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Annotated Bibliography on Civil Society And Health

Civil society contributions to pro-poor, health equity policies

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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.

Civil society contributions to pro-poor, health equity policies

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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.

An overview of the methods used to select the research papers, definitions of civil society, overall findings and research issues arising is provided in the first paper in this annotated bibliography.

This is the third paper in the series and presents the evidence from studies on civic contributions to pro-poor health equity policies.

CSOs at national and grassroots level, are involved in mutual support, building citizen capacities, advocating public interests and rights, meeting social needs, providing services and advocating accountability within private and public health services. What is the impact of this input on health gains and informed health action within poor communities and on equity in health?

This review of the literature explores whether civil society contributes to improved provision, coverage of and access to health services in low-income communities. The paper further examines whether civil society promotes improved responsiveness of health services, or enhances advocacy for and development of policies that are pro-poor and that enhance health equity.

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

3.1 Do civil society organisations contribute to pro-poor and health equity policies?

The second paper in this series on civic-state interactions in national health systems identified a range of current forms of action, where CSOs:

- act as direct service providers
- organise the social mobilisation required to change or implement public health policies and campaigns
- respond to new challenges and test new directions in health action
- mobilise and contribute resources to health.

Further evidence was provided in that paper that these CSO interventions may be supportive of the health needs of poor people, in that they are often driven by a commitment to values, rights or social justice goals, and reach population groups poorly served by the state, including indigenous populations, poor rural and urban communities, those in informal settlements, women, mobile communities and communities displaced by political conflict (Field and Gregory 2000). Beyond the evidence in that section of the bibliography, a further 51 studies are reviewed in this section for the specific evidence they provide on the pro-poor, health equity impact of CSO contributions to health.

A number of these papers describe specific pro-poor service contributions of civil society organisations (Field and Gregory 2000; Acharya 2001; Etemadi 2000; Gwatkin 2002, Kutzin undated, UNFPA 1998, UNDP 2000). An INTRAC study based on a two-year examination of ten CSOs working in low income communities in Ahmedabad, India, found measurable improvements in school attendance levels, literacy, immunization, and mortality rates (Acharya 2001). Etemadi (2000) found improved health status indicators such as immunisation rates, use of oral rehydration solution and child malnutrition rates in areas of CSO health service intervention in Cebu City informal settlements in the Philippines. In Bangladesh, the Bangladesh Rural Advancement Committee (BRAC) has become one of the country's principal providers of health and other services in poor rural areas (Gwatkin 2002). In Bangladesh, Ghana and India CSO maternity outreach services were reported to reduce maternal mortality, even in areas where specialist referral care is not available (Kutzin undated). UNFPA (1999) provide a number of examples at national level of areas where CSOs have enhanced reproductive health in poor communities through service provision, policy intervention, information dissemination and through giving visibility to women's health issues. In a study in Nepal, CSOs were found to encourage healthy practices and to improve utilization of existing maternity services in low-income women (Putney 2000).

While this review did not specifically target the wider literature on CSO contributions to poverty reduction *outside* the health sector, work on large scale poverty reduction programmes suggests that civil society organizations are often an instigating factor and/or an important continuing contributory force to the success of programmes aimed at reducing wider causes of poverty (Mitlin 2000).

Not all reports provide such positive information on CSO pro-poor impacts. Some studies note CSO coverage of poor communities to be patchy, and observe that CSO services have neither resolved the bias against access for the poor nor have they been more effective in coverage and equity than state services. Ahmed (undated) notes that even the largest CSOs in Bangladesh taken together reach only 10–20 % of landless households and that CSO impact on poverty reduction has been minimal. In Tanzania and Zambia, benefit incidence analysis indicates that the economic level of people served through the non-governmental health sector is higher than that of patients in government facilities (Gwatkin 2002).

3.2 Mechanisms for civil society pro-poor contributions

Where CSOs do yield pro-poor impacts this is traced in various studies back to specific features of CSO intervention.

CSO contributions to poverty reduction

Firstly, through both organising evidence and giving voice to low income community issues, CSOs raise the visibility of the health conditions of poor communities. Hence for example, one African network on adolescent reproductive health noted the importance of civil and traditional leadership in making HIV/AIDS in young people visible at national policy level and in leading the response to adolescent HIV/AIDS. Case studies are presented of CSOs involving youth in gathering evidence to support advocacy on HIV/AIDS (Fuglesang et al 2002). In the Philippines, CSOs took specific measures to enhance the capacity of communities in informal settlements to present evidence and issues to city governments (Etemadi 2000). Other studies have similarly documented CSO roles in organising evidence and making input to state planning (Rajkumar et al 2002; Raghuram et al 1999; Niang 2002).

CSOs are also documented to facilitate service outreach and use through informing and organising communities and providing services that respond to community values and cultural norms (Acharya 2001; Etemadi 2000; Osmani undated). CSOs are reported to promote transparency and accountability of services to low-income communities, and to make services more responsive to the perceptions of poor people. This is often explicitly built into participatory methodologies used by CSOs. Participatory methods used by CSOs for identifying poor people have, for example, been found in more than one study to be more valid and more transparent than those used by public sector bureaucracies, and to reduce community dissatisfaction with beneficiary selection processes (Simanowitz 1998; Gwatkin 2000).

CSOs are also less restricted to sectoral boundaries than state bureaucracies. This makes them responsive to the wider range of employment, production, credit, environment and service inputs needed by poor communities. One review of CSOs with pro-poor outcomes in South Asia, Africa and Latin America found that CSOs were more effective in reaching and servicing poor communities when they:

- (a) helped poor households to secure their livelihoods
- (b) supported social mobilisation with the aim of empowering the poor, and

(c) played an advocacy role on behalf of the poor (Osmani undated). Mitlin (2000) observes, from a study of CSOs working on urban poverty in nine urban areas, that the extent to which CSOs can fulfil these roles relates to their internal capacities – their representativeness, style of functioning, leadership and form of engagement with the state.

Impediments to CSO pro-poor contributions

These positive features, observed in some studies, are not uniformly found in all CSO interventions. CSOs have internal weaknesses that impede their work in poor communities. The paper on joint civic–state health actions noted: weak capacities; complex internal politics; unclear legal authorities; unstable funding; donor dependency and weak mechanisms for monitoring and scaling up work (Osmani undated; Nathan et al 2002). The leadership of CSOs is reported to often be dominated by men and higher income groups, who act to secure their own self-interest and may be unwilling to confront state or funding bureaucracies in the interests of poor people (Gomez 2000).

These internal weaknesses reflect in poorly designed inputs that do not provide an adequate quality of service to make real improvements for poor people (Lewis et al 1999). They are also reflected in a gap between the rhetoric and reality of substantive mechanisms for participation of vulnerable groups and in the impact of such participation on services (Ahmed undated, White 1999; Flower et al 2000). The study of CSOs working on urban poverty found that internal weaknesses diminished CSO willingness to challenge the state to address the needs of the poor, and undermined their ability to reach the poorest groups, serve their agenda or strengthen advocacy of their interests (Mitlin 2000).

Not all the obstacles confronting pro-poor CSO interventions are internal. CSOs working towards health equity meet resistance from corporate and state interests, while poorly designed state systems impede their effectiveness in reaching the poor (Gwatkin 2002; Leighton 1995; Mudyarabikwa 2000). For example health financing tools that potentially impact on health equity may not reach CSOs serving poor communities or protect the poor from the burden of payment. State subsidies to private providers have been found, for example, to be weakly applied in CSOs serving the poorest communities, due to weak demand from these communities, weak management capacities in the CSOs that service them and flaws in the design of targeting of subsidies (Leighton 1995; Mudyarabikwa 2000). This targeting problem cannot be solved simply by adjusting the subsidy allocations – it also calls for measures to address barriers in poor people’s use of health services (Castro Leal et al 2000). Analysis of equity impacts of community financing in Benin, Kenya and Zambia found that schemes in all countries failed to protect the poorest from the burden of payment. This was traced in part to failures in ensuring that the views of poor communities were heard in decision-making, attributed to an absence of local decision-making structures with representation from civil society groups able to voice the needs of the poorest (Gilson et al 2001).

Even where state systems allow for such roles for CSOs, incorrect assumptions can be made about the capacity of CSOs to fulfil these roles, and inadequate investment made to support this. This gap between policy and reality was noted

in the rural water supply policies in Pakistan, undermining the viability of the policy and its application (Ackbar 1999).

The evidence presented in this paper thus indicates that CSOs can and do reach poor communities and can and do make improvements in their health through a mix of technical, social and political inputs. There are, however, weaknesses within both CSOs and the systems they work within that impede the effectiveness of such action. The synergies or contradictions between the positive features of CSO pro-poor health actions and the wider public policy environment is an area that merits greater research attention.

At the same time there is a debate about whether CSO interventions directed at specific areas of poverty reduction, or health action confront the real causes of poverty. CSO action to mitigate poverty through limited improvements in service outreach or use are challenged as inadequately confronting the real causes of poverty – and thus indirectly sustaining it. The next section discusses this further.

3.3 The political economy of pro-poor contributions by civil society

Poverty and civil society health action can be located within the wider framework of political economy. Within health systems, recent market reforms are argued to have prioritised efficiency over equity and undermined constitutional provisions guaranteeing the right to health care, particularly at local level. The role of government has diminished and the for-profit health sector has spread, but with negative impacts on equity in access to health care. This is observed in Latin America and Southern Africa (Isaacs and Solimano 1999; Loewenson 1999, Bangser 2000). The impact of such reforms is argued to have skewed health services away from those most in need to those most able to pay and shifted the focus from community-oriented preventative care to individually oriented curative care, exacerbating inequalities in health and health care services.

The shift towards curative care spending, even within the public sector, was found in several African countries to favour the better off rather than the poor (Castro Leal et al 2000). At the same time Gwatkin (2001) demonstrates through benefit incidence analysis that because resources often flow inverse to need, even services that are pro-poor do not benefit the poor as much as higher income groups. He argues that only a sustained universal coverage approach would overcome the initial period of greater coverage improvements among the better-off than among the poor, leading to coverage improvements within poor communities. Should the political momentum behind this policy slacken before the achievement of the ultimate goal of universal coverage, the result would be an equilibrium at an unappealing midpoint of wealth related inequity. The market reforms noted above have threatened and in some cases reversed this momentum, leading to just such an outcome.

While this section does not seek to present a detailed analysis of these changes in the health sector, it raises an issue for civil society of the role it takes, primarily across two strands of possible action:

- Promoting the political momentum for sustained universal health care coverage (nationally and globally)
- Taking part in focused interim strategies which produce (or at least seek to produce) lessened coverage inequalities.

Underlying the former position is the pressure implied to address the wider political and economic trends compromising universal coverage. Underlying the latter is the threat that limited mitigatory actions may further compromise the political momentum for such wider reforms.

This discussion is more specifically developed in relation to the health of poor women. Women's poverty is described within a complex web of persistent inequalities that are traced back to social, cultural, economic and political structures. These are noted to erode women's well-being by restricting their capacity to attain positive health and educational outcomes, secure income and employment, and participate in decision-making within the home and in larger social spheres (Bangser 2000; Moss 2002; Niang 2001; Tolhurst 1999). The poor inclusion of women in public policy is traced to the social devaluing of 'women's work' both in the labour market and the home (Gomez 2000; Gordon et al (undated)).

This set of underlying conditions imply that public policies that are gender-neutral on the surface, such as 'cost-cutting', 'effectiveness', 'efficiency', and 'decentralization', frequently contain gender biases, because they imply transfers of costs from the remunerated economy to an economy founded on the unremunerated work performed by women. For example, some of the adjustment and reform measures in the health sector that have accompanied market reforms, which shift from institutional to 'family' and 'community' inputs to health. This is based on the expectation that women are available, prepared, and morally obligated to provide unpaid home care for dependents, the sick, the elderly, and the disabled (Gomez 2000; Tolhurst 1999).

CSOs confront the choice of where to position themselves in a spectrum of action ranging from political force for more equitable health policies at global and national level to becoming a service provider to mitigate the consequences of inequity. CSOs also need to assess the extent to which their work confronts or adds to the transfer of cost burdens to unpaid, household work, particularly that performed by women, and with what real gains for these groups.

Certainly this implies more for CSOs in pro-poor health equity work than filling gaps caused by state withdrawal (Isaacs and Solimano 1999). Three dimensions of a possible role for civil society emerge from the literature reviewed:

- raising and promoting rights and equity values
- strengthening the voice and agency of poor people within political processes, and
- driving an agenda that refocuses health systems on universal health rights and coverage.

Raising and promoting health rights and values

In the face of persistent inequality at national and global level, explicitly articulating values related to fairness in the distribution of health outcomes is argued to be central to shaping pro-poor health policy (Evans et al 2001). A strengthened civil society is regarded as part of the leadership input needed to re-focus health care systems towards social welfare goals and health rights (Isaacs and Solimano 1999). Lopes de Carvalho (1998) describes work in Brazil, for example, to generate dialogue about health priorities between administrations and committees of citizens, which is reported to have driven an acknowledgement of the need to fight extreme poverty by society at large. The successful CSO-led campaign and court action to ban the use of quinacrine for chemical sterilization in India is also cited as an example of CSO use of ethical and value driven approaches. In this case, CSOs built wider solidarity alliances to pose a legal challenge to the negative effects on poor women of more utilitarian approaches to their reproductive health (Visvanathan 1999).

Strengthening the voice and agency of poor people

One of the critical means for overcoming the most health-damaging effects of social inequality is dealing with poor people's social exclusion (Evans et al 2001; Loewenson 1999; Loewenson 2000). Bangser (2000) argues that the policies and actions of donors and many southern governments neglect the 'agency' of poor people to create lasting social change, fail to promote participation of the poor in agenda-setting, and stifle systems of public accountability.

This issue of agency and voice is raised as important in many papers. In relation to gender equity, the papers report ways in which CSOs strengthen processes by which women act to promote change for themselves and catalyse broader social transformation (Bangser 2000; Behague et al 2002; Niang 2001). McLean et al (2002) describe the positive effects of including culturally marginalised groups through civil society communication channels to ensure the relevance and effectiveness of community mental health services.

These efforts to strengthen agency and voice are embedded by some CSOs within programmes that address material needs. BRAC programs that bring together education, health and credit are reported to strengthen women's roles in household decision making and also to strengthen poor people's engagement in civic decision-making.

Focusing health systems on universal health rights and coverage

CSO efforts to promote social rights and participation in poor communities can, however, be undermined by wider political and economic conditions. Government-CSO programmes of 'Community Solidarity' in Brazil were overburdened by the resources demanded to deal with deeply rooted poverty, reported to be far beyond the means of the federal government (Lopes de Carvalho 1998). A study of CSO action on urban housing in Chicago found that in spite of efforts by low-income and marginalized groups to defend their interests, their housing choices were determined largely by powerful business

coalitions, that had little incentive to accommodate the interests or preferences of low-income groups (Ranney et al 1997).

CSO efforts to strengthen participation need to be matched by institutional reform within the state, for them to have an impact on public spending. An analysis by Rajkumar et al (2002) of data on public spending internationally shows a relationship between improved governance – measured by level of corruption and quality of bureaucracy – and public- spending. Governance indicators (that include voice and accountability, political stability, reduced violence, government effectiveness, regulatory burden, rule of law and reduced graft) are reported to have a strong direct negative impact on infant mortality. The paper reports that public health spending has a stronger impact on reduced child and infant mortality rates in countries where such governance indicators are strong. On the side of the state, governments are observed to strengthen limited powers to reduce the most damaging health inequalities by building coalitions, including with CSOs (Bloom 2000).

This implies that CSOs should go beyond simply ‘organising’ or ‘providing services’ to analysing and engaging with the political and economic interests that impact on pro-poor policies (Ranney 1997; Isaacs and Solimano (1999; Bangser 2000; Bernal et al 1999). In the Philippines, for example, CSOs provided services to low income urban households, but also lobbied for mayors with pro-poor policies and monitored elected leaders (Etemadi 2000). Fuglesang et al (2002) note that such political roles call for wider alliances to strengthen CSO voice. They argue that it is no longer enough for CSOs working in the field of HIV/AIDS to work in an isolated and fragmented manner and they call for concerted action, grounded in research and analysis.

Hence, if CSOs are to move beyond mitigating the consequences of inequity into raising the political momentum for pro-poor public policy, the studies call for a clear, value and rights-driven analytic framework for the work they do, grounded in evidence, supporting direct voice and agency of poor communities, and building the wider solidarity alliances to strengthen pro-poor health action.

3.4 Conclusions and research issues arising

CSO contributions to pro-poor health outcomes thus range from specific inputs to provide or enhance use of services in low-income communities, to increasing pressure and political momentum for wider pro-poor policies. A number of research gaps exist across these areas, indicating a relatively wide potential research agenda. There is a need to better understand the manner in which CSO action organises the experience of poor people, facilitates service outreach, strengthens the voice and agency of poor people, and engages with the political and economic interests that influence health outcomes in poor communities. There are also knowledge gaps in the understanding of the manner in which public policy and health system design reinforces or obstructs pro-poor CSO roles.

The paper highlights the important role that CSOs play in raising the visibility of the experience of poor people. They do this directly, or through bridging

researchers and communities (Shannon 1998). This is highlighted as essential to ensuring qualities of relevance and voice in pro-poor services (Gilson et al 2001; Harrison et al 2000). There is scope for improved research tools for organising the perceptions and experience of poor people, and for measuring the distribution of formal and unpaid cost burdens of different health policies.

One important research method is that of action research (Harrison et al 2000). The Bangladesh Rural Advancement Committee (BRAC), for example advocates and publicises action-linked research as a means to improve both research practice and health outcomes. Other networks and CSOs promote both participatory and action research (PRA) as a means towards ensuring stronger links between research and health equity outcomes (Loewenson 1999). These authors argue that the voice and agency of the poor, noted to be important for promoting pro-poor public policy, are strengthened through the closer control poor communities have over new knowledge through these methods.

The paper notes that CSOs face a choice of whether to take 'mitigatory' or 'transformational' actions in dealing with poverty and health equity. It notes the motivations, risks and interests around these choices. It could be argued that building more participatory forms of generating and reflecting on new knowledge builds insight and analysis within poor communities, and strengthens their voice and agency to make these choices themselves.

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