



Community of Practitioners
on Accountability and Social Action in Health

Politicising Accountability Practice in Reproductive Health

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Improving governance (Lopez-Mikkelsen et al., 2011; Pyone, 2017), in the field of sexual and reproductive health, is increasingly perceived as the pathway to realize realizing accountability between health care providers and health system on the one hand, and communities, on the other. It encompasses a whole gamut of interventions or strategies that seek to “improve institutional performance by bolstering both citizen engagement and the public responsiveness of states and corporations.” (Fox, 2015) Social accountability initiatives are also expected to bolster health providers’ responsiveness to societal pressure (Lodenstein et al., 2015). There are different accountability paradigms, two of which are referred to in relation to SRHR: performance (‘internal’) accountability and social (‘external’) accountability. (Van Belle et al., 2016; forthcoming Van Belle et al., 2018, Kwamie, 2016)

While there has been recognition that social accountability is critical to improving health outcomes, the predominant approach has been to view this as an effectiveness mechanism, producing a beneficial health effect. We argue here that this purported causal chain should be questioned and one needs to take a “deep dive” into the actual accountability practices, and the causal configuration between social mechanisms (collective action, health system values, social status in the community and trust, social capital, professional power) emerging in a given political context and democratic space (Bearman P. & Hedström, P. (eds.) 2011,; Sorensen & Torfing (2006)).

This inherently political process redistributing power, is too often downplayed, to a simple, linear intervention to be implemented through the application of instruments such as balanced scorecards, provider-patient dialogue or health facility committees, leading to improved health outcomes (by way of increased responsiveness). (Joshi and Houtzager, 2012) In the domain of reproductive health, it is assumed that social accountability intervention design will deliver on entitlements prescribed by policy, rather than citizen’s right to self-determination, i.e. reproductive choice (the latter, an all but forgotten concept). (Freedman & Isaacs, 1993)

This managerial conceptualization of accountability, grounded in principal-agent theory, presented first on the global stage by the World Bank in its World Development Report (2004), gained a lot of traction in global health, effectively displacing the notion of accountability as a political process. Such a conceptualization of social accountability ignores the historical

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trajectory of community participation and the discourse around rights and autonomy that it promoted. While the terminology of “social accountability” may be rather recent, (originating with Samuel Paul who is acknowledged as an expert in WDR 2004, see also Paul, S., 1992, vol.20, issue 7: 1047-1060 Accountability in public services: exit, voice and control in World Development and referred to in WDR 2004 bibliography: Paul, Samuel. 2002. *Holding the State to Account: Citizen Monitoring in Action*. Bangalore: Books for Change), the philosophy of collective action and citizen engagement in health is firmly rooted in Alma Ata and deserves renewed attention with its 40 year anniversary this year: “Primary Health Care (...) requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate” and further referred to in articles 4, 6 and 7). Community participation was one of the founding principles of Primary Health Care with the idea that people are more likely to respond positively to health services if they have a say in how services are delivered. (Rosato, M. et al. 2008) In a review of community participation as conceptualized by Alma Ata and as implemented in practice, Rifkin (2009) re-emphasizes the political nature of community participation, asserting that is “not possible to consider participation outside a political context. Effective participation encounters issues of power and control over decisions, particularly those related to resource utilization.”

Within the domain of sexual and reproductive health as well, citizen action and social movements at the country level as well as globally, have paid an important role in highlighting neglected concerns of women and questioning global paradigms such as population control. Ironically however, despite the important role of the global women’s and human rights movements in the participatory processes leading up to landmark conferences such as the ICPD, Cairo and Beijing, (Eager, 2004), reproductive health programming over the past 25 years has been remarkably top-down, performance-driven by global goals and targets, rather than community needs and concerns. (Sundby, 2014) (Beryl Radin, 2004) In the case of maternal health, the push to institutionalize deliveries and to scale up has resulted in subjecting women to poor quality services, undignified treatment, with women even being/ending up penalized in some cases if they fail to use skilled delivery/deliver at home. (Rosen et al. 2015) (Shakibazadeh et al. 2017) (Greeson et al. 2017) (Meiberg et al. 2016) In case of family planning, since the establishment of the FP 2020 initiative by donors like BMGF and DFID, globally, many more countries have up-scaled their family planning programmes. This would be a very positive development, if some key quality and ethical issues were also addressed. Recent publications have demonstrated that, in many resource-constrained settings in LMIC, there is still a consistent disregard for quality of care (lack of referral, delays, lack of trained HR, failure to implement protocols, lack of respect...) leading to high intra-institutional MMR (Lancet issue). (see references used above: Rosen et al. 2015; Meiberg et al, 2016, Greeson et al 2017) In

relation to family planning, Monitoring to guarantee informed choice appears to be insufficient (no quality counseling and no comprehensive range of contraceptive methods on offer). (UPR submissions from India). These issues are of course not new. Population control programmes in countries such as India and Peru led in the past to coercive practices, in part spurred by the paradigm of population control, an overt focus on numbers and a top down push (US as the largest donor until mid 1980s). (Eager, P.W. (2004) *Global Population Policy. From Population Control; to Reproductive Rights*. London: Ashgate)

The issue of informed (or reproductive choice: choose a term) and quality of care were in fact key to the discussions of ICPD (International Conference on Population and Development 1994) and in Beijing FWCW (the inclusion of reproductive rights in art 95). (ICPD Plan of Action, FWCW) Population control programmes in India and Peru and cases of coercion appeared to be a thing of the past. (Eager, 2004) However, in the last ten years, stories of forced sterilization have re-emerged as an issue in Eastern Europe (with Roma communities) as well as in African countries regarding PLHIVs, or people with disabilities in Australia. (Albert & Szilvasi, 2017) (Elliott, 2017) (Rowlands & Amy 2018) A campaign against coercive sterilization was conducted leading to the joint UN Agencies (2014) and FIGO (2011) to adopt guidelines and statements around forced/ involuntary sterilization and the need for quality assurance. (Inter-Agency Statement UN, 2014; FIGO, 2011) With the renewed emphasis and donor interest regarding the need for (long term) family planning methods the issues of quality of care and of informed choice have become important once again. (Family Planning 2020; Shoupe, 2016; Blumenthal et al. 2011)

However, social accountability practice as it is implemented today by global health actors in LMIC within the domain of reproductive health restricts itself to the implementation of multi-component programmes or accountability interventions in one domain of reproductive health at the level of communities. Political processes surrounding these and local political representatives are excluded from the debate. What it fundamentally, seeks to achieve in the present paradigm is good implementation of external donor-funded programs or scaling up of these global health interventions. (Yamey 2011) This ignores the fact that very often, as history tells us, these programmes are not suitable for large swathes of populations, who have little say in how they should be tailored to their needs. (Eager, 2004) (Connelly, 2008) In the domain of reproductive health especially, this takes on great significance because women, by virtue of being disempowered have been typically seen as passive recipients of medicalized reproductive health interventions (sometimes against their will), and their capacity to negotiate with services is also poor by virtue of this. (Behague et al, 2008) (Miranda, 2017) (Connelly, 2008) (Eager, 2004) The situation is further complicated by the fact that people most affected by reproductive health services tend to be marginalized “non-citizens” whose power of negotiation and brokerage with the system is negligible. (Ivanova et al. 2015)

The second important gap in the understanding and practice of social accountability in the reproductive health field, is the lack of appreciation of the complexity of health systems, communities and contexts. (Plsek, 2001; Kannampalil, 2011) A recent systematic review of accountability interventions in sexual and reproductive health and rights (found that while there is growing literature around social accountability in the field, pointing to a complex “accountability ecosystem”, there are some critical gaps, including the poorly described role of context in determining outcomes. The review calls for re-looking at one-size-fits all formulations of social accountability, and appreciating the complexity of both systems, as well as communities across contexts. (Van Belle et al. 2017, forthcoming) The strength of social accountability is dependent on grassroots collective action and the democratic space allowed by the political system. (Van Belle, 2014) In addition, already existing accountability relations outside the health system, grounded in community trust and social exchange or reciprocity within the community, will interact with formal accountability relationships inside the health system. (Van Belle & Mayhew, 2016; Van Belle & Mayhew, 2017; Lodenstein 2018) Therefore, interventions which might ‘work’ as they are embedded in decades long grassroots activism / social movements in certain states in India or political activism in South Africa, but might not work in other Indian states or in central African countries. (Patrick Heller, 2009, on democratization trajectories “Democratic Deepening in India and South Africa” in *Jn African and Asian studies*)

Moreover, there are also other reasons to be cautious about the external validity of social accountability interventions or to remain humble about its results / effects, rather). In their efforts to work at a more actionable, local level (and not the national level) these interventions might put the onus too much on providers, potentially giving rise to a blame game with providers at the centre. (Lodenstein et al., 2016) (Baker & Chassin 2017) Providers, themselves, are also ‘victims’ of structural weaknesses of the health system. (Ndwiga et al. 2017) For example, attempts to address provider-patient dialogue or training of provider to increase patient responsiveness (or respectful treatment) need to take into account that providers in rural areas some LMIC do not share the same cultural background as the communities they work in. (Coast et al. 2016)

Indeed, Rifkin’s review of community participation finds that “It was not realistic to define or pursue a standard model for creating community participation in health programmes. History and culture were strong defining elements of the value, structure and sustainability of any community health programme, with or without community participation.”(reference Rifkin) Similarly, Halloran proposes a similar “ecosystem” to accountability approach that goes beyond considering only community and citizens, but also leverages the potential of other important actors who can bolster accountability – including social movements, oversight bodies, multiple levels of government and so on, using a combination of levers, and thus effectively creating a

system of checks and balances. (Halloran, 2016) *“Civil society efforts must address ‘accountability politics’ and build ‘countervailing power’ if they are to be successful over the long term. When organizations or coalitions work across the scales of government (local, provincial, national, international), build partnerships with key actors and institutions (legislative oversight bodies, anti-corruption commissions, grassroots organizations and movements, etc.), and leverage multiple tactics and tools (legal, media, FOI, collective action, etc.), they can better influence the power relations that make real accountability possible.”* (Halloran, 2016)

The third critical area that needs attention is the dearth of scholarship around existing accountability approaches. As mentioned above, the history of accountability claims pre-dates the World Bank’s PAT model. (WDR 2004) At the national level, there is a rich history of organizing around issues such as abortion rights, against population control, violence against women and so on. (In the Indian context for instance, the feminist movement and health rights movements have actively campaigned to stop the practice of sterilizing women in unsanitary camps) These efforts are poorly documented and valuable lessons from these tend to be lost. Research on social accountability tends to concentrate on donor-funded programmes, not historical shifts/sea-changes. According to Joshi & Houtzager, ‘[B]y treating social accountability initiatives like widgets to improve services, we ignore the broader socio-political context within which these widgets work or do not work – the history of the long-term processes of political bargaining, public–social movement alliances, previous experiences of citizen engagement and the networks within which collective actors (the agents for social accountability) are embedded’ (Joshi and Houtzager, 2012: 154; see also Hickey, 2009). Freedman emphasizes on the need to look inwards towards its citizens rather than copy each other’s policies and approaches. Lynn Freedman suggests it is important to do more grounded research and for increased learning . (Freedman, 2016)

We also need a better appreciation in the global health community (of the structural features underlying intersecting layers of social injustice (intersectionality) impacting on accountability towards marginalized groups. Reproductive health interventions who are not grounded in local knowledge on how these (intersecting) social mechanisms ‘work’ to perpetuate social injustice, might risk inadvertently amplifying them. In conclusion, giving voice to and keeping the needs of the most marginalized should be at the heart of social accountability practice, and should “confront power relations, improve the representation of marginalised groups and transform them in legitimising ways”. (George 2003) Moreover, accountability practices could generate transformative social norms by educating communities as health rights-holders (Malena et al. 2004) (Yamin 2008) Policy makers on the other hand, should foresee how health rights can effectively be enforced and implemented. (Yamin, 2015) This is particularly beneficial in the case of reproductive health, where health outcomes are dependent not just on health system

strengthening, but also on transformation of gender norms related to health-seeking. It is only then that *social* accountability can reach beyond mere 'compassion'. (Yamin, 2008)

However, if social accountability interventions want to trigger long term effects, it is critical that they are re-politicised, give primacy to community autonomy and be cognizant of complexities. There is a rich history of women's organizing around reproductive rights which warrants the attention of researchers and practitioners. (Eager, 2004) Social movements across the world have much to teach us about how change can be achieved.

