COPASAH
GLOBAL SYMPOSIUM 2019
ON
CITIZENSHIP, GOVERNANCE AND ACCOUNTABILITY IN HEALTH

Leaving No One Behind: Strengthening Community Centred Health Systems for Achieving Sustainable Development Goals

OCTOBER 15-18, 2019
NEW DELHI, INDIA

THEME 3:
MOVING FORWARD THE AGENDA FOR SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

CONTEXT

The Community of Practitioners on Accountability and Social Action in Health (COPASAH) is a bottom-up learning global network of community practitioners primarily from the global south, working to strengthen the linkages between communities and health systems to provide quality and accountable health care. Health, wellbeing, and dignity for all and the community's claim for the human right to health are at the core of COPASAH's positioning of social accountability. The community of practitioners of COPASAH encompasses various actors ranging from people-oriented community leaders, organic intellectuals, and institutions committed to such an equitable vision of society. (www.coapsah.net)

Building upon the need to bridge up the gap in the top-down and tool led accountability discourse by focusing on bottom-up approach, forefronting citizen voices, and community-centric focus and bringing the most marginalised within the ambit of health systems as active participants, COPASAH organised a Global Symposium on Citizenship, Governance, and Accountability in Health, between 15-18 October 2019 in New Delhi, India.

The Symposium facilitated interactions between nearly 500 delegates from over 40 countries, which included practitioners in health, policymakers, academics, researchers, and other activists on common issues of concern. This Symposium was collectively shaped by the perspectives and inputs provided by the Steering group of COPASAH, the Global and India Organising Committees that included over 100 leading organisations and intellectuals spearheading the community-centred accountability processes. The Symposium organising group included the COPASAH Steering Committee, People's Health Movement (PHM), Accountability Research Centre (ARC) – American University (Washington DC), Global Health Justice and Governance Programme of the Mailman School of Public Health, Columbia University (New York), Institute of Development Studies (Sussex) and Azim Premji University (Bengaluru).

The COPASAH Global Symposium was woven around the issues of Citizenship, Governance, and Accountability in relation to the lives and living conditions of the marginalised communities. It was designed as a conversation and dialogue between grassroots accountability practitioners and community-centred accountability advocates interfacing with public policy spaces, research and academia, and those engaged with policy-making and policy implementation. Such conversations were facilitated through formal and informal spaces. The formal spaces include plenaries, thematic and inter-thematic sessions, accountability praxis, and assemblies endorsing the practitioners' social accountability charter.

KEY THEMATIC AXES FOR THE COPASAH GLOBAL SYMPOSIUM

The key deliberations in the Symposium were premised around five thematic axes which included Theme 1- Community Action in governance and accountability for health systems strengthening; Theme 2- Improving access to quality health services for the indigenous, excluded, vulnerable communities and those in fragile context; Theme 3- Moving forward the agenda for Sexual and Reproductive Health Rights; Theme 4-Setting the framework and agenda for people-centred accountability of private and corporate health care sectors and Theme 5-Forging alliances between the community and the health care workers.

PERSPECTIVE BEHIND KEY THEMES OF THE SYMPOSIUM

The health systems in developing nations include the public health systems as well as a whole array of private health care providers. The public health systems, which are constitutionally mandated to protect and promote the wellbeing of communities, are increasingly rendered fragile, weak, fragmented, and shrunk. Alongside this, the burgeoning private health care system has set itself progressively on the path of commercialisation and corporatisation, resisting its accountability neither to the constitutional principles nor to patients. Meanwhile, the accountability to the health and wellbeing of citizens and communities has suffered a setback due to the State's evasion of responsibility and the overpowering yet unaccountable presence of the non-state actors in health and health care policy and provisioning. The global and national actors from both the health and non-health sector actors who are operating in this field have contributed to making accountability chains more complex. Such accountability deficits and complexities are created in the upstream and global alignments of private and non-state actors that wield undue influence on global health governance.

Besides, the accountability discourse itself is fret with its own challenges and limitations. The discourses of accountability have been delinked from the policy contexts and the experiences of the community. Some of the predominant approaches are overwhelmingly expert-led and instrumental and narrow in their outlook as a tool (ticking a box) or a digital drive for accountability with an overemphasis on efficiency and outcomes simultaneously undermining potential transformative perspectives of equity. It also undermines the centrality of the community and the understanding of the power imbalances that the overarching policy processes create. Such limited, instrumental, and reductionist accountability perspectives have further exacerbated the alienation of communities. They tend to absolve global actors of their influence on the continuing indignities and violations of rights that the communities are confronted with.

COPASAH has positioned health, wellbeing, and dignity for all and the community's claim for the human right to health at the core of social accountability discourse. Such a discourse is also located in the overarching framework of citizenship, governance, and accountability in health. In the same vein, the understanding of health itself is broadened to include wellbeing, dignity, and social justice, within which health care forms a significant part. It is driven by the belief in and engagement with the transformative potential of the community's power in demanding accountability from the state and non-state actors and for realising such a right. Such an understanding of accountability is a process of changing power equations of communities with various actors and national-global policy processes, most importantly the state which is vested with the constitutional obligation to ensure condition for communities be healthy. Realising that such a process of social accountability is only possible in a strong bond of community to global solidarity, the community of practitioners of COPASAH encompasses various actors ranging from people-oriented community leaders, organic intellectuals, and institutions committed to such an equitable vision of society.

CONCEPT AND ORGANISATION OF THE THEMATIC DISCUSSIONS

Sexual and Reproductive health rights (SRHR) are indivisible aspects of human rights and deeply linked with the fulfilment of all other civil, political, economic, and social rights. Global and national development agendas have over the past two decades, including as part of the Millennium Development Goals and thereafter the Sustainable Development Goals, included some focus on reproductive health concerns – particularly with regard to maternal health and family planning, sexual rights remain largely invisible. However, the goals and agendas, even in the context of reproductive health rights have been limited, fragmented, and overtly focused on narrow targets, with grave implications for women's autonomy, their access to determinants of reproductive health rights, access to quality, affordable healthcare free from coercion.

Social accountability towards sexual and reproductive health rights is gaining momentum; however, the predominant approach has been to view this as an effective mechanism, producing a beneficial health effect, rather than the inherently political process that is negotiating reproductive rights. The accountability deficit, as well as the nature of rights violations that people face in the arena of sexual and reproductive health rights, are challenged by marginalisation and exclusion based on various axes of inequality, including gender, caste, disability, and sexuality. Even as these challenges abound, communities, people's organisations, and social movements have been addressing a range of issues related to sexual and reproductive rights, from the right to self-determination, work, access to services, dignified and respectful services and quality of care.

The discussions on the theme were organized through three sessions of 90 minutes each over a period of three days. The sessions are as follow

- Day 1: Dismantling Social Hierarchies through SRHR Accountability Work – Working with Vulnerable and Socially Excluded Communities
- Day 2: Global Actors and their Impact on SRH Accountability – Negotiating the Power of Donors, Global Health Initiatives and Global Accountability Mechanisms
- Day 3: Critical Engagement with the State on SRH Rights – Pushing the Boundaries of Current Practice

THEMATIC SESSION DAY 1 (OCTOBER 16, 2019): DISMANTLING SOCIAL HIERARCHIES THROUGH SRHR ACCOUNTABILITY WORK – WORKING WITH VULNERABLE AND SOCIALLY EXCLUDED COMMUNITIES

The struggle for realising sexual and reproductive rights is deeply influenced by gender-related social norms and various axes of inequities and injustice prevalent in societies. This panel interrogated how inequities influence sexual and reproductive health rights, and what elements must form a part of accountability practice, both at the interface of communities with health systems but also within health systems and communities themselves. Speakers in this session presented their practice of working with various marginalised communities like Dalit women in India, sex workers in Bangladesh, Roma women in Macedonia, nomadic pastoralist women in Nigeria, HIV positive persons in Zambia, youth from urban slums in Uganda, and citizenship concerns of transpersons in India.

Moderator: Jashodhara Dasgupta, National Foundation for India (NFI), India

Opening Remarks: The moderator opened the session by welcoming the participants. She spoke about how the contours of social accountability can ensure SRH and rights in the context of marginalised and disenfranchised groups. She outlined the modality of the session as wherein four groups would share grounded experiences. She expressed that though much has been done in the last three decades on SRHR, but it is significant to understand how rights are being appropriated and technologised today. She also outlined the substantial focus in working with women and girls, men, and boys. She expressed that there was a need to look beyond binaries - gender identities and sexual orientation and recognise the call from transgender people to be included. The moderator further said that the fundamental question of power needs to be addressed, the struggles for social accountability by the marginalised and excluded need to be

recognised along with addressing the question of power asymmetry in indigenous communities and migrants.

PANELISTS

Narsamma Kotnekal, from **Jagrutha Mahila Sanghatane (JMS), India**, shared experiences of the struggle of caste and class rights violations. She outlined that marginalised people like Dalits have no voice and no place to raise issues. She presented cases of Dalit women who were discriminated in health centres. She highlighted the issue of caste-based denial of health care services for pregnant women. She spoke about the struggles and campaigns of a Dalit Women's collective and the ongoing struggle to realise the right to health for all.

Shruti Arora, from **Y P Foundation, India**, shared findings of the audit of services for youth from two places Delhi and Varanasi. She highlighted findings on respectful health care and structural gaps. She outlined the study which looked at four parameters, and it was found that counselling was better in Varanasi as compared to Delhi. Boys reported better experiences than girls. The audit found out that unmarried girls were subject to moral policing and discrimination. The findings also highlighted that there was limited utilisation of funds, and the hospital environment was not welcoming, especially in terms of location and timing. She also shared the advocacy efforts carried out by the YP Foundation in both locations.

Eugen Ghita, from **Roma Just, Romania** shared about experiences of the Roma community from Romania. He outlined that Roma women faced discrimination and problems in health settings and in accessing health services. He highlighted the challenges like forced sterilisation of Roma women without consent, lack of information, and late outreach of services to pregnant Roma women, etc. He further spoke about other challenges faced by the Roma community, including issues of legal identity, lack of essential services, and health insurance.

DISCUSSION AND REFLECTIONS

- The participants collectively agreed and reflected that there is a focused need for solidarity and strategising across countries as the issues were quite similar, e.g., abortion stigma.
- It was stressed by all that there is a need for more opportunities to share experiences.
- It was agreed that disadvantages and discrimination faced due to gender, caste, ethnicity, class and age, sexual orientation, disability were quite similar all over the globe.
- The significance and the need for quality and appropriate contraception was highlighted
- It was also reflected that donors need to understand that short term projects (three years) do not yield results; there is a need for a longer duration of support and commitments.

THEMATIC SESSION DAY 2 (OCTOBER 17, 2019) : GLOBAL ACTORS AND THEIR IMPACT ON SRH ACCOUNTABILITY – NEGOTIATING THE POWER OF DONORS, GLOBAL HEALTH INITIATIVES AND GLOBAL ACCOUNTABILITY MECHANISMS

Maternal Health and, subsequently, Family Planning have emerged as essential agendas of global health programming over the past two decades. Multiple systems for monitoring progress were established following the MDGs through mechanisms like the Partnership on Maternal Neonatal and Child Health (PMNCH) headquartered in WHO, the WHO Commission on Information and Accountability (CoIA) on Women and Children's Health and the UN-sponsored movement Every woman Every child. The SDGs have introduced new targets that are similarly being monitored at a global level. In addition to this, there remains the United Nations Universal Periodic Review through which countries' human rights records are reviewed. Many international agencies, bilateral donors, and private philanthropies are providing funds and other support to governments to achieve the set targets.

This session saw the sharing of experiences of practitioners who have been linking local community realities with global accountability mechanisms.

Moderators: Rupsa Mallik CREA, India
Sai Jyothirmai Racherla, Asian-Pacific Resource & Research Centre for Women (ARROW), Malaysia

Opening Remarks: Sai from ARROW set the tone for the session and provided an overview of global and regional level accountability mechanisms for SRH. She outlined that there has been a rise in standards and benchmarks for SRH, for example, Asian and Pacific Population Conference (APPC), High-level Political Forum on Sustainable Development (HLPF), Commission for Population and Development, and there are also treaties and charter body mechanisms like The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), **The Committee on the Rights of the Child** (CRC), and Universal Periodic Review (UPR).

Rupsa highlighted the scenario of twenty-five years after the International Conference on Population and Development (ICPD) and stated the aspects of how the political momentum has dissipated. She outlined that deep exclusions continue and further expressed that there has been an explosion of movements, especially LGBTIQ driven movements by the south in the last 25 years. This provides lots of momentum to celebrate and also for reflection.

PANELISTS

Nilangi Sardeshpande, from **Society for Health Alternatives (SAHAJ), India**, shared about initiatives pursued by Equal Measures, International Women's Health Coalition (IWHC), ARROW, and African Women's Development and Communication Network (FEMNET). She outlined the initiative of developing a data hub for advocacy and how state reports are generated in India through this hub and how the reports are further used for advocacy. She highlighted that the challenges in India include limited access to policy corridors at the national level. Even though at the sub-national level, though more doors are open, the state officials are not involved in higher levels. She emphasised that though SDGs may not change things radically, but they help to make a check on where things are lagging.

Nidhi Goyal, from **Women with Disabilities India Network (WDIN), India**, shared about disability rights and gender space. She said that though the Convention on rights of people with disability (CRPD) has included women with a disability, the focus is more on access and not on the facilitation of rights. She highlighted that India was the first country to ratify UN CRPD, which was

a big step for people working in the gender and disability rights space. She added that SRH is seen as a privilege and not an issue. There are gender imbalances in the CRPD committee, which has improved over time, but there are still some movements where women with disabilities are not included, e.g., Beijing +25, she added. She stressed on the need for more collaboration between different movements and more engagement in understanding the context and realities.

Subhashini Tharmalingam, from **Human Rights in Child Birth (HRiC), Australia,** shared her work on human rights in childbirth internationally. They hold multi-stakeholder events and are building a united international voice for others as consumers of maternal health services. She spoke of how women all over the world have no idea of their human rights despite being in rich or poor countries.

Sara Van Belle, from the **Institute of Tropical Medicine (ITM), Belgium,** shared her experiences and findings on accountability research in Africa.

DISCUSSION AND REFLECTIONS

It was reflected that the ICPD Cairo agenda was women centred in 1994, and women drafted the Cairo document. Cairo gave an opportunity for women to voice their concerns, and there was space for civil society engagement also. It was further discussed that things have changed since Cairo and Civil Society Organisations (CSO) have to be realistic and explore how they can make a difference.

- The need to reflect on how gender index can be used for advocacy was also discussed. And it was revealed that civil society needs to explore how it can engage in accountability mechanisms.
- The mechanism to hold duty bearers accountable for denial of services and discrimination was also discussed.
- The significance of experience sharing was reflected along with the need to understand social accountability models used for maternal health

The participants mutually agreed that all women (with their diversity) need to be involved in accountability spaces, and the agenda of SRH for all needs to be pushed through avenues like the ICPD + 25 and Beijing + 25 reviews. The Cairo (1994) agenda, which was women-centric and the language is used like "women can decide when and if they want to have children," needs to be reiterated.

THEMATIC SESSION DAY 3 (OCTOBER 18, 2019): CRITICAL ENGAGEMENT WITH THE STATE ON SRH RIGHTS – PUSHING THE BOUNDARIES OF CURRENT PRACTICE

Accountability practice in a deeply contested field like sexual and reproductive health rights must engage with various levels of the state, from policy and politics to health facilities at the frontline of health service provision. Mainstream social accountability work in the field of maternal and reproductive health tends to comprise of bounded interventions focused on enforcing accountability within a predetermined framework. The fall out is that specific issues tend to be neglected – such as the issue of increasing disrespect, abuse and coercive treatment of women during maternity care, the tension between population control and access to contraception, abortion rights, menstrual hygiene management, the right to express one's gender and sexual identity and so on. This session discussed the issues of social accountability in SRH and attempted to critically evaluate tools such as scorecards, committees, budget tracking, as well as identify challenges and the ways forward.

Moderators:

- Marta Schaaf Columbia University, USA
- Victoria Boydell Graduate Institute, Switzerland

Opening Remarks

Victoria set the tone of the session and highlighted the importance of resilience in the current context and environment. She shared the experience of hearing about decade long struggles and time-bound accountability activities from the previous two days sessions in the Symposium. She expressed that practitioners were using different accountability practices.

Marta raised some concerns and issues around accountability. She shared that classic state-centred accountability doesn't always work, as the paradigm is not always the reality. She highlighted that discrimination continues in SRH for the marginalised groups, especially for the LGBTIQ groups. She reflected that the space for civic action and research and data collection is decreasing.

PANELISTS

A presenter shared her experiences of family planning in China. She outlined that the one-child policy was prevalent in China for 35 years, till 2016. Family planning was considered a key indicator of political performance in the country. She shared about different violations in family planning in China, like instances of forced IUD insertion, forced tubal ligation, and forced abortions.

She added that there had been a new change currently in the scenario in the country as the state is encouraging fertility, and women are now being forced to have children. There have instances of child guarantee money being given to couples, and abortion is getting harder to access, she shared. She added that more restrictions were being imposed on abortion as; local authorities' permission is required for abortion if the pregnancy is more than 14 weeks. These restrictions were pushing women to access unsafe abortions. She added that these restrictions are violations of autonomy and human rights of women. She highlighted that high son preference in China is leading to sex-selective abortions in the country. She reflected that this is a dual attack by patriarchal culture and policies, as the belief is that women should give birth to the nation. This notion completely ignores the autonomy of women.

Esnart Mwila, from **The Treatment Advocacy And Literacy Campaign (TALC), Zambia** shared her personal story and experiences of being a woman living with HIV and the experience of her organisation, TALC, Zambia. She outlined that TALC works with women living with

HIV/AIDS. They tackle issues of stigma and discrimination and service provision. She stated that high incidences of teenage pregnancies were prevalent in Zambia. TALC has been conducting SRH/HIV campaigns on contraception, access to health services, and has been demanding more contraceptive options, beyond condoms. She also highlighted the challenges faced by TALC in the advocacy work like inadequately skilled workforce, lack of male involvement, lack of services integrated with SRH and HIV services for WLHIV.

Obalesh KB, *Karnataka* Janaaroyga Chaluvali (KJC), India, shared the experiences of unwanted hysterectomies conducted by the private sector doctors on Lambadi women in the Gulbarga district of Karnataka state of Southern India. He highlighted that intensive fact-finding was conducted and it was found that the Lambadi women are mostly migrant, poor labourer women. Eighty-two interviews were done with the women, and the fact-finding revealed that the private doctors did 707 unwanted hysterectomies, and 51% of the women on whom it was conducted were under 35 years. The women and their families spent between Rs. 26,000 to Rs. 2 lakhs per operation. Women continued to face health problems after the procedures. He shared that the KJC forum started a campaign for justice for the women, but they faced challenges like lack of support from the government due to the presence of strong private sector lobby.

Caroline Aruho, from **Coalition for Health Promotion and Social Development (HEPS), Uganda** shared experiences of HEPS from Uganda on access to essential medicines and about their work on policy advocacy and community empowerment, especially around abortion issues. Caroline explained about the use of community scorecards to demand more efficient services at the local level.

Mahendra Kumar, from **Centre for Health and Social Justice (CHSJ), India** presented experiences of work on partnering with men and increasing men's involvement and social accountability for maternal health from two districts in the state Madhya Pradesh in the central part of India. He shared the experiences of involving men in maternal health as well as making them accountable. He highlighted that the program brought about changes in gender and social norms within the household, within gender relations and broadly on health awareness and monitoring of health services.

CONCLUSION

This theme of the symposium attempted to showcase community-led social accountability practices that negotiate the politics of sexual and reproductive health rights and focus on enhancing the autonomy and capabilities of citizens.