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Strategic alliances
The role of civil society in health

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Introduction

"We are dealing with the prime public health concerns of our time. We are focusing on conditions with a major impact on the poor and disadvantaged […] and we are working alongside a broad range of partners, maximizing what we can achieve together"

Dr Gro Harlem Brundtland, WHO Director-General

Civil society and non-state organisations have been contributing to public health for centuries. In more recent years, however, they have grown in scale and influence and are having profound impacts on health.

People, as part of the civil society, form the core of health systems. They use health services, contribute finances, are care givers and have a role in developing health policies and in shaping health systems. In all these respects, there is growing pressure for public accountability and increased response to inputs from civil society. The manner in which the state responds to these changes, and the extent to which civil society actors are recognized and included in health policies and programmes, are some of the critical factors determining the course of public health today.

This paper is part of a series produced by the WHO Civil Society Initiative (CSI) to help promote a wider understanding of civil society. It provides a brief overview of civil society trends in development and health, along with a brief discussion of the risks and benefits arising out of future strategic alliances between the state and civil society to improve health. It has been edited by CSI based on a background contribution written by Dr Rene Loewenson, TARSC, Zimbabwe.

Terminology

In the absence of common understanding or definition, civil society is usually understood as the social arena that exists between the state and the individual or household. Civil society lacks the coercive or regulatory power of the state and the economic power of the market but provides the social power or influence of ordinary people.

Within this social domain, individuals and groups organize themselves into civil society organizations (CSOs) to pursue their collective interests and engage in activities of public importance. CSOs draw from community, neighbourhood, work, social and other connections and provide institutional vehicles, beyond the ties of immediate family, to collectively relate to the state or market.

CSOs are broadly understood to be non-state, not-for-profit, voluntary organizations. In reality, however, there may be state or market links to CSOs that blur the borders between the non-state and not-for-profit aspects of these organizations. States or the private for-profit sector may play a key role in the establishment of some CSOs or provide significant funding, calling into question their independence from the state and private sectors. The interests that motivate people to associate may be public but they may also be personal. Associations may form to support kinships or narrow

group interests that have little to do with wider public concerns. Non-governmental organizations (NGOs) are considered part of civil society and the term is often used interchangeably with the term CSOs, particularly the health sector. ***The term CSOs is used in this paper to indicate a wide range of civil society actors including NGOs.***

The expanding role of civil society organizations

In recent years, CSOs have become more prominent, more visible and more diverse all over the world. One of the factors influencing the growth of CSOs has been the increased challenge to imbalances of power between state and its structures on the one hand and civil society on the other. This has been driven by many forces such as reactions to centralized authority in state structures; dissatisfaction with state performance on public services; and dissatisfaction with policy positions taken by the state in international arenas.

Civil society activity has also increased as a response to the perceived weakening of the nation states' authority under globalisation and increasing strength of transnational corporations. CSO networks have been formed within and across countries to promote a wider and more 'transnational' support of public interests on global policy issues such as human rights, environment, debt, development and health. Meetings of the World Trade Organization, Jubilee 2000 on debt relief, civil society lobbies on drug access and pricing, and the many civic lobbies around World Bank /IMF programmes, for instance, have come to dominate global headlines.

Increased public concern over the right to participate in policies and processes that affect people's lives and the growing demand for improved public accountability and responsiveness to citizen inputs at the local, national and global levels has made the work of CSOs more prominent. Their visibility has also been enhanced as CSOs become increasingly widely connected and organised into national and global networks, supported by expanded access to information. Electronic communication through email and the Internet has opened opportunities for communication and association within and across national boundaries.

Civil society organizations in development processes

The growing role of civil society in development processes is not simply a response to political lobbies or to an increased scale of Organization. It also emerges from a shift in the understanding of development processes. When people and human dimensions are defined as the core of development, then social exclusion itself becomes a facet of under-development and social networking a development asset. Under these terms, the fulfilment of human development will require concerted efforts of the State together with citizens and their Organization.

As there has been a shift towards a more rights based approach to development, more prominence has been given to civil society roles in raising, advancing and claiming the entitlements of different social groups. This gives CSOs a vital role as participants, legitimizers, and watchdogs of policy as well as collaborators in national development.

The complexity of development needs, declining resources, declining aid and various structural adjustment policies and global political changes at large, have also contributed to declining service provision by the state. This gap has been increasingly filled by CSOs adding to their importance as development agents within countries. Analysts have noted that these capabilities have had a positive impact on development outcomes and on government accountability and performance.

The increased channelling of bilateral and private financing, in this context, to international CSOs has reinforced the prominence of CSOs and drawn the attention to their potential role in new modalities and strategic alliances for health in development cooperation.

These trends at local, national and global level reflect the changing relationship between the state and the civil society. There are growing demands on governments for democracy, accountability, participation and compliance with human rights. Demands on the state to alleviate economic and social inequalities, provide public services to poor populations, and conform to a liberalised global market has led to a range of state relations with civil society—co-operation, confrontation and, in some cases, repression.

The growing presence and importance of CSOs at global and national levels has also motivated both national governments and global institutions to establish more formal mechanisms for listening to and responding to claims made from within civil society. Mechanisms for judging how representative CSOs are and evaluating the mandate of the civil society actors have also taken on added value.

The role of civil society organizations in the health sector

Civil society has a long history of involvement in public health. Early public health actions to clean up American cities in the 1800s, for example, were led by well known public figures supported by women's' groups. However, the recognition of civil society's contribution to health has varied over time. One of the most significant developments in the recent past has been the 1978 Alma Ata declaration, which is considered a landmark for recognising people's participation in health systems as central to Primary Health Care and for recognising the role that organised social action plays in securing health gains.

Health reforms in the 1990s, however, de-emphasised the welfare state and community participation and gave greater profile to the market. Social values were given less attention than the technical, economic and management factors in health systems. The state's role was 'downsized', either by deliberate policy measures such as Structural Adjustment Programmes, by reduced public spending or by the declining quality of public services. In low-income countries, coverage of the lowest income social groups fell, leaving many people cut off from effective services and dependant on self-help. These trends motivated many CSOs to new actions including health service delivery and renewed advocacy for basic health rights and access to health resources.

As the attainment of health goals has become more evidently influenced by political, legal, investment, trade, employment, and social factors, civil society involvement in health has also widened to include organizations whose main mandate lies outside the health sector. Hence, for example, youth organizations not specifically set up to deal with health issues have been an important contributor to adolescent reproductive health promotion, or groups dealing with economic and trade issues like trade unions have played an important role in essential drug lobbies.

The following sections outline some of the contributions that CSOs have made to various aspects of health:

Health systems

CSOs contributes to a range of health system functions, summarised in Table 1 below.

TABLE 1: HEALTH SYSTEMS AND CIVIL SOCIETY ROLES

Health system function	Examples of roles of CSOs
Health services	Service provision; Facilitating community interactions with services; Distributing health resources such as condoms, bed nets, or cement for toilets; and Building health worker moral and support.
Health promotion and information exchange	Obtaining and disseminating health information; Building informed public choice on health; Implementing and using health research; Helping to shift social attitudes; and Mobilising and organizing for health.
Policy setting	Representing public and community interests in policy; Promoting equity and pro-poor policies; Negotiating public health standards and approaches; Building policy consensus, disseminating policy positions; and Enhancing public support for policies.
Resource mobilisation and allocation	Financing health services; Raising community preferences in resource allocation; Mobilising and organising community co-financing of services; Promoting pro-poor and equity concerns in resource allocation; and Building public accountability and transparency in raising, allocating and managing resources.
Monitoring quality of care and responsiveness	Monitoring responsiveness and quality of health services; Giving voice to marginalised groups, promoting equity; Representing patient rights in quality of care issues; and Channelling and negotiating patient complaints and claims.

Health service delivery

CSOs play a major role in the delivery of health services. Religious organizations have had a long history of service provision while other organisations have become more involved in recent years. In Asia and Latin America, CSOs have been involved in mobilising effective demand for services, building awareness of community needs and experimenting in innovative approaches to service delivery that were later replicated by the state sector. In Africa, among other tasks, CSOs have assisted in working with the state to integrate evidence led health planning and community preferences.

These CSO health services may or may not be contracted by the state. In many cases, CSOs provide cover to groups otherwise disadvantaged in health service access or assist governments in major treatment campaigns and disease control programmes, in drug distribution, in reaching vulnerable communities, and in fostering innovative approaches to disease control.

CSOs contribute to enhanced health care by providing services in response to community needs and adapted to local conditions; they lobby for equity and pro-poor health policies, often acting as an intermediary between communities and government; reach remote areas poorly served by government facilities; and provide services that may be less expensive and more efficient. CSOs also provide technical skills on a range of issues from planning to delivery to services. They innovate and disseminate good practices to other NGOs or the state sector. CSOs contribute to public understanding and enhance public information. This can build more effective interaction between services and clients and enhancing community control over health interventions.

There is, however, significant variability in the quality and scope of non-state services. Some CSOs may not be responsive to the population they serve and may in fact be more accountable to the international agencies that fund them. Many national CSOs struggle with issues of how to access their own national public resources; their capacities to manage and sustain programmes; negative attitudes and non participation of health workers; poverty and other social problems; and how to build strong and active links with their own members.

Analysts have pointed out that CSOs have a long-term and sustained comparative advantage when they can access resources not available to government, or where they can meet a need not currently met such as in improving coverage.

Advocacy, policy and standard-setting

In addition to service provision, CSO make other important inputs to health such as transforming public understanding and attitudes about health; promoting healthy public choices; building more effective interactions between health services and clients; and enhancing community control over and commitment to health interventions.

The recent recognition of health as an outcome of economic, social and political inputs and actions call for participation from a wide diversity of state and non-state

actors. Many developments oriented CSOs are active in political areas such as monitoring of the impact of global agreements on public health, fuelling demand for more effective public health safeguards. CSOs have participated in global policy areas such as trade agreements and health, prices of and access to drugs, international conventions and treaties on health related subjects such as landmines, environment, breast milk substitutes and tobacco and in debates around policies and public health standards.

Many global CSOs promote and use the increasing profile given to human rights instruments and actions in health. They monitor health and human rights issues such as patients rights, women's and children's health rights, reproductive health rights and occupational health risks. Increased CSO activity reflects public discontent over socially unacceptable inequalities in health or access to health care or over falling coverage of public health services, both in terms of increased advocacy for health or in terms of private not for profit service efforts to fill gaps in health care coverage. CSOs have also become more visible and important as primary health care policies have placed emphasis on participation of communities.

These developments within health systems at local, national and global level signal that CSOs are an important channel for public involvement in health systems. They bring human resources, technical expertise and new knowledge to health and provide a powerful additional pressure for the recognition of public interests within the health sector.

State and civil society interactions: benefits and risks

These trends have led to a call for greater 'stewardship' from governments in health, that is for governments to better facilitate the range of stakeholders, relations and inputs needed for health gains, and to balance links with the private for profit sector with stronger links with the public interest organizations in civil society

Clearly the interaction between civil society and state is not without both benefits and risks for both state and non-state agents. Some of these are summarised below

Benefits for the state

Interaction with CSOs can bring to the state:

- Support for national / global values, for state regulation of commercial interests adverse to health, for public policy goals and enhancing public information and legitimacy of state work.

- Introduction of new perspectives, technical expertise, capacities and human resources, networks and informed leadership on health.

- Increased service provision and implementation of public programmes, particularly among marginal communities and in remote areas, and increased financial contributions to health programmes.

Benefits for civil society

Interaction with the state confers on CSOs:

- Increased possibilities of influencing health policy by incorporation of CSO issues in policy processes including counterbalancing of commercial interests and consensus building on health priorities.

- Provision of legal authority for public participation and enhanced legitimacy of CSO work. Enhanced linkages and transparency of interaction with the state and technical inputs to CSO work from the state.

- Enhanced prospects for civic education, participation and building of social capital thus strengthening CSO capacities. Improved options for access to health services. Expanded opportunities for greater involvement in health programmes.

Risks for the state

Interaction with CSOs carry certain risks including:

- CSO representativeness cannot be assumed, pseudo NGOS may be a hidden channel for corporate interests and potential conflicts of interests between the state and CSO interests. For the state, it is important to assess the representativeness, authenticity, interests and capacities of the CSOs it works with.

- Crosscutting and multiple roles among CSOs leading to great diversity in views and numbers can be difficult to manage. CSOs clearly do not speak with one voice, and there are asymmetries in the capabilities and numbers between the North and South.

- CSOs have varying levels of accountability to the communities they speak for. These features may weaken the legitimacy of CSO positions within national and international platforms.

- CSK's political roles and polemic approaches on issues such as human rights, consumer protection, or ethical issues may generate tension with governments.

- Risk of government staff leaving to join CSOs, leaving the state weaker in technical expertise and capacity.

Risks for civil society

Interaction with the state carries with it risks for CSOs, including:

- State links may distort CSO voices and representation by giving privilege to a few interlocutors. If this bias is towards CSOs representing more affluent or Northern Hemisphere interests, then perspectives and access of more marginal, Southern Hemisphere groups can be weakened.

- Dependence on the state for access or resources may compromise the autonomy, accountability or self-determination of CSOs and make CSOs reluctant to criticise the state. Work on government programme or funding priorities could distort CSO priorities.

- Risk of CSO staff leaving to join government units, leaving CSOs weaker in technical expertise and capacity.

Conclusions

There is great potential for improving public health through systematic collaboration between governments and civil society. This document is a first attempt to summarize and provide an overview of the role of CSOs in health. The conclusions at this stage can therefore only be of a very general nature.

What is sure is that there is a need to collect more systematic evidence on the role of CSOs in health, to improve our knowledge and to give visibility to good practice and to the contribution of CSOs in health. As described in this paper, the interfaces are complex and there are many aspects, risks and benefits to be taken into account.

The public health sector must understand CSOs and CSOs must better adapt to the needs of the health sector and better organize themselves as a group. States need to work with civil society to organise the social dimensions of health actions, to build wider constituencies for health rights and goals, and to strengthen public accountability and responsiveness within health systems. As regards CSOs, they clearly do not speak with one voice and their perspectives differ between different interest groups. There are also asymmetries in capabilities and numbers between the North and the South, and CSO have varying levels of accountability to the communities they speak for. All these features may weaken the legitimacy of CSO positions within national and international platforms, and therefore need to be addressed in order to maximize the benefits of the collaboration.

The overall impression and conclusion however, is, that the benefits of collaboration for both the State and CSOs outweigh the risks of possible tensions in CSO-state interactions. Strategic alliances offer opportunities for enhancing the legitimacy of health policies and programmes, improving public outreach, advocacy of health goals, information exchange and increasing resource inputs to health programmes.

Reading list

Dr Gro Harlem Brundtland, "Towards a strategic agenda for the WHO secretariat". Statement to the 105th session of the Executive Board, January 2000

African Development Bank (1999) Co-operation with civil society organisations: Draft policy and guidelines, Mimeo, September 1999

Anello E (2001) Assessing conflict of Interest, Briefing paper prepared for WHO, Mimeo, Geneva 11 June 2001

Brown DL, Ashman D (1996) Participation, social capital and Intersectoral problem solving: African and Asian cases, Institute for development research Vol 12 No 2 USA

Chuengsatiansup K (2001) Civil society and health: Broadening the alliance for Health Development Paper prepared for the Ministry of Public Health, Thailand, Mimeo, Thailand

CIDA (2001) Civil Society and development co-operation: An issues paper, March 15/2001 (draft), Canada

Community Working Group on Health (1997) HEALTH IN ZIMBABWE: Community perceptions and views Research report Zimbabwe, November 1997, Supported by OXFAM and TARSC

CSI (2001) EGB Consultations with Executive Directors on the Civil Society Initiative, Summary Report of Interviews, Mimeo, WHO

EQUINET Steering Committee (1998) Equity in Health in Southern Africa: Overview and issues from an annotated bibliography, EQUINET Policy Series No 2, Benaby Printers, Harare

Gilson L, Kilima P, Tanner M (1994) Local government decentralisation and the health sector in Tanzania Public Administration and Development 14(451-477)

INFACT (1999) Mobilising NGOs and the media behind the International Framework Convention on Tobacco Control: Experiences from the code on Marketing of breastmilk substitutes and conventions on landmines and the environment, WHO/NCD/TFI/99.3, Geneva

Kahssay HM (ed) (1991) Community Involvement in District Health Systems, WHO SHS/DHS/91.4, Geneva

Kahssay HM and Baum F (1996) The role of civil society in District Health Systems , WHO/ARA/96.3, Geneva

Loewenson R (1999) Public Participation in Health: Making People Matter IDS/TARSC Working paper no 84, Sussex March 1999

Loewenson R (2000) Putting your money where your mouth is: Participation in mobilising and allocating health resources Paper presented to the TARSC/Equinet regional meeting on Public Participation in Health, Harare, May 2000

Loewenson R (2000b) Report of the TARSC/Equinet regional meeting on Public Participation in Health, in co-operation with IDRC (Canada) and WHO (AFRO/HSSD) Equinet policy series no 5 Benaby printers Harare

McFarlane C et al (1998) Financial and operational factors influence the provision of municipal solid waste services in large cities, WHO EUR/ENHA, Denmark

Meltzer J (2000) The Micropolitics of Civil Society and Citizen Participation, Report for IDRC (Canada), Canada

Minet (1997) The relationships between the UN system and civil society, Discussion paper prepared for OC, New York 2-6 October 1997

Non Government Liaison Service NGLS UN (1997) Working with civil society: Issues and challenges, NGLS Mimeo, Geneva

Reid G, Kasale H (2000) Tanzania Essential Health Interventions Project Paper presented to the TARSC/Equinet regional meeting on Public Participation in Health, Harare, May 2000

Robinson M, White G (1997) The role of civil society in the provision of social services: the non market, voluntary sector, Mimeo, IDS (Sussex), UK

Schneider H (1999) Participatory Governance: The missing link for poverty reduction, OECD policy brief no 17, OECD 1999

SID/WHO/ISS (2000) Report on the International Seminar on 'Global Public-Private partnerships for health and equity' Nov 23-24 2000, SID/WHO/ISS, Italy

UNDP (1999) Governance for Human Development: UNDP and civil society, New York, December 1999

UNDP (2000) UNDP and civil society – issues for a new policy of engagement, Mimeo, New York

World Bank (1996) Social Capital, Office Memorandum, Washington

World Health Organisation (1997) A new global health policy for the twenty first century: An NGO perspective, WHO, Geneva

World Health Organisation, Govt Ireland (1997) Poverty and Ill health in developing countries: Learning from NGOs, Meeting Report, Kildare, Ireland June 1996

World Health Organisation, Govt Ireland (1997) Poverty and Ill health in developing countries: Learning from NGOs, Meeting Report, Kildare, Ireland June 1996

WHO/DAP (1998) Collaboration between NGOs, ministries of Health and WHO in drug distribution and supply WHO Geneva

WHO Essential Drugs Management (EDM) (1999) Briefing update on non government and pharmaceuticals roundtable 26.1.99, Geneva

World Health Organisation (1999) Corporate strategy, WHO, Geneva