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ISSUES IN CURRENT POLICY

Using Accountability to Improve Reproductive Health Care

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Abstract: *Accountability is best understood as a referee of the dynamics in two-way relationships, often between unequal partners. The literature on accountability distinguishes between political, fiscal, administrative, legal and constitutional accountability. This paper focuses on accountability mechanisms in health care and how they mediate between service providers and communities and between different kinds of health personnel at the primary health care level. It refers to case studies of participatory processes for improving sexual and reproductive health service delivery. Information, dialogue and negotiation are important elements that enable accountability mechanisms to address problems by supporting change and engagement between participants. In order to succeed, however, efforts towards better accountability that broaden the participation of users must take into account the social contexts and the policy and service delivery systems in which they are applied, address power relations and improve the representation of marginalised groups within communities and service delivery systems.* © 2003 Reproductive Health Matters. All rights reserved.

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SOCIAL movements frequently call for greater accountability when bringing attention to neglected issues and marginalised groups. Increasingly, health policy recommendations also suggest that improving accountability leads to more responsive policies and effective services. As a result, many accountability mechanisms, e.g. consumer charters, hospital boards, village health committees, and publicity campaigns are currently being used in implementing health policies and programmes worldwide. These measures support a broad range of activities that include information dissemination, monitoring, mediation and peer pressure between various actors.[1–4]

Why is accountability needed? In poor rural areas such as northern Karnataka, India, government health services struggle to deliver care in the context of corruption, overwhelming staff vacancies and poor infrastructure. By focusing on change within Health Ministries, sometimes in isolation from community governance structures and development efforts, health policymakers may miss important opportunities to improve services in disadvantaged areas. Conversely, by mobilising the public for sexual and reproductive rights without simultaneously engaging health personnel, community-based organisations may contribute to stand-offs that block access to important, albeit at times inadequate, government services. In these contexts, accountability mechanisms can support interactions between communities and services to the benefit of both service providers and their users.

Accountability is best understood as a moderator or referee of the dynamics in two-way relationships, e.g. between service providers and patients, different levels of health care service delivery, health and finance ministries, donors and funding recipients, elected representatives and health officials, and elected

representatives and voters. The literature on accountability distinguishes between political, fiscal, administrative, legal and constitutional accountability and between vertical (external mechanisms used by outsiders against government) and horizontal types of accountability (internal mechanisms between different branches and levels of government).[5–8]

Despite its emerging importance, however, few apart from Cornwall[9] have critically examined how accountability actually operates in health care. Using case studies of participatory processes for improving sexual and reproductive health service delivery,[9–11] this paper focuses on how accountability mediates relationships between service providers and communities and between different kinds of health personnel.

Accountability mechanisms ideally aim to support collaborative solutions. Good collaboration usually takes place between partners who are interdependent and who have joint ownership over decisions.[12] Unfortunately, in a hierarchical world, ideal partnerships of this kind are rare. Accountability measures therefore typically mediate relationships between unequal partners with the aim of redressing the imbalances between them. In order to do so constructively, challenges related to power, representation and transformation need to be addressed.

Confronting unequal power relations

A critical function of accountability is to control the arbitrary use of power by those who wield it. Schedler identifies answerability and enforceability as two main themes defining accountability.[5] Answerability, the obligation to inform and explain, can involve the media, monitoring committees, ombudsmen and advocacy groups, among others. However, as important as it is, answerability alone may not lead to change. Policymakers and programme implementers must also be sensitive to the issues raised and mindful of the enforcement mechanisms that may be used to hold them to task.

Confronting power structures, especially those marked by social inequalities, may seem too ambitious for some. But status quo situations are not static phenomena. They are actively constructed and maintained. Although many situations conventionally do not favour marginalised groups who seek accountability, most authorities require a degree of public support and legitimacy to safeguard their status and mandate.[7,13] Mental health service users and disabled people in the UK have used forums to interact with providers and at times contradicted providers' claims of good quality services with their own bad experiences. They found that although a fundamental shift in the balance of power did not occur, those in positions of power were forced to reconsider their practices.[14]

Understanding power as being fluid and negotiated means that there are always opportunities and mechanisms for contesting power relations in creative ways. Even when abuses of power cannot be confronted directly, they are not necessarily accepted passively. Resistance exists even in the form of petty sabotage, non-cooperation, or humour directed at the powerful.[7,15] Staff who have little say over how their work is organised can protest by not cooperating, by working slowly or calling in sick. Government personnel can take leave to protest against transfers made against their will.

In terms of health-seeking behaviour, women aspire to have control over their reproductive lives through a range of actions, which sit along a continuum of accommodation, subversion and resistance, sometimes at great cost to their health. They show tremendous resilience and courage and "not only cope patiently with meagre resources and intransigent cultural and social barriers… but defy the tradition of female passivity: manoeuvring around, subverting, bending, or sometimes directly challenging those barriers".[16]

Collective identities can be formed on the basis of oppression in ways that counter the dynamics of fatalism and isolation, which marginalise certain social groups.[14] In this way the "political energy of a socially involved adult, prepared to accept conflict and contradiction as a part of life", has enormous potential for social change.[17] Experience also suggests that groups which are internally democratic are more successful in seeking accountability for marginalised people,[1] and that change strategies are more successful when they are presented by broad alliances. This suggests that in order to be successful, accountability mechanisms need to emphasise building broad and democratic constituencies to support social change.

Representation

Building more democratic constituencies means changing the frameworks through which people and issues are represented. Accountability in this way is more than an accounting process between two unequal parties.[1] It also entails having unacknowledged and neglected concerns represented and addressed in policies and programmes. Accountability is therefore particularly important for sexual and reproductive health issues because they are so pervasively affected by social bias. Conditions and experiences such as reproductive tract infections and violence are ''silently endured'' by women. Service delivery can neglect certain life stages and discriminate against some population groups. Legislation continues to criminalise women seeking abortions, sex workers and sexual dissidents.* In such cases representation during policy formulation and implementation is necessary.

Representation within government oversight mechanisms can be shaped in a variety of forms.[1] *Consultation* involves opening areas for information-sharing and dialogue, but with those inviting consultation firmly in control of how the inputs gained are used. A second step entails institutionalising regular access to processes of decision-making. This presence can lead to improved mutual sensitisation of concerns, but can sometimes also be reduced to tokenism by authorities. Presence can change into *influence* if it is coupled with the power to demand investigations and make changes in organisational rules and structures.**

These differences in power mirror differences that distinguish beneficiaries, consumers and citizens.[18] Broadening choices by improving market access to providers, services, drugs or health technologies is important in many contexts. But having more consumer choice does not mean that sexual and reproductive needs are being addressed, if the contexts in which these choices are manufactured and used are not critically examined.[19] Research on user perspectives on contraceptives shows that women may choose a certain method by making trade-offs about which is the least worst method available.[20] Seen in this light, acceptance or continuation of pre-determined options does not necessarily imply satisfaction or accountability.[21] Targeted beneficiaries and consumers may not wield enough influence to ensure that the pre-determined options made available to them adequately suit their needs.

Accountability does still exist even when representation does not manage to counter biases against the less powerful. In these instances, accountability flows in directions that are contrary to the needs of those marginalised by society. In India, for example, women's need for contraception was subverted into a narrower focus on the use of IUDs and sterilisation, as enforced contraceptive targets made health workers more accountable to their supervisors than to meeting women's needs. We need to be more sensitive as to when accountability measures serve to mitigate hierarchies of age, gender, sexuality, caste, race and class, and when they can exacerbate them.

Some accountability mechanisms may address beneficiaries' needs appropriately, even though they exclude the direct representation of users. Evaluations of safe motherhood initiatives list accountability as a key ingredient to their success.[22] In Malaysia, hospitals are assessed twice a year using indicators set by clinical specialists, and quality assurance committees review hospitals found to be outliers. Similarly, in China, provincial governors are required to report progress on maternal mortality, and funding is dependent on progress. Although these measures are certainly beneficial to women, accountability flows upwards from programme officials to expert committees to finance departments. Yet the women they serve are not consulted.

*Language that defines sexuality is continuously contested and revised. I use the term sexual dissidents to encompass alternative sexualities that include lesbian, gay, bisexual, transgendered communities, people in same-sex relationships, and heterosexuals who support democratising rights with respect to sexuality.

**Key features in ensuring that outsiders can influence government oversight mechanisms are: legal standing for non-government participants, their regular presence, clear procedures for meetings between outsiders and public agencies, right to information for outsiders, right for outsiders to issue dissenting reports to legislative bodies, duty of enforcement agencies to investigate dissent and take action against those found guilty.[8]

Although such accountability measures might work well in the short term, without the involvement of those who need the services, continuation may be threatened when key bureaucrats are changed. In Santa Barbara d'Oeste, Brazil, for example, when a new mayor came to power he saw no reason to continue the vasectomy programme in a project initiated by the previous Health Secretary. He also perceived the issue to be a political risk. It took community representatives on the executive committee of the project to defend the programme, its values and services. They not only managed to change the mayor's mind, but he has since become a major supporter of the project.[23] Thus, accountability mechanisms need to be backed by vigilant users to counter conservative lobbies that disagree with the values on which sexual and reproductive rights and health are founded.

Similarly, in the same city, physicians at health posts began to exert pressure to return to previous scheduling patterns that had served their own interests rather than those of their patients. They managed to succeed, due to lack of supervision, until this was addressed by the NGO advising the project.[23] The mobilisation of constituents who support sexual and reproductive health services can in this way counter vested interests and the sometimes negative effects of the transfer of staff or changing political regimes.

Transforming how participants perceive themselves

Those involved in seeking accountability for marginalised people note that the policy process itself can transform their very efforts at representation in both positive and negative ways. Mental health service users and disabled people in the UK found that they were often not taken seriously by decision-makers, as they were not seen to be capable of engaging in policy processes.[14] They were accused of presenting personal problems that did not reflect the general picture. However, when they organised to demonstrate that their issues were not isolated individual cases but part of systemic policy bias, they were labelled as ''activists'' and accused of not being representative of the people they were arguing for. Similar dynamics serve to restrain claims to legitimacy by feminists and other women's health advocates who attempt to change social orders in favour of women's rights. One way for authorities to retain power is by legitimising people as beneficiaries and consumers only if they are passive, dependent and isolated individuals, rather than as citizens and active participants in their own health care.

With respect to sexuality and reproduction, similar power relations define norms that maintain inequality within intimate relationships, households, communities, health services and other social institutions.[24] As health providers and health systems absorb and replicate these societal norms, engagement with the values held by public officials and the values maintained by the broader public is necessary.[14] Guidelines, forms of supervision and training programmes must regularly be reviewed, keeping in mind the values with which they are designed and implemented. Training service providers together in teams can facilitate the implementation of new strategies that may be controversial, as it helps to foster group understanding and support for change. This contrasts with training gender focal points who return to implement strategies in organisations that neither understand nor support the changes suggested.[25]

Improving the representation of marginalised groups can change not only how service providers perceive marginalised groups, but also how marginalised people see themselves. In Andhra Pradesh, India, a pilot project guided by the Academy for Nursing Studies aimed to make the health system more accountable by improving interactions between providers and lower caste women (Dr Prakasamma, personal communication, 9 November 2002). *Mahila arogya sanghas* (women's health groups) were formed and given training to foster group togetherness, empowerment, self-esteem and bargaining skills. These training sessions focused on gender, health and social action (how to hold a meeting, how to speak in public, how to address and handle government officials). Symbolic measures were used to affirm the women as community representatives; the local government doctor, who had been involved in the training, signed and stamped identification badges legitimising their skills, while each *sangha* also had their own banner symbolising their pride in their work.

Subsequently, *sangha* women accompanied a woman with obstructed labour to the nearest

government hospital in the middle of the night. When they were barred from entering the hospital grounds, they flashed their badges at the guard who was so impressed that he let them proceed. When they reached the ward, the nurse informed them that the doctor was not available. When the women again showed their badges, the nurse, after studying the badges, went to look for the doctor. Not only were the woman and infant saved, but the *sangha* women subsequently became village heroines.

Thus, supporting accountability measures that encourage the active participation of marginalised groups can support the assertiveness and empowerment of those who are socially excluded. In this way, citizenship is nurtured by social actions that foster a sense of agency and entitlement.[14,26] Having earnings of one's own and belonging to a community group or trade union are critical factors motivating women's sense of entitlement and the ability to express it.[16] Collective efforts also help to protect individuals who may be put at risk if they contest authorities on their own. Some *sangha* members in northern Karnataka have found that when they accompany poor women to the health centre, their collective presence inhibits health workers from asking for informal payments.[27]

Nurturing a sense of entitlement in this way is critical when considering that many sexual and reproductive health issues are not addressed partly because they are undervalued and shrouded in silence by communities, services and among women themselves. If it is accepted that ''powerlessness and social inferiority in the face of officialdom are themselves dimensions of poverty'',[28] then empowerment resulting from participation in accountability initiatives contributes to better health and improved health systems, and is also an important end in itself.

To help to ensure that accountability processes can improve health service delivery generally and in particular make them more responsive to sexual and reproductive health for marginalised groups, information, dialogue and negotiation are all necessary.

Information

In the field of health care, knowledge, whether traditional or biomedical, is specialised and at times uncertain. Illness or injury cannot always be predicted and expertise cannot always heal the ailing. Nonetheless, health providers usually know more about health and health care than their patients, and the information they provide about diagnosis, treatment options and follow-up can powerfully determine the experience of illness and care. In Mumbai, India, research on client and provider interactions in a women's health service revealed that although 67% of patients were told of their problem, only 43% were told about the investigations that were needed and 35% about their treatment in detail, and only 28% of providers checked to see if their patients had understood them.[29] With such uneven communication, it is no surprise that ''compliance'' with treatment or follow-up visits is so low among poor women. These findings echo results from quality of care research on family planning programmes across the world.[10,11]

Not only is access to information essential for improving health awareness and access, it is impossible to mobilise for change without it. People cannot demand services and accountability if they do not know what they need and what they are entitled to. But information by itself cannot lead to change, unless rights to access information are supported and bureaucracies are prepared to respond to such requests. In India, Right to Information laws, enabling the public to obtain government documents, and Transparency in Procurement laws, allowing the public to access information about current government tenders, have been passed. Nonetheless, government has failed to promote awareness of this legislation within bureaucracies and among the public.[30,31] Moreover, in the national version of the Right to Information legislation, there are no sanctions against bureaucracies that do not respond or an independent appeals process if access is denied.[32]

With these caveats in mind, awareness and accountability can be improved at programme level by publicising health centre data. These data are usually collected by monitoring systems supervised by health managers. Accountability in these cases tends to flow upwards from service providers to managers. Yet data of this kind, if presented appropriately, can foster a sense of awareness and ownership of health services by communities.

Similarly, auditing can also support positive behaviour by using information to reinforce learning and dialogue. Yet in some contexts this may not be advisable. In Indonesia, maternal–perinatal audits of difficult cases were introduced at the district level to serve as a learning tool.[33] Despite guidelines emphasising that this was not meant to be corrective, a young doctor was criticised by specialists for taking life-saving actions that were ''only allowed for specialists'', in spite of the absence of transport to bring the woman to hospital. Such experiences have led to resistance to reporting cases for audit, thereby defeating the original intention. Supervision and performance reviews, when enforced in hierarchical organisations rife with social divisions, lose their supportive functions. The right of less powerful actors not to participate in such contexts must be understood and other ways found to carry out these useful exercises.

Citizen charters are one way of defining expectations and rules of engagement, ideally in ways that protect the rights of less powerful actors. Patients' charters disseminate information defining standards that providers must agree to uphold and therefore shift accountability downwards from providers to patients. Charters can also outline health workers' rights to secure better working conditions. However, these mechanisms may threaten health professionals, who form powerful lobbies, especially if they go so far as to outline mechanisms for lodging complaints that may lead to investigation and punishment. In order to address their objections in Mumbai, the need for better communication was stressed rather than the demand for accountability from them.[29] The development of such public charters can take long periods of negotiation and preparation to ensure that health workers and facilities can address patients' demands.

Dialogue and negotiation

Several quality of care methodologies in reproductive health have used participatory approaches to guide dialogue and negotiation in forming peer groups and developing professional standards and norms.[10,11] Such efforts can help to mitigate social biases and barriers between health professionals and thus improve accountability. For example, in addressing women's health in Mumbai, nurses and doctors were trained together. This was appreciated, as both groups felt it was the first time in a training situation that they were able to learn together and from each other. Doctors gained insights from auxiliary nurse-midwives (ANMs) about the social problems of women patients, while nurses welcomed the clinical perspectives shared by doctors. Such attempts to foster dialogue help to break down misconceptions that exist within the hierarchical world of health services. Prior to this process of collaborative training, doctors hesitated to share information with ANMs as they did not want to promote ''half-baked practices''.[29]

Negative assumptions can also prevail between health service providers and patients. Providers in North and North East Lincolnshire, UK, thought adolescents should accept services even if they did not especially address young people's needs, as they were better than no services at all.[34] In India, poor patients are sometimes seen as supplicants who ought to be grateful for whatever they are receiving at the hands of the state, regardless of its quality.[29] Even more harmful is the assumption that poor women are guilty of causing poverty if they do not use birth control.[25] Dialogue can encourage people to reflect on these assumptions. When service providers listen to the perspectives of those who come from very different social positions, they sometimes come to understand the limitations of their own views on what is in the best interests of their patients.

Participatory research in Mumbai encouraged ANMs to listen to their clients, to reflect on the lives women lead and to explore the reasons behind women's problems. As a result, they no longer saw the women they were serving as guilty or as problem cases who needed to follow orders. They began to see their patients as women like themselves. The insights gained from the guided exploration of their environment and the emphasis on improving communication and group facilitation skills with their patients, also proved useful in their interactions with their colleagues and supervisors. Within their homes, ANMs learned to share responsibility rather than shoulder work alone and to listen to others, especially the adolescent girls in their families.[35] This shows how improving accountability in one sphere can have effects in other spheres.

Efforts to improve dialogue between health workers and communities can lead to alliances that negotiate with higher level authorities for improvements. In Oruru department, Bolivia, Save the Children/US worked to develop a community-based health information system. This led to a better appreciation of maternal and child health issues helping to set priorities for community action, access resources, and evaluate progress. This encouraged community members to express their concerns to hospital health staff: Why was the hospital continuing to charge for consultations when the media had announced that national health insurance covered children under five and pregnant women? The district nurse explained that since the municipal mayor had not reimbursed the hospital for its costs, the hospital was forced to charge for services. Community leaders met with the mayor to insist that he pay what was owed to the hospital. He did so and now services are covered by municipal funds as per the national policy.[36] In this way, communities and health workers can work together to form new kinds of relationships, which establish precedents and a collective history that reinforces demands for accountability.

Similarly, ANMs in rural Karnataka, when supported by more flexibly minded supervisors, responded to the move away from contraceptive targets in ways that were more supportive of community needs. Despite increasing workloads, they gained the respect of both communities and supervisors, which served to transform their jobs for the better.[37] However, for this positive deviance to be reinforced, hierarchies within the health care system need to be critically examined. As important as they are, it is naïve to think that participatory efforts that seek to improve patient–provider relations can by themselves address all the constraints facing service delivery in poverty contexts.

Challenges

In this sense, accountability measures require those in power to be open to the changes they bring. Health watch committees in Bangladesh, formed as a state–community–NGO effort to monitor service performance, ran into problems as committee members were not perceived to be qualified enough to question doctors. Furthermore, they had no mechanism to monitor the NGO that dominated the initiative. The one-day training given proved to be inadequate in preparing the committee with the technical and organisational skills needed to pressure for change. Consequently their role was limited to improving community health awareness and motivating poor users to access the service. When performance monitoring was actually attempted this was restricted to the cleanliness of the facilities, rather than the professional or service performance of providers.[26] Governments must be open to effectively supporting and broadening accountability measures in order for them to succeed. To do this successfully more sensitivity needs to be shown towards the social context and strategic interests of the different kinds of health providers involved.[38–40]

Participatory processes can open up accountability mechanisms to represent broader segments of society and less powerful actors within health services, making them more sustainable, effective, and equitable. However, they cannot be treated as unproblematic solutions, not least because participatory methods are not automatically inclusive. They can actively be used to construct boundaries around communities or user groups by legitimising some voices and not others,[41] mirroring and even exacerbating the social divisions that mark communities.[42] In the early stages of the project that sought to improve access to and quality of Brazilian municipal health services in Santa Barbara d'Oeste, the formation and participation of a local women's organisation helped to ensure that women's reproductive health concerns were represented on the project committee and in its interventions. Nonetheless, it was not until poorer women in the community participated that issues of access were addressed.[23] Those committed to pursuing accountability must be ready to question who is represented and who may have been left out in order to ensure that policy and programme structures do serve the cause of equity.

Concluding remarks

Accountability measures, as a part of regulatory or oversight efforts, are relatively neglected within health systems in comparison to efforts to organise and finance services.[43] They should be playing decisive roles in ensuring that programmes for sexual and reproductive health care

are implemented properly in a manner that is responsive to needs. Considering the time, training, supervision and potential reorganisation of service management that they entail, sustained resources need to be committed to them.

In terms of research, attention needs to be paid to understanding how answerability and enforceability are currently operating within health systems. This means analysing what kind of information is collected and how it is used by monitoring and supervisory systems. This needs to be followed up with an examination of what sorts of actions are used to reward good practices and reprimand bad ones. To have impact, reflection and learning from such experiences need to be effectively transmitted to larger groups.

This paper has focused on how efforts to improve accountability can partner communities with lower level health workers to improve health service delivery in reproductive health. The vision of reproductive health services as codified in Cairo means engaging with women as health care users and equal partners not only in sexual relationships, families and communities but also in planning and implementing sexual and reproductive health services. However, women's low expectations and passivity, the historical paternalism of health care professionals and limited community engagement in the design of most health programmes have all limited the efficacy of reforms envisioned by reproductive health advocates.[11] Accountability serves as an important resource for mediating relationships between service users, providers and managers to overcome these challenges. It is best achieved through negotiated, iterative processes that represent the participants involved, their relationships and the social contexts they operate in. Herein lie its limitations but also its dynamic power.

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References

1. Goetz AM, Gaventa J. Bringing Citizen Voice and Client Focus into Service Delivery. IDS Working Paper 138. Brighton: Institute of Development Studies, 2001.
2. Mackintosh M. Informal regulation: a conceptual framework and application to decentralized mixed health care systems. In: Mackintosh M, Roy R, editors. Economic Decentralization and Public Management Reform. Cheltenham: Edward Elgar, 1999.
3. Mackintosh M, Gilson L. Non-market relationships in health care. Open Discussion Papers in Economics. No. 19. Milton Keynes: Open University, 2000.
4. Brugha R, Zwi A. Improving the quality of private sector delivery of public health services: challenges and strategies. Health Policy and Planning 1998;13(2):107–20.
5. Schedler A. Conceptualising accountability. In: Schedler A, editor. The Self-Restraining State: Power and Accountability in New Democracies. London: Lynne Reinner, 1999.
6. O'Donnel G. Horizontal accountability in new democracies. In: Schedler A, editor. The Self-Restraining State: Power and Accountability in New Democracies. London: Lynne Reinner, 1999.
7. Newell P, Bellour S. Mapping Accountability: Origins, Contexts and Implications for Development. IDS Working Paper 168. Brighton: Institute of Development Studies, 2002.
8. Goetz AM, Jenkins R. Hybrid forms of accountability: citizen engagement in institutions of public-sector oversight in India. Public Management Review 2001;3(3):363–83.
9. Cornwall A, Lucas H, Pasteur K, editors. Accountability through participation: developing workable partnership models in the health sector. Institute of Development Studies Bulletin 200031(1).
10. Cornwall A, Welbourn A, editors. Realising Rights: Transforming Approaches to Sexual and Reproductive Well-Being. London: Zed Books, 2002.
11. Haberland N, Measham D, editors. Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning. New York: Population Council, 2002.
12. Waters H, Hatt L, Axelson H.

Working with the Private Sector for Child Health. Health, Nutrition and Population Discussion Paper. Washington DC: World Bank, 2002. Cited in: Peters, DH. The role of oversight in the health sector: the example of sexual and reproductive health services in India. Reproductive Health Matters 2002;10(20):82–94.
13. Schneider A, Ingram H. Social construction of target populations: implications for politics and policy. American Political Science Review 1993;87(2):334–47.
14. Barnes M. Users as citizens: collective action and the local governance of welfare. Social Policy and Administration 1999;33(1):73–90.
15. Scott J. Weapons of the Weak: Everday Forms of Peasant Resistance. New Haven: Yale University Press, 1985.
16. Petchesky RP, Judd K, editors. Negotiating Reproductive Rights: Women's Perspectives Across Countries and Cultures. London: Zed Books, 1998.
17. Oakley A. Who cares for health? Social relations, gender, and the public health. Journal of Epidemiology and Community Health 1994;48:427–34.
18. Cornwall A. Beneficiary, Consumer, Citizen: Perspectives on Participation for Poverty Reduction. SIDA Studies No. 2, 2000.
19. Wajcman J. Delivered into men's hands? The social construction of reproductive technology. In: Sen G, Snow R, editors. Power and Decision: The Social Control of Reproduction. Boston: Harvard School of Public Health, 1994.
20. Walsh J. Contraceptive choices: supporting effective use of methods. In: Ravindran TKS, Berer M, Cottingham J, editors. Beyond Acceptability: Users' Perspectives on Contraception. London: Reproductive Health Matters, 1997.
21. Heise LL. Beyond acceptability: reorienting research on contraceptive choice. In: Ravindran TKS, Berer M, Cottingham J, editors. Beyond Acceptability: Users' Perspectives on Contraception. London: Reproductive Health Matters, 1997.
22. Koblinsky MA, Campbell O, Heichelheim J. Organising delivery care: what works for safe motherhood? Bulletin of World Health Organization 1999;77(5):399–406.
23. Díaz M, Simmons R, Díaz J, et al. Action research to enhance reproductive choice in a Brazilian municipality: the Santa Barbara Project. In: Haberland N, Measham D, editors. Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning. New York: Population Council, 2002.
24. Cottingham J, Myntti C. Conceptual mapping and evidence. In: Sen G, George A, Östlin P, editors. Engendering International Health: The Challenge of Equity. Cambridge: MIT Press, 2002.
25. Ramachandran V. Mainstreaming gender in the health sector: reflections on South Asian experience. New Delhi, 2001. (Unpublished)
26. Mahmud S. Making rights real in Bangladesh through collective citizen action. Institute of Development Studies Bulletin 2002;33(2):31–39.
27. Gender and Health Equity Karnataka Case Study Planning Meeting, Bangalore, 9 November 2002.
28. McGee R, Norton A. Participation in Poverty Reduction Strategies: A Synthesis of Experience with Participatory Approaches to Policy Design, Implementation and Monitoring. IDS Working Paper 109. Brighton: Institute of Development Studies, 2000.
29. Khanna R, de Koning K. Women's health, human rights and the public health system: a case study of the women-centred health project. (Unpublished)
30. Comparative Table of RTI Laws and Bills in India. Commonwealth Human Rights Initiative/ Consumer Rights Education and Awareness Trust. Distributed on 10 November 2002.
31. Workshop on Operationalisation of Karnataka Right to Information Act 2000. Commonwealth Human Rights Initiative/Consumer Rights Education and Awareness Trust. Bangalore, 10 November 2002.
32. Gopalkrishnan A. Information by Right. Frontline 2003; (17 January):100–102.
33. Geefhuysen CJ. Safe motherhood in Indonesia: a task for the next century. Berer M, Ravindran TKS, editors. Safe Motherhood Initiatives: Critical Issues. London: Reproductive Health Matters, 1999.
34. Westerby M, Harris J. At your service: participatory evaluation in practice. In: Cornwall A, Welbourn A, editors. Realising Rights: Transforming Approaches to Sexual and Reproductive Well-Being. London: Zed Books, 2002.
35. Khanna R, de Koning K, Khandekar S, et al. "As our friends or sisters": the role of participatory research in sensitising Auxiliary Nurse Midwives to a woman-centred approach to health care in Mumbai, India. In: Cornwall A, Welbourn A, editors. Realising Rights: Transforming Approaches to Sexual and Reproductive Well-Being. London: Zed Books, 2002.
36. Howard-Grabman L, Willis CP, Arteaga E, et al. A dialogue of knowledge approach to better reproductive, sexual and child health in rural Andean

communities. In: Cornwall A, Welbourn A, editors. Realising Rights: Transforming Approaches to Sexual and Reproductive Well-Being. London: Zed Books, 2002.
37. Murthy N, Ramachandar L, Pelto PJ, et al. Dismantling India's contraceptive target system: an overview and three case studies. In: Haberland N, Measham D, editors. Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning. New York: Population Council, 2002.
38. Nichter M. The primary health centre as a social system: primary health care, social status, and the issue of team-work in south Asia. Social Science and Medicine 1986;23(4):347–55.
39. Atkinson S, et al. Going down to the local: incorporating social organisation and political culture into assessments of decentralised health care. Social Science and Medicine 2000;51: 619–36.
40. Tendler J. Good Government in the Tropics. Baltimore: Johns Hopkins University Press, 1997.
41. Cornwall A. Locating citizen participation. Institute of Development Studies Bulletin 2002;33(2):49–58.
42. Guijt I, Kaul Shah M, editors. The Myth of Community: Gender Issues in Participatory Development. London: Intermediate Technology Publications, 1998.
43. Peters DH. The role of oversight in the health sector: the example of sexual and reproductive health services in India. Reproductive Health Matters 2002;10(20):82–94.

Résumé

L'obligation de rendre compte est en quelque sorte un arbitre des dynamiques dans les relations bilatérales, souvent entre partenaires inégaux. Les publications distinguent la responsabilité politique, fiscale, administrative, juridique et constitutionnelle. Cet article décrit comment les mécanismes de responsabilité dans les soins de santé font la médiation entre prestataires de services et communautés et entre différents personnels des soins de santé primaires. Il cite des études de processus participatifs pour améliorer les services de santé génésique. L'information, le dialogue et la négociation sont des éléments importants qui permettent aux mécanismes de responsabilité de traiter les problèmes en soutenant le changement et l'engagement entre participants. Néanmoins, pour réussir, les efforts vers une meilleure responsabilité élargissant la participation des usagers doivent tenir compte des contextes sociaux et des systèmes politiques et de prestation des services dans lesquels ils sont appliqués, aborder les relations de pouvoir et améliorer la représentation des groupes marginalisés dans les communautés et les systèmes de prestation des services.

Resumen

La rendición de cuentas se puede entender cómo un árbitro de la dinámica de las relaciones bilaterales, a menudo entre socios desiguales. En la literatura sobre el tema se distingue entre la rendición de cuentas política, fiscal, administrativa, legal y constitucional. Este artículo se enfoca en los mecanismos de rendición de cuentas en la atención en salud, y como funcionan de mediador entre los prestadores de servicios y las comunidades, y entre distintos tipos de personal de salud a nivel de la atención primaria. Se refiere a estudios de caso de procesos participativos dirigidos a mejorar la provisión de servicios de salud sexual y reproductiva. La información, el diálogo y la negociación son elementos importantes mediante los cuales los mecanismos de rendición de cuentas pueden abordar problemas al apoyar el cambio e involucrar a los participantes. Para que tengan éxito, sin embargo, los esfuerzos por mejorar la rendición de cuentas al ampliar la participación de los usuarios deben tomar en cuenta los contextos sociales y los sistemas políticos y de prestación de servicios en los cuales se aplican, enfrentar las relaciones de poder y mejorar la representación de los grupos marginados en las comunidades y los sistemas de prestación de servicios.