**Appreciating Complexity in SRHR Accountability: Insights from the COPASAH Global Symposium 2019**

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**Abstract:**

Social Accountability is fast being recognized as an important strategy for realisation of sexual and reproductive health rights. However, the predominant approach tends to focus on use of top down monitoring and accountability tools that do not appreciate the complexity of politics surrounding this deeply contested terrain. This paper draws on discussions that took place at the COPASAH Global Symposium in October 2019 where grassroots practitioners shared their practices of seeking accountability and reflected on the myriad challenges in this process. The paper calls for greater nuance and awareness of context in the design and implementation of social accountability interventions, which engage with power and politics between actors that determine people’s access to SRH rights.

***Introduction***

Sexual and reproductive health rights (SRHR) are indivisible aspects of human rights, and an essential component of public health services. Some areas of SRHR have been included in the past as part of the Millennium Development Goals (MDGs) and continue within the existing framework of SDGs, whereas others remain largely unaddressed. The focus of policies and programmes has largely been on maternal health and family planning, while important concerns around access to contraception, safe abortion, sexuality education, and sexual health needs of diverse populations have been neglected. More attention is needed towards women’s autonomy and participation, their access to quality, and affordable healthcare for a larger range of SRH services. While the idea of accountability has gained momentum through international mechanisms the main understanding of accountability among large agenda-setting organizations in this field is “upwards accountability” to donors rather than service providers’ public accountability to women. The predominant approach of the monitoring and accountability mechanisms associated with global initiatives like the MDGs, SDGs and FP2020, has been to monitor quantitative targets at higher levels, sometimes leading to concerns around coercion, choice and acceptability. Also, the top-down process of determining and monitoring these targets has side-stepped the participation of women and communities. However, at the same time there has been a robust practice developing around the world on citizen led participatory accountability processes on different areas of social and economic rights and public services. These include services related to sexual and reproductive health rights.

**The Theme of Sexual and Reproductive Rights at the COPASAH Global Symposium**

This paper draws on discussions that took place within the sexual and reproductive health rights theme at the Global Symposium on Citizenship, Governance and Accountability in Health which was organised by Community of Practitioners on Accountability and Social Action in Health [(COPASAH)](https://www.copasah.net/). COPASAH is a southern-led, global community of grassroots practitioners of social accountability and community action in the field of Health. It is a leading voice in discussions on community-centred and citizen-led processes in the field of health. This Symposium brought together field practitioners engaged in long term community-led accountability practice, as well as researchers, policy-makers, donors and other stakeholders to address challenging questions of practice and discussing strategies to realise sexual and reproductive health and rights, in a forum that centres the concerns of practitioners based especially in the Global South. In all, 26 practitioners from 12 countries were represented in the symposium working on diverse thematic areas such as maternal health, access to contraception, access to treatment for HIV/AIDS, menstrual health and hygiene, queer rights and so on. The symposium provided an opportunity to frontline community action and accountability practitioners, to learn from each other’s efforts to build bottom up accountability initiatives and share experiences and concerns around operationalizing accountability in the field of SRH rights. Sharing of practice, identifying emerging models of engagement with state and non-state actors, their strengths and weaknesses, led to discussions about the unique challenges that working on sexual and reproductive health and rights poses in the field of social accountability.

**Emerging Conversations**

Primarily, four arcs of conversation emerged which exemplified and interrogated current practice in the field of accountability and SRH rights.

1. ***Appreciating complexity and dynamism in contexts and its implications for SRHR accountability***: Sexual and reproductive health rights are deeply contested all over the world, but the nature of violations, and forces that control them vary dramatically from context to context and over time. This was amply demonstrated in the challenges that participants posed to realising SRH rights in their particular contexts. In China, for instance, public policy on contraception has moved from enforcing the “one-child norm” to now allowing a larger family, but it still continues to control women’s fertility in different ways. The experience from Uganda suggests that the struggle for access to contraception faces challenges and taboos from socially conservative communities and policy makers alike. Similarly in India, while access to contraception is a challenge for young unmarried persons especially adolescents, contraception is often thrust upon women with two or more than two children through coercive means. In Romania, forced and coerced sterilization of Roma women is widely prevalent. At the heart of these realities, however, is the fundamental aspect of control of women’s bodies and fertility, and using this lens can help to analyse the appropriateness of strategies. This implies that social accountability practice must have different goals in different locations and at different times. In Romania for instance, resisting forced and coerced sterilisation through legal means and policy negotiation are an important part of accountability strategies. In India, influencing policy and health care providers to make contraceptives available to young people, while at the same time monitoring the existing family planning programme in how it implements the concept of “informed choice” are both components of the accountability strategy. Further, accountability practice in a deeply contested field like sexual and reproductive health rights must engage with various levels of the state (from policy and politics, to health facilities at the frontline of health service provision). Mainstream social accountability work in the field of maternal and reproductive health tends to involve bounded interventions focussed on promoting accountability for widely shared priorities that are enshrined within a predetermined accountability framework. The fall out is that emerging violations tend to be neglected – such as issues arising out of the tension between population control and access to contraception, abortion rights, menstrual hygiene management, the right to express one’s gender and sexual identity and so on. Moreover, it is often blind to the complex nature of the “state” and the varying nature of policy contexts. In China for instance, the organization Feminist Voices has been addressing SRH rights largely through public education campaigns, since the state is more or less closed to negotiation. AS the practitioner from China framed it, “pro-choice and pro-life are western notions of individual choice; in China however everyone is expected to be pro-nation and what this means in terms of action varies depending on government policy”. In such a situation, accountability actions have to be directed in different spaces and have different goals. Given the dynamic and contextual nature of SRH rights, therefore, it is imperative that practitioners continuously interrogate how shifts in policies and programmes interact with local realities and landscapes.
2. ***Global actors and their impact on SRHR accountability – Negotiating the power of global health initiatives and global accountability mechanisms -*** Maternal Health and subsequently Family Planning have emerged as important agendas of global health programming over the past two decades. Multiple systems for monitoring progress were established following the MDGs and through the SDGs new targets have been introduced which are similarly being monitored at the national and global level. The UN Universal Periodic Review and the UN treaty regimes offer opportunities for NGOs to offer alternative “shadow” reports on government progress towards realizing sexual and reproductive health and rights. Many international agencies, bilateral donors and private philanthropies are providing funds and other support to governments to achieve the set targets. Practitioners at the symposium discussed their experiences in attempting to link local community realities with these global accountability mechanisms and the strategies that they have adopt. The discussion highlighted inherent challenges in engaging with these mechanisms, such as the disjunct with grassroots realities, the receptivity of governments to recommendations from these forums and the overall effectiveness of global mechanisms. On the one hand, the recognition of sexual and reproductive rights at a global level has brought much needed attention to important issues like maternal health rights, but at the same time, it has also led to top-down target setting and policy making which has been unsuited to varied contexts especially in the global south. The focus on institutionalizing childbirth for instance, has resulted in a whole range of violations that women are subjected to in labour rooms, ranging from physical and verbal violence, to subjecting them to unnecessary procedures without their consent, to denying benefits to women who do not deliver at health facilities and so on. Organizations like Human Rights in Childbirth are using legal instruments in international courts such as the European Court of Human rights to challenge these practices. Other civil society regional networks such as ARROW, and disability rights groups such as the Women With Disabilities Network India have used UN covenants such as CEDAW, CRPD (Convention for Rights of People with Disabilities) to highlight specific SRH concerns of diverse women. Practitioners highlighted the importance of linking these global mechanisms to local realities through involvement of grassroots activists rather than international organizations. What is also unmistakable is the narrowing of global agendas which, in the decade of the 1990s were more broad-based, framing SRH within the larger framework of women’s rights rather than vertical interests in maternal health and family planning. The SDGs have attempted to move away from this narrow definition. Efforts such as the Gender Equity Index developed by Equal Measures 2020 seeks to use the SDG platform to raise critical concerns about SRH rights among other gender related issues, but the process of monitoring lacks buy in from governments and is entirely voluntary unlike processes such as the Univeral Periodic Review.
3. ***Addressing new accountability challenges arising out of the growth of the private sector***: Shifts in the political economy of health, including downsizing of investing in and provisioning of public health services and the resultant move towards privatisation, has given rise to new challenges to accountability. In the field of sexual and reproductive health, the growing influence of the private sector in the provision of health services and the production of health commodities is leading to new forms of violations ranging from unindicated medical procedures (such as unwarranted hysterectomies), overtreatment (such as overuse of C-sections), quality of care to larger questions of a growing industry of interventions to women’s bodies. The rights-based network Karnataka Janaarogya Chaluvali has been actively calling to account the private sector for large scale hysterectomies that have been conducted on indigenous women in the state of Karnataka in India. The strategies have been multi-layered, including building credible evidence on the nature of violations, building a community campaign to mobilize women to demand accountability for the violations, using media and putting pressure on the government to take actions against erring establishments. The challenge however has been in enforcing accountability in a context of gross lack of regulation of the private health sector across India and a concerted opposition to such regulation by medical associations. The other aspect of corporate growth that deserves attention within accountability discourse is that of regulating reproductive health “products”. While the advancement of technology provides greater opportunities for women to make choices on the one hand, there is a growing fear of over medicalisation and dumping of reproductive products onto women especially from the global south. This is especially true in the area of contraceptives where the focus of health programs in many countries and also that of global health initiatives is to increase uptake of contraceptives without due consideration to side effects and health consequences for women who use these contraceptives. Further, introduction of “self-care” in reproductive health packages raises new challenges about accountability especially in situations where a weak health system is unable to monitor for side effects and adverse outcomes.
4. ***Addressing social heirarchies through SRHR accountability work***: The struggle for realizing sexual and reproductive rights is deeply influenced by gender related social norms and various axes of inequities and injustice prevalent in societies. The symposium participants interrogated how these inequities influence sexual and reproductive health rights, and what elements must form a part of accountability practice, both at the interface of communities with health systems, but also within health systems and communities themselves. At the heart of the accountability deficit is the power differential and systemic bias that allows health systems to provide inadequate, poor quality or negligent care to those from less privileged backgrounds, and perpetrate violations with impunity. Women especially those from social excluded and marginalized communities face the brunt of this and social accountability interventions must work to transform this skewed relationship. Experiences of participants repeatedly stressed on the importance of embedding social accountability practice within larger rights based struggles of social movements. The Jagrutha Mahila Sangathan, a grassroots Dalit women’s movement from India located its work on demanding accountability for respectful and good quality maternal health services, within a long-standing struggle against caste-based violence against women spanning over two decades. The women involved in the movement came together owing to a common experience of violence as Dalit women from upper castes in rural north Karnataka, and over two decades of consciousness raising, have attempted to address state apathy to their needs. Within this struggle, the movement for respectful maternal care has specifically demanded that health care providers treat Dalit women with dignity and be responsive to their needs. Another practice that used scorecards to assess the friendliness of health services to young people and adolescents from deprived backgrounds, was rooted in a three decade long intervention that sought to mobilize urban poor women to demand various social and economic rights. There is a need to nurture such sustained struggles such as these to truly transform relationships between the “powerful” and “powerless”, as opposed to induced, bounded interventions that are typical of mainstream social accountability practice.

**Implications for Practice**

Social accountability practice as it is implemented today within the domain of reproductive health restricts itself to the extent to which promises made in policies (global, national, state) are being met at the level of communities. What it fundamentally, seeks to achieve in the present paradigm is good implementation of programs, policies and guarantees of services from the State. This ignores the fact that very often, the policies as designed, are not suitable for large swathes of populations, who have little say in how they should be tailored to their needs. 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 medical reproductive health interventions (sometimes against their will), and their capacity to negotiate with services is also poor by virtue of this. 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. (Schaaf and Dasgupta 2019) In her Lancet article, Freedman critiques the current approach and emphasizes on the need to look inwards towards its citizens rather than copy each other’s policies and approaches. In terms of solutions Lynn Freedman suggests it is important to do more grounded research and for increased South to South learning and calls for robust social accountability measures to be put in place (Freedman 2016). The second important gap in the understanding and practice of social accountability in the reproductive health field, is the lack of appreciation of complexity of health systems, communities and contexts. A recent systematic review of accountability interventions in reproductive health found that found that while there is growing literature around social accountability in the field which points to a complex “accountability ecosystem”, the exist 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. (Boydell et al, 2019) 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.” Unfortunately however, the tendency to implement piecemeal tools through bounded interventions ignores this complexity.

**Conclusions**

In conclusion, a rights-based approach to social accountability seeks to mediate the relationship between users and the system, recognizing that there is an imbalance of power between the two. Giving voice to and keeping the needs of the most marginalized is at the heart of social accountability practice, which can be particularly useful for negotiating sexual and reproductive health rights, provided the social accountability interventions “confront power relations, improve the representation of marginalised groups and transform them in legitimising ways” through information, dialogue and negotiation. (George 2003) Moreover, social accountability can generate new norms around health-seeking behaviours by educating communities about their health rights and mobilising them to take action (Malena et al. 2004). 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. However, if social accountability practice is to evolve into a more substantive intervention, it is critical that it be 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 social movements have much to teach us about how change can be achieved.

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