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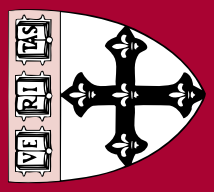

Accountability in Health Services

Transforming Relationships and Contexts

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Abstract

Accountability mechanisms ideally mediate relationships between two unequal partners with the aim of redressing the imbalances between them. In order to do this accountability measures must contest power relations, legitimise marginalised groups, and transform the actors involved. These elements endear accountability to people at the margins of society and to health issues marked by social inequalities and stigma, thus making it particularly useful to sexual and reproductive health, but also to other areas like mental health and disability. An emphasis on information, dialogue, and negotiation can ground this approach to accountability within efforts to improve health service delivery. I review case studies that highlight these elements and conclude that efforts to improve accountability cannot just rely on instituting asocial mechanisms. They must support iterative processes and constructive relationships that together transform their social contexts. Here in lie their limitations but also their dynamic power.

Introduction

Social movements frequently call for greater accountability when bringing attention to neglected issues and marginalised groups. Increasingly, health policy recommendations also suggest that accountability can support more responsive policies and effective services. As a result, many accountability mechanisms like consumer charters, hospital boards, village health committees, publicity and advocacy campaigns are currently being used in implementing health policies and programmes world wide. These mechanisms 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, like northern Karnataka, India, government health services struggle to deliver services in the context of corruption, overwhelming staff vacancies, and poor infrastructure. By focussing on change within health ministries, sometimes in isolation from community governance structures and development efforts, health policy makers may miss important opportunities to improve services in disadvantaged areas. Conversely, by mobilising the public for sexual and reproductive health rights without simultaneously engaging health personnel, community-based organisations may sometimes contribute to stand offs that may block access to important, albeit at times inadequate, government services. By supporting interaction between communities and services, accountability measures should foster synergies that counter these problems to the benefit of both services 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 and 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) [5-7]. Recent research reflecting on the shortcomings of vertical and horizontal accountability efforts that operate independently of each other, documents the strength of hybrid forms of accountability in which outsiders are effectively involved within government oversight mechanisms [1, 8].

Despite its emerging importance, however, few apart from Cornwall [9] have critically examined how accountability actually operates in health. Accountability mechanisms, like conventional approaches to regulation by governments or self-regulating professional associations that operate independently of users, may not by themselves always be responsive to those marginalised by society. With this in mind, I explore the underlying processes and challenges that face accountability in health. To illustrate my arguments I refer to case studies that engage health workers and communities through participatory processes to improve the accountability and responsiveness of sexual and reproductive health service delivery [9-11]. This means looking at relationships between service providers and communities and between different kinds of health personnel (managers and workers, doctors and nurses, female and male providers, etc).

Accountability ideally aims 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 such as ours, ideal partnerships of this kind are rare specimens. Accountability measures therefore typically mediate relationships between unequal partners with the aim of redressing these imbalances. In order to do so constructively, challenges related to power, representation, and transformation need to be addressed.

Confronting Power

A critical function of accountability is to control the arbitrary use of power by those who wield it. Elaborating on this understanding, 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 reporting information and justifications are, answerability alone may not lead to change. In order to be effective, 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. Yet mental health service users and disability people in the UK used forums to interact with providers and at times contradict providers' claims of good quality services with their own bad experiences. These user groups found that although a fundamental shift in the balance of power did not occur, they did force those in positions of power to reconsider their practices [14]. Although most 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].

Understanding power as being fluid and negotiated means that there are always opportunities and mechanisms for contesting power relations in any number of 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 also protest by frequently calling in sick, working very slowly, going on leave.

Similarly, women aspire to have control over their reproductive lives through a range of actions along a continuum of accommodation, subversion, and resistance, sometimes at great cost to their health. In researching reproductive rights "findings paint a picture of tremendous resilience and courage; women who not only cope patiently with meagre resources and intransigent cultural and social barriers…but who defy the tradition of female passivity: manoeuvring around, subverting, bending, or sometimes directly challenging those barriers" [16: 316].

Collective identities can be formed on the basis of oppression in ways that counter the dynamics of fatalism and isolation that 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 suggests that groups that are internally democratic are more successful in seeking accountability for marginalised people [1]. Change

strategies are also 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

Addressing power relationships and building more democratic constituencies entails changing the frameworks through which people and issues are represented. Accountability measures are therefore not just an accounting process between two unequal parties, but must also create opportunities for representing and addressing previously unacknowledged and neglected concerns [1]. In this way accountability is particularly relevant to sexual and reproductive health issues because they are so pervasively affected by social bias. Conditions and issues like reproductive tract infections and violence against women are 'silently endured'. Service delivery can neglect certain life stages and discriminate against some population groups. The development and use of reproductive technologies are socially negotiated. Legislation continues to criminalise women seeking abortions, sex workers and sexual dissidents[1]. In such cases representation during policy formulation and implementation is necessary even though it may not be sufficient to counteract these types of policy bias.

Representation 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 to *influence* if such representation is coupled with the power to demand investigations and make changes in organisational rules and structures[2].

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 doesn't 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 choose a certain method by making trade-offs about which is the least worst one 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 can 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 currently marginalised by the policy process. In India, for example, women's need for contraception was subverted into a narrower focus on IUD use and sterilisation, as enforced contraceptive targets made health workers more accountable to their supervisors than to meeting women's needs.

Some accountability measures may seem to 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 compared twice a year according to indicators set by clinical specialists. Quality assurance committees review hospitals that are found to be outliers. Similarly in China, provincial governors are required to report progress on maternal mortality and funding is dependent on achieving progress. Although these measures are certainly beneficial to women, accountability flows upwards from program officials to expert committees to finance departments. Yet the women they serve are not consulted.

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 change. In Santa Barbara d'Oeste, Brazil, for example, when a new mayor came to power he saw no reason to continue the vasectomy programme supported by 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 and its value and services. They not only managed to change the mayor's mind, he has since become a major supporter of the project [23]. 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 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 Actors

Those involved in seeking accountability for marginalised people note that the policy process itself can transform their very efforts at representation. This can happen in positive and negative ways. Mental health service users and disability 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' who were not representative of the people they were arguing for. Similar dynamics serve to restrain claims to legitimacy by feminists and others who attempt to change social orders. This demonstrates how 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.

This indicates the need to engage not only with the values held by public officials and services, but also the values maintained by the broader public [14]. This is especially true with respect to sexuality and reproduction, areas of life that are socially controlled by power relations that

maintain inequality in intimate relationships, households, communities, health services, and other social institutions [24]. Health providers and systems absorb and replicate these societal norms. Hence guidelines, supervision systems, and training programmes must be regularly reviewed keeping in mind the social values with which they are designed and implemented. Training whole teams together 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 in accountability policy processes can change not only how service providers perceive marginalised groups, but also how marginalised people see themselves. In Andhra Pradesh, a pilot project guided by the Academy for Nursing Studies aimed to make health systems more accountable by improving interactions between providers and lower caste women [27]. *Mahila arogya sanghas* (women's health groups) were formed and given training to foster group togetherness, empowerment, self- esteem, and bargaining skills. These training programmes focussed 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 these 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, during one emergency *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 to 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 child saved, but these poor, lower caste women subsequently became village heroines.

As this example demonstrates, supporting accountability measures that encourage the active participation of marginalised groups can support the assertiveness and empowerment for those who are socially excluded. In this way citizenship is nurtured by social actions that foster a sense of agency and entitlement[3] [14, 26]. Research on reproductive rights found that having earnings of one's own and belonging to community groups or unions are critical factors motivating women's sense of entitlement and the ability to express it openly [16]. Collective efforts help to also protect individuals who may be put at risk if they contest authorities on their own. Some s*angha* 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 is critical when considering that many sexual and reproductive health issues are partly not addressed because they are undervalued and shrouded by silence by communities, services and women themselves. "If it is accepted that powerlessness and social inferiority in the face of officialdom are themselves dimensions of poverty" [28: 53], then

empowerment resulting from participation in accountability initiatives contributes to better health and improved health systems, but is also an important end in itself.

What are the elements that ensure that this approach enables accountability processes to improve health service delivery generally and in particular make them more responsive to sexual and reproductive health for marginalised groups? In this next section I focus on two such elements: information, and dialogue and negotiation.

Information

In the field of health care, knowledge, whether traditional or biomedical, is specialised and at times uncertain. One cannot always predict illness or injury 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, 35% were told about their treatment in detail, and 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 are 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, governments have 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 is no sanction for bureaucracies who don't respond or an independent appeals process for when access is denied [32].

With these caveats in mind, awareness and accountability can be improved at a programme level by publicising health centre data. Health service data are usually collected by monitoring systems supervised by health managers. Accountability in these cases tend 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 a training tool and not meant to be corrective, a young health 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 to not 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]. The following example demonstrates how dialogue can help to mitigate social biases and barriers between health professionals and thus improve accountability between them. 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 ANMs (auxiliary nurse midwives) about the social problems of female patients, while nurses welcomed the clinical perspectives shared by doctors. These attempts to foster dialogue are needed 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 that 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 because of not using birth control [25]. Dialogue can encourage people to reflect on these assumptions. When people listen and experience the perspectives of those who come from very different social positions, people sometimes come to understand the limitations of their own perspectives in deciding what is in the best interest of everyone.

Participatory research in Mumbai encouraged ANMs to listen to their clients and to reflect on the lives women lead. As a result, they no longer saw the women they were serving as guilty, problem cases who needed to follow orders. They now tried to see the reasons behind these

women's problems. They began to see their clients not just as patients, but as women like themselves, as sisters or friends. This changed perspective had spill over effects on both the ANMs' work and home contexts in Mumbai. The insights and experience gained from the guided exploration of their environment led to improved communication and group facilitation skills which they were able to use with their fellow colleagues and supervisors. Within their homes, ANMs learned to share responsibility rather than shoulder work alone and they learned to listen to others, especially to adolescent girls within their families [35]. This shows how improving accountability in one sphere can have effects in other spheres.

In other words external accountability between health workers and the users they serve is linked to internal accountability between health workers and the health systems they work in. In Ceara, Brasil, the central government assisted this synergy by actively constructing the relationships between government, communities and health workers [40, 41]. Central government would only start a programme if communities demanded local government co-sponsorship for it. Once started, the programme recruited health workers through transparent and public processes that informed communities about the nature of the program, the qualifications required of health workers, and their expectations with respect to the services provided. In addition to community support and monitoring, health workers were also supported through technical training, supervision, and morale building publicity campaigns. Lastly, central government ensured that all stakeholders stood to gain from supporting the programme and thus pre-empted negative interference from either supervising nurses or from local party representatives.

Health workers responded by going beyond their original job descriptions in order to fit local community needs. They engaged in mundane household tasks that supported isolated and overworked mothers, broader public health campaigns, and some curative work. As a result, not only did they feel empowered and useful, but they also were able to gain the respect and trust of the communities they worked in. '[T]he agents saw their clients not only as subjects whose behaviour they wanted to change, but as people from whom they actually wanted and needed respect' [41: 1783]. This lead to a cadre of health workers that were strongly motivated and committed to service delivery. ANMs in rural Karnataka, when supported by more flexibly minded supervisors, similarly 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 [37].

In this way efforts to improve dialogue between health workers and communities can lead to common alliances that negotiate blocks in systems at a higher level. 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 as communities, 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 mass 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 the services it provided. 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 and identities, which establish precedence and a collective history that reinforces demands for accountability.

However, for these positive deviances to be reinforced, hierarchies within the health care system need to be critically examined. It is naïve to think that participatory efforts that seek to improve patient provider relationships can by themselves address all the constraints facing service delivery in poverty contexts.

Challenges to Participatory Accountability Processes

As mentioned earlier, accountability mechanisms ideally rely on participatory processes to support relationships that transform the terms of engagement and the actors themselves. This requires commitments to such processes by those in power and a willingness to change. 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. Not surprisingly their role was limited to improving community health awareness and to motivate 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 more sensitivity needs to be paid towards the social status and professional interests of the different kinds of health providers involved [38, 39, 40].

In Makueni district, Kenya, World Neighbours worked with communities and health providers to upgrade the local dispensary into a maternity ward that would provide immunisation, family planning and maternity services [42]. Community involvement was able to influence the type of services on offer, but it was less successful in influencing the quality of care provided. Although the local management committee was responsible for providing physical infrastructure for the clinic, it did not have a mandate to hire or fire health workers. They could submit reports on staff performance but could not act on the recommendations. Lastly they had no control over the timing or quantity of supplies. The risks to women who became dependent on these services are enormous. As one woman stated, 'I was just unfortunate. I became pregnant because the day I went to replenish contraceptives they were not available' [42: 68].

Evaluations of Health Workers for Change also show frustrations with policy and programme decisions whose control lie further up the health system, beyond the remit of local health providers [43]. In order for individuals to be held accountable fairly they must wield authority [5]. Locating responsibility for policy and program decisions is a critical, and not always easy, ingredient of successful advocacy. Questions about who is responsible and under what conditions are critical to understanding how accountability works.

Participatory processes can open up accountability mechanisms to represent broader segments of society making them more sustainable, effective, and equitable. However, they cannot be treated

as unproblematic solutions. Participatory methods are not automatically inclusive. They actively construct boundaries around communities or user groups by legitimising some voices and not others [44]. They can mirror, or even worse exacerbate, the social divisions that mark communities [45]. In the early stages of the project that sought to improve access and quality of Brazilian municipal health services of 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 further participation from poorer women in the community took place 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 existing policy or programme structures in order to ensure that they do serve the cause of equity.

Concluding Remarks

These challenges point to how more research needs to be done in documenting the experience of accountability in health. Accountability measures, as a part of regulatory or oversight efforts, are relatively neglected within health systems in comparison to efforts made to organise and finance services [46]. Yet they play decisive roles in ensuring that programmes are implemented properly and 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 these efforts.

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 kinds of information is collected and how is it used by monitoring and supervisory systems. This needs to be followed up with examining what sorts of actions are used to reward good or reprimand bad practices. To have impact reflection and learning from such experiences needs to be effectively transmitted to larger groups.

To ensure that such efforts remain supportive one needs to carefully assess the social context. This means considering who is represented in current accountability processes and how their needs are articulated. How do hierarchies of age, gender, sexuality, caste/ race, and class affect accountability mechanisms? We need to be more sensitive about when accountability measures serve to mitigate such hierarchies and when they can exacerbate them.

I have focussed on how accountability processes can partner communities with lower level health workers to improve health service delivery in reproductive health. A key challenge is how these efforts can address blockages higher up in the system, especially in highly centralised and rigid bureaucracies. Another concern is how accountability processes can support continuity in health services operating in disadvantaged areas marked by high levels of transfers and staff vacancies. In these contexts it is imperative to analyse how multiple forms and levels of accountability interact with each other. Is accountability to communities counteracted by rigid management systems that enforce targets on health workers? Does community support ensure continuity of objectives in the absence of stable health service personnel postings?

Examining the social context of accountability measures means examining the policy and service delivery contexts in which they are applied. How do health sector reforms help or hinder these efforts? One case study from Peru, mentioned that reform efforts, by creating multi-sectoral health committees, aided feminist organisations to highlight quality of care concerns brought up by poor women [47]. Decentralisation, by increasing decision space at appropriate levels through out the health system, could also improve accountability [48]. At the same time, reform initiatives that focus on improving targeting or creating tiered access to health services could hinder the broad coalition building that makes accountability processes effective, sustainable, and equitable. Attention needs to be paid to how inclusive class strategies may promote financial cross-subsidisation and political solidarity that support accountability in health systems [49].

Despite this concern for social context, it is striking how few case studies fully describe them. Yet without understanding the organisations involved, their ideologies, values, and organisational culture, one cannot assess how they interact with other groups, let alone whether these interactions held them accountable to other groups. Understanding the social background, training, ideology of the participants, and the structures that they belong to help to understand which lessons can be transferred and which are specific to particular contexts.

Similarly processes need to be better documented. How were training sessions developed and entry points negotiated? A critical concern, as mentioned earlier, is how marginalised groups are represented in accountability measures that seek to articulate their needs and empower them. The engagement of marginalised groups within this process may change the nature of the intervention. Perhaps most important is a better understanding of how problems arise and how they were faced? Understanding problems in implementing accountability measures can sometimes lead to a deeper understanding of the dynamics involved than successes.

In conclusion the vision of reproductive health services as codified in Cairo means engaging with women as health care users, equal partners not only in sexual relationships, families and communities but also in planning and implementing sexual and reproductive health services. However, client's low expectations and passivity, historical paternalism of health care professionals, and limited community engagement in the design of most health programmes have curtailed the efficacy of service reforms envisioned by reproductive health advocates [11].

I argue that accountability mechanisms may serve as important resources to mediate relationships between users, providers, and managers. In order for them to overcome inequalities between these actors, they need to be able to confront power relations, improve the representation of marginalised groups and transform them in legitimising ways. Information, dialogue, and negotiation are important elements that enable accountability mechanisms to address problems by supporting learning and changing the terms of engagement between actors. In order for accountability to succeed it cannot be seen as mechanisms that can be implemented universally, without attention to social contexts, practices and actors. Accountability is best achieved through negotiated, iterative processes that represent the participants involved, their relationships, and the social contexts they operate in. Here in lie their limitations but also their dynamic power.

Endnotes

[1] 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.

[2] 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].

[3] A sense of citizenship does not only derive from being a member of a state. Oppressive and exclusionary but socially accepted norms can render formal rights ineffective. Collective action that challenges these norms can generate civic agency and citizen competence [26].

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