Policy Brief

Strengthening service accountability and community participation in health sector reforms

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Background

Sexual and reproductive rights based groups have been demanding greater accountability of public and private health and sexual and reproductive health (SRH) services to marginalised groups. This lobby sees community participation as a human right of citizens, and one of the main strategies to deepen accountability of health institutions to the health and SRH needs of marginalised groups.

The World Bank supported health sector reform (HSR), as has been seen over the last one and a half decades, also calls for greater community participation and accountability of public and private health institutions. World Bank supported HSRs recommend the establishment of community participation structures, decentralisation of health services, and community financing, as strategies for strengthening public health sector accountability.

The review carried out by The Initiative for Sexual and Reproductive Rights in Health Reforms (known as Rights and Reforms) on community participation and sexual and reproductive (public) health service accountability in the context of the World Bank supported health sector reforms in Africa, Asia and Latin America and the Caribbean, reveals that community participation has been envisaged mainly in health programme management and service delivery. The design of policies (including broader reform policies), legislation and allocation of budgets, are not given the same consideration.

Community Participation and Accountability

The limited literature on community participation within HSRs suggests that community representatives have at best been consulted, but have not had decision-making powers. Marginalised groups, and health and sexual and reproductive rights groups, have tended to be less included in consultations or represented in community participation structures than the elite and mainstream health non governmental organisations (NGOs). Community financing strategies have not automatically strengthened health service accountability, let alone sexual and reproductive health (SRH) service accountability, as poor/poor women at times self-exclude themselves if they have to pay for services. Hierarchies in power and information between providers and clients have also undermined community participation and accountability.

Within decentralisation, it is mainly the devolution model that provides room for strengthening community participation and accountability. Here again, the SRH service outcome depends on the following:

- The space available to these structures to make decisions;

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• SRH and rights capacity of elected members;
• The representation, information base, and negotiation skills of marginalised groups; and
• The extent to which the local culture supports SRH and rights.

The preconditions for strong community participation and accountability include the involvement of rights based groups, adequate investment of resources in capacity building, and a tradition of vibrant democracies.

As a result of a combination of the above factors, community participation in the World Bank supported health sector reforms has, with few exceptions, been limited to the provision of maternal health, family planning and prevention of STIs/HIV/AIDS, downplaying the provision of comprehensive SRH services. Neglected areas have included controversial issues such as the provision of abortion services and complications arising out of violence, new areas such as adolescent SRH, low priority areas such as infertility and reproductive cancers, and high cost areas such as treatment for STIs/HIV/AIDS. In addition, most reforms initiated by the World Bank placed low importance on the provision of sexual and reproductive health services for adolescents, the elderly, and those too poor to pay user fees.

On the whole a low level accountability has been promoted. This includes accountability with regard to the implementation of decisions rather than making of decisions, accountability of health workers rather than policy makers, and accountability to the elite rather than marginalised groups. Strategies for enforcement of accountability mechanisms when public health policy makers, planners, doctors and workers, behave unaccountably are rarely emphasised. Thus, though the World Bank has co-opted the participation and accountability language of rights based groups, the underlying perspectives are vastly different.

**Pressure from below**

Civil society groups that have demanded participation in, and accountability of public SRH services, have been more successful in promoting the implementation of controversial legislation, where it exists. Examples from India include:

• The implementation of legally approved abortion services;
• The implementation of legislation against sexual harassment at the work place; and
• Challenging violations of reproductive rights of women by the state (e.g. unsafe trials of harmful contraception).

Civil society groups have also in some instances been successful in advocating user fee exemptions for public maternal health services (e.g. Community Working Group on Health in Zimbabwe), monitoring expenditure on health and reproductive health (e.g. Uganda Debt Network) and pressing for accountability of doctors (e.g. Center for Enquiry Into Health and Allied Themes in India).

However, such participation has tended to be reactive rather than pro-active, and has not been successful in pushing for adequately funded comprehensive sexual and reproductive health policies (covering controversial, low priority and high-cost but essential sexual and reproductive health services). Such participation is difficult to sustain over time. Sustainability has depended on whether the alliance is strong enough to support shared leadership and whether members are able to dedicate the
required time to alliance work over and above their routine work. Marginalised groups have rarely been at the forefront of such struggles, unless the leading organisation itself is mass based, which is rare. Vibrant democracies, investment in capacity building and alliance building across stakeholders, are other pre-requisites for demanded participation to thrive, conditions which are not always present across countries.

The Problem

Policy makers, planners and civil society actors need to strengthen community participation and service accountability within World Bank supported health sector reform processes in order to ensure that affordable, accessible and good quality comprehensive SRH services are provided through public health systems, to marginalised groups.

Organisational strategies and policy options for civil society groups

Organisational strategies are different for different stakeholders. For civil society groups there are three options:

- **Organisational Strategy Option 1**: To enter the negotiation table and influence the direction of HSR from within in order to ensure that they prioritise comprehensive, affordable, accessible, and quality SRH services for all marginalised groups, and are accountable with regard to their implementation. The advantage of this strategy is that, if successful, accountability of a higher order can be promoted i.e. with regard to both what decisions are taken and how they are implemented. The danger is that civil society participation could be used to legitimise decisions already taken or that the language of rights could be co-opted without adherence to the principles.

- **Organisational Strategy Option 2**: To stand outside reform processes, and put pressure on decision makers within the World Bank and Regional Development Banks, national governments, and organisations consulting with above groups in order to ensure that they prioritise comprehensive, affordable, accessible and good quality SRH services for all marginalised groups. The advantage of this strategy is that the pitfalls in direct engagement can be avoided. If successful, pressure from outside could lead to formulation and implementation of gender equitable, rights based SRH policies. The disadvantage of this strategy is that often advocacy and lobbying of civil society groups from outside policy making process is reactive to anti-SRH and rights policies, rather than proactive in pressing for comprehensive SRH services for all groups. Sustaining this kind of momentum is difficult in the long run. A strong tradition of democracy( independent elections, media and judiciary) is necessary.

- **Organisational Strategy Option 3**: To adopt a mixture of both strategies at the same time, with some members of a group/some groups following the first strategy, and others the second. The advantage of this option is that it allows for optimising the strengths of both strategies, while safeguarding against cooption, being too reactive, and a drop in sustained action. This approach also allows for effective use of the variety of skills within community groups and individuals that may compliment either or both strategies. The danger is, of course, that civil society action may not always be coherent.

If civil society groups decide to participate in health sector reform processes (option 1 or part of 3), it is recommended that they negotiate for:

- ‘Participation-contracts’ between civil society actors and governments/the World Bank spelling out who should participate (rights groups, in particular those led by marginalised groups), the scope (in design, monitoring and evaluation), and intensity of participation (decision making); and

If civil society groups decide to put pressure on the health sector reform process from the outside (option 2 or part of 3), civil society groups should:

- Form alliances with each other (including progres-
sive members of professional associations, consumer rights groups and trade unions), and people within the World Bank, governments, researchers and donors who promote rights based SRH policies;

• Develop non-negotiable principles and mechanisms for resolving issues of leadership and decision-making within alliances; and

• Develop a long term advocacy strategy for bringing about changes in HSR policies and practice that ensure SRH service accountability.

Irrespective of the organisational strategy adopted, civil society groups need to negotiate for:

• Expanding the range of community participation and accountability strategies that are used within health sector reforms beyond community participation structures, decentralisation and quality assurance systems (for details see recommendations to the World Bank, donors and national government);

• Prioritisation of comprehensive SRH services and rights within HSR objectives and targets, paying particular attention to reaching marginalised groups in society;

• Removal of user fees for essential SRH services like delivery, contraception, abortion, (detection and treatment of) STI/RTI infection, and violence related complications;

• Strengthening of representation and building the capacities of marginalised groups, representatives of local bodies on claim making and SRH; and

• Strengthening of democratic spaces in their countries, reduction of poverty and social inequalities by their governments.

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Policy Options for the World Bank, national governments and donors

The World Bank, national governments and donors need to move beyond paying lip service to issues of community participation and health/SRH service accountability within HSRs. They have two main policy options:

• Policy Option 1: Establish an independent commission in partner countries to facilitate and oversee community participation and health/SRH service accountability (both within and beyond HSRs), and give it judicial powers and adequate resources. The advantage of an independent commission is that it can, in principle, be free of control by national governments, World Bank and donors, and there is scope for promoting participation and service accountability of a higher order. Having judicial powers, the recommendations of commissions could be binding. It needs to be noted, however, that people who represent the interests of national governments often head commissions hence their actual autonomy is an issue. Ensuring mechanisms for strengthening the accountability of commissions to marginalised groups is another concern.

• Policy Option 2: To set up a committee or task force within the Ministry of Health of national governments to facilitate and oversee community participation and health/SRH service accountability within and beyond HSRs. The advantage is that there is no legislation required for setting up a committee, and it can be easily put in place. It is seen as less threatening, and may be more acceptable to governments and the World Bank. On the other hand, task forces are normally only advisory in nature and have little power to promote participation or service accountability. However, like commissions, normally task forces are overseen by bureaucrats, ministers or pro-government actors, whose accountability and SRH sensitivity may vary.

Irrespective of whether commissions or task forces are established it is recommended that the structure:

• Counts on the participation of women’s health and rights groups (in particular those led by marginalised groups), health researchers, pro-
gressive members of professional associations, consumer rights groups, and health policy makers;

- Is headed by a SRH and rights sensitive person from a civil society group, who is not aligned to any political party;

- Strengthens legislation for community participation and service accountability, within and beyond HSRs, governing areas such as the right to participation, right to use public interest litigation, right to information on public documents, rights of patients vis-a-vis providers and institutions, and professional regulation;

- Strengthens mechanisms of community participation and accountability with respect to health policy like calling for public inputs on health and SRH policies/legislation through posting of advertisements requesting for inputs in media and public hearings;

- Strengthens mechanisms for accountability with regard to implementation of policies like promoting citizen oversight of budget allocation, health expenditure, and rules and protocols from national to local levels;

- Strengthens community participation and accountability structures with regard to planning and implementation like the establishment of district level health committees, hospital boards, local health service committees, local health boards attached to local bodies - ensuring quotas for marginalised groups; and

- Allocates resources for capacity building for participation and accountability, specifically capacity building of members of structures for community participation, Commissions/task forces, as well as health providers.

On the whole, promoting community participation and health/SRH service accountability within HSR requires considerable investment of time and resources. This contradicts the neo-liberal assumption that community participation and the rolling back of the state go hand in hand. It can also not simply be added without regard for the socio-political and economic context. To succeed, the rationale for community participation and accountability has to look beyond the neo-liberal approach.


The full text of the book can be found at www.wits.ac.za/whp/rightsandreforms/globalvolume.htm

Other policy briefs in this series include Health sector reforms in the 1990s: Implications for sexual and reproductive health services; Financial health sector reforms and sexual and reproductive health; Public-private interactions: Implications for sexual and reproductive health services; Priority Setting in the context of health sector reforms: Implications for sexual and reproductive health services; Decentralisation and implications for sexual and reproductive health services; Integration, health sector reforms and sexual and reproductive health. They can be found at www.wits.ac.za/whp/rightsandreforms/policy.htm

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