REPRODUCTIVE HEALTH matters

FEATURE

Act global, but think local: accountability at the frontlines

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Abstract: *There is a worrying divergence between the way that sexual and reproductive health and rights problems and solutions are framed in advocacy at the global level and the complex reality that people experience in health services on the ground. An analysis of approaches to accountability used in advocacy at these different levels highlights the different assumptions at play as to how change happens. This paper makes the case for a reinvigorated approach to accountability that begins with the dynamics of power at the frontlines, where people encounter health providers and institutions. Conventional approaches to accountability avoid grappling with these dynamics, and as a result, many accountability efforts do not lead to transformative change. Implementation science and systems science are promising sources for fresh approaches, beginning with the understanding of health systems as complex adaptive systems embedded in the broader political dynamics of their societies. By drawing insights from disciplines such as political economy, ethnography, and organizational change management – and applying them creatively to the experience of people in health systems – the workings of power can begin to be uncovered and tackled, sharpening accountability towards those whose health and rights are at stake and generating meaningful change.*

The still tentative opening of global policy spaces to civil society has offered opportunities to test the potential of advocacy in these arenas to contribute to change on the ground. From the high point of the ICPD paradigm shift in 1994, through the low point of exclusion of sexual and reproductive health and rights (SRHR) from the original Millennium Development Goals (MDGs) in 2001, to the revival of some aspects of SRH with the Family Planning 2020 initiative in 2012, we are now on the brink of a new era of global activity as the post-2015 Sustainable Development Goals are formulated and launched. Even as new technology makes new kinds of participation possible, the proliferation of global-level forums, institutions and initiatives means that advocates need to be increasingly expert to navigate these spaces effectively – and dedicate massive time and energy to do so.

This raises challenging questions about how, and even whether, a social movement should mobilize to influence global processes.* Questions include how to structure participation, compete for and direct funding, engage media, prioritize goals, enter negotiations, and strike alliances. Perhaps most importantly, advocates face internal contestation over the narrative that shapes the demand for change and the strategies that follow from it.

As health and human rights activists working from a university setting in New York City, we have been privileged to have easy access to the global arena while devoting most of our own effort to initiatives focused on strengthening health services on the ground, particularly in countries where maternal mortality is high. From this dual perspective, we see a worrying divergence between the way problems and solutions are framed at the global level and the reality on the ground. Of course, each advocacy setting must be addressed strategically in the terms that will work there. But a coherent strategy across settings requires a shared understanding of how change happens. The power and glamor that courses though global meetings can be seductive: too often it lures advocates into believing that change at the top, at the pinnacle of intergovernmental and state-civil society relations

*Indeed, the very question of whether a loosely organized initiative, dominated by professional advocacy experts, can even be considered a global social movement has implications for the principles that guide it.

where global goals are forged, will foster change at the grassroots, where people actually experience the hand of the state in their daily lives through the operation of the health system and other institutions.

In this paper, we argue for an elemental shift in our understanding of where and how real change in sexual and reproductive health and rights happens, and in the techniques we use to study it, advocate for it, and create it. We use the idea of accountability as an organizing principle that can be a leading wedge for a broader transformation of public health and human rights practice. Accountability is not the whole answer. But it can spark a set of other processes and transformations that are necessary for the coming phase of global development.

We limit our analysis to that slice of sexual and reproductive health and rights concerned with health services. Although sexual and reproductive health and rights certainly covers a far broader set of conditions that influence women's lives, it is not the case that health services present only a narrow set of essentially technical issues. Indeed, one fundamental premise of our argument is that health services, while they always have a technical dimension, are also always deeply political. They function as core social institutions: people's interactions with the hierarchies of power that shape such institutions often create or reinforce the very exclusion and disempowerment that are at the heart of sexual and reproductive health and rights violations. Conversely, as a reflection of state presence – and, increasingly, of the state's alliance with private sector actors as well – the health system can be a venue in which entitlements are articulated, asserted and vindicated.

Accountability is certainly not a new idea in global development practice. But the way it has typically been conceived and operationalized globally is profoundly disconnected from the reality of women's interactions with the forces that shape their lives on the ground. We make the case for a reinvigorated approach to accountability that begins with the dynamics of power on the frontline of the health system, deeply embedded in the broader social and political dynamics of local life. We argue that this reality needs to infuse and define the ways that global development strategies proceed, forcing a re-think on the engine of change in sexual and reproductive health and rights. In short, in taking a stance on the future Sustainable Development Goals and the direction of ICPD beyond 2014, sexual and reproductive health and rights activists still need to act globally, but their actions on the global stage need to be differently informed by local realities.

Defining accountability

How accountability is defined shapes the way it is operationalized, and ultimately, the change it fosters. We define accountability as "constraints on the exercise of power by external means or internal norms".[1] This definition is more expansive than some of the more prevalent approaches that refer to mechanisms of accountability, e.g. to systems of answerability, enforcement and sanctions between two parties.[2]

Defining accountability as we propose advances concepts that are indispensable to thinking about change in sexual and reproductive health and rights. First, it puts power center stage, which makes the difference between superficial demonstrations of accountability and potentially transformative ones.

Second, it applies to anyone wielding power, not just to those in government. Some non-governmental actors, such as private foundations and religious institutions, play determinative roles in shaping the sexual and reproductive health and rights landscape within the halls of the UN and at country level. For some reproductive health services, such as abortion, there may be no public sector choice to start with. For other services, the sorry state of the public sector often drives women into the unregulated, sometimes dangerous private sector. Finally, the increasing focus within global health on public–private partnerships, and in particular, the reliance on franchises to deliver reproductive health care, makes the inclusion of non-state actors in an accountability framework for sexual and reproductive health and rights crucial.[3]

Third, the definition of accountability we use acknowledges the salience of norms that are internal to individuals and to institutions – whether they are supported by policy or not – as a way that power is expressed and maintained. For example, abusive behavior by health providers may persist not because of a lack of laws or professional standards that prescribe otherwise, but because such behavior is normalized in the system, becoming routine, accepted and expected, and even naturalized.[4] Understanding and acknowledging the influence of such norms is thus central to