Poverty reduction programs and local collective actors: social accountability and public service delivery in São Paulo[1]

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1. Introduction

This paper presents preliminary results from a research still in progress that addresses the forms of accountability activated by collective actors over local level service delivery in health and social assistance, focusing on two Brazilian poverty reduction programs: the Family Health Program (PSF) and the Minimum Family Income Program (*Renda Mínima*), in the city of São Paulo. The results show that societal accountability exercised by collective actors varies according to the specific sector. It appears stronger and more present at the local level of the health sector, which has an older and more organized social movement. Health sector has as well as an administrative and participatory structure, historically rooted in the local level, and open for interlocution with civil society/stakeholders about health policy.

The analysis was based on material gathered through interviews with collective actors mobilized around service delivery in 40 poor regions of the municipality, in which the *per capita* average salary was not greater than half of the minimum salary established by the government.

Based on the definitions and criteria defined by the literature (Joshi et al. 2005; Serafim, 2007; Gurza Lavalle and Isunza Vera, forthcoming) societal accountability was typified in categories that gather activities with different levels of

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institutionalization used by actors or groups to exercise control over public authorities or private providers of public services.

Five preliminary results are highlighted: 1) in general, the local collective actors exercise societal accountability - in two years, the 53 interviewed actors exercised some type of societal accountability for 232 times; 2) the most frequent type of societal accountability was informal demand for improvements and the less frequent was public and institutionalized action; 3) there is a difference in terms of intensity of societal accountability by sector: 74% of the actions aimed health and 26% social assistance; 4) in health, societal accountability includes a broader range of actions, especially through administrative and participatory structures, while in social assistance individual and direct access to political system is predominant, with sparse use of participatory spaces and State agencies; 5) the few collective actors involved in societal accountability over social assistance also participate in other sectors.

The analysis points to the relevance of the historical social movement engaged with the sector as in health sector case, and that its absence (Dowbor1, forthcoming) may explain much weaker local level societal accountability in the social assistance sector. The rooted structure of basic service delivery in health sector (406 Basic Health Units), of administrative instances (three hierarchical levels) and of participatory spaces (more than 500 councils) may influence the intensity of societal accountability by local collective actors. Last, it is significant that there is a spreading effect on societal accountability exercise, as local active collective actors engage with other sectors that lack a structure that promotes participation, going beyond a specific more structured sector such as health.

2. Research Presentation

The decentralizing feature of reform and the existence of collective actors were two of the criteria used in the choice of sectors, for the purposes of this research. Its aim was to verify, among other issues, the hypothesis that those reform processes in which groups of collective actors participated with some power of negotiation, and which represented social segments with precarious or no access to certain services, have a better chance of promoting the engagement capacity of said actors in the medium and long terms, as well as empowering them for a societal accountability interrelation with service providers in question.

Over the last 20 years, the health and social assistance sectors underwent a similar process of reform with regard to their guiding principles. In the 1988 Brazilian Constitution, health care and social assistance became social rights (to which citizens should have a free and total access) organized in a decentralized manner and with community participation as the guiding principle in the elaboration and implementation of these policies. Nevertheless, the configuration of actors involved in the process of these reforms happened in a different manner. In the health care, there was a movement of reformist professionals which acted along the popular movement for health. In assistance, unions and class associations of social workers and the academic sector, supported by charity entities which provided social assistance, had a relevant role in reforms.

The Family Health Program (PSF) and the Minimum Family Income Program (*Renda Mínima*)

As presented above, both sectors were chosen because they have undergone reforms of very similar profiles and also because they counted with the participation of collective actors in the process. Both in Federal and Municipal levels it was possible to recognize different constellations of social actors involved with policy implementation (Dowbor1, forthcoming); Dowbor2, forthcoming) . In order to analyze societal accountability in local level, where service provision takes place, in each of the sectors one program was chosen – PSF in Health and *Renda Mínima* in Social Assistance. The presence of these two programs oriented the selection of regions for the research, and a series of questions about mechanisms and intensity of societal accountability was addressed in the questionnaire.

The programs we examine are very different in the nature of the good they provide and in the form of provisioning. The distinct design of each of them suggests distinct types of actors will enter the process of policy making and implementation, that the institutions for policy making and implementation will differ, and that consequently each program will be characterized by distinct types of political dynamics and outcomes. What is constant is that they serve the same population and both are the most important (in scale and budget) policies for this population group in their respective policy areas.[5] Furthermore, both programs come formally under the jurisdiction of

[5] PSF does not explicitly target the poor, and has no income requirements, but at both the national and São Paulo level implementation of the program has prioritized regions with high concentrations of poor households. In addition, it the poor that rely most of public health care, while the middle class

participatory governance institutions: the Municipal Health Council and the Municipal Social Assistance Council.

PSF was adopted by the Ministry of Health in 1994 as a national strategy to redirect the Country's health care model. It was first implemented in the poorest regions of the country[6]. Its expansion was vertiginous: from a coverage of 1 million people in its first year, to almost 30 million in 2000 and 55 million in 2002. In December of 2008, PSF covered 93.2 million people throughout Brazil (DAB 2009).

The implementation of PSF in the city of São Paulo began in 1996, through the initiative of the State Government. The municipal government adopted the program in 2001, with the goal of 60% coverage of the population. The distribution of health teams followed two directives: emphasis was given to the poorest regions of the city, with the highest concentration of families with up to five minimum wages; and, its implementation in all 41 of the city's health districts. In 2003, the two poorest strata of the city's population (of the five strata) had 56% and 31% coverage, respectively (Bousquat, Cohn, Elias 2006: 1938). Although the original goal was abandoned in 2003, the expansion of PSF continued and reached 37% of the entire population in 2008 (Montone 2007).

PSF is executed through health teams composed of, at a minimum, one general medical practitioner (family doctor), a nurse, an assistant nurse, and six community health agents. The teams were placed in basic health units, generally community health posts. Each team is responsible for the care of a thousand families, approximately 3,000 to 4,500 residents, in a specific territorial area. Different from the traditional model of basic care at basic health units, the community health agent of PSF is a local resident and regularly visits each of the 200 families to which (s)he is assigned. The community agent registers basic information about the family members and channels to consultations with nurses and doctors.

Renda Mínima was created in 2001, the city's first large scale anti-poverty program for people on the margins of the formal labor market. Municipal governments and the federal government have created a series of minimum income guarantee programs that aim to tackle intergenerational poverty on a large scale and to varying degrees within a rights or entitlement framework. These programs represent a revolution in the form and size of government poverty-reduction intervention. In little

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and affluent buy private health insurance and seek out private providers.

[6] PSF was originally part of the national program *Comunidade Solidária*, which consisted of a combination of initiatives to fight poverty.

more than a decade income guarantee programs have become the country's main anti-poverty strategy, dwarfing the patchwork of charitable or non-profit organizations that have, with public funding, historically sought to meet the needs of the poor. In the city of São Paulo, *Renda Mínima* provides monthly income grants to roughly 150,000 families, or approximately 600,000 people (Houtzager, 2008). São Paulo's program is the largest of the municipal initiatives and the immediate predecessor of the federal government's *Bolsa Familia*, which offers similar grants to an unprecedented 11.2 million families, an estimated third of the country's households.

Within a year of the program's start it by-passed all other social assistance programs combined in the size of the population served and in budget share. By the end of 2008, São Paulo's administration expected the program to reach over 200,000 of the 300,000 families – that is, 12% of the city's 10.4 million people – that fall below the poverty line[7]. The program budget in 2006, R$168.9 million (€62.5 million), represented 88% of the budget of the Social Assistance Municipal Secretary (SMADS). The remaining 12% covers the SUAS - related social assistance programs financed by the municipal government and administrative costs.

Families with children under the age of 16, and a per capita income of less than R$175, are entitled to a monthly income grant under the program. The family must have resided in the city for two years and prove legal custody of the children. The monthly grant is R$140, R$170, or R$200 (€52, €63, and €74) depending on whether a family has one, two, or more than two children respectively. Any other income transfers, such as those from the federal *Bolsa Escola*, are subtracted from the benefit. The average benefit in 2006 was R$117.00 (€41) (SMADS 2007: 50). *Renda Mínima* requires that the families fulfill a corresponding obligation: ensure all school-age children attend at least 85% of their classes and that children under the age of 6 complete the government's vaccination schedule. Families register directly with the government and then access their monthly grant through a bank account opened in their name, normally using a bank card. There is no legal requirement that women in the household must be the entitlement holder but women tend to have legal custody of the children and are generally responsible for the education and health of family members.

[7] The poverty line is per capita income of less than half-minimum wage (currently R$190, €70). Current exchange rate, €1=R$2.70.

Field Research Methodology

The field research was undertaken in 44 geographical areas defined by regions assisted by the Basic Health Units (BHU) in operation within the PSF model. By definition, a region assisted by BHU with PSF usually encompasses 2941 families (a variable figure). Today, São Paulo has 407 BHU, 220 of which operates exclusively with PSF assistance. BHU regions were chosen, within this scope, according to the concentration of low income families, whose monthly income is up to half the minimum wage *per capita*, with a relatively high number of beneficiaries of the income transfer program (*Renda Mínima*). Due to differences among macro-regions of the city – East, South, Central, North and Southeast Zones – the researchers were careful in choosing the BHU of two regions that sharply contrast with each other: the East Zone, which went through an early urbanizing process, is nowadays in better urban infrastructure conditions, while the South Zone, which underwent a more recent process of disorderly occupation, and whose urbanization is still incomplete. Beyond these two, there are a few other BHU in the Southeast Zone. 15 of the BHU chosen have the presence of collective actors identified in health sector. The remaining 25 BHU were randomly picked, always considering the control of aspects mentioned above.

In order to identify the leaderships interviewed, initial talks were held with managers of the selected BHU, aiming at identifying the existence of collective actors working in the areas encompassed by each of these units. From the initial information gathered, the area scope of each BHU was mapped in order to locate additional leaderships. Researchers covered these areas in search of information regarding the *most active* leaderships and social entities in that area.

Next, a profile of these collective actors was elaborated with the following reference criteria: i) participation in any collective channel of mobilization, such as public policy-making debate forums, management councils in many levels, communitarian associations, social entities, political parties or social movements; ii) collective action towards health care and/or social assistance improvement or accountability, from a specific and from a general point of view.[8]

[8] Initially, the proposal was to locate collective actors in the areas of health and social assistance, so that the objectives of this research were more directly reached. However, a lack of collective action specifically focused on assistance policies was detected. This determined the search for collective actors performing some kind of societal accountability over general neighborhood issues, on the basis that these actors would have more general data about the location and would be able to point actions and establish interrelations to deal also with questions related to assistance.

Issues regarding societal accountability present in the survey allowed for the creation of a simple societal accountability rate, which in turn made it possible to have a more complete analysis of the variations of societal accountability intensity within BHU scope areas.The societal accountability rate results from the sum of affirmative answers to the eight questions related to societal accountability for each policy, resulting on a simple scale of 0 to 8. Thus, it was possible to classify surveyed areas in one of the three levels of societal accountability: low (0 to 2); average (3 to 5) and high (6 to 8).

3. Trajectory of Policies

Despite the similarities identified among reform processes, one of the main differences between the two social policies examined is that users became organized in health sector, but were collectively absent from social assistance issues.

The popular health movement became, in São Paulo, politically visible from the end of the 70's decade on. Its actions, aimed at the improvement of public service delivery in the poorest regions of the city, included taking part in popular councils accompanying health care facilities, and also making less formal demands, such as street demonstrations, general assemblies and meetings with public power representatives. The civic organization regarding health care issues also represented the axis of a political project by the movement of reformist health professionals, who put it in practice by fostering the organization of São Paulo's popular health movement (Escorel, 1998; Neder,2001).

The popular health movement arose within the national scenario on the second half of the 80s decade, through actors' participation in events and their association with other collective actors. Such process resulted in the creation, historically unprecedented in Brazil, of a health system of free, universal and full access, guided by the principles of decentralization and community participation. The movement attended the 8th National Health Conference, in which a broad representation of social actors consolidated the project for the new health system. They also participated in the National Health Plenary Session, summoned to oversee Constitution works by mobilizing and exerting pressure on the National Congress as well as interacting with it (Faleiros et alli, 2006).

The approval of the Brazilian health system (known as SUS) in the 1988 Constitution was in accordance with the project of reformist sectors, and it was followed by the regulation of the 1991 Organic Law, which contained proposals for

enabling institutions for participatory governance. Apart from having legal support, the enabling of such spaces was also helped by the allotment of federal resources to states and municipalities under the condition that councils had to be created. In São Paulo, the popular movement and the policy makers benefited from previous experiences; thus, councils became operative during the very first years of government after the new Constitution was enacted. This process had a strong setback under the rightist government which ruled from 1993 to 2000; it excluded municipality from the SUS and implemented an alternative proposal for organizing the sectoral health care. Reformist segments, among which is the popular movement, immediately became fierce opponents of the proposal, filing actions of unconstitutionality in both State and Federal Courts. Such dispute resulted in the boycotting, by the Executive Power, of the Municipal health council, which was eventually replaced by another council formed up by municipal government allies.

According to previous literature (GIUGNI & PASSI, 1998), movements tend to become more mobilized during governments that inhibit their access to institutional means of pressure and negotiation. This principle can be verified in the case of popular health movements in São Paulo. Citizen participation in health was strongly inhibited; nevertheless, the popular movement maintained its organization through informal councils spread throughout the city, and by promoting Municipal Conferences with debates about the sector, as well as engaging in several types of protest. When the left party, strongly connected to the movements, won the elections in 2001, it proceeded to reinstall participatory mechanisms, which were still functional by the time the surveys for this research were conducted, in 2007. In that year, there were councils installed in practically all of the 500 health facilities, among BHU, first-aid rooms and hospitals.

There were also councils in two of the three levels in the sector's administrative structure. This structure, despite undergoing a new change with each new government over the last 20 years, functioned in a decentralized manner. In 2007, there were 5 supervisions operating under the Health Secretary; those were, in turn, responsible for 31 coordinations. Each coordination managed an area with approximately 300.000 people, and was also responsible for a number of public health care facilities. Speaking in practical terms, when users were faced with problems in the delivery of basic health services, they were able to resort to the Basic Unit Council (council of the BHU in question) – and if that channel was unable to tackle the issue, it could send it to the Coordination Council. If even then the case was not solved, the next instance would

then be the Municipal Council. In short, users were served by a decentralized administrative structure, public health facilities and a framework of participatory groups as a means of engaging with the Government and as potential channels for communication, demand making and negotiations.

The trajectory of social assistance analyzed from the point of view of its actors is fundamentally different from that of the health sector for both aspects analyzed, regardless of the fact that both areas are guided by the same principles of universality, decentralization and popular participation. Since late 70s, no form of organization by social assistance stakeholders has been registered in São Paulo. As opposed to the network of health councils, there is only one social assistance council, on a municipal level, and the sector's decentralized administrative structure is recent and still being built (Dowbor2, forthcoming).

Similarly to health sector, social assistance was raised to the status of social right and a duty of the State in the 1988 Constitution, having been regulated by the Organic Law five years later. This process was conducted not only by government agencies; reformist social assistants and their representative organizations, along with reformist private institutions which provided this kind of service, took part in the elaboration of subsequent proposals for the sector, pushing towards their approval and implementation. In São Paulo, these actors obtained space in the Social Assistance Municipal Council. Despite a favorable scenario for users participation – 25% of the seats were reserved for them, with a few exceptions – they still had practically no effective participation.

It is out of this article's scope to exhaustively explain the absence of collectively organized actors in the social assistance sector. However, the way through which assistance services are provided sheds a light over the interrelation among users and the public power. Assistance services range from sheltering the homeless to social and educational activities, and these services are provided mostly by private institutions with public financing. Such a vast layer of organizations with diverse origins and guiding principles – constitutes a kind of blockage between users and the State , which becomes hidden from the final user, so to speak.

Income transfer is another way of providing social assistance services in São Paulo – however, it broadens the gap between service beneficiaries and the Government (all considered, the responsible for sectoral policies). The *Renda Mínima*, for example, has no direct interface between citizens and government. The relation is intermediated by a withdrawal card and, occasionally, by subcontracted teams responsible for

monitoring and enrolling beneficiaries. Selection of beneficiaries is made by a software, and they are informed by mail about the benefit. There are no participatory governance structures attached to the program (Houtzager, 2008).

The aforementioned kinds of assistance services provided also reflect the administrative structure of assistance system itself, which has only recently undergone decentralization. In 2007, 31 Social Assistance Supervisions had been implemented by the Social Assistance Municipal Secretary, each one corresponding to a Sub Municipal Administration level. The Sub Municipal Administration role consisted mainly in monitoring activities carried out by institutions, instead of dialoging with the population[9].

To sum up, the health sector in São Paulo has a 30-year history of engagement from popular levels in the form of a popular movement. Its participation was formalized, institutionalized and implemented along 1990 to 2000, despite setbacks caused by the election of two rightist governments in sequence. Structuring of administrative channels in health is decentralized, and councils installed in health care facilities work close to local users. On the other hand, the assistance sector in São Paulo saw no social assistance users collective organization and its administrative and participatory structures are much less developed and decentralized than those at the health sector.

4. Societal accountability

Accountability: concept and mechanisms

From the 1980s decade on, the concept of accountability became central for the debate surrounding representativity of democratic governments in sharply contrasting realities. The concept spread, in the 90s, with the introduction of democratic regimes and state reforms in several countries, particularly in Latin America (O'Donnell, 1991). Manin, Przeworski and Stokes (1999: 8) approach the discussion in its paradigmatic study as follows:

> "Governments are 'accountable' if citizens can discern representative from unrepresentative governments and can sanction them appropriately, retaining in office those incumbents who perform well and ousting from office those who do not. An 'accountability mechanism' is thus a map from the outcomes of actions (including messages that explain these actions) of

[9] In the SUAS scope, the implementation of an additional service level directed towards stakeholders was approved. Its name was CRAS (Social Assistance Reference Center), but it was very initial at the time of this research.

> public officials to sanctions by citizens. Elections are a 'contingent renewal' accountability mechanism, where the sanctions are to extend or not to extend the government's tenure" (Manin, Przeworski and Stokes, 1999: 10).

Peruzzotti and Smulovitz (2001) discuss the concept by considering the Latin-American reality, as follows:

> "the concept of accountability makes reference to the capability of assuring that public officials render accounts for their actions, which means they are obligated to justify and inform about their decisions and they can eventually be punished for them"[10] (Peruzzotti e Smulovitz, 2001: 25, free translation).

The citations above highlight three factors that determine the most common application of the term in international literature: information, justification and, especially, sanction, or punishment (Gurza Lavalle and Isunza Vera, forthcoming; Serafim, 2007; Peruzzotti and Smulovitz, 2001; Manin, Przeworski and Stokes, 1999).

In this debate, elections were considered the quintessential mechanism through which citizens are able to practice vertical accountability, according to the model proposed by O´Donnel (1991)[11]. Elections would represent a moment for citizens to indicate their preferences concerning what should be a representative government, when they would point out towards future actions while, at the same time, sanctioning governments for past actions. Elections would make it possible for citizens to periodically reward those governments which acted most in accordance with voters' interests, and replace those who did not.

Manin, Przeworski and Stokes (1999) notice that elections, as a central mechanism for vertical accountability and government responsibilization, are limited, since they are held on a single moment when punishment or reward are given on the basis of multiple government decisions taken during a long period of time. Besides, they reveal the difficulties in coordinating the orientation of voter's choices, which in turn makes it complex to understand whether results of an election bear a retrospective or prospective meaning. Last, they claim that lack of information is a hindrance to

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[10] On the same volume, Arato has a similar definition for accountability, based on Pitkin (1967). He states that it is "based in the capability of voters, individuals or groups, to make representatives render accounts (answer, be responsible, be punished or rewarded) for their actions" (Arato in Peruzzotti & Smulovitz (orgs.), 2001: 59). We also notice that in this extract, the idea of sanction is essential in defining accountability, and the legal dimension of civil engagement is central.

[11] O´Donnel, Guillermo, "Horizontal Accountability: the legal institutionalization of Mistrust" in Mainwaring, Scott & Welna, Christopher (eds.) *Democratic Accountability in Latin America*, Oxford, Oxford University Press, extracted from Peruzzotti and Smulovitz (2001: 28).

adequate evaluation of a government's performance by the average citizen.

Agreeing with the argument that such a mechanism is insufficient, and analyzing the Latin American experience, Peruzzotti and Smulovitz introduce in this debate other mechanisms for gathering data, rendering accounts, signaling citizen preferences and indirect sanction, which are more permanent and more restricted than the moment of elections[12]. The authors name such mechanisms as social accountability mechanisms. It also includes works of the investigative press, media scandals and mobilization and action of social movements and civil society associations, which monitor government actions as well as exposing and accusing irregularities and corruption by summoning horizontal control agencies.

Ackerman (2004) furthers the debate by establishing two different types of social accountability: direct summoning of horizontal accountability mechanisms by society ("accountability impelled by society") and direct supervision and pressure by actors of civil society ("direct vertical accountability ") (Ackerman, 2004 *apud* Gurza and Isunza, forthcoming).

Gurza and Isunza (forthcoming) point out towards an even broader notion of social control which encompasses several kinds of social and societal accountability within the scopes of information, justification and sanction. According to the authors,

> "the desired escope and effects of control or accountability vary considerably according to the role provided by institutional specifications of the mechanism: from opinion and consultation forms, transparency and right to public information, intercommunication or dialoging, to forms of collective definition of political will and mandate, or to outsorcing and transfer of public functions, or co-responsability and co-management, on the other side (Isunza 2006b; 2006c). This way, the repertory of social control forms comprises a wide range that includes punctual individual participation forms – sometimes fragmented as in the complaints systems - in one side, until, on the opposite pole, collective institutionalized participation, designed for binding decision making" (Gurza and Isunza, forthcoming: 19, free translation).

Apart from these central dimensions constituting the notion of accountability in the international debate, authors include the perspective of guaranteed rights in the analysis of societal accountability[13] and the actions and correlations which make up its

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[12] According to Peruzzotti and Smulovitz (op. cit., p. 29), O´Donnel also recognizes the appearance of vertical mechanisms indirectly related to elections, and he mentions the actions of the independent press and social demands, in spite of not debating it in depth. See O´Donnel, Guillermo, "Horizontal Accountability in New Democracies" in: Schedler, Andreas; Diamond, Larry and Plattner, Marc H. (eds.), *The self restraining Stat. Power and Accountability in New Democracies,* Boulder & London, Lynne Rienner Publishers, p. 30. Extracted from Peruzzotti and Smulovitz (2001).

[13] The authors consider that social control is "la incidencia de ciudadanos sobre procesos decisorios ya

practices and democratizing potential.

Our research stemmed from the wide array of possibilities and actions that constitute societal accountability, and its objective is understanding its practices on a local level in São Paulo, by considering two policies and their specific programs: health, with PSF, and social assistance, with *Renda Mínima*.

According to the structure of public policy systems consolidated in Brazil, the role of social accountability on local level (BHU, hospitals and coordinations, in the case of health) is to ensure that existing policies become effective, and also guarantee the quality of services provided. In this sense, the SUS system is more consolidated than the SUAS, as it has more well-established local councils which make up a landmark for the local population served day-to-day by BHU and hospitals.

Additionally, we recognize that these spaces strongly contribute to societal accountability concerning policies as a whole, including their formulation, implementation, monitoring and evaluation – all of these factors subsidize decision making in other levels. However, the primary objective of decentralized spaces is to ensure service quality, which means putting into practice those policies already defined in more centralized decision making levels. As a consequence, our analysis is focused on the practice of what we call societal accountability[14], inspired by Isunza e Lavalle (forthcoming). We refer to the specific dimension of social control which relates to the delivery of public services and its oversight by the local community – we also address the community's access to necessary means for obtaining information, performing oversight and sanctioning, from the standpoint of guaranteeing rights.

As we intend to show here, our research reveals that these spaces are not only a reference to locals in the practice of societal accountability over service delivery in the units, but they are also a means for debating and bringing forward other neighborhood issues that reach beyond health care.

Findings on societal accountability

From this theoretical framework, five different dimensions of societal accountability were considered: demands for public service improvements; requests for

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sea mediante el suministro de información, la determinación de prioridades, la implementación o como formas de evaluación y supervisión" (Gurza e Isunza, forthcoming: 15). Accountability would then be a subgroup of social control, "una modalidad específica de control social en la que existe responsabilización y sanción".

[14] Gurza and Isunza establish a difference between the societal dimension of the accountability – the practice of accountability is made by civil society organizations, from the social dimension, with reference to the exaction of accountability by individual citizens.

information regarding the management of public services; participation in suits filed in Court or administrative proceedings aimed at the improvement of public services; participation in event or gathering with the community, to collectively discuss public service issues, and, finally, participation in street demonstrations, petitions signing or any other type of community manifestation for improvement of the public services delivery.

In total, actors practiced societal accountability 232 times, both for health policies and social assistance, between 2005 and 2007. This result allows us to state that the local delivery of public services is accompanied by collective actors who perform some kind of societal accountability related to these policies, regardless of historical differences between the two sectors and actors' profiles.

Observing both sectors separately, we noticed that 74% of the societal accountability is being carried out over health policies, while this percentage is only 26% for the social assistance sector, as shown in the chart 1. The chart 2 shows societal accountability actions in health are not only more numerous, but also more intense: 72% of collective actors control health intensely (average and high scores), while in assistance only 23% are engaged in average and highly intense actions.

Chart 1: Two patterns of societal accountability on a local level: assistance x health

Societal accountability	Frequency	%
Health	171	74%
Social Assistance	61	26%
Total	**232**	**100%**

Chart 2: Intensity in local societal accountability: assistance x health

	Assistance		Healthcare	
Intensity in local societal accountability	**Total**	**%**	**Total**	**%**
Low	41	77%	15	28%
Average	11	**21%**	34	**64%**
High	1	**2%**	4	**8%**
Total	**53**	**100%**	**53**	**100%**

These two patterns of societal accountability become even clearer if we take into account the poverty reduction programs connected to both policies; in these cases, 94% of interviewees have some kind of societal accountability with PSF issues, and 34% with *Renda Mínima*. It is worth mentioning that there is more societal accontability over the PSF program than over the health policy in general (94% to 74%), which would indicate the importance of local level public facilities and the existence of a local council. This is particularly important when compared to the low engagement levels

concerning the *Renda Mínima*, which is not supported by local public facilities nor by spaces for societal accountability. The fact also points out the friendly structure of the PSF regarding societal accountability, in the sense that all interviewees wielded civic control over this program.

Chart 3: Local societal accountability: PSF x Renda Mínima

Societal accountability over sectoral poverty reduction programs (PSF or Renda Mínima)	PSF %	RM %
Yes	**94,3%**	**34%**
No	5,7%	66%
Total	**100%**	**100%**

Chart 4: Intensity of local societal accountability: policies x programs

Societal accountability on sectoral poverty reduction programs (PSF or Renda mínima)	Societal accountability on assistance					Societal accountability on health				
	Low	Average	High	Total	%	Low	Average	High	Total	%
None	32	2	**1**	35	66%	3	0	0	3	5,7%
Average	9	**5**	0	14	26,4%	12	18	0	30	56,6%
High	0	**4**	0	4	7,6%	0	16	4	20	37,7%
Total	**41**	**11**	**1**	**53**	**100%**	**15**	**34**	**4**	**53**	**100%**

Furthermore, the chart 3 data demonstrates that 34% of societal accountability was wielded over *Renda Mínima* – more than societal accountability over Social Assistance policy in general (26%). In the chart 4 we observe that those who wield a more intense civil control over Social Assistance do not control *Renda Mínima*. This indicates that local collective actors do not associate the income transfer program to policymaking and to the Social Assistance sector.

Some dimensions of societal accountability

The chart 5 presents the dimensions of societal accountability mentioned above, in general terms and for both sectors:

Chart 5: Some dimensions of societal accountability

Forms of societal accountability	Social Assistance		Healthcare		General	
	Total	%	Total	%	Total	%
Demands for public services improvements	23	9,9%	49	21,1%	72	**31%**
Participation in street demonstrations, petitions or any other kind of community manifestation to exert quality improvements in the delivery of public services	8	3,4%	39	**16,8%**	47	**20%**

Participation in community events or assemblies for collective discussion of issues related to public services	8	3,4%	39	**16,8%**	47	**20%**
Information requests related to the management of public services	14	6%	27	**11,6%**	41	**17,7%**
Participation in suits filed in Court or administrative procedures aimed at the improvement of public services	8	3,4%	17	7,3%	25	10,8%
Total	**61**	26,3%	**171**	73,7%	**232**	**100%**

Among the 232 times in which societal accountability was undertaken by the collective social actors interviewed, there is a quite equal distribution. Still demands that represent 31% of total engagement actions seem to be the favorite mechanism. in both sectors. Of societal accountability actions performed, 17,7% were information requests and 11,6% were related to health.

Concerning collective action mechanisms, the petitions, manifestations and demonstrations represented 20% of cases. In comparative terms, these actions were mainly directed towards health, having been undertaken in 16,8% of cases, while for assistance this figure drops to 3,4% - the numbers repeat when considering the organization of community meetings and assemblies. Put together, these more informal mechanisms represent 40% of societal accountability occurrences. The resource of filing suits, however, was used only 10,8% of times – 7,3% for health and 3,4% for assistance issues.

Such data reveals that, in order to wield control over health, actors resort to the mechanisms considered by this research in a very balanced way. In assistance, although most interviewees declared having performed some kind of demand for the improvement of this policy, a very reduced number of these actors filed suits in court, mobilized the local population around the demands or undertook some kind of manifestation or petition. That is, there were no concrete actions of societal accountability considering these dimensions, such as demonstrations and filing suits. Thus, by not making use of judicial mechanisms nor demonstrating a collective mobilization of the local community around improvements for the sector, the accountability wielded over the assistance policy seems to be made in a much more individualized fashion, instead of a collective one, and it also does not make use of public mechanisms.

Channels for societal accountability

The chart 6 contains, for each policy, the institutional channels interviewees most resorted to, for societal accountability.

Chart 6: Channels most resorted to for local societal accountability: assistance *x* health

Channels most resorted to for dealing with specific issues of each policy	Social Assistance		Health	
	Total	**%**	**Total**	**%**
Public facilities with council	*	*	42	**79,2%**
Intermediate administrative level	8	15,1%	37	**69,8%**
Council for intermediate level	*	*	35	**66%**
Municipal Council for the policy	6	11,3%	28	**52,8%**
Municipal Office for the policy	13	24,5%	33	**67,3%**
Other channels	14	26,4%	32	**60,4%**

* Nor public facilities with council nor council for intermediate level exist in the social assistance sector in São Paulo

First, is it clear that collective actors make frequent use of channels for institutional societal accountability related to health policy. Second, upon monitoring health policymaking, actors resort to all hierarchical levels of this policy: they look for participative channels while at the same time directly addressing units and management bodies. When actors engage in assistance accountability, they have fewer options of participative and administrative spaces, and deal with a much more centralized structure, particularly when considering participatory spaces. Furthermore, with less frequency actors make use of such channels for controlling assistance, as opposed to the use they make of these channels for control over health.

Chart 7: Societal accountability through system entries: assistance x health

Resort to the entries of respective systems (BHU or Social Assistance reference sectors) to place demands or request information about such policies	Societal accountability in assistance					Societal accountability in health				
	low	**Average**	**high**	**Total**	**%**	**low**	**average**	**high**	**Total**	**%**
Yes	3	5	0	8	**15,1%**	9	30	3	42	**79,3%**
No	10	5	1	16	30,2%	2	4	1	7	13,2%
answer not provided	28	1	0	29	54,7%	4	0	0	4	7,5%
Total	**41**	**11**	**1**	**53**	**100%**	**15**	**34**	**4**	**53**	**100%**

The chart 7 is in accordance to previous findings, by demonstrating that almost 80% of actors resort to BHU councils, entries of the system, in order to perform societal accountability. It is known, in social assistance, that entries to the system are reference centers, channels of intermediate level that serve 300 thousand potential users within the area of an Sub Municipal Administration. These channels are not only insufficiently

decentralized: they also have no councils. This results in only 15% of interviewees affirming they look for reference centers in order to carry out societal accountability. Furthermore, the data highlights the facts that reference centers are not relevantly recognized as channels for societal accountability, and they are not used by most of the actors who undertake some form of accountability over assistance.

The research reveals that, whether participation and administrative spaces are used insufficiently or not, they are not the only channel for societal accountability by the collective actors interviewed – this reinforces the concept of extended societal accountability defended by Isunza and Lavalle (forthcoming).

Chart 8: Societal accountability by other means: assistance x health

Other channels sought for dealing with specific issue of each policy	Assistance societal accountability					Healthcare societal accountability				
	low	average	high	Total	%	low	average	high	Total	%
Participation Spaces related to other policies	8	5	0	13	**24,5%**	8	31	6	45	**84,9%**
Civil servants, managers, other public facilities	6	1	0	7	13,2%	12	24	6	42	79,2%
Neighborhood associations	9	1	1	11	**20,7%**	8	19	4	31	**58,5%**
Inhabitants or stakeholders not collectively organized	6	3	1	10	**18,8%**	9	15	1	25	**47,2%**
Social movement specific to a policy	0	0	0	0	0%	3	19	0	22	**41,5%**
Service provider specific to a policy	6	4	2	12	22,6%	2	10	0	12	22,6%
Church	1	0	0	1	1,8%	2	7	1	10	**18,9%**
Collective actors (political parties, NGO and other social movements)	1	0	1	2	3,7%	2	3	2	7	**13,2%**
Others	5	5	0	10	18,5%	1	4	0	5	9,5%

Topping the list of other channels are the participatory spaces for other public policies, and engagement in both policies is relevant. This shows that collective actors, even though they do not make use of participatory spaces for social assistance, still consider the use of this kind of instance. The information seems to be in accordance with the fact that the municipal council of social assistance has little incidence on local levels of this policy and carries out insufficient societal accountability.

Our research analyzed the practice of societal accountability by municipal councils of both policies. It demonstrated the inaction of the Social Assistance

Municipal Council on a local level, particularly regarding services provided – which is one of its attributions. Despite not being locally present and having little effect in controlling service providers, this space is recognized by interviewees as relevant for societal accountability in the policy, which indicates a repressed demand for specific spaces for debating assistance policymaking on a local level. Differently from health, the assistance area does not have a structure of decentralized councils closer to the level of execution of said policy and to the provision of its services. This may be contributing to a shortage in the participation of collective actors in the accountability of services on a local level.

In the case of health, people significantly resort to collective actors in general (neighborhood associations, parties, social movements, unions) and the church, apart from the organized social movement exclusively dealing with this policy. Turning to other actors for assistance seems to be as relevant turning to institutions, which shows the importance of interrelation networks with other leaderships. Still considering networks, the interrelation between non-organized inhabitants or stakeholders appears relevant for societal accountability. It is noticeable that, in the case of assistance, neighborhood associations and non-organized inhabitants are much more resorted to than other collective organizations.

Social Networks

One of the guiding hypothesis of this research stated that collective actors with denser networks[15] would practice more societal accountability. Besides, it was expected that actors connected by local networks to networks of municipal scope would be more able to influence the policy in question. Past evidence demonstrates the confluence (seria isso a relaçao convergente? Deveria ser!) between greater societal accountability over health policies, the use of local, sub-municipal and municipal channels, and the relation with other collective actors. What follows is the presentation of some features in the social networks of these actors in support of previous findings.

[15] The network density is determined by the number of linkages between the interviewee and other people – in this case, other social leaderships and members of the political system. Therefore, denser networks are those with a larger number of linkages. .

Chart 9: Network density for other neighbourhood leaderships: assistance *x* health

Number of links with other leaderships to deal with neighborhood issues	Assistance societal accountability			Health societal accountability			General	
	Low	Average	High	Low	Average	High	Total	%
0	1	0	0	0	**1**	0	1	1,9%
1 or 2	9	0	0	2	**7**	0	9	17%
3 or 4	**13**	**5**	0	**6**	**11**	**1**	18	**34%**
5, 6 or 7	**18**	**6**	**1**	**7**	**15**	**3**	25	**47,2%**
Total	**41**	**11**	**1**	**15**	**34**	**4**	**53**	**100%**

The expressive presence of neighborhood association members among the interviewees demonstrates the importance of local networks in dealing with neighborhood issues, which cover issues such as urban infrastructure, sanitary system, land title regularization, housing, installing and regularizing additional public facilities, and public transport. Here we can see diverging patterns: a) there is a relevant group with dense neighborhood networks and which exerts plenty of accountability over health and assistance policies – this reinforces the importance of local networks; b) it shows that, because there are no specific actors engaging in assistance policymaking, neighborhood networks are central to the wielding of societal accountability over this policy; c) collective actors who most control health policymaking also act in other areas; d) there is a group of actors with dense neighborhood networks who have very little control over both policies, especially concerning assistance; e) one group exercises a certain control over health, despite of not having dense neighborhood networks, which demonstrates that control over this policy may not require relation at the neighborhood level, and that they might be groups of actors with expertise in the health sector.

Chart 10: Network densities with other specific leaders: assistance x health

Number of linkages with other leaderships to deal with policymaking of specific issues (health or assistance)	Assistance societal accountability					Health societal accountability				
	Low	Average	High	Total	%	Low	Average	High	Total	%
0 or 1	31	**7**	0	38	**71,7%**	2	3	0	5	9,4%
2, 3 or 4	7	3	0	10	18,8%	11	18	1	30	**56,6%**
5, 6 or 7	3	**1**	**1**	5	9,4%	2	**13**	**3**	18	**34%**
Total	**41**	**11**	**1**	**53**	**100%**	**15**	**34**	**4**	**53**	**100%**

Considering the linkages established by interviewees to treat each of the policies in question (chart 10), interesting data arose: a) almost 70% of actors have null networks (50%) or networks with only one linkage for dealing with assistance issues; b) in the case of health, there is a considerable share of very dense networks (34%); c)

most of the actors who wield more control in health policymaking present dense networks to deal with issues in this sector; d) the same is not true for assistance: 7 of those with some engagement in assistance have practically null networks.

Chart 11: Scope of networks with other specific leaderships: assistance *x* health and number of linkages with other leaderships to deal with specific issues

Number of linkages with other leaderships to deal with policymaking of specific policies (health or assistance)	Assistance societal accountability					Health societal accountability				
	Low	Average	High	Total	%	Low	Average	High	Total	%
links restricted to region/neighborhood	11	**6**	**1**	18	34%	11	**15**	**1**	27	50,9%
municipal links	6	3	0	9	17%	2	**13**	**1**	16	30,2%
links in the region and in other regions of the city	0	0	0	0	0%	2	**5**	**2**	9	17%
no links	24	2	0	26	49,1%	0	1	0	1	1,9%
Total	**41**	**11**	**1**	**53**	**100%**	**15**	**34**	**4**	**53**	**100%**

Considering the scope of links (chart 11), it is noticeable that: a) the majority of actors who wield a greater accountability over assistance issues present only local links, demonstrating that, in restricted networks, establishing connections on a municipal level is not essential for the practice of societal accountability, or that there are municipal social networks with enough relevance so as to intensify societal accountability b) in health, once more we can observe that the actors who perform more societal accountability are those connected from local to municipal levels, and the interrelations they establish with leaderships from other neighborhoods and regions is quite expressive.

The use of a wide variety of channels from health policies located in different levels is somehow related to actors' organizational features, in part revealed by the density of their social networks in all levels. Such features are present both in networks and in the action of resorting to institutions, and they may be related to the way that the popular health movement is organized (by BHU, neighborhood, region, municipality).

Chart 12: Density of specific networks with politicians: assistance *x* health

Number of links with the political system for specific issues of the health or assistance policies	Societal accountability over assistance					Health societal accountability				
	Low	Average	High	Total	%	Low	Average	High	Total	%
0 or 1	**40**	**6**	0	46	**86,8%**	**13**	**22**	**2**	37	**69,8%**

2 or 3	1	**4**	0	5	9,4%	2	**8**	1	11	20,8%
4 or 5	0	1	1	2	3,8%	0	**4**	1	5	9,4%
Total	**41**	**11**	**1**	**53**	**100%**	**15**	**34**	**4**	**53**	**100%**

Despite being visibly less dense than network links with leaderships, connections with politicians to deal with specific policy issues appear relevant, in their own way. In contrast, it is clear that almost all actors who wield little accountability over assistance do not have networks with politicians. On the other hand, half of those who exert some accountability over the same policy have networks albeit small, with politicians. The same holds true for health: most of those who exert little accountability have virtually null networks with politicians, whilst at the same time part of those who exert more accountability over health have considerable networks with politicians. On the other hand, there are a considerable number of actors who strongly engage in policymaking on both areas and who do not possess expressive networks with politicians.

Furthermore, as already mentioned, societal accountability happens not only through administrative or participatory spaces by sector, but through the interrelation with other actors and channels, as we pointed out in the chart 8. The chart 12 allows us to state that societal accountability is distant from legislative power and from the connection to politicians – this contrast with the quite common idea about clientelism on local networks.

Finally, the main finding of these networks is that some actors have their own decentralized framework of channels, being able to act in specialized ways in health policymaking – thus, they lack connection with other actors who deal with the issues in the neighborhood. Concerning assistance, because there are no specialized actors specifically mobilized for a given policy, they depend exclusively on networks created around neighborhood issues.

Actors profile

The profile of actors presents some data supporting the previous debate. This profile was put together considering the three groups of data with the most evident results: type of organization, to which the collective actor belongs; main areas of action of this organization; educational level.

The research revealed that neighborhood associations are the most recurrent collective actors who undertake societal accountability of public service facilities. In

assistance, as seen before when commenting networks, societal accountability depends in great measure of the actions of those actors involved with several neighborhood issues. Health sector, on the other hand, has a historical actor mobilized around itself which is the popular health movement. Neighborhood associations do not declare themselves as belonging to this movement, and yet are part of it, since they exert societal accountability over health policy on local level (a fact detected from network data demonstrating the existence of links from local levels to municipal levels), and also considering the areas they cover in order to wield control.

Chart 13: Types of entity

Types of entity	Assistance societal accountability			Healthcare societal accountability			Total	%
	Low	Average	High	Low	Average	High		
Neighborhood Association/ Association of Friends of the Neighborhood	**24**	9	0	11	**21**	1	33	**62,3%**
Local/Regional Health Movement	**3**	**2**	0	0	**3**	**2**	5	9,4%
Social Assistance Entity	**2**	0	0	**1**	**1**	0	2	3,8%
Other (parties, churches, unions)	6	0	1	0	6	1	7	13,2%
answer not provided	6	0	0	3	3	0	6	11,3%
Total	**41**	**11**	**1**	**15**	**34**	**4**	**53**	**100**

This finding demonstrates that the interrelation between popular health movement and neighborhood associations is strengthened when we consider areas of action that collective actors declared as the most important among the three most relevant. Health is indicated by 80% of interviewees as one of the three main areas of action of their entities, if we add those who classified the PSF as the main area and those said general health issues are the most important, as systematized on chart 15.

Chart 14: Entities scope of action

Three main working issues of entities or movements	Societal accountability over assistance			Health societal accountability			Total	%
	Low	Average	High	Low	Average	High		
Urban infrastructure (housing, sanitary system, transport)	**22**	8	0	**12**	**18**	0	30	**56,6%**
Health PSF improvements (new units, structure, doctors)	**21**	6	0	2	**23**	2	27	**50,9%**
Contracted services (daycare, social and educational center, sports and leisure)	**13**	5	1	6	**11**	2	19	35,8%
Health (societal accountability over this policy in general)	**10**	5	0	4	**10**	1	15	**28,3%**
Food distribution (basic staples, Viva Leite)	**13**	1	0	5	**7**	2	14	26,4%
Demands for new and/or improved	**6**	3	0	3	**5**	1	9	17,0%

public facilities								
Others	20	**5**	2	**7**	16	4	27	50,9%

Urban infrastructure is the most mentioned area by interviewees. This indicates once more that local actors are concerned with the whole of public services provided to the community, as shown in the network analysis. It is interesting to observe that among the areas of action declared by entities, social assistance was not mentioned as such. Nevertheless, they mentioned many activities belonging to the scope of social assistance, such as contracted services and food distribution – this leads to the conclusion that some of these interviewees act within the extent of this policy, even if they do not classify their activities in this fashion. It is worth highlighting, though, that such actors are inserted, due to their kind of action, in the assistance policy as service providers in the assistance policy, which may be one of the causes for lack of control over local social assistance. Conversely, it highlights once more the detachment between the idea of social assistance and the practice of this policy, in combination with the detachment between social assistance and cash transfer programs.

Last, those actors who claim they demand improvements or new public facilities have little engagement in social assistance, but perform considerable control over health – showing that health, and not assistance, is probably more recognized by them as a public policy.

Many features of interviewees were tested, and, among them, the educational level presented the most expressive results regarding societal accountability.

Chart 15: Educational level of interviewees

Educational Level	Assistance societal accountability			Health societal accountability			Total	%
	Low	Average	High	Low	Average	High		
Incomplete primary school	16	1	0	4	**12**	**1**	17	32,1%
Complete primary school	5	1	0	4	2	0	6	11,3%
Incomplete secondary school	2	0	0	1	1	0	2	3,8%
Complete secondary school	15	**6**	0	4	16	1	21	39,6%
Incomplete higher education	3	**1**	0	1	3	0	4	7,5%
Complete higher education	0	**1**	**1**	1	0	1	2	3,8%
graduate studies	0	**1**	0	0	0	1	1	1,9%
Total	**41**	**11**	**1**	**15**	**34**	**4**	**53**	**100%**

The data above indicates that in health there are low educational level actors responsible for considerable societal accountability. The same does not hold true for social assistance. In this policy, more societal accountability is undertaken by those who

completed at least the secondary level. This might be an indicator that: a) there is a diversity of channels and spaces, and, consequently, of institutional formats accessed by actors when they perform societal accountability over the health policy, which allows for more access of people with varied educational levels, thus with more possibilities of including those with lower educational levels; b) due to the fact that it is more vertical and distant from the average local user, access to societal accountability in social assistance would a require a higher level of education. Therefore, educational issues reinforce the importance of decentralizing policies and participation spaces on a local level, not only because they are territorially closer to stakeholders, but because they are less exclusive in socioeconomic terms.

6. Preliminary conclusions

The research with local level actors addressing societal accountability exercised over health social assistance policies and over PSF and *Renda Mínima* showed essentially the following findings:

a) There is significant societal accountability being exercised over public services in the local level.

b) This control is exercised more frequently and intensively on health policy;

c) Almost all collective actors interviewed had exercised some control over PSF;

d) For societal accountability on health, local actors access various institutionalized channels (participatory and administrative) specific to this policy, at all hierarchical levels. Access to these channels is quite frequent. They also often involve dense local networks to deal with health and neighborhood issues and resort to other collective actors, particularly social movements, church and political parties, being connected from the local to the city level through these relationships. Finally, they use other forms of collective action such as protests, petitions and the organization of the local community to achieve such control. In other words, when they control health policy, the local collective actors mobilize different strategies that go from protests and mobilization of local networks to the access to the administrative and participatory levels. The gateway to the system – the BHU, had been sought by 80% of interviewees. Moreover, this policy has demonstrated the possibility that actors with low education may exercise societal accountability, which shows that the PSF and the decentralized system of participatory spaces and administrative levels form an inclusive structure of social control.

e) In relation to the actors who control health policy, even with a historical actor mobilized around the sector – the popular health movement - we have noted the importance of neighbor associations and actors articulated around the issue of urban infrastructure. By the network structures and the channels that they access, we can say that these actors are connected to health movement.

f) The social assistance policymaking is very centralized and collective actors do not frequently use their participatory and administrative spaces. Nevertheless, these actors do not discard the participation in other policy sectors to achieve control over social assistance. There are no actors organized specifically around the area, as there is in health. Therefore, the policy of assistance depends on the neighborhood issues networks exercise some societal accountability. The networks to deal with the issues of assistance are less dense and the actors who exercise more control over the policy do not use them. And since they do not frequently use the assistance policy formal channels to handle sectoral issues as well as they do not organize collective actions for control over the policy, it is possible to infer that if some accountability over assistance policy occurred, it depended very much on personal relations and other mechanisms that we will need to investigate further. Moreover, actors need to have an education above the average population to make the accountability over social assistance, indicating that the direct users of the sector are excluded from access to the few and centralized instances and mechanisms available to this control.

g) We also observed that there is a difficulty among the actors to identify what specifically social assistance policy is. Some evidences for that: the actors that most exercise accountability over assistance do not do it over *Renda Mínima*, which means the income transfer programs are not recognized by the actors as part of the policy. Likewise, the actors do not relate the provision of services by private organizations and the distribution of food as activities related to this policy. Finally, they do not search for the entry door to the system – the reference centers – either because they don't know about the existence of these public agencies or because they have no access to them for they are far from the local level, where users are.

h) Another important finding is that for both policies, relations with politicians seem to be less important than relations with other leaders to improve local services. This demonstrates that the clientelism thesis as a bound for State access must be discussed.

i) In short, the main finding of the network analysis is that, because they have their own decentralized and capillary channels, some of the actors that exercise specialized accountability over health policy lack close relations with other actors working for neighborhood issues. In the assistance sector, because there are not specialized and mobilized actors to exercise accountability over the policy, they depend exclusively on the networks that arise around neighborhood issues.

Last, there is promising data still to be explored: differences in the pattern of societal accountability exercised in different regions of the City.

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