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Annotated Bibliography on Civil Society And Health

Civil society - state interactions in national health systems

By Rene Loewenson

Civil Society Initiative
WORLD HEALTH ORGANIZATION

Training and Research Support Centre
Zimbabwe

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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 - state interactions in national health systems

R Loewenson, TARSC[1]

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 second paper in the series and presents the evidence from studies on civil society - state interactions in national health systems.

WHO has noted a diversity of situations within which civil society organisations (CSOs) currently interact with the state around health goals. What are the forms, comparative advantages and disadvantages and impacts of civil society contributions to the different dimensions of health action? What factors within health systems, the state and civil society influence these outcomes?

This paper reviews studies of local and national forms of civil society--state interaction and collaboration in the different spheres of health governance and action (policy, health promotion, service provision, community outreach, resource mobilisation and monitoring health systems). It identifies the features within the state, health systems and civil society that produce positive and negative

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

interactions. It also explores any comparative advantages or disadvantages for health system outcomes.

2.1 Forms of civil society intervention in health

The 123 papers reviewed in this section describe a range of CSO actions in health:

- CSOs act as direct service providers, either in co-operation with the state, contracted by the state, or in areas where the state has ceased to operate. CSOs provide promotive, preventive, curative and rehabilitative health services (Akbar Zaidi 1999; Brinkerhoff et al 1999; Carter 1999; Kahssay 1996; Munishi et al 1995; World Bank 2002).

- CSOs reach population groups sometimes poorly served by the state. This includes indigenous populations, poor rural and urban communities, people living in informal or squatter settlements, women, mobile communities and communities displaced by political conflict. CSOs operate in difficult and sometimes high risk environments (Barnes 2000; Joseph et al 1999; Field and Gregory 2000; Grant and Harpham 2001; Etemadi 2000; Hurtig et al 2002; Rajbhandari et al 1999; Theobald 1999; Pinnock 2002; Kalipeni and Oppong 1998; Medicus Mundi Int 1999; Taylor Robinson 2001).

- CSOs provide the social mobilisation required to change or implement public health policies and campaigns. The papers in this review document this in areas such as road safety, tobacco control, reproductive health and HIV/AIDS (Ellevset 1999; Kickbusch et al 1998; McKee et al 2000; Partnership for Health Reform 2000; Salojee 2001). They are also reported to enhance the involvement of communities in health services and make health services more accountable to the public (Lopes de Carbalho 1998; Loewenson 2000; Mittlemark 2001; Mosquera et al 2001; Price 2000; Raghuram and Ray 1999; Etemadi 2000).

- In a number of studies, CSO interventions are linked to community traditions of mutual support, or driven by values, rights or social justice, such as in the services provided by religious organisations (Elliason 1999, Sen 1994; Embuldeniya 2001; Kahssay et al 1996). The common focus of CSO services in primary health care together with an orientation towards disadvantaged communities reflects equity values (Jareg et al 1998). This is not always the case, however, such as in the influence of more urban, curatively oriented professional associations in health reforms (Glassman et al 1999).

- CSOs have taken a lead in responding to new challenges such as HIV/AIDS, through innovative local programmes and national advocacy (Connor 2000; Mboa et al 2001; Piot et al 2001; UNAIDS 1999; UNAIDS 1998).

- CSOs test new directions in health action. This includes innovative programmes and advancing new positions in policy debates, such as on reproductive health rights (Bernal et al undated; UNFPA 1998). CSOs have

challenged legal or commercial interests where these conflict with health (Achieng 2001).

- CSOs mobilise and contribute resources to health, including direct financing of services and infrastructure. They bring in competencies and experience and have been observed to act as a bridge between external donor or international NGO resources and national programmes (Jack 2001; Leighton 1995).

The strength and scale of these inputs varies geographically. CSOs have emerged as major service providers in Africa, growing in number and in the size of the programmes undertaken. In sub-Saharan Africa for example, NGO hospitals provide 43% of medical work in Tanzania, 40% in Malawi, 34% in Ghana, and 9% in Congo (DR). The figures for Asia are 26% for Taiwan, 15% for India (with over 200 CSO hospitals), 13% for Bangladesh, and 12% for Indonesia (Medicus Mundi Int 1999). This growth is not consistently the case across countries and in India and much of Latin America, for example, the state has retained its position as the main provider of social services. Where CSOs occupy the role of junior partners they have had an important role in advocating on behalf of local people for improved state services. In the extreme case of countries that have experienced complex political emergencies and conflict, where the state has collapsed, such as Southern Sudan, Afghanistan and Somalia, CSOs, especially international CSOs, were found to be the only providers of social services such as water supply and health care.

2.2 Features of civil society intervention in health

It is not easy to generalise about the features of CSO health action from the wide ranging forms of intervention. The health sector is itself vast and highly differentiated. In a survey of CSO provision, Clayton et al (2000) report a spectrum of organisations, from huge national CSOs such as Proshika or the Bangladesh Rural Advancement Committee (BRAC) in Bangladesh - each employing thousands of people with multimillion-dollar budgets - to small localised grassroots organisations. Some CSOs have a long history and are deeply rooted in local communities, while others are relatively recent actors. Such differences in scale or background are not always made clear in research studies, making it difficult to contextualise the characteristics raised.

Despite this, some features commonly emerge from the studies reviewed.

CSO contributions to health systems
CSOs are frequently observed to be a source of experience, expertise and information. The studies reviewed indicate that CSOs provide new insights and approaches to people-centred and participatory development. They pioneer and provide services to communities poorly reached by the state or market. They promote transparency and accountability in decision-making, create livelihoods and economic opportunities and promote human rights and improved justice systems. They facilitate policy change in states and societies to reflect people's circumstances and needs. They have helped to generate formal and informal networks of trust, openness, communication and co-operation, as well as shared

norms, goals, beliefs and decision-making institutions (Bissainthe et al 1998; Buturo undated; Elliason 1999; Embuldeniya 2001; Kahssay et al 1996, Sen 1994, UNFPA 1998).

Some CSO services, including those provided by religious organisations, provide quality care at low cost, delivered by committed practitioners with high levels of client satisfaction (Sen 1994; Bitran 1995; Elliason 1999). Personnel working in such services were found in one study to be motivated by service to the poor, by the work experience and by social justice values (Sen 1994; Elliason 1999).

CSOs are commonly observed to have provided resources, personnel, technical expertise and community links to health action (Carter 1999). Their community intervention is noted in some studies to be based on participatory and innovative methodologies. In one comparative assessment of formal public sector and CSO methodologies for identifying poor people, the CSO methods were found to be more valid and transparent and more able to build community and staff support. This reduced community dissatisfaction with beneficiary selection processes (Simanowitz 1998; Embuldeniya 2001).

These positive features of CSO interventions are noted to make rapidly changing demands on CSO roles, challenging their capacities. They have also driven new forms of health action, such as increased policy advocacy in CSOs traditionally involved in service delivery. Flexibility in responding to these challenges and to new role demands is observed as a strength of CSOs (Desai 1999).

Critiques of CSO contributions

Other studies, however, note negative features of civil society that impede their work:

- The proliferation and diversification of CSOs is noted to complicate their links with other CSOs, with state agencies and with communities.
- Weak CSO capacities, complex internal politics and unclear legal authorities pose considerable challenges.
- CSOs are noted in some studies to have an unstable mix of funding sources, weak assets, to depend on volunteer inputs and to receive inadequate support from state or private funds (Embuldeniya 2001; Bissainthe et al 1998; Acharya et al 2001).

These features are reported to weaken the CSOs and impact negatively on the focus and quality of their programmes. CSO dependency on foreign funds is reported to skew their activities towards donor agendas over indigenous priorities, while inadequate understanding of communities by expatriate personnel has been noted to marginalise rather than include key target groups (Ahmed undated; Shretta et al 2001; Simms et al 2001; Styles 2002; Emmanuel 2000).

There is, however, some diversity in the evidence available on this. The critiques may apply more to foreign origin CSOs than to those emanating from long traditions of mutual support and local voluntary activity. A review of 67 grassroots CSOs in India found that while northern CSOs were primarily foreign funded, Indian CSOs were mainly funded through the state (Desai 1999). National and local CSOs have used a range of creative approaches to control their agenda

and preserve accountability to local communities, despite the insecure funding environment. These approaches include pooling resources and capacities through networks; umbrella organisations and coordinating bodies; developing strong leadership bodies; building management information systems to enhance confidence of funders; strengthening strategic and business planning; and using innovative marketing techniques to raise resources from diverse funders (De Roeck 1998; Jareg et al 1998).

North--South CSO relations are also observed to be shifting. Examination of Latin American- Canada CSO coalitions in one study indicated a shift in relations from north--south linkages based on northern welfare support, to coalitions on common issues. These coalitions look more like multistakeholder partnerships with joint status north and south as co-producers and users of information (Jackson et al 1999).

While these case studies reflect positive responses to preserving autonomy in an insecure funding environment, it would appear that they may be the exception rather than the rule. A UNDP assessment of CSO programmes found few to have a serviceable system of monitoring and evaluation and mechanisms for learning and communicating lessons were found to be generally weak. While CSOs were commonly found to be encouraging participation and empowerment of communities, the UNDP review found that this was cost and labour intensive with inadequate thought given to how to reduce costs to enable broader replication of successful projects (UNDP 2000). This review indicates that many CSO programmes, while innovative, are locked into action without monitoring that action; and are too focused on the delivery of their 'product' in their location, with little preparation for scaling up.

CSOs have been noted earlier to be more flexible than state bureaucracies in their interventions. This too is not universally true. Field studies have found areas of inflexible administration within CSOs. A field evaluation of ten CSOs in Ahmedabad, India identified organisational inertia due to founder-directors being unwilling to share experience or consider novel approaches. Some CSOs have operated as geographically focused organisations, making them inefficient in utilising the experience of community based organisations outside their areas (Acharya 2001).

Clearly there is not 'a one rule fits all' option for describing CSO interventions in health. The review highlights the diversity of CSOs and their contributions to health, the potential for a positive and sometimes unique contribution, and the presence of unresolved problems within the sector.

2.3 Features of civil society -- state interactions in health

The nature of CSO relations with the state is as important as their internal features and their health interventions. Across most studies, the state is understood to have authorities and obligations in meeting population health and health care needs. This makes CSO--state relations potentially as important as CSO--community relations.

The profile of CSO inputs to health and CSO roles in health systems have increased as health care access in communities has fallen, as public social protection mechanisms have declined or health resources become more limited. Even in cases where health service access has been sustained or improved, CSO inputs have become more important with the increasing attention paid to improving the responsiveness of services to client needs. These factors have made governments more willing to explore links with non state actors to enhance resource mobilisation for health services and to improve the coverage and quality of health care (Fleury 2000; Agyepong 1999; Winder 1998).

Mechanisms for state-CSO co-operation

The studies document a number of mechanisms by which the state encourages CSO service inputs. States encourage co-operation through legal frameworks, taxation policies, funding and official support. They also offer collaborative partnerships and mechanisms for public consultation and information (Clark undated; Clayton et al 2000). Interestingly, there were almost no examples of research on collaborative projects, and those found were mainly noted in large international disease control efforts (such as the eradication of guinea worm disease) or in the traditional partnerships between church and public sector in health service delivery.

Subsidies have been a long-standing and common form of state support to private providers, including CSOs (Leighton 1995; Mudyarabikwa 2000). They have been found, in practice, to be weakly applied in CSOs serving the poorest communities. This is 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 (Mudyarabikwa 2000).

New forms of state support have emerged under health reforms that are still poorly evaluated. The World Bank documents initiatives to increase public co-ordination of private (and non-profit) services and to encourage greater private (and CSO) participation in preventive services, in some districts of Uganda . These inputs are encouraged through state financial, equipment and training inputs (World Bank 2002b). A further instrument of state support of CSO inputs is the use of contracting (World Bank 2002b). Medicus Mundi International (MMI), itself an international CSO for co-operation in health care, advocates contracting as an efficient method for the integration of CSO health services into the District Health system. Given the size, efficiency and coverage of the CSO sector, MMI suggests that a contract is a useful tool for defining the terms of collaboration between national or local authorities of the health system and a public purpose CSO. They note that contracts provide clear terms for sharing trust, responsibility and transparency, criteria for regular evaluation of the relevance, quality and efficiency of the care provided and an opportunity for joint CSO--state formulation of local priorities (MMI 1999).

In practice, contracting is noted in studies in both high and low income countries to place additional management demands (audit, performance measurement) that are not recognised or rewarded as a core business of public services (Charlesworth 2001). An evaluation of a contracting arrangement in Brazil,

judged by both CSOs and the state to be successful, found a number of features that contributed to the successful outcome. The contracting programee :

- was part of a larger national strategy
- involved the CSOs in the design of the contracting programme
- was backed by a dedicated unit in the state to work with the CSOs. This unit was staffed by two people from the CSO sector and used mass mailings, website, site visits, and other efforts to maximise transparency and facilitate communication with CSOs.
- built on existing CSO and MOH capacity to implement contracts and also provided technical assistance to CSOs in proposal preparation, accounting, monitoring and evaluation (PHR 2000a).

These features are commonly not present. Contracting arrangements in Ghana were not pursued despite longstanding agreements with CSO sector providers, due to lack of skills and experience in the state to design contracts and the possible opposition from public sector unions (McPake and Mills 2000). On the CSO side, the additional capacities and administrative burdens involved were found to be poorly integrated into contracting arrangements (Connor 2000).

Motivations for and tensions in CSO-state interaction

From the papers reviewed, the primary interest of the state appears to be to extend service outreach, while CSOs appear to have wider interests in their collaboration with the state. CSOs seek to advance citizen rights, check state power and hold policy makers accountable. 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). Formal mechanisms for enabling this role are far less developed than for encouraging service outreach. One example is in the joint state--CSO child rights councils set up to protect adolescent and child rights in Brazil (Ahnen 2001).

In contrast, there are a number of studies that document ambivalence in the state towards CSO roles in community organisation, monitoring rights and holding policy makers accountable. The state response to such roles ranges from co-operation, to indifference or non-responsiveness to hostility (Ahmed undated; Birungi et al 2001; Clark undated; Clayton et al 2000). To some extent ambivalence can be read from (and is reinforced by) the absence of clear mechanisms found in the studies to enable such relationships between the state and CSOs. A review of decentralisation initiatives in six countries highlighted the importance in: building relationships of clear legal frameworks; organisational capacities matching their roles; tools such as citizen charters to clarify mutual expectations and roles; mechanisms for effective dialogue; and financing systems that reinforce poilitical objectives (Yongjan and Wilkman 1996). In contrast, a review of 67 CSOs working with the urban poor in India found linkages with the state to be diverse, with weak formal mechanisms for partnership and co-ordination and antagonisms over differences in CSO and state positions on the urban poor (Desai 1999).

Beyond the absence of formal mechanisms, there are also political tensions. A further review of CSO--state relations in India found that whatever the nature of the state--CSO relations at central level, local level relations were generally characterised by the hostility towards CSO activity of politicians, party workers,

local élites, lower level bureaucrats and lower level employees of the state (Sen 1999). While at local level this may be traced to power relations between communities, authorities and political leaders, at national level it also traces to a perceived distortion of national public policy by international CSOs. This is documented for example in policy analysis of user fee and drug policies in Uganda (Okounzi and Macrae 1995), in relation to water and sanitation services in Pakistan (Akbar Zaidi 1999) or in the changing models for social protection in Latin America (Fleury 2000).

Indifference also shifts to hostility where CSOs are perceived to play an oppositional rather than an operational role. State perceptions of hostile political interests is found in situations where CSOs mobilise communities or project constituent antagonism to state policies (Clark undated; Clayton et al 2000). The relationship is also complicated by the fact that where CSOs are large, they be in competition with the state. The emergence of large multitasking NGOs such as the Grameen Bank and BRAC, in a relatively weak state such as Bangladesh is reported to imply CSO competition with government ministries for donor funding. This renders state institutions designed to regulate the activities of such NGOs functionally ineffective (Kennedy 1999).

The state responds to these tensions positively through structured engagement (such as in the participatory councils of Brazil) or through providing support to CSO activities and services in line with state priorities. On the other hand there are reports of state efforts to regulate ‘undesirable’ CSO activity through controlling CSO operations and financing and excluding CSOs from state planning forums (Sen 1999).

While much of the literature documents the problems or tensions from the perspective of the state, CSOs also face difficulties in their interactions with the state. The additional time and administration demands of contracting have been noted. The expectation that CSOs will channel community views and interests into state programmes carries further time and personnel demands, with many constraints to realising effective participation and change (Strobl and Bruce undated). Divisions within civil society and different treatment by the state of different CSOs also pose internal challenges. In Africa, medical professional groups were found to be influential but distant from community based civic lobbies (Jareg et al 1998). There was little research on the impact of these challenges on CSOs, or on the adjustments that CSOs have made to secure their relationships with the state. Only one study looked at this, and this from the perspective of northern CSOs operating in the south. This evaluation found that the ability of the CSO to generate a productive engagement with the state depended on the strength of the CSO, its political profile, its role as a foreign interest, the services it offers, the extent to which its finances are targeted at the state, or at parallel CSO community health work, and the confidence and capacity within government to interact with it (Lorgen 1998). Lorgen observed that CSOs may compete to secure positive relations with the state, duplicating services with other CSOs, producing patchy welfare nets and substituting CSO funding for state funding of basic services.

CSO--state relations are also negatively affected by shortfalls in the capacity of both (Clark undated; Connor 2000; Gilson 1997). While this is further discussed in the assessment of factors influencing the impact of CSO roles in health, the studies indicate that this is not purely a skills gap, but extends to the level of institutional development. Some studies note limits to what civic pressure can achieve in the absence of institutional reform of the state, implying a need for civic-state relations that promote constitutionality, capacity and policy dialogue within the state (Bangura 1999; Cornwall and Gaventa 2001). This has led to some CSO programmes making corresponding investments in state capacities and prioritising early work on capacity building and service delivery to enhance receptiveness to advocacy (Brinkerhoff et al 1998).

This may call for a credible facilitator of CSO--state interactions. UNFPA assessments on progress towards reproductive health goals set by the 1994 International Conference on Population and Development (ICPD) indicate the role of UNFPA in acting as a bridge between CSOs and governments, by forming collaborative networking and in providing the information, evidence of good practice and logistic support needed for such networking (UNFPA 1998, 1999).

While CSO links with the state in health actions are the primary focus of this section, it is important to note that CSOs have built links with other sections of society in their health work. In India academic and training institutions are noted to have increased their demand for CSO links, with mutual benefits of an exchange of professional skills for grassroots contact (Desai 1999).

CSOs have also engaged commercial private sector interests in health (Bendell 1999; Heap 1998; Heap 2001). CSO relationships with the private sector are described as often competitive or conflictual, and sometimes collaborative (Heap 2001). This review did not focus on such relations or their risks and benefits as this needs a more focused investigation of its own.

This profile of CSO health interventions and CSO--state relations indicate the challenges to be addressed and the areas for further work to support productive collaboration and engagement. The motivation for taking up these challenges must lie in the evidence of the positive impact of CSO interventions on health outcomes. What evidence does the research literature provide of this?

2.4 Impacts of civil society health actions

Positive impacts

There are a number of field studies that document the positive impact of CSO interventions on health outcomes. Acharya et al (2001) found that CSOs made measurable improvements in school attendance levels, literacy, immunisation and mortality rates and successfully facilitated the development of community organisation. CSO interventions in urban Philippines were found to have improved service provision, immunisation rates, increased use of oral rehydration solution and reduced child malnutrition rates (Etemadi 2000).

CSOs are documented to have extended service outreach within communities or areas of health delivery not well covered by the state or private sector (Delahanty

et al 1999; Gwatkin et al 2002; Harpham et al 2001; Hanson et al 1999; Munishi et al 1995; Rajbhandari et al 1999; Williams et al 2001). CSOs have tested new approaches in national health strategies (Hanson et al 1999). CSO services were assessed in some studies to be accessible to the poor and to satisfy client perceptions of quality of care (Sen 1994). An evaluation in Senegal between state and non-state non-profit services found the latter to be more efficient than state or other private services in the provision of curative and preventive ambulatory services with high levels of output (Bitran 1995). CSO flexibility, autonomy, and responsiveness were found to have enhanced the speed and effectiveness of primary health care services reform in Kazakhstan (Brinkerhoff et al 1998).

CSOs are observed to have 'role modelled' successful community resource mobilisation strategies, including traditional individual or group insurance, prepayment plans, or community-based funds earmarked for health care (Leighton 1995; Winder 1998).

Beyond changes in health indicators, CSOs are also reported to have had a positive impact on the social processes underlying health and health seeking behaviour. Consultative decision making processes and participatory intervention methodologies in CSO interventions are reported to have integrated community knowledge, evidence, views and values and enhanced community involvement in health systems and health policy (Barnes 2000; Whyte 2002). Local CSOs were observed to bridge western and indigenous knowledge in health, with positive impacts on health seeking behaviour (Barnes 2000; Field and Gregory 2000; Sen 1999). The multisectoral nature of CSO inputs have addressed wider determinants of ill health. For example, recent evaluations of the Grameen Bank and the BRAC credit programmes for women indicate that these programmes' income generation activities increased contraceptive acceptance and use among poor families. Other CSO programmes cited are reported to have reduced socio-economic determinants of women's vulnerability or made statistically significant shifts in information, awareness and attitudes and thus enhanced women's control over reproductive health choices (Whelan et al 1999).

Negative or negligible impacts

The review highlights substantive evidence of the positive impact of CSO actions on health outcomes. Not all the findings are so positive, however. Three reviews of CSO health and poverty interventions in Bangladesh assert that CSOs cover only a fraction of the population and less than 20% of the poorest households. Weakness in CSO outreach to poor communities is traced back to middle class interests, inadequate mechanisms for strengthening participation by the poor and conflicts of interest between CSO institutional needs and those of communities served (Ahmed undated, White 1999; Whyte 2002). A series of studies by the UK's Overseas Development Institute (ODI) in Zimbabwe, India and Bangladesh reported that CSOs have not been successful in benefiting the poorest households or women, nor in ensuring self-sustainability of local CSOs (Buturo undated). Notably these problems are not unique to CSOs and are found equally within the state sector. In a field evaluation of primary health care (PHC) services in rural El Salvador both state and CSO services were found to add little to health seeking behaviour, to preventive health or to address critical quality of care

factors prioritised by the population (Lewis et al 1999). A study in Dar es Salaam, Tanzania, found essential drug stockouts and uneven quality of clinical practice in both the church-based, voluntary agency sector and the state, in some cases with potentially serious clinical errors (Munishi et al 1995) . A review of available studies was found to show little evidence to suggest that CSOs are more effective than governments in reaching the poorest with development assistance, except in direct service provision. The quality and efficiency of CSO services were found to be inadequately researched, while evidence was found of limits to their sustainability (Clayton et al 2000).

Clearly CSOs cannot on their own overcome some of the wider factors disabling health service access and public sector service provision. Neither should CSO services be seen as a substitute for the state. Even where CSO outreach has been successful, caution is expressed by researchers that it is not a substitute for effective state intervention in widespread epidemics such as the HIV/AIDS epidemic (Williams et al 2001, Watts et al 1999).

What is perhaps missing from the literature on impacts is the assessment of the relative changes (possibly improvements?) in impact when CSO and state sectors work *together*, compared to when each operate in parallel. Most of the studies compare the sectors as discrete and non overlapping. Given the new forms of state--CSO interaction there is need for more evidence on the different forms of this collaboration and their impacts on health outcomes. Three separate reviews highlight positive outcomes from closer and more structured civil--state collaboration in outreach in maternal health services, HIV/AIDS interventions, health services access and environmental health (Putney 2000, PHR 2000, Harpham et al 2001). It would appear that there are health potentials in such direct CSO--state collaboration that remain largely untested.

2.5 Factors influencing civil society impacts

What then are the main factors influencing the positive and negative outcomes documented in this review?

Given the diversity of different types of contexts, CSOs and interventions, it is difficult to draw firm generalisations from the literature. However many of the studies do trace factors influencing impact and these are reported here.

A review of ‘successful’ CSOs in South Asia, Africa and Latin America indicates that success is associated with a three-pronged strategy:

(a) helping the poor to secure their livelihoods;
(b) attempting social mobilisation with the aim of empowering the poor;
(c) trying to influence the overall political process by playing an advocacy role on behalf of the poor (Osmani undated).

While ‘success’ in this study was not clearly defined, the findings do signal a blend of factors that that resonate with the findings of other studies, viz: CSO technical competence, ability to deliver; relationships with the community; and relationships with the state.

Factors within the state

The relationship with the state is commonly noted to be a determinant of impact. Formal legal recognition of CSO roles by the state is noted to provide a positive and clear framework for designing effective CSO intervention and for enabling resources to be directed to co-operation, rather than conflict with the state (Ahnen 2001; Birungi et al 2001; Bissainthe et al 1998; Brinkerhoff et al 1998; Clayton et al 2000; UNDP 2000). Studies in Brazil, Mexico and Colombia note that such formal recognition reflects deeper factors that are possibly even more important. This includes the acceptance within political authorities of a more active role for civil society in governance and the capacity of civil society to use the political spaces available to advance their issues (Ahnen 2001; Synergos Institute 1996; Wouters et al 1998; Cardelle 1998). Formal recognition also reflects the extent to which communities trust that they will obtain returns from collective participation in public affairs (Hyden 2001). Notably political acceptance of an autonomous civil sector is differentiated from direct political intervention within civil society. Case studies cited found that CSOs created from the top with state patronage did not achieve effective participation of people at the bottom (Osmani undated).

Formal legal recognition provides a baseline for other enabling factors identified within the state: tax and other financial incentives, agreed mechanisms for CSO involvement in decision-making and state capacities and information mechanisms to support co-operation (Bissainthe et al 2001; Hurtig et al 2002; Olowu 2001, Bitran 1995). Movement of personnel between state and CSO employment was found in the Philippines to enhance mutual understanding and communication (Etemadi 2000). A review of 20 CSO--government collaborative health care reform projects in Guatemala, Chile and Ecuador highlighted three factors in successful CSO--government collaboration, viz: political commitment to collaboration; adequate procedures and processes to guide the relationship between CSOs and the state and a mechanism of dialogue and debate that allows both sectors to air contested matters and to compromise (Cardelle 1998). These factors are sometimes observed by their absence. In Zambia, CSOs observed that their ability to contribute to the reform process was constrained by lack of information flow from government on policy shifts and decisions taken (Nanda 1999). Limited state finances, state capacities and the unwillingness of the state to spend resources on participation mechanisms, were reported to weaken state--CSO links and services in Canada, the Philippines and Africa (Boyce 2002; Orsini 2001; Etemadi 2000; Ntsebu et al 2001; Acharya et al 2001).

Factors within CSOs

Few studies have focused on the factors influencing impact within the CSOs themselves. In those which have evaluated this dimension, CSO impacts, sustainability and credibility were influenced by the extent of positive relationships with and involvement of communities, the clinical expertise of health workers and technical expertise of staff involved, the use of opinion surveys and evidence based advocacy to present issues (Etemadi 2000; Elliason 1999; Barnes 2000). The support obtained from wider authorities -- church, state, civil or international agencies -- provided important sources of financial, information, political and technical support to CSOs (Bernal et al undated; Demin 2001).

The extent to which financing mechanisms provide positive or negative frameworks for CSO--state co-operation is a preoccupation of a number of studies. Several focus on the negative impact of CSO reliance on donor back-funding in terms of the stability of the CSO, their responsiveness to local priorities and their relationship with the state (Ahmed undated; Pinnock 2002). In East Timor and Mozambique studies found that diverting bilateral aid from the state to CSOs for services led to a proliferation of projects, and fragmented primary health care. It also led to wasteful spending on unsustainable projects, built excessive differences between CSO and state budgets in the same province and diverted state personnel time into CSO programmes. This weakened local and state control over health programmes, factors noted earlier as important for effective CSO intervention (Pfeiffer 2000; Pfeiffer undated).

While some attention is focused on negative forms of international financing, others note the contribution of flaws in national and particularly state financing systems. Cardelle's (1998) review of Central American state--CSO relations identified that the current contracting and granting system between CSOs and the state underfunds the CSOs and does not take account of CSO needs for financial stability, predictability and accountability. Studies from Brazil further indicates that the state contracting of CSOs contributes to an imbalance between large and small, and between service and advocacy CSOs. Contracts are further noted to distort CSO inputs away from the social targets they have greater impact in, and to exclude important non financial incentives (Palmer 2000). The evidence on contracting is contradictory, but in all cases indicates that its impact on CSO interventions and outcomes can be profound. While some studies document contracting as a successful way of enhancing delivery on jointly agreed outcomes between state and CSOs, others warn that it diverts CSOs from the social, promotional, monitoring and advocacy roles through which they achieve positive impacts. Both sets of studies indicate that mechanisms for state financing of CSO interventions have a powerful impact on CSO activity and its outcomes (Palmer 2000, Clayton et al 2000, PHR 2000).

CSOs seem thus to be caught between the rock of underfunding from the state and the hard place of politically interested international financing. This places CSOs in a difficult position around their funding choices, that has sometimes driven them towards creative mechanisms for fundraising from the poor (and sometimes not so poor) communities they serve, or towards co-operation with the private sector. The nature and impact on health systems of CSO-private sector relations is an issue that merits its own focus and is not covered here. The review suggests, however, that to strengthen the public interest role of CSOs in health systems, greater focus needs to be given to financing systems and arrangements that support co-operation between the state and CSOsin achieving public health interests.

2.6 Conclusions and research issues

Conclusions

This review provides evidence of a range of CSO roles in health systems. CSOs provide services across a spectrum of health interventions, service areas and communities not well covered by the state or private sectors. They also enhance

the social dimensions of health inputs and outcomes and contribute technical, financial and institutional resources towards health systems. The review presents evidence of the positive impacts of this contribution in health, health care and wider social outcomes.

What then are the comparative advantages or value-added dimensions of civil society contributions to health?

The easy answer to this question refers back to CSO attainments in improving health and access to health care in poor communities and in areas poorly covered by the state or market; in areas of health intervention that demand social action, innovative and community based responses; and in strengthening community interface with and involvement and control in health services. The review provides numerous examples of CSO contributions in these areas, despite the difficulties or shortfalls noted. These studies indicate that there is no generic answer as to whether CSOs are more effective in some types of service delivery than state or other agencies, but they do indicate features of CSO work that support positive health and health care outcomes.

A more complex issue, however, is where the boundaries between CSO and state should fall. This is as much to avoid the inappropriate engagement of CSOs in services better provided by the state as to encourage CSO involvement in areas critical for effective public health services.

The tensions between state and civil society indicate different positions on this. Some studies implicitly characterise a role for civil society of 'rolling back the state' or of coping with its roll back. Civil society is there to contest the state and to shift authority from the state to other spheres of society. Others locate the state as the primary vehicle for meeting social rights and public goods. Civil society is there to complement and not substitute this role of the state. It contests and builds public demand to ensure that this role is effectively delivered, works with the state in organising, informing and supporting communities towards this role, and draws state support and nourishment in fulfilling this role (Baum 1997).

While this rather oversimplifies the problems and tensions noted in the studies, the conflict in views of the role of civil society and state imply that both the state and civil society face problems in their outreach to communities because the relationship between them is unclear, a site of political struggle, and poorly serviced.

Where the necessary synergy between state and civil society in health actions is recognised (legally and institutionally), positive outcomes are observed. These include examples in the review of state--church co-operation in health care in Africa; joint CSO--state mechanisms for child rights protection and HIV/AIDS intervention in Brazil; joint action towards tobacco control; joint programmes for communicable disease control in Africa or for advancing reproductive health in Asia. In these case studies, mutual recognition appears to have triggered greater investment in public financing and public mechanisms for joint action, with positive health impacts.

Where the synergy is not recognised, and parallel or competitive relations exist, for whatever political or economic reasons, the evidence indicates that opportunities for making health gains are missed and inefficiencies introduced into the actions of both. Hence, for example, under these conditions the ability of CSOs to use methods that are better at identifying the poor than bureaucratic targeting systems may not be adequately tapped by government health programmes (Gwatkin 2000). The capacities that CSOs have to facilitate community input to services, or make services responsive to community interests may be ignored, to the detriment of public satisfaction with and use of state services (Acharya et al 2001). Equally, when CSOs get directly involved in service provision without locating their work in the context of wider public services, there is evidence of inadequate inclusion of information needed for scaling up innovation or mechanisms for co-ordinating with wider public services. This may also divert CSOs from other roles needed to secure improvements in the quality of public health services, including community monitoring of services and community outreach to ensure effective health seeking behaviour and early detection of health problems.

Research issues

A central conclusion of this review is that beyond evaluation of CSO programmes, or comparative analysis of the relative efficiency of state and CSO at doing the same roles, there is need for a systematic assessment of the interface between CSOs and the state. The research lens should focus on the primary knowledge gap identified: what are the most productive forms of legal, political, institutional, financial and service relationships between CSOs and the state for improved health outcomes, and what mechanisms, procedures, information and capacities are needed to service such relationships?

Amongst these issues, specific focus needs to be given to the design of financing mechanisms. The paper notes that current approaches to both international aid and national state financing have produced problems in the ability of states to build effective forms of collaboration and in the ability of CSOs to deliver on areas where they have proven advantage. New knowledge is needed on the financial tools available to the state, which are feasible (given current capacities); achieve the joint health goals of CSOs and state; and do not generate financial disadvantage or instability in either. Equally greater evidence is needed of mechanisms for international financing that do not disrupt the balance between the public and civil sectors, but that build joint action.

Poorly explored across much of the research are the gains and losses of different approaches for the poorest within communities. Women have for example traditionally been the pillars of many community groups and supported civil society through their informal and unpaid labour. Poor resolution of the civil--state conflicts in health, poorly designed financing systems or unsustainable demands on civil society organisations to substitute state roles may increase the pressures and burdens on women, with negative health outcomes (Baum 1997).

If poor communities are ‘barometers’ of the success or failure of health actions, then they have an interest in ensuring that valid evidence of their situation reaches policy attention. CSOs have played an important role in building bridges

between researchers and communities, and more importantly, in bringing community participation into research to ensure that evidence judged valid by the poor is brought into policy advocacy. Transparency International, for example, has successfully involved community members as co-researchers in the conduct of sentinel community surveys, which combine qualitative and quantitative data. Numerous other examples exist (Whyte 2002). This suggests that CSOs provide an opportunity that can be better tapped in future health research to strengthen community--researcher relations and make communities more central to the production of evidence used in health planning.

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