**Annotated Bibliography
on Civil Society And Health**

Overview of issues from the bibliography on Civil Society and health

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This paper is part an annotated bibliography which is presented in a searchable web format on the WHO site (http://www.who.int/en/) and the TARSC site (http:/www.tarsc.org). There you can view and download the following **theme papers** highlighting research findings and issues arising from the literature.
1 Overview of issues from the bibliography on civil Society and health
2.Civil society-state interactions in national health systems
3.Civil society contributions to pro-poor health equity policies.
4.Civil society influence on global health policy;

You can also view and search a data base on the research **articles** within the last three theme areas: An abstract is provided on each of the articles reviewed

Overview of issues from the bibliography on civil society and health

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The involvement of civil society organisations (CSOs) in health brings new institutional, technical, political and financial resources to health. How best can these resources be marshalled towards local, national and international health goals? Policies and programmes that seek to engage and utilise the resources within civil society for health need to be informed by evidence and experience of good practice.

Collaboration with CSOs is not new for WHO, and interaction, consultation and co-operation with CSOs are encouraged by its Constitution. The growth of the scale and policy influence of CSOs, the relevance of civil society to WHO's strategic agenda for health and to the attainment of global and national health goals, and the increased formal interaction with CSOs within the UN system have, amongst other factors, stimulated a review of civil society roles in health within and beyond the WHO. If policy shifts in relations with CSOs are to be sustainable and relevant, they need to be backed by evidence and supported by dialogue. Towards this aim, the WHO Civil Society Initiative and Training and Research Support Centre (TARSC) have collaborated in work to gather evidence from research on key areas of civil society engagement in health, to identify the knowledge emerging from current research in these areas and the issues informing future research on civil society and health.

Three theme questions were identified as initial entry points to this synthesis of evidence. The review examines
- Civil society – state interactions in national health systems
- Civil society contributions to pro-poor, equity policies in health
- Civil society influences in global health policy.

These three themes were used as the basis for review of over 300 papers and selection of 230 papers, presented in the form of an annotated bibliography. This bibliography is presented in a searchable web format as a resource to the wider research, policy and practitioner community on civil society influences in, and contributions to, health.

Analytic overviews of each of the three theme areas identify current knowledge within these areas, as presented in the studies included in the annotated bibliography. They also highlight the research gaps to be filled. This first paper in the series of four presents the broad findings from the three theme areas of the bibliography and the research issues they raise on civil society and health.

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[1] The views expressed in this paper are those of the author and do not necessarily reflect the views of the World Health Organisation.

1.1 Defining civil society and the context for the bibliography

Civil society is the social arena that exists between the state and citizen, and is not part of the state or the market (for profit sector). It is an autonomous sphere of social interactions in which individuals and groups form many types of voluntary associations and networks to formulate and articulate their interests, negotiate conflict and provide and use services. It is a sphere where people engage in activities with public consequence. Civil society provides norms and networks of trust that can improve the efficiency of society by facilitating co-ordinated public action. Civil society organisations (CSOs) generally emerge from civil society, although in some cases with state and corporate links. CSOs generally draw from community, neighbourhood, work, social and other connections and provide the institutional vehicle, beyond the ties of immediate family, to satisfy shared necessities or interests and to collectively relate to the state. They cover a variety of organisational interests and forms, ranging from formal organisations registered with authorities to informal social movements coming together around a common cause. In this bibliography the term non government organisation (NGO) is used to mean the same thing as CSOs.

It is not the intention of this paper to provide a formal typology of CSOs. Nor does this paper explore the extremely rich literature on CSO relationships within policy and governance outside the health sector. There are however terms used in the theme papers that call for some definitions of CSOs in health, that for consistency with other WHO work draw largely from the WHO CSI paper above.

In theory, the state can be strictly separated from non-state actors. Non-state actors refer to both the market and civil society. While the market refers to the private for-profit sector, civil society actors are known by their not-for-profit operations. In practice these boundaries are far from being clear cut. The interests that motivate people to form CSOs are largely public, but may also be personal, backed by private for profit interests, and linked to wider national or international interests. CSOs can also be broadly differentiated by how they are constituted, who they represent, what they do and to whom they are accountable. This makes such areas as: the membership, mechanisms for internal accountability; functions, composition; scale of organisation from community to global level; and sources of funding, matters of concern in understanding the role and performance of the CSO. Equally, the capacity, resources, expertise and coverage of CSOs is of relevance in health systems.

Many of these critical areas of information are not covered in the literature on CSO work on health, weakening the understanding of the processes being described. There is a tendency to treat CSOs as an undifferentiated group, and to ignore the competition and conflict over different values and interests that may occur even within civil society itself.

Civil society has a long history of involvement in public health, and represents one of the organised non state mechanisms through which society contributes towards health gains. CSOs have contributed for more than a century towards health service provision, and have played a role in transforming public understanding of, and attitudes towards, health; promoting healthy public choices; building more effective interactions between health services and clients; and enhancing community control over and commitment to health interventions.

In recent years, CSOs have become more prominent, more visible, and more diverse, with a growth in their number, types and budget turnover. Within the health sector, CSOs have intervened across all areas of health activity, generating a diversity of experiences and issues. Within the broad spectrum of CSO work in health, the three areas of concern identified earlier were selected for this annotated, bibliography, on the basis of their relevance to current public policy issues in health at national and global level.

These selected areas reflect to some extent the forces that have been associated with the growth of CSO profile and influence in health systems, including:
- The challenge to imbalances of power between state and society, between market and non profit sections of society and between rich and poor, and the demand for improved public accountability and responsiveness to citizen inputs in dealing with these imbalances.
- The impact of globalisation in making national states more vulnerable to cross border risks and powerful transnational business interests. This has raised pressure for greater and more transnational support of public interests within civil society, supported by opportunities for information flow through new technologies, facilitating increasingly widely connected networks of civil society.
- The recognition of people's rights to participate in development processes, and of the positive role of social networking and participation in development outcomes

The three themes clearly do not reflect all the priority areas for which there would be benefit from greater sharing of documented evidence and analysis. For example the relationship between CSOs, state and the private for profit sector merits examination in a future review. It is an area with important ethical and policy implications in health. The bibliography is structured to easily enable new theme issues such as this to be added in the future.

1.2   Methods used in compiling the bibliography

The three theme areas above were used to search research and policy analysis publications in United Nations, academic and other institutional libraries, publications and scientific journals available on the internet or on paper. The searches used key words drawing from the theme titles and comparable expressions for the same concepts. For example, the term 'non governmental organisation' (NGO) was used in searches as well as CSO.

About 350 papers were found through these searches over a four month period between March and June 2002. Letters were also sent by WHO to health and UN institutions, included within major geographical regions, and any input sent before 30 June 2002 was included in the bibliography. Information received after 30 June will be included in later updates to the bibliography.

A screening of the papers was carried out. Papers were included if they synthesised or reported on new evidence specifically relevant to the three theme areas gathered directly through research, case study review or literature review. In the work on global health policy, given the paucity of original research and the social science and content analysis approaches used in policy analysis, a more inclusive approach was used to draw also from papers that gave insight into policy processes and CSO roles. In this section papers that presented perspectives and reviews of processes were included. In the other two themes the search criteria were more rigorous in selecting papers that raised or reviewed empirical evidence. Of the initial 350 papers obtained from the search, 230 met the criteria above and were included in the data base.

A web-based data base was constructed using fields judged to be relevant to WHO and its network of health workers, administrators in state and civil society organisations and to people interested in the role of civil society in health. Included in the data base are summaries of each paper. This data base is found on the WHO site (http://www.who.int/en/) and the TARSC website (http://www.tarsc.org).

The annotated bibliography presents a finite subset of a rapidly growing field of evidence and experience that will be strengthened by regular update. Already, the current data base of work done to date reveals a wealth of learning about civil society and health. It also identifies additional areas for research. These issues are briefly presented below. A more detailed presentation of the issues raised in this summary and citation of the supporting evidence is presented in each of the subsequent three theme papers.

1.3   Issues from the three themes on civil society and health

Changing forms of CSO involvement in health
The literature indicates that community based networks, non government organisations (NGOs) and other types of CSOs have a long history of participation in health, in both policy advocacy and service outreach. Even in the relatively new domain of global policy, CSOs are noted to have played a role in initiating or contributing to new areas of global policy.

At national level, while some CSO services have a long historical presence, such as in mission hospital services and in emergency relief, there is evidence of a widening engagement of CSO services in poor communities, in remote areas and in informal and squatter settlements. CSO studies

document innovative approaches to meet health needs of groups sometimes marginalised, such as indigenous communities and adolescents. The literature also documents growing CSO involvement in organising, informing and supporting communities so that they can make services responsive to their concerns. Studies of pro-poor CSO interventions indicates that traditional religious and social value driven interventions by CSOs are now being matched in scale by rights based and social justice driven interventions. CSO roles in health are changing.

There are some tensions regarding the appropriate boundary between state and civil society in these roles. A number of studies evaluate the role of CSOs in taking on services that were previously provided by the state. In new arrangements for CSO services, such as contracting, service delivery and health outcomes are very variable and not always an improvement on state services. Service performance is affected by the nature of the contracts, and the processes and institutional relations for developing, implementing and monitoring contracts. In a number of studies, there is evidence of poorly designed services for poor communities, based on incorrect assumptions about state and civil society capacities to respectively regulate and provide services. There is a deeper negative impact identified of CSOs filling in for the 'roll back' of the state. This undermines universal health care coverage and does not resolve critical weaknesses within the state.

At global level, the transnational nature of health risks and benefits has driven policy that has to some extent transcended the individual interests of member states. This has opened a (cautious) space for the involvement of civil society. Within civil society, the literature gives evidence of an increasing scale of networking, cross-border links, information sharing and concerted action within CSOs, which has grown to fill (and demand more of) this space across a range of areas of global health policy.

CSO contributions to health policy and their impacts
There is significant evidence of CSO contributions of technical expertise, community or social experience and information to health systems. CSOs also bring institutional and financial resources for health outreach. CSO contributions are reported to be more effective in areas of health intervention that demand social action, public advocacy, or innovative and community based responses to health problems.

At the national level, case studies demonstrate CSO impacts in enhancing the public accountability of policy processes. Some CSOs organise evidence from low income communities and vulnerable groups in health planning, and enhance the voice of these communities more directly within public policy and planning. There is criticism that many CSOs do not, however, represent poor communities, and even in cases where CSOs have improved the 'voice and agency' of poor communities, this has not always led to real budgetary resource shifts towards these communities.

Within global policy processes, CSOs are found to strengthen public interest lobbies and balance corporate and market pressures, making what is reported

to be a valuable and sometimes essential contribution to successful policy outcomes.

CSO influence on global health policy was judged to be less determined by the strength of the technical evidence they bring in support of policy inputs than the strength of their political force. This is related to the networking, alliances, linkages, advocacy and financial strength of CSOs, arguing for civic coalitions as an effective form of policy engagement.

Factors influencing CSO impacts

The impacts of CSOs in health policy, health services and outcomes are influenced by factors internal to CSOs: technical and institutional capacity, internal politics, autonomy and financial stability. They are also affected by external factors, particularly within the state. This includes the extent of formal recognition and integration of CSOs into national health systems.

The literature indicates diversity in the strength and form of relationship between state and civil society in local and national health action. When legal, institutional and procedural mechanisms support the synergy between state and civil society, positive health outcomes are reported. These include better co-ordinated public financing and public mechanisms for joint action, and improved health equity. In contrast, parallel, competitive or poorly managed relations are reported to introduce inefficiencies into the actions of both state and civil society. Weak national integration is noted to leave CSOs vulnerable to dependency on international agencies.

The impact of CSO interventions is also associated with the quality, capacity, political stability and effectiveness of the state. States play a role in enhancing CSO contributions through the design of pro-poor subsidies, the incentives and mechanisms they provide for CSO providers and the of use CSO inputs. This means that CSO work and advocacy faces serious barriers when it meets resistance from political and economic interests within the state.

At international and global level, CSO impact on policy is related to the extent of networking, concerted action, the resource base and the evidence used. There is evidence of the positive impact of strategic linkages between CSOs and the state and UN policy actors.

Debates and dilemmas

While empirical evidence is presented of these costs and benefits, there is still weak understanding of how best to structure civil-state relations. There are a rather large number of studies at national level with a limited focus on contracting arrangements. These do not address the spectrum of legal, institutional, procedural and social issues that need to be explored to build sustainable, mutually beneficial and productive CSO- state relations in health.

Hence while state–CSO capacities and relations appear to be a key determinant of health outcomes, the mechanisms for CSO–state relations are poorly resourced and serviced and there is still sparse evidence on how best to formalise and support these mechanisms. In part this reflects the

ambivalence and lack of consensus noted earlier on the relative roles of state and civil society within health systems. It also indicates that the matter goes beyond technical questions, as CSO–state relations are a site of political struggle. For CSOs there are debates about whether civil society should be putting its effort into becoming increasingly efficient at interim strategies for 'serving the poor', or whether it should be building the political momentum for wider challenges and responses to poverty, even when this necessitates confronting the state.

At global level, CSOs are reported to have shifted from being outsiders to informed insiders in global policy processes. This is not uniformly true. CSO integration into global policy processes is greater in CSOs (generally northern) with greater access to funding, to technical support and to the 'corridors of power' , giving them greater political leverage. This is reinforced by procedural barriers in access to global policy processes, ranging from bureaucratic and financial barriers to negative attitudes towards CSOs from state and international agency personnel. This bias towards well organised, internet linked and often northern based CSOs in global health policy blocks southern hemisphere participation and perspectives. Some authors suggest that this also blocks critical analyses of deeper structural problems and views that challenge the status quo.

1.4   Conclusions: Where to shine the research spotlight

The studies reviewed in this bibliography indicate a rapidly changing profile of CSO involvement in health, with significant potential for pro-poor and public interest health outcomes. They indicate that this potential is constrained, in part by political ambivalence and tensions, and in part by inadequate evidence on critical dimensions of CSO activity, including mechanisms for state–CSO interaction in health systems.

Moving from descriptive to analytic research
Many of the studies in the bibliography are descriptive. Few, for example, specifically map the impact of CSO influence in global health policy, assess the relative performance of different forms of state-civil interaction, or explore the effectiveness of different forms of CSO intervention in enhancing pro-poor outcomes. In the face of processes that are often neither linear nor simple (and sometimes influenced by political or economic factors that are not in the public domain), the paucity of analytic research on CSOs and health leaves a number of questions unanswered.

The descriptive research helps to make transparent what is taking place and brings evidence to the table of CSO contributions to health: but it leaves gaps in analysis around areas that are constraining effective mobilisation and utilisation of CSO resources for health goals.

Research gaps
At a global level, there is need for analytic research that explores the impact of the differential access to global health policy processes of civil society

actors in the north and south on policy processes and outcomes. How does this differentiation between CSOs in power, influence, funding and information capacity influence the internal processes within civil society of mandate, information flow, synthesis of evidence and policy articulation. What impact does this have on the policy content of CSO contributions?

What factors and processes enhance equity within CSO coalitions (north–south; rich –poor; male–female amongst others) and with what impact on policy content, and on global health policy development and implementation.

At a national level, there are partially answered questions about where CSOs have comparative advantage in health systems, but there are also largely unanswered questions about what legal, political, institutional or financial mechanisms would support CSO roles in areas of proven effectiveness or what forms of CSO–state co-ordination work best. Neither is it clear which mechanisms, procedures, information and capacities are needed to service the CSO–state relationship. The bibliography highlights one study of different local government areas in Brazil in terms of the features influencing the inclusion and impact of CSO health interventions. Such a structured comparative analysis of different local government systems or of different national systems provides one method for understanding the different dimensions of CSO–state relationships in health. Such research needs however to recognise, analyse and assess the political dimension of (and barriers to) choices being made around CSO–state interactions, for both civil society and state.

Poorly explored across much of the research are the gains and losses of different approaches for the poorest within communities. The research highlights the potential for cost burdens to be shifted to poor households (and women) through poorly structured CSO and state inputs to health. Conversely, it highlights benefits from CSO interventions that:
- enhance voice of poor communities
- strengthen processes by which poor people can promote change for themselves
- match these with accessible, reliable and quality services.

Research on poverty, equity and health will not adequately analyse these burdens and benefits if such social dimensions of health are not given visibility, measured and factored into health research.

CSO involvement in research processes
While this bibliography was essentially focused on research about CSOs, the final paper on pro-poor policies highlights the role that CSOs have played in providing a link between researchers and communities. More importantly, CSOs have brought community participation into research, to ensure that evidence judged as valid by the poor is included in policy advocacy and programme evaluation. This is highlighted as essential to ensuring the relevance of pro-poor services.

There is scope for further developing and using research tools for organising the perceptions and experience of poor people. Towards this, a number of CSOs use participatory action research as a means to improve both research practice and health outcomes. This type of research builds a role for communities in defining research problems, in the systematic collection of information, in reflection on evidence and identifying and testing areas of action. Such research has been noted in this bibliography, for example, to provide a more valid and socially acceptable definition of beneficiaries for poverty related relief measures than quantitative measures developed by external agencies.

Integrating values into evidence based policy
The series of papers in this bibliography highlight that beyond contributing empirical evidence, CSOs contribute values and perspectives, particularly rights based perspectives. This raises debates outside the domain of quantitative research, but that have far reaching impact. Hence, for example, CSOs face choices of how to deal with political and market interests, and over whether to focus on improving service outreach for poor people or on building the political momentum for wider challenges and responses to poverty.

Strengthening the evidence base for enhanced CSO action on health is an important step to making clearer the values and interests around these choices. It could be argued further that building more participatory forms of generating and reflecting on new knowledge builds insight and analysis within communities and strengthens their voice and agency to make these choices themselves.