in the process of procuring and moving commodities through the supply chain into facilities at different levels, as well as barriers to citizens' enacting full, free and informed contraceptive choice.

Box 2: Defining Full, Free and Informed Choice

The reproductive health sector has defined the goal of RHCS as every person being able to enact full, free and informed choice; to be able to obtain and use quality contraceptives and other essential reproductive health products whenever they need them.

Full choice: Access to the widest range of methods possible from which to choose (short-acting, long-acting, permanent, hormonal, non-hormonal, client-controlled, provider dependent)

Free choice: The decision whether or not to use contraceptives and what method to use, made voluntarily, without barriers or coercion

Informed choice: A decision based on complete, accurate, unbiased information about all contraceptive options, including benefits, side effects and risks, and information about the correct use of the method chosen, as well as the risks of non-use, based on respectful treatment by providers

Source: The Respond Project 2014

The workshop will draw on recent thinking in the field of TPA to strategic approaches that "connect the dots" with multiple levels of monitoring, in response to the mixed results of numerous "tool-led" initiatives that attempt to use information dissemination and citizen voice to improve public service delivery. In response, TPA strategists have been discussing the strengths and limitations of more integrated approaches to monitoring, such as multi-level, multi-actor coalitions that coordinate independent third party monitoring of the supply chain (Fox and Halloran 2016). The rethinking in the TPA field is moving beyond approaches focused on the tactical application of specific tools, to the creation of space for more strategic approaches with greater prospects for sustainable institutional change (Joshi and Houtzager 2012, Joshi, 2014, Fox 2015).

At the end of the two day Learning Exchange, we hope participants will have:

1. Shared analytical insights, key concepts and practical developments from both TPA and RHCS sectors;
2. Learned from experiences with CSOs that address issues of supply chain and service delivery challenges in various sectors - e.g. pharmaceutical procurement and distribution (Nepal, Dominican Republic), community-based health policy monitoring (India, Guatemala, Peru), access to ARVs (Malawi), the Medicines Transparency Alliance (Uganda), maternal mortality prevention policy (Mexico), strategic use of public information requests (Mexico), analysis of public budget allocations (Mexico), and government-CSO partnerships to monitor national supply chains and distribution of textbooks (Philippines);
3. Identified research gaps and/or questions for addressing the monitoring challenges involved in tracking the determinants of access to contraceptive services;
4. Contributed to a practical research agenda and developed a strategy for recruiting researchers to address the knowledge gaps; and
5. Discussed possible strategies for improved monitoring of contraceptive provision.

Collectively, we will have a drafted a Learning Agenda to guide possible future research and action. This will be developed in a rapporteur's report for sharing the workshop highlights via a webinar and presentation at the RHSC annual meeting (Seattle, October 2016).

Background:

Currently there are 225 million women of reproductive age who have unmet need for modern contraceptives—although there are many reasons for this, a huge proportion of women's unmet need is attributable to lack of access to contraceptives (physical, financial, and social). As the largest-ever adolescent population in the world is currently aging into becoming sexually active, this cohort will increase the global population of women of reproductive age by one-third in the next 15 years (Singh et al 2014). Because adolescents often have more difficulty accessing contraceptives due to financial, social and other barriers, the level of unmet need is likely to increase during this time period.

A sub-sector of the reproductive health field has emerge - reproductive health commodity security (RHCS) - that specifically deals with supply chain-related drivers of unmet need. The RHCS effort began in 2001, when the Interim Working Group on Reproductive Health Commodity Security (IWG), made up of U.S.-based and international nongovernmental organizations (NGOs), technical agencies, and a private foundation, convened the *Meeting the Challenge* meeting in Istanbul. This meeting identified the need for more coordination among global and national stakeholders in response to declining international assistance for RH supplies. In 2004, 12 organizations established the Reproductive Health Supplies Coalition (RHSC) to ensure better coordination and collaboration in global advocacy, fundraising, and supply chain strengthening for RH commodities; marking the start of a coordinated global reproductive health commodities security movement. [5] Soon after, two related large scale projects began. In 2006, USAID launched the USAID|DELIVER PROJECT that worked with national and international partners to increase the availability of health supplies by, among other things, developing forecasting and monitoring tools and resources. In 2007, UNFPA began its flagship thematic fund on reproductive health commodity security: the RH Supplies Global Program. More recently, Chemonics received a new USAID contract to provide global health supplies: "Global Health Supply Chain-Procurement and Supply Management Project." This much-needed and valuable contribution of aid-funded approaches may have the unintended effect of focusing monitoring, measurement and 'accountability' to issues within RHCS that resonate with national agencies and donors – without also bolstering citizen oversight and public institutions capable of responding to citizen voice. Front line providers (who often have a lot of responsibility but no voice) may also be cut out of feedback loops.

There are commonalities between the USAID, UNFPA and the RHSC initiatives, including a focus on creating enabling policy environments, and on creating interoperable monitoring and oversight systems for forecasting, projections and product registration at the country level. These initiatives have also supported the creation of formal working relationships between/among national governments and with line ministries. These efforts have focused on better communication and coordination (e.g. National RH Commodity Commissions), diagnostic tools to better assess the situation (e.g. SPARHCS),[6] monitoring and forecasting tools (e.g. RH Interchange, standardized indicators and procurement planning and monitoring), and related advocacy tools (e.g. updating the WHO essential medicines list and budget advocacy). Many of these activities aim to close the information and implementation

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[5] See http://www.rhsupplies.org/
[6] Strategic Pathways to Reproductive Commodity Security. See: http://www.rhsupplies.org/fileadmin/uploads/rhsc/Tools/SPARHCS/Documents/SPARHCSProcessGuide_EngPDF_1_.pdf

gaps between different areas of the supply chain, and have reportedly increased international funding for supplies, increased the political profile of supply chain systems and investments in these systems, donor coordination and investments (Lauro and Chattoe-Brown 2012). But the impact on the last mile and frontline service delivery is less clear and here we find some 'wicked problems'.[7]

Providers are seen as the end of the supply chain in that they are the ones who need to report on stock levels and contribute to forecasting but a challenge is that the quality of care and provider-patient interactions are currently measured by different monitoring systems than logistics/commodities. How can we connect these measurement systems? Each system has different units of measurement: one focuses on "stuff" and the other on "people". The focus has been more on ensuring "coverage" of services, yet quality and patient perception/experience of those services is key.

Box 3: Stuff or People? Where you stand depends on where you sit

- For some, key barriers that restrict access and choice for women wishing to use contraception, thereby contributing to unmet need, include contraceptive commodity production; pricing; forecasting procurement needs, efficient supply logistics, and quality assurance.

- From the point of view of citizens, barriers would also include limited choice of methods, limited access to information about those choices, culturally inappropriate social marketing, linguistic and ethnic differences between providers and citizens, as well as governmental incentives to providers that are intended to influence citizens' choice of methods.

Another challenge is how to develop monitoring systems that can identify institutional weakness in order to more effectively support providers who are committed to their mission, while also identifying vulnerabilities to corruption and abuse. While from the point of view of senior service delivery managers, these two problems - institutional weakness and abusive providers - may look very different, from the citizens' perspective these differences are not so clear. This suggests greater attention to developing precise user complaint mechanisms that are linked to institutional decision-makers who have the capacity to respond (e.g., Vian 2013). These are types of questions that broaden our thinking about the process involved with ensuring access to appropriate supplies and information for citizens.

Recent research underscores why there are challenges involved in building robust systems capable of monitoring "health systems strengthening" efforts (Wisniewski et al 2016). The findings stress underfunding, technical challenges (e.g., data availability), and under-utilization of existing resources because of lack of buy-in and perceived relevance by sector. Recent research sheds light on important institutional limitations: monitoring initiatives are still limited to donors and governments, leaving out public interest groups and directly affected citizens as stakeholders with both the

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[7] Notable exceptions to this include the work being undertaken by Ibis, HEPs and Mexfam.

motivation and the right to act in response to performance information. Broadening the range of recognized stakeholders could help to address the issue of the perceived lack of demand for and relevance and benefits of the data generated by a range of monitoring systems.

Monitoring of monitoring systems may sound redundant, excessive, and even comical, but the classic phrase of the Roman poet Juvenal, "who guards the guardians?" is a reminder that this dilemma was recognized as an issue two thousand years ago. Conventional monitoring and evaluation systems have been designed to meet the needs of national or district ministries of health or international donors, which may not reflect the needs of the citizens. Many monitoring professionals and programmers follow the creed "*what gets measured gets done.*" The design and implementation of conventional monitoring systems often leaves out citizens for a wide range of logistical, financial or technical reasons.

This workshop will treat the monitoring systems agenda-setting process as open for discussion rather than routine and predetermined by existing institutional priorities – in order to create space for introducing citizen-centered approaches. Taking citizen voice seriously involves recognizing that different stakeholders have different needs, and therefore different goals, for monitoring systems. For example, national MOHs and international donors get data on citizens in aggregate form, which helps them to understand and better design programs and allocate and direct funding. Meanwhile, citizens may be more interested in monitoring of accessibility, acceptability, quality of services, and satisfaction and choice of methods that enhance user experience (e.g., Barlan and Shiffman 2012).

Integrating TPA Concepts into RHCS:

In program implementation, for monitoring systems to be effective, their design needs to focus on accurately tracking supply and demand outcomes, which can in turn provide a basis for diagnosing the causes of disconnects. Disentangling the distinct factors that cause supply shortfalls is a challenge – how much of the problem is under-resourcing, poor procurement practices, inefficiency in delivery systems, bias in distribution vs. leakage, or a mismatch between what women want and what is available? What steps in the service delivery process are the most vulnerable to weakness? Which service delivery decision-making processes are most relevant for reducing disconnects between supply and demand? How can systemic approaches to third-party monitoring contribute to reducing vulnerability to inefficiency, corruption and abuse?

Methodologies and interventions developed in the TPA field to improve effective service delivery provide new ways to tackle these questions. These approaches have demonstrated improvements in the timely provision of supplies, in skilled staff to provide the supplies, quality assurance for drugs and commodities, district level funding disbursements and allocations, and capacity to provide oversight and monitoring of health services (Boydell and Keesbury 2014; Fox 2015; Joshi 2014; Lipsky and McGinn 2015; Ringold et al 2014). In some cases, community level monitoring has resulted in significant increases in both uptake of services and satisfaction, processes closely related to women's access and choice.

In relation to service delivery, the TPA field has focused on identifying and addressing system inefficiencies (such as leakages and blockages) and ways to improve the quality of services through independent third party monitoring, combined with problem-solving and advocacy initiatives. This emerging TPA repertoire

presents a new set of approaches that can be applied to improving reproductive health commodity security – both in terms of assessment methodologies and strategic interventions. Moreover, evidence from the experience of an established and functioning transnational issue network, such as the RHCS community, offers the TPA field the opportunity to identify knowledge gaps about what works, as well as how and why, in transparency, accountability and participation. This workshop's proposed dialogue also challenges TPA strategists with a "reality check," in the search for approaches that resonate with the agendas of leading practitioners in the RH field.

There are several lessons from the TPA field that can help us to think differently about RH supply chain challenges and barriers to full, free and informed choice. For example:

1) **The Reproductive Health Supplies Coalition (RHSC) is one of a growing set of transnational multi-stakeholder initiatives (MSIs). Research on MSIs that address governance reform found that the process of leveraging transparency and participation can promote public information disclosure and civic participation (Brockmyer and Fox 2015).** Pharmaceutical MSIs have successfully identified weaknesses in the pharmaceutical system and provided important baseline data; generated a greater awareness about the issue, and in some instances created important alliances and sector-specific initiatives (Kohler and Ovtacharko 2013). The experience of the Medicines Transparency Alliance may be especially relevant, but it appears to be little known outside of the seven countries in which it has been active.

   However, global multi-stakeholder initiatives are not automatically delivering accountability for commitments and improving systems and services (GHV 2015, Freedman and Schaaf 2013, Brockmyer and Fox 2015; Parks et al 2015; Kohler and Ovtacharko 2013). There are several issues at play. First, there is "the problem of many hands" - that is institutional decisions that involve many parties, which means that no one actor is really held accountable (Fox 2015). Second, aid-funded approaches focus more on financial reporting and 'upwards accountability,' over quality of access and 'downwards accountability'. Numerous experiments with innovative ICT-enabled citizen voice/complaint platforms that are intended to improve service delivery have fallen short when it comes to institutional response (Peixoto and Fox 2016). There is also the issue of scale, e.g. the *links* between levels. Actions tend to be bound by the original intention – what is local stays localized, what was national remains in the national capitals, what is global stays global. This can create gaps in monitoring policy implementation and performance from the local to the global. To link the local, national and global may require more of a systems approach to monitoring. Within a systems-approach, how can we focus more on reproductive choice, whether appropriate methods are available, and who is deciding what exactly is in the supply chain? What would it take to have a more systems-driven approach to monitoring to ensure a strong focus on choice, the availability of appropriate methods and more demand-driven decision-making?

2) **In commodity security, the emphasis has been on improving systems that deliver the supplies (such as funding, pricing, forecasting, supply logistics, etc.).** Routine measurement systems do not focus on citizens' reports and experience but rather respond to donor and government priorities. Moreover, the data produced by these systems are not publicly disclosed in user-friendly, actionable ways, thereby excluding stakeholders from the opportunity to contribute to targeted problem-solving. What tends to get measured are the

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number of new and existing citizens that service providers are reaching and the volume of distribution of different family planning methods. What is not routinely measured in these systems is citizens' experience with accessing services — are there providers and commodities available when they present for care? Do providers offer high-quality, respectful services to citizens that encourage them to return for re-supply? Can citizens exercise full, free and informed choice in deciding which method to use in accordance with their reproductive intentions?[8] The current measures prevent us from knowing if system and service are aligned with, and responsive to, citizens' experiences and needs. So what would measurements look like if the user's experience was at the center of commodity security?

3) **The frontline service delivery point is where commodity security systems inefficiencies are felt most acutely. From the citizens' point of view, what policymakers and donors call the 'last mile' is actually the 'first mile' – their first interface with the long chain of decisions that drives contraceptive provision. [9] The 'last/first mile' of the supply chain is a critical juncture in the supply chain but remains a 'wicked' black box – can we learn more about the range of formal and informal relationships and incentives of providers and citizens that affect the supply chain?** Where would it be strategic to focus efforts in order to improve commodity security from a citizens' perspective? What impact do top down financial and non-financial incentives have on provider behavior? In a context where line ministries do not oversee the lower tiers of the health system (due to decentralization[10], conflict, weak supervision systems), does community monitoring become an effective means of monitoring systems over top-down approaches? What can we learn about the distribution practices of 'street-level bureaucrats' in health service delivery? (Lipsky 2010, Gilson et al 2013, Freedman and Schaaf 2013, Kaler and Watkins 2001, Schaaf and Freedman 2015, Tendler and Freedhiem, 1994)? How do 'street-level bureaucrats' perceive the context that influences their performance?[11] What are some key variables to take into account when localizing monitoring efforts? Are there actors, such as community health workers, who could be better engaged to project citizen voice "upwards"? Currently their role is to represent health service delivery systems to citizens, rather than to represent citizens to health systems. Is there a need for more bottom-up monitoring and partnerships to support citizens to voice their health needs and link these efforts with national and global efforts to improve RH commodity security response?

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8 Some of the less routine metrics are measured through one-off or infrequent population-based surveys—it is great that they are being measured at all; however, lack of routine monitoring of issues that are essential to citizens directs attention away from metrics that can inform and promote a responsive, rights-based health system that provides services aligned with user needs. Moreover, surveys often measure "unmet need" indirectly, by inference rather than asking explicitly. Thanks to Rachel Robinson of AU for pointing this out.

[9] This distinction of positionality and perspective is analogous to the difference between upwards and downwards accountability, mentioned above.

10 In some contexts, the consequence of decentralization is that only responsibility for service delivery is devolved; and there are few feedback loops for those at subnational levels (let alone service provision points) to have influence more systemic issues.

[11] To bolster health worker performance, Derick Brinkerhoff of RTI suggests attention "to public service values and professional standards as a source of both motivation and incentives… [plus] The role of professional associations for self-policing might be an added element to consider as part of the "sandwich strategy" of accountability, particularly in settings where, for example, MOH oversight capacity is weak."

4) **What are the strengths and limitations of efforts to build and sustain independent, community-based monitoring of reproductive health supply chains services?** In indigenous communities in Guatemala and Peru, trained grassroots activists engage in continuous, real-time monitoring of health service delivery, and they attempt to link their findings to official complaint and ombudsperson systems (Ashton 2015, Flores 2016, Frisancho 2015). In Mexico, nation-wide and state level civil society coalitions of health rights defenders and researchers have been monitoring services intended to prevent maternal mortality for 25 years (Freyermuth 2015, Díaz and Gruenberg 2016). Mexican reproductive rights activists have also used public access to information rights strategically, to document previously invisible legal and institutional obstacles (GIRE 2013). In the Philippines, CSO coalitions have extensive experience with partnering with government agencies to monitor a wide range of public services, sometimes covering the full supply chain and most of the distribution points (Aceron and Fox, forthcoming). In Malawi, thousands of HIV-positive women campaigned for the right to appropriate ARVs and are following up with independent grassroots monitoring of access and adherence (Essof and Khan 2015). In India, government health agencies and CSOs have partnered to create robust complaints mechanisms (Vian 2013). Yet building capacity for citizens to report problems may or may not lead to actually addressing them. Moreover, sustaining these initiatives over time has proven to be a major challenge. Community-based monitoring also raises important methodological and ethical issues (Das 2013, Khanna 2013). What are the relevant lessons from these experiences?

It is important to look at the experience of other sectors that have applied TPA methodologies, particularly maternal health (demand-based financing) and education (textbook procurement and distribution) to see what lessons can be transferred to reproductive health commodity security. How can TPA approaches to citizen engagement help improve the track record of intervention to address health care fraud, which so far has had little impact (Rashidian, Joudaki and Vian 2012)? For instance, a cross-verification exercise for district and health facility records (distribution of different contraceptive methods) and the procurement system (forecasting, disbursement) records against the reports of facility citizens (informal fees, stock-outs, method mix) could help to identify blockages and leakages for strategic intervention.

Proposed Format:

In order to identify research gaps and priorities, and to contribute to a practical, forward-looking research agenda, we propose several sessions for the learning exchange (see below). The learning exchange will be followed by a rapporteur's report based on the discussion, including a learning agenda for informing recruiting researchers.

Session	Further Exploration
Jargon busting for cross sectoral communications and finding common ground.	This will include sharing understanding and definitions of commonly used terms in each sector that may not translate across to the other sector (Demand; Client; Policy; Monitoring; and Systems Approaches
Panel on transparency, participation and accountability initiatives	TPA experts will share with the participants the key concepts and lessons emerging in the TPA field and will use concrete examples of how these tools have been applied in different sectors and to what effect. This includes how to understand advocacy/problem solving /monitoring)
Panel on Reproductive Health Supplies Security	In this session, RHCS experts will share with the participants the key concepts and structures in place for ensuring RH commodity security and the impacts these have had to date. Lessons from monitoring in the RH supplies field. In this session, practitioners that have been applying governance tools in aspects of RH supplies will share their experiences and reflection.
Learning from civil society oversight initiatives in other sectors	In this session, practitioners that have been applying governance tools in other public sectors to address inefficiencies and quality issues will share their experiences and reflection.
Transparency initiatives and corruption diagnostics	Review of national and international initiatives, their lessons and limitations
Implementation science: health systems 'software'	Health worker incentives/motivations, role of human resource management (transfer and posting), informal payments, possible causes of bias or abuse
What are the "next generation" questions that need to be asked?	Based on the conversation and debate, how can we start to ask big questions differently? What kind of implicit powerful assumptions need to be questioned?
Towards a practical research agenda	Facilitated Discussion on key research gaps and/or questions for addressing RH commodity security. Experts in research utilization will assist the group through a process to identify research gaps, select priority areas to address and develop strategies for recruiting researchers. We hope to identify three or four research areas/agenda settings. These will research gaps and priorities will contribute to a practical research agenda

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