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Strengthening Community Participation and Accountability in Sexual and Reproductive Health and Rights

Since the 1990s there has been renewed interest in community participation[1]. The impetus for this interest has stemmed from both the neo-liberal agenda of mobilising community resources due to cutback on social budgets, and the emergence of radical debates on rights of citizens to participate in policy decisions, monitoring and evaluation. In the sphere of health, the neo-liberal perspective is reflected in many of the World Bank-supported health sector reforms in developing countries, while the radical perspectives are reflected in citizen action, demanding health service accountability. Reflecting both perspectives, the ICPD Programme of Action recommends that governments should involve NGOs and communities in decision-making, programme planning, cost recovery, training and expanding outreach, monitoring and evaluation. The World Bank assumes that reforms such as financing, decentralisation, evaluation, along with strategies to increase competition from the private and non-profit sectors, will strengthen public sector accountability.

However, a regional review carried out by the Initiative for Sexual and Reproductive Rights in Health Reforms[2] revealed that community participation and accountability within and outside World Bank-supported health sector reforms in Asia has done little to strengthen sexual and reproductive health services. Within health sector reforms in Asia, community representatives have tended to be consulted at a lower level but not given decision-making powers (see table). Such consultations have been prevalent at the level of service delivery, not in policy formulation, thus having little impact on the nature of policies that were designed. As a result, World Bank-supported health sector reforms in Asia have tended to downplay comprehensive sexual and reproductive health services, especially in the area of reproductive cancers, infertility, sexuality, abortion and prevention of gender-based violence. Neither have they placed priority on the value of equity that would ensure availability of services for adolescents, sex workers, and those too poor to pay user fees.

Available evidence does not support the assumption of the World Bank that community financing of health services strengthens participation of and accountability to marginalised people, as there are hierarchies of power and information between providers and clients. Furthermore, for community participation under decentralisation to positively influence access to sexual and reproductive health services, community members would need to have information on why such services are critical in protecting women's, men's and young people's health and on what services can be delivered at what costs.

Table: Levels of Community Participation (CP) and Accountability (AC)

	Lower level of CP/AC	Middle level of CP/AC	Higher level of CP/AC
CP			
– Who	Powerful clients	Powerful groups/NGOs	Marginalised/NGOs
– Why	Expand outreach and resources	Improve health service management	Improve accountability
– Depth	Being informed	Consultation	Decision-making
– Scope	Service delivery	Service delivery	Health policy
– Mode	Through invitation	Through invitation	Through invitation and civil-society pressure
AC			
– Of whom	Health workers	Doctors and managers	Health policymakers and others
– To whom	Management	Management and colleagues	Community members and elected representatives
– On what	Input	Inputs, finance and output	Impact and social relevance
– Why	Detect any error	Detect any error	Prevent & detect error

Source: Murthy, R.K. 2003

Community participation and accountability outside the context of health sector reforms has taken place both at the invitation of the government, as well as through demands of civil-society organisations that represent the interests of marginalised people. Understandably, community participation and accountability strategies in demanded spaces have been more diverse and innovative. Sexual and reproductive health and rights issues have been raised in this space, strengthening accountability of not just health workers but also policymakers. Here, participation has not remained merely at the level of consultation, but extended to pushing or setting agendas. However, it must be pointed out that strong traditions of democracy and space for dissent seem a pre-requisite for such demanded participation to thrive, but these spaces are often not present.

Demanded participation and accountability strategies in Asia have been more successful in reducing violations of women's sexual and reproductive health rights than in institutionalising comprehensive sexual and reproductive health services. For example in India, women's groups have used public interest litigation to ban harmful trials of injectable contraception and introduction of the female sterilisation drug, Quinacrine. However, without the presence of enabling factors like adequate government resources, conducive cultural environment, and sexual and reproductive health and rights advocates working within the bureaucracy, pushing comprehensive sexual and reproductive health services into the essential service delivery package will be an uphill battle. To address the gaps discussed, national governments in Asia, the World Bank, and multi and bilateral donors need to adopt the following strategies:

- Enter into 'participation-contracts' with civil-society actors, spelling out respective roles and responsibilities, and mechanisms for conflict resolution.
- Stop justifying community-financing arrangements in the name of strengthening accountability to communities.
- Promote the devolution model of decentralisation of health services, along with the necessary pre-requisites.
- Expand the range of accountability and participation strategies which can include placing of media advertisements, inviting public inputs on policy, holding public hearings, institutionalisation of ombudsman centres and patient rights charters, conducting reproductive mortality audits, strengthening professional councils and legal reform to permit public interest litigation and rights of public to information.
- Raise additional resources for investing in relevant capacity building required for quality and accessible sexual and reproductive health services.
- Conduct advocacy at local and national levels for strengthening democratic spaces.
- Advocate for higher sexual and reproductive health budgets.
- Build capacity of members of locally elected bodies, community health structures, hospital boards, professional councils and trade unions on their roles and responsibilities, as well as on sexual and reproductive health concerns.

Endnotes

[1] As early as the 1970s, community participation was advocated for strengthening effectiveness of government development and health services (within the Alma Ata declaration of 1978).

[2] The Rights and Reform Project, coordinated by the Women's Health Project, South Africa, is a research and advocacy project launched in 2002 to strengthen understanding amongst activists and decision-makers of the role of health sector reform in facilitating or undermining efforts to achieve sexual and reproductive health and rights policies and programmes.

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Decentralisation, Accountability and SRH Services: Lessons from Philippines

By Ranjani Krishnamurthy

This case study in the Philippines explores the potential and limitations of one model of decentralisation - devolution of powers to local bodies - in strengthening accountability to communities with regards to sexual and reproductive health (SRH) services.The Philippines government embarked on devolution of health and social services after the passing of the Local Government Code of 1991. As part of the devolution in health services, 95 per cent of its facilities, 60 per cent of its personnel and 45 per cent of the budget was transferred from the Department of Health to local government units (LGUs) at provincial, city and municipality levels. To oversee the functioning of health services in decentralised units, local health boards were set up in each unit, comprising the Governor or Mayor as its chairperson, Municipal Health Officer as vice chairperson, the local councillor for health, a representative of the Department of Health and a representative of a health NGO.

Local government expenditures increased by 51.9 per cent in 1993 when compared to the pre-devolution period, with 66 per cent being allocated for the health sector. Though this amount in principle is untied, a significant proportion goes for salaries of health workers. The Local-Government Assistance and Monitoring Service (LGAMS) was set up within the Department of Health to monitor LGU health programmes and provide technical assistance. The LGAMS was also supposed to augment resources of LGUs, if they agreed to implement national health programmes, including the Reproductive Health Programme[1]. However, there were no incentives or punitive measures to ensure that units complied with the agreements.

Impact of Devolution on SRH Services

Researchers have observed that the implementation of reproductive health programmes has suffered because of decentralisation[2]. Provision of a wide range of contraceptives by local clinics depended on attitudes of members elected to LGUs at different levels. This in turn led to high rates of unsafe abortions. While emergency obstetric care has been on the priority list of many LGUs, in practice such services have been affected because of weakening referral systems as different levels of healthcare are being managed by different elected bodies. Access to diagnosis and management of HIV/AIDS is still limited and unequally distributed across rich and poor areas.

Men's sexual and reproductive health needs are often not prioritised by LGUs. By and large, curative care was given more priority over preventive care by most LGUs. Another area of concern is the LGUs' preoccupation with being re-elected. They are fearful of promoting any policy or programme that goes against the interests of the Church, as this institution still influences voting patterns of communities. There has also been little effort to build capacities of local health boards and LGUs on their roles and responsibilities as elected members as well as on sexual and reproductive health and rights issues.

The potential role that NGOs could play to promote sexual and reproductive health and rights (SRHR) within the process of devolution is illustrated through the experience of the Development of People's Foundation in Davao city[3] which strengthened SRH services in the area by providing research and capacity building support to LGUs, and by putting pressure on LGUs from outside by building advocacy skills of NGOs and community women.

This case illustrates that the devolution model of decentralisation offers potential for strengthening accountability with respect to SRH services when adequate powers and resources are devolved to LGUs, inequities between resources of LGUs in resource-poor and resource-rich areas are addressed by governments and when incentives are provided to LGUs to provide essential SRH services. At the local level, it is important that women and marginalised groups are proportionately represented in these bodies, members of elected bodies are aware of their roles and responsibilities and sensitive to issues of SRHR, and citizens are in a position to put external pressure on local bodies to provide comprehensive SRH services.

■ Endnotes

1. The Reproductive Health Programme of the Philippines includes services to improve contraceptive choice and access, MCH and nutrition, prevention and management of abortion complications, prevention and treatment of RTIs, including HIV/AIDS/STDs, education and counselling on sexuality and sexual health, detection and treatment of breast and reproductive tract cancers, men's and adolescent reproductive health, care and counselling for victims of violence against women and prevention and treatment of infertility and sexual disorders

2. **Tadiar, F.M.** 2000. Reproductive health programmes under health reform: The Philippines case. International Council on Management of Population Programmes, Malaysia. Available at http://*www.icomp.org.my/Country/inno7b.html.* pp 14

3. This effort is part of a broader strategy (called Gender Watch) of the Foundation to monitor the implementation of the 'Women's Development Code of Davao City' which was passed by city council in 1997. (Pacaba-Deriquito, http://*www.icomp.org.my/Policy/CSSeminar06.htm)*

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Bangladesh: Participation and Accountability in Health and Population

By Ranjani Krishnamurthy

This case study in Bangladesh is used to illustrate the potential and limitations of community participation. During the pre-health reform years, the Ministry of Health and Family Welfare (MOHFW) of Bangladesh implemented over 120 projects related to health and family planning in the mid-1990s, resulting in overlaps and wastage of resources[1]. Though a consortium of 25 donors has existed since the early 1970s, it was only in 1996 that the consortium, led by the World Bank, assisted the government to prepare a Health and Population Sector Strategy (HPSS). To implement the HPSS, a five-year (1998-2003) Health and Population Sector Programme (HPSP) was formulated by the government in 1998, again with assistance from the World Bank and the donor consortium.

The specific objectives of the HPSP were to: (a) reduce maternal and childhood morbidity and mortality; (b) reduce prevalence/incidence of poverty-related communicable diseases; (c) reduce fertility; and (d) improve the cost-effectiveness and efficiency of health and family planning services. Both policy and institutional reforms were proposed to achieve these objectives. The policy reform components included earmarking of 65 per cent of funds for an Essential Service Package; establishing a gender strategy; involving stakeholders in the design and implementation of the programme; adopting a Patients Charter of Rights; financing reforms (including cost recovery and insurance), reviewing of the National Drug Policy; upgrading safety standards; and involving NGOs and the private sector in service delivery. The institutional reforms included the promotion of a client-centred focus through the setting up of one-stop clinics, integration of the health and family planning departments (under threat with change in government in 2001), sector-wide management, and decentralisation of health planning and management to thana (sub-district) and union levels.

Community Participation Involved in Programme Design

A unique feature of the HPSP is the emphasis on stakeholder participation in design, implementation and monitoring of projects, as well as institutionalising mechanisms for accountability to the community. A task force on community and stakeholder participation was formed during the time of preparation of the HPSP. The task force carried out a stakeholder analysis, identifying and mapping 34 stakeholders under three categories: primary stakeholders (clients, in particular women, children, and the poor), secondary stakeholders (providers, MOHFW officials, drug companies, donors, private sector doctors) and external stakeholders (like media, political parties, and religious leaders). The task force, comprising of 40 members from all the three categories, held consultations with stakeholders and gathered feedback on key components to formulate the HPSP. NGOs, health networks, professional associations and women's organisations facilitated most of the consultations. The Swedish International Development Agency hired two international consultants to provide inputs on gender and equity issues and stakeholder participation. Consultants in turn, attempted to mobilise national gender advocates from both women's organisations, bureaucracy and research institutions. In coordination with the Gender Issue Office, a gender-equity strategy was developed to address gender inequalities that undermine women's health.

The experiment to promote stakeholder participation in the design of HPSS and HPSP was considered a huge success by the World Bank. Women activists and researchers, while acknowledging that consultations with different stakeholders in the design of HPSS on this scale was a step forward, however were more critical of the consultation processes. Some activists observed that NGOs in the 'good books' of the government were invited to such forums, while many women's organisations working with a rights perspective, were invited to policy formulation processes only upon their insistence. Furthermore, the consultations with women's organisations remained ad-hoc, with some of the women's organisations being called for the first round of consultations, but not the final ones in which the HPSS and HPSP designs were finalised. If one unpacks the components of the Essential Service Package (ESP), which includes reproductive health (family planning, emergency and essential obstetric care, prevention and control of STD and HIV/AIDS), control of communicable diseases, child health, limited curative care (for accidents and injuries) and behaviour change communication, it is evident that the rights-oriented recommendations were not incorporated. Recommendations to include services in the areas of violence against women, safe abortion, infertility and diagnosis of reproductive cancers as part of ESP were not included, although counselling and legal services in the area of violence are provided for in a few women-friendly hospitals.

Community Participation in Monitoring

To institutionalise stakeholder participation beyond the planning stage, the Ministry of Health and Family Welfare (MOHFW) of Bangladesh established a National Steering Committee for stakeholder participation, consisting of representatives of women's organisations, NGOs and government. However, it has

not been as active as envisaged, with no national level meetings held during the first two annual programme reviews of the HPSP.

To promote participation and accountability at the thana and union levels, the HPSS and HPSP recommended that Health Watch Committees, consisting of local communities (including women and households without land), be established by NGOs. The purpose of the committee was to make users' claims more visible, as well as to make providers answerable to users with respect to the quality of service. This programme has been operationalised now in nine thanas. An in-depth study at one Health Watch Committee (HWC), indicated that though members were supposed to be selected through a voting system in the village, in practice the Health Watch Committee, comprised of members of community groups formed by NGOs. While this has ensured representation of the marginalised, it has totally excluded the elite and influential persons. Defacto leadership rested with the NGO, to whom the members looked up to for guidance. As the NGO staff were friends of the Thana Health and Family Planning Officer, the HWC could not perform a watchdog role, and in fact was restricted to only raising awareness about health concerns. Progress reports from other HWCs indicate that this problem was prevalent in other committees as well.

At the Upazilla (district) level, Health Advisory Committees, formally constituted bodies of the government, were set up to play a regulatory role. However, many of these committees are not functioning. The potential of this committee to strengthen accountability of district level health complexes, if backed by research and capacity building inputs, is indicated by the success of Naripokkho, a women's rights group (see box).

Complying with the requirement of the HPSS, the Government of Bangladesh adopted a Patients Charter of Rights. However, very few members of the community, in particular poor women, are aware of it. In response to the Patients Charter of Rights, doctors are now demanding their own Charter to protect their interests vis-a-vis clients. Another accountability mechanism that is being developed as part of HPSS is to strengthen the Obstetrical and Gynaecological Society of Bangladesh, so as to make them more pro-clients in their orientation.

On the whole, the experience in implementing the HPSS and HPSP points to both the potential and limitations of community participation in spaces invited by the government or World Bank, as well as accountability strategies initiated from the top that do not allow much community participation. Invited spaces for community participation at the service delivery level can bring further access to, and improve quality of health and sexual and reproductive health services. However, the boundaries of such participation are shaped by the priority-setting processes defined by the World Bank that are based on cost-effectiveness. The challenge then is to influence priority-setting processes through advocacy.

Making Participation and Accountability Mechanisms Work: Naripokkho's Action-Research Experience

Naripokkho undertook an action-research project on decentralisation and accountability of health services (part of an international study on Gender, Citizenship and Governance by the Royal Tropical Institute, Netherlands) with the objectives of:

a) studying the delivery of health services at the Upazilla Health complex, in particular focussing on its treatment of women,
b) re-activating Upazilla Health Advisory Committee (UHAC) in Pathorghata Municipality, and
c) initiating citizen pressure (local NGOs, women's groups, clients) from outside

Using research and local advocacy to activate the UHAC, and building capacity of members of the UHAC, NGOs and service providers, the project has strengthened accountability of health service providers to meet women's health needs. It has also encouraged women to assert their rights as citizens by making demands on the government health services, monitoring quality of services, and protesting against any wrong doings. As an outcome of these processes, there has been an increase in client flow, improvement in quality of health services, and reduction in fees charged. It is now using this experience to influence changes at the national level with regard to health service delivery.

Source: Gupta, Rina Sen and Shireen Huq. 2003. "Decentralization and accountability of health services for women", [presented at] *Making the Link: Sexual-Reproductive Health and Health Systems* conference, Leeds, UK, 9-11 of September.

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India

■ Women's groups in India, including HealthWatch Uttar Pradesh, announced a campaign for monitoring State accountability to ensure equal rights for women in Uttar Pradesh, India. The campaign, *Complete Citizen, Total Rights*, drew from earlier efforts by women and human rights organisations to demand accountability from the State on the basis of constitutional obligations to protect, promote and fulfil women's rights. The campaign used primary evidence from women survivors and secondary data from state sources to prove that the government had failed in upholding the Constitution and its obligations in the areas of maternal mortality, violence against women, coercive population programmes, poor quality of services and compensation for women survivors of communal violence. The first phase of the campaign started on November 25, the International Day of Action Against Violence Against Women and concluded on December 18, 2003, the anniversary of CEDAW. Highlights of the campaign included the launching of a report card on the State, signature campaign addressed to the Chief Minister, disseminating issue briefs, screening film testimonies of rights violations of women survivors and their families and demonstrations. The campaign culminated in a march for women's equal rights through Lucknow.

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Regional

■ Some 36 individuals representing three sub-regional groups of the Asia-Pacific Women Watch (APWW) and 24 women's organisations and networks, as well as UNIFEM and UNESCAP officials, met at the first Asia-Pacific NGO Convener's Meeting held on February 13-14, 2004 in Bangkok. The meeting was organised for groups to discuss the forthcoming Regional NGO Forum that will feed into the Beijing + 10 review process. The Regional NGO Forum has been instrumental in the processes leading to Beijing and to the Beijing + 5 review and this time the APWW is being joined by other regional networks including ARROW in organising the NGO Forum which will take place on July 1-3, 2004 in Mahidol University, Salaya Campus, Thailand.

At the meeting, the convener's group agreed that the upcoming forum should meet the following goals: To consolidate the outputs on the gains achieved and remaining gaps, through NGOs monitoring of Beijing PFA implementation and other UN conventions and conferences, as feedback to governments, the UN, international development agencies and civil-society; To articulate the position of women in the region on the new/emergent issues which have arisen from an environment which had become hostile to women's rights, empowerment and development. (These factors include rapid globalisation, militarism and the global war against terror, and resurgent conservatisms and fundamentalisms); To catalogue innovative interventions and successful projects with particular focus on the role of NGOs and civil-society and partnerships with government; and To establish a mechanism to influence the official UN review and appraisal process.

Although no global conference is planned for 2005, the UN Regional Commissions will hold regional meetings. In the Asia-Pacific region, UNESCAP will hold a High Level Intergovernmental Meeting from September 6-9, 2004. A questionnaire was sent out in November 2003 by the Division for the Advancement of Women (www.un.org/womenwatch/daw/) to all governments to assess the implementation of the Beijing PFA and the Outcome of the Twenty-third Special Session of the General Assembly (2000). UNESCAP organised an Expert Group Meeting in Bangkok in March 22- 24, 2004. The objective of that meeting was to formulate the conceptual and organisational framework for the September meeting. Issues discussed included the social and economic impact of globalisation, trafficking in women and girls; violence against women; women in decision-making; human rights; information and communication technology; HIV/AIDS; and peace and conflict resolution.

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International

■ Gender and poverty issues were high priorities at Forum 7 of the Global Forum for Health Research, held in Geneva on December 2-5, 2003. Over 500 researchers, policymakers, NGOs and donors discussed cutting edge concerns, which would make a difference to reducing the 10/90 Gap, the goal of the Forum. The 10/90 Gap refers to the fact that only 10 per cent of funds for health research is directed to research that benefit the poor who experience 90 per cent of the world's ill health. A pre-forum session on "Gender, health and health sector reform" brought together experts like: Hilary Standing, Research Fellow, Institute of Development Studies; Gustavo Negenda, Director, Centre for Social and Economic Analysis in Health; and Yogan Pillay, Chief Director, Strategic Planning, National Department of Health, South Africa. They and other experts discussed the diverse impact of health sector reform on women and men and the implications for health policy and research. The next Forum will be held in Mexico City from November 16-20, 2004.

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India

■ The Third International Health Forum for the Defence of People's Health was held on January 14 - 15, 2004 in Mumbai. Some 700 medical practitioners, health-based NGOs, academicians and World Health Organisation officials (AIDS Department) from 43 countries gathered for this conference, organised by the People's Health Movement (PHM Global) and Jan Swasthya Abhiyan (PHM India). It was the first time PHM organised the International Health Forum, the third such international forum held since 2002, to mainstream health into the World Social Forum. The previous three World Social Forums were held in Porte Alegre, Brazil, and India as the host country marked the first time the venue has changed. Objectives of the PHM conference included reviewing health concerns like globalisation, militarism and war and exclusion because of gender, ethnicity, disability, poverty and marginalisation. Participants shared experiences, strategies, responses and alternatives evolving at local, national, regional and global levels to meet existing challenges. The Mumbai Declaration was drafted based on recommendations made at thematic workshops, which included health sector reform and women's health.

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Malaysia

■ The AMDD Network Conference held in Kuala Lumpur from October 21-23, 2003, brought together 300 people from various government officials, development practitioners and leading figures from international agencies, including Carol Bellamy, the Executive Director of UNICEF, Kunio Waki, Deputy Executive Director of UNFPA, Stefan Bergstrom of the Karolinska Institute, Raj Karim of IPPF ESEAOR as well as Barbara Kwast, Deborah Maine, Allan Rosenfeld and Lynn Freedman of the AMDD programme. However, noticeably absent from the conference was the involvement of other civil society actors, and NGOs in particular. The conference focus moved beyond lamenting that high maternal mortality is a problem and a violation of women's human rights. Collectively, members of the AMDD network shared evidence on effective ways to reduce maternal deaths and disabilities based on the experiences of implementing the programme in over 80 projects in 51 countries. AMDD is a five-year programme established in 1999 to work with developing countries and international agencies to improve availability, quality and utilisation of emergency obstetric care (EmOC). It is based on the understanding that maternal mortality is a development and public health failure, and that while most of the obstetric complications can neither be predicted nor prevented, a vast majority of women can be saved through good, timely medical care. The programme is based at the Mailman School of Public Health at Columbia University, with funding support from the Bill and Melinda Gates Foundation. The diverse group of AMDD partners gathered in Kuala Lumpur to report on their progress to date, while policymakers and practitioners shared their experiences. In general, AMDD partners have been successful in demonstrating: Measurable progress, namely improvements at community and policy levels; Limitation of working within health systems due to corruption, health sector reforms, and attitudes towards poor women; and Positive approaches such as the use of the rights-based approach, involvement of international movements, and involvement in larger processes such as health sector reforms or sector-wide approaches. The sessions were grouped into three broad areas related to EmOC: upgrading services, improving quality, and moving beyond facilities.

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Thailand

■ With a view to build capacities and skills as well as enhance confidence of NGOs in Asia to influence public opinion, national laws and government policies and practices in relation to sexual reproductive health, a workshop was organised jointly by Interact Worldwide, London and International Council on Management of Population Programme (ICOMP) Malaysia on December 1-5, 2003. Some 17 representatives from 13 NGOs from seven Asian countries participated in this event, hosted by the Population and Community Development Association (PDA) in Bangkok, Thailand. The participants were introduced to the different stages of advocacy, lobbying and influencing styles, networking for advocacy and the importance of communication. At the workshop, the participants identified two issues to advocate, namely 'violence against women' and 'mainstreaming life useful skill education in formal schools'. A plan of action was developed at the international, national and organisational levels.

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Ramiro, Laurie [et al]. 2001. "Community participation in local health boards in a decentralised setting: cases from the Philippines". *Health Policy and Planning*. No. 16 (Suppl. 2), Oxford University Press. pp 61-69.

Decentralisation has been associated traditionally with participation and empowerment in local decision-making. This study looks at four cases, analysing the role of local health boards in enhancing community participation and empowerment under a decentralised system in the Philippines. Local government units (LGUs) with functioning local health boards were compared with LGUs whose health boards were not meeting regularly as mandated by law. The study found that there were more consultations with the community, fund raising activities, health initiatives and higher per capita health expenditure in LGUs with functioning local health boards. But in general, only the mayors and municipal health officers felt empowered by devolution. Awareness of devolution and understanding roles in health decision-making was low among members of the community. Participation and empowerment was influenced largely by: 1) Awareness of the importance of the issue; 2) Capacity to influence decisions; and 3) Opportunities available for participation. These findings can be attributed to the socio-cultural and historical traditions of centralised governance with little popular participation, overall attitudes of the community and board members, perceptions of health as primarily a medical matter, economic circumstances of LGUs, and insufficient preparation for devolution. To enhance community participation and empowerment, the authors suggest measures such as building community consciousness toward participation, democratic selection of the community representatives, providing a sufficiently purposeful role for the local health board, and ensuring that board members fully understand their roles and responsibilities with clear mechanisms for accountability.

Source: Health Policy and Planning, Department of Public Health and Policy. London School of Hygiene and Tropical Medicine, Keppel (Gower) Street London, WC1E 7HT United Kingdom. Website: www. heapol.oupjournals.org

Suoratikto, Gunawan [et al]. 2002. "A district-based audit of the causes and circumstances of maternal deaths in South Kalimantan, Indonesia". *Bulletin of the World Health Organisation 2002. 80(3)*, Geneva: World Health Organisation. pp 228-235

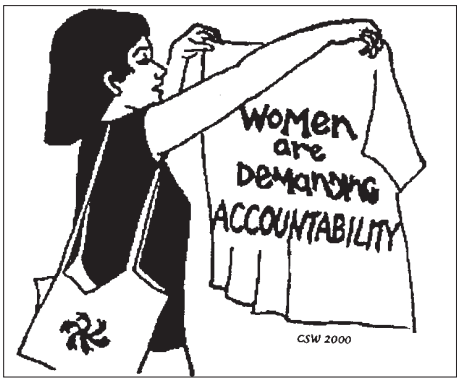
A district-based audit of maternal and perinatal mortality began in 1994 in three provinces of South Kalimantan, Indonesia. Both medical and non-medical factors were documented and an effort was made to progress from merely assessing standard care to recommending improvements in access to care and the quality of care. Extensive discussions of maternal death cases were held during regular meetings with providers, policymakers and community members. The sources of information included verbal autopsies with family members and medical records. Between 1995 and 1999, the audit reviewed 130 maternal deaths. The leading causes of death were haemorrhage (41 per cent) and hypertensive diseases (32 per cent). Delays in decision-making and poor quality of care in health facilities were seen as contributory factors in 77 per cent and 60 per cent of the deaths, respectively. Economic constraints were believed to have contributed to 37 per cent of deaths. The distance between a patient's home and a health provider or facility, did not appear to have a significant influence, nor did transportation problems. The audit led to improvements in the quality of obstetric care in the district. Its success was especially attributed to the process of accountability of both health providers and policymakers, and to improved working relationships between health providers at different levels and between providers and the community. With a view to further expand on the audit, it may be necessary to reconsider the role of a provincial team, the need to incorporate scientific evidence into the review process, and the possible consideration of including birth complications as well as deaths. It may also be necessary to recognise that village midwives are not solely responsible for maternal deaths.

Source: Bulletin of the World Health Organisation, World Health Organisation, 1211 Geneva 27, Switzerland. Website: www.who.int/whr/en/

Newell, Peter; Bellour, Shaula. 2002. Mapping accountability: origins, contexts and implications for development. IDS Working Paper. Brighton, England: Institute for Development Studies. 28 p

This background paper was produced for the Development Research Centre on Citizenship, Participation and Accountability. It provides an overview of the political uses and applications of the term 'accountability' in contemporary discourses and practices of development. The first section of the paper reflects on the historical origins of the different meanings and contexts of accountability and what this means for the parties involved, and the processes in which they are applied. The second section looks at tools, strategies and processes of accountability in formal and informal settings, assessing the role of law, protests and a variety of managed approaches in the creation of mechanisms of accountability. The third section looks at how these diverse practices of accountability apply to key development players, traditionally the nation state, but increasingly also the public authority at supra and sub-state levels, as well as the private and non-governmental sectors. The authors argue firstly, that the right to demand and the capacity and

willingness to respond to calls for accountability assumes relations of power. Indeed the very function of accountability is to ensure that those that wield power on behalf of others are answerable for their conduct. Secondly, these power relations are in a state of flux, reflecting the contested basis of relations between the State, civil-society and market actors. These relations both create and restrict the possibilities of new forms of accountability by generating material change and shifts in the organisation of political authority. The authors discuss how prevailing notions of accountability and the entitlements they presume reinforces the patterns of power. These contexts, which are the product of particular sets of historical and material circumstances, validate some forms of power and delegitimise others. The interaction between political action, material change and practices help us to understand the different expressions of accountability politics in diverse settings and issue-arenas, and how they are applied to a range of players in development. These interactions also provide the basis for understanding the place of accountability in the broader context of citizenship and the discussion about rights, who gets to define these rights and the implications of this for the poor.



Source: Institute of Development Studies, Brighton, Sussex BN1 9RE, England. Website: www.ids.ac.uk/ids/

George, Asha. 2003. "Accountability in health services: transforming relationships and contexts". Cambridge, MA: Harvard Centre for Population and Development Studies. *Working Paper Series*, Vol. 13, No. 1. pp 16

Accountability mechanisms ideally mediate relationships between two unequal partners with the aim of redressing the imbalance between them. In order to do this, accountability measures must contest power relations, legitimise marginalised groups, and transform the actors involved. These elements endear accountability to people at the margins of society and those concerned about health issues marked by social inequalities and stigma, thus making it particularly useful to sexual and reproductive health, but also to other areas like mental health and disability. An emphasis on information, dialogue, and negotiation can facilitate this approach to accountability to improve health services delivery. The author reviews case studies and concludes that efforts to improve accountability cannot merely rely on instituting social mechanisms without paying attention to social contexts, practices and actors. Accountability is best achieved through negotiated, iterative processes that represent participants involved, their relationships, and the social contexts they operate in. The author argues that accountability mechanisms may serve as important resources to mediate relationships between users, providers, and managers of health services. In order for them to overcome inequalities between these actors, they need to be able to confront power relations, improve the representation of marginalised groups and transform them in legitimising ways. Information, dialogue and negotiation are important elements that enable accountability mechanisms to address problems by supporting learning and changing the terms of engagement between actors.

Source: Harvard Center for Population and Development Studies, 9 Bow Street, Cambridge, MA 02138. Email: cpds@hsph.Harvard.edu Website: www.hsph.Harvard.edu/hcpds

Murthy, Ranjani K. 2003. Service Accountability and Community Participation in the Context of Health Sector Reform in Asia: Implications for Sexual and Reproductive Rights and Health. Johannesburg. Women's Health Project, South Africa. {unpublished} 41 p.

This paper starts out with the premise that participating in governance will strengthen the extent to which those who hold power at different levels are accountable to citizens, and will lead to better enforcement of penalties in cases where they are unable to do so. The author examines the practice of community participation and accountability within and outside the context of health sector reforms in Asia. The focus is on accountability of health and sexual and reproductive health (SRH) services delivered by governments in Asia, not those offered by for profit institutions or NGOs. The thrust is on accountability to communities (external accountability), not accountability of one government branch or level to another (internal accountability). The emphasis is on examining accountability strategies through community participation, or participation through NGOs. The first section of the paper develops a critique of the understanding of community participation and accountability underpinning health sector reforms of the 1990s. The second section summarises different strategies used for community participation and accountability with regard to health policy formulation and management in the Asian region, both as a part of health sector reforms and independent of them. The third section reviews the scant literature available on the impact of community participation and accountability strategies on SRH

Graphic Source: ReproWatch (Institute for Social Studies and Action, Philippines)

services. The fourth section outlines key lessons and recommendations (to policymakers and planners from government and aid agencies, as well as to community organisations, NGOs and social movements), identifying advocacy gaps that need to be addressed in the coming years to foster accountability and participation which promote quality SRH services.

Source: The Rights and Reform, Women's Health Project, PO Box 1038, Johannesburg 2000, South Africa. Fax: 27 11 489 9922 Email: rightsandreforms@sn.apc.org Website: www.wits.ac.za/whp/rightsandreform

Cornwall, Andrea; Lucas, Henry; Pasteur, Kath. 2000. "Accountability through participation: developing workable partnership models in the health sector". *IDS Bulletin*. Vol. 31 No. 1, January 2000. pp 1-13.

The IDS Participation and Health and Social Change Groups convened a workshop in October 1999 to share experiences in the use of participatory approaches in enhancing accountability in the health sector, and to explore some of these challenges. The papers mentioned in this introductory article to the bulletin reflect some of the valuable experience on the ground in building effective participation as well as some of the many issues that arise in moving towards more active citizen engagement with service providers. The authors bring experience from current and ongoing work to reflect the links between participation, accountability and improvement in health. The workshop explicitly aimed to reflect on experiences that were moderately successful, in order to identify potential elements that contribute to and impede the success of efforts to build accountability through participation. The article is divided into the following sections: 1) The health sector context; 2) The changing role of participation in health; 3) Accountability: to whom, by whom and for what: 4) Partnership and participation (partnership in theory, and in practice; new partnership models); 5) Accountability through participation (partnership for accountability; enhancing genuine community control; participation and accountability in disabling environments; improving transparency; and enhancing accountability through participation); and 6) Directions for the future: linking participation, accountability and partnerships to improve health outcomes. Two checklists are included: the first takes into account some of the complex layers, levels and procedures that need to be considered when determining how best to enhance transparency for improved accountability; the second highlights a series of key themes, including the centrality of mechanisms for the inclusion of diverse stakeholders, for the provision of appropriate information at each level and for different purposes, for establishing and enforcing agreements between different parties, and for decision-making, monitoring and ensuring transparency.

Source: Institute of Development Studies, University of Sussex, Brighton BN1 9RE, United Kingdom. Tel: 44 1273 606 261 Fax: 44 1273 621 202 Email: a.cornwall@ids.ac.uk

OTHER RESOURCES

Lakshminarayanan, Rama. 2003. "Decentralisation and its implication for reproductive health, The Philippines experience." *Reproductive Health Matters*, Vol. 11 No. 21, May 2003. Amsterdam. Elsevier Ltd. pp. 96-108.

Zhang, Kaining. 1997. *Multidisciplinary Participation in Reproductive Health Research and Action: a path-breaking experience of YRHRA*. Kunming, China: Institute for Health Science, Kunming Medical College. 8 p.

Peters, David, H. 2002. "The role of oversight in the health sector: the example of sexual and reproductive health services in India". *Reproductive Health Matters*, Vol. 10, (20). Elsevier Ltd. pp. 82-94.

ARROW'S PUBLICATIONS

ARROW. 2003. *Access to Quality Gender-Sensitive Health Services: Women-Centred Action Research.* Kuala Lumpur:ARROW. 147p.
■ *Price: US$10.00 plus US$3.00 postal charges.*

ARROW. 2000. *Women's Health Needs and Rights in Southeast Asia.* A Beijing Monitoring Report. Kuala Lumpur: ARROW. 39p.
■ *Price: US$10.00 plus US$3.00 postal charges.*

Rashidah Abdullah. 2000. *A Framework of Indicators for Action on Women's Health Needs and Rights after Beijing.* Kuala Lumpur: ARROW. 30p.
■ *Price: US$10.00 plus US$3.00 postal charges.*

ARROW. 2000. *In Dialogue for Women's Health Rights: Report of the Southeast Asian Regional GO-NGO Policy Dialogue on Monitoring and Implementation of the Beijing Platform for Action, 1–4 June 1998, Kuala Lumpur, Malaysia.* Kuala Lumpur: ARROW. 65p.
■ *Price: US$10.00 plus US$3.00 postal charges.*

ARROW. 1999. *Taking Up the Cairo Challenge: Country Studies in Asia-Pacific*. Kuala Lumpur: ARROW. 288p.
■ *Price: US$15.00 plus US$5.00 postal charges.*

ARROW. 1997. *Gender and Women's Health: Information Package 2*. Kuala Lumpur: ARROW. v.p.
■ *Price: US$10.00 plus US$3.00 postal charges.*

ARROW. 1996. *Women-centred and Gender-sensitive Experiences: Changing Our Perspectives, Policies and Programmes on Women's Health in Asia and the Pacific. Health Resource Kit.* Kuala Lumpur: ARROW. v.p. ■ *Differential pricing. Contact ARROW for details.*

ARROW. 1994. *Towards Women-Centred Reproductive Health: Information Package No. 1.* Kuala Lumpur: ARROW. v.p.
■ *Price: US$10.00 plus US$3.00 postal charges.*

Note: Payments accepted in bank draft form.

Health Sector Reforms

Health Sector Reforms are sustained processes of fundamental change in policy and institutional arrangements in the health sector.

Source: World Health Organisation. 1997. The Regional Consultative Meeting on Research on Health Sector Reforms, Bangkok. World Health Organisation. Available at *http://w3.whosea.org/rdhome/rdspeech/55health.htm*

Neo-liberalism and Women

The pillars of neo-liberalism are large-scale privatisation, dismantling of the welfare state, de-democratisation of economic activities and curtailing the influence of politics to the benefit of the so-called Global Players in business life. Women are proportionally far more affected by the negative consequences of these developments than men. The gradual dismantling of the welfare state hits women in two ways: First, due to their weaker economic position, they are usually more dependent on government benefits. Second, they are forced to supply certain social services that used to be supplied by the government. They are usually expected to do so for little or no remuneration and are thus pushed out of the regular labour market entirely or into precarious working conditions.

Source: Available at http:// www.attact. Austria.org

Accountablity

The right to demand and the capacity and willingness to respond to calls for accountability assumes relations of power. Indeed, the very function of accountability is to ensure that those that wield power on behalf of others are answerable for their conduct. Secondly, these power relations are in a state of flux, reflecting the contested basis of relations between the State, civil-society and market actors. These relations both create and restrict the possibilities of new forms of accountability by generating new dynamics of power through material change and changes in the organisation of political authority.

Source: Newell, Peter; Bellour, Shaula. 2002. Mapping Accountability: Origins, Contexts and Implications for Development. IDS Working Paper. Brighton, England: Institute for Development Studies. 28 p.

Community Participation

Community participation implies participation of clients as well as other stakeholders who function at the community level like health providers, health managers, political leaders, NGOs and non-health department personnel. This broad partnership or community health partnership is a voluntary collaboration of diverse organisations at community level which have joined forces in order to pursue a shared interest in improving community health.

Source: Mitchell, Shannon; Shortell, Stephen. 2000. "The governance and management of effective community health partnerships: A typology for research, policy and practice". *The Milibank Quarterly*, Vol. 78, No.2, 2000.

Decentralisation

With regard to the health sector, decentralisation is concerned with changing the way health systems are organised. It is conceptually a change in power relations between the central government level and other actors in the health system, including statutory local government entities, lower levels of government administration, private enterprises and non-governmental organisations. Essentially, decentralisation is about strengthening health system performance. That is, improving the ability of health systems to deliver better health services and programmes that are responsive to local needs, efficient and more equitable.

Source: Mary Kawonga. 2003. Decentralisation - Africa Regional Paper. Johannesburg. Initiative for Sexual and Reproductive Rights in Health Reform. Women's Health Project, {unpublished}. pp 48.

Citizenship

With emphasis on inclusive participation as the very foundation of democratic practice, a more active notion of citizenship recognises the agency of citizens as 'makers and shapers' rather than as 'users and choosers' of interventions or services designed by others.

Source: Cornwall A and J Gaventa. 2001. "Bridging the gap:citizenship, participation and accountability." *PLA Notes* 40:pp 32-35

Reviewing World Bank-Financed Health Projects in Asia

The World Bank is financing health sector reforms in low-income and middle-income countries of Asia. A review of community participation and accountability strategies within nine World Bank-financed projects (see table) spanning nine Asian countries reveals that most of them envisage some form of community and NGO participation and accountability. Women constitute an important target group of all the nine projects, with maternal and child health services being a priority in eight and improving access to contraception in five. However, few projects envisage community participation in design and policy formulation, provision of comprehensive sexual and reproductive health (SRH) services, and services for adolescents, men and sex workers.

The challenge for governments, the World Bank and donor agencies is to widen the scope of community participation, so that communities and in particular marginalised people, can influence what services get prioritised, for which group, at what level of healthcare, and at what cost. Issues of who represents the community, capacity building on SRH issues, and monitoring of the process of community participation are other areas to be looked into, in particular by civil-society groups. The assumption that NGOs are better with respect to health and SRH service delivery and the long-term political implications of the State absolving itself of responsibility for providing health services needs to be discussed by all stakeholders concerned.

■ **By Ranjani Krishnamurthy**, Independent Researcher on gender, health and poverty.

Table: Community Participation (CP) and Accountability (AC) in World Bank-Financed Health Projects in Asia

	Cambodia	Vietnam	Indonesia	Philippines	China	India	Bangladesh	Pakistan	Nepal
Reproductive health focus STIs/HIV/AIDS prevention	●			●			●		
Maternal and child health		●	●	●		●	●	●	●
Family planning		●		●		●	●		
Strategies for promoting CP/AC *Civil society participation in:* – in identifying needs		●				●	●		
– in designing the project	●						●		
– in operational planning	●						●		
– in reviewing/monitoring	●						●		
– in assessing inequalities			●						
Elected representative participation In all aspects at local level			●	●					
User participation in – financing	●	●		●		●			
– project coordination						●			
– managing clinics	●								
– monitoring						●			
– satisfaction assessments	●					●			
Others Patient rights charters							●		
Provider-agreements	●								
Provider-accreditation				●					
Improve self-regulation			●						
Implementation by: – professional association – NGO	●		● ●	●				●	●

Source: Compiled from http://www4.worldbank.org/sprojects/