Accountability to citizens on gender and health

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Background paper prepared for the Women and Gender Equity Knowledge Network of the WHO Commission on Social Determinants of Health
Background to the Women and Gender Equity Knowledge Network

The Women and Gender Equity Knowledge Network (WGEKN) of the WHO Commission on Social Determinants of Health was set up to draw together the evidence base on health disparities and inequity due to gender, on the specific problems women face in meeting the highest attainable standards of health, and on the policies and actions that can address them.

The work of the WGEKN was led by two organizational hubs – the Indian Institute of Management Bangalore (IIMB) and the Karolinska Institute (KI) in Sweden. The 18 Members and 29 Corresponding Members of the WGEKN represent policy, civil society and academic expertise from a variety of disciplines, such as medicine, biology, sociology, epidemiology, anthropology, economics and political science, which enabled the work to draw on knowledge bases from a variety of research traditions and to identify intersectoral action for health based on experiences from different fields.

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- Gender and Health Equity Network (members from India, China, Mozambique, Sweden, UK and USA),
- Campaign Against Sex Selection, Sahayog and Center for Health Education Training and Nutrition Awareness from India, and
- Health Watch, Naripokko, and Bangladesh Women’s Health Coalition from Bangladesh.

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The author is grateful to all the above people. However, they bear no responsibility for any limitations of the paper.

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Chennai, June 2007
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<th>Description</th>
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<tr>
<td>ARROW</td>
<td>Asia Pacific Research and Resource Center on Women</td>
</tr>
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<td>BWHC</td>
<td>Bangladesh Women’s Health Coalition</td>
</tr>
<tr>
<td>CASSA</td>
<td>Campaign Against Sex Selection</td>
</tr>
<tr>
<td>CBMES</td>
<td>Community based monitoring and evaluation</td>
</tr>
<tr>
<td>CHETNA</td>
<td>Center for Health Education Training and Nutrition Awareness</td>
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<tr>
<td>CLADEM</td>
<td>Latin American and Caribbean Committee for the Defense of Women’s Rights</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All forms of Discrimination Against Women</td>
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<td>CMS</td>
<td>Cooperative Medical Scheme</td>
</tr>
<tr>
<td>COSATU</td>
<td>Congress of South Africa Trade Unions</td>
</tr>
<tr>
<td>CRLP</td>
<td>Center for Reproductive Rights Law and Policy</td>
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<td>DAWN</td>
<td>Development Alternatives for Women’s Network</td>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
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<tr>
<td>ECOSOC</td>
<td>Economic and Social Council</td>
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<tr>
<td>EmOC</td>
<td>Emergency Obstetric care</td>
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<tr>
<td>ESP</td>
<td>Essential Service Package</td>
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<tr>
<td>FGM</td>
<td>female genital mutilation</td>
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<tr>
<td>HIPC</td>
<td>Heavily Indebted Poor Countries</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>HPSS/HPSP</td>
<td>Health and Population Sector Strategy/Programme</td>
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<tr>
<td>LGAMS</td>
<td>Local-Government Assistance and Monitoring Service</td>
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<td>MIGEPROFE</td>
<td>Ministry of Gender and Women and Development</td>
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<td>MMR</td>
<td>Maternal Mortality Rate</td>
</tr>
<tr>
<td>MOHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<tr>
<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
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<tr>
<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
</tr>
<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education and Communication</td>
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<tr>
<td>LGU</td>
<td>Local government unit</td>
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<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>PAF</td>
<td>Poverty Action Fund</td>
</tr>
<tr>
<td>PCPNDT</td>
<td>Pre-Conception and Pre-natal Diagnostic Techniques</td>
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<tr>
<td>PIL</td>
<td>Public Interest Litigation</td>
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<tr>
<td>PPPs</td>
<td>Public-private partnerships</td>
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<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
</tr>
<tr>
<td>RAINBO</td>
<td>Research Action and Information Network for the Bodily Integrity of Women</td>
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<tr>
<td>RTI</td>
<td>Reproductive tract infection</td>
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<tr>
<td>SRHR</td>
<td>Sexual and reproductive health and rights</td>
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<tr>
<td>STD</td>
<td>Sexually transmitted disease</td>
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<tr>
<td>SWAP</td>
<td>Sector wide approaches</td>
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<td>UDN</td>
<td>Uganda Debt Network</td>
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<td>UHAC</td>
<td>Upazilla Health Advisory Committee</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<td>UNESCAP</td>
<td>United Nations Economic and Social Commission for Asia and Pacific</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td>WHRAP</td>
<td>Women’s Health Rights Advocacy Partnership</td>
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POLITICAL BRIEFING

Five key problems related to accountability to citizens on gender and health:

1. Rarely have power holders in the health sector been held to account to reduce gender inequalities in health, or comprehensively address gender-specific health needs of women and men (in short accountability to gender and health).
2. There are few mechanisms for citizens to hold private health sector, public-private health partnerships (PPPs), multilateral financial institutions, and health donors to account.
3. Rarely have power holders in the health sector been accountable to marginalised women or men. Accountability has been stronger to elite sections, medical lobby, and mainstream NGOs.
4. International treaties relevant to health accountability have not been ratified by all countries. Only few countries have passed accountability legislations like rights of citizens to participate, access information, and litigate on others behalf. Right to health and gender equality is, again, guaranteed only in few countries.
5. The pre-conditions- vibrant democracy, political will, and resources - for making accountability mechanisms (to citizens) work for reducing gender inequalities in health are not present in several countries.

Five key recommendations:

1. Strengthen accountability to gender and health through the following measures:
   - Visibilising gender and health issues in the eyes of all stakeholders,
   - Engendering health accountability structures, tools and processes,
   - Weaving in health into gender accountability mechanisms,
   - Supporting use of CEDAW by civil society organisations to hold governments accountable to gender and health
   - Establishing a gender and health accountability desk within WHO and Ministries of Health of national governments.
2. Strengthen accountability of new health actors through the following measures:
   - UN monitoring of adherence of PPPs, multilateral financial institutions, and health donors to international agreements,
   - Strengthening representation and participation of rights based citizens’ groups in the boards of the above actors,
   - Extending public sector accountability legislation to the above actors.
3. Strengthen accountability of power holders to marginalised groups through enhancing the latter’s access to information, accountability spaces, and negotiation skills, and improving capacity of power holders to be accountable.
4. Pressurise all countries that have not signed and ratified relevant health and gender related international treaties to do so, as well as pass accountability legislations and right to health/gender equality legislation.
5. Strengthen democracy, political will and resources through implementing Recommendation 4, supporting growth of civil society organisations, and pressing donors/government to allocate resources to engender accountability mechanisms and outcomes.
EXECUTIVE SUMMARY

Context:
Gender inequalities in health access and health outcomes persist in-spite of several international declarations and agreements seeking to bridge the same. These inequalities mainly discriminate against women and girls, but at times also disadvantage men and boys. In this context, furthering accountability of the health sector to gender and health is important. Accountability to citizens on gender and health is defined as the processes by which power holders in the health sectors engage with and answer to citizens, and enforce actions in such a manner to reduce gender inequalities in health and address gender-specific health concerns and rights of women and men.

Objectives:
This paper reviews the practice of accountability to citizens on gender and health, draws out lessons, assesses gaps, and recommends strategies. Through a review of literature, the paper examines who within the health sector is held accountable, to whom (amongst citizens), with regard to what, and how accountability is operationalised.

Practice of accountability to citizens on gender and health
Review of literature, suggests that five strategies that are listed below, have been used by citizens to promote accountability of health policy makers, managers, and providers to gender and health:

1. Use of international human rights instruments, agreements reached in gender/health specific conventions, MDGs, and other targets,
2. Use of new aid infrastructure (PRSPs and SWAPs) for furthering accountability to citizens on gender and health,
3. Use of progressive legislation on rights of citizens to accountability,
4. Use, as well as advocating, of gender sensitive health legislation, policies, programmes, and budgets for furthering accountability
5. Use of community level health structures, funds, and audit tools to demand accountability with regard to health services.

Lessons on Accountability to Citizens on Gender and Health
Flowing from the practices on accountability to citizens on gender and health are the following lessons:

1. Accountability to citizens on gender and health is closely linked to accountability to development, to health, and to women’s rights.
2. In the context of globalisation on the one hand, and decentralisation on the other, citizens need to press for accountability on gender and health at multiple levels.
3. Citizens need to hold a variety of institutions accountable to gender and health, viz. inter-state organisations, state, health markets, communities, and households.
4. Citizens need to combine the five accountability strategies listed above, and different accountability mechanisms within each (ranging from shadow reports, citizens public hearing, patient rights charters, ombudsmen centers, hospital boards, community based budget and service monitoring, provider report cards etc)
5 ‘Gender aware’ health accountability strategies/mechanism and ‘health aware’
gender accountability strategies/mechanisms are essential for accountability to
gender and health.
6 Citizens need to address accountability (on gender and health) in its different
facets, namely as engagement, answerability, and enforcement. Mere engagement
is not enough.
7 Accountability to marginalised citizens entails addressing power relations
between power holders in the health sector and citizens, and staff at different
levels of the health sector, and between elite citizens and marginalised ones.
8 Vibrant democracies, political will, and resources are required to make
accountability to citizens on gender and health a reality.

Gaps on accountability to citizens on gender and health:
An analysis of practice of accountability suggests the following gaps:
1 Private health sector, PPPs, donors, multilateral financing institutions,
religious/community leaders and male household heads are least likely to be held
to account by citizens on gender and health.
2 Accountability (to citizens) processes have rarely involved marginalised groups
directly. More often it is the middle class leaders of citizens groups (at national
level) or elite leaders (at local level) who have taken part in accountability
processes initiated by the government.
3 Accountability processes tend to address less controversial gender and health
issues than the controversial ones (e.g. abortion services, mental depressions) or
those incurring high cost (e.g. infertility services, breast cancer). Rarely are men’s
gender-specific health concerns addressed (e.g. alcohol use disorders).
Accountability processes have rarely reduced gender inequalities in health access
and outcomes.
4 Several countries have not put in place legislation on citizens’ right to
accountability, health or gender equality, and some have not ratified international
human rights instruments and passed gender and health legislation in keeping
with international agreements (e.g. liberal abortion laws, laws against domestic
violence) This makes it difficult for citizens of all countries to use the five
accountability strategies.
5 Two important preconditions for ‘replicating’ good practices in accountability are
absent in over 50% of countries, notably a vibrant democracy and availability of
adequate resources. Lack of adequate political will to gender and health, and to
make accountability to citizens work is another issue.

Recommendations:
1 Strengthen accountability of new health actors through the following measures:
   • Promoting UN, government and civil society monitoring of adherence of
     PPPs, multilateral financial institutions, and health donors to international
     agreements,
   • Strengthening representation and participation of rights based citizens
     groups in the boards of these actors, and
   • Extending public sector accountability legislation to the above actors.
2 Strengthen accountability of power holders to marginalised groups through the following measures:
   - Enhancing the access of marginalised groups to information, accountability spaces, mass based organisations, and negotiation skills,
   - Improving capacity of power holders to be accountable to marginalised groups, and
   - Strengthening sanctions if power holders do not adhere to accountability (to citizens) procedures.

3 Strengthen accountability to citizens on gender and health through the following three measures:
   - Visibilising gender inequalities in health and gender specific health needs of women and men (in particular those considered low priority and controversial)
   - Engendering health accountability mechanisms, and
   - Weaving in health into gender accountability mechanisms.
   - Supporting civil society organisations to use CEDAW to press for government accountability to gender equity in health and gender specific health needs of women and men.

4 Pressurise the countries that have not signed and ratified relevant health and gender related international treaties to do so, and those who not passed right to accountability, health and gender equality legislation to do so.

5 Strengthen democracy, political will and resources through implementing Recommendation 4, supporting growth of civil society organisations, and pressing donors/government to allocate resources to engender accountability mechanisms and outcomes.

6 Establish gender and health accountability desks within appropriate departments of WHO and its regional offices, as well as within Ministry of Health within national governments vested with the responsibility of operationalising the above recommendations.
1.0 INTRODUCTION

It is nearly three decades since the Alma Ata declaration of ‘Health for All’ in 1978, the framing of the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in the same year, and over a decade since the 1994 International Conference on Population and Development (ICPD) which aimed at furthering reproductive rights and health for all. However, gender inequalities in health access and outcomes continue throughout the developing world (Sen and Ostlin, 2006). Gender inequalities in health mainly discriminate against women and girls, but at times they also disadvantage men and boys (Macklin 2006). Persistence of gender-biases within the health sector, in terms of health policies, budgets, programmes, human resources, and service delivery is one amongst the important reasons for the persistence of gender inequalities in health. In this context, it is essential to strengthen accountability of health policy makers, managers, providers, multilateral financial institutions, and donors to reduce gender inequalities in health, as well as address gender-specific health needs and rights of women and men (in short, referred to as accountability to gender and health in this paper).

The main aims of this paper are to review the practice of accountability to citizens on gender and health, assess gaps therein, learn lessons, and suggest strategies for strengthening accountability processes. Specific objectives of this paper are to:

- Review concepts of accountability, gender and health, and explore what accountability to citizens on gender and health could mean,
- Review experiences (both successful and unsuccessful) from the developing world in promoting accountability to citizens on gender and health
- Draw out lessons on factors that are crucial to the success of initiatives to promote accountability to citizens on gender and health,
- Identify gaps in strengthening accountability to citizens on gender and health, and
- Recommend strategies that could be adopted by international agencies, national governments and civil society actors for strengthening accountability to citizens on gender and health.

Sections 2 to 6 address each of the above objectives. At the outset it must be stressed that there is far more literature on strengthening internal health accountability (in particular through quality control) than on external accountability or accountability to citizens. Moreover, there is little literature on the impact of accountability to citizens on bridging gender inequalities in outcomes, or addressing issues beyond maternal health, contraception and prevention/management of sexually transmitted infections. The bulk of the available literature documenting experiences on the ground is on strengthening accountability of the public health sector to citizens, with relatively less on strengthening accountability of private health sector. Nevertheless, this review can provide rich insights despite such limitations.
2. CONCEPTS OF ACCOUNTABILITY

2.1 Accountability:
Two current definitions of accountability shape the concept of accountability adopted by this paper. Goetz (2006) defines accountability as whether and how power holders answer for their actions, and are sanctioned for their abuse. She considers there are two aspects of accountability: *answerability* and *enforcement*. Caseley (2003) argues that the concept of accountability is broader than, though linked to, these two aspects.

In the context of public sector service delivery, Caseley sees *engagement* and *responsiveness* as two key elements of accountability. Engagement refers to a reciprocal relationship between two actors whereby demands are articulated by one actor in a transparent manner to the other. Responsiveness refers to the extent to which the party on which demands are placed, acts on its. Responsiveness, in turn, is seen as comprising of one or more of the following three elements:

- Answerability (passing information and justifying decisions on the basis of demands placed)
- Enforcement (ensuring compliance with decisions)
- Organisation change (changing the way the services are delivered).

This paper combines elements of both definitions, as summarised in Box 1

<table>
<thead>
<tr>
<th>Box 1: What is accountability?</th>
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<tr>
<td>Accountability refers to whether, and how, power holders at different levels engage with those who make demands on it, answer to them on decisions and actions, and are sanctioned for violations of rules to implement decisions. Accountability encompasses three elements: engagement, answerability and enforcement.</td>
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<tr>
<td>Source: Adapted Caseley, 2003 and Goetz, 2006</td>
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2.2 Health accountability:

Health accountability experiences can be explored from the different angles listed below.

- Who is accountable?
- To whom?
- With regard to what?
- When?
- How is accountability operationalised?


Review of literature on health accountability points to two different perspectives on the above questions. The World Development Report 2004 (see Box 2) essentially sees
health workers and providers as the people who should be held accountable, and not health managers and policy makers. Donor agencies and multilateral financial involved in health are outside the scope of strategies advocated for accountability. Accountability is to clients, higher ups, and community groups. The term ‘citizen’ is not used in the report. Accountability is mainly with regard to service delivery, and not with regard to health policy, legislation and national budgets. Accountability is to be operationalised through co-production and monitoring of services by clients, result-oriented payment of providers, strengthening voices of poor, and introduction of user fees (Murthy et al. 2005).

Box 2: World Development Report and Health Accountability

The 2004 World Development Report argues that health accountability strategies need to be tailor-made to the kind of health service, as discussed below.

- Accountability of transaction-intensive and individual-oriented clinical services (e.g. EmOC) can be ensured through financial contributions and third-party payments, co-production of services by clients, and monitoring of workers and services by organised clients
- Accountability of population-intensive health programmes (e.g. immunization) can be ensured through strengthening poor people’s voices so that the required resources are allocated through result-oriented contracts with public/private providers
- Accountability of family-oriented services that support self-care (e.g. safe sex education) can be strengthened through involving civil society and community groups in provisioning and monitoring.


A more dynamic and citizens focused view on accountability places emphasis on accountability of the health sector to citizens, and not just higher-ups (adapted from Gaventa 2006). In this model of accountability, health policy makers, managers, donors and multilateral financial institutions should be held accountable in addition to health providers and workers. Accountability is of both the public and private health sector, and of public-private health partnerships. Accountability is with regard to service provision as well as health policies, legislation, budgets and expenditures. Accountability is to be promoted through the watchdog role of citizens, co-governance of health services at local level, and policy advocacy at national and international levels (see Hulme and Sandaratne, 1997, Murthy et al, 2005). The ultimate objective is to promote citizens’ right to health as mandated in the General Comments, 2000, to the UN ICESCR (Box 3)
2.3. Accountability to citizens on gender and health

Accountability to citizens on gender and health refers to accountability processes (to citizens) that reduce gender inequalities in health and address gender-specific health concerns and rights of women and men.

As observed by Sen and Östlin (2006), gender differences lead to different exposure of men and women to health risks (together with sexual differences), different vulnerability of men and women to diseases and disability (together with sexual differences), different access of men and women to health services, different abilities of men and women to adhere to advised treatment, and different consequences to men and women of ill health. Women in developing countries are more disadvantaged than men with regard to the last three, while men and women face different kinds of exposure and vulnerabilities, leading at times to different sex/gender-specific health needs. For example, incidence of mental depression and breast cancer is higher amongst women than men, while incidence of substance use disorder and injuries due to traffic accidents is higher amongst men than women (WHO, 2004). Thus an important concern of the paper is to examine whether accountability practices (to citizens) reviewed in this paper have reduced unequal health access, adherence to treatment, and consequences to women, and addressed sex/gender specific health concerns.
Some of the gender specific health needs of women and men are controversial or/and low priority, while others are non-controversial or/and high priority (adapting from Jaqueline Pitanguay). What is controversial and low priority varies from context to context. Provision of safe abortion services for women where they are illegal (e.g. Philippines) may be controversial, while they may not be controversial in contexts where they are legal. There may be nothing controversial about treatment for higher incidence of depression amongst women or alcohol use disorder amongst men, but they may be of low priority given national goals and resources available (Murthy et al 2005). An important focus of this paper is to examine whether accountability practices (to citizens) have strengthened addressing controversial and low priority gender specific health needs of women and men, in addition to the non controversial and high priority ones.

3. ACCOUNTABILITY IN PRACTICE TO CITIZENS ON GENDER AND HEALTH

This section takes a closer look at the practice of accountability to citizens on gender and health. The available literature points to five broad strategies that have been used by citizens for demanding accountability to gender and health:

1. Using and protecting international human rights instruments, agreements reached in gender/health specific conventions, MDGs and other targets
2. Using spaces for citizens’ participation in new aid infrastructure (PRSPs and SWAPs)
3. Using progressive legislation on rights of citizens to accountability (in all public services)
4. Using, protecting, and demanding gender sensitive health legislation, policies, programmes, and budgets for furthering accountability
5. Using community level health structures, funds, and audit tools to demand accountability with regard to health services.

This section outlines some experiences of using these five broad strategies from the developing world. When case studies fall into more than one strategy, they have been allocated to one according to the main emphasis. The evidence largely takes the form of case study mapping, as summarised in Table 1. Both successful and unsuccessful experiences have been chosen, with the objective of drawing lessons (in the next section)

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### Table 1: Mapping of case studies on accountability to citizens on gender and health

<table>
<thead>
<tr>
<th>Accountability (to citizens) strategies</th>
<th>Mapping of case studies on accountability to citizens on gender and health: Of Whom? With regard to what? How?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bilateral donors, World Bank Regional banks, UN</strong></td>
<td><strong>Private health providers, public-private partnerships</strong></td>
</tr>
<tr>
<td><strong>Using, protecting and expanding international human rights instruments, agreements, goals and targets</strong></td>
<td>DAWN protecting ICPD</td>
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<td></td>
<td>Policy dialogue on MDG, WHRAP</td>
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<tr>
<td><strong>Using new aid infrastructure and approaches</strong></td>
<td>Engendering HPSP Bangladesh</td>
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<td></td>
<td>Engendering PRSP, Rwanda</td>
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<td><strong>Using national legislation on accountability to citizens</strong></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Using, demanding, and protecting national and provincial health legislation, policies, structures and accountability tools</strong></td>
<td>Monitoring private scanning and health clinics, CASSA, India</td>
</tr>
</tbody>
</table>
| Using and creating community health structures and community accountability tools | Provider report cards, Uganda | Facility report cards, Uganda | CMS, China
Provider report cards, Uganda
Monitoring ANM schedule, India
Engendering UHAC, Naripokko |
3.1. Human rights instruments, international agreements and accountability to gender and health

Several civil society organisations have used international human rights instruments and agreements reached in international conferences for demanding accountability of nation states to gender and health. Women specific human rights convention like the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW), as well as general human rights conventions like the International Covenant on Economic, Social and Cultural Rights (ICESCR) and International Covenant on Civil and Political Rights (ICCPR) have been used for pressing for accountability. Though not legally binding as these Conventions, civil society organisations have also used Programme of Action, Cairo and Beijing Platform For Action for pressing for accountability of the state to gender and health.

These efforts of civil society actors are worth recording, and drawing lessons from. This is done next through examining four case studies:

a) Poland: The first case study is about how the jury of the Citizens Tribunal, Poland used human rights instruments to point out that the 1993 anti-abortion legislation of the Polish government was violating the articles of these Conventions/Covenants (which the government had signed), and hence should be revoked.

b) Egypt: The second case study is from Egypt. It reveals that, although the Programme of Action, Cairo is not legally binding, it can be used by civil society actors to press for answerability of the governments, in this case to ensure that the progressive legislation against female genital mutilation is not repealed.

c) Peru: The third case study describes how civil society organisations in Peru helped two women whose sexual and reproductive rights were violated by two service providers to hold the latter to account.

d) Asia-Pacific: The fourth case study describes how civil society actors, with the support of official delegates from progressive governments, successfully protected the Cairo ICPD agreements amidst US government opposition in the post-Cairo 5th Asia Pacific Conference on Population and Development held in 2002.

Two of the four case studies record successful experiences of citizens’ groups holding governments to account (Egypt and US government), one records a partially successful experience (Peru government), and the fourth case study (Poland) records an unsuccessful experience.

3.1. (a) Poland: Using human rights instruments for demanding repeal of national anti-abortion legislation

From 1956 to 1993 abortion was widely available in Poland on therapeutic and socio-economic grounds. In 1993, the Act on Family Planning, Human Embryo Protection and Conditions for Legal Pregnancy Termination was adopted by the Polish Parliament
following a systematic anti-abortion campaign by the Roman Catholic Church supported by conservative political parties, and a part of the medical profession. The 1993 Act permits abortion only when the pregnancy poses threat to the life of the women, when abnormalities with the fetus are detected, or when the pregnancy is an outcome of a criminal act. The 1993 Act was briefly liberalised in 1996 by the left wing Parliament elected into power, but abortion was once again restricted when the Polish Constitutional Court declared the liberalised Act unconstitutional. The limited conditions under which abortion was allowed led to abortions becoming underground and expensive, and women going abroad to access it.

As the elections were due in September, 2001, the Federation of Women in Family Planning, a national NGO, decided to organise a citizen’s Tribunal against the anti-abortion legislation in July, 2001. The jury comprised of members of progressive national and international human/women’s rights activists, lawyers, media personnel, physicians and academic institutions. Cases of women who were legally eligible for abortion and women who were not; women who had managed to access abortion and women who had not were selected for hearing. Two women came in person, while others were represented by a third party, either because they were no longer alive, or because of fear of reprisal. The press gave the citizen’s Tribunal huge coverage. The jury held that the Polish Anti Abortion legislation violated constitutional mandate on right to health (Article 68 of the Constitution). The jury also argued that banning a service that affected mainly women was a direct discrimination against them (and hence against the principle of non-discrimination in CEDAW). While the 1993 Anti Abortion Law is yet to be repealed, the representatives from other Eastern European countries who attended the Tribunal have ensured that such laws are not passed in their countries (Girard and Nowikca 2002).

3.1.(b) Egypt: using Cairo, ICPD follow up structures and processes as a tool for protecting pro-women legislation

While in Poland the struggle continues, in Egypt citizens’ groups managed to combat a move to reverse a progressive legislation- this time on female genital mutilation- using international agreements. Although a Ministry of Health decree in 1959 prohibited health professionals and public hospitals from performing the procedure of female genital mutilation (FGM) in Egypt, and national law makes it a crime to permanently mutilate anyone, the practice was common in the 1990s in Egypt, as in several African countries, countries in the Arabian Peninsula (Nelson, accessed 2006).

During the Cairo ICPD conference (1994), the Population and Family Welfare Minister vowed that Egypt was going to work towards the elimination of FGM. But some members of Egypt's religious community saw this proclamation as a form of Western imperialism and challenged the then secular government. In response, the then Minister of Health issued a decree permitting the practice by medical doctors in public health institutions for a fee (Nelson, accessed 2006).

The Egyptian Task force against FGM constituted in late 1994, under the auspices of the Egyptian National NGO Commission on Population and Development (organised to
follow up ICPD implementation), was successfully able to advocate for the reversal of the new decree, and re-affirm the earlier decree banning the practice of FGM. They backed their advocacy by citing data on the deaths of several young women who underwent FGM in hospitals and also the declaration of a progressive religious leader who stated that the practice had no sanction in Islam. The appointment of a new sympathetic Minister of Health also helped in this reversal.

In-spite of the legislation banning the practice, FGM continued in 1995. Young women saw the practice as a passport for social acceptance, while their mothers saw it as necessary to gain marriage alliance for their daughters. Concerted community level campaigns and empowerment programmes through its Task Force member organisations followed. According to a study in the late 1990s, the practice has declined amongst girls in the year 10-14 years age group in the post ICPD period (Petchesky 2005).

3.1.(c) Peru: Using human rights instruments for demanding answerability on health and rights violations for an individual citizen

Unlike the previous two examples, this case study from Peru illustrates the potential and limitations of using international instruments to hold providers to account when they violate an individual (woman) client’s health right. Marina, a woman living in Puno, in southern Peru, was making a living through street vending. During one of her visits to the market she met with an accident, and went to a public hospital in the city for treatment on 15th January, 1996. A general practitioner in that hospital, using the pretext of a gynecological examination, raped her. This sexual assault produced vaginal bleeding and severe emotional suffering. She reported the violence to the police who, with great reluctance, recorded her case. When the matter came up to the court, she was verbally humiliated by the perpetrator. The verdict, based on an arbitrary evaluation of the evidence, declared the rapist innocent.

The Latin American and Caribbean Committee for the Defense of Women’s Rights (CLADEM) and the US based Center for Reproductive Rights Law and Policy (CRLP) brought Marina’s case to the Inter-American Human Rights Commission on April, 1998, charging the Peruvian state with violation of the CEDAW and the Inter-American Convention to Prevent, Sanction and Eradicate Violence Against Women. In March, 1999, the Commission granted a hearing attended by Marina. The Commission’s mediation resulted in an amicable solution amongst the parties. CLADEM and CRLP are now monitoring the implementation of the agreement (Movimento Manuela Ramos cited in Petchesky, 2005)

While Marina’s case ended on a good note in terms of securing justice, at times it may be one step forward and two steps backwards. Between 1996 and 2000, several Peruvian women underwent forced sterilisation as part of the public health policy on population control. One woman died at the operation table when she was undergoing sterilisation. The Peruvian Ombudsman Center, with the help of human rights and women’s rights organisations, documented the case and submitted it to the Inter-American Human Rights Commission. The Commission held the government responsible for her death. What
occurred in response, however, was restriction of contraceptive and abortion services by the government. In September, 2002, the Ombudsmen center filed another case stating that the new policy, like the earlier one, also discriminated against women. It is not clear whether the Ombudsmen center was successful in demanding a gender sensitive health policy (Macklin 2006).

3.1(d) Asia-Pacific region: NGO advocacy holds 5th Asia Pacific Conference Accountable to protect Programme of Action, Cairo

While international agreements have been used by citizens to promote accountability to gender and health, it is also important to protect the past agreements reached in a period of rise in conservatism. The UNESCAP organised the fifth Asia and Pacific Conference on Population and Development in Bangkok in December 2002, one of the series of meetings leading up to the 10th year review of the Programme of Action, Cairo ICPD, 1994. Between the 11th and 14th of December, 2002, Senior Officials’ meeting was held, while the Ministerial meeting was held between the 16th and 17th December, 2002. The US delegates to the Senior Officials meeting refused to affirm reproductive rights and health, as well as adolescent reproductive health, as they felt that these promote abortion and pre-marital sex. The draft document produced by the Officials Meeting included a number of comments reflecting the concerns of the US government.

To thwart the US opposition to abortion and adolescent RH services, the Development Alternatives for Women’s Network (DAWN), along with its allies, lobbied government officials and civil society actors with ECOSOC status to support and take forward the Cairo ICPD commitments. They also put pressure on the official delegates from outside. Several Official Delegates, including those from India, Netherlands, New Zealand, UNFPA and International Planned Parenthood Federation, tilted the voice of the proceedings of the Official Meeting, and the final document which came out of the drafting committee of the Senior Officials meeting relegated the US concerns to a footnote.

In the Ministerial meeting, the US moved for a recorded vote on whether Section F (reproductive rights and health) and Section G (adolescent reproductive health) should appear in the official text. The US lost the vote, and the Chair of the Ministerial meeting declared that the drafted Plan was officially adopted. The process signaled a victory for women’s and adolescents’ health rights (Francisco 2003).

3.2. New aid architecture, country level programming, and accountability to gender and health

Civil society organisations have used the new aid infrastructure that have emerged in the 1990s and early 2000s to press for accountability to gender and health. These include the Poverty Reduction Strategy Papers (PRSPs), Poverty Action Funds (PAFs), and sector wide approaches (SWAPs) to health.

Three case studies illustrating the above will be described in greater detail in this section.
a) Rwanda: The first case study is of how civil society participation in RWANDA PRSP, along with the adoption of a gender-sensitive planning process, led to engendering of the PRSP, including the health component 

b) Uganda: The second case study elaborates on a community based monitoring and evaluation system of the Poverty Action Fund (follow up of PRSP), and how it was used to promote health accountability in Uganda. 

c) Bangladesh: The third case study describes how citizens and women’s health rights groups in Bangladesh engaged with the design of SWAP to health.

3.2.(a) Rwanda: using PRSPs to promote accountability to gender and health:

The Interim Rwanda PRSP, 2000, led by the Ministry of Finance and Planning, was considered not particularly gender-sensitive or an example of civil society participation (Zucherman 2001). The Ministry of Gender and Women and Development (MIGEPROFE) hence decided to take the lead in mainstreaming gender into the final PRSP and holding consultations with women’s NGOs.

The Ministry, with the support of Department for International Development (DFID), invited an external gender consultant to facilitate the process. The consultant produced an engendering tool and indicators for each of the proposed PRSP chapters. With the help of the consultant, the MIGEPROFE and Ministry of Finance and Planning held a PRSP engendering workshop, at the end of which a PRSP engendering committee was formed.

NGO leaders were represented in the workshop and in the engendering committee. As some of the senior staff of the MIGEPROFE were honorary heads of NGOs, NGO inputs were taken seriously (Zucherman, 2001). Sectoral and issue specific gender teams were constituted, including one on gender and health and socials services. Ministers of both Finance and Gender stressed in the beginning of the workshop, that gender was not an add-on, but an integral part of the PRSP. The PRSP Engendering Committee reviewed existing sex disaggregated government data, and carried out new surveys to fill in gaps in data availability (Zucherman 2001).

The Rwanda PRSP document which evolved through this process was considered gender sensitive on several counts. The poverty analysis section included a gender analysis of household poverty, and the gender specific reasons for women slipping into poverty. The PRSP recommended that budget be allocated to address women’s gender specific needs like women’s rights to land, improved access to fuel and fodder, and female literacy. Legal strategies for ending post-genocide problems like polygamy, non-legal marriages and prostitution were outlined. In addition, the PRSP report outlines strategies to address sex/gender specific health needs of women and men. These include improving maternal health care (including for delivery), improving contraceptive choice and services for women, improving access of women to health care, and strengthening prevention of HIV/AIDS (Zucherman and Garett 2003). However, conspicuous by its absence was male responsibility with regard to contraception.

An evaluation of the implementation of Rwanda PRSP (phase I) notes that while access of the poor to health services has improved, maternal and child mortality continues to be
high. Further, improvement in education indicators has been faster than health, partly because 30% of the budget in 2005 was allocated to education, when compared to only 9% for health (International Monetary Fund and International Development Association, 2006).

3.2.(b) Uganda: community-based monitoring/evaluation of Poverty Action Fund:

The Uganda Debt Network (UDN) case study illustrates the need to not only influence PRSP form a gender and health lens, but also monitor its implementation. The UDN is a civil society organisation monitoring the Poverty Action Fund (PAF) set up as part of PRSPs in 17 districts. The PAF was to be used for five sectors, including health. In May 2000, the UDN established PAF Monitoring Committees in 17 districts with the objective of enabling community members to monitor the functioning of PAFs and to check for corruption. However, these district level structures were found to be inaccessible by members of the community (UDN, 2002).

The UDN then decentralised the monitoring further through a Community Based Monitoring and Evaluation System (CBMES). The CBMES is a system of community monitoring PAF at not only district level, but also sub-county, parish and village levels. The CBMES was piloted, along with the Kamuli District PAF monitoring committee, in eight villages in two sub-counties. The initial meetings to select participants were held in public spaces accessible to all, with approximately 33% of the participants being women. Of these participants, 80 were selected for training, with women constituting nearly 40% of those selected. The participants in the training programme identified the following indicators for monitoring health: number of medical personnel in health centers, their time of reporting and hospitality, availability of medicines, syringes, gloves and cotton wool, waiting time for services, distance of health center, availability of immunisation services and number of beds. The participants were trained in collecting and recording data on these indicators, and in interacting with government officials. The findings were fed back to the district officials, chairperson and members of the sub-counties, members of the press and local radio, government officials and members of the communities. During these feedback meetings, the members of the CBMES committees (beyond the pilot phase) were selected and the indicators for monitoring were refined.

The following changes were reported in the health services due to the CBMES: removal of user fees (one county), improvement in stock of medicines and supplies (one county), establishment of immunisation outreach services (one county) and increase in beds in general ward and in labour ward (both counties). The improvement in water and sanitation services through the monitoring of other services led to reduction in work load of women, and thus improved their health. However, the availability of beds and drugs was far from adequate. The removal of user fees in one county increased women’s access to health care. In one county, treatment for HIV/AIDS continued to be unavailable. Corruption, and long distances to reach health care services continued to pose problems. Inadequate resources to cope with increase in demand after the improvement in infrastructure and removal of user fees led to a slight deterioration in quality of service.
Lack of adequate resources for travel and other costs incurred by monitors posed problems in replication (UDN 2002).

3.2.(c) Bangladesh: engendering sector wide approaches in health

Another aid infrastructure that has been used to press for accountability to gender and health is the sector wide approach to health. In Bangladesh, as part of formulating the Health and Population Sector Strategy (HPSS) 1996 and Health and Population Sector Programme: 1998-2003 (HPSP), a 40-member task force on stakeholder participation was constituted by the Ministry of Health and Family Welfare (MOHFW). The task force consisted of primary stakeholders (marginalised women and men), secondary stakeholders (providers, health officials, donors, health NGOs) and external stakeholders (media, political parties, and religious leaders). NGOs organised most of the consultations with primary stakeholders (Social Development Notes 2001).

The stakeholders prioritised reproductive health (family planning, basic emergency obstetric care, and prevention and control of STI/RTI and infertility), childhood communicable disease control (e.g. diarrhoea, measles, diphtheria, poliomyelitis), and limited curative care as part of the Essential Service Package (ESP). These services were to be implemented through one-stop clinics at the village level, and more comprehensive health services at the Upazilla (sub-district) level. The government also adopted a Patient Charter of Rights, which was to be enforced during implementation of the HPSS/HPSP. To institutionalise stakeholder participation in implementation, the MOHFW established a National Steering committee for stakeholder participation. At the clinic level, community groups were to be established to oversee construction, maintenance and functioning, comprising of local elected representatives, local health providers, and influential leaders. At the Upazilla level, Community Health Watch Groups were to be set up consisting of citizens, NGOs, providers, elected representatives and health administrators. These health watch groups were to monitor the quality of service and client-needs satisfaction (Social Development Notes 2001, Mahmud, 2006).

While the World Bank sees stakeholder participation as a success story, researchers have critiqued it on several accounts. Murthy et al. (2005) note that rights based women’s organisation were not invited for consultation, and had to demand that they be invited. Certain controversial women specific health services, like treatment for health needs arising out violence against women, have been kept outside the ESP, though provided for in a few urban based hospitals. Jahan (2003) points out that while the HPSS/HPSP was designed in a participatory manner, citizens were not involved in overseeing the implementation. Implementation has been better with regard to the child health component when compared to maternal health component. Mahmud (2006) observes that the clinic community groups did not perform any oversight functions, and over a period of time became defunct. The health watch groups succeeded in promoting accountability to citizens only when supported by rights based intermediary organisations and local

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2 This case study has been updated from Murthy, Klugman, Weller, and Aizenberg, 2005
associations (Mahmud 2006). To strengthen accountability with regard to implementation of HPSS, civil society actors have recently formed ‘Health Watch’, Bangladesh³.

3.3. Making use of participation and accountability (national) legislation to press for accountability to citizens on health

Citizens and civil society organisations have used legislation to promote accountability to citizens (on all public social services) to demand accountability to gender and health. Three case studies, which illustrate the above, have been chosen for elaboration.

a) South Africa: This case study illustrates how civil society organisations have used the constitutional clause on right to participation to successfully advocate for liberal abortion laws.

b) Brazil and Argentina: The second case study is on the mandatory Brazilian Policy Councils and Argentinean participatory budgeting, and how these have been used by citizens for influencing health policy (Brazil) and demanding that budget be allocated for child care (Argentina).

c) India: This third case study suggests how the mechanism of public interest litigation has been used by women’s rights organisations for putting a stop to unsafe clinical trials of hormonal contraception with poor women.

Civil society organisations in India have also used Right to Information Act to monitor implementation of national legislations, which is discussed in section 3.4 (a).

3.3.(a) South Africa: making use of the Constitution Mandate on right to public involvement in legislation and policy formulation⁴

The legendary African National Congress, when it won the first elections based on universal suffrage in 1994, invited public inputs into new constitution through placing advertisements in diverse local language media asking for inputs. The Clause 59.1 of the constitution, which emerged through this process, requires that that the Parliament facilitates public involvement in the legislation and other processes of the assembly and its committees. By the year 2002, this consultative process had become ad-hoc, depending on the interests of particular politicians or bureaucrats concerned. But once laws get to parliament, there is an established practice of public hearings at which any individual or group in civil society can ask to present their concerns (Klugman, 2002).

The Congress of South Africa Trade Unions (COSATU) established an office with the specific brief of keeping watch on parliamentary processes and ensuring that union members’ voices are heard. NGOs involved in health and women’s rights have used this space for advocating progressive policies, including favourable policies on abortion and violence against women (Klugman, 2002).

³ Correspondence of the author (November, 2006) with Rounaq Jahan, Senior Research Scholar and Adjunct Professor, Southern Asia Institute, Colombia University, USA
⁴ This case study has been condensed from Murthy, Klugman, Weller and Aizenberg, 2005
These NGOs allied with the Medical Research Council to study the costs of abortions (including illegal abortions) to the public health system. Based on this research, they were able to present evidence that liberalising abortion laws could reduce costs to the government and improve the country’s performance with respect to reduction of maternal mortality. Women who had borne the burnt of unsafe illegal abortion were also mobilised to speak before parliament, and the support of the mass based organisation COSATU and the African National Congress Women’s League was solicited on this issue. The space for participating in policy making through ‘speak outs’ in parliament, along with the presence of allies within the Parliamentary Committee and the Ministry of Health significantly helped to push through the controversial policy on liberalising the abortion law. The present law is one of the most liberal in the world: it permits abortion on request in the first trimester and allows adolescents to access abortion without requiring parental consent (Klugman 2002).

3.3.(b) Brazil and Argentina: Policy Councils and Participatory Budgets and issues of accountability to gender and health

After 21 years of military rule, civil rule was restored in 1985 in Brazil. A new constitution which supports democratic elections and universal suffrage followed in 1988. The (new) constitutionally mandated policy councils and the practice of participatory budgeting being implemented since 2002 in Brazil have been used by citizens for influencing health policies at the local level (in all municipalities) as well as allocation of health budgets (in some municipalities)⁵.

Health Councils comprise of representatives of users, health workers, health managers and elected members. Analysing what motivates participation in the Health Councils, Cornwall (2006) argues that some users were previous contractors with municipal government and interested in securing personal gains, while others were genuinely interested in exercising their voice. There was substantial tension between those users who believed that their role is holding the health council answerable for delivering services and those who believed that they were there to deliberate on health policies. Three concerns were expressed from a user perspective: politicisation of councils, lack of effective independence of health councils (as health personnel are also represented), and de-facto implementation role of health councils. Health workers pointed to the hierarchy between users/health workers in council and health managers. Health managers pointed that elected members had an interest to get reelected and prioritised infrastructural interventions. They also felt that users were not competent to take technical decisions (Cornwall, 2006).

While literature on impact of citizen’s participation in Brazilian health councils and participatory budgets on gender and health could not be found, a study from Argentina on participatory budgeting found that there were different committees on different social services, and they had to argue their proposal in a larger assembly where decisions

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⁵ Participatory budgeting is not constitutionally mandated, but has been introduced by the Workers’ Party in the municipalities that they control. This practice is nevertheless spreading to municipalities governed by other parties.
(through voting) were taken on what to allocate resources for. In one municipality, a woman activist with prior experience in negotiating with such spaces, brought women supporters in large numbers to cast a vote for a child care programme, so that women could earn income without worrying about their children (Rodgers, 2006). One could argue that better child care and income would improve the health of women and their access to health services.

3.3.(c) India: using Public Interest Litigation for pressing for accountability on gender and health

Changes to promote accountability to citizens can be brought anytime, and not just when a repressive regime is overthrown. In 1982, the progressive Supreme Court of India ruled that a third party could petition the Supreme Court directly when rights of another party or group is violated. Even a letter or telegram to the Court is adequate. That is, the aggrieved party need not approach the court directly. This system of litigation is referred to as public interest litigation (PIL). Filing a PIL is also less cumbersome and expensive than a private litigation (Dasgupta, 2002).

Women’s and health rights groups in India have used the procedure of PIL to take up matters of custodial rape of women by police, violence against sex workers, and unsafe (hormonal contraceptive) clinical trials by the government. Between 1980 and 2000, the use of PIL has led to the suspension of clinical trials of injectable contraceptives, and banning the use of Quinacrine for non-surgical female sterilisation. The government was also pressed, using PIL, to press for banning sex selective abortion.

Amongst the constraints in using PIL in India have been the paternalistic attitude of some members of the judiciary, difficulty in enforcing progressive judgments (due to reluctance on the part of the local police and, disappearance of the perpetrators or victims), and over dependence of victims on intermediary organisations to take up such cases. Moreover, not all legal rights groups are familiar with gender specific health violations. Neither are all health or women’s NGOs familiar with using PIL for demanding accountability (Dasgupta, 2002).

3.4. Demanding and using progressive gender and national health legislation, policies and programmes for pressing for accountability

Civil society organisations have pressed for, and used, progressive gender and health national legislation, policies and programmes in their attempt to promote accountability on gender and health. Three case studies are discussed in this section, with the first documenting how citizens and allies in the bureaucracy together pressed for a new and gender specific health service in Ghana, while the second and third case studies focus on how citizens have pressed for enforcement of sound policies in South Asia.

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6 This case study has been condensed from Murthy, Klugman, Weller, Aizenberg, 2005
a) Ghana: The first case study is of how government WID structure and a civil society organisation (headed by elite) came together to successfully press the health department to strengthen breast-cancer screening services for women in four government hospitals.

b) India: The second case study is of the strategies used by one campaign in the state of Tamil Nadu, India for pressing for the strict enforcement of the Prohibition of sex selection Act, 1994.

c) South Asia: The third case study is of a Women’s Health Rights Advocacy Partnership, South Asia, an initiative of the Asia Pacific Resource Center on Women (ARROW), Malaysia and its six partners from South Asia, and the strategies of this partnership at regional, national, provincial and local levels for pressing for accountability of governments from these countries.

The initiative from Ghana has come under fair amount of criticism, but has nevertheless been included here as it points to several lessons

3.4(a) Ghana: Pressing government to provide breast cancer screening facilities

During the 1970s and 1980s, breast cancer in Ghana was addressed as a clinical issue by the medical community. Breast cancer accounted for 7.45% of all cancers treated at Korle Bu teaching hospital between 1972 and 77. There were no screening based studies on incidence of breast cancer (Reichenbach, 2002).

During the 1990s, political attention to breast cancer as a public health issue increased, spearheaded by the National Council for Women in Development (the official national body working to improve women’s status) and the 31st December Women’s Movement (which is a NGO which mobilises rural and urban women throughout the county). In 1996 31 DWM had a base of 1.5 million women. It was headed at that time by the First Lady of Ghana, which gave the organisation a lot of clout. In March, 1991, breast cancer was raised as an issue in one of the NCWD’s regional meeting at Accra. A medical professor also released a book on breast cancer in Ghana, which received wide media publicity. NCWD and 31 DWM came together with the objective of creating awareness on breast cancer and to raise funds for government to purchase mammography equipment. The NCWD and 31 DWM arranged to have copies of a video of a US television programme with a popular American Actress on her experience with breast cancer. This video was shown in beauty parlours and hair salons. October was designed as the breast cancer awareness months. At the community level, regional rallies were held on breast cancer and to instruct villagers to perform self examination. Funds were raised from Ghanians and charity organisations abroad for mammography equipments. By 1996 four mammography units had been acquired and installed in three regions of the country. The Ministry of Health trained staff on using the equipment and paid for recurring costs (Reichenbach, 2002).
While the advocacy by NCWD and 31 DWM has led to availability of screening facilities in four hospitals, it is yet to be institutionalised within the government health programmes. While the National and Reproductive Health Service Policy and Standards discussed about the prevention and management of breast cancer, it did not provide screening or treatment protocols. Mammography services were limited to four government hospitals. Treatment facilities are not readily available in government facilities, and are very expensive outside. Further, the incidence of cervical cancer amongst poor women is higher than breast cancer like in most developing countries, but has not received the same priority by civil society organisations and NCWD. While the Ministry of Health has been concerned about cervical cancer screening and treatment, it has not been in a position to mobilise funds (Reichenbach, 2002).

3.4.(b) India: pressing government to implement the Prohibition of Sex Selection, Act

Studies on functioning of scanning centers in the city of Mumbai in the late 1980s and early 1990s brought to light the practice of sex-selective female fetus abortion in India. The Government of India was pressurised by civil society organisations to pass a legislation (the Prohibition of Sex Selection Act) in 1994 to combat this practice, which was amended in 2002 (as the Pre-Conception and Pre-natal Diagnostic Techniques Act (PCPNDT Act)).

The Campaign Against Sex Selection (CASSA) launched in Tamil Nadu in 1998 focused on combating the prevalence of sex selective abortion in the state. The mission of the campaign is to prevent the declining sex ratio at birth and juvenile sex ratio (0-6 years) in Tamil Nadu while at the same time protecting and promoting the rights of women to abortion when it is for reasons other than sex selection. The objectives of the campaign are to raise awareness amongst all stakeholders on the PCPNDT Act, to make the state machinery answerable for its implementation, to monitor compliance by public and private scanning facilities, and to demand from the government data on sex ratio at birth (and relevant vital statistics) and compile alternative data when necessary.

An innovative monitoring intervention of the campaign is to send pregnant women (who are allies of the campaign) for scanning to private and public scanning centers/facilities, and ask for information on the sex of the fetus. Through this process, they find out which are the scanning centers that violate the Act and report the matter to the District and State Authorities. The Campaign members also visit scanning centers to find out if they are registered under the PCPNDT Act and complying with the provisions of the Act. Another unique strategy is the monitoring of registration of pregnancies, outcomes of pregnancies, and sex of the fetus. Discrepancies between data gathered through this process and official data is used to press accountability of health and revenue services.

As a result of the campaign (and campaigns in few other states and at the national level), both the Central and State Government issued notifications in leading dailies for the registration of prenatal diagnostic centres. The government has issued directives to registered clinics to refrain from disclosing the sex of the fetus. Over a period of time, the government has constituted Advisory Committees in all the districts of Tamil Nadu with members of the campaign represented in these bodies. The appropriate authorities in
Tamil Nadu have registered more than 95 per cent of the scanning centres and have taken action against the unregistered ones whose existence the campaign pointed to. The government has started collecting data on sex ratio at birth, which is a good indicator of prevalence of sex selection disadvantaging females (natural sex ratio at birth is supposed to be 952 females per 1000 males). The media coverage on the campaign and violations of the PCPNDT Act has increased. Medical Associations have committed themselves to work for effective enforcement of the Act (CASSA 2006). Data on sex ratio at birth in the different district of Tamil Nadu gathered from the government by the campaign reveals a steady increase in the same between 2001 and 2004 in 45% of the districts, and a slight increase at the state level. However a concern is that all districts have not seen such an increase in sex ratio at birth (CASSA 2006).

3.4.(c) South Asia: pressing for accountability on safe motherhood and young people’s SRH: Women’s Health Rights Advocacy Partnership

While the CASSA case study illustrates civil society action to press for ‘enforcement’ of sound policies/legislation in one province of a country, the Women’s Health and Rights Advocacy Partnership (WHRAP) case study points to how such initiatives can be scaled up. The initiated by ARROW brings together six women NGO partners from India, Bangladesh, Pakistan and Nepal to advocate directly, and through community based organisations, for safe motherhood and young people’s SRH services. The partnership observed that good policies exist on safe motherhood, but implementation was weak. Policies on young people’s SRHR were still at a nascent stage. The challenge, then, was to strengthen implementation, as well as to advocate new policies.

At the community level, the focus of the Partnership is on raising awareness amongst women of legislation, policies and programmes of government, and on mobilising them to put pressure from below on government health services. At the provincial and national levels, the partners come together along with other progressive actors to hold policy dialogues with government officials to demand effective implementation of safe motherhood policies. At the South Asian level, parliamentarians, health bureaucrats, WHRAP partners, donors and relevant experts from the four countries come together to share country level experiences, and review progress in achieving safe-motherhood and young people’s health goals in the MDGs and Cairo, ICPD.

Early impact is already visible in Bangladesh and India. In Bangladesh, because of advocacy and monitoring by Naripokko and Bangladesh Women’s Health Coalition (two of the WHRAP partners) and the community based women’s organisations, the number of physicians in the 12 Upazilla (sub district) Health Advisory Committees (UHACs) where WHRAP is operational has increased. At the beginning of WHRAP only 2-4 physicians were present in each of the UHCs. There are now 7-8 physicians including an obstetrician/gynecologist in each Upazilla health centers (Naripokko 2006, BWHC, 2006).

In Sarso, a village in Uttar Pradesh where WHRAP is operational through the partner NGO Sahyog, the auxiliary nurse midwife would visit the village infrequently and often
charge for services that should have been provided free. The community women asked the chief medical officer at the concerned district for a photocopy of the midwife’s mandatory visiting schedule, and started monitoring her actual schedule. As a result, the concerned midwife is visiting and providing pre and post natal services regularly (ARROW 2006).

In the state of Gujarat, WHRAP partner Center for Health Education Training and Nutrition awareness (CHETNA), and other NGOs working with youth were asked to draft a Gujarat Youth Policy in keeping with the National Youth Policy. The National Youth Policy emphasises the need to address reproductive and sexual health needs, substance use disorders, psychological problems, and nutritional needs of the young. The draft Gujarat Youth Policy has been forwarded to the legislative assembly for approval (CHETNA 2006).

3.5 Community health structures and accountability tools, and gender and health accountability

Governments, donors and NGOs have attempted to promote accountability to citizens through devolution of health services, community based health financing, and health accountability tools. Three examples, of varying success, listed below are illustrated in this section:

a) Philippines: The first case study from Philippines discusses the impact of devolution of health services on strengthening accountability to sex/gender specific health services.

b) China: The second case study from China discusses the experience of an effort to revamp the Cooperative Medical Scheme and how far it has strengthened accountability to gender and health.

c) Uganda, Costa Rica and Haiti: The third case study documents experiences in using provider report cards to strengthen accountability of providers to citizens on health, and gender and health

3.5(a) The Philippines

Devolution is a popular mechanism used by donors and government to promote accountability to citizens on social services. The government of the Philippines embarked on devolution of health and social services after the passing of the Local Government Code of 1991. As part of the devolution in health services, 95 per cent of its facilities, 60 per cent of its personnel and 45 per cent of the budget was transferred from the Department of Health to local government units (LGUs) at provincial, city and, municipality levels (Tadiar 2000). Local health boards were set up in each LGU, comprising the Governor or Mayor as its chairperson, Municipal Health Officer as vice

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chairperson, the local councilor for health, a representative of the Department of Health and a representative of a health NGO. Local government expenditures on health increased after devolution. Though this amount in principle is untied, a significant proportion goes for salaries of health workers. The Local-Government Assistance and Monitoring Service (LGAMS) was set up within the Department of Health to monitor LGU health programmes and provide technical assistance. The LGAMS was also supposed to augment resources of LGUs, if they agreed to implement national health programmes, including the Reproductive Health Programme. However, there were no incentives or punitive measures to ensure that units complied with the agreements (Tadiar 2000).

Researchers have observed that the implementation of gender aware health programmes has suffered because of decentralisation. Provision of a wide range of contraceptives by local clinics depended on attitudes of members elected to LGUs at different levels. This in turn led to high rates of unsafe abortions. While emergency obstetric care has been on the priority list of many LGUs, in practice such services have been affected because of weakening referral systems, as different levels of healthcare are being managed by different elected bodies (Lakshminarayanan 2003). Access to diagnosis and management of HIV/AIDS is still limited and unequally distributed across rich and poor areas. Men’s gender specific health needs are often not prioritised by LGUs. By and large, curative care was given more priority over preventive care by several LGUs, as these are more visible and aid reelection. There has also been little effort to build capacities of local health boards and LGUs on their roles and responsibilities as elected members as well as on gender and health issues (Lakshminarayanan 2003, Tadiar 2000).

The potential role that NGOs could play to promote accountability to gender and health within the process of devolution is illustrated through the experience of the Development of People’s Foundation in Davao city which strengthened SRH services in the area by providing research and capacity building support to LGUs, and by putting pressure on LGUs from outside by building advocacy skills of NGOs and community women. (Pacaba-Deriquito, http/www.icomp.org.my/Policy/CSSeminar06.htm). Information on outcome of this effort is not available.

3.5.(b) China: community based health financing and management structures

Community based health financing is presently being encouraged by multilateral financial institutions as both a health financing and accountability mechanism. This method of financing was operational in the past in centralised economies. During the Cultural Revolution, China introduced the community based health pre-payment scheme.

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8 The RH programme in Philippines includes services to improve contraceptive choice and access, MCH and nutrition, prevention and management of abortion complications, prevention and treatment of RTIs, including HIV/AIDS/STDs, education and counseling on sexuality and sexual health, detection and treatment of breast and reproductive tract cancers, men’s and adolescent reproductive health, care and counseling for victims of violence against women and prevention and treatment of infertility and sexual disorders (Tadiar, 2000)
(referred to as the Cooperative Medical scheme or CMS) and management of health care (through CMS Fund Committees). The CMS provided free outpatient treatment to villagers who contributed to the scheme. The service providers included a barefoot doctor (normally a herbal doctor trained in Western medicine) and a male and female health worker responsible for prevention, immunisation and MCH. With the introduction of the household responsibility system in the early 1980s, the scheme collapsed in most parts of China, but survived in places where the Fund Committee took interest in its continuation.

The Laba village CMS, covering four hamlets bordering Myanmar, is one such example. Until the mid 1990s, each villager was paying two yuan per year for the CMS but with rising drug prices, the Laba CMS could no longer sustain subsidised service provision. The CMS committee then approached OXFAM for seed fund of 10,000 yuan to run the scheme. Two additional health workers began to serve the villagers under the direction of the doctor who was in turn responsible to the Laba Fund Management Committee. The role of the CMS Fund Committee was to review the financing, as well as the quality of health care provided.

In 1998, a participatory evaluation of the CMS in Laba village was held by Yunnan Participatory Rural Appraisal Network. Three key issues that emerged from the evaluation were: lack of representation in decision making structures, lack of exemptions for poor households, and lack of services for maternal health care and RTIs (as the health workers were not trained in this area). Members of only the main village, and not the hamlets, were represented on the CMS committee. The doctor and two health workers were also represented in the committee, and were thus responsible for monitoring their own functioning! Though, the committee included the village leader, he was the son of the herbal doctor. Prior to the evaluation, women had no channel to voice their needs.

The findings from the evaluation were taken back to the villagers in each of the four hamlets covered under the scheme, and resulted in the poor being given partial exemption with respect to pre-payment fees, democratisation of committee through representation of marginalised groups (poor and women) and strengthening of maternal health and RTI services. Because of the presence of external actors, the Committee took the recommendations seriously (Wilkes 2000).

3.5.(c) Provider specific reports in developing countries

Provider report cards refer to any effort to compare providers within a specified geographical region on a routine basis, according to certain standards of quality performance. These report cards can be public (results made available to citizens) or private (results made available only to providers), they can be voluntary or mandatory, and can be sponsored by professional associations, government, health plans, or civil society organisations. When provider cards are made public, mandatory and promoted by government or civil society actors they tend to promote accountability to citizens on health (Mcnamara 2006).
The Yellow Star Program in Uganda is one example from a developing country. It is sponsored by the government and donors. The Program evaluates health care facilities (public and private) on a quarterly basis using 35 indicators, spanning technical and interpersonal domains like standard of infrastructure, management systems, infection prevention, health education and interpersonal communication, clinical skills and client services. Ratings of a provider are made available to the public. A facility in which all providers have received a 100% score for two quarters receives a yellow star, which is then posted prominently outside. If performance falls, it is removed. The average score climbed from 47% in the first quarter to 65% in the second. Initially implemented in 12 of the 56 districts, plans are now afoot to expand to all the 56 districts of the country (Uganda, DISH, 2004 cited in Mcnamara, 2006).

While the Uganda report cards have not included sex/gender specific indicators for monitoring, Costa Rica has included the criteria of existence of a mechanism to analyse maternal death and delivery complication rate. Haiti has included availability of family planning supplies as one of the indicators (Mcnamara, 2006). However, there are concerns that providers may be constrained by availability of resources or civil service rules from addressing shortcomings. There are also concerns that performance will improve only on the variables measured, and not on those left out. The clout of the medical lobby may also come in the way of effective implementation (Mcnamara, 2006).

4. LESSONS ON ACCOUNTABILITY TO CITIZENS ON GENDER AND HEALTH

Several lessons on promoting accountability to citizens on gender and health flow from the practice of accountability documented in section 3.0.

4.1 Accountability on gender and health is closely linked to accountability to development, to health, and to women’s rights

A first lesson is that accountability to citizens on gender and health cannot be looked at in isolation. It is closely tied with accountability to development (all public services), to health, and to gender/social equality. In the case of the CBMES, Uganda, citizens’ pressing for accountability with regard to water and sanitation services improved women’s work burden and their health. Citizens’ success in advocating removal of user fees for health services in one sub-country in Uganda increased the number of women using health services. In Egypt, civil society organisations’ success in combating FGM at policy and community level is likely to improve women’s health.

4.2 Need to engender existing health/citizen accountability structures, process and tools

At the same time, it is essential to engender health accountability processes, and weave in health strongly into gender accountability processes. Otherwise gender inequalities in health access and outcomes, and gender specific health needs of women and men may not
be addressed comprehensively. The CMS, China case study suggests that without quotas for women, women may be largely absent in community health structures. This in turn may lead to their gender specific health priorities not being heard. The Nari Pokko and BWHC experience of working with Upazilla Health Advisory committees illustrates that representation of women alone is not enough. There is a need to strengthen gender sensitivity of women and men members in these structures, as well as build pressure groups of marginalised women from below. The two case studies from Uganda- CBMES and provider report cards- illustrate that monitoring and quality assessments by citizens need not automatically be gender sensitive. There is a need to include indicators of whether sex/gender specific health needs have been addressed, and whether gender inequalities in access have been reduced. While CEDAW (a gender accountability tool) has been used by citizens groups for bringing providers who have violated women’s health rights to book, it is also essential that citizens use it to make government’s accountable to reduce gender inequalities in health access and outcomes.

4.3 Need to press for accountability at multiple levels

Another lesson is that accountability mechanisms on gender and health are required at multiple levels. International human rights instruments and agreements that pertain to development, health and gender are essential for creation of spaces for citizens groups to push for accountability of governments to gender and health (example of anti-FGM Task force, Egypt). At the national level, legislation, policies and structures in keeping with the international agreements, and to address context specific problems are important. A case in point is the legislation against sex-selective abortion in India and FGM in Egypt. At the local level, these legislation and policies need to be followed up with structures, tools and processes for promoting accountability. The health watch groups in Bangladesh, where supported by a rights based NGO and community groups representing marginalised, played an important role in monitoring the implementation of HPSP/HPSS.

4.4 Need to press for accountability of multiple institutions

Related, accountability of multiple institutions, and organisation forms they take, to gender and health is necessary. State is an obvious institution, and the accountability or lack of accountability of public health sector has been much discussed since the 1990s. Several examples in this article have dealt with public health sector accountability. However, it is important to press for accountability of market organisations involved in health as well, like pharmaceutical companies, private clinics and hospitals, and public-private partnerships that are emerging. The campaign against sex selection in Tamil Nadu has met with some degree of success in lowering this practice because it monitored both the private and public scanning clinics and providers as well. Inter-state organisations like the World Bank and regional development banks are other key players in health, whose accountability needs to be ensured, as illustrated by citizens’ engagement with Bangladesh HPSP/HPSS and Rwanda PRSP. Further, as illustrated by the Egyptian anti-FGM Task force experience, it is important to bring gender aware changes at the community and household level.
4.5 Need to use multiple mechanisms to press for accountability to citizens

Given the multiple levels, institutions and facets at which accountability to gender and health needs to be promoted, no one accountability mechanism (instruments, structures, tools and processes) is adequate. As noted in the beginning of section 3, the case studies point to the existence of five strategies for accountability to citizens. Within these five broad strategies, multiple accountability mechanisms are available, described in Table 2. Not all methods would be appropriate in all contexts. If a country has not signed or ratified ICESCR it may be difficult to hold the government accountable to implementation of the right to health components. If the literacy levels are low in a country, placing of media advertisements in paper would not be appropriate to solicit public inputs into policies. It is hence to promote an appropriate mix of accountability mechanisms.

Table 2. Strategies and mechanisms to promote accountability to citizens on gender and health

<table>
<thead>
<tr>
<th>Accountability strategies</th>
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| Making use of/protecting human rights instruments and international agreements | - Signing and ratification of ICESCR and CEDAW, and optional protocols  
- Programme of Action, Cairo and Platform for Action, Beijing  
- Shadow reports on international treaties  
- International or regional courts of justice  
- Regional human rights commissions  
- Concluding remarks on gender and health  
- NGO (with ECOSOC status) participation in international conferences |
| Making use of new aid infrastructure | - Civil society consultations that are part of PRSPs and health SWAPs  
- Gender mainstreaming tools applied to PRSPs and SWAPs.  
- Citizens’ monitoring of implementation of PRSPs, PAFs and SWAPs |
| Making use of accountability legislation | - Procedure of Public Interest Litigation  
- Legislation on Right to information  
- Constitutional mandate on public participation in policy  
- Media advertisements seeking inputs by government  
- Decentralised policy councils  
- Constitutional mandate on public participation in budgeting  
- Decentralised participatory budgeting processes  
- Legislation on right to health and gender equality  
- Legislation on devolution of services |
| Demanding and making use of gender and health legislation policies, and | - Citizen-led tribunals and public hearing  
- Media campaigns  
- Citizens’ task forces |
programmes
- Policy dialogues with government
- Community based monitoring of implementation
- Community based monitoring of expenditure
- Legislation against gender based violence

Community level structures, accountability, processes
- Clinic health structures
- Hospital boards
- Professional associations
- Local health boards attached to local government
- Complaint boxes
- Provider report cards that are in public domain
- Alternative health service and outcome surveys

4.6 Need to address accountability in its various facets:

Yet another lesson is the importance of addressing accountability in its three facets: engagement, answerability, and enforcement. Citizens’ participation in the Rwanda PRSP, Brazil health councils, and Bangladesh HPSP are examples of accountability as engagement. The use of public interest litigation by women’s groups in India to put an end to unsafe trials of hormonal contraception is an example of accountability as answerability. The Peru case study of women’s groups using the Inter American Human Rights Commission to bring a provider who raped a woman client to book is an example of accountability as enforcement. At times citizens have to go beyond these three facets of accountability, and protect gains made. In the Asia Pacific Conference, DAWN and its allies focused not so much of making new demands, but protecting gains that were made in the past. This was also the case with the Egypt FGM task force.

4.7 Need to address power relations:

The review of accountability practices suggest that accountability is about challenging power relations. Health workers who took part in health councils in Brazil pointed to the hierarchies between managers and themselves, and managers and citizens, which came in the way of how far health councils were accountable to citizens. In Egypt, Poland and part of Philippines, certain section of religious leaders exercised power over government (national or local), which came in the way of accountability to citizens on gender and health. Gender based power relations within the household and community were cited as a reason for the continuation of FGM in Egypt and sex selection abortion in India in spite of legislation banning these practices. The Ghana breast cancer case study illustrates how at times power relations amongst women based on their economic background, comes in the way of how far gender specific health priorities of poor women get articulated and addressed through representation of civil society organisations. Several of the case studies point to the need for alliance building between progressive actors to alter these power relations. The gains in terms of policy changes in Bangladesh HPSP were possible due to alliance building between sensitive people in donor agencies and government, international gender experts, women’s rights organisations (who pushed their way in), and progressive providers (Jahan, 2003).
4.8 **Need for vibrant democracies, political will and resources**

Lastly, promoting accountability to gender and health requires vibrant democracy, as well as earmarking of resources on the part of international donor community and national governments. Resources are required to make health policy makers and providers sensitive to importance of accountability to citizens, as well as to gender and health. Resources are also essential to build pressure groups of women, marginalised men, and adolescents from below to make accountability mechanisms work and to address their specific health needs, reduce gender inequalities in health, and uphold their health rights.

5. **GAPS IN ACCOUNTABILITY TO CITIZENS ON GENDER AND HEALTH**

The review of evidence in Section 3 points to the existence of a rich gamut of experiences in promoting accountability to citizens on gender and health. At the same time there are several gaps which relate to who is being held to account, to whom, how, and in relation to what issues. These gaps are elaborated in this section.

5.1 **Who are citizens not holding to account?**

There are more examples of citizens holding governments to account on gender and health, than of the private health sector or public private partnerships in health (also see Ravindrans 2005a). In the context of the receding role of the state, and expanding role of the private health sector this gap is an area of great concern. Another concern is that there are few examples of citizens holding multilateral financial institutions, health donors, or global public private partnership to account despite the fact that their role is increasing in the health sector. At a more local level, examples of citizens holding traditional community organisations and male household heads to account on gender and health are largely absent; unless it is an act of physical or sexual violence.

5.2 **Who is being left out in the accountability to citizens’ process?**

Examples of direct accountability to marginalised women, men, and adolescents are rare, leave alone to sexual minorities. With few exceptions, accountability through government initiated community level structures has been stronger to the social and economic elites (often men), than to marginalised women, men and adolescents. The China CMS, Bangladesh clinic committees, and Philippines health boards are examples. At provincial and national levels, accountability to citizens on gender and health has been equated by government and donors with accounted to civil society organisations working with marginalised groups, and rarely to marginalized groups directly. Marginalised women and men have rarely been invited to national level consultation. A gap is the absence of federations of local organisations representing marginalized women and men at national level. While rights based civil society organisations do represent the interests of marginalised groups, at times they are not called to policy dialogues by governments, as illustrated by the Bangladesh HPSP/HPSS case study (where rights based groups had to demand that they be invited). In Ghana the power of elite women’s groups led to greater
priority being government to breast cancer, when cervical cancer was more common amongst the poor.

5.3 What issues are being left out in accountability processes?

Few accountability processes show evidence of having reduced gender inequalities in health, furthered implementation of controversial policies or legislation, or furthered availability of low priority but expensive health needs of women.

Accountability through spaces created by government and donors has been stronger with regard to less controversial women’s health issues (e.g. antenatal care, delivery care, child care services), than the more controversial issues (e.g. access to unconditional abortion services, services to deal with complications arising out of domestic violence, providing contraceptive services to unmarried adolescents). Controversial gender specific health issues have been better advocated when citizens or rights based organisations have demanded accountability on their own. Women’s rights groups in South Africa, for example, have used constitutional mandate on citizens’ right to participation in public policy in the 1990s to press for liberalising abortion law. However, such organisations have been less able to press for actual enforcement of ‘controversial’ policies and legislation that they have promoted at the policy level. Neither have women’s groups in low income countries succeeded in advocating for provision of low priority but expensive gender specific health services like screening and treatment for breast cancer, infertility and mental illness. In Ghana resources for mammography could be mobilised only for four hospitals, and treatment of women with breast cancer is limited. Yet another concern is the invisibility of some issues in the eyes of citizens groups. Citizens’ groups have rarely prioritised gender inequalities in health access, and tended to focus more on blatant violations of rights to survive, sexual and reproductive rights of women, and gender/sex-specific health needs like maternal health services. CEDAW has rarely been used successfully for bridging gender inequalities in health access and outcomes. Gender inequalities in health outcomes disadvantaging men, like higher traffic accidents and higher substance use disorders amongst men have again not been prioritised by citizens groups, including those headed by men.

5.4 Which preconditions for accountability are met and which are not?

The preconditions for accountability to citizens (i.e.: vibrant democracy, political will and resources) are not met in many countries. Several examples of accountability to citizens come from India, South Africa, and Brazil where vibrant democracy presently exists. A survey by Freedom House (2006) on civil and political freedoms in 192 countries found that only 46% of the countries scored well on political rights (multi-party free elections) and civil liberties (including freedom of association, freedom of press). Resources are another constraint in low income countries, limiting what the ‘engagement’ route to accountability can achieve in terms of policy change, and ‘enforcement’ route can achieve in terms of implementation. According to the Report on the Commissions on Macroeconomics and Health, 2001 providing minimal essential health services (major communicable diseases and maternal and perinatal conditions) would require public
expenditure in 2007 of at least US$ 34 per capita in low income countries. A vast majority of least developed countries and other low income countries spend much lesser than this amount (cited in Ravindran et al, 2005b).

5.5. How is accountability to citizens ensured?

The review of accountability practices also suggests that few health accountability mechanisms are gender-aware or gender-specific. Provider report cards, for example, often do not include indicators on gender sensitivity of health providers or whether providers ensure privacy (see review by Mcnamara, 2006). The community based monitoring and evaluation of health services by the Uganda Debt Network, again, did not include indicators of gender sensitivity of health services and gender equality in utilisation of health services (Uganda Debt Network, 2002).

While the lessons point to the need for citizens to adopt multiple accountability mechanisms (see Table 2), a gap is that not all mechanisms are available in all countries. As of June, 2004, 177 countries had signed the CEDAW, 152 the ICCPR and 149 the ICESCR (UN, 2004). Right to Health is part of ICESCR, and this Convention has one of the lowest numbers of signatories. In the case of CEDAW it is the optional protocol which empowers individuals and civil society organisations to appeal to treaty monitoring bodies when rights have been violated. Only 60 countries had signed the optional protocol as of 2004. While progress has been made in moving towards Beijing Platform for Action (1995) and Cairo Programme of Action (1994), not all countries have progressive national level gender and health legislation or policies. Some countries in Latin America have seen a reversal in abortion policies over the last decade due to influence of the Catholic Church (Macklin, 2006). Few countries have passed legislation on rights of citizens to participate in public policy or demand accountability.

6. RECOMMENDATIONS ON STRENGTHENING ACCOUNTABILITY TO CITIZENS ON GENDER AND HEALTH

Five recommendations follow to address gaps and strengthen accountability to citizens on gender and health. These recommendations draw on the lessons listed in Section 4.

**Recommendation 1: Strengthen accountability of new actors**

It is recommended that accountability of private health sector, public private partnerships in health, donors, multilateral financial institutions and community leaders to citizens on gender and health be strengthened urgently. The accountability strategies and mechanisms that right now apply to the public sector should be extended to the private health sector, multilateral financial institutions, public-private partnerships in health and donors. For example the right of citizens to participate should apply to not only formulation and monitoring of public health policies and budgets, but also to formulation and monitoring of policies of donors, PPPs and multilateral financial institutions involved in health in a country. Citizens’ right to participation should also extend to their
participation in regulation of the private health sector. Right to Information should include the rights of citizens to information not only from the government, but also the other stakeholders in the health sector. It may be made compulsory for private hospitals to have representatives of civil society organisations in their boards, have grievance redressal mechanisms, and make all quality assessment reports available to the public. At the international level, a UN structure for holding international health donors and global public-private partnerships comply with international agreements, ICESCR and CEDAW is urgently necessary. Civil society groups should be empowered to submit shadow reports, and take up cases of violation of agreements by donors and public private partnerships with this body. At the community level, there is need for legislation on democratisation of (customary) community and religious organisations, and policies to promote engendering these organisations.

**Recommendation 2: Strengthen accountability to marginalised constituencies**

To strengthen direct accountability to poor women, men and adolescents it is recommended that all health policy, programme and budget documents are translated into local language, and made accessible to marginalised groups through mass print, audio, and visual media. Mechanisms for proportionate representation of marginalised groups in health accountability structures at local, district and provincial levels may be promoted. Capacities of marginalised groups on negotiation, health, and gender issues may be strengthened. Accountability tools involving citizens’ feedback or dissemination to citizens reach them. Local associations may be formed of these constituencies so that they can put pressure from outside on health accountability structures (Mahmud 2006). These associations need to be federated at district, provincial and national levels, to input into national policies. Resources may be allocated by governments and donors for building capacities of different stakeholders to make these accountability structures work in favour of marginalised women, men and adolescents (Cornwall 2006).

**Recommendation 3: Strengthen accountability on gender equity in health and on all gender and health issues**

To address the fact that few accountability processes show evidence of having reduced gender inequalities in health, furthere implementation of controversial policies or legislation, or furthere availability of low priority and at times expensive health needs of women (e.g. breast and cervical cancer) or men (e.g. de-addiction), it is important to bring such issues into public debate in the first place. Sensitisation of media, religious leaders, health providers and managers and elected government representatives on these issues is a must. Mechanisms of health priority setting at national level that go beyond cost effectiveness models may need to be adopted, as these principles lead to the exclusion of equity goals and gender and health needs, listed above, which do not follow under the ‘public good’ category (Castillo et al. 2005). Donors may promote civil society initiatives to use CEDAW to press for accountability of governments to reduce gender inequalities in health access and outcomes (beyond gross violations of sexual and reproductive rights).
Recommendation 4: Strengthen democratic spaces, political will, and resources

To strengthen democratic spaces, a prerequisite for accountability to citizens, it is recommended that that pressure be put on countries that have not signed and ratified the International Covenant on Civil and Political Rights (without reservations), and the optional protocol pertaining to this Covenant to do so. Citizens groups should be encouraged to prepare shadow reports on status of civil and political rights. In countries where electoral democracies exist, they need to be deepened through strengthening ability of the poor women and men to contest and win elections, as well as creating legislation and structures for participation in policy formulation, budgeting and local governance along the lines attempted in Brazil and Argentina. An activist press and judiciary may be advocated and promoted. Low income countries need to increase resources to health through increased flow of funds from donors and greater allocation of budget by national governments.

Recommendation 5: Addressing challenges in using the five possible accountability strategies

To enable citizens to use a combination the five strategies and multiple mechanisms for accountability on gender and health, international and national pressure should be put on national governments which have not signed the ICESCR, CEDAW, and the optional protocols (where applicable) to do so without reservations. Shadow reports by health and women’s rights groups monitoring progress towards Cairo, ICPD, MDGs, Beijing Platform for Action need to continue, along with advocacy for policy and legal change where necessary (national and provincial levels). Advocacy for right to health to gender equality is essential. It is suggested that WHO and health donors support initiatives to engender health accountability structures and tools, and weave in health issues into gender accountability structures and tools.

To operationalise these recommendations, it is suggested that an Accountability Desk be established within an appropriate Department of WHO. It may be vested with the responsibility for institutionalising concerns of accountability to citizens within all programmes of other departments with governments, public-private partnerships, social research institutions, and civil society organisations, as well as coordinating a global programme on strengthening accountability to citizens on health in general, and gender and health in particular. Similar structures may be evolved at the regional and country offices of the WHO, as well within Ministries of Health of national governments.
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