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Enhancing Funders' and Advocates' Effectiveness: The Processes Shaping Collaborative Advocacy for Health System Accountability in South Africa

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Introduction

Contemporary theory emphasizes that social-change advocacy outcomes are difficult to predict because of the complexity of political and social systems. As a consequence, grantmakers should not assume that supporting one or two groups or single strategies will necessarily achieve their intended outcomes, nor should they require grantees to predict outcomes.

This article brings together experiences drawn from four mixed-method retrospective case studies on the achievements of five organizations supported by the The Atlantic Philanthropies (AP) that, individually and sometimes collaboratively, advocate to improve the quality of health services. The groups have different constituencies – from people living with HIV to health care providers to journalists – and strategies that range from protest, including street marches, mobilizing media, and litigation, to working inside the system to collectively shape solutions.

This article, using advocacy for access to drugs as a lens, identifies some of the features that enabled effective informal and formal collaboration among advocacy groups, including their shared values, diversity, and capacity to adapt strategies to shifting political contexts and in response to their own victories. It then draws out generic lessons on advocates' collaborations and funders' grantmaking strategies that are most likely to be successful, including a selection-based rather than sanction-based approach to accountability when supporting advocacy in complex terrains.

Key Points

- This article describes the roles of five advocacy groups that built collaborative initiatives to address the collapsing health system in South Africa.
- The findings presented are based on retrospective reviews of annual reports, organizational evaluations, interviews, and focus group discussions with each of four participating organizations and existing literature on the fifth.
- The key findings, for both advocacy groups shaping alliance strategies and for funders, are that flexible funding and a shared value system among groups with diverse capacities, constituencies, and reputational resources is a good approach for enabling adaptive and innovative strategies for holding the public sector accountable.

The Atlantic Philanthropies' Public Health Strategy

The Atlantic Philanthropies established a population health program in South Africa in 2005 and awarded more than 100 grants, totaling more than \$100 million¹, with the objective of improving access to quality health care for all and reducing health inequities across South Africa (Friedman, 2015). Its funding had three goals: strengthening the public primary health care system, with a focus on rural practice; strengthening health professionals' training, with a focus on rural public health services; and amplifying the voices of

¹ This is an estimate because of high fluctuations of South Africa's currency in relation to the U.S. dollar.

Advocacy to governments occurs in complex systems where results are unpredictable and seldom attributable to the actions of a single group.

disadvantaged populations by supporting advocates in monitoring the implementation of health care policies and the quality of health services to ensure that the government delivered on the promise of the South African Constitution (Parker, 2013). This article focuses on the civil-society monitoring and advocacy dimension, or “community accountability” (Westthorp, et al., 2014).

The case studies draw on a theoretical approach that recognizes that advocacy to governments occurs in complex systems where results are unpredictable and seldom attributable to the actions of a single group (Patton, 2008). For this reason, the evaluators looked for outcomes that marked a contribution toward achieving each group’s advocacy goals rather than population-level impacts (Klugman, 2010). The case studies were developed using mixed methods, including document reviews, observation of key organizational meetings, questionnaires, secondary quantitative data analysis of organizational outputs and outcomes, and in-depth interviews and focus group discussions with the leadership of the four groups.

Finally, in keeping with the principle of participation in and utilization of evaluation (Patton, 2012), case study development included each group framing its own objectives for the evaluation and group learning workshops with staff and elected leadership where applicable, including reflection on findings. Participating organizations also presented, at two public conferences, findings that surfaced additional reflections incorporated into this article.

South African Health System Context

More than 20 years after the country’s first democratic elections in 1994, the South African public

health system has made significant strides in realizing the right to health that is enshrined in the constitution, in part through progressive health policy and improving access to universal health coverage. The government has also built a large network of decentralized primary health care facilities. Despite considerable investment, however, providing high-quality services to all has not been achieved. Inequities in access to services persist, with the country’s most rural provinces served by the fewest health professionals and poorest infrastructure. The impact on poor communities is severe and includes long waiting times, unnecessary referrals, poor quality of care, and even avoidable deaths.

The management of the drug supply illustrates the complexity of and challenges inherent in a dysfunctional health system. In South Africa, drugs are procured through a national tender system. After contracts have been awarded, provincial authorities purchase drugs directly from suppliers. Health facilities place orders for drugs at the sub-district level, which sends orders to districts; from there orders go to provinces, where orders are placed and the supply of medicines from suppliers to regional pharmacy depots is channeled. Each province is responsible for ensuring the effective distribution of drugs from the depots to health facilities. Public health clinics and hospital pharmacies run out of medicines – or face “stock outs” – because of inadequate funds, inaccurate and nonparticipatory forecasting, insufficient buffer stocks of essential medicines at all levels of the supply chain, inefficient national and regional distribution systems, and poor record-keeping (Stop Stockouts Project, 2013).

Reflecting the political values of the post-1994 constitutional dispensation, there are legal mechanisms for communities to engage health services and hold them accountable, in particular through clinic and hospital committees. But these committees have not been established in many facilities, and where they do exist they are not always resourced or capacitated and seldom fulfill their intended functions (Mdaka, Haricharan, & London, 2014). This has left a critical gap in accountability mechanisms envisioned in the National Health

FIGURE 1 The Organizations



Act. The primary civil-society actors engaged in holding government accountable for quality health-service delivery are community-based and nongovernmental organizations.

The Organizations and Their Strategies

Treatment Action Campaign

Established in 1998, the Treatment Action Campaign (TAC) is best known for challenging pharmaceutical companies, "quacks," and government AIDS denialists, forcing provision of anti-retroviral treatment for HIV-positive South Africans and thereby saving thousands of lives. It did so by building a base of support among people infected or affected by HIV and AIDS and creating powerful partnerships with lawyers, service providers, researchers, and advocacy groups locally, nationally, and internationally.

Having ensured the right to treatment, the TAC turned to ensuring that people infected with HIV are willing and able to take advantage of treatment and that high-quality health services are accessible to everyone who needs them. Members pride themselves on knowing the science of HIV and rights to health care through the campaign's magazine, *Equal Treatment*, through which the TAC branches keep members informed, and the NSP Review, which assesses implementation of the HIV and AIDS National Strategic Plan. TAC has 228 branches operating nationally and a total membership of approximately 6,000, 35 percent of whom are openly living with HIV. Its 2014 budget was US\$2.8 million and it has 20 national staff, 27 in provinces, and 76 on stipends.

These networks allow rural health workers to identify and address barriers to good health services without fear of retribution. The RHAP also focuses on “rural-proofing” health policies – advocating for all health policies to take account of the rural context.

Health-e News Service

Established in 1999, Health-e News Service is a nonprofit agency that provides coverage of public health issues to television stations, newspapers, magazines, and websites in South Africa. It has seven full-time staff and 22 citizen journalists (CJs), mostly recruited from community-based social justice organizations in urban slums or rural areas across the country. The CJs write at least one story a month on a local issue; these stories are purchased by media or posted on Health-e’s website. Health-e’s 2014 budget was \$500,000. Health-e produced 1,860 print stories between January 2005 and December 2014; since 2008 it has produced 74 TV programs. Health-e’s radio unit, which is now closed, supplied the South African Broadcasting Corp. with 664 stories between 2005 and 2012. Staff and citizen journalists have received numerous national and international awards for health journalism. “During the era of AIDS denialism, Health-e played the role of almost the ombudsperson,” remarked Francois Venter of the Southern African HIV Clinicians Society, “like an investigative arm if you had a complaint” (Parker, 2013, p. 27).

Rural Health Advocacy Project

Established in 2009, the Rural Health Advocacy Project (RHAP) provides a coordinated voice and

safe place for rural health care workers to channel concerns and recommendations. It has played a critical role in strengthening and coordinating cadres of health providers, including doctors, rehabilitation workers, and clinical associates, through networks of professional organizations. These networks allow rural health workers to identify and address barriers to good health services without fear of retribution. The RHAP also focuses on “rural-proofing” health policies – advocating for all health policies to take account of the rural context. It has six staff members and in 2014 had an annual budget of US\$400,000.

The Southern African HIV Clinicians Society

Established in 1997, the Southern African HIV Clinicians Society partners with government to develop evidence-based policies and guidelines, implement optimal HIV and tuberculosis programs, and disseminate evidence-based information about HIV to health care workers. It has about 3,500 members, seven staff members, and an annual budget of US\$580,000.

Through its publications, the quarterly *Southern African Journal of HIV Medicine and HIV Nursing Matters*, as well as training courses, monthly branch meetings, and symposia, the society reaches thousands of health care workers every month. It also operates continuing medical education at 26 sites across all of South Africa’s provinces. Its chairperson describes it as “the biggest brains trust of HIV physicians in the world” (Conradie, 2015, at meeting).

Section27

While not included in the case studies, Section27 features prominently in this article. Established in 2010 when it incorporated the AIDS Law Project (which started in 1993), Section27 is a public interest law center focusing on access to health care and other socioeconomic rights enshrined in Section 27 of the constitution. It was also funded by The Atlantic Philanthropies, which commissioned a book on the history of the AIDS Law Project (Moyle, 2015). Its director was one of the founders of the Treatment Action Campaign and is represented on its national council.

Civil Society's Role in Health System Crises: Addressing "Stock Outs"

South Africa has the world's highest rate of HIV and has more than 3 million people on anti-retrovirals – more than any other country (UNAIDS, n.d.). Interruptions in these treatments are particularly dangerous given South Africa's twin epidemic, tuberculosis, and the growth of drug-resistant TB.

The Southern African HIV Clinicians Society's initial approach to stock outs was to provide rapid, expert response to alerts of drug shortages – for example, advising clinicians on appropriate substitutes for unavailable medications. The Rural Health Advocacy Project reached out to the appropriate health-system managers, who took action that frequently resolved stock outs within days. In cases where there was no immediate resolution, the RHAP would alert partner organizations to mount a joint response.

The Treatment Action Campaign identifies problems at the local level by monitoring the health system's capacity to deliver services, and seeks solutions through engagement with health facilities. Where that fails, the TAC helps organize marches, sit-ins, and media engagement. At quarterly TAC meetings, national officers discuss emerging local trends and build national campaigns around common problems. In response to stock outs specifically, it investigates each case where a community member is told necessary medicine is not available and pushes for action. Even health care providers have asked the TAC for help. In a focus group held by Klugman with TAC leadership in South Africa's Eastern Cape, Ndiphwiwe Bekwapi of the TAC/Stop Stockouts Project reported:

If a clinic operational manager or pharmacy assistant is expecting a delivery today and it is not made, they approach me and I do follow up on their behalf to find the actual cause of the delay in the depot, and if need be refer to the provincial Department of Health.

Health-e's role has been to inform the public and government about the issues. It broke the story of the rising incidence of drug-resistant TB, which

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can develop when infected individuals do not complete their treatment – a problem exacerbated by stock outs of TB medicines. Its citizen journalists monitor stock outs of 22 medicines in an average of 26 clinics each month and report problems, through a formal agreement, to the Department of Health, which has committed to take action. Health-e drew public attention to stock outs through 26 articles produced between November 2012 and September 2014 alone, and its investigations frequently result in government action even before articles are published.

Informal Connections

By identifying citizen journalists from the TAC's ranks, Health-e created an immediate synergy: The day one citizen journalist returned home from training, he noticed that his local clinic had closed. Learning that the Department of Health had failed to pay the rent on the clinic, he wrote an article for Health-e and then notified the TAC. The TAC took up a campaign at local, provincial, and, ultimately, national levels, persuading the minister of health to open a temporary clinic and build a new one. Subsequent Health-e articles provided support for the TAC's pressure on political leadership for action.

The TAC routinely asks the Clinicians Society for input on the science of HIV, and members of

FIGURE 2 Informal Collaborations



the Clinicians Society frequently run trainings for TAC staff and members to ensure they understand the science and their rights under national policy. The Clinicians Society draws some of the material it uses to educate its members from stories published elsewhere by Health-e; its June 2015 issue of *HIV Nursing Matters* included Health-e stories on the pneumococcal vaccine, sex work, and about a young woman who was having sex with older men to get money to feed her family. The magazine's March 2015 issue carried Health-e stories on a Constitutional Court judgment regarding health care providers and on the RHAP's "rural proofing" guidelines.

The RHAP in turn invited the TAC onto its board because, according to director Marije Versteeg-Mojanaga, "it is the only membership-based group in health in South Africa that has elected

leadership who reflect the experiences and demands of those in rural and impoverished areas about health". As a component of the Clinicians Society's continuing professional-development program, the RHAP also conducts a training program to inform health providers of their rights and how to report problems.

And so these groups strengthen their work by drawing on one another's capacities, which has drawn them into much more substantive collaborations. When the Mthatha Depot, serving more than 300 medical facilities in the rural Eastern Cape, suspended striking staff and was no longer supplying medicines, more than 100,000 patients on anti-retrovirals faced interrupted treatment (TAC, 2013). The RHAP alerted the TAC and Section27; together they sent repeated complaints to the national and provincial health departments.

FIGURE 3 Formal Collaborations



While receiving no response on those fronts, the TAC ultimately obtained permission to intervene and in December 2012 took over the running of the depot with guidance and funding from Médecins Sans Frontières (MSF). It deployed more than 20 volunteers to pack and ship medicines to affected clinics and hospitals (TAC Eastern Cape, 2013); thousands of patients received their HIV and TB drugs within two weeks (Edlmann, 2014). The TAC worked there with the support of a few nursing students until March 2013, when 15 newly appointed staff took over. In addition to facilitating the handover, the TAC contributed to a report with recommendations to the National Department of Health (Lawson, 2013).

It was in this context of increasing awareness of system failure that these groups established joint initiatives, thus maximizing their diverse constituencies, capacities, and brands. (See Figure 3.)

The Clinicians Society, in partnership with the RHAP and Section27, conducted a needs assessment on the reasons for drug shortages and developed a list of essential medicines that required routine monitoring. They shaped the language of “stock outs” as a shorthand that would draw public and political attention to the broader health crisis – a standardization of language that is a sign of a network consolidating itself (Hoppe & Reinelt, 2010).

The Stop Stockouts Project

In 2013 the Clinicians Society, RHAP, TAC, and Section27, together with the Rural Doctors Association of Southern Africa and MSF, consolidated their informal collaboration into a consortium – the Stop Stockouts Project (SSP). With its pooled resources, the SSP was able to hire project staff and engage in full-time monitoring and reporting of medicine stock outs across the country.

The SSP has two tracking methods. The first reaches out through member organizations to offer health providers and users of community services, including formal clinic committees where community members have representatives, a system to alert the SSP of stock outs using free mobile phone numbers and WhatsApp. Given the poverty of most consumers, this free service is a critical innovation.

The SSP has two tracking methods. The first reaches out through member organizations to offer health providers and users of community services, including formal clinic committees where community members have representatives, a system to alert the SSP of stock outs using free mobile phone numbers and WhatsApp. Given the poverty of most consumers, this free service is a critical innovation. Staff follow up at clinic level and escalate queries until they are resolved. These individual alerts provide early warning of potential national stock outs resulting from supplier problems.

The second surveillance system is a national phone survey that asks facility respondents – a head nurse or pharmacist – to identify the magnitude of drug stock outs. A report based on those responses identifies the number of public health facilities reporting a stock out or shortage of anti-retrovirals or TB drugs in the preceding three months. In late 2013, the SSP shared the findings

of the first survey with the National Department of Health and Provincial Heads of Pharmacy and publicly released its report, whose findings were covered by media. Health-e posted a story by Laura Lopez Gonzalez (2013):

More than ten percent of all health centers in the country have experienced stock outs of HIV and tuberculosis (TB) medicines in the last three months, jeopardizing the health of millions of South Africans. The findings are part of a new report released 28 November by a civil society coalition ... under the banner of the Stop Stockouts campaign. Between October and September 2013, the campaign interviewed about half of all health facilities in the country. One in five health centers surveyed reported shortages of HIV and TB medicines in the last three months. The Free State was the worst affected province, with more than half of facilities surveyed reporting stock outs. (paras. 3-6)

The survey was met with hostility by the national minister of health, who accused the TAC of dishonesty and placed blame on manufacturers. But the SSP found that only 20 percent of stock outs reported during the survey were related to manufacturing and that the bulk were attributable to poor planning, management, and coordination. Still, the SSP learned from the experience. Partners tightened the methodology of the second survey and worked hard to build relationships within the Department of Health. The SSP negotiated an “escalation protocol,” which gives the department two days at each level (clinic, district, and province) to respond to a stock-out query and address the problem before the SSP goes to the media. Dumisani Malele (2015), acting director of the medical supplies depot in Gauteng Province, observed,

It didn't start on a good footing, but when we set up the escalation protocol it worked better. It is benefiting government because it is working closely with the very patients we serve – we have a shared interest and we appreciate that. Going forward, we need to understand what society is saying and how they think the process can be improved, instead of a top-down approach.

The Eastern Cape Health Crisis Action Coalition

Recognizing the Mthatha Depot situation as the tip of the iceberg, the TAC, RHAP, Rural Doctors' Association, and Section27 held two meetings in April 2013 with representatives of communities, nongovernmental organizations, and health care professionals. In June they founded the Eastern Cape Health Crisis Action Coalition, which has since grown to 25 member organizations. The RHAP coordinated the campaign until early 2014, when it was handed over to the elected chairperson of TAC Eastern Cape. The TAC and Section27 released a damning report, *Death and Dying in the Eastern Cape* (Section27/TAC, 2013). In the wake of the report the government suspended a doctor for leaking information; after efforts by Section27 and the RHAP, the doctor was reinstated.

Informed by the report's findings, the coalition held a protest march in September 2013 in the provincial capital and attempted to deliver a memorandum to the Eastern Cape's member of the executive committee (MEC)² – the political leader responsible for health – but he was “unavailable.” The new head of the department accepted the memo and promised “engagement,” but none of the coalition's efforts to communicate bore fruit.

But the National Department of Health (2013) did send a fact-finding mission in response to the report's “allegations on [the] state of health services in the Eastern Cape” (p. 5). In November the national parliament called on the coalition to report on the situation; the coalition used that opportunity to also report on the health crisis itself. The mission's recommendations were implemented and a provincial committee was mandated to continue the work. After the May 2014 national elections the provincial MEC was replaced; since then the provincial department has recognized the coalition as a legitimate body advocating for change and has established mechanisms for cooperation and rapid-response teams to address specific crises.

² “Member of the executive committee” is the title used for provincial cabinet members, in this case the person responsible for health services in the province.

One of the experiences described in this article is how civil-society groups, separately and together, constantly shifted strategy from “outsider” to “insider” as circumstances required, sometimes while working with government – at one point, actually operating a government medicines depot while simultaneously calling for the firing of the political leader in charge of it.

Lessons in Collaborative Advocacy

One of the experiences described in this article is how civil-society groups, separately and together, constantly shifted strategy from “outsider” to “insider” as circumstances required, sometimes while working with government – at one point, actually operating a government medicines depot while simultaneously calling for the firing of the political leader in charge of it. The process from outsider strategy to insider collaboration has not been linear: while most provinces and the national government are now collaborating with the SSP, one province refuses to do so for political reasons and the groups are still protesting on the streets and through the courts to hold that province accountable. Mansbridge (2014) argues that the extent to which one uses trust-based versus sanction-based accountability has to be calibrated according to the context. The case studies here show the high degree of adaptability and innovation shown by civil-society groups in building trust-based accountability with government when they can, but using public sanction when necessary.

Both the Clinicians Society and the RHAP use the fact that society grants authority to health care providers – particularly doctors – to present their organizations as legitimate voices of reason and technical expertise. They also capture and capitalize on the rich insider perspectives of health care workers on the causes and impacts of health care challenges. At the same time, they recognize that TAC’s brand and its mechanisms of community engagement and representation legitimize and validate the claims of the groups collectively. They also look to TAC to bring in the experiences of poor and marginalized.

Leveraging Differences in Power Among Civil-Society Groups

A striking feature of this story of advocacy is how each of the groups consciously used its own position to powerful effect, but did so in ways that were mutually supportive rather than competitive. Lynn (2014) describes how power imbalances and competition for funder resources can undermine potential connectivity among groups that are

ostensibly working toward the same goals. In this case, each group acted in accordance with its own strengths, capacities, mandate, and power.

For example, the TAC can mobilize members to march and protest, but can also mobilize its reputation and brand such that both elected representatives and health system staff recognize its ability to gain traction in public discourse and with decision-makers. But it cannot be as effective as it is without up-to-date information on clinical best practice from the Clinicians Society and without the efforts of Section27 and other legal groups to ensure that its constituency knows its rights and can threaten and use litigation where necessary.

Both the Clinicians Society and the RHAP use the fact that society grants authority to health care providers – particularly doctors – to present their organizations as legitimate voices of reason and technical expertise. They also capture and capitalize on the rich insider perspectives of health care workers on the causes and impacts of health care challenges. At the same time, they recognize that TAC’s brand and its mechanisms of community engagement and representation legitimize and validate the claims of the groups collectively. They also look to TAC to bring in the experiences of poor and marginalized people. And Health-e, while formally an independent journalistic enterprise, facilitates responses from a government fearful of critical news coverage while informing the public about the work of advocacy groups. This ability to take best advantage of the diverse capacities and specialties of members is a key feature of effective networks (Plastrik & Taylor, 2006).

Shared Values and Equitable Power Relations

What made it possible for this disparate group of organizations to find one another and work so collaboratively? The key is shared values, deriving from two sources. First, South Africa has a history dating from the struggle against apartheid of mobilizing around questions of inequality. There is already recognition in the national psyche and discourse, and formally in the constitution, of the right to equality and the right to health – despite the lived reality of being the most unequal society

in the world. Second, public health as a discipline is built around the notion of equity. So the historical context and the specific field provide a fertile base of shared values for fostering collaboration on access to health care. In addition, the individuals who lead these groups recognize that the collective goal is more important than any institutional brand – a recognized feature of collaborative success (Wei-Skillern & Silver, 2013).

Each group's ways of working embody recognition of the others; they are not only working toward shared goals, but they include those goals in their ways of working. While one might expect leaders of health care groups to see themselves as “above” leaders of an organization of unemployed, HIV-positive people, all participants have modeled mutuality and respectful recognition of each other. The experience of being treated with dignity is a key dimension of network effectiveness in this case.

Self-Selection Through Trust-Building

Another striking feature of these collaborations is that they were consolidated over time. Group members slowly got to know their counterparts in other organizations. By building relationships through working together, formal collaborations developed organically as changes in the context and greater understanding of the challenges made it increasingly clear that working alone would not achieve their shared goals.

While this article does not consider the other grantees that comprised The Atlantic Philanthropies' public health program strategy, it is worth noting that it was mostly the advocacy groups who built the strategic partnerships described here. While other grantees have developed significant health-system innovations, such as in the training, recruitment, and retention of health care providers in rural areas, The Atlantic's efforts to create learning collaborations among those groups have not proved effective during the current review of lessons for the field. This may be because advocacy groups are driven by the goal, while academic and research groups – even in the study of improving equity in the health system – are driven by the need for academic recogni-

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tion within their institutions and through peer-reviewed journals, which introduces competition and limits the motivation to collaborate.

Lessons for Funders

Zola Madikizela (2015), the program executive responsible for The Atlantic Philanthropies' public health programming in South Africa, says the advocacy-grantee portfolio was a response to shrinking civil-society organizing, as funders shifted their resources to government and many change-makers moved into that arena; yet it was a period of AIDS denialism that needed advocacy. Its first grants were to the Treatment Action Campaign and the AIDS Law Project, which were already leading the challenge against denialism. Atlantic began funding Health-e when its initial donor defunded it on short notice (Parker, 2013), possibly because the government was unhappy that Health-e was generating media outrage at AIDS denialism.

The Atlantic Philanthropies began funding the Clinicians Society when it had no legal status and was operating from a garage. Its incoming president knew Madikizela and approached him, arguing that with ample funding it could have an im-

Even funders who specifically support grassroots or membership-based organizations need to consider whether they have the necessary infrastructure, such as producing evidence and providing legal advice. Without it, grassroots efforts are unlikely to succeed.

pact within a couple of years on both government policy and in providing AP's advocacy grantees with scientific evidence. Madikizela (2015) notes:

This aligned with AP's approach – focusing on strong people whose perspectives aligned with ours, and taking big bets – having confidence in people to make a difference and giving them big funds that allow them to do so; supporting groups that punch above their weight.

In the case of the RHAP, Madikizela first offered to fund a feasibility assessment for the Rural Doctors Association of South Africa, a voluntary organization, believing that it could be making a bigger impact. The association preferred to remain voluntary, but proposed that AP fund a group that could generate academically rigorous evidence on conditions facing rural health providers. Thus, the RHAP was born.

Grantee Selection

The Atlantic Philanthropies was able to select an effective mix of grantees in part because it had in-country staff with long histories of work and relationships in the sector that were continually reading the terrain – both the political context and civil-society capacities. Mansbridge argues that the most effective form of accountability lies in selecting those people and organizations most motivated and committed to particular goals. Account-

ability results from effective selection and trust, rather than post-action sanction (Mansbridge, 2014). Donor investment in local staff or consultants, or at minimum in an effective network of embedded informants, increases the likelihood of successful selection. Even funders who specifically support grassroots or membership-based organizations need to consider whether they have the necessary infrastructure, such as producing evidence and providing legal advice. Without it, grassroots efforts are unlikely to succeed.

Grantee Cohesion

The Atlantic Philanthropies program staff say one weakness of its strategies was that it did not bring grantees together to learn about each other's work. While not all of its grantees are aware of one another's innovations in training public health leadership or in health-service delivery, this is not the case with the advocacy groups it supports. Those grantees initiated connections with one another without AP's prompting or assistance.³ This speaks to the care of AP's approach in so far as its selection of grantees recognized the mix of necessary capacities. But it did not issue instructions or create forums that forced collaboration; rather, it recognized "the hidden networks already embedded in the civil sector" (Plastrik & Taylor, 2006, p. 103). That said, it engaged in ongoing informal conversations which no doubt contributed to connectivity.

Wei-Skillern and Silver (2013) note that "[m]any partnerships have failed because they have been forced from the top down, often by well-intentioned funders" (p. 124). Hence part of the art of grantmaking is selecting for the values and competencies that favor collaboration over competition, and then trusting groups to collaborate when strategically necessary.

Grantee Accountability

Just as a civil-society organization's choice of partners evidences a trust-based accountability model,

³ These groups do have other donors in common that do convene "their" grantees. But those convenings are not strategy sessions of the kind AP now believes it should have facilitated, especially for its academic and health-training grantees, to learn from other innovations and maximize impact through collaboration.

a funder's grantmaking needs to be based on careful selection followed by trust; it is not possible for effective advocates to commit in advance to strategies or activities. The Atlantic Philanthropies' grantees say it was an effective funder because its staff gave them the leeway to use funds as needed based on their shared overarching goal of the right to health. Some of these grantees' other donors require reporting against results predicted often a year or more before action is taken, and the grantees fear failing to deliver these results even when they are no longer optimal. This form of sanctions-based accountability – which leads to the fear among grantees that failure to check the agreed boxes may mean the loss of future funding – is a barrier to more innovative approaches from grantees that would otherwise have the flexibility to adapt to shifting contexts.⁴ Patrizi, Thompson, Coffman, and Beer (2013) characterize this as “indicator blindness.”

These case studies highlighted a fundamental problem: some of the donors who fund these groups would like to see civil-society groups take on roles, such as providing services, that are now performed and funded by the government – which is why those donors require quantitative, predictable deliverables. That motive makes for a mismatch in goals and, hence, tensions around reporting. Funders who expect immediate outcomes also fail to understand that advocacy is taking place in a highly complex terrain and that it takes time to establish the issues, build trust and collaboration among groups, and reach a point where the public expresses dissatisfaction and decision-makers feel forced to act. It is impossible to know in advance which of the multiple strategies deployed will be most effective. In addition, lessons learned over time strengthen relationships among civil-society groups and the effectiveness of their advocacy. Similarly tight controls over spending would have precluded the pooling of funding for collective campaigns.

⁴ This situation was compounded for grantees that saw government funding cut in response to their criticism of health system failures. In addition, the closure of The Atlantic Philanthropies (most grantees are in their last year of funding) is creating major challenges for some of these grantees because of the absence of other donors offering similar large, multiyear, core-support grants.

Some of the donors who fund these groups would like to see civil-society groups take on roles, such as providing services, that are now performed and funded by the government – which is why those donors require quantitative, predictable deliverables. That motive makes for a mismatch in goals and, hence, tensions around reporting. Funders who expect immediate outcomes also fail to understand that advocacy is taking place in a highly complex terrain and that it takes time to establish the issues, build trust and collaboration among groups, and reach a point where the public expresses dissatisfaction and decision-makers feel forced to act.

Preconceptions by a grantee about whom it should work with on what issues would appear to prevent it from finding synergies as needed. The groups considered here could achieve what they did only because they had core funding that allowed them to read and adapt to the terrain. As they identified the need for the Stop Stockouts

The cases discussed here show that by giving organizations funds to allocate as needed, donors ceded power to the grantees. Those grantees, in turn, chose to collaborate rather than compete and pooled knowledge, expertise, and money to make a stronger impact.

Project, they were able to fund it – without having to wait for the next funding cycle to make a specific case for it.

Lynn (2014) notes that “power over resources” is a factor in shaping a field (p. 54). The cases discussed here show that by giving organizations funds to allocate as needed, donors ceded power to the grantees. Those grantees, in turn, chose to collaborate rather than compete and pooled knowledge, expertise, and money to make a stronger impact. Selection-based accountability lends itself to a different kind of reporting – not against outcomes committed in advance, but against actual outputs and outcomes.⁵

Conclusion

These case studies illustrate how a funder’s decision to support the strategy of ensuring effective civil-society capacity to hold government to account for its constitutional responsibility to provide health services involved selecting a variety of players with very diverse capacities and positions, in terms of skills, reputation, and relation to the

⁵The “outcomes harvesting” approach can be deployed by grantees in reporting to donors that have this more flexible approach, drawing out what changes have actually been initiated by social actors (the outcomes), and the contributions of grantees in influencing those actors (the outputs). (See Wilson-Grau & Britt, 2012.)

health system. Working independently and, where strategic opportunities presented themselves, together, both informally and formally, those players built and sustained a voice that spoke truth to power and forced government action to strengthen the public health system.

This experience suggests that funders would do well to put time and care into grantee selection, finding the individuals and groups with the passion, shared values, and skills to develop and adapt effective strategies, instead of relying on preconceived commitments to reporting on products and outcomes that preclude strategic adaptation and may promote competition over collaboration.

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