

1 Introduction

In recent years, and at least partly in response to an emerging crisis in health care provision in many countries, there has been a major shift in attitudes to community involvement. Approaches that saw communities primarily as passive recipients of health care have given way to those which seek to make more of the potential that more active community participation might offer for enhanced accountability and improved responsiveness of services. With this shift has come a greater emphasis on issues of governance and, within that, on the institutional dimensions of community participation. Recent experience in seeking to develop workable partnership models in the health sector lends a new dimension to debates about community participation in health. It focuses attention beyond the involvement of beneficiaries to relationships at the interface between communities and service providers and managers. Changing emphases, then, give rise to new challenges.

The IDS Participation and Health and Social Change Groups convened a workshop in October 1999 to share experience with the use of participatory approaches in enhancing accountability in the health sector, and to explore some of these challenges. The articles in this bulletin reflect some of the richness of 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 provision. They bring experience from current and ongoing

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Introduction: Accountability through Participation

Developing Workable Partnership Models in the Health Sector

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work to reflect on the links between participation, accountability and improvements 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. It is important to emphasise that understanding of the complexities of this approach is at a very early stage. The design of interventions is complex and often highly context-dependent. Rather than attempt to establish any blueprint for future activities, the workshop sought to explore the issues and attempt to advance the debate. In this introduction we draw out some of the principal themes emerging from the articles included here, and from workshop discussions.

2 The Health Sector Context

Public health services in many low income countries perform increasingly like an unregulated market (Leonard 1999; Bloom and Standing 1999). For many primary health care workers, government salaries now only provide part, and often a small and diminishing part, of their incomes. Private practice and drug sales, whether legal or illegal, are both widespread and, apparently, widely accepted (Bennett 1997). In many countries the capacity for even basic performance monitoring is extremely limited, and providers are often fully aware that existing regulations are very unlikely to be effectively enforced.

This *de facto* marketisation of public health services has potentially serious implications for equity and efficiency. Health providers gain disproportionate power in their transactions with patients and may promote expensive forms of treatment, effectively excluding the poor from access to care. For poorer women, existing barriers to access are exacerbated. Strategies are needed that improve access, particularly of women and the poor, to effective health services at an affordable price (Lucas and Nuwagaba 1999).

The decentralisation of public sector management to cost centres, shifting authority and responsibility to districts, was to have provided increased incentives for district level monitoring and regulation of providers. Yet a number of critical constraints render

this strategy problematic. District level authorities typically have extremely limited resources, including qualified personnel, equipment and functional transport, available for monitoring activities. Health workers at district level with responsibility for monitoring performance are often themselves receiving very low salaries and may well have little motivation to provide adequate supervision and control over their subordinates (World Bank 1997). The legal framework for professional regulation is weak in many countries; in others, professional bodies operate mainly in the interest of their members. And the difficulty in replacing qualified health workers in remote locations can render them immune to disciplinary action, even where it is considered. The implications both for government health expenditures and for donors who have recently become increasingly involved in the co-funding of health care programmes are potentially serious. New thinking on measures to strengthen accountability is clearly a priority.

3 The Changing Role of Participation in Health

There is a long history of advocacy of participation in the health sector in international health policy. Participatory approaches have been used for many years in the health sector, primarily for needs assessment and implementation. Rapid and participatory appraisal methods have gained increasing popularity over the last decade as a means through which health service users can be consulted in the design and evaluation of interventions (see, for example, Rifkin 1996). Engaging users through mechanisms such as user groups and committees has generally been regarded as a means to ensure the appropriateness of service provision, and to enhance project efficiency. In this context, users have been viewed as recipients of services that are designed for their benefit. As communities have come to contribute more and more, in terms of time, labour and other resources, their roles have begun to change. This has implications for the ways in which 'community participation' is viewed, especially in terms of where the locus of control over resources and decision-making is situated (Cornwall and Jewkes 1995). Rather than passive recipients, communities have in many contexts become the active makers and shapers of services, exercising their preferences as consumers and their rights as citizens (Loewenson 1999; Cornwall and Gaventa 1999).

Changing roles and responsibilities in the interface between communities and service providers, planners and managers bring with them new challenges and new opportunities. Increasing community involvement opens up the space for positive transformations in service provision, from ensuring more appropriate service delivery to enhancing the quality of care. Effective engagement requires not only institutional changes, and most particularly changes in procedures for decision-making and control over resources, but also a focus on enhancing the capabilities of communities to exercise their new rights and responsibilities.

Mechanisms to enhance health service accountability are not only a means to render service provision more effective. They also offer an entry point for more meaningful community engagement in shaping the nature of provision and enhancing service responsiveness to the needs communities themselves identify (Perry *et al.*, 1999). As the articles in this bulletin illustrate, participatory processes might have much to contribute to strengthening accountability and improving health outcomes. The use of these strategies to strengthen the capabilities of communities to respond to these new opportunities, however, brings with it a series of questions. What kinds of roles can community-based organisations take on, and what might be needed to prepare them for this? How do such organisations relate to existing health management, local government, NGO and provider interests – and what strategies might help build closer and more equitable relationships between these different actors? To what extent can community members hold their own institutions accountable, and how do these organisations take account of different ‘community’ needs?

Two articles, both based coincidentally on experience in Zimbabwe, focus on these issues as they relate to the development of sustainable structures for community participation within the institutional framework of the public health system. Rene Loewenson is concerned with the challenges faced in moving away from a health system largely planned and governed by technical personnel to one that involves wider public participation and accountability in planning, implementing and monitoring health services. Set within the current environment of real declines in access to health care, the liberalisation of health provision and consequent

demand for informed consumers, the article explores consumer demand for improved quality services and ways to tackle the need to ensure that resource use has a greater impact. Mungai Lenneive considers the lessons to be learned from community involvement in feeding programmes and management of rural water supply throughout the 1980s. He argues that both started off with community interests at the centre, but gradually gave way to the needs of the bureaucracy. The main lessons he takes from these programmes are that information on entitlements and obligations is a prerequisite for successful community development projects and that the extent of accountability to communities is directly proportional to progress made towards the devolution of power to democratic development structures. Both articles draw attention to the role that accountability can play in enhancing equity and efficiency, raising wider questions about the nature of accountability in the health context.

4 Accountability: To Whom, By Whom and For What?

What does ‘accountability’ mean, how is it interpreted in practice and what are the implications of the various interpretations? What is the relationship between participation and accountability? As a composite concept, ‘accountability’ has a range of connotations (Jabbara and Dwivedi 1988; Jenkins and Goetz 1999).¹ It can be understood as ‘giving an account’ to another party who has a stake in what has been done. It is frequently applied in the context of maintaining financial ‘accounts’, which demonstrate that funds have been used appropriately. It evokes a sense of taking responsibility, but it also holds the meaning of being held responsible by others; being ‘held to account’. In the context of governance, it refers to holding bearers of public office responsible for their performance and the results of their decisions (Jalal 1999; Edwards and Hulme 1994). As such, it encompasses a vast array of potential power relationships.

A first step in disentangling some of the meanings of accountability is to establish what kinds of accountability exist: for what, by whom and to whom. Complex patterns of accountability are commonplace in the health sector. Public health providers, for example, would usually describe

themselves as accountable, not to those who use their services but to their district health service manager (and possibly to their professional associations). The latter may technically be accountable to users for the quality of services provided, but their *precise* responsibilities and the procedures for holding them to account may be obscure. A village committee might volunteer to be accountable to the community for the funds generated from user fees, but object when local government officials insist that this should also entail responsibility for the establishment of transparent accounting procedures and regular presentation of financial accounts.

Effective accountability would clearly seem to require that all parties in an 'accountability relationship' fully understand and agree their obligations and rights, and believe that the other will act accordingly. There is a fundamental inseparability of accountability, transparency and trust. At least superficially, the language of contracts might appear useful in this context (Mills 1998). In company law, directors are legally accountable to their shareholders. They are deemed to have a contract with those shareholders which defines the responsibilities of each party and entails expectations in terms of appropriate behaviour. However, as Mackintosh (1997) points out, contracts work best when the services to be delivered are relatively easy to measure and monitor. They are also greatly reinforced if there are effective penalties for default and both parties have equal recourse to enforcement procedures.

In the present context, it is evident that neither of these conditions will usually apply. Typically, the services involved, for example health care of a reasonable quality, are difficult to specify or assess and the parties concerned, for example service users, service providers and local officials, are highly unequal in terms of information, influence and institutional support. District managers may indeed have an 'implicit contract' with users, but it would usually be extremely difficult for a user to enforce that contract in a conflict situation. Realistically, rather than aim for very specific 'contractual' agreements, it may be more useful to think in terms of mechanisms to encourage broad collaborative arrangements between parties to attain agreed objectives, even if this sometimes involves compromises with respect to access or even quality of

services. It should not be assumed that the various stakeholders, for example providers and users, necessarily have conflicting interests. A focus on contracts and incentives risks encouraging a fatalistic belief that providers are 'doomed by their self-interest to be uncommitted' (Tendler 1997), whereas many certainly appear to be motivated at least as much by a genuine desire to perform well, and be well regarded in the community, as by financial rewards.

Two articles in this bulletin are particularly concerned with such conceptual issues, both in the context of China. Fang Jing explores the idea of participation and its practical implications. Her paper, illustrated by case studies in which participatory approaches were employed to conduct health projects, focuses on two key issues: is participation always appropriate and, when views of stakeholders differ strongly, whose voice is strongest and who makes the final decision? It concludes that participation should imply the involvement of all stakeholders at an early stage, and the sharing of responsibilities and power openly among stakeholders through a process of communication and negotiation. The article by Andy Wilkes argues that participation does not necessarily lead to accountability. He analyses micro-level interactions in a case study that appears to demonstrate a 'high degree of community participation'. However, analysis of the process points to the influence that different interests, different channels for voicing interests, and unequal power relations have in determining the outcome of decision-making processes.

5 Partnership and Participation

Partnership has become one of the new development buzz words. Yet often there is little clarity about what exactly is meant by the term. Jalal (1999) offers a useful lens through which to examine the ways in which the term 'partnerships' is used in health. She differentiates between two versions of partnership. In the first, the primary purpose is provide a way to match means and competencies between public and private actors. In the second, the definition moves beyond simply providing services to embrace the notion of 'responsible partnership', one which is based on promoting 'a sense of co-ownership not only among the providers but also among the service users' (Jalal

1999:8). Gibbon (this bulletin) suggests the adoption of a relatively ambitious definition that builds on this sense of 'responsible partnership'. She draws on Cadbury's definition of partnership as 'power being shared equally with all partners' (1993:11) and Fowler, who describes authentic partnerships as 'understood and mutually enabling, interdependent interaction with shared intentions' (1997:117).

Seeking to achieve these kinds of interactions, as many of the articles in this bulletin illustrate, is an extremely complex and contested undertaking. One of the aims of the workshop was to explore what kinds of partnership models have been used, to what extent and how effective they have been in improving accountability and effectiveness in the delivery of health services. Many of the articles presented here address this general theme, either directly or through empirical examples of different partnership models.

5.1 Partnerships in theory

Two papers propose new approaches to the development of partnerships aimed at enhanced accountability. Drawing on lessons from other sectors, John Milimo identifies a particular community-based organisation in Zambia, the Health Neighbourhood Committees (NCs), as an institution through which effective partnerships between health service providers and consumers might be forged. He argues that they are already carrying out important partnership functions and could be developed further to articulate community concerns on health and other related social issues to other, often more powerful and better organised, stakeholders. In collaboration with these stakeholders, the NCs could ensure equitable access to quality health services and create a sense of ownership over health facilities. Adebisi Edun also emphasises the potential advantages of giving greater responsibility to community-based organisations. He proposes that they should take a major role in project monitoring and evaluation and, more radically, in consequent modifications to project design. He suggests that this could greatly assist in fostering project ownership and hence the potential for sustainability. Making clear the accountability of the project to the intended beneficiaries in this manner could also encourage them to ensure financial accountability with respect to project funds.

5.2 Partnerships in practice

For many years international donors have stressed the need to 'involve the community' in health projects, though such involvement has usually had strict limitations. Aijaz Ali Khuwaja describes community involvement as practised in the World Bank-funded Family Health Project in Pakistan. With the stated objectives of improving utilisation of outreach services and accountability of service providers, Village Health Committees were formed and trained to understand the basic concepts of the project, identify factors which affected the health of the community, and suggest local methods for combating these problems.

Similarly, there have been many examples of links between international NGOs and community groups aimed at improving their health situation through increased participation. Marion Gibbon describes partnerships between women's groups and the Women's Empowerment Support Team (WEST) in Eastern Nepal. Through the use of an empowering approach called the health analysis and action cycle, WEST attempted to enable women to analyse their local environment, identify their problems and identify solutions to improve their health situation. This led to the planning and implementation of activities and small projects intended to encourage improvements in both health and social capital. Florence Musembi and Christine Kilalo examine a model piloted by World Neighbours in the Mukuyuni Health Centre in Kenya. Their article explores the extent to which communities can effectively influence the type and quality of services that are offered, or improve access to those services, where they have no control over management, staffing or supplies. They consider whether improved institutional arrangements can of themselves spur the energy of a community to influence health service delivery.

Two articles take the NGO–community partnership model one stage further, to consider community-based management and financing of health services. Gopal Nakarmi describes the activities of the Baudha Bahunipati Family Welfare Project, which was set up by the Family Planning Association of Nepal to distribute contraceptives and provide a basic medical service. The project set in motion a process of initiating bottom–up planning, handing over responsibility to locally formed organisations

and creating a sustainable programme of local activities. It describes in detail the experiences of one such organisation that became financially self-supporting through charging for medicines and services. Mok Samoeun documents the experience of Catholic Relief Services, through its Community-Based Primary Health Care Programme in Cambodia, in the development of structures and systems of community and health centre co-management and co-financing. The article discusses the role of community health structures in the development of these systems and the relationship between health centre quality of service and community financing.

5.3 New partnership models?

As indicated above there is currently a growing interest in the development of new partnership approaches to community involvement in health care. Innovative interventions have been undertaken by donors, NGOs and national governments. Three examples are provided in the present bulletin. Sam Unom reviews the development of community participation and accountability under the auspices of a DFID basic health services project in Nigeria, which adopted a social action fund approach. The Benue Health Fund provided support for health-related projects proposed by local community groups. It was in part a donor response to the challenge of operating in an extremely difficult environment. This involved an unstable and often unsupportive policy regime; a bureaucratic system not given to devolution and decentralisation; managers with limited capacity to support a process of accountability through participation; and a virtual breakdown in relations between the people and the state. The project developed specific mechanisms to strengthen participation in this situation that may offer lessons for practice elsewhere.

Lisa Howard-Grabman reviews work by Save the Children and Johns Hopkins University in two USAID-funded pilot projects, which attempt to facilitate effective provider–community partnerships. In Peru, a Ministry of Health-led project is facilitating dialogue and action to define and improve the quality of health care. In Bolivia, communities and service providers have developed and are using a community health information system that provides them with data upon which they can jointly make decisions, set priorities, plan activities

and monitor their progress. Finally, a related approach, which seeks to engage a broader partnership between health service providers, managers and users, is described by Kate Butcher. It combines core components from the Client Oriented Provider Efficient process (COPE), which has been proved an effective tool to improve the quality of reproductive health services, with Participatory Learning and Action (PLA) methods. Preliminary results are said to indicate that including all stakeholders in such a process can work, as long as the exercises are accessible to all, but the need for effective follow up to maintain levels of enthusiasm and quality is seen as a crucial issue.

6 Accountability Through Participation

In moving from a system of health provision that is run along clearly hierarchical lines to the vastly more complex configurations of stakeholders that these new partnership models involve, broader issues of governance emerge as a key focus. Not only does this require a clearer specification of roles, responsibilities and terms of engagement between different parties. It also raises a series of issues regarding relations between and across the different levels involved in the management and co-ordination of health services. Workshop discussions focused on unpacking some of the complexities involved.

6.1 Partnerships for accountability

Exploring the potential linkages between partnership and accountability, workshop discussions focused on mechanisms for enhancing partnerships and the implications of different configurations of actors and interests in current partnership models. A series of criteria that enhance partnerships were suggested. These include:

- agreement on a shared vision
- transparency of information and resources
- agreed roles and responsibilities
- all interests represented
- agreed mechanisms for conflict resolution

Issues of transparency emerged as a crucial factor in determining the potential responsiveness in dyadic partnerships in which there is a considerable imbalance in power, such as between government and

community. One conclusion that emerged from these discussions was the promise that multilateral partnerships, despite their potential complexity, might hold for maintaining accountability and enhancing the effectiveness of service provision. In this and in supporting partnerships between organised civil society and communities, donors were felt to be able to play an important role in facilitating transparency.

6.2 Enhancing genuine community control

Technical approaches aimed at enabling communities to manage health resources through training in management and financial systems often fail to recognise the importance of community organisation and mobilisation. Control cannot simply be given away: it needs to be claimed and gained by communities in order for them to play a meaningful role in the management of local health services. Decentralisation may have opened spaces for community engagement, but decentralisation of responsibility without corresponding changes in political, management and financial authority can easily lead to a 'democracy of disempowerment'. Handing over more control to communities should not imply that communities are charged with the sole responsibility for implementing health programmes and raising the resources to fund them. Unless the locus of decision-making and control over resources is shifted, what amounts to 'pseudo control' can lead to further atomisation that marginalises poorer communities.

Political as well as technical elements form the basis for community control, and these elements operate on both internal and external levels. Communities must be able to negotiate and manage internal political, organisational and financial issues. This involves ensuring that the process of priority setting, resource allocation and decision-making takes place in a democratic manner with the participation of more vulnerable groups. Communities must also be able to negotiate externally: with other communities, various levels of government, private companies, banks, donor agencies and other relevant institutions. Such negotiations are needed, for example, to maintain functioning referral services to tertiary care, to achieve economies of scale in terms of purchasing drug and other supplies, to access national and international resources, and to ensure participation in larger governance structures. These internal and external forms of community

negotiating power reinforce one another and are both necessary if community 'control' is to include control over required resources.

6.3 Participation and accountability in disabling environments

Realities on the ground are rarely conducive to increased participation of service users in efforts to strengthen accountability. A major focus for workshop discussions was exploring the ways in which disabling environments affected both participation and accountability, and what might be done to address these constraints. Three areas were identified: constraints within health structures; within the wider social, political and cultural environment; and within communities.

The absence of mechanisms for regulation and co-ordination within health system structures limits the potential engagement of users. A lack of awareness among users of their rights and responsibilities, coupled with resistance at higher levels, can make any attempt to introduce mechanisms for accountability ineffectual. The emergence of alternative market mechanisms within the health system adds a further layer of complexity. Two avenues for intervention were suggested. The first would seek to establish legal mechanisms and procedures that could give users a more effective basis for involvement in decision-making and control. The second would focus on the horizontal expansion of accountability mechanisms at the local level, creating a critical mass to sensitise management at different levels and promote a culture of accountability.

Where social, political and human rights cannot be exercised, the prospects for enhancing accountability may be limited. If the penalties associated with participation outweigh potential benefits, people clearly would be deterred from active engagement. Discussion on the possible ways forward in this context focused on the need to allow spaces to be established where negotiation could take place and priorities might be agreed. It was, however, pointed out that, even in countries where legal frameworks for participation exist, local governments, for example, typically refuse to enter into this kind of process.

The absence of democratic fora, limited access to information, lack or denial of rights, participation

models created from above and inability of users to influence decisions all act to constrain participation at the local level. A series of strategies to overcome this were discussed: building alliances, improving user capacity in both management and negotiation, establishing mechanisms for the dissemination of information and improving access to information about entitlements. These last two points are taken up in more detail below. It was suggested that by active promotion of informed participation in the health system and opening up various alternative accountability mechanisms, for example using local media, some of these constraints might begin to be addressed.

6.4 Improving transparency

Unpacking the need for transparency and exploring the kinds of information and processes that might be involved at different levels, workshop discussions highlighted the complexities of establishing mechanisms to improve accountability. As Jenkins and Goetz (1999) argue, transparency does not automatically result in accountability; it serves as a tool to begin to open officials and other responsible parties up to wider scrutiny. Much depends on what information is sought, by whom and for what purpose. A first step, then, is to distinguish between the purposes to which information might be put which will determine what information is sought. Several types of purpose were identified: to increase awareness (of the situation, rights, alternative priorities etc.), judge (is the situation 'good' or 'bad'), identify problems, provide evidence, locate responsible persons and make decisions. Each of these purposes might call for different types of information. Similarly, different categories of stakeholder – users, providers, officials, donors – might require different forms of information flow.

Principles to inform the development of information systems for transparency were suggested:

- there should be a clearly specified right of public access to information
- information should be available at each level where there are interested stakeholders
- information should be available at each level at which relevant decisions are made
- the burden of information collection should be at the level of information use
- there should be agreement on the domain and

burden of information collection

- indigenous information/knowledge is at least as valuable as that from other sources
- there should be a right to present and a responsibility to feed back information
- those presenting information must be mandated by those whom they claim to represent

The working group went on to develop a checklist that took 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 (see Box 1).

6.5 Enhancing accountability through participation

Drawing together workshop discussions on the issues of accountability and transparency, different models of partnership and the relationship between participation, accountability and health improvement, workshop participants developed a checklist of factors to be taken into account (see Box 2). This checklist highlighted 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.

7 Directions for the Future: Linking Participation, Accountability and Partnerships for Health Improvement

Participation offers the promise of enhancing accountability, and with it improving the effectiveness, scope and impact of health provision. But there are clearly many complex challenges involved in putting participatory mechanisms and structures into practice. In conclusion, we would like to explore some of these priorities and, in doing so, draw attention to issues that need to be addressed to fulfil the promise of participation.

As the examples in this bulletin illustrate, exciting and innovative work is taking place to turn the rhetoric of participation into workable models for health improvement. There is a need for systematic documentation and sharing of existing experiences in order to understand the processes and relationships

Box 1: Transparency for accountability

Level	Resource availability	Resource use	Roles, interests & responsibilities	Rights and entitlements	Service options & standards	Technical reports	Policies and priorities	Needs/performance audit
Local	Resources <ul style="list-style-type: none"> • at the same level • at the next level 	Actual vs planned Who accounts?	Mission statement and mandates	Formal laws and statutory procedures	Standards/targets Technical options		What? Set by whom? Where?	Efficiency, technical equity Source, quality and legitimacy
District	Allocation Criteria <ul style="list-style-type: none"> • within health • to health 	Who audits? Who is accountable to whom?	Exit, expectations, legitimacy	Social norms, mechanisms for enforcement and grievance	Costs/benefits Impacts	As for all areas	Criteria Mechanisms	
Regional	Sources <ul style="list-style-type: none"> • objective • filling gaps 	Reasons for variance			Risks and assumptions			
National	Who controls? Who administers?	Procedures and authorities					Conflicts Limits	Feedback of findings criteria
International								

that have supported effective and accountable partnerships in health, as well as learning from those that have not.² More work is needed to explore the complexities of accountability in the health sector and the relationship between different forms of accountability and participation, to focus our understanding of the term as its popular use increases. Equally, research is needed to explore further the implications of different types of partnership, as set within different political and cultural environments.

An analysis of good practice could lead to further

innovation with models and implementation strategies in other contexts. However, as discussions on disabling environments and the contextual particularities of the contributions to this bulletin show, identifying 'good practice' should not be taken as a recipe for use in every context. Rather, greater understanding is needed of the broader contextual factors that condition the effectiveness of attempts to introduce new models, systems or procedures. While the articles in this bulletin focus largely on positive experiences, there is much to be learnt from the failures that litter the development landscape.

Box 2: Enhancing accountability through participation: a checklist

Stakeholders	Partnerships	Community control	Transparency	Mechanisms for dealing with disabling environments
Common relationship	Are all stakeholders involved?	Representative leadership diversity of voice	Is there information at the level where the interests are?	Potential for contracts between relevant stakeholders
Fulfilled promises	Is there transparency regarding all aspects of partnership?	Monitoring – collective level: co-ordination mechanisms in place and in use	Is there information at the level at which decisions are made?	Potential for enforcement of contracts
Mobilisation of resources	Are roles and responsibilities clearly defined for all stakeholders?	Ability to: make decisions, identify problems, articulate solutions, derive consensus, take action, set budget priorities	Burden of information collection should be at the level of information use	Diverse spaces for discussion and negotiation
Availability of quality services	Is there common understanding of goals and plan of activities?	Access to information for all	Agreement on domain and burden of information collection	Established rights to information on rights and obligations
Well informed	Are there functioning partnerships at all levels?	History of working together	Right to represent and responsibility to feedback	Potential mechanisms for informed participation in health system
Sustainability	Are there mechanisms to ensure representation of different interests?	Ability to resolve conflicts, negotiate	Representation/mandate within accountable structures	Consumer options
Effective mechanisms	Are there clear processes for decision making? Is there a clear process for monitoring adherence to agreements?	Demonstrated awareness, reflection, learning	Right of public access to all information Parity of different kinds of information/knowledge) medical/non-medical)	Potential for targeted empowerment Potential climate for recognition of client rights Potential for capacity creation Extent of shared visions at each level Alternative mechanisms for accountability

The capability of institutions to respond to this new agenda raises further questions. How might capacity for partnership be enhanced? What is needed to enable the values of participation and partnership to be internalised even in highly bureaucratic systems? What are the relative costs and benefits to different actors of establishing and operating the mechanisms necessary for participation and partnership? Whose interests do 'community organisations' represent and how can the voices of the less powerful within the community be strengthened within them?

One key requirement, in order to progress from the mode of local experimentation to that of influencing national health policies, will be to explore the attitudes of central and local government and those working in the existing public health sector. Will governments accept innovations which may have radical implications for this sector? They would clearly have to be persuaded both that there is at least a real potential for improving access to services of reasonable quality and that their own policies and programmes will not be undermined. In addition, many governments have limited control over the performance of health providers, even those in the public sector, and have to negotiate changes. Health workers would also have to feel that their reasonable aspirations could be met within this new environment where, for example, they may be required to enter for the first time into serious negotiations with users.

While none of these questions are in themselves new, they remain important for those working in the health sector to address in more depth than has been hitherto the case. There is much that can be learnt from existing practice in other spheres, most notably in natural resource management where there has been considerable experience with community-based management.³ What has become

evident from this work is the need to go beyond assumptions about an homogeneous 'community' to consider the contested dynamics of intra-community relations, especially in terms of gender (Guijt and Kaul Shah 1998; Cornwall 1998). In focusing on the interface between communities and providers, issues of difference within communities can be all too easily overlooked. Questions remain about issues of equity at the local level, and mechanisms that might promote more equitable engagement with 'community-based' initiatives. Without explicit attention to issues of difference, increasing 'community' control over priority setting and resource management can all too easily further entrench the exclusion of marginal groups, and with it their particular health needs.

These initiatives are set in the broader context of a crisis in health care provision in many countries, particularly in Sub-Saharan Africa (Bloom and Lucas 1999). Where resources are desperately constrained and state capacity to regulate health services is minimal, community involvement in health care may be not simply a desirable objective in its own right, but an essential component of any plausible strategy to maintain access to basic health care. However, even in countries where health services do not operate in such a severe economic environment, it seems apparent that the 'technical fix' approach has singularly failed to meet the health needs of large sections of their populations. In general, poor households in most countries still have serious problems in gaining access to basic health care of a reasonable quality. The lack of effective accountability mechanisms may be one of the key factors in explaining this failure and in a period of rapid social change and increasing demands for community participation in other areas, its application to the task of strengthening accountability in the health sector may provide one clue on the way towards finding solutions.

Notes

- 1 As workshop participants pointed out, in other languages it is often hard to find a word that adequately captures and conveys these meanings.
- 2 One outcome of this workshop was a commitment to take further the sharing of experience that the workshop facilitated, through networking and research activities at the national and regional level and continued exchange of experiences through web-based networking.
- 3 For example, there are important lessons from experience in natural resource management (Shepherd 1995; Pretty and Scoones 1995; Pratt *et al.* 1998), and public sector management and governance (Andrews 1999; Jabbara and Dwivedi 1988; Paul 1994; Edwards and Hulme 1994; Songco 1997; Gaventa and Valderrama 1999; Jenkins and Goetz 1999).

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