SERVICE ACCOUNTABILITY AND COMMUNITY PARTICIPATION IN THE CONTEXT OF HEALTH SECTOR REFORMS IN ASIA: IMPLICATIONS FOR SEXUAL AND REPRODUCTIVE RIGHTS AND HEALTH

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INTRODUCTION

The concept of community participation has a long history in development discourse. Its allure can be traced to the failure of top-down, state led, economic-growth oriented development models of the 1950s and 1960s adopted by newly emerging nation states (Kahssay and Oakley, 1999). In the sphere of health, the Alma Ata declaration in 1978 heralded international recognition of the model of primary health care implemented through the participation of the community. The recent Programme of Action of the International Conference on Population and Development (ICPD) also upholds principles of participation. It views women’s participation in reproductive health service management and delivery as central to ensuring quality of care and promoting human rights (United Nations 1994), a position held by the women’s rights and health movement in Asia.

Recently, the concept of participation is also being related to rights of citizens to participate in governance and issues of accountability. The traditional view that it is adequate if citizens’ preferences are represented through electoral processes, and, in-turn, elected representatives hold public officials accountable is being challenged. Problems of high levels of corruption, inability to respond to the needs of citizens and high wastage of resources persist in electoral democracies. It is now being recognised that in addition to putting in place electoral processes, it is necessary to work at the other end of the spectrum as well, i.e. promote direct participation of citizens in decision making and monitoring processes at different levels through decentralised governance and other mechanisms for direct connection between citizens and the state (Gaventa, J, 2002). Such direct participation in governance, it is argued, will strengthen the extent to which those who hold power at different levels are accountable to citizens, and will lead to better enforcement of penalties in case they are unable to do so.

Equally, community participation and accountability is espoused in the contemporary neo-liberal discourse adopted by the World Bank and International Monetary Fund. To counter the weak performance and accountability of the state, this discourse calls for cutting back the role of the state, greater reliance on private-for-profit sector and greater participation of NGOs and community. It recommends removal of barriers to the

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emergence of private sector in social services, community participation in the form of contributions of their labour, time and resources, and NGO participation as contractors for delivering social-services designed by the government. There is an underlying assumption, yet to be proved, that the private for-profit sector and NGOs are more efficient and accountable to citizens that the government.

The neo-liberal ideology\(^1\) also underpins many of the health sector reforms (HSRs) promoted by the World Bank since the 1990s in developing countries in Asia and outside. Such HSRs seek to address the problem of weak accountability of the public health system through increasing competition from the private health sector (along with regulation), introduction of community financing schemes or decentralisation of public health services (see World Bank, 1993)\(^2\). There is evidence that regulation of the private sector is not an easy task, given the different interest groups against regulation (Mills et al, 2001). The strategy of recourse to user fees or pre-payment schemes to strengthen accountability of providers assumes that clients have the required expertise to judge the quality of care and have the required money to pay for it, which is often not the case with a significant section of the population in developing countries. HSRs per se have rarely promoted devolution model of decentralisation\(^3\) (unless the government has already devolved powers), and it is only the devolution model of decentralisation which offers potential for strengthening accountability to communities, that too when resources and power are devolved with responsibilities, and when marginalised groups enter these bodies.

The concept of community participation within many HSRs has been quite different from the concerns of rights of citizens to participate in governance. Participation of the poor is envisaged in the form of community financing of services rendered and contribution of labour and time for expanding outreach and maintaining health care infrastructure\(^4\). NGOs are often seen as contractors for delivering health services designed by the government, and their participation is mainly restricted to this aspect.

At the same time, health sectors reforms in a few countries\(^5\) espouse, atleast on paper, a commitment to community participation in policy formulation, program planning, monitoring and evaluation (see the Health and Population Sector Strategy, Bangladesh case study in section 3 for an example). Outside the context of reforms, civil society groups and occasionally national governments in Asia have adopted a variety of strategy for strengthening community participation in health governance and thus accountability, which nevertheless point to useful lessons for health and sexual and reproductive health (SRH) service accountability.

The paper examines the practice of community participation and accountability within and outside the context of health sector reforms in Asia, and raises the following questions:

- Who is ‘the community’? Through what mechanisms and to what extent do marginalised people\(^6\) participate in health policy formulation and management?
- Has their participation enhanced responsiveness of the public health system to their health needs and strengthened the provision of SRH services\(^7\)?
• In the context of the multiple demands on the time of marginalised people, are there ways of ensuring accountability to them that demand less investment of time on their part?
• To what extent have other elements of health sector reforms – like decentralisation and community financing aided accountability to, and participation of, marginalised people?
• Do community contexts and political contexts have a bearing on community participation and accountability to communities?

The focus of this paper is on accountability of health and SRH services delivered by governments in Asia, and not those offered by private for profit institutions or NGOs. The thrust is on accountability to communities (external accountability) and not accountability of one government branch or level to another (internal accountability). The emphasis is on examining accountability strategies that entail direct community participation, or participation through NGOs, and not so much on strengthening electoral democracy at the central or provincial level as a strategy for improving health/SRH service accountability, which entails participation of communities mainly as voters.

This research has been constrained by the paucity of written material on community participation in health policy formulation and management especially in the context of health sector reforms. Further, most of the available literature focuses on community participation in NGO health initiatives, and less on participation in government ones. Whether the community is interested to participate, and in what, as well as impact of such participation on SRH services (to communities, from now on referred to as accountability) is another less documented area.

In spite of these constraints the study offers several useful findings and lessons on Asian experiences in community participation and accountability within and outside the context of HSRs, and their impact on SRH services, presenting which is the main purpose of this paper. The first section develops a critique of the understanding of community participation and accountability underpinning health sector reforms of the 1990s, and defines the alternative conception underlying this paper. The second section summarises different strategies used for community participation and accountability with regard to health policy formulation and management in the Asian region, both as part of health sector reforms and independent of them. The third section reviews the scant literature on impact of the community participation and accountability strategies on SRH services. The fourth section outlines key lessons and recommendations flowing from the study for different stakeholders, and identifies knowledge and advocacy gaps that need to be addressed in the coming years to foster accountability and participation which promote quality SRH services.

1.0 CONCEPTS OF COMMUNITY PARTICIPATION AND ACCOUNTABILITY

1.1 Community Participation:
behaviour on their own part and in managing their local health services” is an integral element of the agenda for reform in the health sector (World Bank, 1993, p170). The report, however, does not define the term communities. Community participation is seen more as a vehicle for spreading outreach of health services, and as a tool for efficient management of local health services. Higher levels of community participation such as in policy making, resource allocation, health administration are not really envisaged, except in situations wherein HSRs promote, or are taking place in the context of, devolution of powers to elected bodies. The phrase “involvement of communities in managing local health services”, rather than “decision making or partnership” leaves room for doubt as to whether higher depth of participation are not part of the reform agenda. The document is silent on the political, economic, social and cultural contexts within which community participation can be fostered, giving the impression that community participation can be added through health sector reforms even by dictatorial governments, and irrespective of the levels of poverty or inequalities in society.

A review of literature on community participation suggests that there are different possible answers to the question “who is the community?”, “why community participation in health?”, “community participation in what?”, “community participation to what extent?” and “how should community participation occur?”. These possible responses are indicated in Table 1. The understanding underpinning the World Development Report-1993 is perhaps the lower or conservative end of the spectrum in the range of responses possible, while several health and SRRH (sexual and reproductive rights and health) advocates and researchers envisage the higher or more radical end of the spectrum, which the authors also uphold. As illustrated through case studies in section 3, it is the higher degree of community participation, wherein marginalised sections and NGOs that represent their interests have a say in framing (or demanding) policies, and monitoring (or demanding) their implementation that can strengthen the extent to which those holding power are accountable to marginalised groups for their actions.

Table 1: Community Participation (CP): Lower to higher degree of participation

<table>
<thead>
<tr>
<th>Definition of community</th>
<th>Who represents community</th>
<th>Rationale for CP in health</th>
<th>Depth of CP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower degree of CP</td>
<td>Clients or users</td>
<td>CP as a means to</td>
<td>Manipulation</td>
</tr>
<tr>
<td>Middle degree of CP</td>
<td>Any body living in an</td>
<td>- Expand outreach</td>
<td>Informing</td>
</tr>
<tr>
<td></td>
<td>area or locality.</td>
<td>- Raise resources</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Powerful clients</td>
<td>- Support infrastructure</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Higher degree of CP</td>
<td>Marginalised groups of</td>
<td>CP as a means to</td>
<td>Advice/Consultation</td>
</tr>
<tr>
<td></td>
<td>the population</td>
<td>- Increase effectiveness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Marginalised groups in</td>
<td>- Improve accountability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>population</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- NGOs who represent</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>community</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- NGOs who represent the</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>interests of marginalised</td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CP as a right by itself*</td>
<td></td>
</tr>
</tbody>
</table>

*Collective or community decision making
### Scope or level of CP

<table>
<thead>
<tr>
<th>Service delivery</th>
<th>Service delivery and management at periphery</th>
<th>Health policy, health management and service delivery at all levels</th>
</tr>
</thead>
</table>

#### Mode of CP:

<table>
<thead>
<tr>
<th>As individuals</th>
<th>As members of small collectives</th>
<th>As members of mass-based organisations and small collectives.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through invitation by government</td>
<td>Often through invitation by government</td>
<td>Both through invitations, and demands from below.</td>
</tr>
<tr>
<td>Participation along with other stakeholders (health workers, officials)</td>
<td>Participation along with other stakeholders</td>
<td>Participation without other stakeholders</td>
</tr>
</tbody>
</table>


#### 1.2 Accountability

The article “Accountability, Transparency and Corruption in Decentralised Governance” of the World Bank observes that accountability “is the degree to which governments have to explain or justify what they have done or failed to do” (www1.worldbank.org/publicsector/decentralisation). The WDR, 1993, Investing in Health, views strengthening accountability as one of the components of health sector reforms, and is concerned with accountability of both the public and private health sectors (World Bank, 1993).

Apart from recommending increasing competition, the report recommends four sets of strategies for strengthening health accountability with the last two sets being recently termed as “oversight” (watching over) in the recent World Bank literature (World Bank, 2002 a, b):

- Community financing, which it envisages will strengthen accountability of providers with respect to quality of services they offer, as clients who contribute user fees or prepayment will not come to the provider again if the services are of poor quality.
- decentralisation of health services (in particular devolution)
- Regulation by government of health sector professionals, hospitals, medical colleges and pharmaceutical companies through licensing, accreditation and quality assessments
- Self regulation of health sector by professional associations, associations of medical schools, hospital/clinic boards, insurance boards and medical ethics committees
Other than decentralisation the other three strategies are seen as strengthening accountability of both the public and private health sector. Regulation, in the WDR-1993, is seen as particularly essential for strengthening accountability of the private sector.

The broader literature on accountability draws attention to other dimensions of accountability apart from answerability of officials in positions of power to citizens. Goetz and Jenkins (2001) observe that the notion of answerability cannot be operationalised unless there are mechanisms for penalising or meting out sanctions for poor performance. Thus the concept of accountability implies both answerability and enforceability (Goetz and Jenkins, also see Cornwall, Lucas, Pasteur, 2000). The literature review also highlights different people to whom public and private health offices can be accountable, different kinds of accountability, different purposes of accountability, different timings of accountability and a more diverse set of accountability strategies than those recognised in the WDR, 1993. Some of the elements of diversity are captured in Table 2, with a higher degree of accountability signifying accountability of both policy makers and workers, to community members and elected representatives (in particular from marginalised), colleagues and higher ups, with respect to issues of impact as well as delivery of inputs, to prevent as well as detect errors, and enforced through citizen regulation, pressure from below by citizens groups, and legal strategies (see section 3). It is this higher degree of accountability that this paper upholds.

### Table 2:
**Accountability: Lower to higher degree of accountability to communities (AC)**

<table>
<thead>
<tr>
<th>Accountability of whom</th>
<th>Lower degree of AC</th>
<th>Middle degree of AC</th>
<th>Higher degree of AC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health workers</td>
<td>Health workers, doctors, trainers, and middle level managers</td>
<td>Health personnel at all levels, including policy makers</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accountability to whom</th>
<th>Higher ups</th>
<th>Higher ups and colleagues</th>
<th>Community members (including marginalised) and elected representatives</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Accountability with respect to what</th>
<th>Input Management</th>
<th>Inputs, finance and output</th>
<th>All variables, in particular impact and social relevance(^{12})</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ex-post (post-implementation)</td>
<td>Ex-post</td>
<td>Ex-ante (policy formulation and design stage) and ex post(^{14})</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When accountable</th>
<th>Purpose of accountability</th>
<th>How accountability is operationalised</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To detect any error</td>
<td>Bureaucratic rules and procedures</td>
</tr>
<tr>
<td></td>
<td>To detect any error</td>
<td>Professional self-regulation</td>
</tr>
<tr>
<td></td>
<td>To prevent error, as well as detect</td>
<td>Legal mechanisms and Pressures from below(^{15})</td>
</tr>
</tbody>
</table>


Such a higher degree of accountability to communities cannot be operationalised only through community participation in health policy formulation and programme
management. The extent to which central governance systems responds to recommendations of marginalised sections in community, and holds public officials accountable to implement them is crucial. Military regimes at the central level may or may not accommodate such interests. While the scope for marginalised groups influencing central governance is higher in democratic regimes (through electing representatives who represent their interest, who in-turn hold public officials accountable), much depends on the vibrancy of democracy, vis whether elections are held through free and fair elections, whether elected political parties represent interests of marginalised groups, whether voters are mature politically and whether judiciary and media are allowed to function independently (adapted from Kabeer, N, 2002).

The accountability impact of direct community participation in health policy formulation and programme management also depends on levels of dependency of governments on bi-lateral aid agencies and multilateral aid agencies, whose accountability lies elsewhere. Bi-lateral aid agencies are accountable to their tax payers in their own country, while multi-lateral aid agencies are accountable to policies of member governments, whose interests may not match marginalised sections in developing countries16.

2.0 STRATEGIES FOR PROMOTING COMMUNITY PARTICIPATION AND ACCOUNTABILITY IN HEALTH AND SRH POLICIES AND PROGRAMMES:

Several community participation and accountability strategies have been attempted by government and non governmental actors with respect to health and SRH policy formulation and programme management. Some of these initiatives are part of HSRs, while others are happening outside this context.

A review of 18 World Bank supported health reform projects of the 1990s/early 2000s in Asia reveals that 12 include a component of community participation and accountability17. The strategies used to promote community participation and accountability as part of reform processes include holding of one-off consultations during design stage, constitution of national structures for stakeholder participation in implementation and monitoring, decentralisation of health management (ranging from devolution to de-concentration), promotion of community financing, formation of community health structures for managing health clinics and, more recently, strengthening of health regulation through patient rights charters, professional associations and health superintendence. Thus, the main strategies for CP and AC in the context of HSRs are very much in keeping with those outlined in WDR, 1993.

The CP and AC strategies outside the context of HSRs are broader, and include NGO/community monitoring of government health policies (including to see whether they adhere to international commitments like Cairo-ICPD) and programme implementation, budget and expenditure monitoring by citizens, public interest litigations when health policies and legislation are violated, launching of right to information campaigns, and conducting of mortality audits by multiple stakeholders.
The nature of participation (who participates, in what, to what extent) and accountability (who is accountable, to whom, when, with respect to what) promoted by these strategies—within and outside the reform contexts— is illustrated in Table 3. The Table is based on review of literature, and does not claim to be a comprehensive summary of existing strategies in the region.

**Table 3: Strategies for Community participation & accountability in health/SRH services**

<table>
<thead>
<tr>
<th>Strategies for CP and AC in health/SRH services</th>
<th>Examples of countries where it is provisioned</th>
<th>Context in which happening</th>
<th>Nature of CP</th>
<th>Of Who</th>
<th>In What</th>
<th>Depth</th>
<th>Initiated by</th>
<th>Of whom</th>
<th>Natur</th>
<th>To whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Policy/legislation</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1. One off Consultations and Dialogues</td>
<td>India: - RCH policy</td>
<td>*</td>
<td>NGO/LG</td>
<td>Design</td>
<td>Con.</td>
<td>Govt.</td>
<td>National Policy Makers Provincial policy makers</td>
<td>Hsteol</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- UP Health Systems Development Project</td>
<td></td>
<td>Clients, NGOs</td>
<td>Design</td>
<td>Con.</td>
<td>Govt.</td>
<td></td>
<td>Hsteol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Government Initiated stakeholder forums</td>
<td>Bangladesh - Health and population sector strategy</td>
<td>*</td>
<td>NGOs, women’s groups, clients health personnel</td>
<td>Design</td>
<td>Con.</td>
<td>Govt.</td>
<td>Policy Makers Planners</td>
<td>Hsteol</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Cambodia Health Sector Support Project</td>
<td>*</td>
<td>NGOs, clients, and health personnel</td>
<td>Design</td>
<td>Con.</td>
<td>Govt.</td>
<td></td>
<td>Hsteol</td>
<td></td>
<td></td>
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<tr>
<td>3. NGO advocacy campaigns</td>
<td>Health Watch India</td>
<td>*</td>
<td>Women’s movement</td>
<td>Design</td>
<td>Agency</td>
<td>Movemen</td>
<td>Policy makers and planners</td>
<td>Wngr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. NGO Monitoring of government policies and service delivery</td>
<td>ARROW members</td>
<td>*</td>
<td>NGO, research groups, communit ies</td>
<td>Monitoring</td>
<td>Agen  cy</td>
<td>NGOs</td>
<td>Policy makers, planners and implemen tators</td>
<td>Nco ur &amp; rech gr</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Public Interest Litigation</td>
<td>India</td>
<td>*</td>
<td>Public</td>
<td>Anti / for new policy</td>
<td>Agen  cy</td>
<td>Movemen ts</td>
<td>Policy makers</td>
<td>Pt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Right to information campaign on budgets, expenditures, implementation</td>
<td>India</td>
<td>*</td>
<td>Public</td>
<td>-design-implementation</td>
<td>Ageny</td>
<td>Movements</td>
<td>Policy makers</td>
<td>Pt</td>
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<tr>
<td>In programme management</td>
<td>Philippines</td>
<td>*</td>
<td>*</td>
<td>Locally elected bodies</td>
<td>PME, Finance Management Delivery</td>
<td>Partnerships/cooperation</td>
<td>Govt.</td>
<td>Health workers, local health officials</td>
<td>Loc el bc</td>
<td></td>
</tr>
<tr>
<td>7. Devolution of powers</td>
<td>India (AP)</td>
<td>*</td>
<td>*</td>
<td>Community, elected representatives and NGOs</td>
<td>Implementing</td>
<td>Monitoring</td>
<td>Govt.</td>
<td>Doctors, and health workers - primary, secondary &amp; tertiary</td>
<td>Natio nal bc</td>
<td></td>
</tr>
<tr>
<td>Hospital Advisory committees</td>
<td>India (AP)</td>
<td>*</td>
<td>*</td>
<td>Community, elected bodies, Chief Medical Officer</td>
<td>Moni toring</td>
<td>Consul ted</td>
<td>Govt.</td>
<td>Hospital management and doctors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>District Health Committees</td>
<td>India (Orissa)</td>
<td>*</td>
<td>*</td>
<td>Community, elected bodies, Chief Medical Officer</td>
<td>Moni toring, resource management</td>
<td>Not clear</td>
<td>Govt.</td>
<td>District managers, providers and workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. De-concentration District Referral committees</td>
<td>Bangladesh (B)</td>
<td>*</td>
<td>(B, C)</td>
<td>*(I)</td>
<td>Community</td>
<td>- access - supporting delivery - PME</td>
<td>Partnership Coop eration</td>
<td>Govt. (B)</td>
<td>Health workers/officials</td>
<td>Count ry</td>
</tr>
<tr>
<td>Family Planning Associations</td>
<td>India (I)</td>
<td>*</td>
<td>*</td>
<td>Community</td>
<td>- access - delivery</td>
<td>Information</td>
<td>Govt.</td>
<td>*</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>10. Community health management structures</td>
<td>Cambodia</td>
<td>*</td>
<td>*</td>
<td>Community, doctors health workers</td>
<td>-PME of clinic - Funds monitoring</td>
<td>Information</td>
<td>Donors</td>
<td>Physicians/health center staff</td>
<td>Count ry</td>
<td></td>
</tr>
<tr>
<td>11. Delegation of implementation functions</td>
<td>Indonesia</td>
<td>*</td>
<td>Community women</td>
<td>- access - delivery</td>
<td>Information</td>
<td>Govt.</td>
<td>*</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Community financing</td>
<td>China Pakistan18 Orissa, India</td>
<td>*</td>
<td>*</td>
<td>Community, doctors health workers</td>
<td>-PME of clinic - Funds monitoring</td>
<td>Information</td>
<td>Donors</td>
<td>Physicians/health center staff</td>
<td>Count ry</td>
<td></td>
</tr>
<tr>
<td>13. Community volunteers</td>
<td>Cambodia</td>
<td>*</td>
<td>*</td>
<td>Volunteer - Impl. - monitoring</td>
<td>Informatio n</td>
<td>Govt.</td>
<td>Doctors/health center staff</td>
<td>Cl ient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Mortality audits</td>
<td>Indonesia</td>
<td>*</td>
<td>*</td>
<td>Health officials, physician</td>
<td>Audit of deaths</td>
<td>Cons/Information</td>
<td>Govt.</td>
<td>Health workers, officials,</td>
<td>Hist ol</td>
<td></td>
</tr>
</tbody>
</table>

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1. Right to information campaign on budgets, expenditures, implementation.
2. Devolution of powers.
3. De-concentration District Referral committees.
4. Hospital Advisory committees.
5. District Health Committees.
7. Family Planning Associations.
8. Community health management structures.
10. Community volunteers.
11. Mortality audits.
<table>
<thead>
<tr>
<th>15. Accreditation systems</th>
<th>Malaysia</th>
<th>*</th>
<th>Clients</th>
<th>Feedback on service</th>
<th>Consulted</th>
<th>Govt. Physician</th>
<th>health workers</th>
<th>Cl</th>
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16. Regulation by clients: *Patient right charters with redressal system*

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<th>Consumer courts</th>
<th>Bangladesh</th>
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<th>Access to and quality of care</th>
<th>Agency</th>
<th>Govt. Physician/ workers/hospitals</th>
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<th>17. Self regulation: Professional Councils</th>
<th>India and Indonesia</th>
<th>*</th>
<th>Indon esia</th>
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<th>Govt. Professional council</th>
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<th>18. Government Regulation - by a body within MOH like the: Directorate General for Inspection/National institute of Public Health</th>
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<th>*</th>
<th>Health stakeholde rs</th>
<th>M &amp; E</th>
<th>Infor mant</th>
<th>Govt. Planners</th>
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Acronym: B: Bangladesh, Con: Consultation, Govt.: Government, M: Malaysia


The above Table suggests that community participation and accountability in the context of HSRs is slightly different from those happening outside.

- Within the dynamics of health sector reforms, there are more examples of community participation in health programme management, than in health policy. While this is also true of CP outside the context of HSRs, there are more examples of CP in health and SRH policy. This implies, that the community has less voice in shaping health or SRH policies, and comparatively more in implementing or managing the process of implementation of these policies. Thus the nature of accountability promoted through the participation of community is more managerial in nature than political or strategic in nature, and more after implementation, than during or before design. There are more mechanisms for promoting accountability of health workers and providers pertaining to inputs and
outputs than of health managers and policy makers with respect to social relevance and impact.

- Community Participation, in the context of HSRs, takes place mainly through spaces invited by the government or World Bank, while this is not always true in the case of community participation outside the context of reforms. In invited spaces, the level of participation has mainly remained at the level of consultation, irrespective of whether it is in policy or programme management, and controversial recommendations (for example, services in the area of violence and abortion, removal of harmful contraception from public health provision) from community and women’s groups are often not accepted (see the Bangladesh Health and Population Sector Strategy case study in the next section). This indicates the need for institutionalising mechanisms for increasing powers of community representatives. Where community participation is taking place in demanded spaces (spaces demanded through pressure from outside), the level of participation has been higher and controversial issues have been raised more effectively (see Public Interest Litigation case study in the next section). However participation in demanded spaces has been reactive rather than pro-active, pertained to a single health issue rather than a comprehensive policy, often not been sustained once the issue is addressed, and at times not been successful. Vibrant democracies are pre-requisites for demanded participation to thrive.

- Community financing is seen as a strategy for furthering community participation and accountability only in the context of health sector reforms. The available evidence suggests that it does not automatically further community accountability or participation, in particular to/of marginalised people. Experience with pre-payment schemes (see case study on China cooperative medical scheme in next section) suggests that the poor do not easily get exemptions. Further, the asymmetrical relation between providers and marginalised groups comes in the way of interests of marginalised groups being addressed by health clinics run through community financing strategies (Wilkes, 2000). The lack of expertise on the clients in general, and marginalised groups in particular, to assess quality of health care also implies that community financing cannot be an effective tool for ensuring effective quality.

At the same there are some commonalities in CP and AC within and outside the health sector reform contexts.

- Participation of marginalised people has been mainly indirect in policy formulation, that is, through the participation of middle class leaders of NGOs, social movements, and researchers who seek to represent their interests. Direct participation by community members has been higher in community health structures that manage local health service delivery, though often it is the powerful groups in the community that become members of such groups. This raises the key issue of whether the views and perspectives of NGOs and leaders of social movements at policy and programme management levels match those of
marginalised groups. This aspect has been little reached, but evidence from Tamil Nadu in India points that there are occasions of mismatch. A section of the Indian women’s movement put pressure on the government to call of clinical trials of Norplant, a hormonal contraception, in 1983, which was introduced to widen contraceptive choice, stating that the side effects were too many, while a later research in Tamil Nadu when the trial was re-introduced in 1993 showed that women themselves preferred Norplant to Intra Uterine Devices or oral pills which were part of the government contraceptive package due to lesser side effects. Both IUD and Norplant according to them required good follow-up (Ramanathan, Mala, 1997). This example, points to the need for NGOs and social movements to listen to the voices of marginalised groups, as well as for such groups to directly express their views in policy forums.

- Scope for community participation and accountability with respect to health policy and programme management is greater when it is taking place in the context of devolution of powers to local bodies, provided devolution a) has been accompanied by transfer of resources, b) there is provision for elected bodies at the lower levels to be represented at higher levels of decisions making (so as to influence policy), c) the elected representatives have received adequate information and powers to assume their roles. Community participation and accountability is lower when decentralisation is restricted to de-concentration or delegation. This is discussed at greater length in the next section.

- Most accountability strategies to community seem to involve consider investment of time by community. Few strategies exist for strengthening accountability to communities that involve less of their time. While on the surface this trend may seem to be favourable as intensive participation provides space for empowerment, whether marginalised groups have time to participate, desire to participate, have powers to influence, and are equipped to participate are key issues. The answer to the first, third and fourth is often negative (the ‘desire’ aspect having been little explored). Hence, it becomes important to explore and disseminate strategies for strengthening AC (like use of public interest litigation by third parties, self regulation within professional councils, and so on, see the coming section for two examples) that demand less time from communities, along with promoting strategies to enhance powers and capacities of communities to participate.

- There is a need to choose participation and accountability strategies appropriate to different contexts. Public Interest litigations are appropriate only when there is an independent and unbiased judiciary, and where people have faith in the judiciary. In countries where legal accountability is weak it may be better to institutionalise bureaucratic accountability mechanisms like government regulation, mortality audits etc.

3.0 THE IMPACT OF COMMUNITY PARTICIPATION AND ACCOUNTABILITY STRATEGIES ON SRH SERVICES
There are significant information gaps on the extent to which CP and AC strategies have strengthened SRH services. Of the 26 case studies or examples of CP and AC reviewed, information on SRH outcomes was available only in the case of 12. In particular there is little literature on the impact of regulation mechanisms (popular under recent HSRs) like patient rights charters, professional councils, consumer protection acts and health superintendence on SRH services. There was greater information on India, Bangladesh, Philippines, China and Indonesia, when compared to other Asian countries. Overall, there is more information on impact of community participation and accountability outside the context of HSRs than within, though lessons can be drawn from the available literature for reform processes. From the available literature, ten small case-studies are presented below.

**Policy**

i) Stakeholder (inviting) participation in Health and Population Sector Strategy: The case of Bangladesh

In the mid 1990s, the Ministry of Health and Family Welfare of Bangladesh was implementing over 120 projects related to health and family planning, resulting in overlaps and waste of resources. Though a consortium of donors has existed since the 1970s, it was only during 1996-1998 that the consortium, led by the World Bank, assisted the government to prepare a Health and Population Sector Strategy (HPSS) as part of the move towards a sector wide approach (Jahan, R, 2003). A task force on community and stakeholder participation was constituted, which held consultations with primary stakeholders (e.g. clients), secondary stakeholders (health managers and workers) and indirect stakeholders (e.g NGOs, women’s groups) and gathered feedback on key components for formulation of HPSS. Most of the stakeholders prioritised reproductive and child health services, communicable disease control and limited curative care as part of the Essential Service Package (ESP). However, the reproductive health component of the ESP component placed emphasis only on maternal health and family planning, and not on other aspects like prevention and treatment of violence against women and adolescents’ RH (see package outlined in Social Development Notes, 2001) that were highlighted by women’s organisations. As a token measure, counseling and legal services in the area of violence were provided in a few urban based hospitals, outside the ESP.

Though the HPSS proposed integration of health and family planning departments, this policy has not been implemented in practice, and is now under threat in the context of change of government at the center (Jahan, R, 2003).

Primary stakeholders were involved more in local needs assessment, rather than framing of policies. While mainstream NGOs were invited to such forums, some of the women’s organisations working with a rights perspective were invited to policy formulation processes only upon their insistence. The consultations with women’s organisations remained ad-hoc, with some of the women’s organisations being called for the first round of consultations, but not the final one in which the HPSS was finalised. Further, the process of donor coordination in this project has largely been owned by the donors, in particular the World Bank, and not by government. Some aid agencies have even
refrained from joining the process, as it is seen as controlled by the World Bank (Buse, Kent, 1999). Certain section of the government was opposed to the exercise of such control by the World Bank, as well as the nature and scope of some of the reforms, in particular integration of health and family planning administration (Jahan, R, 2003)

ii) Influencing policy from outside: The case of coalitions of women’s and health groups in India (Health Watch)

The Government of India introduced method specific family planning targets, with a focus on sterilisation, in the mid 1960s as a method of population control (Visaria, Jejeebhoy and Merrick, 2000). This policy led to large scale violation of poor men’s (in 1970s) and women’s (1980s and early 1990s) reproductive rights and health, as they were often forced to undergo sterilisation, under unhygienic conditions, with little follow up services being provided. Advocacy efforts by coalition of women’s and health rights groups led to the declaration of one or two districts in each state as ‘target-free’ soon after the Cairo conference on Population and Development in 1994, and the total abolishing of this policy by the Indian government in 1996. Instead, an integrated Reproductive and Child health (RCH) package was introduced (though not fully implemented in practice24), which included maternal health services, expanding contraceptive choice and services for prevention and syndromic management of STI/RTIs.

The national level coalition, Health Watch, formed in 1994, was one of the key players in pressing for the policy shift from method specific family planning targets to integrated RCH package. The coalition continues to play a watchdog role to promote the implementation of the target free and integrated RCH approach in different states, as well as in strengthening the position of Auxiliary Nurse Midwives in health service. In addition, it pressurised the government to include women's groups in community-based planning strategy within the RCH programme, as well as framing of state level population policies. The acceptability of Health Watch in the eyes of the Indian government and donors has varied across time, varying, according to Ramachandran, with the sensitivity of decision makers in higher echelons of central and state government to sexual and reproductive rights and health and how well they know actors from civil society active on this issue. Though invited for discussions on the draft document on RCH approach, it was not invited for the final round of discussions (Ramachandran, 1998).

iii) Combating anti-women RH policies and practices: The use of public interest litigation in India

In 1982 the Indian State recognised that a third party could directly petition, whether through a letter or other means, the Court and seek its intervention in a matter where another party’s or the general public’s fundamental rights were violated. This system of litigation is referred to as public interest litigation (PIL). In contrast to private litigation, once a PIL case has been filed it cannot be withdrawn. As PIL cases are handled at High Court or Supreme Court level, the rulings are delivered faster than private cases, a majority of which are handled at lower levels of the judiciary (Dasputa, 2002). Some of
the SRRH specific issues taken up through PIL include issues of rape of women by police or employers, enforcement of ban on sex selective abortions, violence against sex workers by clients and promotion of harmful reproductive trials and contraception by the government through its public health program. Between 1980 and 2000 harmful trials of injectable contraceptives (Nat En and Depo Provera) and introduction of the drug called Quinacrine for female sterilisation have been banned through using PILs (Indian Express, Friday, April, 10, 1998). Some of the constraints in using PIL in India have been the paternalistic attitude of some of the members of the judiciary, difficulty in enforcing progressive judgments (due to reluctance on the part of the local police, disappearance of the perpetuators and at times the victims) and over dependence of victims/groups on intermediary organisations to take up such cases (Dasputa, 2002). Further, not all SRRH advocacy groups in the country are familiar with using PIL to enforce accountability of health/SRH services. When not backed by sound research on what women from marginalised groups want, advocacy groups can use PIL to prevent progressive policies, as happened in the case of Norplant in the 1980s, which was discussed earlier.

Health management

Different modes of Decentralisation as a strategy for promoting community participation and accountability in health management: Indonesia, India and Philippines

iv) In Indonesia the family planning programme has been delegated to village family planning groups by the Indonesian Family Planning Coordination Board (BKKBN). The groups made contraception available to women in even remote parts of the country, and acted as agents of family planning motivation. These family planning groups are formed, developed and monitored by the most powerful women’s organisation in the country - PKK- which comprises of wives of politicians and bureaucrats and has a national presence. The members of the groups comprise of female members who are willing to practice contraception. These groups are expected by BKKBN to raise awareness on family planning, assist in service provision and referral, conduct regular meetings of members, collect data and maintain records on contraception use and undertake activities beyond family planning. One of the reasons for the reduction in fertility rate can be attributed to the good functioning and expansion of these family planning groups. However few groups have addressed SRH service needs beyond family planning (Shiffman, 2002). Men are excluded from these groups, and do not benefit from the services offered. The extent of community participation has been restricted to service delivery and consultation rather than community agency.

v) In India, World Bank supported Orissa Health Systems Development Project (ongoing) and Andhra Pradesh First Referral Health System Project (project completed) experimented with de-concentration of health administration from state (equivalent to province) to district levels. In Orissa, district health committees were established, with the responsibility of surveillance of health diseases, monitoring the project, and collecting and utilising revenues generated through user fees (World Bank, 1998d). In Andhra Pradesh, District Referral Committees and Hospital Advisory Committees were set up. These committees include members of NGOs, community groups and locally elected
representatives, apart from health and revenue administrators at the district level. The leadership of these committees rests with either the health administrators or the District Collectors. The Completion Report of the Andhra Pradesh project (1995 to 2002) indicates that the access to and quality of services offered at district hospitals and primary health centers has improved because of the project, in particular access of poor and women and their satisfaction with services, including maternal health services. The report however does not highlight any reduction in maternal or reproductive morbidity or mortality in the area during the project period (World Bank, 2002c). The Completion Report also does not throw light on the powers of community and NGO representations in decision making and how conflicts were resolved.

vi) The Philippines government embarked on devolution of health and social services after the passing of the Local Government Code of 1991. As part of the devolution process, a significant proportion of public health employees and clinics were transferred to Local Government Units (LGUs). Local government expenditures increased by 10.7% in 1992 and 51.9% in 1993, with 66% being allocated for the health sector (cited in Bossert, Beauvais, and Bowser, 2000). Though this amount is in principle untied, a significant proportion goes for salaries of health workers fixed as per central scales. The Local Government Assistance and Monitoring Service was set up within the Department of Health to monitor LGU health programs, provide technical assistance and, upon entering an agreement, augment LGU resources. However, entering into such agreement also meant committing to implement certain health programs that were part of national priority (including MCH) (ibid, 2000). To oversee functioning of health services, local health boards (LHBs) were set up in each LGU, comprising of the Governor or Mayor as its chairperson, Municipal Health Officer as vice chairperson, the local councilor for health, a representative of the Department of health and a representative of a health NGO (Bossert, Beauvais, and Bowser, 2000). A study of four local health boards (two meeting regularly and two meeting rarely) noted that there were more consultations with the community in planning and budget allocation, fund raising activities, health initiatives and higher per capita health expenditure in those LGUs with functioning local health boards (meeting regularly). However, even in such boards, the Mayor had a greater say in decision-making, including in selection of NGOs. Though the functioning LHBs tended to introduce programs of their own (herbal medicines) none of them pertained to reproductive health (Ramiro et al, 2001). In a few provinces, under the influence of the strong Catholic lobby, in fact the locally elected bodies have banned the provision of modern contraceptive methods. As HSRs in Philippines are supporting devolution process introduced by the government (World Bank, 2002e), one of the challenges is to weave in SRH concerns into devolution process.

vii) Community financing, community health structures and participatory evaluations as strategies to promote accountability and participation: Example from China

Pre-payment schemes or/and user fees are being introduced as part of HSRs in several Asian countries (including Pakistan, Orissa and Andhra Pradesh in India). As the impact of these on participation and accountability, as well as SRH services has been little researched, a case study from China is presented to examine possible implications.
The case study also throws light on some of the challenges in promoting community health structures as a strategy to promote local health/SRH service accountability.

During the Cultural Revolution, China introduced the community-based health pre-payment scheme (referred to as the Cooperative Medical scheme or CMS) and community-based management of health care (through CMS Fund Committees). The medical services were prepaid through the CMS by a combination of subsidies from high levels, welfare funds set by communes through their agricultural income, and annual mandatory contributions by the population which ranged from 0.5 to 2% of their annual income. The CMS provided free outpatient treatments to villagers who contributed to the scheme. The service providers included a bare foot doctor (normally a herbal doctor trained in Western medicine) and a male and female health worker responsible for prevention, immunisation and MCH. With the de-collectivisation of agriculture in the early 1980s the commune resources decreased. Consequently, the CMS scheme died a natural death in most parts of China and was replaced by fee for service and drugs system, but survived in certain parts where the bare foot doctors and Fund committee took interest in its sustenance. Laba village CMS is one such example. Laba village is an administrative unit consisting of four hamlets close to the border of Myanmar. Most of the villagers belong to an ethnic minority group called Lahu. Until the mid 1990s each villager was paying two yuan each year for the CMS. But with rising drug prices, the Laba CMS could no longer sustain subsidised service provision. CMS committee hence approached OXFAM for seed fund of 10000 yuan to run the drug scheme. Two additional health workers began to serve the villagers under the direction of the doctor. In 1998 a participatory evaluation of CMS was held by Yunnan PRA Network along with the Committee, the villagers and relevant agencies. Three key issues emerged from the evaluation were: lack of representation of poor, women and remote hamlets in the CMS Fund Committee, lack of fee-exemptions for poor households and lack of services for RH needs. The evaluation team further observed that doctor and two health workers were also represented in the CMS committee, and were thus responsible for their own functioning. Though, the committee included the village leader, he was the son of the herbal doctor. The health workers were unable to provide treatment for RTIs or provide ante natal and post natal check ups, though related medical incidents were not infrequent. The findings from the evaluation were taken back to the community, and resulted in the poor being given partial exemption with respect to pre-payment fees, democratisation of committee through representation of marginalised groups (poor, women and people from remote hamlets) and strengthening of RH services (Wilkes, 2000).

ix) Audits into maternal mortality: Experiences from Indonesia

In Indonesia the Ministry of Health introduced district level audits on both maternal and perinatal mortality in 1994 as part of the Safe Motherhood program. Such audits begin with the identification and reporting of deaths, and then explore reasons for mortality, lessons that can be learnt from the analysis, and the changes that need to be brought about in policies and guidelines. Health administrators and hospital physicians at district level carry out the audits, and the findings are presented to a wider group comprising of community groups, women’s organisations, midwives and staff from community health
centers with the objective of drawing lessons and recommendations. Guidelines have been evolved for such audits (see Supratikto et al, 2002). A study of the functioning of the audit system in three districts of South Kalimantan revealed that between 1995 and 1999, 130 maternal deaths were reviewed. Delays in decision-making by the family and poor quality of care in health facilities were seen as contributory factors in 77% and 60% of the cases respectively. Economic causes were seen to have contributed to 37% of the deaths. The audits led to changes in the quality of obstetric care on the part of the providers (in particular strengthening of capacity of midwives and quality of protocols for obstetric emergencies) and strengthening of community-based responses to obstetric emergencies (village referral teams, establishment of community funds, community managed transport arrangements, and use of religious leaders for persuasion of families that refused referrals). It also led to improvement of working relationship between health managers and providers, and providers at various levels. At the same time the team observed that there was a tendency to fix blame on village level midwives ignoring the underlying problems with the health system. Given the hierarchy within the health system, the final recommendations often tended to represent the opinions of the obstetricians. Further, although the idea of participation of community and religious leaders in the above meeting is good, it is difficult for officials to openly admit failures and problems in the health system. There were no systems in place to promote learning across districts. The team opined that some of these loopholes could be addressed if the audit focused more on morbidity than mortality (as there will be lesser fear of penalisation by managers, providers and health workers, and hence more openness to identify shortcomings at one’s level) and if separate forums could be institutionalised for different purposes (a separate health system meeting with health managers and providers, before the community-health system meeting may create more room for open debate amongst the latter, without losing the benefits of community insights). It also recommended systems for cross learning across districts like inter-district meetings to learn lessons from findings from maternal death audits in respective districts.

ix) Accreditation with the Malaysian Society for Hospital Accreditation (MSQH): The case of Seremban Hospital, Department of Obstetrics and Gynecology Department.

Seremban Hospital is located in Seremban, the capital of the state of Negeri Sembilan in Malaysian peninsula. The Hospital is publicly funded, and is also the training and referral hospital for the state. The Hospital has 800 beds, 20 clinical specialisations and a variety of support services. Services are provided free of cost to those who cannot afford to pay. Seremban Hospital has experienced different kinds of quality assessments leading to different accreditations. In 1999 (and then again in 2001) the Hospital achieved a three-year hospital accreditation through the MSQH which is the focus of this case study, with a particular thrust on its Department of Obstetrics & Gynecology. The team for quality-check with MSQH comprised of participants from the public and private health sector. The quality standards and indicators used by the Obstetrics and Gynecological Department were developed through the Ministry of Health, the State Department of Health and Seremban Hospital’s quality assurance committee. The tool which was used covered aspects such as client satisfaction, quality of service, effectiveness of and adherence to guidelines, extent of teamwork and competencies of staff. Each assessment
process took three to four days (though the hospital prepared for three years\textsuperscript{30}) with the assessors interviewing clients and staff, as well as surveying the facilities. The wider community was informed of the independent quality assessment through non-government organisations, community leaders and publicity banners. Lessons from the quality assessments have led to the setting up of an early pregnancy assessment unit and day-care surgery to reduce admissions in the obstetrics and gynecology ward. They have helped shorten client-waiting times in the Department (through one staff providing multiple services) and encouraged clients’ husbands to be more involved in their wives’ care. The numbers of referral and repeat cases have reduced, leading to decongestion in wards. The complaints of patients are more speedily addressed than before, and the quality of interaction with staff has improved. The exact impact on maternal health outcomes, and other dimensions of women’s reproductive and sexual health is not clear. At the institutional level, a community fund raising campaign was initiated to meet infrastructure gaps that were highlighted through the study (e.g. medical equipments). Accreditation has also enabled the Hospital to source funding more easily. Through participation in such processes, the hospital has developed skills to train other hospitals in quality assessment.

x) Professional Councils: Examples from India of accountability strategy that demands less time from communities

Along the lines of the Medical Council Act in United Kingdom, the Indian government enacted the Indian Medical Council Act, 1956. This Central Act has been amended several times subsequently, and different states have also enacted state level acts. As per the Central Act the doctors are bound by the Code of Medical Ethics, which states that “the prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration” (Medical Council of India, 2002). The Central Act includes several rules that pertain to reproductive-health and rights of women and men. Doctors, irrespective of their religion, have to comply with the Medical Termination of Pregnancy Act of 1971\textsuperscript{31} and the Pre-natal Sex Determination Test Act of 1994 (under which they should not disclose the sex of the foetus). They have to obtain the consent of both the wife and husband before performing any operation that would affect sterility of either party. Doctors have to obtain consent of patients before performing any clinical trials. Adultery with patients is strictly prohibited. However, the code of ethics does not protect the reproductive rights of married women in the absence of consent from husbands, or adolescents. It is silent on the duties of doctors in providing services like artificial insemination, sterilisation and medical termination to single women who are outside the institution of marriage. Further the extent to which it has actually protected health and reproductive rights of clients has been minimal. As a result of lack of knowledge or lack of faith of clients in Medical Councils, few clients or their relatives choose to place their grievances before these, and rarely does a Council support the position of clients due to strong self protecting tendency amongst medical doctors. Iyer (1996) observes that in Maharashtra, on an average only one case per year was placed before the Dental Council since 1990 and even fewer before the Council of Indian Medicine. The Council of Homeopathy received a slightly higher figure of five to six complaints per year. There are very few examples of disciplinary actions taken on the
basis of investigations on complaints received\textsuperscript{32} (Iyer, 1996, Jesani, and Pilgaokar, 1995, Jesani, 1995 a,b).

**Findings and Lessons from case-studies:**

Evidence from the case studies indicate that community participation and accountability (to community) strategies with respect to policy and programme management in the context of HSRs have at best strengthened maternal health, family planning and, to a lesser extent, prevention of RTIs/STIs/AIDS. Community participation and accountability strategies have had little impact on provision of services in the contested areas of violence against women and abortion, new RH agendas like treatment of RTI/STIs, or less priority areas such as infertility and reproductive cancer. Community participation and accountability has mainly improved SRH services for women in reproductive age, and rarely for groups like adolescents, single and elderly women and men. These shortcomings are due to a variety of factors, vis women’s rights and health rights groups are less invited for policy dialogue when compared to those working within a welfare mode, few adolescents and elderly advocacy groups exist in many Asian countries, and even when they participate little powers are granted to civil society actors when they are invited to HSR dialogue processes. Often, the priorities identified by the World Bank using their priority setting tools and methods for the countries define the boundaries of what suggestions from communities and other civil society actors are accepted, and what are not (of 18 HSR projects in Asia only 7 listed some SRH services as a component (mainly, FP and MCH))\textsuperscript{33}. The absence of infrastructure and resources to take on issues like treatment of HIV/AIDS and reproductive cancers is yet another constraint in the case of developing countries within Asia.

While these findings are also true of community participation in invited spaces by government outside the context of reforms, participation in demanded spaces (Health Watch, PIL, India) and participation in invited spaces facilitated by progressive donors (community participation in Oxfam initiated evaluation in the case of CMS study) has at times strengthened provisioning of new SRH services (for example, treatment of RTIs/STDs) and challenged violations of reproductive rights of women through government policies (for example, prevention of trials of harmful contraception). However, even such participation has not had much impact on provision of services in the contested areas of violence against women or on implementation of services that demand heavy investment (reproductive cancers, routine provision of anti-retrivorals)

Community participation and accountability strategies (both within and outside reforms) some times have had unintended negative effects. While the maternal death audits in Indonesia strengthened emergency obstetric care, they also led to victimisation of health workers, who were often blamed for maternal deaths even though the entire health system was in many ways responsible. In Bangladesh, the move to operationalise patient rights charters as part of HSRs, has led to the mooting of health providers’ rights by health professionals to protect their interests against claims of patients, for example right of providers not to provide health care if infrastructure is weak\textsuperscript{34}.
Analysis of the factors that seem to influence the impact of CP and AC in policy formulation and programme management within and independent of HSRs on strengthening SRH services points to the importance of:

i) The legal and policy environment.
ii) The broader cultural and political milieu.
iii) The strategising skills of civil society organisations
iv) The SRRH sensitivity and competence of different stakeholders\(^{35}\)
v) Institutionalising mechanisms for enforcing recommendations

The national and international legal and policy environment has a bearing on impact of community participation in, and accountability with respect to, SRH programme management, as it defines the boundaries of what changes are possible at service delivery level through CP and AC strategies. Significant progress has been made with respect to SRH policies of national governments in Asia in the aftermath of ICPD-Cairo (1994) and the Fourth World Conference on Women held in Beijing (1995). Nevertheless, SRH policies of none of the countries reflect the full range of commitments in the Programme of Action adopted in ICPD-Cairo (see integration of service paper in this volume) or commitments pertaining to reproductive and sexual health in the Platform for Action, adopted at Beijing.

At times HSRs define the boundaries of what, and how much, accountability strategies can achieve. For example, reforms in some of the countries in Asia are institutionalising user fees as part of health sector reforms (see Table 3). Consultations are more held on programmatic issues, than financing reforms; though the latter has immense bearing on access to services. Patient rights charters and Code of Medical Ethics have limited impact when financing reforms are not open to debate. For example, though the Code of Medical Ethics state that doctors should provide health services irrespective of ability to pay, it may not be possible for poor women with complications during pregnancy to avail emergency obstetric services if they do not have the required cash. For community participation and accountability strategies to be effective, elements of health sector reforms themselves need to uphold principles of equity, and there is need for mechanisms to ensure this (see Box 1 for an example of an effort to analyse whether HSRs promote fairness).

### Box 1

**Benchmark of fairness for Health System Reform: Experience in Thailand**

The Health Care Reform Project of the Ministry of Public Health in Thailand proclaims the goals of reform as strengthening equity, quality, efficiency and social accountability. In 1998/1999 the Asian Development Bank (ADB) provided technical assistance to ensure that the health and other social sectors were not affected as part of the economic crisis, and that the (so called) achievements of HSR goals were protected. On behalf of the ADB, technical assistance was provided by Management Science for Health (MSH) and the Thai independent research institution Health System Research Institute (HSRI). The team proposed further and more
comprehensive reforms to achieve equity, efficiency and quality, in a situation of economic crisis.

The Center for Health Equity Monitoring, Narseuan University and the Ministry of Public Health were given the task of assessing the fairness of the proposal of the above team, as well as its implementation on trial basis in two provinces. The tool as used in Thailand entailed subjective ranking by central and provincial health officers and hospital Directors on the following nine parameters: i) inter-sectoral public health, ii) financial barriers to equitable access, iii) non financial barriers to access, iv) comprehensiveness of benefits and tiering, v) equitable financing, vi) efficiency and quality of health care, vii) administrative efficiency, ix) democratic accountability and empowerment and x) patient and provider autonomy. The participants in the exercise were asked to not only assess the proposal and implementation (in two provinces were it was being implemented on a pilot basis) across the above variables, but also to come up with recommendations to address shortcomings. The score given varied across the level of stakeholder and their background (provider, manager, and researcher). However, one criterion on which the score was uniformly low was “addressing non-financial barriers to health care”. In particular, the proposal as well as its implementation in one province was considered weak in addressing gender and other socio-cultural barriers to health and reproductive health like cultural beliefs which prevent people coming promptly for treatment (not elaborated further) and reliance on traditional faith healers. The study led to several changes in the proposal of MSH/HSRI. The participants in the study appreciated the benchmark as a tool, but recommended combining some of the criteria, explaining each criterion before hand in detail, providing information to come to conclusions more objectively and inclusion of clients and civil society groups in assessing fairness.

Source: Pannarunothai, S and S, Srithamrongsawat, 2000

The cultural milieu also defines the contours of ‘which’ SRH policies are promoted through CP with respect to health policy, as policy outcomes are constrained by issues of political feasibility. As a result any controversial policy that goes against the views of the majority or powerful sections of it (like religious groups, pharmaceutical lobby) is less likely to be passed. As discussed, in Philippines, under the influence of the Catholic lobby, elected bodies in a few provinces have barred the provision of modern contraceptive methods. This also flags the issue of limited role of public accountability systems which do not represent community interests. At the same time, culture is not monolithic, and progressive individuals within not so progressive institutions can be mobilised for change. In Indonesian maternal audit case study, religious leaders were mobilised to reduce delays on the part of the community in availing emergency obstetric facilities.

The political milieu also seems important in several respects. It has a bearing on the extent to which policy makers take into account recommendations that come from community groups and other civil society organisations (NGOs, social movements and research institutions) through direct participation strategies. It also influences the sustainability of SRH policies introduced. In Bangladesh, when a new government was elected, it started questioning the policy adopted under HPSS by the earlier regime of integrating health and family welfare administration. The political milieu also has a bearing on the extent to
which conditions that lead to demanded participation exist and thrive: space for civil society to organise, space for dissent and space for free judiciary and media to function.

At times the strategising and alliance building skills of CSOs can enable them to overcome both policy, cultural and political barriers pertaining to SRH services. In India several health NGOs, women’s NGOs, research institutions, demographers, and sensitive providers came together through the forum of Health Watch to successfully campaign against method-specific family planning target approach. Using findings from research studies, they successfully advocated with policy makers that a gender sensitive SRH strategy can in-fact lower fertility through improved well being of women, and family planning targets where not necessary. In Nepal the transition to democracy was a result of concerted campaigns by civil society organisations in the country, along with support from international human rights organisations.

This brings us to another set of issues that have a bearing on the impact of CP and AC strategies on SRH services: the SRRH sensitivity and competence of different stakeholders. Needless to say, the sensitivity and competence of policy makers to SRRH issues has a bearing on outcome of CP and AC in policy making processes. In the consultations around HPSS in Bangladesh recommendations of women’s organisations to include violence against women as a reproductive health issue were rejected by policy makers, as they were not considered as a priority issue having a bearing on RH by policy makers. In India the Medical Councils are yet to emerge as a strong lobby for protection or promotion of sexual and reproductive rights as doctors who are members are not necessarily sensitive to these issues. In the CMS case study from China, the doctors and health workers were not sensitive to the maternal health and RH care needs of women. In the Philippines case study, members of the local health boards did not prioritise SRH concerns. If attention is not paid to capacity building, there is a danger that the community health structures, consultative forums and stakeholder committees put in place as part of reforms may not have significant impact on strengthening accountability with respect to SRH services.

However, not all NGOs/health NGOs/women’s organisations are themselves equipped to undertake this task of SRRH capacity building of other stakeholders. Thus another challenge is to strengthen SRRH expertise of development and health advocacy networks and women’s organisations which are not specifically focusing on SRRH issues. To have significant impact, it is also imperative that civil society organisations combine single issue (often re active) advocacy (on unsafe contraception, abortion and female genital mutilation) with proactive advocacy on SRH policy as a whole. Policy analysis, advocacy and networking skills are other areas for capacity enhancement.

Lastly, the case studies point that strategies are required not only for strengthening answerability of public officials to communities for their decisions, but also for holding officials accountable with respect to their implementation. The policy decisions taken through stakeholder consultations and pressure were impressive in the case of Bangladesh HPSS and Indian Health Watch case studies, but their implementation was weak in both cases. Strong enforceability mechanisms are also necessary when patients’ rights are
violated. The different Professional Councils in India do not get many cases as, in the past, they have failed to take disciplinary actions against erring providers when they have received complaints from clients. Thus, answerability and enforceability mechanisms are both important for strengthening accountability to communities.

4.0 LOOKING AHEAD: KEY ISSUES, GAPS AND RECOMMENDATIONS

The analysis of the preceding sections suggest that many national governments in Asia have put in place structures and strategies for community participation and accountability in health policy and management, both as part of HSRs, and outside them. The community participation and accountability strategies within HSRs chiefly comprise of decentralisation, community financing, establishing of community health structures and, recently, regulation of the health sector (client, government, and self-regulation). Available evidence suggests that other than in instances wherein HSRs have entailed devolution of powers, CP in HSRs has been limited to the level of “consultation”. Controversial issues have either been kept out of the agenda or not addressed (including in instances of devolution). Such participation has strengthened at best managerial accountability (that too mainly with respect to programmes, and not internal health systems36), and rarely political accountability or accountability with respect to what policies get made. Available evidence does not support the assumption of the World Bank that community financing strengthens participation of, and accountability to, marginalised people. While a detailed critique of user fees and pre-payment schemes and its impact on access of poor to health services and quality of care is provided in the financing paper in this volume, the CMS case study reviewed in this paper points to how the Fund Management committee was dominated by providers and elite groups, and did not prioritise maternal health or RTI prevention and treatment though a key need of local women.

Community participation and accountability outside the context of HSRs has taken place both in spaces created by the government, as well as those demanded by communities and civil society organisations that represent their interests. The shortcomings of community participation and accountability in reform processes/projects well apply to participation in invited spaces outside the context of reforms. On the other hand, community participation and accountability strategies in demanded spaces has been more diverse and innovative, raised controversial health issues, promoted not just managerial accountability (of health workers, providers and managers) but also political accountability (of health policy makers) and, when such participation has been demanded, entailed a higher level of participation by community and civil society organisations. Yet demanded participation is beset with problems of indirect representation of marginalised people, reactive orientation, short term life-span, and fluctuating legitimacy (depending on sensitivity of bureaucrat and politician holding power at that time). Strong tradition of democracy and space for dissent seems a prerequisite for such demanded participation to thrive, but are not always present.

The impact of community participation and accountability within and outside the context of HSR on SRH services has been little researched in Asia, and perhaps elsewhere too.
The available evidence suggests that only 33% of HSR projects in Asia include HSR services. Even in these cases, services are limited to strengthening FP and MCH care for women in reproductive age. Rarely have interventions in the area of violence against women, or services in the area of abortion, infertility treatment, reproductive cancers, or contraception for adolescents been prioritized as part of Essential Service Packages. Community participation and accountability strategies outside the context of HSRs and in spaces demanded by women’s and health activists have more often raised such issues, in particular when backed by sensitive people within bureaucracy and supported by capacity building inputs on SRH and advocacy. However the success of such efforts has varied. Demanded participation and accountability strategies have more successfully prevented violations of women’s reproductive rights by the state, than furthering SRH services in the areas of abortion, (preventing) domestic violence, adolescent RH services or reproductive tract cancers. Some of the issues that have a bearing on impact of community participation and accountability within and outside HSRs on SRH services include the broader cultural context, the extent of democracy, funds available with government and legal and policy environment (including other elements of HSRs like financing).

Given the diverse socio-economic-political context, health policy and legal context, and financing and institutional arrangement (public/private, decentralisation) for delivery of health care across regions and countries it is difficult to generalise and say that one or a set of community participation and accountability strategies are more suitable for strengthening SRH services all over, both within and outside the context of reforms. Instead this concluding section will identify key cross cutting issues pertaining to community participation and accountability with respect to SRH services in the context of reforms and outside, main research and advocacy gaps, and recommendations for addressing these.

4.1 Key issues and gaps

Given the low levels (in service delivery or programme management) and depth (consultation) of community participation within health sector reforms, as well as its inadequate impact on strengthening accountability with respect to SRH services, a question that emerges is what approach should women’s health organizations, social movements and other civil society actors take vis a vis health sector reforms. Should they ‘hop on to the health sector reform buses and push the direction of the buses from within’, or ‘push the buses from outside’? The answer may vary with the commitment of the government, who is sitting in key Ministries and skills of the civil society organisation, and often straddling both strategies may be essential.

From within the buses, one of the key challenges for all actors- civil society organizations, the World Bank and national governments- is to ensure that lip service is not provided to issues of community participation, and community or civil society representatives have actual say in decision making process, and with respect to both health sector reform policies (including priority setting, health financing) and their implementation. There is perhaps a need for an independent body to oversee the process.
and facilitate consensus when there are conflicts between civil society representatives and
governments or World Bank (WB) over policies or their implementation. “Participation-
contracts” between civil society actors and governments/WB spelling out the scope and
intensity of participation, and mechanisms for conflict resolution are necessary if
community participation is to strengthen health and SRH policy and programme
implementation.

Another challenge is to expand the range of accountability and participation strategies
used in the context of health sector reforms. The review suggests that some of the
strategies that could be used in addition to devolution, community health structures,
promoting quality assurance systems, government regulation of health services include:

1) seeking inputs on health and SRH policies/priorities/legislation through media
and public hearings,

2) promoting citizen oversight of budget allocation and rules and protocols on
programmes to see whether these match policies,

3) promoting citizen (not just client) regulation of public health services through
public interest litigation, demanding right to information on health/SRRH
policies and implementation, citizen health expenditure reviews at national
and provincial levels and community monitoring of expenditure at grass roots.

In particular, it seems essential to oversee the impact of community financing
arrangements under reform processes. The finding that community financing does not
necessarily promote accountability to marginalised groups suggests that it is important to
not justify community financing arrangements as part of HSRs on the name of
strengthening accountability to community.

While decentralisation is important, evidence suggests that delegation and de-
concentration have little impact on strengthening accountability to communities. It seems
important to push the devolution model of decentralization, along with efforts to
strengthen the representation and capacities of marginalized in the locally elected bodies,
and to devolve necessary resources and power (staff and programmes) along with
responsibilities. On sensitive SRH issues which go against cultural norms, the broader
cultural environment may need to be sensitised. Ensuring these pre-conditions is a key
challenge in the coming years. Otherwise, there is a danger that decentralisation becomes
a way of transferring the blame for failure to meet health and SRRH needs from
government to communities (Conference on CBHC 1997, Mills 1990:13)

Irrespective of whether one is within or outside the buses, and which organization one
belongs to, a challenge in the coming years is to facilitate the direct participation of
marginalised people in health/SRH policy and management or the participation of NGOs
with accountability to such groups (e.g. including marginalised groups in the Board).
Representation of marginalised through powerful groups in communities or NGOs with
little accountability to marginalised groups should be avoided.

The capacity of marginalised groups (time, information, literacy, skills, resources) and at
times NGOs to engage in policy advocacy or health/SRRH management is, however,
limited. Thus financial investment by the state in capacity building is a must, demanding more state funding. This contradicts the neo-liberal paradigm which dominates the community participation discourse of public sector reforms of cutting back state expenditure, and increasing community (and private sector) contributions. While mobilising donor funds is an option for resource-scarce governments for supporting participation of marginalised groups, there are limitations of donor involvement. Most donors have their own health and reproductive health agenda, which may or may not match priorities of marginalised groups. Further, sustaining the quality of support extended by NGOs to marginalised groups beyond the donor project period is another issue. Thus a major challenge is ensuring sustained funding for capacity building for participation and accountability, as well as for actual costs of participation (e.g, travel, food, opportunity costs) in SRH policy/programmes.

A related issue is the limited time available on the hands of poor, in particular poor women, to participate in health policy formulation or management, and their desire to do so. Often elite sections of communities access services without contributing their labour or time in any way, while poor people are expected to expend their already stretched time in the name of community participation. Hence to be non exploitative, utilitarian or manipulative kind of community participation, wherein community participation is restricted to the level of contribution of labour and time or their consent is got for predetermined activities, should be avoided. Further, community participation in policy formulation process should be matched by strategies to enforce their implementation.

Finally, the analysis in this paper reiterates views, articulated in the conceptual section, vis. community participation and accountability strategies, irrespective of whether they are operationalised within or outside the context of reforms, can actually further community accountability with respect to health and SRH services (for that matter, any development service) only when three key pre-requisites exist: i) the state is governed by a democratic regime which is elected through free and fair elections, represents the interest of marginalized, and allows media and judiciary to function independently, ii) where laws do not reflect social inequalities, iii) where the social-cultural context is egalitarian, and a cultural of claiming rights exists In the absence of these preconditions, there are limits of what can be achieved by putting in place quick fix solutions for community participation and accountability. Thus community participation and accountability cannot be added on through HSRs irrespective of context, a challenge is to push for such contexts in the first place.

5.2 Recommendations:

The implications of this analysis of issues and gaps are many, and are different for different stakeholders in Asia. National governments and multi-lateral and bi-lateral aid agencies are best suited for implementing/furthering recommendations that are related to systems and procedures, while non-governmental organisations and social movements (in particular women’s health movements) are more suited to implement those recommendations that are to do with reversing issues of power and social norms.
Recommendations to policy makers and planners from government and aid agencies

It is recommended that the World Bank, national governments, WHO and aid agencies ensure that HSRs in Asia compulsorily include a strong component of strengthening community participation in, and accountability with respect to, health/SRH policies and programme management. They should enter “participation contracts” with representatives of civil society organisations, which truly share powers of decision making with respect to both policy and programme management. Mechanisms for dealing with non-implementation of policy recommendations agreed upon may also be spelt out as part of the participation contract.

As the World Bank and aid agencies normally support time bound projects, it is important that national governments in Asia frame a national policy (or sub policy within health or SRH policy) on community participation and accountability, which will continue beyond the project time-frame. Task forces may need to be established by national governments at central, provincial and district levels to monitor implementation of community participation and accountability policy, and indicators on community participation and accountability may also need to be evolved.

Given that community financing does not necessarily promote community accountability, it is important that the World Bank moves away from the assumption of linear linkage between the two. Instead the World Bank, as well as national governments and aid agencies, should promote multiple strategies to ensure community accountability of health and SRH services discussed in this paper, in particular those which promote political accountability, i.e. accountability of policy makers with respect to the relevance and impact of the policies they make. While devolution is important to strengthen political accountability, strategies to bridge inequalities in resources between different local government units, ensure representation of women and other marginalised groups in locally elected bodies, and build their capacities to participate in these forums need to be promoted by national governments, aid agencies and the World Bank.

As promoting community participation and accountability requires investment of resources in capacity building (of communities, CSOs and government staff) and, at times, compensating for time spent by marginalised groups, it is important that national government allocate required budget for the same, and the World Bank and aid agencies consider supporting this component as a grant. Resources- financial and technical- should ideally be allocated to document and scale up successful pilot endeavors in community participation and accountability in public health and SRH policy and services across and within countries, in demanded and invited spaces, while paying attention to the lessons and contexts that made these a success.

Recommendations to community organisations, NGOs and social movements:

Since promoting accountability demands reversing relations of power between state and citizens, national governments are not easily going to agree to operationalise some of the strategies that challenge this hierarchy. This is particularly true of dictatorial regimes and weak democracies. Civil society organisations (CSOs) in Asia hence have a key role to
play in promoting the pre-conditions for official mechanisms for community participation and accountability to be effective, ensuring that participation contracts are adhered to, and putting pressure to further health and SRH policies where necessary. Specifically, five kinds of interventions are recommended for civil society organisations (community organisations, NGOs, social movements and research institutions): advocacy, expanding women’s agency, capacity building, research, and pilot interventions.

CSOs need to study existing official policies and strategies for community participation and accountability with respect to health and SRH services in their country/region, and put pressure on their respective governments to fill in gaps, and monitor and support (through capacity building inputs) operationalisation of these policies and strategies. In fact, in the case of countries ruled by dictatorial regimes or weak democracies, CSOs may first need to press for free and fair multi-party electoral processes to take place, and raise awareness amongst the public on their political rights and responsibility to vote progressive parties to power.

There is need for CSOs to influence the broader health and SRRH legislation, policies and budgets which have a bearing on outcomes of community participation and accountability. Many countries are yet to put in place progressive legislation and policies with respect to contraception, abortion services, preventing and addressing violence against women, adolescent reproductive health (see introduction chapter in this volume). The country assessments around Millenium Development Goals and Poverty Reduction Strategy Papers are yet other policy spaces to influence. In instances where favourable SRH policies and legislation are in place, but cultural and religious barriers prevent their implementation, it is important for CSOs to influence the broader environment on gender and SRRH concerns. Thus strategies would have to be country specific within the Asian region.

Given the complexity of issues of representation by middle class of interests of marginalised, an aspect that merits further study, CSOs in Asia need to organise women and other marginalised groups and build their capacity to enter and make use of spaces for community participation and accountability, be it community health structures, locally elected bodies or consultations feeding into policy. At the same time, CSOs need to be cautious not to overstretch the already stretched time of marginalised, and examine in different contexts the interests of different marginalised groups to participate. This is indeed a tricky balance to achieve.

As not all civil society organisations are sensitive to issues of community accountability and SRRH concerns, it is important for SRRH groups (amongst CSOs) to sensitise professional councils, trade unions and other groups on medical ethics, accountability and SRRH concerns, and support them to place SRH issues into their agenda, and build alliances with them to bring about above changes in government policy. SRRH groups may need to draft model guidelines that could be used by government, professional councils, consumer movements, and citizen’s groups for regulation of health sector/services (including SRH services).
There is a need for CSOs with research skills to examine further context specific issues that have a bearing on community participation in, and accountability with respect to SRH services. For example, the inter-linkages between democracy and community participation and accountability, as well as different degrees of inequalities (gender and others) and different literacy levels and degrees of participation and accountability. Bridging country and regional gaps in literature indicated in the introduction is another challenge. Last but not the least, the actual working of community participation in demanded and invited spaces, need to be better documented, and lessons learnt from successful experiences around controversial, new and low priority health and SRH issues.

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**ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AC</td>
<td>Accountability to communities</td>
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<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency syndrome</td>
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<td>AP</td>
<td>Andhra Pradesh</td>
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<td>ARROW</td>
<td>Asian Pacific Resource and Research center for Women</td>
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<td>BKKBN</td>
<td>Indonesian Family Planning Coordination Board</td>
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<td>CP</td>
<td>Community Participation</td>
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<td>CAG</td>
<td>Consumer Action Group</td>
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<td>CBO</td>
<td>Community Based Organisation</td>
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<td>CBHC</td>
<td>Community Based Health Care</td>
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<td>CHC</td>
<td>Community Health Committees</td>
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<td>CEHAT</td>
<td>Center for Enquiry Into Health and Allied Themes</td>
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<td>CIROAP</td>
<td>Consumer International Regional Office for Asia and Pacific</td>
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<td>CMS</td>
<td>Cooperative Medical Scheme</td>
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<td>CSO</td>
<td>Civil Society Organisation</td>
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<td>DAWN</td>
<td>Development Alternatives With Women for a New Era</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>ESP</td>
<td>Essential Service Package</td>
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<td>HPSS</td>
<td>Health and Population Sector Strategy</td>
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<td>HIV</td>
<td>Human Immunodeficiency virus</td>
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<td>HSRs</td>
<td>Health sector reforms</td>
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<tr>
<td>HSRI</td>
<td>Health System Research Institute</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IDS</td>
<td>Institute of Development Studies</td>
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<td>IUD</td>
<td>Intra-uterine device</td>
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<td>IMF</td>
<td>International Monetary Fund</td>
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<td>LHB</td>
<td>Local Health Board</td>
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<td>LGU</td>
<td>Local Government Unit</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>M &amp; E</td>
<td>Monitoring and evaluation</td>
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<td>MSH</td>
<td>Management Sciences on Health</td>
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Neoliberalism refers to the resurfacing of the economic theory promoted by the European Economist Adam Smith in 1776, calling for the abolishment of state role in economic matters, and leaving it to markets to promote economic development and growth. Economic liberalism prevailed in the United States through the 1800s and early 1900s. This theory was challenged by Keynes in the aftermath of the economic depression in the 1930s. He expressed that full employment was necessary for capitalism to grow and it can be achieved only if governments and central banks intervene to increase employment. The capitalist crisis over the last 25 years, with its shrinking profits has led to resurgence of free market theory, which now dominates the thinking of the World Bank and the International Monetary Fund (Creative Resistance, 2002) http://www.bcpolitics.ca/left_neo.htm.

The WDR, 1993 of the World Bank conceives that community financing will make health providers more accountable to their clienteles (as they pay for the service) and will thus improve reliability and quality of services (see WDR, 1993, p 159, parenthesis added).

Mills 1990 distinguished between three different models of decentralisation: devolution, de-concentration and delegation. Under devolution, political and administrative authority for health is transferred to locally elected government units. Under de-concentration, administrative responsibilities are transferred from central to provincial or district levels of health administration. Under delegation, management responsibility is transferred to a semi-autonomous entity representing different interest groups. The three models are discussed at greater length in the decentralisation paper in this volume.

See the examples cited in Table 3 of community health structures established in Bangladesh and Cambodia, community volunteers system in Cambodia and community financing institutionalised in
Pakistan and Orissa, all as part of Health Sector Reforms in these countries/provinces. (World Bank, 1998a, 2002a, 2002d, 1998d)

5 A review of 18 World Bank documents on health sector reform projects in Asia (see endnote 16 for details of the projects reviewed), reveals that in 6 community participation is weak, in 6 community participation is more at an instrumental level, and in six (listed below) community participation of a higher degree is emphasized, i.e. in policy formulation and programme management. HSRs in Bangladesh, Uttar Pradesh, and Cambodia envisage community participation in design of health sector reforms (through consultations and stakeholder forums), and in Philippines, Andhra Pradesh, India and Orissa, India in management and monitoring of health services (through devolution, hospital advisory committees and district health committees) (World Bank 1998a, d, 2000a, 2002a, c). Of these, the Bangladesh experience in promoting community participation while framing Health and Population Sector Strategy, which is part of World Bank initiated reforms, alone appears well documented, and has been reviewed in section 3 of this paper.

6 The term ‘marginalised people’ refers to those who are disadvantaged through their lower position in unequal social relations of gender, race, class, caste, ethnicity, religion, minority status, sexual orientation, age, physical ability and so on. Context and situation specific analysis is required to arrive accurately at who is marginalised, but in Asia this category often includes women, those in the informal sector, landless, marginal farmers, dalits, tribal population, indigenous groups, people from minority ethnicities and religions, lesbians and gays, adolescents and elderly.

7 The term sexual and reproductive rights and health is defined in the introductory chapter of the book.


9 Gibbon 2000 distinguishes between eleven ranges in depth of community participation, of which five have been cited in this table. The depth of participation under information is low, in the sense that there are no mechanisms for feedback. Under manipulation the local people are made to act as public relations vehicle, mouthing the message of the intermediary organisation. Under advice, organisations present a plan of action, invite questions from the community, and are prepared to modify based on feedback. Consultation is different from advice in the sense that views of the people are solicited with the aim to facilitate acceptance from the community or gain compliance. Collective Action refers to situations when the local people set their own agenda and mobilise resources to carry it out without outside support.

10 Cornwall, Lucas and Pasteur (2000), make a distinction between participation in invited and demanded spaces. Invited spaces are those created and substantively controlled by health planners and policy makers, while demanded spaces are those demanded, created, claimed or chosen by communities or the health movements themselves.

11 For an introduction to the concept of oversight in the health sector, and examples of its operation in SRH services in India, see Peters, David H, 2002.

12 Smith Sreen (1995) distinguishes between different kinds of accountability based on the function they serve. Financial accountability refers to accountability with respect to resource mobilisation, allocation and use. Input accountability refers to delivering inputs on time, of the right quality, and in the right place. Output accountability refers to whether the expected outcomes are being reached or not (for example, drop in repeat STI cases coming for treatment). Impact accountability refers to whether the outcomes are leading to the anticipated impact (for example, drop in STI incidence in the area covered by the center), and relatedly social accountability refers to the relevance of the choice of intervention itself. Newell and Bellour (2002) classify these different kinds of accountability into two categories: political and managerial accountability, with the former referring to accountability with respect to decisions (social and impact accountability), and the latter refers to accountability in carrying out tasks according to agreed performance criteria (financial, input and output). The focus of this paper is on all these aspects, and particularly with respect to political dimensions or impact and social relevance.

13 Newell and Bellour (2002) classify these different kinds of accountability into two categories: political and managerial accountability, with the former referring to accountability with respect to decisions (social and impact accountability), and the latter refers to accountability in carrying out tasks according to agreed performance criteria (financial, input and output).

14 This is an adaptation of Church et al, 2002 and Hulme and Sandaratne, 1997 who make a distinction between pre-audit or ex-ante accountability and post-audit and ex-post accountability. Pre-audit or ex-ante accountability refers to accountability before commencing or implementing a health programme. The purpose of pre-audit or ex-ante accountability is to prevent errors. Accountability to communities at this
stage helps ensure that policies and plans are responsive to their needs and their preferences regarding service organisation are taken into account. Post-audit or ex post accountability, on the other hand, is carried out after implementing a health program. The purpose of post-audit accountability is to detect error in order to improve future services.

15 Church et al (2002) make a useful distinction between four natures of accountability and mechanisms for enforcement: bureaucratic accountability, legal accountability, professional accountability and institutional accountability. Bureaucratic accountability refers to accountability of lower level staff to higher ups enforced through guidelines, government orders and memos. Legal accountability refers to accountability of health staff to the judiciary and legislature enforced legally by the courts. Professional accountability refers to accountability of health professionals to professional bodies like medical associations and unions, enforced through penalties, removal of registration and legal action. Institutional accountability refers to accountability of health personnel to clients and other stakeholders, enforced morally or through community pressure.

16 Communication with Gabrielle Ross, WHO South East Asian office.

17 The 18 HSR (national or provincial) projects of the World Bank reviewed cover the following Asian countries: Bangladesh, Cambodia, China, Indonesia, India, Kazakhstan, Kyrgyzstan, Laos, Pakistan, Philippines, Uzbekistan and Vietnam. For details see World Bank, 1994, 1995d, 1998a, 1998b, c,d,e,f, 1999a, 2000a, b, 2001a,b, 2002a,c, d and www4.worldbank.org/sprojects/Project.asp?pid=P003483 (Integrated Regional Health Development Project China) and www4.worldbank.org/sprojects/project.asp?pid=P004518 (Health Development Project, Philippines).

18 Prepayment schemes are also part of Health Sector Reforms in Cambodia, but are not mentioned as part of the strategy for strengthening community participation or accountability (World Bank, 2002a)

19 Cornwall, Lucas and Pasteur, 2000 make the distinction between demanded and invited spaces. See endnote 10 for details.

20 See endnote three for a brief explanation of different models of decentralisation.

21 Discussion with Nari Pokko, Bangladesh NGO, representatives Shireen Huq and Rina Sen Gupta.

22 Personal communication with Shireen Huq, Nari Pokko and Nasreen Huq, ex Nari Pokko.

23 Personal communication with a woman’s organisations that took part in consultations in Bangladesh

24 RH services through public health delivery are still weak for elderly and adolescents. Violence against women is not a seen as a reproductive health issue.

25 For example, in some instances recommending that the state rehabilitate sex workers and get them married

26 46000 or 62% of the DOH’s employees, 12850 rural health units, municipal health centers and barangay health stations, and 594 public hospitals were transferred from the control of DOH to the of local government units (cited in Bossert, et al, 2000).

27 Communication with members from Philippines in the Programme Advisory Committee of ARROW.


29 1 Chinese Yuan = 0.120882 US$ as of November 3\textsuperscript{rd}, 2003

30 Details of preparatory activities were not available

31 Under the Medical Termination of Pregnancy Act of 1971 doctors should provide services to terminate pregnancies if it protects the health and well being of the mother.

32 Iyer (1996) observes that in the state of Maharashtra, India on an average only one case per year was placed before the Dental Council since 1990 and even fewer before the Council of Indian Medicine. The Council of Homeopathy received a slightly higher figure of five to six complaints per year. There are very few examples of disciplinary actions taken on the basis of investigations on complaints received.

33 The HSRs with a SRH component include Health and Population Project Bangladesh (World Bank 1998a, focus on FP and MCH), Cambodia-Health Sector Support project (ibid, 2002a, focus on STI/HIV), Orissa-Health Sector Development project (ibid, 1998d, focus on MCH), Socialist Republic of Vietnam-Population and Family Health Project (ibid, 1995d, focus on FP), Laos Health System Reform and Malaria Control Project (ibid, 1994, with a focus on FP), China Regional Health Development Project (focus on MCH), The Pakistan Northern Health Programme Project (ibid, 2002d, with a focus on MCH)

34 Personal communication with a health activist in Bangladesh.

35 Of community representatives, elected bodies, groups that represent interests of marginalised in community, of health providers, workers and inspectors, of policy makers from government
The term internal health system refers to aspects such as the way health administration is organized and covers aspects such as organizational structure, staffing, job description, human resource development policies etc.

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