Building a transformative agenda for accountability in SRHR: lessons learned from SRHR and accountability literatures

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Abstract: *Global strategies and commitments for sexual and reproductive health and rights (SRHR) underscore the need to strengthen rights-based accountability processes. Yet there are gaps between these ambitious SRHR rights frameworks and the constrained socio-political lived realities within which these frameworks are implemented. This paper addresses these gaps by reviewing the evidence on the dynamics and concerns related to operationalising accountability in the context of SRHR. It is based on a secondary analysis of a systematic review that examined the published evidence on SRHR and accountability and also draws on the broader literature on accountability for health. Key themes include the political and ideological context, enhancing community voice and health system responsiveness, and recognising the complexity of health systems. While there is a range of accountability relationships that can be leveraged in the health system, the characteristics specific to SRHR need to be considered as they colour the capabilities and conditions in which accountability efforts occur.* DOI: 10.1080/26410397.2019.1622357

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Introduction

Over the last 25 years, a host of global normative frameworks, standards and guidelines have been put in place to foster the respect, protection, and fulfilment of people's sexual and reproductive health and rights (SRHR). Among these are the UN Committee on Economic, Social and Cultural Rights General Comment No. 22 and the Sustainable Development Goals, which outline the need to improve the availability of, and access to, a full range of sexual and reproductive health (SRH) services and ensure people's rights to make their own choices about their sexuality and reproduction, and receive non-discriminatory care.[1,2] Though elements of these frameworks have been adopted into domestic legislation, policies, and programmes, millions of people still lack access to high-quality and respectful sexual and reproductive healthcare services and are vulnerable to social factors that infringe their rights, well-being and health.

These gaps between rights frameworks related to SRHR and people's lives reflect a range of political dynamics; these dynamics shape government accountability for realising SRHR. For instance, politicians and decision-makers in the public sector are more likely to improve a service in ways that are visible to the electorate, where individuals benefit in the short-term, and when improvements can be clearly attributed to the politician, such as

purchasing new hospital equipment.[3,4] For their part, service users are more likely to mobilise around visible, ongoing, and predictable healthcare issues, concerns or problems.[3] But some healthcare issues and services are more politically contested than others. Contraception, abortion, comprehensive sexuality education, and other elements of SRHR may be contested due to their relationship to debates around gender, sexuality, the role of the state in more intimate domains, and the relationship between organised religion and the State, among other issues.[5,6]

In terms of promoting accountability in SRHR, there is a little synthesis of what works, why, and what should be prioritised, including the explicit consideration of the political and social determinants of SRHR. Most of the authors on this paper collaborated on a recent systematic review that assessed research on what works in terms of accountability in SRHR, and found the empirical, peer-reviewed evidence to be limited.[7]

We use the term accountability to describe the processes by which government actors are responsible and answerable for the provision of high-quality and non-discriminatory goods and services (including the regulation of private providers) and the enforcement of sanctions and remedies for failures to meet these obligations.[8–10] Accountabilty can take many forms. Brinkerhoff[8] elaborates three types of accountability that are relevant to health systems: (1) financial, (2) performance, and, (3) political/democratic. Financial accountability relates to the allocation, disbursement, and utilisation of financial resources. Performance accountability concerns health services and results, including for the provision of high quality, respectful care. Political/democratic accountability encompasses government delivery on electoral promises and the representation of constituent priorities. Furthermore, for the purposes of this paper, we understand accountability in SRHR to include: the appropriate prioritisation of SRHR and its implementation throughout the health system and ensuring access to SRHR services, with attention to high-quality and respectful care.

Background

Van Belle et al.[7] set out to synthesise evidence on interventions that aimed at ensuring accountability in SRHR in the peer-reviewed literature in low- and middle-income countries (LMICs), given the disproportionate health burden in LMICs and the burgeoning of accountability initiatives in those same contexts. The paper examined forty studies published between 1994 and 2016, found through a systematic search of legal, public health and social science literature.

The review identified three broad accountability strategies: performance, social, and legal.[7] Performance and social accountability interventions related to those that aimed to improve the quality of maternal, neonatal and child health care and increase coverage and service utilisation. Performance accountability mainly consisted of the Ministry of Health and other government departments holding service providers and the health administration to account. The social accountability efforts identified entailed community members attempting to hold service providers and the local health administration to account. Legal accountability could be initiated by the government, or by outside actors. The examples of social, legal and performance accountability found in the review specifically related to gender-based violence, LGBT access to health care, reproductive health care in general, and pursuing redress for wronged citizens and communities. While these three accountability strategies are distinct in terms of the purpose, the actors, what was done and achieved, and the conditions in which they were undertaken, they shared certain commonalities and, in some contexts, were not mutually exclusive.

The review found that most studies did not fully describe the interventions, the context, or the various processes and outcomes. Thus, though the authors of the review[7] articulated the categories of various accountability efforts, they were unable to examine the conditions under which groups decided to use particular strategies, nor the conditions under which accountability strategies could be invoked to address failures to respect, protect and fulfil SRHR. Therefore, a more nuanced understanding of contextual factors, the interplay across different strategies and processes, and the capability of individuals and communities to negotiate accountability in SRHR were needed to promote more successful accountability efforts in SRHR.

Systematic reviews require a narrowly framed research question, often leading authors to consider only a "rigidly defined subset of the available body of work" (p. 3).[11] Consistent with this, the studies identified through the above-mentioned review yielded a small cross-section of what is actually happening on the ground. It was limited to the

peer-reviewed literature, and articles that explicitly used the term "accountability". However, we know that over decades, accountability in SRHR has been pursued through broad efforts ranging from social movements, human rights advocacy and litigation, to more specific initiatives related to facilitating community engagement, and service quality improvement programmes, such as provider training and efforts to eliminate stigma and discrimination associated with specific SRHR services.[12–15]

To expand the discussion and to identify some of the conditions and processes that are likely germane to accountability in SRHR, we (authors of the current paper) conducted a secondary analysis of Van Belle et al.[7], and drew on reviews and articles that used the language of community participation, social action or coalition-building. We also analysed additional literature on accountability in health and development more broadly.[16–20] In keeping with the initial review, we limited our analysis to low- and middle-income countries. While our analysis draws upon literature from LMICs, much of our analysis is also likely to be relevant to high-income countries, where certain specific aspects of SRHR, such as access to safe abortion, might be widely contested. The analysis was conducted between 2017–2019 and additional literature covering the time-period of the original review (1994–2016) and publications up until the end of 2018 were included. The themes that evolved from this broader consideration of writing on accountability included the crucial importance of considering the political and ideological context, community voice, health system responsiveness, and the complexity of health systems. We share some emerging considerations regarding how these themes influence the implementation of accountability measures in SRHR in this paper.

Expanding the evidence on accountability in SRHR

The context of macro-level politics and ruling ideologies

Macro-level politics and ruling ideologies often have a profound impact on both an individual's realisation of their SRHR and the ability to demand accountability. A series of reviews have discussed how contextual conditions shape the institutional structures, incentives and social norms that frame the capacity and willingness of duty bearers to respond, as well as circumscribe citizens' ability to express voice and claim rights.[16,19,21–24]

At the macro level, broad socio-political forces such as relationships among political elites, the nature of civil society, and the interaction between civil society and elites influence accountability processes.[22,23] These dynamics play out in specific ways in the domain of SRHR. For example, civil society may mobilise around widely shared, comparatively less politically contested issues, such as child mortality, but not around the contested issues included within SRHR.[25] In addition, the interactions between political elites and civil society can be shaped by the extent to which women's rights NGOs are (a) actually representative of women they purport to represent, and (b) vulnerable to co-option by the state.[26] In some contexts, women's rights NGOs with the best access to decision-makers may be comprised disproportionately of educated or wealthy women; these groups may not address some issues affecting poor women, women with disabilities, ethnic minorities, and others.[26–28]

Accountability in SRHR is situated in state-building processes and political, cultural, and religious ideologies. Evidence shows that these factors can foster a target driven approach to reproduction to meet development goals, the encouragement or discouragement of reproduction among women, or the promotion of certain types and forms of sexuality over others.[29,30] Dominant political, religious, and cultural ideologies about gender, sexuality and reproduction can bleed into social practices and implicit rules within the health system, skewing the distribution of resources and shaping how providers treat certain patients.[31–33] Gender and racial bias and population control ideology, for example, have skewed resource allocations to long-acting contraception and sterilisation despite some women's preferences for other contraceptive methods or unmet desire for fertility treatment.[34] Similarly, the state may limit the reproductive autonomy of women with disabilities, by passing laws mandating that they are sterilised, by allowing parents to sterilise their minor children with disabilities, or by passing expansive guardianship laws that allow guardians to make unilateral decisions about the reproduction of women with disabilities.[35] Adolescent sexuality is another area where social norms and mores about what is appropriate sexual behaviour of young people can impinge significantly, limiting government and citizen will to implement evidence-based programmes.[36,37]

While broader accountability literature has focused on contextual factors, ranging from

national, sub-national, facility and community level, for SRHR contextual influences also include those at the global level. Given the globalised nature of funding and health guideline-setting in SRHR, global debates about sex and reproduction are particularly pernicous. For instance, opposition to SRHR by different actors has often dampened the realisation of relevant treaties and declarations, resulting in a more limited set of global guidance and domestic implementation.[38,39] Furthermore, certain policies have resulted in the restriction of SRH information and services that directly affect health actors' capacity to promote, protect and provide SRH services.[40–42] New transnational, inter-disciplinary coalitions among advocates and funders may be required to disrupt the dynamics giving rise to such policies and associated harms.[43] Yet such efforts are not well captured in the literature related to accountability in SRHR.

Unpacking community voices

Awareness of rights and entitlements and the capacity and opportunity to voice them are central to demanding accountablity for the implementation of policies and improved service delivery. Community involvement in priority setting and democratic deliberative spaces through participatory tools and processes has demonstrated positive effects on the realisation of SRHR. However, internal hierarchies and power imbalances may end in certain voices within the community overpowering others; this can be an inherent challenge for accountability efforts in the field of SRHR.

The ideologies and related social norms outlined above also result in many women not seeing themselves as "worthy of having rights", let alone feeling that they are empowered to exercise the right to register a complaint and demand redress, limiting women's ability to negotiate and demand accountability.[26,32,44,45] In addition to internalised discrimination (conscious or unconscious acceptance of discrimination), affected individuals may have little knowledge about their rights and entitlements, excluding them from debates and actions around accountability.[45]

The internalisation by women of being unworthy of rights can preclude the sense of shared injustice and solidarity that are the preconditions for organising and collective action.[45] A sense of isolation, futhermore, may prevent solidarities forming; individuals may be too diverse to mobilise, or the real threat of personal and social reprisals may be too high.[16,31,46,47] Yet, when

collective identities are fostered it can generate a sense of shared injustice, leading to people mobilising according to this shared identity to defend [themselves] as a collective.[31,48,49] Solidarities can have an impact well beyond the local; strong, vibrant domestic feminist movements have been a key driver in the domestication of global norms on gender-based violence.[50]

Even within unequal and hierarchical relationships (e.g. those dominated by gender, class, ethnicity, caste or other inequalities), we find examples of women taking action by themselves. Our review yielded instances of individuals claiming their personal rights, whether by voicing their personal testimony or challenging hierarchies through a range of subvert/covert approaches. This often relates to experiences of near misses in delivery, gender-based violence and poor access to reproductive health.[51] A review by George found "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" (p. 13, 163).[31]

Promoting and channelling critical thinking about power and privilege that underline community voice is necessary for making claims and demanding accountabilty. Social scientists have long described critical consciousness and other reflective learning processes whereby women and other marginalised groups learn about their formal entitlements and reflect on their life experiences.[32,52–55] An illustration of an intervention addressing accountability through strengthening community voice is provided by Scott et al.,[20] which explains how government-supported Village Health Committees (VHCs) in Northern India provided opportunities for "micro-resistance"; women with percieved low status who normally have no opportunity to speak out leveraged the formal rules of the VHCs to voice their concerns. Structured opportunities to express voice and collaborate with others and decision-makers to improve policies and services can contribute to personal conscientisation and collective action.[26,47,56–58] Many social accountability efforts build on consciousness-raising processes by planning events where grassroots organisations and ordinary citizens interact with local authorities to discuss concerns about the health system and to jointly plan a response.[47,59,60]

From an accountability perspective, this empowerment and capacity for organising and

collective action can serve as an effective and legitimate countervailing force to seemingly impervious institutions.[61] Collective action can yield collective power to overcome stigma and harmful norms at all levels and encourage public institutions to respond and address inequities.[31,46,62] Our review identified examples of when this has been successful; such efforts are characterised by long-term, iterative and inclusive engagements, and led by actors perceived to be credible.[26,32,63]

Despite a long and rich history of social movements and citizen participation efforts in health priority setting and planning, the comparatively young field of accountability for health has focused on service delivery and health outcomes, and generally treats other impacts, such as empowerment, collective efficacy and action, and deliberative democratic practice, as instrumental, "intermediate outcomes".[16,19,64–66] Yet, voice, empowerment, collective action, and a changed relationship between state and society – at least locally – have been found to be both key mechanisms and outcomes across a range of accountability activities.[58,59,65,67,68] Our secondary analysis suggested that processes to strengthen community voice may be particularly germane to efforts that aim to strengthen accountability in SRHR. Since stigma and discrimination contribute to governmental policy and practice in some aspects of SRHR, overcoming these dynamics to claim rights and engage collectively can represent a significant, meaningful change.

Health care system responsiveness

Whereas the State has the ultimate role as duty-bearer to address the social and political determinants of SRHR, and to ensure the provision of high-quality SRHR services and access to these services, there are a range of duty bearers within the health care systems and beyond (e.g. justice systems, private sector, etc.) who are responsible for ensuring the realisation of SRHR. The capacity and willingness of these duty bearers to respond is a vital, albeit often under-recognised, element of effective accountability.[17,67,69]

Within the context of health care systems, we define responsiveness as the extent to which the health system and individual providers demonstrate "receptivity to the ideas and concerns raised by citizens by implementing changes to the decision-making or management structure, culture, policies or practices" (p. 130).[70] This receptivity is shaped by decision-maker and provider perceptions of the legitimacy of the people and entities making claims.[71,72] Given the politically and socially embedded nature of SRHR, the knowledge, motivation, and decision space of actors involved in policy and service provision can be more difficult to anticipate and address in SRHR than in other health domains. For instance, a service provider can independently conscientiously object to provide certain servies (e.g abortion, contraception) based on their own personal bias or incorrect information outside professional standards or clinical guidance leading to denial or restriction of such services.

In the context of SRHR, the literature highlights that values, norms, and associated judgments relating to issues such as fecundity, single motherhood, and perceived promiscuity can shape health policy and service delivery and thus, accountability. They can influence providers' attitudes toward specific patient groups, services, and related accountability efforts.[73,74] Acts of disrespect and abuse are often explicitly or implicitly related to provider judgements about the appropriateness of patient behaviour, such as whether young, unmarried women are entitled to contraception or should be having children.[44,51,75–77] The internalised discrimination described earlier can be exacerbated by the entrenched hierarchies in patient/provider interactions. As a result, in their interactions at the health facility, women may have very limited autonomy, further constraining their ability to negotiate and demand accountability.[26,32] Thus, outright disrespect and abuse in clinical settings may be normalised and expected.

There are multiple constraints on the capacity of those in decision-making roles to respond to accountability claims made by affected groups. Funding and programme management mechanisms imposed by donors and/or central government may emphasise programme efficiency and performance through accountability upwards to governments and donors, displacing accountability to communities seeking and receiving SRH services.[61,78] These dynamics can occur in top-down, heavily donor-subsidised health programmes, such as HIV treatment and services, though they may be exacerbated in contexts where there is not a strong national consensus on the relevance of the health concern. From a reproductive health programming perspective, women are often still perceived as "recipients" or "beneficiaries" with programmes designed to achieve utilisation and coverage rather than quality goals.[46] Health

providers likewise may face peer pressure and may feel compelled to demand informal payments from low status obstetric patients as a part of peer group behaviour.[79–81] Combined, these wider dynamics might constrict health actors' ability to respond to claims voiced by affected groups.

The complex nature of the health system

Health systems can be described as complex adaptive systems; they are dynamic in nature and evolve based on the changing relationships and connections between the component parts and actors.[82] Change in one part of the health system will likely affect others, often in unexpected ways. At the same time, the system may adapt to resist new policies and rules and limit any meaningful change. The systems complexity is driven by the number and diversity of interconnected actors with a range of formal and informal accountability relationships, that produce parallel and overlapping webs of accountability with varying degrees of autonomy and sources of control/oversight. For example, public providers, health ministries, finance ministries, parliamentary health committees, budget commitees, insurance agencies, and hospital boards are often linked. These webs of accountability relationships are not just shaped by remote, rational, apolitical policies and formal hierarchies; they are "constructed through human behaviour and interpretation", which is in turn shaped by the flows of power and ideologies within and beyond health systems.[7,83,84] Appreciating this complexity within the health system, such as assessing the advantages or disadvantages of strengthening different nodes in the web, is critical to accountability in SRHR.

Successful accountability efforts may work on multiple levels by reaching deeply into the formal health sector, as well as into other sectors of the government, such as education, social protection, and national human rights institutions. The utility of such intersectoral action may seem intuitive but accountability efforts may fail to engage relevant actors at multiple levels within and beyond the health sector.[17,85] Such an approach may be particularly relevant to SRHR, where reasons for weak service delivery go beyond technical deficiencies and lack of resources, to address ideological and political determinants. In South Africa, the Treatment Action Campaign, a South African HIV/AIDS advocacy organisation, combines a range of strategies to engage multiple levels of government, including treatment literacy for communities to demand their entitlements at the local level, and social justice/strategic/public interest litigation to establish new entitlements.[86] In another example of a successful effort to improve accountability, recourse was sought from judiciary/national level ombuds-offices in relation to the coerced provision of long-acting methods and sterilisation, resulting in successful remedies (compensation) being awarded to affected populations.[87]

Another accountability strategy used to strengthen SRHR across the health system is improving existing legislation. Significant investment in time and resources may be required to change laws, and, consistent with the complexity principle of policy resistance, laws may be necessary, but insufficient to effect change. Changes in laws and policies when accompanied with other initiatives such as social and legal accountability can have a positive influence on SRHR. For instance, in Senegal, along with broader community outreach and awareness raising in relation to female genital mutilation (FGM), legislation was enacted to address the practice. This led to large scale investment in building awareness and initiatives to stop FGM.[88] Evidence also suggests that when legislative/punitive measures are implemented as stand-alone interventions, they could have a detrimental effect resulting in the practice going underground and reducing services for affected populations. Where such approaches are combined with other factors such as social movements, space for civil society organisation, and investments in community awareness, that laws can engender more transformational impact.

Recognising complexity entails valuing concurrent accountability strategies that work simultaneously on different parts of the health system's web of accountability. In an effort to raise awareness among communities on their SRHR, in recent years NGOs have led legal empowerment programmes to promote government fulfilment of legal obligations. These programmes strive to help individuals to understand and use laws and policies, often by educating community members about SRHR entitlements and pursuing remedies via a variety of state institutions.[67,89–91] Such approaches have been successfully used to address disrespectful treatment and demands for informal payments, among other challenges.[89–92] As noted above, these challenges may be common in SRHR services, where stigma and provider judgements

about motherhood, sexual behaviour, and gender hierarchies permeate patients' encounters with health providers and the larger health facility. Another concurrent accountability strategy applied in different contexts is financial accountability. Budget monitoring can be a useful strategy to advance accountability and particularly successful in addressing the poor implementation of national policies. An NGO in Mexico, for example, monitored the budget allocations for adolescent SRH services and this third-party scrutiny likely contributed to increased allocations over a six-year period.[46]

Applying a complexity lens brings to the fore different health system actors and broadens the scope beyond just the publicly funded government system. The use of public money to support private health providers and the use of private money to support public systems are proliferating.[93] Collaborative governance arrangements and public-private partnerships are especially challenging in terms of transparency and oversight.[94] In some settings, the private sector is an important funder and provider of SRH health services, particularly for people who face discrimination in public facilities, such as young people.[95,96] Regulation of the private sector can be a political undertaking and is a fairly new area in the distinct field of accountability for health. There are few examples of performance, legal, or social accountability efforts successfully targeting private service providers, in part because regulatory frameworks may be weak and/or poorly enforced.[97,98] This certainly merits further research, particularly assessment of current efforts to regulate the private sector, ranging from performance-based financing to civil society advocacy.

Conclusion: building a comprehensive agenda on accountability for SRHR

Accountability in SRHR within the overall context of health systems is conditioned by a web of accountability relationships. Yet there are specific characteristics of SRHR that need to be considered as they colour the personal, social, organisational and institutional conditions in which accountability efforts take place. Politically and culturally charged gender norms shape power dynamics, resource allocation, health sector actors' attitudes and responsiveness, and whether people see themselves as "worthy" of rights. Moreover, the influence of conservative political, religious, and

cultural forces on SRHR, sometimes with a global remit, are arguably one of the "best examples of the detrimental intrusion of politics into public health",[99] shaping both government ability to be accountable to the population and the population's ability to demand accountability.

To strengthen accountability in SRHR, several areas should be prioritised. First, targeted and concerted efforts are needed to overcome norms, values, bias and stigma that discourage individuals from feeling they can demand better SRHR and that limit those in positions of power from responding. Though there is a significant literature within HIV and other fields on the impact of stigma, collective struggle, social risk, human rights, and conscientisation, these are not extensively explored in the accountability for health literature, which, for now, seems to privilege awareness raising/knowledge of entitlements over transformational change in norms – including gender norms – within health systems and communities.[32,100] Second, realising accountability in SRHR would entail efforts to be made by those most marginalised by gender and other hierarchies to claim their rights and disrupt the system that gives rise to unacceptable inequities. This requires accountability strategies to focus on empowerment and solidarity, including appreciating the personal risk of those most affected by lack of accountability. It also requires focusing on the institutional and structural challenges at the root of inequalities in SRHR with a view to systematically address them and counteract reversals in the longer-term. Third, given the close link with the political systems of a given country, accountability approaches should consider not just the formal health sector but also extend to the judiciary, other governmental sectors, and the social arena.

When comparing the wider evidence on accountability for health against the specificities of SRHR, several gaps emerge that require further examination. Documenting community driven efforts is essential, as it is apparent that the current peer-reviewed literature does not reflect the diversity of accountability efforts and that the use of different terminology and jargon creates fragmentation in discussions about the same struggle. Regardless of whether they describe themselves as accountability programmes, efforts undertaken by grassroots organisations are often under-represented. Better examination of gender and other social hierarchies and power dynamics overall is also critical. Rather than addressing gender as a

demographic category, we need to understand how gender and other intersecting identities are negotiated among citizens making rights claims, and in government responses. Finally, we need to rethink questions about the intent of accountability efforts, particularly within the health field. Beyond health service quality and efficiency, we might consider the professional values of those who work in the system, the citizenship of those who use the system, and the relationship between them.

To conclude, this review highlights the fact that accountability in SRHR is highly charged and deeply politicised on an individual, interactional and institutional level and that this needs to be made explicit in accountability efforts. Political and ideological contexts, including the ability of all members of the community to express voice and the commitment and capacity of duty bearers to respond to accountability strategies, colour the capabilities and conditions in which accountability efforts occur. These dynamics may be different for SRHR than for less contested areas of health.

Disclaimer

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Résumé

Les stratégies mondiales et les engagements internationaux en faveur de la santé et des droits sexuels et reproductifs montrent qu'il faut renforcer les processus de redevabilité fondés sur les droits. Pourtant, il existe des lacunes entre ces ambitieux cadres de droits relatifs à la santé et aux droits sexuels et reproductifs et les réalités sociopolitiques limitées dans lesquelles ces cadres sont mis en œuvre. L'article aborde ces lacunes en examinant les données sur les dynamiques et les préoccupations relatives à l'opérationnalisation de la redevabilité dans le contexte de la santé et des droits sexuels et reproductifs. Il s'inspire de l'analyse secondaire d'un examen systématique des données publiées sur la santé et les droits sexuels et reproductifs et la redevabilité et se fonde également sur la documentation plus large relative à la redevabilité dans le secteur de la santé. Les principaux thèmes incluent le contexte politique et idéologique, la consolidation de la voix des communautés, l'amélioration de la réactivité du système de santé et la reconnaissance de la complexité des systèmes de santé. Il y a effectivement un éventail de relations de redevabilité pouvant être exploitées dans le système de santé; il convient cependant de prendre en compte les caractéristiques spécifiques à la santé et aux droits sexuels et reproductifs puisqu'elles influent sur les capacités et les conditions dans lesquelles se produisent les efforts de redevabilité.

Resumen

Las estrategias y compromisos mundiales a favor de la salud y los derechos sexuales y reproductivos (SDSR) recalcan la necesidad de fortalecer los procesos de rendición de cuentas en materia de derechos humanos. Sin embargo, existen brechas entre estos ambiciosos marcos de SDSR y las limitadas realidades sociopolíticas vividas en las cuales se aplican estos marcos. Este artículo aborda esas brechas revisando la evidencia sobre las dinámicas y preocupaciones relacionadas con operacionalizar la rendición de cuentas en el contexto de SDSR. Se basa en un análisis secundario de una revisión sistemática que examinó la evidencia publicada sobre SDSR y rendición de cuentas, así como en la literatura general sobre la rendición de cuentas en materia de salud. Los temas clave son: el contexto político e ideológico, mejorando la voz comunitaria y la capacidad de respuesta del sistema de salud, y reconociendo la complejidad de los sistemas de salud. Aunque hay una variedad de relaciones de rendición de cuentas que se pueden aprovechar en el sistema de salud, se debe considerar las características específicas de SDSR, ya que éstas influyen en las capacidades y condiciones en las que ocurren los esfuerzos de rendición de cuentas.