Developing Political Capabilities with Community-Based Monitoring for Health Accountability: The Case of the *Mahila Swasthya Adhikar Manch*

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Abstract

Community-Based Monitoring (CBM) is a participatory process in which citizens gather evidence on services to hold governments accountable to their commitments. Research on CBM for health in developing countries has mostly measured its impact on service performance. Overall, these studies have produced mixed evidence of CBM's effectiveness. This has led some authors to question the role of civic engagement, especially in communities where expectations from public services and power to demand for change are low. This conclusion, we argue, overlooks the role of the CBM process in fostering both participation and social change. Drawing from qualitative research with the Indian grassroots women's organisation *Mahila Swasthya Adhikar Manch*, we argue that CBM can foster political capabilities through mediating communities' relationships with the state as well as relationships within communities. The engagement of women and their power to demand for change in the health sector and beyond emerges at the intersection of these two spheres. This suggests that measuring the impact of CBM on health services is not sufficient. Expanding the focus of research on CBM to its process is necessary to fully understand the role of civic engagement and to restore its political relevance.

Key Words: *Community-Based Monitoring, Social Accountability, Political Capabilities, Women's Health, India*

Introduction

Community-Based Monitoring (CBM) strives to improve public services through engaging citizens in documenting their 'availability, accessibility and quality' against specific commitments or standards (Open Society Foundations [OSF], 2011:7). As such, CBM is a major tool in the realm of social accountability, defined as a participatory approach to pressure power-holders to take responsibility for their actions (Malena, Forster & Singh, 2004).

Emerging from the integration of the participatory development and good governance agendas, social accountability has gained considerable popularity throughout the last two decades (Gaventa, 2002) due to its potential to complement accountability mechanisms internal to the state (eg. political, administrative, fiscal and legal forms of oversight, Goetz & Gaventa, 2001), which are often nullified by scarce transparency, corruption and the weak commitment of power-holders (Dasgupta, 2011). Consequently, CBM has been increasingly used in developing countries with the goal to generate improvements in different sectors, including health (Croke, 2012).

Despite the proliferation of initiatives using this approach, formal research on CBM for health accountability remains scarce (OSF, 2011). Studies examining CBM in developing countries have often focused on its impact on the performance of health services, measured through Randomised Control Trials (RCTs). Overall, these studies have produced mixed evidence of CBM's effectiveness. The use of CBM has been associated with improvements in service utilisation rates; child health indicators, staff behaviour (Bjorkman & Svensson, 2009; Bjorkman Nyqvist, de Walque & Svensson, 2014); pregnant women's registration and the display of village health calendars (Kulkarni & Doke, 2013). However, nurses' absenteeism (Banerjee & Duflo, 2006); the physical state of health facilities; types of services provided and health expenditures (Kulkarni & Doke, 2013) remained unaltered in certain studies.

Conversely, the procedural components of CBM – how it works, for whom and why - remain largely overlooked (McGee & Gaventa, 2011). While a handful of studies have measured the impact of communities' involvement (Bjorkman & Svensson, 2009; Doke & Kulkarni, 2013) and of social diversification on CBM effectiveness (Bjorkman & Svensson, 2011), insufficient attention has been paid to the perspective of the communities involved. While some qualitative studies have explored community perspectives on specific CBM components such as public hearings (Papp, Gogoi & Campbell, 2013; Shukla, Scott & Kakade, 2011), most of this literature has focused on the role of Non-Governmental Organisations (NGOs) and Community-Based Organisations (CBOs) in CBM (Donegan, 2011; Unnithan & Heithmayer, 2012) rather than on the process undertaken by communities in demanding accountability.

In this paper, we aim to explore CBM from the perspectives of the communities involved. Our arguments are drawn on qualitative research with the Indian grassroots women's organisation *Mahila Swasthya Adhikar Manch* (MSAM, Women's Health Rights Forum). Our data - collected through focus groups, in-depth interviews and participant observation - suggest that community motivations to engage and the power to demand accountability arise from within the process of CBM at the intersection of a complex set of individual and social changes. Drawing on this, we argue for the importance of considering community voices in assessing the effectiveness of CBM.

In particular, we argue that attention to the CBM process is needed to counter assumptions about the effectiveness of community involvement that are based on failures to generate expected outcomes within a set timeframe (e.g. Banerjee & Duflo, 2006). Such assumptions reflect a linear vision of social change and envision CBM as a fixed intervention rather than as a process defined, not by the objectives and timeframe of the evaluation, but rather by the dynamics of participation (Das, 2013; McGee & Gaventa, 2011).

In taking this focus, we respond to calls for new understandings of social accountability as a complex, long-term process whose social components are integral to its success (Joshi & Houtzager, 2012; Bukenya, Hickey and King, 2012). Scholars have highlighted the need to understand the mechanisms that foster empowerment and citizenship as elements of sustainability in social accountability (Gaventa & Barrett, 2010), as well as how those outcomes interact with health accountability (Joshi, 2010). These fundamental questions should no longer be ignored.

The Research Context

With a population of about 200 million (Census of India, 2011) and less than average socio-economic indicators (Government of India, n.d.), the northern state of Uttar Pradesh (UP) is the most populous and among the least developed in India. The predominantly agrarian society upholds strong caste-based hierarchies particularly unfavourable to the sizable *dalit* population (Ajeet, 2016; Lerche, 1999).

The status of women in society is largely subordinate to men (Jeffery & Jeffery, 1996), with significantly lower educational levels (Census of India, 2011), limited mobility and participation in the public sphere, multiple forms of domestic discrimination, high rates of violence against women (Srivastava, 2002) and poor health outcomes (Government of Uttar Pradesh, Planning Department, 2006).

Maternal health is particularly distressing with a maternal mortality ratio among the highest in the country (285 in 2011-2013; Census of India, n.d.). A weak public health system, lack of accountability and widespread corruption contribute to this situation. Inequities in health services provisioning including neglect and discrimination at the point of care, act as barriers for disadvantaged groups (Das & Dasgupta, 2013).

CBM was introduced in India in 2007 as part of a governmental programme to increase health sector's accountability through community participation (Shukla et al., 2011). Despite its success in other Indian states (Garg & Laskar, 2010), CBM is not yet implemented in UP where other institutional participatory mechanisms - such as the Village Health Sanitation and Nutrition Committees (VHSNCs) – are also weak (Singh et al., 2009). In this scenario, civil society-led CBM has flourished in UP throughout the past decade.

The MSAM was launched in 2006 following a large campaign on maternal mortality in UP. The campaign was initiated by the NGO SAHAYOG and various CBOs with the participation of around 200 grassroots women. From inception, MSAM was designed as a user-driven process to voice the claims of marginalised women for better maternal health services (Dasgupta, 2011).

At the time of research MSAM was present in nine districts across UP with a total of around 12,000 members- mostly poor, non-literate, rural, lower-caste women. Its core strategy is women's capacity building and community empowerment (Das & Dasgupta, 2013). In a process inspired by Paulo Freire's *conscientization* (Campbell, 2014) and facilitated by local CBOs and SAHAYOG, MSAM members learn about their rights and concurrently problematise maternal death as social injustice, often for the first time.

On this basis, demands for change emerge and advocacy is promoted based on data collected through simple pictorial tools. CBM exercises on entitlements are usually conducted by MSAM leaders, elected by and among members every three years with a mandate to lead on collective action to demand for change. Alongside this process, MSAM leaders and members are supported by local CBOs and SAHAYOG who facilitate meetings and interaction with district and state officials thereby promoting a higher level of advocacy (Dasgupta, 2011).

Theoretical Framework

In this paper we adopt political capabilities as our theoretical framework, and in particular Whitehead and Gray-Molina's (1999) work on assessing how pro-poor policies generate resources for political action. Drawing on this framework, we conceptualise CBM as a complex and long-term process towards accountability that implies the renegotiation of citizenship as experienced by communities rather than as a 'widget' (Joshi & Houtzager, 2012) for producing standardised outcomes through short-term, technical interventions to improve health services.

A political capabilities approach focuses on the 'institutional and organisational resources as well as collective ideas available for effective political action' (Whitehead & Gray-Molina, 1999, p.6). These resources are perceived as key to opening up a space for sustainable social change beyond the artificial timeframe of an intervention.

For Whitehead and Gray-Molina (1999), political capabilities emerge as a result of 'cumulative and sustained interactions that socialize the poor into potentially constructive relationships with their social partners and with […] the policymaking state' (p.5). The development of political capabilities is non-linear and always dependent on 'cycles of reconstruction and relegitimation' (p.9), while their resilience is based on communities' appropriation of the skills and ideas that determined past successes, including that of communities' power to leverage change.

Moreover, according to Whitehead and Gray-Molina, 'the process of bargaining and negotiating… often sets the standard by which pro-poor policy outcomes are judged by the poor' (1999, p.7). This is particularly important for communities who bear low expectations towards public services as it assumes that those can be increased throughout the process.

By focusing on political capabilities, we look at CBM as a process with the potential to generate resources for political action through promoting meaningful interactions with

peers and the state. Pivotal in this process is the renegotiation of communities' participation as well as the generation of new expectations towards their rights.

Methodology

This paper draws on data collected by the first author with ethical approval from the London School of Economics and Political Sciences.

Fieldwork was conducted in 2014 in four villages in the district of Kushinagar: three where MSAM had activities and one where MSAM had no activities, the latter included to better appreciate the impact of the MSAM.

Data collection included semi-structured interviews, focus groups, participant observation of one MSAM meeting, as well as several hours of informal discussions with community members and staff of the CBO *Purvanchal Gramin Seva Samiti* (PGSS) which facilitates MSAM in the district.

***INSERT TABLE 1*: Data collection (p.29)**

Topic guides were developed based on our research question and the theoretical framework. Participants were introduced orally to the purpose of the study and to the consent process including the possibility to opt out at any time without giving a reason. All participants were given an information sheet and asked to sign or cross a consent form. Interviews and focus groups were conducted in Hindi or Bhojpuri with a translator. Interviews with NGOs and CBO staff were conducted in English. All conversations were audio-recorded with the participants' consent.

Participant observation was also used to a limited extent. Observing an MSAM meeting helped picturing how collective ideas and actions come to life. Casual conversations

adding invaluable information were captured in the researcher field notes. Audio tapes were transcribed *verbatim* and subsequently translated by a local assistant.

Data were analysed using a thematic network approach (Attride-Striling, 2001) with the help of *NVivo10*. Explicit and latent contents were coded and transformed into themes at three different levels. Findings were then described and interpreted in the light of our theoretical framework.

Limitations

Our findings reflect our informants' representation of reality, which might differ from what happens on the ground. Our methodology and a relatively short fieldwork did not allow for an exploration of these possible discrepancies.

Findings

CBM mediates Communities' Relationships with the State

Our analysis suggests that, in this context, CBM generates social change by mediating communities' relationships with the state through conceptualising rights, challenging state representatives and promoting state representatives' recognition of communities.

In MSAM members' accounts, conceptualizing rights as entitlements of all citizens is the result of a complex process conveyed through capacity building, meetings, and collective action. This process is described by one MSAM leader:

> In a meeting we were told that everyone has the right to get (nutritious rations). Before we thought it was a favor they were doing to us, we did not know about rights. (MSAMLeader1, VillageX)

Education about benefits is an important capacity building component for the poor and non-literate women who compose MSAM. Case stories and members' direct experiences

are also used to develop their capacity to question power inequalities such as those represented by health workers' demands for money for free services, as in the quote below from an MSAM meeting facilitated by PGSS:

> Member - Munna's wife fought; the doctor said he didn't want to see the child, she said: 'it's a Government Hospital, just take the money as instructed, not more '.
> PGSS Staff - You all have the same right as they have. It's the Government, it means for everybody. (MSAMMeeting, VillageZ)

With these new critical analysis skills, MSAM members become increasingly vocal in demanding change. Frequently, demands are initially dismissed by power-holders, for instance, through blaming the poor or offering individual benefits *in lieu* of collective entitlements, as in this example provided by an MSAM leader:

> We went to the Child Development Project Officer, we were told: 'you can take the ration but don't tell others' and 'you all steal from the farms'! We said: 'you sell it to others'! When all the members went there they started giving it to everybody. (MSAMLeader1, VillageX)

Here, rights become an ideal tool to oppose discourses and practices commonly used to silence the marginalised in a context of strong inequalities and diffuse corruption. For some members, this is the beginning of a different relationship with/relation to the state where claiming entitlements becomes possible.

However, engagement in MSAM also encourages members to conceptualise rights as a matter of active participation within the structures of the state. This is realised by making members accustomed to forms of political participation beyond demanding accountability such as voting and running for elections. This resulted in several MSAM members winning seats in the 2010 local elections, an important step for grassroots women who are traditionally relegated to the domestic sphere, as suggested by one MSAM leader:

> Some time ago our family members joked with us […]. They said we would not be able to do this, we said: 'with one hand we will do our housework and with the other, the work of *Panchayati Raj* (local council)'. (MSAMLeader4, VillageY)

Such change is nor linear or uncontested in a patriarchal context, as suggested by the fact that some husbands were said to occupy *de facto* the council seats won by their wives. However, the conceptualisation of rights opens the possibility for women to feel and be in an active relationship with the state.

For many members, this is an achievement in itself and the beginning of their ability to demand change through challenging state representatives. By definition, the pressure is exercised in CBM through producing evidence about service provision. This is accomplished by MSAM through monitoring exercises, complaints hot-lines and public audits. However, 'monitoring' translates into a plethora of strategies in members' stories, well beyond structured data gathering. In the following quote from an MSAM leader, monitoring is pictured as an immediate reaction to warnings from community members:

> Villagers know that I do this. So when kids don't get enough food in schools their parents look for me. I go there and check, sometimes I hide. Then I go and say: 'give it to them'! (MSAMLeader4, VillageX)

In their roles of MSAM leaders, women are often invested by communities with a new responsibility towards ensuring quality services. This ultimately changes their relations to these services and generates unexpected ways to challenge state representatives.

Even more commonly, members challenge state representatives by preventing neglect or abuse, for example by sitting beside nurses to prevent bribing on vaccination day, by hanging informational posters to discourage cheating where subsidised grains are sold, or as in the quote below, by taking others to hospital to ensure they are cared for:

> Now when we go they listen to us and don't bribe. Because now not only ill persons go, healthy persons go as well, we go together to help others. (MSAMLeader3, VillageY)

By 'going to help others' and other ways to prevent discrimination, MSAM members pressure the state through their physical or symbolic presence.

MSAM members also seek to activate the state apparatus by demanding action from unresponsive state structures, including those with a mandate to promote social accountability in the health sector like the VHSNCs:

> We asked for a part in the activation of the Village Health Sanitation and Nutrition Committees. Because it was only happening on paper, now we are asking them to have meetings, minutes and […] actions taken. (PGSSStaff)

As in this quote from a PGSS staff member, the activation of state structures assumes and thereby produces a form of relationship with the state mediated by knowledge of the rules of participation.

Lastly, MSAM also uses direct action when authorities remain unresponsive. This was most often referred to as 'solving problems' by 'doing it themselves', as in the following quote from an MSAM member:

> There was a place, (some villagers) were fighting in court for years but did not get the permission to build a drain. Women from 3-4 villages united, some picked an axe, bricks and pebbles and we made the drain ourselves. The police was coming but women said: 'we will take out our (MSAM) badges', so they did not come and now it is good for all. (MSAMMember, FocusGroup1, VillageX)

As in this example, where villagers overcame upper castes' opposition to a drain on their land, direct action brings about agency in women as they face both the state and society.

Regardless of the strategy used, promoting communities' recognition by state representatives is key to generating change in a context where class, caste and gender

discrimination contribute to poor care. Knowledge of entitlements acquired through engagement is often said to open up spaces for fairer treatment. In the quote below from an MSAM leader, attendance at trainings and meetings in UP's biggest cities is presented as a proof of their new skills:

> Earlier we did not know anything. Now women go to Varanasi, Lucknow, Gorakhpur […] we have the knowledge now, doctors have to agree with what we say. (MSAMLeader3, VillageY)

But recognition by state representatives is often presented as best channelled through MSAM as a group with a collective identity and power to challenge the status quo, for example, when 'going together' to 'solve problems'. This results sometimes in increased quality of care, as in the quote below by an MSAM leader:

> [Our relationship with health professionals] is good now, they fear us! Once they told me to lie down on a bed, the sheets were dirty with blood, I refused and threw them. All these women were there, we asked them: "is this what you are paid for?'. They gave me a cleaner bed. […] At the beginning they treated us as common people, but now they treat us well, they know that we are MSAM, that we can do anything. (MSAMLeader4, VillageX)

Lastly, recognition is linked by members to the ability to relate to state actors and rules, as in the story, told again and again, of a District Commissioner who gave them his phone number during a public hearing with instructions to call when denied care.

> For the women this becomes a very empowering exercise, […] I met your boss, they say that when they negotiate with health providers, I met the Health Minister, so you don't try to fool me. (SAHAYOGStaff1)

As this quote suggests, recognition is exponential: MSAM members experience proximity with the state apparatus which in turn increases their recognition by state representatives as well as their power to leverage change.

CBM mediates Social Relationships within Communities

Our analysis suggests that CBM also mediates social relationships within communities by fostering collective agency, by negotiating social disadvantage and by promoting gender equality. These dimensions interact with each other and with changes in the communities' relationship with the state, fostering women's engagement and power to affect change.

MSAM members and their communities often discussed fostering collective agency as a key outcome of the network. Members repeatedly talked about the process of engagement as increasing unity within the group and the community. In the following quote, CBM emerges as an occasion to strengthen relationships and develop collective agency:

> Interviewer - What do you like about MSAM?
> Participant - We live together and don't fight, we meet and get to know each other's problems and help each other (MSAM Leader5, VillageX)

Along these lines, members often refer to engagement as an occasion to advocate for each other's health. As social factors contribute to poor women's health in this context, women' social environment is also addressed by MSAM, as described by one leader:

> If a women is suffering and her husband is not getting her treated or he is a drunk, we go and tell him to get her treated, that the treatment costs one rupee only, we convince him. (MSAMLeader3, VillageY)

Here, MSAM is presented as a resource for women to mediate social relationships and, in so doing, to improving access to health care.

For MSAM, however, collective agency extends well beyond health and involves the ability to 'solve all problems', as mentioned by an MSAM leader in the quote below:

> Interviewer - What do you like about MSAM?
> Participant - We go to solve all problems together […] if we are called from anywhere, we go for our rights.
> Interviewer - What kind of problems?

Participant - All of them! (MSAMLeader1, VillageX)

This idea - expressed again and again - highlights the re-appropriation of CBM for other uses from building a drain to mediating a family dispute, extending well beyond health accountability.

Moreover, as MSAM expands across UP, members get to know and relate to women's problems in other villages and districts. This generates an even broader community for collective action, as in this example where women from nearby villages united to fight an injustice:

> In BM someone was building a house on [a woman's] land. They tried through police but they had bribed them […]. That woman came to us, so we all went […] we removed the house […] and made a wall. Women of 2-3 villages went. (MSAMLeader5, VillageZ).

Such broader involvement is the result of relationships built through engagement. This expands women's community and their capacity to mitigate some aspects of their marginalisation through collective action.

As an organisation predominantly composed of rural, poor, uneducated and low caste women, MSAM is said to also contribute to negotiating social disadvantage. This is even more true as MSAM developed in connection with interventions by the facilitating CBO PGSS, such as adult education and micro-credit.

> Interviewer - Why did you join MSAM?
> Participant - Taking money from outside was difficult. We thought to open our own (micro-credit) group. Now we use money for the work of [MSAM] (MSAMMember, FocusGroup2, VillageY)

As in this quote, economic and educational resources channelled by PGSS are often mentioned as the initial motivation for women to engage in MSAM, as well as a common motivation for families to allow women's engagement.

Resources channeled by PGSS and MSAM were often said to decrease dependency on upper castes, for instance through providing the know-how to access entitlements, cash from micro-credit groups, or collective agency, as in this quote from an MSAM leader:

> Participant - Doctors used to say 'take (away) that patient or pay', so I used to borrow money […] from upper castes.
> Interviewer - What happens now?
> Participant - This [MSAM] is everywhere now. If a woman goes to deliver 4-5 women go with her, they raise their voice, they say they know it's free, why are you asking for money? We won't give money, we don't borrow anymore! (MSAMLeader3, VillageY)

Here, collective action is presented as helping poor villagers avoid bribes, and therefore debt with upper castes - a common practice, as confirmed during the focus group in the non-MSAM village. In this way, CBM changes social relationships within the community and links members' demands for health accountability to broader issues of social justice.

To MSAM members, the process of engaging also contributes to promoting gender equality. A starting point is the rejection of the gendered value of humbleness (well represented by members' continuous jokes about someone's past shyness or observation of the practice of covering the face with a veil) and the embracement of boldness, as a leader suggests in this quote:

> I went to Varanasi, Gorakhpur, Lucknow, my fear is lost now. Before I was so afraid that I didn't come in front of anyone. But now I can eat sitting with others, I can talk to anyone, go anywhere […]. These fears were completely lost. (MSAMLeader5, VillageX)

Here, boldness gained through engagement in MSAM is necessary for demanding accountability as much as for negotiating women's positioning in society. In the accounts of some members, moreover, this new attitude also directly contributes to demands of equality at home:

> Now we don't have any fear and we ask for equality at home as we are also earning. If a man eats two roti (bread), then I also have the right to eat two roti! It is this kind of confidence that I got. (MSAMLeader2, Village X)

As this quote exemplifies, the confidence acquired through the CBM process has led some members to start questioning gender inequalities, including domestic discrimination.

Moreover, in a context that traditionally relegates women to the house, the increase of women's mobility is portrayed as a key outcome of CBM, as well as a common reason for women to engage:

> Earlier we didn't speak to anyone because we were at home all the time. When we moved out, we started talking to people about their problems which increased our knowledge and experience, so we became leaders. Now we go everywhere to fight for our rights. (MSAMLeader2, VillageY)

As this quote from an MSAM leader suggests, mobility is central to women's ability to acquire new skills as well as to demand change by 'going everywhere' to fight for their rights.

Women's engagement is both instrumental to demands for change and a change in and of itself in a context where social norms limit it. While women's participation in MSAM is often pursued by members and families to access resources at first, women gain new skills and legitimacy through the process:

> Interviewer - Why did your husbands change their minds?
> Participant - The work they are not able to do, we do it. If anything happens they call us and ask us to solve it. It is good for them also (MSAMMember, FocusGroup1, VillageX)

As this quote illustrates, women's efficacy in the public sphere is portrayed as key to the legitimisation of their engagement. In other words, when marginalisation is multi-faceted,

women's right to participate emerges at the intersection of transformed relationships with the state and society.

Discussion

Our analysis suggests that CBM can generate change by mediating communities' relationships with the state as well as social relationships within the community. At the intersection of these changes, we argue, CBM contributes to developing women's political capabilities and, consequently, to promoting engagement and the power to affect social change.

This inherently counters Banerjee & Duflo's (2006) argument that 'where many households appear to have largely given up on the public sector […] beneficiary control cannot be the primary tool for fighting [health workers'] absence' (p.127) and poor accountability. Drawing on our findings, we suggest that such conclusions are misleading as they do not take into account the role of the CBM process in shaping both engagement and social change. Conversely, we show how CBM interacts with complex aspirations that often extend beyond health accountability. Such aspirations are concurrently the premise and the outcome of specific processes leading to the development of capabilities to affect change at the intersection of state and society.

In their meta-analyses of RCT's of initiatives to monitor health staff's absenteeism, Banerjee and Duflo (2006) affirm that 'people in [certain] countries seem to have low expectations from the health care system, and as a result, have little desire to invest time and energy into making it better' (p.127). We argue that to dismiss the role of community participation in demanding accountability on this basis is doubly short-sighted. The MSAM's experience suggests that it is reductive to think of the 'desire to engage' as solely linked to expectations from the health sector. Instead, other aspirations are a fundamental engine of

engagement, for instance, access to education and credit, recognition and collective agency, increased mobility and gender equality. Far from simply being a premise for CBM, communities' expectations towards health services emerge while engaging in collective processes which are sometimes initiated by other aspirations.

Moreover, this happens in an iterative pattern that also includes the generation of other expectations beyond health services, such as that of increased class and gender equality. Thus, to dismiss the role of community participation in demanding accountability not only undermines the importance of generating expectations towards health services, but also denies communities the opportunity to gain access to new skills and resources, and advance claims in other domains (class, caste, gender, etc.) that also contribute to their marginalisation. The role of community engagement in demanding accountability should be weighed with this in mind.

In this perspective, our work supports the conceptualisation of social accountability as part of a dynamic relationship with rights and resources. For Newell and Wheeler (2006), access to resources is shaped by contextual relationships of power that also frame communities' ability to voice claims. Thus, 'gaining the right to access resources and to claim accountability is a political project' (p.10) towards expanding substantive citizenship.

In a context where women's agency in the public sphere is limited, women's right to participate in demanding accountability is a key outcome of CBM. As our work suggests, this right can only emerge at the intersection of two forms of citizenship: one which relates to the state and that is mediated, for instance, by ideas of rights and recognition by state representatives; and the other located within the social environment that contributes to shaping the forms of participation of women, for instance, by limiting their mobility or political engagement (Kabeer, 2002). This suggests that community engagement in demanding health accountability is crucially anchored to those complex and iterative changes

that redefine the way women think and exert their citizenship. As for Newell and Wheeler (2006), such a process invests women's relationship with resources (health services, credit and education, etc.) as well as with their own participation. MSAM members' demands for health accountability could not emerge outside this complex network of changes.

However, access to resources and the re-negotiation of citizenship are not obvious outcomes of CBM as such. For instance, Banerjee, Deaton and Duflo (2004) (cited in Banerjee & Duflo, 2006) analyse a programme where absenteeism is monitored by a paid local and communities are then asked to choose how to act on the basis of the data. Similar programmes appear to rely on the assumption that access to data in itself increases power to demand change. In the experience of MSAM, however, empowerment is fostered throughout a continuum of relational occasions (meetings, trainings, monitoring, public hearings and follow-up) where new skills and resources emerge.

In this perspective, our analysis supports Donegan's argument that is 'the relationships […] developed through the data collection process which cultivate empowerment' (2011, p.50). As in Whitehead and Gray-Molina (1999), political capabilities emerge through CBM as a result of 'cumulative and sustained interactions' (p.5) with peers and the state, and the transformation of women's relationships with both. For MSAM, it is in the interaction of these transformed relationships that accountability emerges, as when health care is provided thanks to the collective action of women who have come to conceptualise rights, developed skills to voice demands, been recognised by state representatives, and overcome limitations to their mobility and participation. Political capabilities - essential for social accountability – are generated through tackling the complex nature of power relationships in a specific society.

The changes women experience throughout the process open up possibilities for the expansion of their social and political agency. We cannot make a claim for the sustainability

of the changes described or their impact in the long term project of promoting health accountability and expanding substantial citizenship, nor underplay the role of the broader political context in generating accountability (Dasgupta, 2011). However, our findings suggest that MSAM members have reinterpreted CBM in a plethora of uses and strategies beyond its traditional definition as an advocacy tool to improve public services through participatory data collection. Rather, for the MSAM CBM has become a way to 'solve all problems' - from social disputes to gender inequality - through a variety of strategies including preventing poor quality care through their own presence, advocating for each other's health, or exercising direct action. Within a political capabilities framework, it is precisely through the appropriation of locally relevant skills by communities that CBM becomes part of a sustainable process of social change for health accountability and beyond. The role of the CBM process in generating political capabilities should no longer be ignored.

Conclusion

This paper suggests that social change instigated by CBM does not happen in a vacuum but within social processes that connect state and society. In conclusion we argue that research on CBM should explore the role of these processes in fostering engagement as well as social change.

Research in the field has mainly measured CBM impact on health services performance, overlooking its ability to produce forms of engagement and its complex processes of change. This is partly ascribable to privileging of RCTs as the gold standard for evaluating health programmes, which limits our ability to capture the processes involved in CBM and to take note of unexpected outcomes (Barnes & Parkhurst, 2014). Those processes and outcomes, however, are what render CBM a political project with the potential to shape how citizenship is experienced by particular subjects. To uncover the political project behind

CBM, it is pivotal to broaden our focus and diversify our methodology. By qualitatively exploring the perceptions of communities involved in CBM, as we have shown, it is possible to uncover the dynamics of communities' engagement and power to leverage change.

Our work suggests that demands for health accountability do not arise in isolation from demands for social and economic rights relevant to specific communities. Crucially, demands arising from marginalised communities often include the right to participate in and of itself (Cornwall & Gaventa, 2001). By exploring the CBM process, research can shed light on these demands, the conditions for their emergence, the components of their effectiveness and their relation with health systems' accountability. Conversely, research which focuses solely on measuring predetermined outcomes risks missing an occasion to amplify communities demands for complex forms of social change.

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Table 1- Data collection

	Interviews	**Focus Groups (FGs)**
	▪ SAHAYOG staff- 2 ▪ Centre for Health and Social Justice (CHSJ) staff- 1 ▪ MSAM leaders- 6 ▪ MSAM leaders' family members- 3 ▪ VHSNC members- 3 ▪ PGSS staff- 2 ▪ Senior health staff- 2	▪ MSAM members- 2 FGs, 8 and 10 participants ▪ Women in MSAM village - 7 participants ▪ Men in MSAM village- 6 participants ▪ Women in non-MSAM village- 12 participants
Total	**19**	**5** **33 participants**