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COMMUNITY PARTICIPATION IN HEALTH: GLOBAL LITERATURE REVIEW¹

TECHNICAL PAPER

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INTRODUCTION

Background

The involvement of communities in various aspects of the health system dates back to the late 1940s when Sidney Kark and others introduced the concept of Community Oriented Primary Care based on their experiences in South Africa.^{2 3} Subsequently, based on the experiences of a large number of experiments in the provision of health care like Jamkhed^{4 5 6} and Mandwa^{7 8} in India, and a number of examples from abroad, the World Health Organization (WHO) incorporated the concept of Community Participation as one of the central tenets of the Alma

² Longlett, S.K., Kruse, J.E. & Wesley, R.M., 2001. Community-oriented primary care: historical perspective. *The Journal of the American Board of Family Medicine*, 14(1), 54

³ Yach, D. & Tollman, S.M., 1993. Public health initiatives in South Africa in the 1940s and 1950s: lessons for a post-apartheid era. *American Journal of Public Health*, 83(7), 1043.

⁴ Arole, M., 1988. A comprehensive approach to community welfare: growth monitoring and the role of women in Jamkhed. *Indian Journal of Pediatrics*, 55, 100–105.

⁵ Arole, M. & Arole, R., 1994. Jamkhed: a comprehensive rural health project.

⁶ Arole, R., 2001. Community based health and development: the Jamkhed experience. *Health Promotion Journal of Australia*, 11(1), 5–9.

⁷ Antia, N.H., 1986. The Mandwa experiment, an alternative strategy. *British Medical Journal*, 292(6529), 1181.

⁸ Antia, N.H., 1988. The Mandwa project: an experiment in community participation. *International Journal of Health Services: planning, administration, evaluation*, 18(1), 153.

Ata Declaration. Community participation was also a crucial feature of various movements like the Women's movement and the People's health movement. Among these groups the demand for participation has been on the basis of the Right to participate.

Two broad motivations for the interventions to involve communities at different levels may be discerned:

- The rights approach: In this approach, participation in any system that is affecting them is seen as the right of the community.
- The efficiency approach: In this approach participation is seen as a means to an end. Many of the benefits of technological interventions that were meant to bring about 'development', especially in the post war period when a number of developing countries won independence from colonial rule, never reached the people who needed them the most. Thus it was felt that community involvement, by enlisting the voice and 'wisdom' of the community and increasing ownership, would enable the benefits to reach all those who needed them.

Parallel to these early trends was also the move towards decentralization at the system level. Decentralization was also seen largely from the point of view of efficiency and taking governance closer to the people. It was obvious that in decentralized systems people would have more chances to participate and express their views. People's participation in health

systems also came to be seen as crucial from the point of view of accountability of the system to the people and the consequences for governance.⁹

A number of findings also increased the awareness among development experts about the capacity of local communities to participate meaningfully. Some examples of these are:

- Successful training of a number of minimally educated and poor women to perform quite complicated tasks as health workers and assistants at hospitals.^{5 8}
- Work by a number of 'participatory' researchers, led most prominently by Robert Chambers, beginning from the field of agriculture, showed that communities had the capacity to appreciate the complexity of local issues and provide unique insights into various problems.^{10 11 12} Such work has resulted in a number of uses of participatory methods in planning and monitoring in a wide range of fields, from work in HIV/AIDS to responses in post-disaster situations.
- The consistent and significant body of research on the management of natural pool resources, Elinor Ostrom¹³ and others showed that left to themselves communities

⁹ Potts, D.H., 2008. Participation & the right to the highest attainable standard of health. *Human Rights Centre, University of Essex*. Available at: http://hrbportal.org/wp-content/files/1247661790_8_1_1_resfile.pdf.

¹⁰ Chambers, R., 1994a. Participatory rural appraisal (PRA): Analysis of experience. *World development*, 22(9), 1253–1268.

¹¹ Chambers, R., 1994b. Participatory rural appraisal (PRA): Challenges, potentials and paradigm* 1. *World Development*, 22(10), 1437–1454.

¹² Chambers, R., 1994c. The origins and practice of participatory rural appraisal* 1. *World development*, 22(7), 953–969.

¹³ Economics Nobel Laureate 2009

actually managed common pool resources as well as or better than governments and experts.^{14 15}

The rights approach

It has been noted that, “Participation is a crucial part of the extensive common ground shared by health and human rights”.⁹ Furthermore, “The active and informed participation of people and groups in all health-related decision making is a component of the right to the highest attainable standard of health (CESCR General Comment 14)”.¹⁶ The right to health places the well-being of people, groups, communities and populations at the centre of a health system. In the context of health systems, this includes active and informed participation in the identification and development of health policy, as well as in its implementation and ensuring accountability.¹⁷ Under this approach it is the duty of the government/system to create such structures and environments as to enable the participation of all, including, and especially, the most marginalized and poor.⁹ In the 2008 World Health Report titled, ‘Primary Health Care: Now More Than Ever’, the international body details the present conceptualization of participation as given below:

¹⁴ Ostrom_lecture.pdf. Available at: http://nobelprize.org/nobel_prizes/economics/laureates/2009/ostrom_lecture.pdf [Accessed February 4, 2011].

¹⁵ Ostrom, E., 2010. Beyond markets and states: polycentric governance of complex economic systems. *American Economic Review*, 100(3), 641.

¹⁶ Committee on Economic, Social and Cultural Rights, General Comment No. 14: The right to the highest attainable standard of health (2000) UN Doc E/C.12/2000/4, paragraph 54. URL: www2.ohchr.org/english/bodies/cescr/comments.htm (accessed 13 August 2008).

¹⁷ Hunt, P. (2008) Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health UN Doc. A/HRC/7/11, 31 January 2008, paragraph 38. URL: www2.essex.ac.uk/human_rights_centre/rth/reports.shtm (accessed 13 August 2008).

“The PHC (Primary Health Care) values to achieve health for all require health systems that: *“Put people at the centre of health care”*.⁴ What people consider desirable ways of living as individuals and what they expect for their societies – i.e. what people value – constitute important parameters for governing the health sector. PHC has remained the benchmark for most countries’ discourse on health precisely because the PHC movement tried to provide rational, evidence-based and anticipatory responses to health needs and to these social expectations.^{5,6,7,8} Achieving this requires trade-offs that must start by taking into account citizens’ *“expectations about health and health care”* and ensuring *“that [their] voice and choice decisively influence the way in which health services are designed and operate”*.⁹ A recent PHC review echoes this perspective as the *“right to the highest attainable level of health”, “maximizing equity and solidarity”* while being guided by *“responsiveness to people’s needs”*.⁵ Moving towards health for all requires that health systems respond to the challenges of a changing world and growing expectations for better performance. This involves substantial reorientation and reform of the ways health systems operate in society today: those reforms constitute the agenda of the renewal of PHC”¹⁸

¹⁸ WHO 2008, World Health Report – Primary Care Now more than ever (www.who.int/whr/2008/whr08_en.pdf)

CONCEPTUALIZING PARTICIPATION

Common Frameworks

While participation became a catch word very soon, its implementation varied due to the potential challenge to the status quo resulting from such participation, and the mindset of the people responsible for implementing these programmes, who were socialized into believing that a hierarchy existed between experts and lay people. There was also a wide variation in the usage of the term “participation” by the different groups, in response to which attempts were made to classify the various aspects of participation.

The concept of the “Ladder of Participation” was introduced to describe the 'increasing' participation of communities in health. Rungs on the ladder represented increasing degrees of participation, from: non-participation or manipulation and therapy; through the tokenism of informing, consulting and placating; to citizen power through partnership, delegated power and citizen control.¹⁹

Murthy and Klugmann devised another framework based on a number of studies which they used to assess the quality of community participation in various projects of the World Bank.²⁰ This is presented below:

¹⁹ Arnstein, S.R., 1969. A ladder of citizen participation. *Journal of the American Planning Association*, 35(4), 216–224.

²⁰ Murthy, R.K. et al., 2005. Service accountability and community participation. *RADP (Ed.) The Right Reforms*.

Table 1. Community participation (CP): lower to higher degrees of participation

	Lower degree of CP	Middle degree of CP	Higher degree of CP
Definition of community	Clients or users	Relatively easy to reach people living in an area	Marginalized groups of the population
Who represents community	Powerful clients	Powerful groups in population; NGOs who represent community	Marginalized groups in population; NGOs who represent their interests
Rationale for CP in health	CP as a means to – expand outreach – raise resources – support infrastructure	CP as a means to – improve management of local health services (efficiency)	CP as a means to – increase effectiveness – improve accountability
Depth of CP	Manipulation Informing	Advice/consultation	CP as a right by itself Collective or community decision-making
Scope of CP	Service delivery	Service delivery and management at periphery	Health policy, health management and service delivery at all levels
Mode of CP	As individuals Through invitation by government	As members of small collectives Often through invitation by government	As members of mass-based organizations and small collectives Both through invitations, and demands from below. ^a

Sources: Church et al. (2002), Cornwall et al. (2000), Gaventa et al. (2002), Gibbon (2000), Gonzalez (1998), Kahssay and Oakley (1999), Loewenson (1999), Mitchell and Stephen (2000), Morgan (2001) and Rifkin (1996).

^a Cornwall et al. (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.

Nilsen and colleagues, in a recent systematic review have developed the following framework:²¹

²¹ Nilsen, E.S. et al., 2006. Methods of consumer involvement in developing healthcare policy and research, clinical practice guidelines and patient information material. In The Cochrane Collaboration & E. S. Nilsen, eds. *Cochrane Database of Systematic Reviews*. Chichester, UK: John Wiley & Sons, Ltd. Available at: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.cd004563> [Accessed February 4, 2011]

Intervention	Comparison
DEGREE OF CONSUMER INVOLVEMENT (1) Consultation (2) Collaboration (3) Collaboration	DEGREE OF CONSUMER INVOLVEMENT (1) No involvement (2) No involvement (3) Consultation
FORUM FOR COMMUNICATION (1) Consultative fora, eg. town meeting, written consultation, interviews, focus groups (2) Collaborative, eg. committee membership, permanent consumer panels	FORUM FOR COMMUNICATION (1) No consumers in consultative forum - different/multiple fora for consultation (2) No consumers in collaborative forum - different/multiple fora for collaboration

(3) Collaborative forum	(3) Consultative forum (eg. invitation to a single committee meeting)
INVOLVEMENT IN DECISION MAKING (1) Involvement in decision-making implied, eg. committee membership (2) Involvement in decision-making explicit, eg. voting, ranking (3) Explicit involvement	INVOLVEMENT IN DECISION MAKING (1) No involvement in decisions (2) No involvement in decisions (3) Implicit involvement
RECRUITMENT OF PROFESSIONALS/CONSUMERS (1) Targeted, personal invitations (2) Wide advertisement (a) Mass media (b) Telephone (c) Mail (d) E-mail	RECRUITMENT OF PROFESSIONALS/CONSUMERS (1) Target, personal invitations versus wide advertisement (2) Different/multiple methods of wide advertisement
TRAINING AND SUPPORT FOR PROFESSIONALS/CONSUMERS (1) Education (2) Counselling (3) Introduction day	TRAINING AND SUPPORT FOR PROFESSIONALS/CONSUMERS (1) Training versus no training (2) Different/multiple methods of training (3) Different/multiple trainers (4) Different timing of training (introductory, on-going)
FINANCIAL SUPPORT (1) Funding/staffing specifically to support consumer involvement enterprises (2) Reimbursement of consumer expenses (3) Fee or honoraria (4) No financial support	FINANCIAL SUPPORT (1) Financial support versus no financial support (2) Different/multiple policies for financial support
PRACTICAL SUPPORT (1) For example, administrative support for consumer groups	PRACTICAL SUPPORT (1) Practical support versus no practical support (2) Different/multiple types of practical support

Newer Spaces

In the recent past there have been a number of experiments with the evolution/creation of newer spaces for participation. These spaces are represented by the formation of various committees at the local and regional level, some of which are formed by governments and mandated by constitutions (as in Brazil) are termed the 'new democratic arenas' by authors like Gaventa.²³ Such literature discerns three broad streams of people's participation:

(1) The neo-liberal stream, where people are seen merely as consumers and exercise their voice merely by making a 'choice' in the market arena.

(2) The liberal representative model, which “puts a great deal of stress on getting the institutions and procedures of democracy right, especially as measured through competitive, multiparty electoral processes. In this view, the role of citizens is somewhat passive. Citizens participate through elections, and enjoy certain rights, primarily the individual rights of freedom from interference by the states in matters of private property, expression and political association”²².

(3) An extension of the liberal representation view which is sometimes termed as the 'deepening democracy' approach. It sees participation as a, “process through which citizens exercise ever-deepening control over decisions which affect their lives through a number of forms and in a variety of arenas”. This approach believes that, “full democratic citizenship is attained not only through the exercise of political and civic rights, but also through social rights, which in turn may be gained through participatory processes, and it is also about the ‘right to create rights’ through struggles and demands from below”. While the role of civil society in these spaces is seen as largely in preparing citizens for their role in democratic institutions, and thus developing a countervailing power to the state, newer approaches talk of citizens directly engaging with the state in a relationship of “co-governance”. These participatory forms of governance, “seek to supplement the roles of citizens as voters or as watchdogs through more direct forms of involvement”.

A confluence of developmental and democratization agendas have brought citizen engagement with governance to centre stage. Common to all is the conviction that participatory fora, that open up more effective channels of communication and negotiation between the state and citizens, serve to enhance democracy, create new forms of citizenship

²² Foreword by John Gaventa, Cornwall, A. & Coelho, V.S.P., 2007. *Spaces for change?: the politics of citizen participation in new democratic arenas*, Zed Books.

and improve the effectiveness and equity of public policy. However, the limited studies done on these spaces that are being opened up, have shown that while there is great potential in these spaces, left to themselves, in their functioning they merely play out the hierarchies of the larger society. Some of the major requirements that researchers and practitioners list for these spaces in order to fulfil their democratic potential are, 'champions of change' from within the system, civil society groups who can facilitate the challenging of traditional hierarchies by people who have till now been voiceless ("schools of citizenship"). In addition, chances/platforms for discussion and negotiation, and regular updates and support are seen as essential.^{23 24}

Literature on the regulation of the health sector in developing countries shows that traditional forms of regulation like legal and self-regulation (through professional bodies) have not worked. It has been suggested that people's participation in regulation under the concept of "institutionalized co-production" will be the way forward.²⁵

Our Framework

²³ Gaventa, J et al, 2008. Power and Knowledge. In *The Sage handbook of action research: participative inquiry and practice*

²⁴ Gaventa, J. & Cornwall, A., 2006. Challenging the Boundaries of the Possible: Participation, Knowledge and Power. *IDS Bulletin*, 37(6), 122-128.

²⁵ Peters, D.H. & Muraleedharan, V.R., 2008. Regulating India's health services: To what end? What future? *Social science & medicine*, 66(10), 2133–2144.

While communities need to get involved in health systems at all levels and for all activities, experience over the past many decades seems to be clustered around the following six broad areas. We will be using these areas to structure the subsequent sections of the paper.

- **Community Health Workers:** Community members after getting short term training provide a range of services including interventions which are curative and preventive and promotive. Being from the community they are expected to act like bridges between the system and the community.
- **NGO delivery of information and services:** Communities have been involved in the health system through a number of civil society initiatives. In these instances the NGOs either put forth models providing a range of services, or government contracts out various services that the NGOs provide on its behalf.
- **Community financing:** This includes a number of community based financial initiatives which have tried to improve access to, and ownership of, the health system by pre-payment mechanisms.
- **Community monitoring, health rights and accountability:** This includes various examples of communities actually getting involved in monitoring activities and holding the health system accountable. Such monitoring may focus on availability of services, accessibility of services and quality and equity.
- **Participatory planning:** The focus is on initiatives where communities are involved in the actual articulation and evolution of village level health plans.
- **Inter-sectoral convergence:** While inter-sectoral convergence is recognized as a crucial aspect of the comprehensive PHC approach and essential for the success of any universal health care system, the exact mechanisms and structures need to be evolved based on complex local realities. While departmental differences may remain a factor for service providers and bureaucrats, for the people at the village level convergence is the rule. There is thus great potential both for non-health work benefitting the overall health of the community and also for communities to understand the importance of inter-sectoral activity and take the lead in making it happen.

THEME: COMMUNITY HEALTH WORKERS

Introduction

“Community health worker programmes have been repeatedly tried by the government – and have repeatedly failed. The surprise is not any longer in their failure. but how, despite the worst prognosis, they always bounce back – in one form or another”.²⁶

The concept of Community Health Workers (CHW) has been around since the before the Declaration at Alma-Ata. CHWs are known throughout the world by different names²⁷ but overall have similar features and roles. The universally accepted definition of CHW by the WHO is “*Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers.*”²⁸

As highlighted in the above definition and observed throughout the literature, CHWs are usually from within the communities which they serve and also selected by them.²⁸ Hence,

²⁶ State Health Resource Center, 2003. Mitandin Programme- Conceptual Issues and Operational Guidelines. Available at : <http://nipccd.nic.in/mch/fr/pi/erl7.pdf>

²⁷ Bhattacharyya, K. & Winch, P., 2001. Community Health Worker Incentives and Disincentives. *BASICS II*.

²⁸ Lehmann, U. & Sanders, D., 2007. Community health workers: What do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers. *World Health Organization*, 41

use of CHWs is often seen as a critical strategy to facilitate community participation in health care delivery. CHWs have been involved in preventive, promotive and curative initiatives.²⁹ The CHWs have been known to provide “generalist” services or “specific” services such as for tuberculosis (TB) or act as “agents of change”.²⁷ CHWs have been active in multifarious activities such as prevention and awareness campaigns on communicable and non-communicable diseases, maternal and child health (safe deliveries, breast feeding promotion, nutrition), and inter-sectoral issues (water and sanitation, literacy, income generation).

Outcomes and Impact

It has been widely reported that the implementation of programmes with CHWs as an integral part, have significantly benefitted the health of communities.^{27 28 30 31 32 33} A reason for this is that CHWs form a link between the communities and the larger health system and social system, thus they are better able to connect community needs and health system initiatives.

²⁹ Bhutta, Z. et al., 2010. Global experience of community health workers for delivery of health related Millennium Development Goals: a systematic review, country case studies, and recommendations for integration into national health systems. *Global Health Workforce Alliance, World Health Organization*, 377.

³⁰ Glenton, C. et al., 2010. The female community health volunteer programme in Nepal: Decision makers' perceptions of volunteerism, payment and other incentives. *Social Science & Medicine*.

³¹ Viswanathan, M. et al., 2010. Outcomes and Costs of Community Health Worker Interventions. *Medical Care*, 48(9), 792-808.

³² Bhutta, Z.A. et al., 2005. Community-based interventions for improving perinatal and neonatal health outcomes in developing countries: a review of the evidence. *Pediatrics*, 115(2), 519.

³³ Hermann, K. et al., 2009. Community health workers for ART in sub-Saharan Africa: learning from experience—capitalizing on new opportunities. *Human resources for health*, 7(1), 31

In areas with underserved populations, their impact is highly visible especially for certain health conditions.³⁰ During our literature review, we came across several outcomes and impact measures which have been used to assess the impact of CHW initiatives. Varied levels of improvements have been noted in different aspects of health outcomes such as knowledge, health care utilization and behaviour.³⁴ Use of CHW has improved immunization coverage.³⁵ Interventions with CHWs have resulted in a decrease in maternal and child mortality and have been crucial in reducing the burden of disease of TB and Malaria.²⁸ There have been reported improvements in health and screening related behaviours.³⁶ Although very few publications actually associate equity and the role of CHW in achieving it; the use of CHW in some cases has resulted in improvements in equity in access to health services, ensuring that the poor get access..³⁷ It is also reported that interventions using CHW appear to be more cost effective than those without the CHW component; for example when a BRAC run CHW programme was compared to a government run programme without CHW, the former turned out to be more cost effective.³⁸ But such cost effectiveness studies are rare and they do not account for other factors which come into play when considering community participation.

³⁴ Viswanathan, M. et al., 2009. Outcomes of community health worker interventions. *RTI International*, 181.

³⁵ Lewin, S. et al., 2010. Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases. *Cochrane Database of Systematic Reviews (Online)*, (3), CD004015.

³⁶ Perez, L.M. & Martinez, J., 2008. Community Health Workers: Social Justice and Policy Advocates for Community Health and Well-Being. *Am J Public Health*, 98(1), 11-14.

³⁷ Berman, P.A., 1984. Village health workers in Java, Indonesia: Coverage and equity. *Social Science & Medicine*, 19(4), 411-422

³⁸ Islam, M.A. et al., 2002. Cost-effectiveness of community health workers in tuberculosis control in Bangladesh. *Bulletin of the World Health Organization*, 80, 445–450.

Issues and Challenges

Some key issues in the roll out of CHW initiatives, which are critical in determining the success of these initiatives have been identified and listed in a paper by Hermann as “ *Selection and Motivation; Initial Training; Simple Guidelines and Standardized protocols; Supervision, Support and relationship with the formal health services; Adequate remuneration/career structure; Political support and a regulatory framework; Alignment with broader health system strengthening; Flexibility and dynamism*”.³² A paper by Haines³⁹ also lists determinants of success of such programmes and he links the success of CHW initiatives to four interconnected factors – national socioeconomic and political factors, community factors, health system factors and international factors.

The importance of appropriate selection and training of CHWs has also been stressed consistently.²⁸ Lack of standardized mechanisms for selection and training has been seen as a deterrent to success of the CHW initiatives. Education level and the provision of continual training sessions have an impact on the retention as well as effectiveness of CHW. Educated CHWs appear to have better ability to enhance their skills and perform their tasks but are more likely to leave by getting alternative jobs⁴⁰. Continual training is also seen as imperative to maintain the quality of the CHWs.

³⁹Haines, A. et al., 2007. Achieving child survival goals: potential contribution of community health workers. *The Lancet*, 369(9579), 2121–2131.

⁴⁰ Prasad, B.M. & Muraleedharan, V.R., 2008. Community health workers.

Several other challenges hamper the success of CHW initiatives such as their fragmented role, the lack of incentives, lack of integration with existing systems and weak support systems.⁴¹ All this and more result in high rates of attrition (3.2% to 77%) in CHW programmes.²⁷ Attrition results in higher overall costs for the system as all the processes need to be repeated.

Integral to the success of the programme is understanding the extent and scope of work of the CHW. Over-burdening them is a matter of concern as more often than not their involvement is voluntary and one must consider the associated opportunity costs. This raises the question of the appropriate number of people who should be under the coverage of one CHW. Literature points to the obvious fact that the smaller the population the more far reaching is the impact of the CHW.³⁸ However, despite this, several CHW programmes are plagued by low utilization.²⁸

The issue of incentives is debated extensively in the literature. Considering the opportunity costs of CHW, it is only understandable that some incentive should be provided to keep them motivated. Many questions arise on this issue – financial versus non-financial incentive? Who is responsible for paying the CHW?²⁷ An interesting incentive being discussed in literature is of possible career prospects for the CHW.

⁴¹ Friedman, I., 2003. Community based health workers. *Published by the Health Systems Trust 2002*, 161.

Scalability and sustainability of CHW initiatives are also challenges as these initiatives are resource and time intensive and slow to show their results.²⁹ Thus it is crucial to have a high level of political commitment to strengthen the health system in order to ensure that long term benefits are reaped.

Another challenge that faces these programmes regularly is the balance between the “service provision” dimension and the “agent of change” dimension of a CHWs work. Linked to this is the issue of acting as a bridge, is it a one way or a two way bridge? Does it only allow the CHW to present government’s views and programmes to the community, or can the community’s views and needs also be conveyed back to the government, and influence policy]?

THEME: NGO DELIVERY OF INFORMATION AND SERVICES

Introduction

Non-governmental organizations (NGOs) and community based organizations (CBOs) such as self help groups are increasingly becoming important players in health service and information dissemination. One reason is the easy acceptance of the NGO’s work by the community as most of them are based in, or near, the community.^{42 43} This feature of NGOs

⁴² DeJong, J., World Bank. Population, H. & Division, N., 1991. *Nongovernmental organizations and health delivery in sub-Saharan Africa*, World Bank.

has been recognized by governments which need help in provisioning services. Sometimes these NGOs include, or are formed by, the community members themselves. Frequently NGOs are active in areas of reproductive and child health services, primary care services and prevention campaigns, and in some non-health related areas such as micro-finance.

NGOs are active in both urban and rural areas. The involvement of different NGOs vary and include health service delivery, capacity building (training) initiatives, health financing and advocacy. However, the most common form of NGO involvement has been in health service delivery, especially through contracting. There are several reasons for this including more focused and targeted interventions (hence faster observable results) and the existence of competition among NGOs resulting in efficiency. This leaves the government to focus on aspects of health care other than provisioning.⁴⁴ Many countries such as India, Guatemala, Bangladesh, Haiti, Cambodia, Pakistan and Thailand are using the approach of delivering health services through NGOs.

NGOs are into service provisioning in various ways.

- Setting up facilities in areas where there are no public facilities.⁴⁵

⁴³ Gilson, L. et al., 1994. The potential of health sector non-governmental organizations: policy options. *Health Policy and Planning*, 9(1), 14 -24.

⁴⁴ Loevinsohn, B. & Harding, A., 2005. Buying results? Contracting for health service delivery in developing countries. *The Lancet*, 366(9486), 676-681.

⁴⁵ Sepehri, A. & Pettigrew, J., 1996. Primary health care, community participation and community-financing: experiences of two middle hill villages in Nepal. *Health Policy and Planning*, 11(1), 93-100.

- Contracts to NGOs by government to run the government facilities.^{42 46}
- As facilitators.⁴⁷
- Helping in capacity building.^{48 49}
- Prevention-promotion campaigns.⁵⁰
- The spillover effects of other non-health programmes of NGOs.⁵¹

Outcomes and Impact

Several outcomes have been used to measure the impact of NGO provisioning of health services. These include health indicators, access, service utilization, quality of care, efficiency,

⁴⁶ Bloom, E. & Institution, B., 2006. *Contracting for health: evidence from Cambodia*, Brookings Institution.

⁴⁷ Björkman M, Svensson J., Power to the People: Evidence from a Randomized Field Experiment on Community-Based Monitoring in Uganda*. *Quarterly Journal of Economics*. [doi: 10.1162/qjec.2009.124.2.735]. 2009 2009/05/01;124(2):735-69

⁴⁸ Chowdhury, A.M.R., Aminul Alam, M. & Ahmed, J., 2006. Development knowledge and experience--from Bangladesh to Afghanistan and beyond. *Bulletin of the World Health Organization*, 84(8), 677-681.

⁴⁹ Mercer, A. et al., 2004. Effectiveness of an NGO primary health care programme in rural Bangladesh: evidence from the management information system. *Health Policy and Planning*, 19(4), 187-198.

⁵⁰ Benotsch, E.G. et al., 2004. HIV prevention in Africa: programs and populations served by non-governmental organizations. *Journal of Community Health*, 29(4), 319–336.

⁵¹ Amin, R. & Li, Y., 1997. NGO-promoted women's credit program, immunization coverage, and child mortality in rural Bangladesh. *Women & Health*, 25(1), 71-87.

cost of delivery of services and cost effectiveness.⁵² Improvement in health indicators such as maternal mortality,⁴⁷ neo-natal mortality,⁵³ and child mortality have been observed in most places where NGO provisioning of services happens.^{43 47} In a TB care programme based in Hyderabad (India), the NGO arm of the programme was better at diagnosing TB cases than a similar programme managed by government.⁵⁴ One of the biggest impacts of NGO provisioning has been better access, especially among the poor.⁴⁷ Equity is another outcome of interest while measuring the impact of NGO provisioning; a study in a district of India, reported equitable health care utilization after NGO provisioning.⁵⁵ This is attributed to better development of aids for capacity building activities, monitoring and supervision by NGOs.

The authors also found that contracting out was substantially more expensive for the government compared to traditional public service provision, but it substantially reduced the level of client household out-of-pocket expenditures on health care services. Sometimes the observed benefits of NGO provisioning are a result of simultaneous development programmes implemented by NGOs.⁴⁷

Issues and Challenges

⁵² Liu, X., Hotchkiss, D.R. & Bose, S., 2007. The effectiveness of contracting-out primary health care services in developing countries: a review of the evidence. *Health Policy and Planning*.

⁵³ Morrison, J. et al., 2005. Women's health groups to improve perinatal care in rural Nepal. *BMC Pregnancy and Childbirth*, 5(1), 6.

⁵⁴ Loevinsohn, B. et al., 2004. *Contracting for the delivery of community health services: a review of global experience*, World Bank.

⁵⁵ Baqui, A.H. et al., 2008. NGO facilitation of a government community-based maternal and neonatal health programme in rural India: improvements in equity. *Health Policy and Planning*, 23(4), 234-243.

Questions regarding cost effectiveness, scalability and sustainability arise when one looks into NGO service provisioning. Studies have stated that provisioning through contracting out entails equal or greater expenditure than government provisioning of health services.⁴⁴ Sometimes the same problems which plague government services are also faced by NGO-run services.⁴¹

In Bangladesh, implementation of a nutrition programme by NGOs has revealed less efficiency in delivery when one uses cost per person-days of services as a measure of efficiency.⁴⁵ A fear associated with contracting out health provisioning to NGOs is that instead of strengthening the health system it will result in further fragmentation of the system in the future.⁵⁰ Also, sustainability of projects initiated by NGOs is dependent largely on external support.⁵⁶ Thus the choice is either further government support or termination of the programmes as the funding ceases.

NGO success is based on a collaborative effort of NGO activities, community participation and empowerment.⁵⁷ Hence, a project which is successful in one location will not necessarily achieve equal success in another. We assume that the proximity of NGOs with communities will facilitate active community participation and focus on community needs, but this might not always be true.³⁹

⁵⁶ Solomon, Y. et al., 2008. The dynamics of community and NGO partnership: primary health care experiences in rural Mali. *Promotion & Education*, 15(4), 32-37.

⁵⁷ Wallerstein, N., 2006. What is the evidence on effectiveness of empowerment to improve health. *Health Evidence Network Report*, 1–37

THEME: COMMUNITY FINANCING

Introduction

This section looks at the issue of health care financing by the community as a means of bringing about reforms in the health sector in low and middle income countries. In these countries there was an urgent need to adopt an alternative financing mechanism to make health care more accessible to the poor and destitute in remote, rural regions.

Community health insurance (CHI) can be broadly defined as any scheme that has three essential features: community control, voluntary membership and pre-payment for health care by community members. It is a non-profit health financing scheme aimed primarily at individuals working in the informal sector.

CHI has been applied in different contexts to improve access and reduce the financial obligations which might prevent the target individuals from accessing good health care facilities. CHI relies on the ability of the community to pool resources and utilize them efficiently to fulfil its unmet needs. The success of a scheme depends on the technical design, management, organizational and institutional characteristics.⁵⁸ Thus, the community's ability to collect revenue, subsidize premiums negotiate rates with providers, ensure population coverage and provision of good quality care are necessary for the success of the scheme .

⁵⁸ Jakab M, & Krishnan, C., . HNP Discussion Paper. Community involvement in Health Care financing. A survey of the Literature on the Impacts, Strengths and Weaknesses. 2001.

Outcomes and Impact

CHI schemes have been shown to reduce the out of pocket expenditure in communities that have adopted them. They have also reduced catastrophic health expenditure to a significant extent. Studies in India, for example, showed that on average such schemes reduced out of pocket expenditure and catastrophic expenditure by 3% and 52 - 57% respectively.⁵⁹ CHI also increases access to health care as seen by the increase in the utilization rate.⁶⁰

Communities who are covered by CHI schemes also seem to have an increased voice.⁵⁹ ⁶¹ When used in the agent-partner or linked model, the NGO which acts as the intermediary between the community and the formal insurance company is able to negotiate specific types of payments that are priorities for the community,.Furthermore, by negotiating Preferred Provider System contracts with private providers they are empowered with certain means of ensuring basic quality.⁶²

⁵⁹ Soors W., Devadasan, N., Durairaj V., & Criel B. Community Health Insurance and Universal Coverage: multiple paths, many rivers to cross. World Health Report. Background Paper 48. Geneva: World Health Organisation; 2010.

⁶⁰ Ekman B., Community-based health insurance in low-income countries: a systematic review of the evidence. Health Policy and Planning. 2004;19(5):249-70

⁶¹ Preker A.S., & Carrin G., Health financing for poor people: resource mobilization and risk sharing: World Bank Publications; 2004. Available from:
<http://books.google.co.in/books?id=I9CPF8W0M3MC&lpg=PA139&dq=advantages%20of%20community%20health%20financing&pg=PA55#v=onepage&q=%20community%20health%20insurance&f=false>

⁶² Ranson M.K., Sinha T., Gandhi F., Jayswal R., Mills A.J., Helping members of a community-based health insurance scheme access quality inpatient care through development of a preferred provider system in rural Gujarat. Natl Med J India. 2006 Oct;19(5):274-282.

Issues and Challenges

Revenue collection appears to be more successful when the contribution scheme takes into account the nature of revenues of the membership population. When the contribution collection period is synchronized with the cash earning period, the ability of the schemes to raise resources goes up significantly.⁵⁷ The Bwamanda Hospital Insurance Scheme has a community rated system of premium collection during the crop selling season.⁶³ Also in Central and West Africa, most of the Mutual Health Organizations (MHOs) designed their collection time during the cash endowment period.⁶⁴

Generating resources from in-kind contributions should also be considered in the case of people who were unable to pay the premium.⁵⁷ In the Philippines, under the Health community scheme, they were allowed to convert livestock such as chickens into cash in the hospital and were able to pay for health care.⁶⁵ In India, pre-payments in the form of rice and sorghum are accepted. This scheme employs a community health worker to collect the produce during harvest time and sell it on the open market. These measures are used to ensure that the poor people are not excluded from the pool.⁶⁶

⁶³ Criel B., Van der Stuyft P., Van Lerberghe W. ,The Bwamanada hospital insurance scheme: effective for whom? A study of its impact on hospitalisation utilization patterns. *Social Science & Medicine*. 1999;48:897-911.

⁶⁴ Atim C., Contribution of Mutual Health Organisations to Financing, Delivery and Access to Health Care. Bethesda, MD: Partnerships for Health Reform Project. Abt Associates. 1998.

⁶⁴ Preker, A. 2001. Philippines Mission Report. [Internal Document] Washington DC: World Bank.

⁶⁶ Dave P., Community and self-financing in voluntary health programmes in India. *Health Policy and Planning*. 1991;6(1):20-31

Subsidizing part or all of the premiums of the poor can be carried out as in Mutelles de Santé in Rwanda, where a system for the identification of the extremely poor was used. The government subsidized a part of the premium for these persons and channeled the Global Fund money through the CHI. In Ghana, the government cross-subsidized resources, by transferring money from the contributions of formal sector workers to enrollees from the informal sector.

As CHIs are voluntary and charge a flat premium, wrong selection of participants is a key issue which might lead to risk pooling problems. To maximize the risk pooling potential, schemes can join forces as in Mali, where mandatory health insurance was introduced among government and formal sector employees together with social assistance for the extreme poor.^{67 68}. Or, CHI can be made mandatory, as in Ghana and Rwanda, so that potential defaulters are covered by others.

Purchasing and Resource allocation: The WHO report 2000 mentions the importance of Strategic purchasing. It emphasizes the role of the CHI scheme in providing good quality health care to all members. In the Self Employed Women's Association (SEWA), the Preferred Provider system (PPS) is practiced, which facilitates access by making payment to members

⁶⁷ Togo L., Ponzio, N., Bouaré, M., Ouattara, O., Rapport Mali sur la couverture sociale de la maladie. Background document for the colloquium L'amélioration de l'accès aux services de santé en Afrique francophone : le rôle de l'assurance, 28-29 April 2004. . Paris: Collège des Economistes de la Santé; Réseau Economie de la Santé dans les Pays en Développement; 2004.

⁶⁸ Letourmy A., Ouattara, O., L'assurance maladie obligatoire au Mali : discussion d'un processus en cours. In: Dussault G, Fournier P and Letourmy A [Editors] L'assurance maladie en Afrique francophone : améliorer l'accès aux soins et lutter contre la pauvreté. Washington, DC: the World Bank, Human Development Network; Health, Nutrition and Population Family; pp 229-262. . Health, Nutrition and Population discussion paper. 2006.

prior to their discharge from hospital thereby shifting the burden of compiling the claim from the member to scheme staff. Providers for individual cases are selected based on the assessment of a list of structural quality indicators in a set of hospitals used by the SEWA members.

Scheme Flexibility: in areas where the necessary treatment coverage is not available an alternate service structure should be arranged to increase access. For example, in Nongon, where there was unavailability of a minimal package of services, an ambulance service for those in need of referral care as well as screening and therapy for tuberculosis were arranged.⁶⁹

The CHI scheme in Cambodia monitors patient satisfaction and follows up on feedback received at the village and provider levels. This has helped in improving the quality of care and utilization of services. Community participation and decision making helps in empowering the vulnerable and destitute. Evidence from women in Nongon and Ahmedabad, to poor city dwellers in Nouakchott and Pune suggests that CHI can have a positive transformative impact.

SKY, Cambodia negotiated a range of initiatives to upgrade the quality of care. It worked exclusively with public providers and used a capitation system for health centres and first referral hospitals and a third payer system at provincial and national hospitals.⁷⁰

⁶⁹ Audibert M., de Roodenbeke E., Utilisation des services de santé de premier niveau au Mali : analyse de la situation et perspectives. Washington, DC:: the World Bank; Région Afrique; Département du développement humain. 2005.

⁷⁰ Duffau A., Díaz Pedregal V., To what extent does non profit private micro health insurance help improve public health care? 2009: Available from: <http://factsreports.revues.org/index360.html?file=1>

The contractual relationship that Mutual Health Insurance schemes in Senegal's Thiès region negotiated with St. Jean Hospital enabled the members to get up to 50% reduction for treatment. They negotiated preferential and acceptable contribution rates with the hospital, which in turn offered considerable benefits. This makes the scheme very attractive and acceptable to the population and has led to a high penetration rate among the target group.⁶³

The SKY and CAAFW scheme in Cambodia established contractual relationships with 55 health centres, 10 first referral hospitals and five provincial or national hospitals. The terms of the contract covered compliance with intervention protocols, essential drug stocks, opening hours, staff presence and an established referral system.⁶⁹

THEME: COMMUNITY MONITORING, HEALTH RIGHTS AND ACCOUNTABILITY

Introduction

Community monitoring (CM) is a form of public oversight, ideally driven by local information needs and community values, to increase the accountability and quality of social services. The push toward community monitoring of public services in development projects is based on the notion that local oversight raises the social accountability of public service providers.⁷¹ Within the CM framework, members of a community targeted by a social programme generate demands, suggestions, critiques, and data that they provide to the organization

⁷¹ Khemani S., Does Community Monitoring Improve Public Services? September 2008: Available from: http://siteresources.worldbank.org/INTPUBSERV/Resources/477250-1172079852483/Khemani_10908print.pdf.

implementing the programme. It aims to strengthen local decision-making, public education, community capacity, and effective public participation in local government. CM is a tool to facilitate greater inclusivity on issues deemed important to the community at large.

It is not sufficient to concentrate on supply driven mechanisms alone in efforts to improve service delivery. There is also the need to build capacity on the 'demand' side. by ensuring that users of social services are informed of their rights and obligations and are enabled to exercise their rights by holding the government and service providers accountable.⁷² There are a number of monitoring methods to enable public oversight in service delivery, ranging from Community Score Cards, Citizens' Report Cards, Public Expenditure Tracking Surveys (PETS), Social Audits and the Right to Information..Monitoring without indicators (used for internal monitoring of project success by organizations) and Monitoring to global standards (which monitors and brings civil society organization representatives closer to international institutions) are community monitoring initiatives conducted at a relatively higher level.

Outcomes and Impact

Community based monitoring programmes have been seen to lead to open dialogue with local service providers and provide an evidence base to lobby the local government authorities. Such initiatives improve public awareness and demonstrate significant improvement in user satisfaction with services.⁷³ Another study showed that subsequent to dialogue based on people's perceptions and monitoring, there was a rise in immunization

⁷² Sundet G., Public expenditure and service delivery monitoring in Tanzania: Some international best practices and a discussion of present and planned Tanzanian initiatives. HakiElimu Working paper series2004.

⁷³ Larrauri H.P., Community monitoring : Report for the Open Society Institute's Public health watch. 2009.

rates, fall in child mortality rates by 33% and reduction in absenteeism among care providers.⁷⁴

Such monitoring and social accountability mechanisms also brought about significant systemic change. A study in Africa showed that such processes increased the regularity in salary payments, improved interaction between users, health staff and administrators and led to a 20% increase in the allocation for local budgeting and monitoring.⁷⁵

These programmes are seen as useful to government departments to complement their oversight actions. The community monitoring programme was seen to be highly beneficial for the Philippines' Commission on Audits (for example), as it provided a new dimension of capacity, providing 'value for money' audits, as well as enabling corrective actions in the implementation of public works projects, in addition to the post-audits traditionally performed by the Commission.^{76 77}

⁷⁴ Björkman M., Svensson J., Power to the People: Evidence from a Randomized Field Experiment on Community-Based Monitoring in Uganda*. Quarterly Journal of Economics. [doi: 10.1162/qjec.2009.124.2.735]. 2009 2009/05/01;124(2):735-69.

⁷⁵ Sanjay Agarwal RH, Myrtle Diachok Scaling up social accountability in World Bank Operations. Social Development Department at the World Bank [serial on the Internet]. May 2009: Available from: <http://siteresources.worldbank.org/EXTSOCIALDEVELOPMENT/Resources/244362-1193949504055/Scalingup.pdf>.

⁷⁶ Transparency International (TI). Press release: Transparency International Integrity Award Winners. Transparency International [serial on the Internet]. 2000.

⁷⁷ Sumangil P. ,The concerned citizens of Abra for Good Government: An NGO watchdog in the Province of Abra. 2 nd Global conference on Fighting corruption & safeguarding integrity; May 28-31,2001; Hague. 2001.

Issues and Challenges

Please see the following boxes:

Community Monitoring is not a Panacea

- Participation is complex: establishing indicators in a participatory way takes time and it is difficult to ensure the participation of all stakeholders. Participation of women is particularly low. Hence it is difficult to disaggregate data based on gender to assess the differential impact of services on men and women.
- Local ownership is crucial: involving local stakeholders is essential as it will greatly increase the chances of the monitoring being more useful and sustainable. There is a need to invest in a dialogue prior to data collection to foster a common understanding and to ensure transparency. Lack of literacy and numeracy in the community are also major inhibitors and the information needs to be presented in a way in which it can be understood.
- Dissemination and use of monitoring data: monitoring should be aligned with the national policy making processes to influence policy change. It should focus on national goals and be timed to synchronize with, and thus contribute to national planning.
- Monitoring is a political process: NGOs are better placed to monitor but risk political clashes when they release unwanted results. Hence, to gain legitimacy, monitoring processes should be supported by local leaders, The presence of a local 'champion' to drive social accountability is critical to generate

support and participation.

- Capacity constraints: these exist in terms of access to resources, information and the availability of appropriately skilled individuals. The facilitation of ‘public meetings’ also requires training and investment.⁷⁸

Making monitoring more efficient

- Reporting verbally through group meetings will allow participation regardless of literacy levels.
- Phasing in interventions slowly during training, enabling volunteers to assimilate the information and use it immediately in their work.
- Multiple strategies for individual and group learning reinforcement ensure that volunteers are well prepared to serve the families on their blocks.
- Rewards can function as motivators as well as for recognition and group identification.
- Quarterly surveys can be used to verify the data collected by the volunteers.
- Information sharing and relationship building between the community and the Ministry of Health are essential to build local ownership of the project.
- Group meetings will function as venues for problem solving, peer counseling and social and educational activities. They will also help as venues for training and testing.

⁷⁸ Governance and Social Development Resource Centre. Community Monitoring of Service Delivery. Malawi: GSDRC2008.

- When group leadership and decision making power has been systematically built, responsibilities can be successfully transferred from paid staff to community members.⁷⁹

A number of lessons may be derived from the 'best practices' presented above. The generation of data, whether on finances or user satisfaction, is an essential component of ensuring accountability in the delivery of services. This needs to be in the public domain and to be presented in a fashion that is comprehensible to the users of services. In addition, partnerships between government and civil society or user groups can significantly enhance the capacity of government to perform its oversight function.⁷¹

⁷⁹ Bhojani U, Devadasan N., Community based monitoring – An operational guide to the process. 2007

Introduction

A literature review by Victoria Saint forms the basis of this review.⁸⁰ It identifies certain programmes implemented in different parts of the world which have community participation and planning as integral components. It attempts to assess the impacts and issues arising due to these components. Covered by this literature review are programmes with the Women's Group for Maternal and Child Health (the WARMI project, Bolivia); the Law of Popular Participation (Bolivia); the MIRA trial (Makwanpur, Nepal); SUS, People's Health Councils and Conferences (Brazil); the EKJUT trial (Jharkhand and Orissa); the FRHS project (Husur, Karnataka); a randomized controlled trial (RCT) involving Health Watch Committees (Bangladesh) and Nijero Kori, NGO in rural Bangladesh.

Outcomes and Impact

Several outcomes and limitations have been highlighted in this review, some of which are presented below:

Positive Outcomes	Negative Outcomes/Limitations
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⁸⁰ Saint, V., 2010. Community participation and planning in health: An exploratory literature review. Chennai: Community Health Cell Extension Unit.

<ul style="list-style-type: none"> – Improved health outcomes – Changes in health behaviour and socio-environmental risk factors – Strengthened social capital and networks – Empowerment – Better accountability – Pro-poor policies – Efficiency gains and rational administration – Local needs are considered – Utilization of health services – Inter-sectoral action 	<ul style="list-style-type: none"> – Exclusion and lack of genuine representation – Differing levels of success of implementation of these strategies/ Ambiguity in success of scaling up – Further fragmentation and increased inequities – Difficulty in measuring and evaluating the impact – Lack of mechanisms for participation and planning
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Improvements in health outcomes such as perinatal mortality rates,⁸¹ neonatal mortality rates,^{82 83} and the infant mortality rate⁸⁴ have been well documented in literature. Changes

⁸¹ O'Rourke, K., Howard-Grabman, L. & Seoane, G., 1998. Impact of community organization of women on perinatal outcomes in rural Bolivia. *Revista Panamericana de Salud Pública*, 3, 9–14.

⁸² Tripathy, P. et al., 2010. Effect of a participatory intervention with women's groups on birth outcomes and maternal depression in Jharkhand and Orissa, India: a cluster-randomised controlled trial. *Lancet*, 375(9721), 1182-1192.

⁸³ Manandhar, D.S. et al., 2004. Effect of a participatory intervention with women's groups on birth outcomes in Nepal: cluster-randomised controlled trial. *Lancet*, 364(9438), 970-979.

⁸⁴ Cornwall, A. et al., 2008. *Brazilian experiences of participation and citizenship: a critical look*, IDS.

in health behaviour (nutrition, sanitation, home care practices, utilization of maternal health services) have also been noted.^{85 86} In the municipality of Vallegrande, Bolivia, participatory planning has resulted in increased life expectancy along with reduced levels of poverty.⁸⁷ Gains in efficiency which come about from community planning and participatory budgeting include increased attendance at assemblies and better implementation of projects.⁸⁸

Empowerment arising from enhanced community involvement increases the confidence level of individuals, enabling them to identify and tackle negative issues affecting their lives.^{89 90 91} The municipal health councils in Porto Alegre, Brazil, have seen the rise of inter-sectoral actions for health as communities realize that their needs are not just for curative services,

⁸⁵ Rosato, M. et al., 2008. Community participation: lessons for maternal, newborn, and child health. *The Lancet*, 372(9642), 962–971.

⁸⁶ Mahmud, S., In Bangladesh Citizens Leave a Legacy (Citizens in Action, DRC Case Study Series: Citizen Prescriptions for Better Health Policy, #3). *Development Research Centre*. Available at: www.drc-citizenship.org/news%20and%20events/2009/Case_Study_Series.htm.

⁸⁷ Beneria-Surkin, J., 2005. The struggle for resources: citizen engagement and democratic governance in the municipality of Vallegrande, Bolivia. In *workshop proceedings for the "International Conference on Resources, Citizen Engagement, and Democratic Local Governance," December*. pp. 6–9

⁸⁸ Zamboni, Y., 2007. *Participatory Budgeting and Local Governance: An Evidence-Based Evaluation of Participatory Budgeting Experiences in Brazil*, Working Paper, 2007

⁸⁹ Morrison, J. et al., 2010. Understanding how women's groups improve maternal and newborn health in Makwanpur, Nepal: a qualitative study. *International Health*, 2(1), 25–35.

⁹⁰ Kabeer, N., Kabir, A.H. & Huq, T.Y., 2009. Quantifying the Impact of Social Mobilisation in Rural Bangladesh: Donors, Civil Society and 'The Road not Taken'. *IDS Working Papers*, 2009(333), 01–54.

⁹¹ Pardasani, M., 2005. A Context-Specific Community Practice Model of Women's Empowerment. *Journal of Community Practice*, 13(1), 87–103.

and this has resulted in better water and sanitation services and higher school enrollment⁸⁷ Capacity building services provided by NGOs also have far reaching effects; Nijera Kori's involvement has resulted in improvements at the household level in the nutrition, child immunization and access to latrines.⁸⁸

Issues and Challenges

Despite the reported positive impacts, involving communities in planning is not that simple. The biggest problem is that representation of communities is sometimes just in name. There are various barriers to successful participation such as time constraints, lack of money and lack of skills and capacities.⁹² Skill/capacities are required to be able to identify and prioritize the different issues and design solutions to address them. Inequities are reported to have increased with the adoption of community participation and planning.⁹³ High levels of accountability have not been achieved especially in holding officials to account.⁹⁴ Additionally, disadvantaged populations still risk being excluded from participatory planning perhaps because they themselves do not see themselves as part of such a process.^{83 86 95}

⁹² Murthy N., 2003. Community Involvement in Reproductive Health: Findings from a Research Project in Karnataka, India; Final Report. Ahmedabad, India; Foundation for Research in Health Systems.

⁹³ Cornwall, A. & Shankland, A., 2008. Engaging citizens: lessons from building Brazil's national health system. *Social Science & Medicine* (1982), 66(10), 2173-2184.

⁹⁴ Hossain, N., 2009. Rude Accountability in the Unreformed State: Informal Pressures on Frontline Bureaucrats in Bangladesh. *IDS Working Papers*, 2009(319), 01–35.

⁹⁵ Wheeler, J.S., 2003. New Forms of Citizenship: democracy, family, and community in Rio de Janeiro, Brazil. *Gender and Development*, 11(3):36-44

Although the perceived benefits of community involvement have been highlighted here, these benefits are seen only after a long time and the whole process of community mobilization is a resource and time intensive exercise. Despite world-wide acknowledgement of the success of the Brazilian and Bolivian models, their scalability has been questioned due to lack of uniform results from all areas.^{86 87 92 87 88 93} Similar problems were faced when attempting to scale up projects in Bangladesh, Nepal (MIRA trial) and India (EKJUT).^{81 82 96}

Some key requirements imperative for the successful enhancement of the role of communities and for integrating communities into the planning process, as identified by this literature review, are listed below:

- Conducive political environment
- Strong civil society
- Resources and investment
- Institutional mechanisms for participation and planning

⁹⁶ Azad, K. et al., 2010. Effect of scaling up women's groups on birth outcomes in three rural districts in Bangladesh: a cluster-randomised controlled trial. *Lancet*, 375(9721), 1193-1202.

THEME: INTER-SECTORAL CONVERGENCE

Introduction

The concept of inter-sectoral action for health has been around since the Alma Ata Declaration in 1978. It has been defined by WHO as “actions affecting health outcomes undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector.” This concept arose from the understanding that diverse factors affect health; many of which may not be directly related to it.⁹⁷

Over the years, the inter-sectoral approach to health has been initiated by players both in the health as well as non-health sectors. Important stakeholders include government (national and local), civil societies, institutions/organizations and the community. Participation by the community has been reported to be integral for success in any such approach, especially in the context of disadvantaged populations.⁹⁸ Also, due to the involvement of non-health players, not all initiatives are targeted at health or health outcomes directly but have indirectly resulted in health benefits.

⁹⁷ Sahan, T.S.D.A.K.B., 1988. Intersectoral Coordination For Health. *Asia-Pacific Journal of Public Health*, 2(3), 163 -166.

⁹⁸ Attree, P. et al., 2010. The experience of community engagement for individuals: a rapid review of evidence. *Health & Social Care in the Community*. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/21138495> [Accessed December 15, 2010].

The inter-sectoral approach can be either top-down or bottom-up.⁹⁹ Bottom-up implies that the initiator is at the community or local level while in the top-down approach, initiatives are started by the government. Several studies cited in this review acknowledge the use of both approaches. As mentioned earlier, the community has a key role to play in both approaches.

During the process of this literature review, we identified a review by the Public Health Agency of Canada for the Health Systems Knowledge Network and the Regional Network for Equity in Health in East and Southern Africa (EQUINET). This review looks into various aspects of inter-sectoral action for health.¹⁰⁰ The synthesis report “Health equity through intersectoral action – an analysis of 18 country case studies”⁹⁹ tries to answer the questions arising from the aforementioned literature review. From the 18 case studies, we focused primarily on those dealing with primary health care/community level interventions and participation/empowerment. Besides these two documents, any other study relevant to the topic has been included in our review.

From our survey of the literature, we identified that education, sanitation, income generating activities and empowerment strategies have had a positive impact on health. In the following section we illustrate this with examples.

Outcomes and Impact

⁹⁹ Peake, S., Gallagher, G. & Valentine, N., 2008. *Health equity through intersectoral action: An analysis of 18 country case studies*, WHO, Minister of Health, Canada.

¹⁰⁰ Government of Canada, 2007. *Crossing Sectors – Experiences in intersectoral action, public policy and health*, PHAC, Health Systems Knowledge Network (HSKN), EQUINET.

The literature shows two things, first that work on non-health, but health related/social sector related issues can lead to positive health impact; and second, that working with communities can lead to the operationalization of inter-sectoral linkages.

Education of mothers has a beneficial effect on child health and survival.¹⁰¹ The basic needs development programme (BNDP) in 12 countries in the WHO Eastern Mediterranean region is an example of inter-sectoral approach to health. A study on BNDP states that “the literacy and vocational training centres for women contribute to improvements in maternal care, family planning, and immunization coverage for children”.¹⁰²

The relationship between health and economic development is a known fact.¹⁰³ Participation of women in self help groups and credit programmes has been seen to have a positive impact on the health status of the women.¹⁰⁴ A study in Bangladesh finds that members of the micro-credit group were more likely to have lower child mortality and better immunization coverage.⁵¹ Community based organizations may directly or indirectly facilitate the access of people to treatment either by providing finances or transport, or by building health facilities

¹⁰¹ Desai, S. & Alva, S., 1998. Maternal education and child health: Is there a strong causal relationship? *Demography*, 35(1), 71–81

¹⁰² Assai, M., Siddiqi, S. & Watts, S., 2006. Tackling social determinants of health through community based initiatives. *BMJ*, 333(7573), 854.

¹⁰³ Rodriguez-Garcia, R., Macinko, J.A. & Waters, W.F., 2001. *Microenterprise development for better health outcomes*, Greenwood Press.

¹⁰⁴ Mohindra, K., Haddad, S. & Narayana, D., 2008. Can microcredit help improve the health of poor women? Some findings from a cross-sectional study in Kerala, India. *International Journal for Equity in Health*, 7(1), 2.

and carrying out capacity building initiatives.¹⁰⁵ The Self Employed Women's Association (SEWA) in India has been using the inter-sectoral approach and has expanded its activities from those which are merely economic to include health and social issues.¹⁰⁶

An empowerment strategy is to make women financially independent. The implementation of an income generation programme for women in rural China led to the community demanding the services of barefoot doctors, demonstrating how a non-health initiative can eventually lead to a health related one.¹⁰⁷ The authors noted that once basic needs are met, women (communities) look for improvements in health.

The government of Iran has taken up the inter-sectoral approach for health and incorporated community involvement in planning and setting priorities. This is done by setting up village development committees which consist of elected cluster representatives from the villages, and by conducting community needs assessments. In Brazil, due to the presence of participatory municipal committees, sectors indirectly related to health such as water services and sewage have seen improvements.¹⁰⁶

¹⁰⁵ Molyneux, C. et al., 2007. The role of community-based organizations in household ability to pay for health care in Kilifi District, Kenya. *Health Policy and Planning*, 22(6), 381 -392.

¹⁰⁶ Nayar, K., Kyobutungi, C. & Razum, O., 2004. Self-help: What future role in health care for low and middle-income countries? *International Journal for Equity in Health*, 3(1), 1.

¹⁰⁷ Manderson, L. & Mark, T., 1997. Empowering women: participatory approaches in women's health and development projects. *Health Care for Women International*, 18(1), 17-30.

Sometimes, health related initiatives spread to areas like education. In Sonagachi, India; attempts to reduce transmission of STDs to sex workers resulted in effects beyond health. During the project tenure it was realized that to have an overall impact on health, there was the need to diversify to non-health related areas. This led to the development of a literacy programme for the sex workers. Further, with the aid of the supporting organizations occupational protection and financial security initiatives were also started.

Issues and Challenges

Although benefits have been observed for this approach, convergence is not necessarily a panacea. Such initiatives have been noted to be resource intensive and results are not immediate¹⁰⁰. Also coordination between various sectors might not always be seamless. Largely the success of these initiatives depends on the extent to which communities participate.

EMERGING LESSONS

The review above presents a wide range of evidence for the significant contribution to health system strengthening and positive impacts on health brought about by community participation. As mentioned in the early sections of this paper, however, participation is a right and it is the responsibility of the state to ensure conditions conducive for participation. Today there is rich experience in diverse settings and with respect to different approaches with regard to community participation. Among the critical debates are those on how to actualize citizen involvement and ownership, how to deepen democracy and how to transform systems (especially those in low and middle income countries), to make them not only more effective, but also more responsive to people's needs and equitable in their functioning. This section presents the major learnings emerging from the literature.

- Citizen and community participation at all stages and levels of health planning, including planning, implementation, monitoring and evaluation has been recognized as a fundamental right of citizens and communities.
- Citizen participation and NGO involvement have been seen to contribute very positively to a number of outcomes including awareness, availability, accessibility, quality and equity of

services. Citizens and communities have also been seen to contribute not only to curative but also to preventive and promotive interventions.

- Major issues include training capacity to empower and enable community members to play these constructive roles, sensitization of the whole system to go beyond the expert/lay person hierarchy and to see community participation as a useful and essential aspect of all health systems.
- Spaces created for these purposes do not become 'democratic' simply by virtue of their creation and objectives. These spaces invariably reproduce the hierarchy and power relationships present in the larger society. Thus to make them truly democratic we need a process of active contestation and debate.
- There is a significant move from seeing civil society as a 'countervailing' force to the state to giving it the role of "co-governance", where there is direct and active involvement of the citizens in the activities of governance.
- It is obvious that a complex set of facilitating factors are necessary for community participation to bring about impacts and lead to social change. Some of the factors that emerge from the literature include the need for: strong political will, 'champions for change' from within the system, a legal mechanism and spaces and mechanisms for such engagement, and "schools of citizenship", where people, especially the poor and marginalized 'learn' to overcome traditional hierarchies and occupy these spaces as equals. Such 'schools' usually refer to various social movements.

A NOTE ON CIVIL SOCIETY

Civil society consists of a wide range of organizations ranging from those which are for-profit, to those which are not-for-profit, from those which are funded to those which are non-funded and function on the basis of membership and contribution.

The role civil society plays in such a situation is important to analyze. Some of the important advantages civil society groups have over government line departments are the closeness to people and flexibility in functioning. Civil society groups also play important roles in awareness building, empowering communities and people, facilitating the voice of the voiceless to be heard, and in research and advocacy. The other role that has been described for civil society groups is that of schools of citizenship – where they help in empowering

individuals and communities to go beyond traditional hierarchies and occupy the higher spaces as equals.

Care needs to be taken, however, that civil society engagement does not lead to either duplication of services or the erosion of the state's capacity to provide services. Where the state withdraws its provisioning role, it can no longer play the crucial role of being one of the important 'competitors' in today's market of health care. This could easily lead to increasing privatization and the state left with little bargaining power or regulatory power.