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Learning Exchange Report

Transparency and Accountability Strategies & Reproductive Health Delivery Systems

Victoria Boydell
Jonathan Fox
Sarah Shaw

Reproductive Health SUPPLIES COALITION

IPPF

Accountability Research Center

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About the Authors

Victoria Boydell is the Rights and Accountability Advisor for the Evidence Project/IPPF, a USAID-funded initiative to improve family planning policies, programs, and practices worldwide. Before joining the Evidence Project, she oversaw global monitoring and reporting for the Fund for Gender Equality at UN Women and held a range of positions at the International Planned Parenthood Federation. She has over 15 years' experience in the field of family planning, reproductive health and gender equality. Her research has addressed such reproductive health issues as contraceptive use, provider-client interaction and patient centered quality of care. She works on community participation and engagement in sexual and reproductive health programs and developing new methodologies for measuring health facility adherence to rights based programming.

Jonathan Fox is a professor in the School of International Service at American University. He studies the relationships between accountability, transparency and citizen participation. He directs the new AU Accountability Research Center, an action-research incubator. His most recent publications include articles in *World Development* and the *IDS Bulletin*, and reports published by Making All Voices Count, U4: Anti-Corruption Resource Center and the Transparency and Accountability Initiative. His books include *Accountability Politics: Power and Voice in Rural Mexico* (Oxford 2007) and *Mexico's Right-to-Know Reforms: Civil Society Perspectives* (co-editor, Fundar/Wilson Center 2007). He was a founding member of the International Expert Panel of the Independent Reporting Mechanism of the Open Government Partnership and currently serves on the boards of directors of Fundar (Mexico) and the Bank Information Center (DC). For online publications, see http://jonathan-fox.org/.

Sarah Shaw has been an advocate for RH supplies for the last 14 years, working globally and supporting national partners. Whilst working at the International Planned Parenthood Federation she coordinated a series of national advocacy projects, supporting local organizations in Africa and Asia to advocate for improved policy and funding for SRHR. Between 2007–10 she coordinated Project RMA—supporting national networks to advocate for increased funding for contraception and reform of national commodity security groups, essential medicines lists and financing mechanisms. She has also administered a small grants fund for national and subnational advocacy. Focus then shifted to the global level, coordinating civil society participation in the review processes for the International Conference on Population and Development. She now represents Marie Stopes International as head of advocacy and supporting national advocacy in East and Southern Africa to increase access to safe abortion and contraception services. She has been an active member of the Reproductive Health Supplies Coalition since 2007 and co-chaired the Advocacy and Accountability Working Group of the RHSC between 2013 and 2016.

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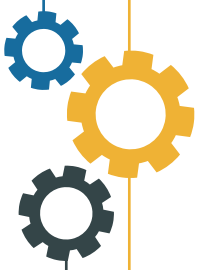

Disclaimer

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Summary

This June 2016 Learning Exchange held at American University in Washington, D.C. convened over 40 practitioners and researchers to discuss potential contributions from the field of Transparency, Participation and Accountability (TPA) to the performance of reproductive health (RH) delivery systems.

The conversation focused on how strategic citizen oversight initiatives can facilitate monitoring of reproductive health systems and promote more accountable health systems. The main themes that emerged through the panel presentations and subsequent discussions were:

- **Include multiple perspectives:** Bridge political and technical analysis, the first mile, and downward accountability
- **Re-politicize RH supply chains:** Map power, identify incentives and collective action opportunities
- **Integrate research and practice across TPA and RH:** Implementation science and action research
- **Anticipate challenges of applying TPA principles to RH delivery systems**

The Learning Exchange culminated with discussion on possible areas of relevant collaborative research. The Learning Exchange and this document are intended to spur cross-field collaboration, practice and learning.

I. Introduction

"Wicked problems"[1] associated with different points in health systems often prevent reproductive health (RH) supplies from reaching women wanting to use modern contraceptives. Unmet demand for RH supplies results from untimely delivery of commodities, disrespect, abuse and rent-seeking by health service providers and providers' biases. Though the public health community has acknowledged these challenges, they remain under-addressed due to their complexity, controversial nature, and the limited effectiveness of technical solutions in the face of deeper governance challenges.

The Accountability Research Center at American University, in collaboration with the Evidence Project, International Planned Parenthood Federation, and the Reproductive Health Supplies Coalition's Advocacy and Accountability Working Group, hosted a Learning Exchange to examine the feasibility and ramifications of applying governance reform approaches (including citizen engagement and monitoring) throughout the supply chain to tackle the barriers to citizens enacting full, free and informed contraceptive choice.

The June 2016 Learning Exchange at American University convened over 40 practitioners and researchers to discuss potential contributions from the field of Transparency, Participation and Accountability (TPA) to improve the performance of reproductive health delivery systems. The conversation focused on how strategic citizen oversight initiatives can help to identify practical solutions for monitoring reproductive health systems and increasing accountability within health systems more broadly.

There was much discussion about the underlying analytical assumptions in the RH field. Applying a TPA lens raised questions about where the supply chain starts and ends, what is and is not included—i.e., people, health care providers, etc.—and who decides whether a service has actually been delivered.

In the RH field, the term "last mile" is used to describe the final point of service provision from the perspective of the provider. Learning Exchange participants proposed that this point could actually be re-conceptualized as the "first mile." This framing puts reproductive health recipients—rather than reproductive health products—at the center of the discussion.

"The Reproductive Health Commodities Supply (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."

"What are the goals of the two communities present—RH and TPA—does it matter to articulate them (I think yes), are they the same, and if not, does it matter?"

"In published literature on health, the overriding value is on utilization or health outcomes."

"We view accountability as a process of empowerment. A long term process that is not limited to a budget or a grant cycle. We also view accountability as a counter-veiling force—that is, generating knowledge from practice—to the expert/research led paradigm."

"Using a systems thinking approach, we brought the two fields [maternal health and accountability] together. Here, accountability is an attribute of a system that comes to be, rather than a linear outcome that we pursue as answerability/incentives."

1 "Wicked problems" lack both technical certainty and political agreement, are well known but are often complex and difficult to address.

Many at the learning exchange felt that in order to hold decision makers to account, there is a need to re-politicize RH supplies and thus create public momentum among a larger constituency. Such re-politicization is not easy given the uniquely private decision-making regarding contraceptive use in many contexts.

The Learning Exchange culminated with discussion on five possible areas of relevant collaborative research. Both TPA and RH are complex fields to study, regardless of the specific methodologies selected. The learning exchange and this document are intended to spur cross-field collaboration, practice and learning. The table below summarizes some of the key potential research areas discussed.

Table 1.

	Research Areas Identified in Learning Exchange
Data	• Given the push for collecting monitoring data – how can advocates translate, communicate and use health systems and performance data? • How can proactive, user-friendly dissemination of existing health system monitoring data be encouraged? • How can citizens use available data strategically to improve system performance?
Systems	• Who makes the key decisions at different points in the forecasting, procurement and distribution? • What are reproductive health decision makers' incentives? • Are there spaces for citizen engagement in health delivery decision-making processes? • How do the different stakeholders and decision makers—NGOs, INGOs, donors, governments, local officials—interact across the supply chain?
Interfaces	• How do we understand power relationships between frontline service providers and citizens? • How can we move from tension to alliance? • Public service workers are also members of their communities, but how can they become more accountable to citizens? • How can frontline providers become allies of citizens and even agents of accountability?
Scale	• How can we strengthen links between demand generation, commodity supply, service delivery at the different points in the health system? • Linking local to sub-national and national? • How can advocacy be linked to the operational needs?
Citizen Power	• How can "unmet demand" be converted more effectively from an invisible problem to public claims for rights to services? • What are the personal and political sensitivities specific to reproductive health care that prevent constituencies and agency being built? • How can "unmet demand" become a basis for collective identity, as a step towards collective action?

The report is organized around the four main themes that emerged from the Learning Exchange:

- **Include multiple perspectives:** Bridge political and technical analysis, the first mile, and downward accountability
- **Re-politicize RH supply chains:** Map power, identify incentives and collective action opportunities
- **Integrate research and practice across TPA and RH:** Implementation science and action research
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This report is based on the notes and transcripts from the proceedings in the Learning Exchange.

II. Learning Exchange Overview and Purpose

The Learning Exchange was primarily convened to identify research gaps and priorities, and to contribute to a practical research agenda and strategy for recruiting researchers. Greater mutual understanding between TPA and RHCS was a necessary component throughout this Learning Exchange.

Meetings between different communities can flounder due to misunderstandings of sector specific technical terms, acronyms, short cuts and definitions. To enhance mutual learning and ensure clear communication, participants highlighted and discussed key terminology throughout the Learning Exchange during "jargon-busting" sessions.[2] The dialogue around "jargon" also highlighted some of the underlying perspectives of participants and the values attributed to words and the way they are used.

jar·gon (järgən)
Special words or expressions that are used by a particular profession or group and are difficult for others to understand.

"Conversations about jargon were the richest in that they drew on participants' experience and different backgrounds, but also brought up the fundamental issues that the RH community will need to address if incorporating accountability."

The Learning Exchange consisted primarily of panel presentations followed by rich plenary discussions. Both practitioners and researchers from the RH and TPA fields presented examples of their work. For the full Learning Exchange agenda, please see **Annex 1**. The major sessions are presented in the table below.

Table 2.

Session	Some Details of the Discussion
Panel: Transparency, Participation and Accountability initiatives	TPA experts shared with the participants the key concepts and lessons emerging in the TPA field and used concrete examples of how these tools have been applied in different sectors and to what effect.
Panel: Reproductive Health Supplies Security	RH and TPA experts shared the key concepts, structures and tools in place for ensuring RH commodity security and their impacts to date as well as described lessons from monitoring in the RH supplies field.
Panel: Learnings from civil society oversight initiatives in other sectors	Practitioners that have been applying governance tools in other public sectors to address inefficiencies and quality issues shared and reflected on their experiences.
Panel: Corruption diagnostics and transparency initiatives	Panelists reviewed national and international initiatives, their lessons and limitations.
Panel: Implementation science: health systems software	Presentations included health worker incentives/motivations, role of human resource management (transfer and posting), informal payments, possible causes of bias or abuse.
Discussions: What are the "next generation" questions that need to be asked? Towards a practical research agenda.	Discussion on key research gaps, questions and priorities for addressing RH commodity security.

2 Some key terms discussed were: Stakeholder; Disrespect and Abuse; Quality; Entitlement versus Right; Wicked Problem (participants preferred complex or multi-faceted); Participation; Advocacy versus Accountability.

Spotlight: **Learning from Mexfam on RH Supplies Budget Tracking & Advocacy**

Throughout the Learning Exchange, practitioners and researchers from both the RH and TPA fields presented examples of their work. Esperanza Delgado of Fundación Mexicana para la Planeación Familiar, Mexico (Mexfam) provided a compelling example of a civil society coalition traditionally involved in service delivery that pivoted towards an accountability and advocacy approach. The text below is taken from her presentation and the dialogue that followed.

Mexfam is a service provider organization in Mexico. I will mainly share Mexfam's experiences, but it's not just our work, Mexfam is part of a broader coalition. We have mainly been working in this area [RH] for 50 years. We just started to focus more on advocacy work. We mainly work at the national level. Our one big challenges was we did not have answers to what we were finding in the field.

For instance, our decision to focus on budget is related to our finding that the adolescent program in Mexico did not have a budget. Second, in the Family Planning and Contraception program in Mexico, there were constant contraceptive stock outs although at the national level we found there was adequate health budget allocations to prevent them. In order to understand this discrepancy, we started budget analysis.

What also motivated us to take up budget tracking (as opposed to another advocacy strategy) is that Mexico requires budget lines to be linked to performance-based indicators. Another factor is the public budgets need to be transparent. We were also encouraged to take up budget tracking due to the high corruption and low transparency scores (internationally).

Main Findings

- *We found that contrary to institutional and legal frameworks that require budget lines to be linked to performance indicators, this was not the case.*
- *Rules on purchasing supplies did not make sense with the programmatic focus. We found irrelevant supplies purchases.*
- *We also learnt how difficult it is to get budget allocations for our priorities—particularly adolescent programs. As a result, we found large amounts of unspent funds that were returned to the central level at the end of the year.*
- *We also found dedicated budget heads were absent for some of the programs we focus on.*
- *We found considerable delays in the release of funds from the national to the sub-national level.*
- *Understanding budgets is a complex task and takes time. Based on our experience it can take up to 3 years to learn this skill.*

We started in 2010, and 6 – 7 years later we are able to ensure budget allocation for adolescent programs. In 2010 we found no allocation and in 2016 adolescent program budget allocation is now 94%. Another visible change is when the central funds are transferred to the sub-national level. This [now happens earlier in fiscal year] addresses the challenge of unspent funds. Another change is contraceptive stock-outs. By tracking the budget, we found that stock-outs were occurring because state and local governments, particularly mayors, were not prioritizing purchase of contraceptives. So we took this information and advocated for legislative changes and as of 2013 the purchase of contraceptives is now taking place through the federal government. We now have 100% budget allocation for contraceptives.

We don't have specific donor projects for our budget tracking work. But it is important for us and we will continue to do it.

III. Learning Exchange Discussion

The main themes that emerged from the Learning Exchange are presented in this section:
During the Learning Exchange it was clear that any attempt to apply TPA to RH supplies would require a conceptual shift and as a consequence, a change in methods we typically use. The main shifts required would be:

1. Understand the intersection between the "technical" and the "political"
2. Make the "last mile" the "first mile" by placing people, not supplies, at the center
3. Critically examining the data to shift focus from "upward" to "downward" accountability.

1. Include Multiple Perspectives

There was much interest in adapting the insights from TPA to the advocacy and monitoring of RH supplies and services. From a reproductive health angle, the interest was to use TPA approaches to help achieve set health outcomes and improve program performance and efficiency. Specifically, the primary purpose of TPA approaches is to put citizens at the front to frame the agenda, thus emphasizing meaningful participation in decision-making and monitoring.

"From an accountability point of view [entitlement] is not rights, it's a governmental program vision as opposed to a citizen's rights vision. It's not preferred by those working on a rights-based approach. It's government deciding you are entitled to something as opposed to a broader notion of rights."

Table 3.

Different Fields, Different Perspectives	
Public Health	**Transparency, Participation and Accountability**
Use TPA approaches to help achieve set health outcomes and improve program performance and efficiency.	Primary purpose is to put citizens at the front to lead the conversation; with more of an emphasis on meaningful participation.
Who: Beneficiary/users What: Entitlement Where: Last mile	Who: Citizen What: Rights Where: First mile

1.1 Bridge "Technical" and "Political" Perspectives

A wide range of technical challenges involving complex, logistical systems emerged in discussions about delivery of RH supplies. Many of these challenges relate to accountability and can be framed from a TPA perspective.

The public health field more generally, and the RH sub-field specifically, has focused problem-solving on issues and their "technical" solutions. This comes, at times, at the expense of fully addressing underlying or systemic political issues.

Problems that seem purely technical may actually have political components or underlying causes. Mapping out the checks and balances and power relations can provide a new and tangible way to for the RH community to acknowledge the role of politics and tackle intractable issues. Because this emerged as such a key theme in the two-day Learning Exchange, specifics are covered more substantially in the section below on "Re-Politicizing Reproductive Health (RH) Supplies."

"Identifying the technical vs. the political (and recognizing that one may masquerade as the other) is crucial for both accountability and RH."

"If you want to reduce maternal mortality by half, what goes into it? It requires all stakeholders to make demands, monitor the obligations in the different institutional and legal frameworks and demand compliance."

*"Budgets are specific and contextual and **technical** at the same time it's also **political**. What priorities are set by countries; it's probably the most political act there is. That opens up the field for citizens to leverage budgets for social change."*

1.2 Conceive of the "Last Mile" as "First Mile"

Currently the standard definition of stock outs refers to a failure to get one or more methods onto the stockroom shelves. It does not capture the next step—getting contraceptives into the hands of women. The all-important exchange between provider and patient is not considered part of the supply chain. There is limited evidence on how women and health care providers experience stock-outs. One key point that surfaced in the planning of the Learning Exchange (through the collaborative writing of the concept note) and in the discussion, is that the supply chain needs to be conceptualized as ending further down the road than the facility shelf, with the user.

Making the shift from "last mile" to "first mile" places people—not supplies—at the center. Starting with citizens' perceptions of why contraception is not in individuals' hands challenges the more "top-down" perspective of donors and health care providers. This difference of perception also surfaced in the "jargon-busting" discussion of the term "entitlement." There are tensions between the terms as used by the RH community ("beneficiary-entitlement") and the TPA community ("citizens-rights").

While great progress has been made in placing the women at the center and delivering rights based RH services, there is still something missing if women are still perceived as "recipients" or "beneficiaries." Applying the TPA perspective suggests that RH communities may need to critically examine their notions of rights and agency.

A more comprehensive definition of the "last mile" as "first mile" would reemphasize downward accountability—from donors, governments and providers to the women they are responsible for serving, recognizing the role of choice, agency and empowerment in contraceptive choice.

1.3 Address "Downward" as Well as "Upward" Accountability

International donors readily fund data collection on health system performance and monitoring of RH supplies, yet this data is rarely proactively distributed to the public. One by one, participants discussed donor impact on the political economy[3] of RH supplies and how the heavy reliance on donor funding emphasizes "upward accountability." Despite the strong culture of data monitoring for upward reporting (to donors, higher level government or global initiatives) of performance in much of the RH system, the broader range of stakeholders has little sense of the data collected and how it might inform efforts to improve system performance.

Neither governments nor donors are applying open governance principles to the RH system. A growing number of countries now have public information access laws, but participants felt that the RH community has insufficient capacity to utilize these tools to access relevant data (with the notable exception of Mexico).

Data collection and analysis are often top-down. The indicators and data collection agendas may not always reflect the realities of service provision or the challenges of data collection in low resource environments. Reporting requirements driven only by "upwards accountability" rather than by practitioner problem-solving lead to little buy-in or ownership among providers. Since front line providers are responsible for delivering services and collecting data, we need to better address the constraints they face.

Some private service providers have elaborate tracking and data collection systems whose capacity exceeds those of the state. Often the only time these data become transparent is if government requests them to fill gaps in their own monitoring systems, but even then, those data may not be publicly disclosed. Limited data disclosure may be a missed opportunity for independent citizens' oversight that could contribute to better performance from the system.

Participants also highlighted a need for more sub-national analysis, to understand how national systems connect to local services relative to health systems, financing processes, supply chains and political and technical decision making. There are also often issues with the data itself, beyond access. Problems may include its quality, topic, level of detail and disaggregation, completeness, and format (pdfs, Jpeg). Participants reflected on how current monitoring and evaluation data as well as public analysis of government budgets can be used for concrete action or change in policy (see Box on page **ten**).

"We heard from JSI about a sophisticated and comprehensive tracking system—yet it is not public-facing. The technical challenge is tracking the info, the political challenge is who gets access—and whether/how to publicly disclose it."

"We heard there is lots of investment in data collection, but not in how to use it. I would like to suggest that there is a politics there."

"For Mexican women—national averages make vulnerable populations invisible. In municipalities with higher illiteracy and speakers of indigenous languages the rate at which these women die is 4–7 times higher than other parts of the country. As a result, with the new SDGs, it appears Mexico has no problems in maternal health."

"Accountability has to be integrated, health programs are still very vertical (and FP2020 is a regression), but at the end of the day it's one person at the end of the line providing all the services and maybe collecting all the data."

3 Bridging the traditional concerns of politics and economics, political economy analysis (PEA) focuses on how power and resources are distributed and contested in different contexts, and the implications for development outcomes. https://www.odi.org/sites/odi.org.uk/files/odi-assets/events-documents/3797.pdf

2. Re-Politicize Reproductive Health (RH) Supplies

When people are conceived of as "users" or "recipients" of health services, it can be disempowering. Drawing on ideas from the TPA field, participants proposed that citizens can contribute to improved delivery of health services by identifying and organizing public constituencies for change. Translating "unmet need" into citizen demands involves building constituencies for reproductive rights, which requires empowered citizens and collective action (power in numbers). Reshaping the role of contraceptive users in the RH supply change requires addressing power inequities and prevailing norms at all levels within the system.

"On contraceptive use: ideology and prevailing customary laws are huge factors that influence use and demand generation."

2.1 Understand and Re-Insert Power

Reaching the "last (first) mile" (people getting services) is more complex than just supplying commodities. There are multiple actors and uneven power relationships in the reproductive health commodities supply chain. Relevant actors include donors, commodity manufacturers, faith-based organizations, governments (local, sub-national and national), service providers and individual households and women. Each has a different power position relative to all other actors, and inequalities can lead to: information asymmetry, cultural backlash, marginalization and disrespect, upwards accountability to donors, and lack of awareness of rights. Although many involved in RHCS are implicitly aware of such power differentials, a key outcome of the Learning Exchange was the expressed need to explicitly recognize and re-insert power into our understanding of RH supplies.

Mapping out the power relations of these supply chains requires political economy analysis, to identify the interested parties whose influence could potentially distort resource allocation (such as large pharmaceutical companies—see **section 2.2**). This analysis can also help to determine what kind of oversight mechanisms and actions are most appropriate for each link in the supply chain (e.g., open contracting, public audit bureaus, civil society oversight, public information access, facility based electronic monitoring tools, commodity or technical working group).

"I am going to try and connect the morning session on supply chain and this session on TAP. It might be useful for supply chain analysis to map out what are the checks and balances in the supply chain? And how do you deal with discretionary power, and develop an understanding of who or what form of control exists within this system?"

"Power is always relational. How does power play out for each of these actors? Vertical, horizontal, within the family? Frontline health workers might be powerless within the hierarchy of the bureaucracy, but would exert power over the woman/patient."

"Dominant professional hegemonies often question the technical capacity of civil society activists, community leaders."

2.2 Examine Incentives and Supply-Chain Decision-Making at Multiple Levels

Day one of the Learning Exchange made clear the complexity of the accountability "ecosystem" for RH supplies. Unpacking decision-making and incentives throughout a service delivery system can clarify where opacity and discretionary power might create vulnerabilities—and where oversight could be bolstered.

The prequalification of generic products surfaced as a key issue. Prequalification is an international review process that certifies a range of quality medicines for bulk purchase by procurement agencies.[4] Generic producers often do not consider the time and expense involved in prequalification worthwhile, so donors are often limited to procuring more expensive pre-qualified products.

The private sector (whether providers or pharmaceutical companies) also plays a significant role in the RH system and should be included in any political economy or other analysis of the "accountability ecosystem." Throughout the Learning Exchange there was an underlying, on-going dialogue about who holds power and what incentives drive decisions related to RH commodities.

While much of the TPA field focuses on the public sector, the key role of donors and private corporations in RH systems means that we need to understand incentives, motivations and vested interests for a broad range of stakeholders. The RH supply case presents an opportunity to push thinking on TPA.

Systems or political economy analysis would identify the key decisions, from procurement through the supply chain to distribution, where accountability mechanisms should be inserted.

Key actors and decision-makers may include:

- Global regulatory agencies like the WHO responsible for pre-qualification and standard-setting
- Global/regional private-sector manufacturers
- National regulatory bodies
- National public/private drug supply entities
- Various government ministries—health, finance, etc.
- Civil society—national and local
- Sub-national governments
- Service providers—public and private
- Families/individuals in the "last (first) mile"

"The WHO qualification process is slow because contraceptives are complicated, but it is also a manufacturing and political will issue. There is not a lot of incentive for generic producers to get products pre-qualified, which means donors don't procure them, which means they aren't available in the market."

"We try to promote generics, which is often easier said than done. In some countries due to registration issues there are provider monopolies that create asymmetrical negotiations, they segregate markets and determine process. There is no counter-veiling force to prevent this. In some countries the regulations allow the manufacturers to be on top."

"My suggestion is, can we apply the lens of competing for resources throughout the public administration so we can then identify bottlenecks that we will be unable to identify if we concentrate on the actual tools for procurement and monitoring?"

"There are problems with procurement, especially late deliveries at lower levels. Service providers go to the regional medical stores to pick up drugs, and sometimes use their own biases and exclude reproductive commodities."

"I think we need more mixed method research to understand what goes into people's contraceptive behavior and how that relates to providers and provider bias."

4 Prequalification of medicines by WHO http://www.who.int/mediacentre/factsheets/fs278/en/

2.3 Explore Opportunities for Collective Citizen Action for Reproductive Health

In many countries, the RH sector does not have a clear public constituency to build the necessary countervailing power to support policy advocacy work, and to transform passive acceptance of unmet demand for contraception into an active demand to service providers and the state to fulfil these rights. Yet from the perspective of governance reform, the countervailing force which can be generated through collective action and alliances with reformers in government systems is very important.

Collective action can provide leverage for overcoming stigma and encouraging public institutions to listen. Shared collective identity—including a sense of shared rights—is often in turn a precondition for collective action. However, currently, there does not seem to be much in the way of collective identity formation around RH concerns. The lack of collective identity and action could result from concerns about confidentiality. If a woman fears that demanding access to contraception will result in stigmatization from family or community, or violence from a partner, how will she undertake collective action? Are there unique barriers to constituency-building and collective action on RH given the very private nature of decision-making in many contexts?

In some countries, using contraception is considered a subversive act by the woman (sometimes accompanied by the threat of violence) and a political act by the providers. Under these conditions, fear may prevent contraceptive users from linking up and becoming a constituency. But not all settings are so constrained, so why is there less public action even in more open settings?

Participants reflected quite deeply on how the rise of more technical solutions and the de-politicization of the field in recent years may have affected opportunities for more collective and political action on RH. This is an area for much further reflection and collaboration across RH and TPA fields.

"Participation can also be disempowering where it is superficial, manipulative and where you are telling people without any space for their agency or shape decision-making."

"For citizens to hold a government or a corporate actor to account means they are contesting power, on an uneven terrains of power so they need to develop their own sources of power… Contested accountability means working collectively, and outside the system. You can elect officials and wait for the next round to elect someone new or you can find, create other kinds of spaces/ways of pressuring decision-makers or influencing decisions."

"One thread linking the high level presentation on regulations and the frontline presentation on provider constraints is who are the potential constituencies for accountability? How can they be deepened, broadened, activated? Whose job is it to make more 'noise' that is calibrated to produce the power shift?"

"Yesterday a question that was posed to us is who is not here? I think we need more activist organizations around the table. Perhaps even groups of providers."

"It is an interesting observation for those of us who were around in the early 1990s. This field focused on building constituencies. There was discussion on the backlash and that has pushed us back and forth. It's worth stepping back and asking how that has changed overtime. Can IS [implementation science] and participatory research help rebuild movements who were crushed?"

3. Integrate Research and Practice Across TPA and RH

3.1 Bring in Implementation Science

Day two of the Learning Exchange opened with discussions about what implementation science, defined as a body of knowledge about what is required to make programs work, can tell us about the last (first) mile. Although not a new approach, the public health field has only recently turned to implementation science. As a result, there is a growing body of evidence about what is required to get from a well-designed policy to the actual functioning of health service delivery systems and utilization. Implementation science can thus help to re-politicize public health by focusing on *how* people actually experience the operation of complex systems.

3.2 Acknowledge the Relevance of Action Research

Panel presentations and plenary discussions also brought out an appreciation for the disconnect between strategic TPA practitioners' participatory action research (which often provides rich description of what is happening "on the ground") and what is often produced as formal research and evidence.

Participants also focused on the emancipatory and organizing opportunities that can come from doing research on power relations and documenting citizens' experiences. Action research can be an important component of citizen monitoring, collective action and advocacy.

Action research is a subset of applied research. Much of applied research is designed for system maintenance, intended for policy elites, and is often not publicly disclosed. Action research asks questions intended to inform change strategies.[5]

"This field is called 'implementation science' or understanding what is required to make programs work. One element of IS, is accountability, which is necessary but not sufficient."

"How do the politics and technical issues blend together in everyday reality—in the context of evaluations?"

"We get a sense of IS as a scientific push for the re-politicization of public health: how do people actually experience the operation of complex systems."

"It is important to note the gap between what's published and what's happening on the ground, as evidence. Published work is more externally induced, and is different from iterative long term processes led by activists on the ground."

"The technical and political are not necessarily separate. Research can have an organizing aspect. Collecting qualitative data and experience of participating in the research to collect that data can influence providers' perspectives of what is possible."

"We use participation action research which functions on a different paradigm —research linked to unearthing, addressing power relations; collective generation of knowledge. It's an individual, organizational choice what paradigm you want to use."

5 For more discussion, see https://jonathan-fox.org/publications/action-research/

3.3 Research Areas Identified in Learning Exchange

The last sessions of the Learning Exchange focused on small groups drilling down on possible areas that could be explored through research that would be relevant to both the TPA and RH field. Both are complicated fields to study in the real world context. The areas identified and described below may form the basis of future discussions, and with refinement can open opportunities for cross-field researcher-practitioner collaborative learning.

"How to link up immediate problems of stock outs with systemic problems like informal payments and absenteeism, disrespect and abuse? And, how do these problems begin to lay the foundation for designing accountability programs/ research that does not 'whitewash' or seek to change power dynamics?"

Table 4.

	Research Areas Identified in Learning Exchange
Data	• Given the push for collecting monitoring data—how can advocates translate, communicate and use health systems and performance data? • How can proactive, user-friendly dissemination of existing health system monitoring data be encouraged? • How can citizens use available data strategically to improve system performance?
Systems	• Who makes the key decisions at different points in the forecasting, procurement and distribution? • What are reproductive health decision makers' incentives? • Are there spaces for citizen engagement in health delivery decision-making processes? • How do the different stakeholders and decision makers—NGOs, INGOs, donors, governments, local officials—interact across the supply chain?
Interfaces	• How do we understand power relationships between frontline service providers and citizens? • How can we move from tension to alliance? • Public service workers are also members of their communities, but how can they become more accountable to citizens? • How can frontline providers become allies of citizens and even agents of accountability?
Scale	• How can we strengthen links between demand generation, commodity supply, service delivery at the different points in the health system? • Linking local to sub-national and national? • How can advocacy be linked to the operational needs?
Citizen Power	• How can "unmet demand" be converted more effectively from an invisible problem to public claims for rights to services? • What are the personal and political sensitivities specific to reproductive health care that prevent constituencies and agency being built? • How can "unmet demand" become a basis for collective identity, as a step towards collective action?

4. Anticipate Challenges of Applying TPA to RH Delivery Systems

Accountability is a process, which takes time to achieve and often exceeds the length of donor funding cycles. Participants discussed practical questions involving monitoring systems in the broader context of the potential for strategic citizen oversight initiatives. Some emergent challenges to collective action for more accountable health systems were also discussed in the broader context of shrinking civic spaces and reprisals against local activists.

Table 5.

Challenges	Operational Implications and Questions
Asking difficult questions of authority can strain relationships.	• For service providing organizations this might threaten their funding, or risk reprisals against service providers. How can this be mitigated? • How can working in coalitions, and partnerships with TPA organizations, enable divisions of labor to advance sensitive work? • How can linking citizen advocates to the independent government accountability offices actually help to protect citizen advocates?
How to build inter-organizational linkages which enable engagement from front-line workers up to national and international level decision-makers.	• Some problems are not under the control of local authorities – they are systemic. How can strategic partnerships identify structural determinants of problems of reproductive health systems, raise the profile of a problem, as well as scale up local advocacy efforts and get traction at higher levels? • There is need for new monitoring partnerships, both between civil society and governments, and across different constituencies within civil society (health, advocacy, budget monitoring, journalists). Such partnerships will make it possible to diagnose challenges and address symptoms and causes, to connect the technical practitioners with the activists, and to apply accountability approaches to solve technical problems. • What strategies may build trust between municipalities and community organizations builds over time so that they are able to jointly apply pressure on the system higher up?
There is a tension between service provision, monitoring and autonomy. To be credible, monitoring needs to be completely independent.	• To be effective for informing problem-solving by stakeholders, the results of monitoring need to be publicly disclosed. • What constitutes "objectivity" and "conflict of interest" in this space? • Many agencies in the RH sector have vested interests, as they are receiving government funds or are active partners in programming or service delivery of the governments they are monitoring. Partnerships with NGOs who are funded independently and maintain a pure policy role (not involved in service delivery) are needed to overcome this tension.
How to build synergy between the technical and political actions needed to ensure that policy delivers more and better services.	• Any policy change to how or what services are delivered or what commodities are available will require many downstream changes in: clinical service delivery guidelines, changing in the training curriculums, retraining existing providers, development of new monitoring guidelines, etc. This does take time. • How can activists build cross sectoral accountability campaigns that bolster health systems when internationally-funded health programs are still very vertical (reproductive health, HIV/AIDS, etc. tend to operate in siloes)?

IV. Reflections of the Co-Convenors

Understanding and improving RH service delivery requires unpacking multiple complex interconnected processes that link together a range of decision makers, stakeholders, tasks and power dynamics. Each component of the system must be working effectively and efficiently to ensure supplies reach the "last (first) mile".

Taking forward the complex issues discussed in the Learning Exchange and highlighted in this report will require concerted efforts and consistent collaboration across epistemic and sectoral boundaries. New data and methodologies that better capture a more broadly defined supply chain, such as implementation science, balanced researcher-practitioner partnerships, and political economy analysis of reproductive health systems. We need a strategic balance of research methods that provide thick descriptions (in-depth case studies) of women's experiences of services as well as quantitative analysis. Different decision-makers may be influenced (or compelled to action) by different information, oversight or advocacy approaches.

"Whatever happens with the incubation efforts and the ideas; the thing about incubation is that some of them hatch, some don't. But whatever happens, this conversation, I'm confident will have possible multiplier effects in and of itself. That was part of the vision to have an event that would combine possible longer term spin offs and have some practical impact."

There was also an underlying concern that the suggested re-framings required to build citizen voice and oversight in to RH systems would require a radical (and unrealistic) overhaul that may meet with understandable resistance. The proposition put forward was to modify and adapt existing expertise and systems to address and tackle some of the missing pieces and partner with organizations with different skills and reach. For example, the discussions raised a key opportunity for bridging TPA and RH agendas: making already existing RH monitoring data both publicly available and user-friendly.

Like most dialogues or exchanges between thoughtful practitioners, researchers and action-researchers on complex problems, this one yielded more reflections and questions than clear answers. Recognizing this diversity of opinion, the table below describes some key reflections from the co-convenors of the Learning Exchange.

Table 6.

Key Reflections from the Co-Convenors of the Learning Exchange	
Co-Convenor	**Operational Implications and Questions**
Accountability Research Center	This was the first Learning Exchange co-convened by ARC in its "soft launch" year of 2016. The Learning Exchange itself (and the report) will help guide and enrich the development and facilitation of future Learning Exchanges among strategic practitioners and researchers. The ARC has also encouraged practitioner participants to document more of their work in the form of case studies that can be shared more broadly among organizations. Developing a joint concept note prior to the workshop involved extensive researcher-practitioner dialogue, which facilitated agenda-setting for the discussion.
Evidence Project, International Planned Parenthood Federation	As part of our ongoing and future studies on social accountability and citizen oversight, we have started to develop more sensitive measures for tracking the range of outcomes that reflect the political character of many apparent technical interventions. By outlining the assumed pathway through which change takes hold (both technical and political), measures and outcomes can be linked to the theory of change, and data on the assumed change processes better captured. These outcomes will be captured using mixed methods—capturing both outcome and implementation research, as well as the rich intersections between them.
Reproductive Health Supplies Coalition, Advocacy and Accountability Working Group	We are interested in understanding the bottlenecks in decision-making that limit the delivery of contraceptive supplies. The provision of contraceptives is part of a complex supply chain that requires a range of decision-makers to implement protocols and procedures, enact approvals and push forward processes. Any delays, error or inefficiencies can result in negative effects on the ability of the system to delivery of much needed contraceptives. These delays or inefficiencies in the administrative and political process that could be tackled with strategic and targeted accountability and advocacy actions by citizen and CSOs. The RHSC Advocacy and Accountability Working Group links global and country level advocacy, in the areas of policy, finance and programs, to create an environment favorable for scaling up equitable access to a wide range of affordable and high quality RH commodities. The RH Financing workstream focusses on the broader scope of financing issues related to reproductive health supplies. The Last Mile advocacy workstream works on strengthening policies that increase the availability of a full range of quality RH supplies on the shelves in the clinics, pharmacies and hospitals, or in the hands of community health workers.

Annex 1 – Detailed Learning Exchange Agenda

Learning exchange about transparency and accountability strategies and reproductive health systems

Washington D.C, June 27th to 28th, 2016
Butler Board Room (6th floor)
American University

Conveners:

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

Objectives:

1. Share analytical insights, key concepts and practical developments from both transparency, participation and accountability and the reproductive health systems, including commodity security;
2. Learn from experiences with addressing issues of supply chain challenges in various sectors
3. Identify research gaps and/or questions for addressing the monitoring challenges involved in tracking the determinants of access to contraceptive services;
4. Contribute to practical research agendas, and
5. Discuss possible strategies for improved monitoring through collaboration and sharing between RHSC and TPA sectors.

Note to panelists: Please limit your comments to ten minutes each

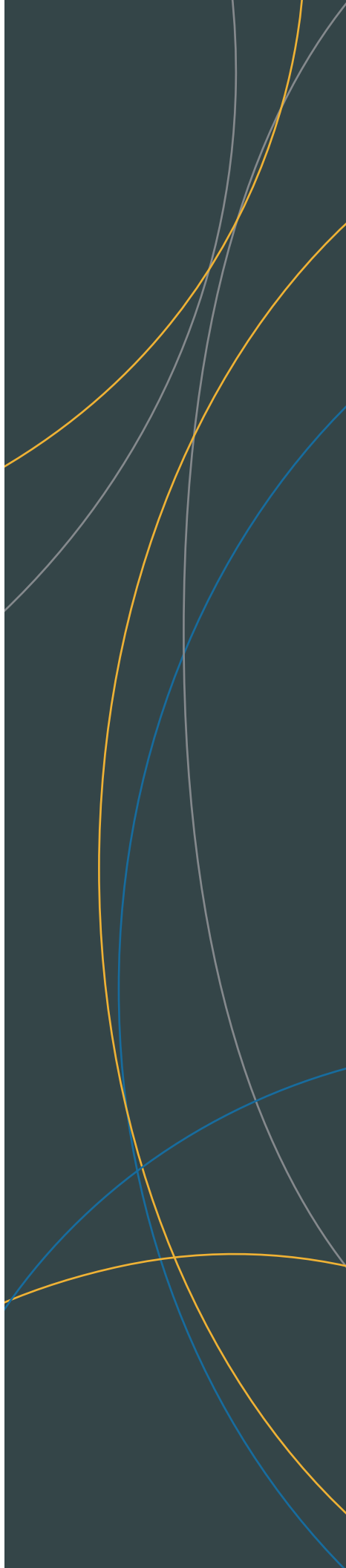
Time	Session	Moderator
	Monday, June 27th 2016	
08:30 - 09:00	Greetings and light breakfast	
09:00 -10:30	***Opening and Introductions*** Welcome & overview – Jonathan Fox Introductions and why you were interested in participating in this dialogue (one minute each) Review objectives and agenda – Vicky Boydell Summarize participants' interests and jargon busting – Sarah Shaw Explain to participants that we will be keeping a running register of key (1) jargon terms and (2) possible tensions (e.g., how can CSOs remain independent; how can we ensure clinical needs are met?).	Jonathan Fox, ARC/SIS, AU
10:30 -10:50	Coffee break	
10:50 -12:00	***The World of RH Supplies*** In this session, RHCS experts will share key approaches and structures in place for ensuring RH commodity security and the impacts these have had to date. How do monitoring processes both document and influence service provision in practice. Speakers (10 minutes each) • Suzy Sacher, Jon Snow International • Sarah Shaw, MSI/RHSC AAWG • Moses Muwonge, SAMASHA Medical Foundation, Uganda • Nana Amma Oforiwaa Sam, Planned Parenthood of Ghana Discussion	Vicky Boydell, Evidence Project/ IPPF
12:00 -12:30	***Introduction to Jargon Busting*** Since participants come from different sectors and experiences this session will encourage participants to share definitions of their terminology.	Sarah Shaw, Marie Stopes International
12:30 -13:30	Lunch	
13:30 -14:45	***Key concepts and lessons from the emerging field of Transparency, Participation and Accountability*** This session will introduce some key concepts and lessons emerging in the TPA field and will use concrete examples of how they have been applied in different sectors and to what effect. This includes approaches to advocacy, problem solving and policy monitoring. Speakers (10 minutes each): • Brendan Halloran, International Budget Partnership • Esperanza Delgado, Mexican Family Planning Foundation • Edward Premdas, Center for Health and Social Justice/COPASAH Discussion	Kelsey Wright, Evidence Project
14:45 -15:00	***Jargon Busting 2.0*** This will include sharing understanding and definitions of commonly used terms that may have different meanings in different sectors (Demand; Client; Policy; Monitoring; and Systems Approaches). Post-it notes – new confusing terms	Sarah Shaw, Marie Stopes International

15:00 -15:15	Tea Break	
15:15-16:30	***'Wicked Problems'– Accountability failures and lessons from reform initiatives*** This will cover a review of national and international policy reform initiatives, their lessons and limitations Speakers(10 minutes each): • Alyson Lipsky, Research Triangle Institute International • Taryn Vian, Boston University • Denis Kibira, Coalition for Health Promotion and Social Development (HEPS), Uganda • Duff Gillespie, Advance Family Planning/Johns Hopkins Discussion	Beth Scott, DFID
16:30 -17:15	***What monitoring systems look like from a service providers' perspective – constraints and opportunities*** This session aims to remind participants of the real-life demands placed on service providers and facilities in terms of the range of monitoring systems already in place and what would be realistic and feasible to add to this workload. Competing regulations, monitoring systems, demands, financing etc Speakers (10minutes each): • Juan Jaramillo, IPPF/WHR • Irene Pachawo, Marie Stopes International, Zimbabwe Discussion	Lauren Carruth, American University
17:15 -17:30	***Closing-*** Identify the key takeaways from the day.	Rachel Robinson, American University
18:00- 20:00	Dinner: School of International Service, Founders' Room, lower level (short walk)	
Tuesday, June 28th 2016		
08:30 - 09:00	Greetings and light breakfast	
09:00 -10:30	***Research on the implementation science of the last mile*** Participants will share policy, research and action strategies to address major bottlenecks (e.g. social, behavioral, economic, management) that impede effective implementation, including health worker incentives/motivations, role of human resource management (transfer and posting), informal payments, as well as bias or abuse. Speakers (10 minutes each): • Laura Reichenbach, the Evidence Project • Marta Schaaf, Averting Maternal Death and Disability (AMDD), Columbia University • Kelly Blanchard, IBIS Discussion	Lynn Freedman, Columbia University
10:30 -10:45	Tea break	

10:45 -12:30	***Challenges of independent monitoring and advocacy*** Practitioners that have been combining monitoring and advocacy to advance health rights, drawing on citizens' "right to know," will share experiences and reflections. Speakers(10 minutes each): • Regina Tames – Information Group on Reproductive Choice – GIRE, Mexico • Renu Khanna, SAHAJ- Society for Health Alternatives, India • Hilda Arguello Avendaño, Maternal Mortality Observatory Health Defense Campaign, Mexico • Walter Flores, Center for the Study of Equity and Governance in Health Systems, Guatemala (plus documentary video) Discussion	Sono Aibe, Pathfinder
12:30 -13:30	Lunch	
13:30 -14:15	***To bolster the contribution of citizen voice and policy oversight, what are the "next generation" questions that need to be asked?*** What key issues should be at the top of a next generation research agenda that can support innovative action strategies? What criteria should inform new agenda-setting? Jonathan Fox: on the potential synergy between monitoring and advocacy. Based on the conversation so far and a framing diagram about seeking synergy between monitoring and advocacy, in plenary discussion how can we start to ask big questions differently? What kind of implicit assumptions need to be questioned? **Brainstorming and prioritizing** Participant discussion of research gaps structure the small group for the afternoon	Jonathan Fox, ARC/SIS, AU
14:15 -15:30	***Towards a practical research agenda (small group discussions)*** Divide into self-selecting groups, assign 1 topic to each. Have them develop recommendations for steps that could and should be taken over the next year: 1. Define research gap and research questions, 2. Answer the "so what?" question/ why this is important; 3. Which combinations of research methods are most appropriate for addressing the priority research questions identified 4. How can we ensure the findings can be applied in real life implementation (research utilization).	Vicky Boydell, Evidence Project/ IPPF
15:30 -16:00	Tea Break	
16:00–17:00	***Small group report back and possible next steps*** Small Group report back to plenary and facilitated discussion Allow each group up to 7 mins to report. Plenary discussion will consider the following questions: • What needs clarification? • What are strengths and limitations of each proposed agenda? • Which recommendations seem most feasible? • What could be done in the short-term? What would require longer-term commitment?	Vicky Boydell, Evidence Project/ IPPF Jonathan Fox, ARC/SIS, AU
17:00-17:30	***Takeaways, suggestions for next steps and closing***	Jonathan Fox, ARC/SIS, AU

Annex 2 – Participants

1	Alyson Lipsky, RTI International, DC
2	Angela Bailey, GOAL Uganda (incoming staff of ARC/SIS, American University)
3	Beth Scott, DfID, UK
4	Brandon Brockmyer, ARC/SIS, American University
5	Brendon Halloran, International Budget Partnership, DC
6	Denis Kibira, Coalition for Health Promotion and Social Development, Uganda
7	Dana Aronovich, Jon Snow International
8	Duff Gillespie, Advance Family Planning, Johns Hopkins University, Baltimore
9	Edward Premdas, Center for Health and Social Justice/Community of Practitioners on Accountability and Social Action in Health, India (COPASAH)
10	Ellen Tompsett, Contractor for USAID | GHSC – PSM, DC
11	Esperanza Delgado, Mexican Foundation for Family Planning, Mexico
12	Hilda Arguello Avendaño, Maternal Mortality Observatory, Mexico
13	Irene Pachawo, Marie Stopes International, Zimbabwe
14	Jeremy Shiffman, SPA, American University, DC
15	Jillian Larsen, White Ribbon Alliance, DC
16	Jonathan Fox, ARC/SIS, American University, DC
17	Juan Jaramillo, IPPF/WHR
18	Karen Hardee, Evidence Project, DC
19	Kelly Blanchard, Ibis Reproductive Health, North Carolina
20	Kelsey Wright, Evidence Project, DC
21	Kristy Kade, PATH, DC
22	Laura Malajovich, IPPF Western Hemisphere Region, Argentina
23	Lauren Carruth, SIS, American University, DC
24	Lynn Freedman, Averting Maternal Death and Disability, Columbia University, NY
25	Marta Schaaf, Averting Maternal Death and Disability, Columbia University, NY
26	Moses Muwonge, SAMASHA Medical Foundation, Uganda
27	Naana Sam, Planned Parenthood Association of Ghana
28	Pat Scheid, Hewlett Foundation, California
29	Patty Skuster, IPAs, North Carolina
30	Rachel Robinson, SIS, American University, DC
31	Regina Tames, Information Group for Reproductive Choice (GIRE), Mexico
32	Renee Van de Weerdt, United Nations Foundation for Population, New York
33	Renu Khanna, SAHAJ- Society for Health Alternatives, India
34	Sarah Shaw, Marie Stopes International, UK
35	Sathyasree Goswami, National Foundation for India
36	Sono Aibe, Pathfinder, California
37	Suchi Pande, ARC/SIS, American University, DC
38	Suzy Sacher, Jon Snow International, DC
39	Taryn Vian, Boston University, Boston
40	Taylor Williamson, RTI, DC
41	Victoria Boydell, Evidence Project/IPPF, UK
42	Walter Flores, Center for the Study of Health System Equity and Governance (CEGSS), Guatemala



ACCOUNTABILITY RESEARCH CENTER

American University
School of International Service
4400 Massachusetts Ave NW
Washington, DC 20016
www.accountabilityresearch.org