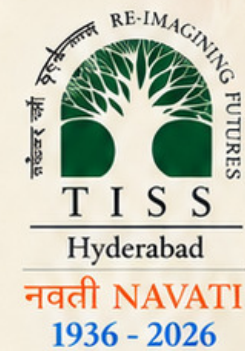


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FROM COMMITMENTS TO ACCOUNTABILITY

*A Human Rights-Based Framework for
Multisectoral Health Governance in
South-East Asia Region*

Sunayana Swain and Ipsita Sapra

School of Public Policy and Governance, TISS Hyderabad

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From Commitments to Accountability

A Human Rights-Based Framework for Multisectoral Health Governance in South-East Asia Region

Sunayana Swain^{*} and Ipsita Sapra^{**, ***}

Abstract

Governments across South-East Asia have committed to multisectoral action as a route to health equity, recognising that conditions shaping health lie well beyond the health sector. Commitments alone, however, do not establish who is responsible, who must answer for performance, or what happens when promises go unmet. These gaps fall hardest on vulnerable and marginalised populations. This paper develops a Human Rights-Based Multisectoral Accountability Framework (HRBA-MSAF) to examine how political, bureaucratic, fiscal, and social accountability are institutionalised across sectors and carried through to implementation. We apply it through a documentary case study analysis of eight countries in the World Health Organization South-East Asia Region (India, Bangladesh, Sri Lanka, Nepal, Thailand, Timor-Leste, Bhutan and the Maldives) across six health domains: maternal and child health, non-communicable diseases, HIV/AIDS, tuberculosis, mental health, and climate-related health vulnerabilities. The analysis distinguishes answerability from enforceability and examines the role of institutions across accountability relationships. Across countries, commitments to vulnerable populations run well ahead of the mechanisms needed to enforce them. Accountability is concentrated within the health sector, while multi-sector responsibilities, fiscal accountability and the meaningful participation of affected communities remain weak. Moving from commitments to accountability requires institutional structures that make clear who decides, who delivers, who pays and who answers.

Keywords: multisectoral accountability, human rights-based approach, health governance, institutional design, low- and middle-income countries, South-East Asia Region

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Section I: Introduction

Across the South-East Asia Region (SEAR), vulnerable populations bear a disproportionate burden of ill-health.¹ The paper argues that persistent inequities cannot be explained by resource scarcity alone; they also reflect weakness in governance, accountability and institutional design.

The Governance Problem

Vulnerable groups cannot be understood through a single lens. Vulnerability is produced through overlapping structural marginalities such as poverty, gender inequality, caste discrimination, irregular migration status, sexual identity, and spatial exclusion that compound across generations.² Homogenising them into a single category obscures the mechanisms through which ill-health is produced and sustained. The Sustainable Development Goals (SDG) framework and the United Nations Development Programme (UNDP) both recognise that these determinants cut across sectors and levels of governance,³ and COVID-19 exposed a pre-existing architecture that lacks coordinated multisectoral accountability, leaving the most marginalised without institutional recourse precisely when they needed it most.⁴

The Accountability Problem

Addressing these determinants demands more than coordinated service delivery; it requires accountability: the enforceable obligation of governments and institutions to justify their actions and face consequences for failure. Accountability constitutes the *de facto* constraints on government's use of political power through requirements for justification and the possibility of sanction,

¹ H. Wang, L. V. Torres, and P. Travis, "Financial Protection Analysis in Eight Countries in the WHO South-East Asia Region", *Bulletin of the World Health Organization* 96, no. 9 (2018): 610–20E, <https://doi.org/10.2471/BLT.18.209858>; Organisation for Economic Co-operation and Development (OECD) and World Health Organization (WHO), *Health at a Glance: Asia/Pacific 2024* (Paris: OECD Publishing, 2024), <https://doi.org/10.1787/51fed7e9-en>.

² R. Thapa et al., "Caste Exclusion and Health Discrimination in South Asia: A Systematic Review", *Asia-Pacific Journal of Public Health* 33, no. 8 (2021): 828–38, <https://doi.org/10.1177/10105395211014648>; C. H. A. Kuran et al., "Vulnerability and Vulnerable Groups from an Intersectionality Perspective", *International Journal of Disaster Risk Reduction* 50 (2020): 101826, <https://doi.org/10.1016/j.ijdrr.2020.101826>.

³ World Health Organization (WHO), "The Sustainable Development Goals: Interlinking Health and the Social Determinants of Health", 2018, <https://www.who.int/europe/about-us/our-work/sustainable-development-goals>; United Nations Development Programme (UNDP), "UNDP's Work on Human Rights, Key Populations and Gender", 2022, <https://healthimplementation.undp.org/functional-areas/human-rights-key-populations-and-gender/undps-work-on-human-rights-key-populations-and-gender/>.

⁴ J. S. Okello, T. Ginindza, and J. N. Odhiambo, "Multisectoral Coordination during the COVID-19 Pandemic: Practices, Challenges and Recommendations for Future Preparedness – A Systematic Literature Review Protocol", *BMJ Open* 15, no. 7 (2025): e099016, <https://doi.org/10.1136/bmjopen-2025-099016>.

by both citizens and oversight institutions.⁵

It operates across three relational forms: vertical, based on the obligation of the state to answer to those it governs; horizontal, between institutions of roughly equal standing such as inter-ministerial bodies or parliamentary committees; and diagonal, involving civil society organisations (CSOs), community groups, and people directly affected by policy, who can make claims on power without holding formal authority.⁶ These forms are further expressed through four substantive dimensions: political, bureaucratic, fiscal, and social accountability. The two classifications are complementary rather than competing. A single mechanism may be simultaneously bureaucratic and diagonal, or political and horizontal.

Yet a critical gap persists. Across the region, accountability frameworks have consistently reduced vulnerable populations to data points: people living with human immunodeficiency virus (HIV), marginalised migrants, women in poverty, and gender minorities appear in surveillance data but rarely as rights-holders with legitimate claims on the system. This instrumentalisation of vulnerability is not a technical failure but a governance failure, one that weakens the very mechanisms intended to serve these groups.

The Limits of Multisectoral Governance as Institutional Design

The determinants of ill-health do not sit within the health sector alone. Housing insecurity, nutritional deprivation, lack of education, precarious employment, and climate-related displacement all operate as upstream drivers of disease burden that fall under the mandate of entirely different institutional actors. Multisectoral frameworks have recognised this reality: the SDG architecture, the World Health Organization's (WHO) Multisectoral Accountability Framework (MSAF) emerging from the Moscow Declaration to End Tuberculosis (TB),⁷ and national responses such as Thai-

⁵ A. Lührmann, K. L. Marquardt, and V. Mechkova, "Constraining Governments: New Indices of Vertical, Horizontal, and Diagonal Accountability", *American Political Science Review* 114, no. 3 (2020): 811–20, <https://doi.org/10.1017/S0003055420000222>.

⁶ Lührmann, Marquardt, and Mechkova, "Constraining Governments"; S. I. Lindberg, "Mapping Accountability: Core Concept and Subtypes", *International Review of Administrative Sciences* 79, no. 2 (2013): 202–26, <https://doi.org/10.1177/0020852313477761>; G. A. O'Donnell, "Horizontal Accountability in New Democracies", *Journal of Democracy* 9, no. 3 (1998): 112–26, <https://doi.org/10.1353/jod.1998.0050>; E. Peruzzotti and C. Smulovitz, "Social Accountability: An Introduction", in *Enforcing the Rule of Law: Social Accountability in the New Latin American Democracies*, ed. E. Peruzzotti and C. Smulovitz (Pittsburgh: University of Pittsburgh Press, 2006), 3–33.

⁷ World Health Organization (WHO) and Ministry of Health of the Russian Federation, *Moscow Declaration to End TB: First WHO Global Ministerial Conference on Ending TB in the Sustainable Development Era: A Multisectoral Response* (Geneva: World Health Organization, 2017), https://www.who.int/sites/g/files/tmzbd1486/files/our_work/DMM/Migration-Health/moscow_declaration_to_end_tb_final_english.pdf.

land's inter-ministerial HIV financing model and Nepal's district-level coordination structures.

However, improved coordination is not the same as built-in accountability. Multisectoral approaches have frequently brought agencies to the same table while failing to assign enforceable responsibilities, define consequences for non-delivery, or create meaningful channels through which vulnerable communities can hold any single actor answerable. When accountability is distributed across sectors without clear ownership, it effectively belongs to none. This is the second and deeper structural gap: existing frameworks have improved the architecture of cooperation but have not embedded accountability into its design.

The Human Rights-Based Approach as the Normative Anchor

Both gaps share a common missing anchor. Neither is adequately addressed without a Human Rights-Based Approach (HRBA) at the centre of health governance design. HRBA reframes the relationship between citizens and the state. Where conventional accountability frameworks position vulnerable populations as beneficiaries or subjects of monitoring, HRBA reconstitutes them as rights-holders with enforceable claims, and makes governments, ministries, and agencies duty-bearers obligated not merely to deliver services, but to justify their actions, respond to failures, and be held liable for violations.

Applied to multisectoral health governance, this supplies the integrating logic that coordination alone cannot. Constitutional and political commitments to the right to health, when embedded into framework design rather than treated as aspirational declarations, transform sector-level responsibilities into enforceable obligations: the right to health becomes the goal, a rights-embedded accountability framework the process, and improved responsiveness to the most marginalised the measurable outcome. Yet across low- and middle-income countries (LMICs) in the SEAR, HRBA has remained underused as an operational anchor: commitments exist at the constitutional and international level but are rarely translated into the institutional design of accountability frameworks.

Towards an HRBA-Anchored Multisectoral Accountability Framework

This paper develops a Human Rights-Based Multisectoral Accountability Framework (HRBA-MSAF): one that centres vulnerable groups not as subjects of intervention but as rights-holders with enforceable claims, and that embeds accountability into the design of multisectoral health governance rather than treating it as an add-on. The framework is built through a systematic case study

analysis of eight countries across the WHO South-East Asia Region, namely India, Bangladesh, Sri Lanka, Nepal, Thailand, Timor-Leste, Bhutan, and the Maldives, and tested across six health domains: Maternal and Child Health (MCH), Non-Communicable Diseases (NCDs), HIV and acquired immunodeficiency syndrome (HIV/AIDS), Tuberculosis, Mental Health, and health vulnerabilities arising from Climate Change. These were selected on the basis of disproportionate disease burden, a plurality of institutions, and the uneven existence of accountability mechanisms at macro, meso, and micro levels.

The paper translates this framework into concrete diagnostic tools that governments, WHO, and member country partners can use to assess existing accountability arrangements, identify structural gaps, and design more rights-responsive multisectoral systems, deriving its recommendations from what has demonstrably worked, and where it has failed, across the region's own governance experience.

The paper is organised as follows. Section II sets out the conceptual architecture; Section III elaborates the HRBA-MSAF and its diagnostic matrices; Section IV presents the comparative case study methodology; Section V presents comparative evidence across the four accountability dimensions, the re-centring of vulnerable groups, and Health-in-All-Policies (HiAP) convergence; Section VI identifies cross-cutting patterns; Section VII discusses the theoretical contribution and the framework's limits; and Section VIII concludes.

Section II: Conceptual Pillars

Global health governance faces a transformative period in which deep-seated inequities between and within nations demand more integrated, rights-based models. This paper argues that a Human Rights-Based Approach nested within a Multisectoral Accountability Framework (HRBA-MSAF), synthesising three pillars – intersectional vulnerability, multisectoral approaches and systemic accountability – offers a pathway to equitable health outcomes.

Pillar 1: Vulnerability and the Imperative of Intersectionality

The concept of vulnerability, as used in global health governance, risks flattening the very complexity it seeks to address: rendered as a static category, it invites responses that target groups as fixed objects of intervention rather than as rights-holders embedded in dynamic social structures. Vulnerability is instead intersectional, emerging from the convergence of multiple, mutually rein-

forcing axes of disadvantage including gender, class, caste, geographic location, migration status, and legal recognition.⁸ These intersections are not additive but constitutive.

This insight is grounded in Crenshaw's work on intersectionality,⁹ elaborated in health equity scholarship as the architecture for moving beyond single-axis analyses of health disparities.¹⁰ A maternal health programme targeting 'women' as a homogeneous category may thus systematically underserve Dalit, Adivasi, and migrant women, for whom barriers to care are qualitatively different, not merely quantitatively greater.

Pillar 2: Multisectoral Approaches – Beyond Coordination

The multisectoral approach draws its rationale from the social determinants of health literature,¹¹ which holds that health outcomes are products less of healthcare systems than of the conditions in which people are born, grow, live, work, and age. This is the intellectual foundation for the Health-in-All-Policies (HiAP) agenda and for the multisectoral collaboration that an MSAF seeks to institutionalise. Multisectoral approaches succeed when guided by clear policy goals, delineated institutional roles, and robust accountability frameworks for each participating sector.¹² In their absence, what presents as multisectoral collaboration is frequently a loosely coordinated collection of sectoral programmes with minimal shared governance, producing documents rather than outcomes.¹³

Institutions are the sites at which accountability is either enacted or evaded, and the rules of the

⁸ Kuran et al., "Vulnerability and Vulnerable Groups".

⁹ K. Crenshaw, "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics", *University of Chicago Legal Forum* 1989, no. 1 (1989): 139–67.

¹⁰ O. Hankivsky, "Women's Health, Men's Health, and Gender and Health: Implications of Intersectionality", *Social Science and Medicine* 74, no. 11 (2012): 1712–20, <https://doi.org/10.1016/j.socscimed.2011.11.029>; G. R. Bauer, "Incorporating Intersectionality Theory into Population Health Research Methodology: Challenges and the Potential to Advance Health Equity", *Social Science and Medicine* 110 (2014): 10–17, <https://doi.org/10.1016/j.socscimed.2014.03.022>.

¹¹ Commission on Social Determinants of Health (CSDH), *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, Final Report of the Commission on Social Determinants of Health (Geneva: World Health Organization, 2008); M. Marmot, "Social Determinants of Health Inequalities", *The Lancet* 365, no. 9464 (2005): 1099–104, [https://doi.org/10.1016/S0140-6736\(05\)71146-6](https://doi.org/10.1016/S0140-6736(05)71146-6).

¹² V. Tangcharoensathien et al., "Multisectoral Actions for Health: Challenges and Opportunities in Complex Policy Environments", *International Journal of Health Policy and Management* 6, no. 7 (2017): 359–63, <https://doi.org/10.15171/ijhpm.2017.61>.

¹³ K. Buse and S. Hawkes, "Health in the Sustainable Development Goals: Ready for a Paradigm Shift?" *Globalization and Health* 11 (2015): 13, <https://doi.org/10.1186/s12992-015-0098-8>.

game, formal and informal, determine what actors can and cannot do.¹⁴ When accountability for health outcomes is vested in inter-ministerial committees without enforcement powers, or in community feedback mechanisms without formal linkage to bureaucratic decision-making, the result is procedural accountability without health outcomes.

Pillar 3: Accountability in Health Systems

Accountability, in health governance as in political science more broadly, has a definitional core: it is the obligation of a power-holder to explain and justify their conduct to those affected by it, and to face consequences for failure to do so.¹⁵ This two-part structure, answerability and enforceability, is the core of any accountability system. A government that publishes health reports but faces no consequence for persistent exclusion has answerability without enforceability; both are required, and they must be linked.

The literature on accountability, especially on social accountability in health, shows that community-based initiatives improve service responsiveness only where they are formally linked to public sector decision-making; without that linkage they are expressive rather than effective.¹⁶ This is the missing link the HRBA-MSAF is designed to address.

The distinction between political, bureaucratic, fiscal, and social accountability¹⁷ matters because each fails differently: political commitment without follow-through does not deliver, bureaucratic monitoring risks proceduralism, fiscal allocation is undercut by utilisation gaps, and social accountability presupposes empowered civil society organisations. A robust MSAF must address all four simultaneously.

¹⁴ J. G. March and J. P. Olsen, *Rediscovering Institutions: The Organizational Basis of Politics* (New York: Free Press, 1989).

¹⁵ Lindberg, "Mapping Accountability".

¹⁶ S. Molyneux et al., "Community Accountability at Peripheral Health Facilities: A Review of the Empirical Literature and Development of a Conceptual Framework", *Health Policy and Planning* 27, no. 7 (2012): 541–54, <https://doi.org/10.1093/heapol/czr083>; N. Naher et al., "Do Social Accountability Approaches Work? A Review of the Literature from Selected Low- and Middle-Income Countries in the WHO South-East Asia Region", *Health Policy and Planning* 35, suppl. 1 (2020): i76–96, <https://doi.org/10.1093/heapol/czaa116>.

¹⁷ S. I. Lindberg, *Accountability: The Core Concept and Its Subtypes*, Africa Power and Politics Programme Working Paper No. 1 (London: Overseas Development Institute, 2009), <https://assets.publishing.service.gov.uk/media/57a08b4740f0b652dd00bd6/APPP-WP1.pdf>.

Synthesising the Pillars: HRBA-MSAF

The Human Rights-Based Approach provides the integrating logic that makes these three pillars coherent. Under the HRBA, states are duty-bearers obliged to respect, protect, and fulfil the right to health, and individuals, including members of vulnerable groups, are rights-holders with claims rather than recipients of charity. This reframing makes accountability non-optional: if health is a right, failure to deliver it constitutes a violation.

The HRBA operates through goals, processes, and outcomes. These map onto the three pillars: intersectional analysis informs Goals, the multisectoral approach provides the architecture for Process, and the four dimensions of accountability provide the mechanisms for verifying Outcomes.

What the HRBA adds to a conventional MSAF is directional coherence. The HRBA-MSAF insists that accountability flows toward the rights-holder, and that the test of any mechanism is whether it reaches the most excluded. Critically, the HRBA-MSAF logic rejects reducing vulnerable groups to mere “numbers and data points” in hierarchical collection systems. It centres them instead as agents, as in the induction of people living with HIV into leadership roles in India’s National AIDS Control Organisation (NACO) and the statutory inclusion of those with lived experience on Review Boards under the Mental Healthcare Act 2017.

In sum, an intersectional lens, a multisectoral approach to health determinants, and an enforceable accountability framework together create the conditions for health systems to move toward substantive health equity.

Section III: The HRBA-MSAF Framework – From Health Commitments to Multisectoral Accountability

Developing a multisectoral accountability framework (MSAF) that situates health within an HRBA requires, as a prerequisite, an understanding of health as a binding commitment within multisectoral action, and a delineation of the roles of institutional actors in the design, implementation, and evaluation of such a framework.

3.1. Health as a layered commitment

The framework begins from the premise that health is not simply a policy objective but a layered commitment undertaken by the State, which in a multisectoral context must be translated across

levels of political and institutional obligation. The paper therefore distinguishes between international, constitutional, and political commitments.

International commitments arise from global agreements, declarations, conventions and development goals to which States subscribe. They establish the normative direction within which national health commitments are formulated; examples include the SDGs, the Global Plan to End TB, and the Paris Agreement.

Constitutional commitments represent obligations embedded within a country's constitutional and legal architecture. These may not articulate a directly enforceable right to health, but they establish obligations concerning public health, nutrition, welfare, equality or the protection of particular groups, as India's Article 47 illustrates. Statutory frameworks such as India's Mental Healthcare Act 2017 translate broader rights principles into specific institutional obligations.

Political commitments refer to priorities articulated by political leadership and translated into programmes and targets, such as India's Ayushman Bharat or national NCD commitments.

These three layers form a continuum rather than separate entities. Their analytical significance is that a commitment at one level does not automatically generate accountability at another. An international commitment may establish a normative obligation without creating an identifiable domestic actor responsible for implementation; a political commitment may become a programme without corresponding fiscal provisions or mechanisms through which citizens can demand performance. The framework therefore asks how commitments travel across levels of governance and become institutionalised.

The cases vary: some commitments become dedicated multisectoral institutions, such as India's National Multisectoral Action Plan for NCDs or Thailand's inter-ministerial AIDS mechanisms; elsewhere multisectorality is embedded less formally, through decentralisation or participatory review.

The presence of a document labelled “multisectoral” is therefore not decisive. The analytical question is whether the commitment creates shared responsibilities and accountability across sectors and levels of governance.

3.2. Commitments and the Human Rights-Based Approach to Health

The second layer is the Human Rights-Based Approach, which provides the normative foundation for examining whether multisectoral health governance eliminates discrimination and structural inequality in access to health services.

The HRBA is operationalised through three interconnected dimensions: goals, processes and outcomes.

Goals: What is health governance trying to achieve?

At the level of goals, health policies and programmes are assessed in relation to the realisation of health rights and the reduction of inequalities. This asks not ‘*has the programme improved outcomes?*’ but ‘*whose health has improved, whose remains underserved, and does the policy address the conditions producing those inequalities?*’

Process: How are decisions made and implemented?

The process dimension examines whether rights-based principles are embedded in how policies are designed, implemented and monitored: meaningful participation and inclusion, equality and non-discrimination, transparency in decision-making, and robust monitoring and evaluation (M&E). Participation is not treated as a desirable programme feature but as an indicator of whether people affected by health policies have a meaningful role in the governance processes through which those policies are implemented.

Outcomes: Do rights become actionable?

The outcome dimension concerns the extent to which institutional arrangements enable States to fulfil their obligations and enable rights-holders to understand, claim and exercise their rights. This distinguishes formal recognition from substantive realisation: a law recognising the rights of people with mental illness is an important normative commitment, but does not establish that rights are realised in practice, just as a programme may create participation structures without communities having influence over decisions.

3.3. *From HRBA to Multisectoral Accountability*

The HRBA establishes the normative question – what governments ought to achieve in relation to health and rights. The Multisectoral Accountability Framework (MSAF) adds the institutional question – who is responsible, what are they responsible for, how is performance monitored, and what happens when commitments are not fulfilled? The study therefore nests the HRBA within the MSAF rather than treating them as parallel frameworks: the HRBA provides the normative foundation on which the MSAF builds the institutional architecture, with accountability mechanisms as the operational pathway to rights-responsive health outcomes.

This nesting matters because responsibility for health is rarely located within the health ministry alone; outcomes are shaped by education, nutrition, labour, social protection, housing, environment, transport and taxation. The framework consequently asks whether a health commitment has been translated into shared institutional responsibility rather than merely identifying whether multiple sectors have been mentioned in a policy document.

3.4. *Nature of Accountability and its Dimensions*

To examine how the MSAF operates in practice, the study distinguishes four dimensions of accountability: Political, Bureaucratic, Fiscal, and Social accountability. These represent different but interconnected relationships through which actors can be required to explain, justify and correct their actions.

Political Accountability concerns the relationship between political authority, public commitments and citizens, examining whether health commitments are reflected in political agendas, legislative action and oversight, and whether they are periodically reviewed against stated objectives.

Bureaucratic Accountability concerns the administrative translation of commitments into implementation: whether responsible institutions are identified, responsibilities distributed, operating procedures and monitoring systems established, and corrective action follows from monitoring.

Fiscal Accountability concerns whether commitments are supported by resources subject to oversight: whether budgets are allocated across sectors, expenditure reviewed and audited, and financial review informs subsequent planning.

Social Accountability concerns the capacity of communities, civil society organisations and affected populations to hold institutions responsible, through participation, community monitoring, pub-

lic hearings, social audits, scorecards, grievance and feedback mechanisms.

Together these dimensions form an interconnected system: political accountability establishes direction, bureaucratic accountability organises implementation, fiscal accountability enables it, and social accountability tests responsiveness and legitimacy.

3.5. Answerability and Enforceability: Strength of Accountability

The four dimensions above describe the nature of accountability relationships, whereas this section discusses the strength of those relationships through Answerability and Enforceability.

Answerability

Answerability concerns the obligation of an actor to provide information, explain decisions and justify actions. It asks: who has to explain what they have done, to whom, and through which mechanism? Reporting requirements, programme reviews, monitoring systems, parliamentary reporting, published performance indicators, community feedback and financial reporting all make institutional action visible and open to scrutiny.

Enforceability

Enforceability concerns whether an actor can be held liable or required to take corrective action when commitments are not met or obligations are violated. This may involve legal sanctions, administrative action, financial penalties, regulatory consequences, mandatory corrective action, grievance redressal, judicial remedies or other mechanisms through which failure carries consequences.

This distinction is critical to the framework because answerability does not necessarily imply enforceability. A minister may be required to submit an annual report but face no consequence for missing its targets; a community may be invited to give feedback without any obligation on the responsible institution to respond.

The framework therefore does not stop at explanation but extends to course correction, remedy and consequence. Political accountability may be high in answerability, because ministers report to parliament, while enforceability remains weak where failure carries no consequence.

The analytical framework therefore examines accountability as a two-dimensional relationship by mapping type of accountability across degree of answerability and enforceability. This

distinguishes the existence of accountability mechanisms from their institutional strength.

3.6. Diagnostic Matrix I: Commitments and Accountability

The first diagnostic matrix translates the conceptual framework into a set of questions for examining how commitments become accountability arrangements. It captures key international, constitutional, and political commitments and examines accountability across the political, bureaucratic, fiscal, and social dimensions.

Rather than beginning with institutional mechanisms, the matrix begins with commitment itself. This matters because accountability cannot be assessed without first establishing what a government has committed to do.

In the backdrop of international, constitutional or political commitments, the matrix therefore asks the following:

- Is the commitment reflected in the political agenda of the government, and how is it operationalised? (*indicative of political accountability*)
- Is the commitment interpreted as necessitating a multisectoral response, requiring an appropriate accountability framework across the relevant institutional layers and instruments? (*indicative of bureaucratic accountability*)
- Are budgetary provisions in place for the multiple sectors involved, and is the sustainability of such provisions planned for? (*indicative of fiscal accountability*)
- Does the commitment mandate the involvement of members of vulnerable groups not merely as beneficiaries, but as proactive agents of change in processes affecting their health? (*indicative of social accountability*)

Matrix I: Commitments and Accountability Matrix

Accountability dimension	Commitments (International/Constitutional/Political)
Political Accountability	Are the international commitments reflected in the political agenda? Are policy instruments in place? Are progress and achievements reported? Is there political oversight of implementation? Are political commitments revisited in light of performance?
Bureaucratic Accountability	Is there a mandate requiring multisectoral action?

continued on next page

Matrix I: (continued)

Accountability dimension	Commitments (International/Constitutional/Political)
	Are responsible actors and institutions identified? Is there an institutional framework that outlines convergence of multiple sectors? Are implementation and M&E¹⁸ arrangements established? Are there monitoring and evaluation frameworks for each of the concerned sectors? Is M&E undertaken as planned? Do the data collected inform decision making or implementation course correction? Are institutional failures identified and addressed?
Fiscal/Financial Accountability	Are there budgetary allocations made by the relevant sectors? Are resources allocated for M&E processes? Are the budget utilisation and expenditure reviewed? Do budget and expenditure reviews guide further planning?
Social Accountability	Does the policy framework stipulate for the inclusion of members of the vulnerable groups? Does the policy provide for inclusion of the vulnerable groups? Are goals and entitlements communicated? Are mechanisms for social audit, community monitoring, or feedback provided? Can communities participate in monitoring and review? Can their feedback influence implementation? Are civil society organisations a part of the social audit process? Are members of CSOs involved in the policy formulation process? Do social audits, community monitoring, and community feedback generate institutional response?

The matrix is diagnostic rather than evaluative: it assigns no single score to a country or programme. Instead, it enables the researchers to trace where accountability is present, where it is weak, and where the chain between commitment and implementation breaks down. A programme may show strong political accountability because its objectives are recognised by political leadership while showing weak fiscal accountability because the relevant sectors have no identifiable budgetary responsibilities.

3.7. Diagnostic Matrix II: Institutionalisation of Accountability

The first matrix records what the State has committed to do. The second begins with the institutional arrangements through which those commitments are translated into accountability rela-

¹⁸ Monitoring and evaluation.

tionships. This distinction is necessary because multisectoral health governance involves multiple actors and institutions whose responsibilities may differ across political, bureaucratic, fiscal, and social domains.

The second diagnostic matrix therefore examines the institutionalisation of accountability through two dimensions: Answerability and Enforceability. For each dimension, it asks:

- Is the institution required to explain and report its actions? (under Answerability)
- Can it be required to correct, remedy, or face consequences for non-compliance? (under Enforceability)

Where a policy framework articulates the involvement of multiple sectors, this indicates the answerability dimension of political accountability; where mechanisms exist to hold the state legally or financially liable, this demonstrates its enforceability dimension. Similarly, policy-stipulated monitoring by vulnerable groups indicates the answerability dimension of social accountability, while mandatory social audits reflect its enforceability dimension.

Matrix II: Institutional Structure and Enactment of Accountability

Accountability dimension	Answerability	Enforceability
Political	• Is there a policy framework for multisectoral engagement? • Are relevant sectors and stakeholders involved in policy formulation? • Are political commitments subject to reporting or review?	• Are there legal, administrative or financial mechanisms through which political authorities can be held liable for failure to fulfil commitments?
Bureaucratic	• Are responsible institutions identified? • Are roles/standard operating procedures (SOPs) defined? • Is there a monitoring and evaluation (M&E) framework? • Are reporting and review mechanisms established?	• Are there mechanisms to hold implementing institutions or officials responsible for non-compliance? • Are corrective actions mandatory?
Fiscal	• Are budgetary provisions identifiable? • Are resources for implementation and M&E provided? • Are financial reports and audits produced?	• Are financial audits mandatory? • Are there consequences for financial mismanagement or failure to comply with approved allocations?
Social	• Are vulnerable groups and civil society organisations (CSOs) formally included in monitoring? • Are communities able to access information and provide feedback?	• Are social audits, grievance mechanisms or community review processes institutionally binding? • Must responsible agencies respond to findings?

The matrix allows the analysis to move beyond identifying whether an accountability mechanism

exists to examine how institutionalised and consequential that mechanism is. A financial audit demonstrates answerability by making expenditure visible; it contributes to enforceability when it can trigger corrective action or sanction.

3.8. Operationalisation of the multisectoral accountability framework in the case analysis

The framework developed above informed the case analysis in three connected stages. First, commitments were mapped and their translation into national policies, strategies, legislation or action plans traced. Second, the four accountability dimensions were examined across answerability and enforceability. Third, the institutions responsible for implementation were identified across macro, meso and micro levels.

The analysis also examined whether vulnerable populations were positioned merely as data sources and beneficiaries, or whether they were able to participate as rights-holders, monitors, decision-makers and agents for accountability.

The framework consequently treats accountability as more than the presence of monitoring mechanisms. It is the process through which commitments become institutional responsibilities, supported by resources, subjected to scrutiny, and connected to opportunities for correction. The HRBA asks whether governance is oriented towards rights and equity; the MSAF asks how responsibility is organised across sectors; the four dimensions identify the pathways through which it is enacted; and the answerability-enforceability distinction assesses their strength.

The framework therefore provides a basis for examining not merely whether multisectoral accountability mechanisms exist, but whether they are institutionalised, consequential, and centred on the populations whose health rights they are intended to advance.

Section IV: Methodology

4.1. Methodological orientation and research design

The study adopts a qualitative, interpretive and comparative case study approach because multisectoral accountability for vulnerable populations is contextual, relational and institutionally embedded, and cannot be understood from formal policies or health outcomes in isolation.

The method permits a “thick description” of how multisectoral action is organised in practice,¹⁹ asking not simply what accountability mechanisms exist but how they vary across health problems and governance contexts. The study is therefore oriented towards analytical rather than statistical generalisation.

4.2. Case Selection and Study Setting

The study examines multisectoral health governance across eight countries of the WHO SEAR: India, Bangladesh, Sri Lanka, Nepal, Thailand, Timor-Leste, Bhutan and the Maldives. Rather than treating each country as a standalone case, the study develops six thematic comparative studies around major health concerns:

- Maternal and Child Health (MCH): India, Bangladesh, and Sri Lanka
- HIV/AIDS: Thailand and Nepal
- Non-Communicable Diseases (NCDs): India and Timor-Leste
- Tuberculosis (TB): India
- Mental Health: India and Bhutan
- Climate Change and Health: the Maldives and Timor-Leste

This enables comparison within and across domains, spanning communicable and non-communicable disease and determinants ranging from household conditions to environmental processes. The selection of countries and health domains was purposive and theoretically informed.

Selection applied three criteria. First, substantial population-level burden and significant consequences for vulnerable groups, which NCDs, TB, MCH and HIV/AIDS all carry in low- and middle-income settings.²⁰ Mental Health and Climate Change were included as newer domains where determinants and institutional responsibilities are less clearly bounded.

Second, responsibility extending beyond the Ministry of Health to other departments, subnational institutions, private providers, civil society and communities, since the object of inquiry is multi-

¹⁹ C. Geertz, “Thick Description: Toward an Interpretive Theory of Culture”, in *The Interpretation of Cultures: Selected Essays* (New York: Basic Books, 1973), 3–30, cited in A. Bryman, *Social Research Methods* (3rd ed. Oxford: Oxford University Press, 2008); J. W. Creswell, *Qualitative Inquiry and Research Design: Choosing among Five Approaches* (2nd ed. Thousand Oaks, CA: Sage, 2007).

²⁰ World Health Organization (WHO), “Noncommunicable Diseases”, fact sheet, 2025, <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>.

sectoral rather than health-sector accountability. Maternal and child health, for instance, requires coordination across health, nutrition, education, sanitation and social protection.

Third, governance arrangements documented sufficiently for systematic examination. This does not presume accountability to be effective; rather, the existence of institutional mechanisms makes the gap between commitment and implementation observable, and the study includes cases where accountability appears institutionalised alongside cases where it remains fragmented.

4.3. Unit of Analysis and Case Architecture

The primary unit of analysis is the multisectoral accountability arrangement surrounding a defined health concern, rather than the country: India's TB governance architecture cannot be assumed to represent its mental health or NCD governance. Each case was examined as a bounded governance system consisting of:

- The health problem and its affected populations
- Policy and legal commitments
- Institutions responsible for action
- Relationships among sectors and levels of government
- Financial resources arrangements
- Monitoring and review mechanisms
- Community and civil society participation; and
- Mechanisms through which institutions can be held answerable

4.4. Data Sources and Evidence Base

The study draws on documentary and secondary evidence relating to multisectoral health interventions and accountability mechanisms, spanning international, regional, national and programme-level sources. These include:

- WHO strategies, reports, and monitoring documents
- United Nations (UN) and SDG-related commitments
- National health policies and strategic plans
- National action plans (disease- and issue-specific)

- Legislation and regulatory instruments
- Ministry and government documents
- Institutional mandates and implementation frameworks
- Programme monitoring and evaluation reports
- Financing and budget-related documents where available
- Secondary evidence relating to programme implementation and outcomes

Data were treated as evidence of institutional commitments, responsibilities and accountability arrangements. Attention was paid to whether commitments were accompanied by identifiable responsible institutions, financing arrangements, monitoring systems and avenues for participation, and sources were triangulated to separate formal commitment from evidence of implementation.

Documents were identified through institutional repositories, including WHO's Institutional Repository for Information Sharing (IRIS) and regional and country office sites, and through academic databases. National sources were searched directly through ministries of health, national disease programmes and relevant sector ministries, since strategic plans, operational guidelines and annual reports are rarely indexed academically.

Inclusion required that documents be publicly available in English, issued by a government ministry, WHO, a UN agency or a peer-reviewed source, and directly relevant to the accountability architecture under review; foundational instruments were retained regardless of date where they remain in force.

Document density varies across cases, with India and Thailand yielding more primary material than Bhutan or the Maldives. This reflects the documentary landscape rather than the search strategy, and its implications are addressed in Section 4.10.

4.5. Analytical Framework: Nesting the HRBA within the MSAF

The analysis used the Human Rights-Based Approach (HRBA) nested within the WHO Multi-sectoral Accountability Framework (MSAF) as its principal analytical architecture. The two are treated as complementary rather than parallel, the HRBA supplying the normative lens through which the study examines:

- Recognition of vulnerable populations as rights-holders

- Non-discrimination and equity
- Participation and inclusion
- Transparency
- Empowerment
- State obligations, and
- Accountability for the progressive realisation of the right to health

The MSAF supplies the governance architecture through which those commitments are traced into institutional processes, running from commitment to action, monitoring and review, and then to corrective action. Accountability was operationalised through the four dimensions, each assessed on answerability and enforceability.

Nesting the two allows the study to examine both what governments are obligated to achieve and how those obligations are organised across institutions: the nested framework connects rights with institutions, commitments with implementation, and participation with accountability.

4.6. Analysing vulnerable populations: an intersectional approach

A central methodological premise of the study is that vulnerability cannot be treated as a fixed or homogeneous category. It may arise through poverty, social exclusion, discrimination, geography, gender, occupation, migration, disability and environmental exposure.

Accordingly, the analysis examined both:

- Which populations are identified as vulnerable within policies and programmes, and
- How those populations are positioned within accountability relationships

The analysis charts whether populations are identified, targeted, served, consulted, represented, empowered, or involved in governance, and therefore whether they are constructed as beneficiaries or recognised as rights-holders with agency.

4.7. Analysing Health-in-All Policies and Intersectoral convergence

Because multisectoral accountability is closely connected to Health-in-All Policies (HiAP), intersectoral convergence was examined separately. An inter-ministerial committee was not treated as sufficient evidence of HiAP; instead, convergence was examined at four levels:

- Policy Convergence: do different sectors recognise shared health objectives?
- Institutional Convergence: are formal structures established to coordinate action across sectors?
- Resource Convergence: are financing and resources aligned across sectors, or do sectors continue to operate through separate budgets and priorities?
- Accountability Convergence: do different sectors share responsibility for health outcomes, monitoring and corrective action?

This distinguishes intersectoral collaboration from intersectoral governance.

4.8. Within-case analysis

Each case was first analysed independently to preserve its institutional and historical context. Each followed a sequence: contextualising the health concern and its vulnerable populations, mapping commitments, identifying institutions and actors, then mapping accountability types and intersectoral convergence and identifying implementation gaps.

4.9. Ethics

As the study relied exclusively on publicly available documentary and secondary sources and did not involve human participants or collection of identifiable personal data, individual-level ethical approval was not required.

4.10. Reflexivity and methodological limitations

A documentary approach inevitably privileges what institutions formally record, and policy documents articulate intended arrangements more clearly than everyday experiences of implementation or exclusion. The analysis therefore distinguishes the institutionalisation of participation from the experience of participation: a community committee, consultation or grievance mechanism does not itself demonstrate meaningful influence.

The study also does not seek to establish causal relationships between accountability arrangements and health outcomes. Its purpose is to identify governance patterns and examine how they support or constrain the progressive realisation of the right to health.

Purposive selection also means the findings are analytically transferable rather than statistically rep-

representative.

A related limitation is asymmetry in country coverage. India appears across five of the six domains while Sri Lanka, Bhutan and the Maldives each anchor one, reflecting India's institutional complexity and better-documented federal arrangements. Cross-country patterns should therefore be read with awareness that India-specific dynamics may carry disproportionate weight; where a pattern also holds across the smaller, more centralised systems, it is treated as a more robust cross-case finding.

Section V: Comparative Evidence

This section examines how the HRBA-MSAF framework operates across the selected health domains and countries. The evidence is organised around analytical propositions derived from the framework rather than presented case by case, making it possible to distinguish the presence of accountability mechanisms from their institutional strength, consequentiality, and responsiveness to rights-holders.

The analysis distinguishes the four dimensions while recognising that they overlap in practice, examining which accountability relationships are institutionalised and where the links between commitment, responsibility, answerability and enforceability break down. It also draws on a cross-cutting typology distinguishing vertical, horizontal and diagonal accountability,²¹ since any single mechanism can be classified as predominantly one of the three.

5.1. Political accountability: From political commitment to institutionalised responsibility

Political accountability is robust when political commitments are translated into durable institutional mandates, identifiable responsibilities, oversight mechanisms, and continuing review, rather than remaining as executive declarations or programme-level priorities.

The framework therefore treats political commitment as the starting point rather than the endpoint of political accountability. The cases suggest several forms: *developmental political accountability*, in which sustained commitment becomes embedded in long-term public institutions; *mission-oriented governance*, in which authority is concentrated around a defined national objective; *multisectoral action approach of political accountability* which witnesses coordination among different ministries beyond health and *rights-based political accountability*, in which legislation creates

²¹ Lührmann, Marquardt, and Mechkova, “Constraining Governments”.

formal obligations and avenues for claiming entitlements. Political accountability also manifests through *international commitments* that countries are signatory to and hence commit to fulfilling their mandates.

5.1.1. *Developmental Political Accountability: Maternal and Child Health in Sri Lanka and Bangladesh*

Sri Lanka's trajectory in maternal and child health illustrates developmental political accountability. A maternal mortality ratio of 36 per 100,000 live births reflects a commitment architecturally embedded in health governance from the 1920s onwards:²² successive governments institutionalised universal free public healthcare and child health surveillance in policy, legislation and budget, irrespective of electoral change. This is a horizontal pathway, in which the health bureaucracy sustains commitments largely independent of the electoral cycle that produced them.

While Bangladesh has also achieved remarkable success, the pathway has been markedly different. The Chowgacha model (2005–2014) brought local politicians together with women, health personnel and policy makers at the *upazila* (sub-district) level to discuss obstetric care implementation, a vertical and personal relationship in which politicians were answerable to constituents in a structured forum. Political interest was institutionalised through monthly departmental reviews, annual reviews with development partners, and quarterly national reviews chaired by the Prime Minister, a horizontal layer alongside the vertical Chowgacha relationship.

The two cases therefore demonstrate that sustained political accountability does not require a single institutional model. Sri Lanka relies on continuity through the public health bureaucracy, Bangladesh on political oversight combined with non-governmental organisation (NGO) and community mobilisation:²³ Sri Lanka's model is predominantly horizontal while Bangladesh's combines a vertical core (Chowgacha) with a horizontal review layer and a diagonal NGO–community channel operating alongside both.

²² Center for Global Development, "Case 6: Saving Mothers' Lives in Sri Lanka", in *Millions Saved: Proven Successes in Global Health* (Washington, DC: Center for Global Development, n.d.), https://www.cgdev.org/sites/default/files/archive/doc/millions/MS_case_6.pdf.

²³ S. El Arifeen et al., "Community-Based Approaches and Partnerships: Innovations in Health-Service Delivery in Bangladesh", *The Lancet* 382, no. 9909 (2013): 2012–26, [https://doi.org/10.1016/S0140-6736\(13\)62149-2](https://doi.org/10.1016/S0140-6736(13)62149-2); J. Shiffman and S. Sultana, "Generating Political Priority for Neonatal Mortality Reduction in Bangladesh", *American Journal of Public Health* 103, no. 4 (2013): 623–31, <https://doi.org/10.2105/AJPH.2012.300919>.

5.1.2. *Mission-oriented Political Accountability: Tuberculosis in India*

India's TB elimination architecture represents a different model. The National TB Elimination Board provides high-level political authorisation for multisectoral action, convening political leadership, government departments, affected communities and NGOs, a horizontal body whose inclusion of communities gives it a diagonal dimension. India has not met its 2025 elimination commitment, but treatment coverage rose to 92% of estimated cases in 2024 from 53% in 2015.²⁴ The case distinguishes political accountability for a commitment from achievement of the commitment itself.

5.1.3. *Multisectoral Action Approach of Political Accountability: NCDs in India*

The NCD architecture demonstrates a related model. India's National Multisectoral Action Plan is operationalised through a whole-of-government approach assigning responsibilities to ministries beyond health, including education, finance and environment. Coordination runs through the Committee of Secretaries, an Inter-Ministerial Committee, and National Steering Committees responsible for monitoring, a horizontal architecture in the strict sense: everyone listed sits in the executive, with no vertical or diagonal channel built into its design.

5.1.4. *Rights-based political accountability: Mental Health in India and Bhutan*

Mental health provides a contrasting comparison between statutory and executive forms of political accountability.

In India, the Mental Healthcare Act 2017 creates institutional obligations concerning accessibility, non-discrimination and rights protection, a predominantly vertical mechanism creating a legally claimable entitlement. Bhutan by contrast relies on executive leadership: its National Suicide Prevention Programme involves health, education, local government, police and religious institutions, with the PEMA Secretariat, the name of Bhutan's national nodal agency for mental health and child protection service as focal point,²⁵ a horizontal model coordinating across ministries rather than creating a claimable entitlement.

The difference is consequential: India's statutory approach creates robust formal possibilities for

²⁴ Central TB Division, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India, *National TB Elimination Programme: India TB Report 2024* (New Delhi: Government of India, 2024), https://tbcindia.mohfw.gov.in/wp-content/uploads/2024/10/TB-Report_for-Web_08_10-2024-1.pdf.

²⁵ R. Pelzang, "Mental Health Care in Bhutan: Policy and Issues", *WHO South-East Asia Journal of Public Health* 1, no. 3 (2012): 339–46, <https://doi.org/10.4103/2224-3151.207030>.

legal enforceability, though uneven implementation and limited public expenditure weaken it in practice, while Bhutan's permits flexible coordination but depends on continued political and administrative commitment. Vertical mechanisms carry stronger formal enforceability but depend on citizens' capacity to invoke them; horizontal mechanisms are more flexible but depend entirely on continued executive will.

5.1.5. Internationally scaffolded political accountability: Climate Change in the Maldives

Political accountability takes a different form when scaffolded by international commitments alongside constitutional mandate, as in the Maldives' response to climate change, sustained through the Strategic Action Plan and sector-specific policies on renewable energy, water security and environmental conservation as per the country's climate change policy framework.²⁶ Constitutional recognition of environmental protection embeds climate action within the State's legal obligations, showing that accountability can extend beyond the domestic political system when nested within intergovernmental governance.

Political accountability is prominent where commitments are translated into institutional mandates rather than declarations alone, and becomes robust as health issues move from sector-specific concerns to national development priorities requiring multisectoral action. It is also overwhelmingly built through horizontal machinery across the region, with vertical accountability appearing only where legislation has deliberately created it. Bangladesh's Chowgacha model and India's Mental Healthcare Act are the two clear examples, unusually consequential precisely because they afford citizens a direct or legally claimable channel to state actors.

However, it cannot by itself secure rights-responsive outcomes unless accompanied by corresponding bureaucratic, fiscal, and social accountability mechanisms.

5.2. Bureaucratic Accountability: From Institutional Responsibility to Implementation

Bureaucratic accountability determines whether political commitments are translated into effective implementation through institutional coordination, clearly defined responsibilities, monitoring systems, review mechanisms, and corrective action across levels of governance. Multisectoral arrangements are visible across countries but differ in decentralisation, coordination and adminis-

²⁶ Ministry of Environment and Energy, Maldives, *Maldives Climate Change Policy Framework* (Malé: Ministry of Environment and Energy, 2015), <http://www.environment.gov.mv/v2/wp-content/files/publications/20150810-pub-maldives-cc-policy-framework-final-10aug2015.pdf>.

trative capacity.

A recurring problem is that administrative systems generate stronger upward answerability to bureaucratic hierarchies than downward accountability to rights-holders. Bureaucratic accountability is the dimension most aligned with horizontal accountability, and the central question is where, if anywhere, a diagonal channel to affected communities has also been built in.

5.2.1. Institutionalised administrative architecture: TB in India and Climate Change in the Maldives and Timor-Leste

India's TB programme provides a robust example of multilayered bureaucratic architecture. The National TB Elimination Programme (NTEP) operates through the Central TB Division, TB Cells, Technical Support Units, District TB Forums, surveillance systems and reporting arrangements, extending horizontally to nutrition, social welfare, labour, prisons, tribal affairs and urban development.²⁷ Most of this is horizontal, administrative bodies reporting to administrative bodies, with one notable exception: District TB Forums formally include affected persons and civil society alongside officials, creating a diagonal channel embedded within an otherwise horizontal architecture.

The Maldives' climate governance arrangements similarly distribute responsibilities across specialised departments dealing with climate adaptation, environmental protection, water and sanitation, renewable energy, and waste management. Institutional answerability is strengthened by linking implementation to periodic national reporting on adaptation targets and environmental indicators, while Timor-Leste adopts a comparatively centralised model incorporating climate-risk assessment into ministry planning.²⁸ The cases show different institutional responses to multi-sectoral complexity, but all are predominantly horizontal, coordinating between ministries rather than between the state and affected communities.

²⁷ Central TB Division, Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India, *National Strategic Plan for Tuberculosis Elimination 2017–2025* (New Delhi: Government of India, 2017), <https://tbcindia.gov.in/WriteReadData/NSP%20Draft%202020.02.2017%201.pdf>.

²⁸ Secretariat of State for Environment, Coordinating Minister for Economic Affairs, Democratic Republic of Timor-Leste, *Timor-Leste's National Adaptation Plan: Addressing Climate Risks and Building Climate Resilience* (Dili: Government of Timor-Leste, 2020), <https://www4.unfccc.int/sites/NAPC/Documents/Parties/Timor%20Leste%20NAP.pdf>.

5.2.2. *Administrative decentralisation: NCDs in India, MCH in Sri Lanka, Mental Health in India and Bhutan*

India's NCD governance and Sri Lanka's MCH architecture demonstrate the value of decentralisation in distributing implementation responsibility across national, state, district, and community levels. India's statutory mental health model establishes Central and State Mental Health Authorities and Mental Health Review Boards responsible for regulating establishments, protecting patients' rights and monitoring compliance.²⁹ As with the TB programme, these bodies are predominantly horizontal, with the Act's mandated inclusion of persons with lived experience introducing a diagonal element.

Bhutan relies more strongly on administrative coordination through the Department of Public Health, the National Suicide Prevention Steering Committee, and district-level response teams. It also relies on the Government Performance Management System, under which participating agencies submit quarterly, biannual and annual progress reports. Implementation is decentralised to District Suicide Prevention Response Teams, embedding mental health within routine public administration.³⁰ This combines horizontal coordination across sectors with vertical coordination between national and local government.

5.2.3. *Monitoring and Digital Governance: TB in India, MCH in Sri Lanka, HIV/AIDS in Thailand*

Monitoring is a particularly important mechanism through which bureaucratic accountability becomes visible. India's e-Nikshay platform provides real-time information on TB notification, treatment initiation and outcomes, while Central and State Evaluation Departments, Central Review Missions and Joint Monitoring Missions provide multiple levels of review,³¹ a horizontal reporting chain end to end. Its significance lies in its limitation: the system creates extensive information and upward reporting, but this does not automatically translate into accountability to vulnerable populations.

Sri Lanka provides a contrasting model. Community-level data collection feeds into maternal and

²⁹ M. M. Firdosi and Z. Z. Ahmad, "Mental Health Law in India: Origins and Proposed Reforms", *BJPsych International* 13, no. 3 (2016): 65–67, <https://doi.org/10.1192/s2056474000001264>.

³⁰ Ministry of Health, Bhutan, *Annual Health Bulletin 2021* (Thimphu: Royal Government of Bhutan, 2021), https://www.moh.gov.bt/wp-content/uploads/ict-files/2021/06/24.06.2021_Bulletin-Book-2021.pdf.

³¹ Ministry of Health and Family Welfare, Government of India, *India TB Report 2022: Coming Together to End TB Altogether* (New Delhi: Government of India, 2022), <https://tbcindia.gov.in/WriteReadData/IndiaTBReport2022/TBAnnualReport2022.pdf>.

perinatal reviews, and community health units and mother-support groups participate in identifying preventable deaths and developing remedial action,³² introducing a diagonal channel directly into the monitoring architecture rather than layering it on afterwards. The data system creates a lateral connection between evidence, community structures and programme revision.

Thailand provides another model in which surveillance has been linked to adaptive programme development. Nationwide HIV surveillance and subsequent decentralisation allowed epidemiological information to inform the 100% Condom Use Programme, prevention of mother-to-child transmission (PMTCT) and Key Population-Led Health Services (KPHS) for men who have sex with men, transgender persons and sex workers.³³ KPHS provide a strong diagonal mechanism, consulting on monitoring and accounting for the services themselves.

The key distinction is whether information is merely collected, is reported, is reviewed, triggers corrective action, and is accessible to or generated by rights-holders. India's TB system is highly developed in the first four respects but remains weaker in the fifth. Sri Lanka provides a clear example of connecting administrative information with community-level review.

The comparative evidence suggests that data-intensive bureaucratic accountability does not necessarily produce rights-responsive accountability. Under the HRBA-MSAF, a strong monitoring system is one in which information travels upward for oversight, laterally across sectors, and downward to communities, and then feeds back into decision-making. The essential distinction is between monitoring as surveillance and monitoring as accountability, the latter requiring evidence to generate review, explanation, correction and, where necessary, remedy.

Furthermore, similar to political accountability, bureaucratic accountability is overwhelmingly horizontal by its very structure – administrative bodies reporting to other administrative bodies. The diagonal exceptions are therefore analytically important out of proportion to their frequency: India's District TB Forums and Mental Health Review Boards, community-linked maternal death reviews in Sri Lanka, and Thailand's KPHS bring affected communities into monitoring rather than working through officials alone. Horizontal and diagonal accountability are complementary rather than competing design choices.

³² Center for Global Development, "Case 6: Saving Mothers' Lives in Sri Lanka".

³³ B. Ross-Larson et al., "Thailand: Addressing HIV/AIDS – Proven Solutions and New Problems", in *Reducing Poverty, Sustaining Growth – What Works, What Doesn't, and Why: A Global Exchange for Scaling Up Success* (Washington, DC: World Bank, 2004), <http://web.worldbank.org/archive/website00819C/WEB/PDF/THAILAND.PDF>; T. Siraprasiri et al., "The Impact of Thailand's Public Health Response to the HIV Epidemic 1984–2015: Understanding the Ingredients of Success", *Journal of Virus Eradication* 2, no. 4 (2016): 7–14, [https://doi.org/10.1016/S2055-6640\(20\)31093-1](https://doi.org/10.1016/S2055-6640(20)31093-1).

5.3. *Fiscal Accountability: From Political Priority to Resourced Responsibility*

Fiscal accountability determines whether political commitments are supported, and bureaucratic efficacy realised, by adequate and sustained financial resources. Within the HRBA, adequate financing is a core State obligation, while the MSAF holds that financing for prevention and promotion must extend beyond the health sector. Fiscal accountability therefore concerns more than whether a budget exists: it involves prioritisation, mobilisation, allocation, utilisation, oversight, learning and reallocation.

While budget allocation is institutionalised through well-structured mechanisms across the selected countries, the extent to which resources reach the most vulnerable remains underdeveloped, and cross-sectoral financing arrangements lag behind political commitments and bureaucratic structures.

5.3.1. *Statutory Commitment without adequate financing: Mental Health in India and Bhutan*

India's mental healthcare system illustrates the gap between legal commitment and financial capacity: institutional obligations and audit mechanisms exist, but insufficient allocation weakens the translation of legal commitment into realised rights.³⁴ Bhutan distributes financial responsibility across sectors, a stronger basis for multisectoral fiscal accountability, though limited capacity and the absence of dedicated oversight constrain enforceability. Both mechanisms are horizontal, and the vertical accountability created by India's Act has no fiscal counterpart.

5.3.2. *Programme-based financing: TB in India, NCD management in India and Timor-Leste*

India's TB programme illustrates strong fiscal institutionalisation, supported through Mission allocations, state contributions and partner support. Nikshay Poshan Yojana extends financing beyond clinical care by recognising nutrition as a determinant of outcomes, while Nikshay Mitra, a clear diagonal fiscal mechanism identified, channels civil society and corporate resources directly into the accountability architecture. The evidence nonetheless identifies persistent funding gaps, delayed utilisation, and insufficient coordination across sectors responsible for nutrition and social protection.

India's National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Dis-

³⁴ S. Gupta and R. Sagar, "National Mental Health Policy, India (2014): Where Have We Reached?" *Indian Journal of Psychological Medicine* (2021), <https://doi.org/10.1177/02537176211048335>.

eases and Stroke (NPCDCS)³⁵ is financed through the National Health Mission, with resources flowing across national, state and district levels. Financial reporting and utilisation certificates establish answerability, but evidence of pooled or genuinely coordinated expenditure across ministries remains limited, so the rhetoric of multisectorality is stronger than the fiscal architecture supporting it.³⁶ Timor-Leste demonstrates more integrated planning and resource mobilisation through its multisectoral action plans but operates under greater fiscal constraints and greater dependence on external technical and financial assistance.

5.3.3. Domestic and external financing: HIV/AIDS in Thailand and Nepal, Climate Change in the Maldives and Timor-Leste

Thailand represents a strong example of sustained domestic financing for HIV/AIDS. Dedicated budgetary allocations, decentralised financial management, inter-ministerial financing and the Universal Health Coverage Scheme transformed HIV financing from project expenditure into a sustained component of public financing.³⁷ Nepal by contrast relies substantially on development partners, which expands service capacity but raises questions of sustainability and domestic ownership.³⁸ The Maldives similarly combines domestic expenditure with international climate finance, while Timor-Leste combines domestic budgets with development-partner support.³⁹ These cases demonstrate the tension between resource mobilisation and fiscal autonomy.

5.3.4. Fiscal accountability and intersectional exclusion: MCH in Bangladesh

The conditional cash transfer example in MCH in Bangladesh demonstrates a different fiscal problem: policy design can itself produce exclusion. Eligibility restrictions disadvantage women, whose

³⁵ Ministry of Health and Family Welfare, Government of India, *Operational Guidelines: National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)* (New Delhi: Government of India, 2013).

³⁶ A. Kastor and S. K. Mohanty, "Disease-Specific Out-of-Pocket and Catastrophic Health Expenditure on Hospitalization in India: Do Indian Households Face Distress Health Financing?" *PLOS ONE* 13, no. 5 (2018): e0196106, <https://doi.org/10.1371/journal.pone.0196106>.

³⁷ M. Ainsworth, C. Beyrer, and A. Soucat, "AIDS and Public Policy: The Lessons and Challenges of 'Success' in Thailand", *Health Policy* 64, no. 1 (2003): 13–37, [https://doi.org/10.1016/S0168-8510\(02\)00079-9](https://doi.org/10.1016/S0168-8510(02)00079-9).

³⁸ S. P. Wasti et al., "Issues and Challenges of HIV/AIDS Prevention and Treatment Programme in Nepal", *Global Journal of Health Science* 1, no. 2 (2009): 62–72.

³⁹ World Bank Group, *Climate Risk Country Profile: Maldives* (Washington, DC: World Bank Group, 2021), https://climateknowledgeportal.worldbank.org/sites/default/files/2021-08/15649-WB_Maldives%20Country%20Profile-WEB.pdf; NAP Global Network, *How Timor-Leste Is Using the National Adaptation Plan Process to Scale Up Ecosystem-Based Adaptation* (Winnipeg: International Institute for Sustainable Development, 2021), <https://napglobalnetwork.org/wp-content/uploads/2021/11/napgn-en-2021-timor-leste-using-nap-scale-up-eba.pdf>; Asian Development Bank, *Climate Risk Country Profile: Timor-Leste* (Manila: Asian Development Bank, 2021), <https://www.adb.org/sites/default/files/publication/751241/climate-risk-country-profile-timor-leste.pdf>.

circumstances are shaped by gendered decision-making, age, marriage and family structure.⁴⁰ This is a vertical mechanism, a direct state-to-citizen transfer, whose exclusionary design means the intended relationship never reaches the women it is meant to serve: the issue is not simply whether resources are allocated but who can access them under the eligibility architecture.

From the cases, three broad fiscal models emerge. The first is tax-funded universal public financing, exemplified by Sri Lanka's investment in maternal and child health and Thailand's Universal Health Coverage financing of HIV services. The second is programme-based financing, as in India's TB, NCD and mental health programmes, where dedicated budgets, expenditure reporting and audits strengthen answerability but not adequacy. The third is hybrid financing combining domestic budgets with external donor support, as in Nepal's HIV response and climate adaptation financing in the Maldives and Timor-Leste.

Across all three models a recurring distinction emerges between financial answerability, through budgets, audits and expenditure reports, and financial enforceability, meaning consequences for inadequate, misallocated or inequitable expenditure. Fiscal accountability is where the multisectoral character of health governance is hardest to institutionalise: responsibility may be distributed across sectors while budgets remain sectoral. Its mechanisms are overwhelmingly horizontal, with Nikshay Mitra the single clear diagonal exception, making this the dimension with the fewest direct channels back to the communities those commitments are meant to serve.

Fiscal accountability must therefore be understood not as a one-time budgetary exercise but as a recurring governance process: the question is not merely whether resources are spent correctly, but whether fiscal arrangements enable the most vulnerable to access the rights and services to which commitments relate.

5.4. Social Accountability: From Participation to Consequential Voice

Social accountability becomes consequential when affected populations and civil society are not merely consulted but institutionally connected to monitoring, decision-making and corrective action. Participation runs along a spectrum from information provision through consultation to shared governance, and the critical question is whether community voice creates an institutional obligation to respond. Every mechanism discussed below is diagonal; the comparative question is

⁴⁰ S. Rajia et al., "Trends and Future of Maternal and Child Health in Bangladesh", *PLOS ONE* 14, no. 3 (2019): e0211875, <https://doi.org/10.1371/journal.pone.0211875>.

whether that channel carries enforceable weight or remains advisory.

Bangladesh provides the strongest example in the cases of social accountability being linked to institutional response. Their significance lies not in participation but in the feedback loop between community evidence and administrative response, with scorecards in multiple upazilas feeding into district-level planning.⁴¹ These are textbook diagonal mechanisms, and the strongest-performing ones precisely because the evidence they generate feeds into planning rather than terminating in a report.

5.4.1. Community-led accountability: HIV/AIDS management in Nepal and Thailand

Nepal's HIV/AIDS interventions used community scorecards and client feedback to generate district-specific action plans. Thailand provides a stronger model still. Government funding supported civil society organisations, while Key Population-Led Health Services enabled members of affected populations to provide testing, prevention, referral and treatment support.⁴² This is among the strongest diagonal mechanisms identified, since affected populations do not merely feed information into a state channel but deliver and co-govern the service itself.

5.4.2. Participation without strong enforceability: TB management and Mental Health in India

India's TB programme has developed multiple mechanisms for community engagement, including TB Champions, TB Forums, survivor networks, grievance mechanisms and Nikshay Mitra,⁴³ an extensive diagonal architecture on paper. Formal mechanisms through which communities can independently monitor, audit and compel institutional response nevertheless remain comparatively weak; in other words, the diagonal channel exists but its enforceability lags well behind its answerability.

The Mental Healthcare Act 2017 creates provisions for representing persons with mental illness, caregivers and civil society within governance structures. This strengthens formal representation and therefore answerability – yet another diagonal channel, formally strong. Yet the evidence suggests that representation remains largely consultative and does not consistently translate into influence over planning, budgeting, monitoring or evaluation.

⁴¹ A. Begum and S. A. Hamid, "Maternal Healthcare Utilisation in Rural Bangladesh: A Comparative Analysis between High and Low Disaster-Prone Areas", *PLOS Global Public Health* 3, no. 7 (2023): e0001409, <https://doi.org/10.1371/journal.pgph.0001409>.

⁴² Siraprasiri et al., "Impact of Thailand's Public Health Response".

⁴³ Ministry of Health and Family Welfare, *India TB Report 2022*.

5.4.3. Community participation and constrained enforceability: Mental Health in Bhutan, Climate Change in the Maldives and Timor-Leste

Bhutan's suicide-prevention architecture incorporates village health workers, local governments, volunteers, monastic institutions, academia, and community response teams. The Maldives uses community consultations, local councils, youth groups and civil society in climate-resilience activities. Timor-Leste goes further by incorporating customary institutions such as *Tara Bandu* into climate adaptation planning,⁴⁴ showing how institutionally varied diagonal accountability can be. These approaches enhance legitimacy and local ownership, but the evidence indicates limited institutional provision for mandatory social audits or binding mechanisms through which citizen-generated evidence systematically affects budgets, reviews, or decisions.

5.4.4. Institution-supported participatory model: NCDs in India and Timor-Leste

India adopts an institution-supported participatory model for NCDs in which community engagement complements government-led implementation, with civil society and academic partners in the National Multisectoral Action Plan and Accredited Social Health Activists (ASHAs) facilitating screening and referral.⁴⁵ It remains programme-oriented rather than accountability-driven, with limited evidence of social audits or structured mechanisms through which feedback informs planning or budgeting. Timor-Leste's more partnership-oriented model relies on civil society to compensate for limited institutional capacity. In both, participation enhances answerability rather than enforceability.

The strongest cases are those in which community-generated information has a defined institutional pathway into decision-making. The crucial distinction is not participation versus no participation, but participation with institutional response versus participation without it. Social accountability is where diagonal mechanisms are most abundant and where the gap between their formal existence and their enforceable weight is widest: Thailand's Key Population-Led Health Services and Bangladesh's scorecards are consequential precisely because they are built into service delivery and planning rather than layered on as consultative add-ons.

Civil society organisations occupy a particularly important position because they frequently reach

⁴⁴ Asian Development Bank (ADB), *Civil Society Brief: Timor-Leste* (Manila: Asian Development Bank, n.d.), <https://www.adb.org/sites/default/files/publication/498631/civil-society-brief-timor-leste.pdf>.

⁴⁵ A. Krishnan et al., "How to Effectively Monitor and Evaluate NCD Programmes in India", *Indian Journal of Community Medicine* 36, suppl. 1 (2011): S57–62, <https://doi.org/10.4103/0970-0218.94710>.

populations that public institutions cannot. Their role within formal accountability arrangements nevertheless remains predominantly advisory rather than decision-making.

5.5. Centring Vulnerable Groups: From Data Points to Agents of Change

Across the case studies most programmes define vulnerability administratively rather than through accountability, classifying citizens by disease, demographic group, exposure, geography or behavioural risk. A recurring pattern across all eight countries and six domains is therefore the position of vulnerable groups within the accountability architecture: across the cases they appear as information points and data providers, achieving administrative visibility without agency. Where they have been recognised as agents of change, results have been transformative, as with sex workers treated as partners in HIV/AIDS programmes in Thailand and India, and women formally recognised as health workers in Bangladesh. India's HIV/AIDS programme offers a particularly clear example: the National AIDS Control Organisation inducted people living with HIV/AIDS into national leadership roles, the single strongest diagonal mechanism identified, since representatives sit on bodies that shape and review programme priorities. The documented effect was improved responsiveness, because the system surfaced implementation gaps that would not otherwise have emerged. The dominant model nonetheless remains governance for vulnerable populations rather than governance by them.

These examples share a structural feature: they do not merely include vulnerable groups in programme activities but assign them formal roles within accountability systems. The principal gap across the case studies is therefore not recognition of vulnerable groups but the institutionalisation of agency. Realising the HRBA requires accountability systems that move beyond consultation towards shared governance, in which vulnerable groups exercise meaningful influence over priority setting, budget allocation, monitoring and evaluation. Where this is applied, even partially, accountability becomes more substantive and the cases provide strong evidence of responsiveness to implementation gaps.

5.6. Health-in-All-Policies: Intersectoral Convergence

The HiAP principle is formally endorsed across all eight countries, manifesting in inter-ministerial committees, national NCD action plans, climate change adaptation frameworks, and related governance instruments. The comparative evidence reveals, however, that HiAP as a governance practice

is substantially more demanding than HiAP as a policy aspiration. Intersectoral convergence is evident but unevenly institutionalised: HiAP remains coordination-oriented rather than governance-oriented, with horizontal collaboration more in evidence than integrated planning, budgeting, accountability and shared decision-making.

Thailand provides clear evidence of HiAP working as designed. The Bangkok and provincial Ending AIDS Sub-Committees linked health, education, social protection and law enforcement in a structure with allocated budgets, defined deliverables and review processes, while the 100% Condom Programme required the Ministry of Interior, police, brothel owners, NGOs and health workers to operate within an accountability system monitored against shared targets.⁴⁶ It combines a horizontal sub-committee structure with a diagonal channel through NGOs and affected populations.

MCH too provides a robust example of intersectoral convergence. Across India, Bangladesh and Sri Lanka, improvements were achieved not only through clinical services but through coordinated investment in nutrition, sanitation, female education, family planning, immunisation and poverty reduction, with female literacy and community-based women's empowerment showing the strongest linkages. Convergence nonetheless remained largely health-sector-led, operationalised rather than institutionalised.

Moving across the spectrum, mental health policies in India and Bhutan explicitly recognise that mental health is shaped by education, employment, housing, social protection, justice and community support, reflecting the HiAP framework. Compared with HIV/AIDS, however, convergence remains weak, lacking integrated planning, pooled financing or joint accountability, again representing policy recognition with limited institutionalisation. NCD governance in India and Timor-Leste similarly assigns responsibilities across ministries for education, agriculture, finance, urban development and transport, yet implementation remains uneven despite being articulated as a governance strategy.

HiAP in the climate change domain in the Maldives and Timor-Leste comes across as the most expansive application of its framework because health becomes embedded within environmental governance rather than environmental concerns being incorporated into health policy. HiAP here extends beyond government coordination to encompass climate finance, ecosystem management, community resilience and international governance.

⁴⁶ Ross-Larson et al., "Thailand: Addressing HIV/AIDS".

HiAP works when every sector in the plan is subject to the same quality of accountability as the health sector. HiAP thus far suffers from weak governance despite intersectoral implementation being the strongest element across domains, and accountability is asymmetric, with the onus of monitoring, budgeting and evaluation continuing to rest on health-sector institutions. The intersectoral framework therefore tends to include sectors that are, in practice, non-accountable.

Section VI: Cross-Cutting Findings

The comparative analysis across eight countries and six domains generates a set of findings that are not artefacts of individual country contexts but structural patterns in how multisectoral accountability for health operates in the SEAR. The following section engages with some emerging patterns:

6.1. Political Commitment Is Necessary but Not Sufficient Without Institutionalisation

Across the cases examined, political commitments to vulnerable groups varied. The variation lies not in the presence of commitment but in whether it has been architecturally embedded in governance structures that sustain accountability beyond the electoral cycle and the tenure of those who made it. India's mental health commitments are articulated through legislative rights, Bhutan's through executive leadership; in the Maldives, political transitions periodically slow implementation of ambitious climate commitments, illustrating that leadership alone does not guarantee sustained execution.

Sri Lanka's durable MCH achievements are the product of seven decades of institutionalised commitment that has withstood regime change, whereas Bangladesh's Chowgacha model produced demonstrable results but was not institutionalised in a way that survived shifts in funding.⁴⁷ Political accountability is therefore insufficient on its own: it must be converted into legal and administrative instruments with substantive enforcement mechanisms that give it permanence.

6.2. Ad Hoc Accountability Fails Vulnerable Groups: Only Institutionalised Mechanisms Produce Sustained Outcomes

Community feedback sessions, participatory reviews and civil society consultations occurring as periodic events generate authentic information and political legitimacy, but without institution-

⁴⁷ El Arifeen et al., "Community-Based Approaches and Partnerships".

alisation they remain ad hoc and do not produce sustained change in health outcomes. Institutionalisation requires encoding participation requirements in legislation, mandating community audit as a programme requirement, and legally including vulnerable group representatives in governance bodies, as India's institutionalisation of the representation of people living with HIV/AIDS (PLHA) in NACO demonstrates.⁴⁸

6.3. Civil Society Is Close to Vulnerable Groups but Excluded from Formal Accountability Systems

Civil society organisations occupy a structurally ambivalent position, their influence contingent on political approval. Despite their proximity to vulnerable groups their formal standing as seen across cases is mostly advisory: they can implement, identify failures and inform, but cannot enforce remedial action. Bangladesh's scorecards and Nepal's district-level HIV feedback systems show that where their findings trigger defined administrative responses, they become effective accountability agents.

6.4. Strong Monitoring and Data Systems Correlate with Better Programme Performance

India's TB programme, Sri Lanka's MCH system and Thailand's HIV/AIDS response all combine sophisticated data infrastructure with relatively better outcomes compared with domains where monitoring is weaker. The cases with more developed monitoring infrastructures also tend to demonstrate strong programme-level evidence of implementation and review. This does not establish a causal relationship between monitoring capacity and health outcomes but suggests that robust information systems are an important enabling condition for evidence-based accountability. Investment in monitoring infrastructure, including disaggregated reporting by vulnerability category, is therefore integral to accountability rather than a technical supplement to it.

6.5. Feedback Loops from Vulnerable Groups to Policy Revision Are the Most Consistently Missing Element

A recurring pattern across all eight countries is the absence of institutionalised feedback mechanisms through which the assessment of vulnerable groups flows back into programme design. Monitoring systems collect data and reviews assess indicators, but the mechanism through which those

⁴⁸ National AIDS Control Organisation (NACO), "Civil Society", Ministry of Health and Family Welfare, Government of India, n.d., <https://naco.gov.in/civil-society-o>.

most exposed to service failures inform the revision of those services as seen in the cases is underdeveloped. Closing the loop requires re-designing accountability systems so that the experience of rights-holders constitutes evidence structurally equivalent to bureaucratic monitoring data.

6.6. Fiscal Accountability is the most difficult dimension to Institutionalise across sectors

Across all six domains, political and bureaucratic structures are consistently more developed than the fiscal architecture required to sustain multisectoral commitments. Budget allocation is institutionalised in every case examined, but the extent to which resources reach the most vulnerable remains underdeveloped, and even where financial answerability is comparatively strong, evidence of pooled or coordinated cross-sectoral expenditure remains limited.⁴⁹

Responsibility can be distributed across sectors and implementation monitored while budgets remain predominantly sectoral, and multisectoral accountability remains incomplete where responsibility is distributed without corresponding fiscal responsibility. Fiscal accountability, in other words, is not a one-time budgetary exercise but needs to be treated as a recurring governance process linking commitment, implementation, review, and continuous improvement, the very dimension on which the framework's other three pillars depend.

6.7. Health-in-All-Policies Remains Coordination-oriented rather than Governance-oriented

Across the cases examined, HiAP type commitments and arrangements were evident through inter-ministerial committees, NCD action plans and climate adaptation frameworks, but intersectoral collaboration is consistently more developed than integrated planning, pooled financing or shared accountability. Thailand's HIV/AIDS response comes closest to functional intersectoral governance, with budgets, deliverables and review processes that bind sectors together rather than merely coordinating them.⁵⁰

The recurring pattern is asymmetric accountability, in which the onus of monitoring, budgeting and evaluation rests with health-sector institutions even where a plan formally distributes responsibility elsewhere. Sectors outside health are frequently included in name but remain non-accountable in practice. HiAP functions as designed only where every sector is held to the same standard as the health sector, a condition met most clearly in the climate change cases.

⁴⁹ Kastor and Mohanty, "Disease-Specific Out-of-Pocket and Catastrophic Health Expenditure".

⁵⁰ Ross-Larson et al., "Thailand: Addressing HIV/AIDS".

Section VII: Discussion

Towards a governance theory of multisectoral accountability

The case studies demonstrate that accountability in health governance is best understood as a dynamic governance process rather than a set of institutional arrangements. Existing frameworks treat the critical components, political commitment, institutional capacity, financing, participation and human rights, separately: the WHO MSAF is read as an implementation cycle, the HRBA as a normative framework. The HRBA foregrounds participation, non-discrimination, transparency and state obligations but offers no operational guidance for the multisectoral institutions through which health outcomes are actually produced. Neither interpretation is sufficient on its own.

The WHO-MSAF provides a structured implementation cycle, commit, act, monitor, review, but is largely managerial and does not theorise accountability in terms of rights, power, equity or citizen agency. Nesting the **HRBA** within the MSAF bridges this conceptual divide. The HRBA supplies the normative foundation, defining why and how governments are accountable; the MSAF supplies the institutional architecture, explaining how those obligations become commitments, implementation, monitoring, review and learning across sectors. The combined framework links rights with governance, normative obligations with institutional processes, and citizen agency with state capacity.

The integrated framework reveals dimensions of governance that remain less visible under either framework alone. The mental healthcare case shows that legal recognition of rights does not produce effective accountability without complementary bureaucratic and fiscal arrangements; the HIV/AIDS case shows that participation becomes transformative only when institutionalised; the TB case shows that strong bureaucratic systems require corresponding political and social accountability. Accountability is therefore relational and dynamic, emerging through the interaction of the four mechanisms rather than any single institutional reform.

When is the HRBA-MSAF most and least useful?

The framework is particularly valuable for complex challenges characterised by multiple determinants and shared responsibilities, where it helps identify where accountability resides and whether rights-holders are meaningfully included. It is less useful where health problems are narrowly clinical, and has limited explanatory power for organisational behaviour or political economy dynamics

such as elite bargaining, regulatory capture, or commercial determinants of health.⁵¹ While it identifies where mechanisms exist, it cannot explain why some institutions comply and others do not. It is therefore a governance framework rather than a theory of institutional change.

Implications for WHO as a norm-setting organisation

WHO has traditionally been viewed primarily as a norm-setting organisation responsible for technical guidance, global standards and monitoring frameworks, but the case studies suggest its role increasingly extends towards facilitating multisectoral governance. Across all six cases WHO norms, strategies and technical guidance frequently provided an important external reference point for national policy commitments, from the End TB Strategy and the Global Action Plan for NCDs to climate-resilient health system frameworks. Their effectiveness depended less on the existence of international norms than on translation into national political leadership, institutional coordination, sustainable financing and community participation.

This suggests that WHO's comparative advantage lies not only in producing normative guidance but also in supporting countries to institutionalise accountability across sectors. Rather than monitoring disease-specific outcomes alone, WHO could facilitate multisectoral governance assessments, design accountability scorecards incorporating all four dimensions, and build peer learning between countries. It could act as a global steward of governance and accountability, enabling countries to operationalise Health-in-All-Policies through context-sensitive institutional arrangements.

Implications for LMIC Health Governance

The six case studies also challenge a common assumption that sophisticated multisectoral governance is feasible only in high-income settings. Several of the strongest examples of accountability emerged from low- and middle-income countries operating under significant resource constraints.

Thailand's HIV response demonstrated that political leadership, surveillance systems, and community partnerships could compensate for limited initial resources. Bangladesh's maternal health improvements relied on community health workers and civil society rather than expensive tertiary care, Bhutan institutionalised mental health through multisectoral coordination despite the absence of comprehensive legislation, and Timor-Leste integrated climate adaptation and NCD governance

⁵¹ I. Kickbusch, L. Allen, and C. Franz, "The Commercial Determinants of Health", *The Lancet Global Health* 4, no. 12 (2016): e895–96, [https://doi.org/10.1016/S2214-109X\(16\)30217-0](https://doi.org/10.1016/S2214-109X(16)30217-0).

despite limited administrative capacity. India's TB programme illustrates how digital platforms and community participation can strengthen accountability within a complex federal system.

These cases suggest that institutional effectiveness depends less on resource availability than on the quality of governance arrangements. For LMICs the principal challenge is therefore not simply expanding health expenditure but strengthening the relationship among political leadership, bureaucratic capacity, financing mechanisms and citizen participation.

The insights from the case studies also reinforce that multisectoral governance should not be interpreted as creating new institutions for every health challenge. Effective governance more often emerged through reconfiguring existing institutions, establishing coordination mechanisms, and embedding health objectives within broader development policy.

Limitations of the HRBA-MSAF

Several limitations should be stated. First, the framework assumes institutional commitments will translate into implementation through coordinated governance, which the cases show to be only partially valid: political commitments frequently exceeded bureaucratic capacity, while strong institutional arrangements were undermined by inadequate financing. Second, it pays limited attention to power, and does not explain how commercial interests, donor influence or elite bargaining shape outcomes.

Third, it conceptualises accountability largely as a relationship between government and citizens, whereas the cases show networks comprising governments, donors, civil society and private actors; future adaptations should incorporate networked and polycentric governance. Fourth, participation often remains consultative, with vulnerable populations recognised as participants but rarely as co-governors, so the framework would benefit from distinguishing participation, shared decision-making and institutionalised citizen oversight as progressively clear forms of accountability.

HRBA-MSAF beyond the WHO South-East Asia Region

Although developed using South-East Asian cases, the framework has broader applicability because the underlying challenges are not region-specific. Adaptation should nonetheless recognise regional differences: the Eastern Mediterranean Region would require attention to conflict, displacement and fragile institutions, while Latin America could build on constitutional rights to

health and judicial enforcement.⁵²

Across the regions or countries, the underlying principle of the HRBA-MSAF is that it should remain as a flexible analytical architecture rather than a prescriptive institutional model. Its value lies in providing a common language for examining how rights-based commitments become governance arrangements, while allowing mechanisms to vary with constitutional structures, administrative traditions and political contexts.

Section VIII: Conclusion

The paper has demonstrated that health accountability for vulnerable populations is fundamentally a governance and rights challenge rather than solely a question of service delivery. Across the eight countries, the progressive realisation of the right to health depends on the interaction of political, bureaucratic, fiscal and social accountability: commitments establish direction, bureaucratic institutions translate them into implementation, fiscal accountability sustains action, and social accountability anchors governance in the agency of affected communities.

Accountability is cumulative rather than sequential. Strong political commitment does not produce equitable outcomes without administrative capacity and adequate financing, just as well-functioning institutions cannot ensure rights-based governance while communities remain excluded from decision-making. Multisectoral convergence is increasingly evident, but intersectoral collaboration is more developed than genuinely shared governance, and vulnerable populations are more often positioned as beneficiaries or implementation partners than as actors with substantive influence over agenda-setting, resource allocation, monitoring and evaluation.

This underlines the value of nesting the Multisectoral Accountability Framework within the Human Rights-Based Approach: the HRBA establishes who is entitled to health and what obligations governments hold, while the MSAF examines how those obligations are translated into commitments, action, monitoring and review across sectors. Together they frame accountability not as a discrete mechanism but as a governance ecosystem connecting rights, resources and citizen agency.

The evidence from the eight countries also demonstrates that this accountability architecture is context-dependent. There is no single institutional model that can be replicated across health sys-

⁵² A. E. Yamin and S. Gloppen, eds., *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Cambridge, MA: Harvard University Press, 2011); E. Lamprea, *Colombia's Right to Health System: A Right to Health Approach to Health Law* (New York: Palgrave Macmillan, 2017).

tems. Effective accountability emerges instead where rights-based commitments are embedded in national institutions, supported by sustainable financing, translated through capable bureaucracies, and anchored in meaningful community participation.

Centring vulnerable populations therefore requires more than identifying them as priority groups. It requires institutionalising their rights, strengthening the accountability of those responsible, and creating avenues through which communities can influence governance. For WHO and other global health institutions this means supporting countries to build the mechanisms through which normative commitments are realised. The choice is not between horizontal and diagonal accountability, but whether a horizontal architecture has a diagonal channel built in from the outset rather than added as a consultative supplement.

Ultimately, the challenge is to move from governance for vulnerable populations to governance with vulnerable populations. The HRBA-MSAF provides a foundation for making that transition systematic, connecting rights to institutional responsibility, multisectoral commitments to resources, implementation to monitoring, and participation to accountability. The next generation of health accountability must focus not only on whether commitments are made, but on whether institutions are equipped and communities empowered to ensure they are fulfilled: how commitments become institutions, institutions become accountability, and accountability becomes realised rights.

Annex 1: Illustrative application of the Diagnostic Matrices

The diagnostic value of the two matrices lies in their application. Both are applied to India's National TB Elimination Programme, the most extensively documented case in the evidence base, allowing the two instruments to be compared against the same institutional architecture. Table 1 presents the responses to Matrix I traces how the commitment to eliminating TB has been carried through all four accountability dimensions; Table 2 shows the responses to Matrix II as it re-examines those dimensions through the narrower lens of answerability and enforceability.

Table 1: Matrix I applied to India's TB Elimination Programme

Accountability dimension	Diagnostic question (Matrix I)	Applied to India's TB Elimination Programme
Political Accountability	Are the international commitments reflected in the political agenda?	Yes. India's commitment under the WHO End TB Strategy and the 2017 Moscow Declaration was translated into a national goal of eliminating TB by 2025, five years ahead of the global 2030 target. ⁵³
	Are policy instruments in place?	Yes. The National Strategic Plan for Tuberculosis Elimination 2017–2025 sets out the policy architecture and is periodically revised. ⁵⁴
	Are progress and achievements reported?	Yes. Annual India TB Reports publish treatment coverage, incidence, and mortality trends, and these figures are also reported to WHO. ⁵⁵
	Is there political oversight of implementation?	Yes. The National TB Elimination Board provides high-level political authorisation, complemented by state, district, and panchayat-level oversight, and reinforced through public campaigns such as 'TB Harega Desh Jitega'. ⁵⁶
	Are political commitments revisited in light of performance?	Partial. The 2025 elimination target was not met, and this has been publicly acknowledged, but the case material does not clearly document a formal, recurring review-and-recommit cycle tied to missed targets.
Bureaucratic Accountability	Is there a mandate requiring multisectoral action?	Yes. The National Multisectoral Action Framework for TB-Free India formally mandates cross-sectoral responsibility beyond the health ministry. ⁵⁷
	Are responsible sectors and institutions identified?	Yes. The Central TB Division, State TB Cells, District TB Centres, and Treatment Support Units are clearly designated with defined roles. ⁵⁸
	Is there an institutional framework that outlines convergence of multiple sectors?	Yes. The framework extends horizontally to nutrition, social welfare, labour, prisons, tribal affairs, and urban development sectors.
	Are implementation and monitoring and evaluation (M&E) arrangements established?	Yes. The e-Nikshay platform provides a real-time digital reporting system integrated into day-to-day programme implementation.

⁵³ Central TB Division, *National Strategic Plan*.

⁵⁴ Central TB Division, *National Strategic Plan*.

⁵⁵ Ministry of Health and Family Welfare, *India TB Report 2022*; World Health Organization (WHO), *Global Tuberculosis Report 2025* (Geneva: World Health Organization, 2025), <https://www.who.int/publications/i/item/97892401116924>.

⁵⁶ U. B. Singh et al., "Progress and Challenges in Achieving Tuberculosis Elimination in India by 2025: A Systematic Review and Meta-analysis", *IJID Regions* 14, suppl. 2 (2025): 100599, <https://doi.org/10.1016/j.ijregi.2025.100599>.

⁵⁷ Ministry of Health and Family Welfare, Government of India, *National Multisectoral Action Framework for TB-Free India* (New Delhi: Government of India, n.d.), https://tbcindia.gov.in/WriteReadData/1892s/57479351National%20Multisectoral%20Action%20Framework%20for%20TB-Free%20India_30-8-19.pdf.

⁵⁸ Central TB Division, *National Strategic Plan*.

	Are there M&E frameworks for each sector, or are responsibilities, procedures and reporting arrangements operationalised?	Yes. Standard operating procedures define reporting arrangements at central, state, and district levels, with clearly defined roles at each tier.
	Is M&E undertaken as planned?	Yes. Central and State Internal Evaluation Departments, Central Review Missions, and Joint Monitoring Missions conduct regular supervision, including large-scale joint supportive-supervision exercises. ⁵⁹
	Do the data collected inform decision making or implementation course correction?	Yes. Joint Monitoring Mission findings feed into corrective administrative action, although the consistency of this varies across states — a distinction taken up in Matrix II below.
	Are institutional failures identified and addressed?	Partial. Failures are identified through the review architecture, but sanctions for persistent underperformance are inconsistently applied — precisely the answerability/enforceability gap Matrix II is designed to isolate.
Fiscal/Financial Accountability	Are there budgetary allocations made by the relevant sectors?	Yes. Central and state budgetary provisions fund the programme, supplemented by patient-support schemes such as Nikshay Poshan Yojana. ⁶⁰
	Are resources allocated for M&E processes?	Yes. Investment in e-Nikshay and the Joint Monitoring Mission architecture indicates dedicated resourcing for monitoring and evaluation.
	Are the budget utilisation and expenditure reviewed?	Yes. Programme implementation plans, utilisation certificates, and periodic expenditure reviews formally track budget utilisation. ⁶¹
	Do budget and expenditure reviews guide further planning?	Partial. Reviews are conducted, but the case material does not clearly document a consistent link from expenditure review into subsequent budget planning across all states.
Social Accountability	Does the policy framework stipulate for the inclusion of members of the vulnerable groups?	Yes. TB disproportionately affects the poor, and the multisectoral framework explicitly targets vulnerable populations in urban slums, tribal areas, and prisons.
	Does the policy provide for inclusion of the vulnerable groups?	Yes. Nikshay Poshan Yojana provides nutritional and financial support specifically targeted at economically vulnerable patients.
	Are goals and entitlements communicated?	Yes. Public campaigns such as ‘ <i>TB Harega Desh Jitega</i> ’ and patient-facing information on free diagnosis and treatment are widely disseminated.
	Are mechanisms for social audit, community monitoring, or feedback provided?	Yes. TB Forums at national, state, and district level formally include community representation as part of their mandate.

⁵⁹ Ministry of Health and Family Welfare, *India TB Report 2022*.

⁶⁰ Ministry of Health and Family Welfare, *India TB Report 2022*; S. Yadav and G. Rawal, “The Organizational Challenges in the Management of the Revised National Tuberculosis Control Programme of India: An Overview”, *Pan African Medical Journal* 36 (2020): 213, <https://doi.org/10.11604/pamj.2020.36.213.16501>.

⁶¹ Ministry of Health and Family Welfare, *India TB Report 2022*.

Can communities participate in monitoring and review?	Yes. TB Forums are mandated to review the progress of non-governmental organisation (NGO) and community-related activities.
Can their feedback influence implementation?	Partial. TB Forums have an advisory mandate, but the extent to which their input is binding on implementation decisions is not clearly documented.
Are civil society organisations a part of the social audit process?	Yes. Civil society organisations (CSOs) are formally represented on TB Forums alongside affected persons, elected representatives, and programme managers.
Are members of CSOs involved in the policy formulation process?	Partial. CSOs participate in forums with an advisory mandate, but formal involvement in national policy formulation, such as drafting the National Strategic Plan, is not clearly documented.
Do social audits, community monitoring, and community feedback generate institutional response?	Partial. Nikshay Mitra and TB Champion mechanisms generate community-level engagement, but a guaranteed, binding institutional response to community-generated grievances is the weakest-documented link in the chain — consistent with the feedback-loop gap identified across the broader evidence base.

Table 1 shows that India's TB programme is strong on answerability across all four dimensions: policy instruments, reporting systems, budgetary provisions and community-facing structures are well established. The weaker answers cluster around whether mechanisms are revisited, whether failures are addressed once identified, and whether community input is binding rather than advisory.

Table 2: Matrix II applied to India's TB Elimination Programme

Accountability dimension	Answerability	Enforceability
Political	The National TB Elimination Board provides high-level political authorisation for multisectoral action; the 'TB Harega Desh Jitega' campaign creates sustained public visibility; oversight extends to state, district, and panchayat levels. ⁶²	Central TB Division reporting feeds into Cabinet Secretariat-level review, no specific legal or financial sanction attached to failure to meet the elimination target – enforceability here is largely reputational.
Bureaucratic	The National TB Elimination Programme (NTEP) operates through the Central TB Division, TB Cells, Treatment Support Units (TSUs), and District TB Forums, with defined standard operating procedures (SOPs) and a monitoring and evaluation (M&E) framework. ⁶³	e-Nikshay's real-time reporting and periodic Joint Monitoring Missions can identify non-performance and trigger corrective administrative action, though sanctions for persistent underperformance are inconsistently applied across states.
Fiscal	Budgetary provisions are identifiable through programme implementation plans, utilisation certificates, and periodic expenditure reviews. ⁶⁴	Financial audits are mandatory, but consequences for under-utilisation of allocated funds are rarely enforced at the state level.

⁶² Singh et al., "Progress and Challenges".

⁶³ Central TB Division, *National Strategic Plan*.

⁶⁴ Ministry of Health and Family Welfare, *India TB Report 2022*.

Social	TB Forums, TB Champions, survivor networks, and Nikshay Mitra formally include civil society and community members in monitoring. ⁶⁵	Community-generated grievances rarely carry a guaranteed institutional response; this remains the weakest link in the accountability chain for this domain.
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Read against Matrix I, Matrix II sharpens rather than repeats the diagnosis. Matrix I responses as shown in Table 1 are almost uniformly affirmative, portraying a well-functioning architecture; the responses shown in Table 2 (pertaining to Matrix II) shows why that reading is incomplete. On every dimension the answerability half is markedly stronger than the enforceability half: political oversight carries no sanction for missed targets, corrective action is inconsistently applied, under-utilised funds are rarely penalised, and community grievances do not reliably compel a response. The chain between commitment and realised rights is intact at the answerability end and breaks down at the enforceability end.

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