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Maternal and Child Survival Program

Literature Review: Civil Society Engagement to Strengthen National Health Systems to End Preventable Child and Maternal Death

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Abstract

Background

This document summarizes a literature review on civil society engagement to strengthen national health systems to end preventable child and maternal death. The role of civil society in national health system strengthening remains ill-defined as disagreements continue to exist concerning the roles and responsibilities of donors, governments and civil society itself. The authors aim to showcase the potential of civil society engagement to strengthen national health systems.

Methods

Using an iterative approach, the authors searched for public health articles between the years 2000 and 2015, including public access databases such as Google Scholar, Popline, World Bank's Knowledge Repository and e-library, the USAID Development Experience Clearinghouse and PubMed. Other documents were identified through article bibliographies and suggestions of colleagues. Although it was not an exhaustive search, we believe most recent public health articles that featured civil society engagement, both peer reviewed as well as not, have been captured. In the end, more than 160-documents fit these criteria. These were composed mostly of journal articles, briefs, meeting reports and guides, and occasionally books. For all the articles chosen for use, the authors classified them into four categories, by their purpose: information, guidance, evidence, and advocacy. In all, 108-sources were referenced for this review. Based on this literature review, the authors determined that results fell into three recurring themes: (1) Roles of civil society and civil society organizations, (2) Key elements of successful civil society engagement, and (3) Reported benefits of civil society engagement.

Results

The reported benefits of civil society engagement include: 1. Increased public awareness of unmet health priorities and the importance of health service quality; 2. Increased funding for high priority public health topics; 3. Participatory governance introduced, supported and capacity developed; 4. Demand and use of high quality health care increased and improvements made to service quality; and 5. Outcomes improved, including increased health service equity among marginalized populations. These benefits are most often achieved in an enabling context, and the degree to which these enabling conditions are not met, benefits may be reduced, not realized and/or not sustained over time. However, civil society organizations and the systems they work within often have weaknesses that impede effectiveness. The challenges between positive civil society organization pro-poor health actions and the wider enabling environment is an area that merits much greater attention and study.

Engagement between government and civil society requires openly and readily available data at various levels, as well as mechanisms to induce regular discussions on findings. Therefore, by improving transparency and accountability, civil society engagement can lead to strengthened relationships between government and civil society and improvements in outcomes. It's important to note that community responses are not a replacement for weak national plans. Rather, communities can assist national health programs, but must also operate under realistic objectives and with financial and technical support.

The authors found that community involvement seems to improve resource sustainability and infrastructure quality. Studies that are able to assess the impact of participation typically find that although inducing community engagement alone has little impact on outcomes, community

engagement can substantially amplify the impact of investments in public health or inputs. In the case of health service delivery, for example, the formation of community health groups appears to be effective when combined with inputs such as trained health personnel or the upgrading of health facilities.

Interestingly, successful programs are often located within larger government health delivery systems. This finding is encouraging because government participation is usually central for scaling up health initiatives. The evidence also suggests that the most successful programs tend to be implemented by local governments that have some management autonomy and are downwardly accountable. The authors introduce a model for the role of civil society in strengthening national health efforts based on information synthesized in this literature review (Exhibit 3, page 27).

Conclusions

Based on the results of this literature review, the authors conclude that community engagement can substantially amplify the impact of investments in public health. Community engagement leads to significantly larger reductions in maternal and child mortality, larger improvements in health-related behaviors, and greater use of health facilities than investments in health inputs alone can deliver. Successful programs are often located within larger government health delivery systems. This is encouraging because government participation is usually central for scaling up health initiatives. The evidence also suggests that the most successful programs tend to be implemented by sub-national governments that have some management autonomy and are downwardly accountable.

When civil society is engaged in multiple ways (e.g., using mutually-reinforcing tools, such as social accountability through shared governance, public advocacy, and governmental reforms), in the context of a safe and enabling environment (even if nascent), the evidence is strong for positive health impacts.

Introduction

"Real development requires more than assistance and aid. One of the things we've learned is you can't skip the governance component, and that's been a painful and important lesson."

–Chris Beyrer, MD, MPH, Associate Director of the Center for Global Health at the Johns Hopkins Bloomberg School of Public Health, and Director of the JHU Center for Public Health and Human Rights, remarking on the release of the Sustainable Development Goals (APHA Newsletter, November 2015).

This document summarizes a literature review on civil society engagement to strengthen national health systems to end preventable child and maternal death. These results will be applied to the development of a civil society engagement strategy for use within the United States Agency for International Development (USAID) funded Maternal and Child Survival Program (MCSP), USAID's flagship maternal and child health technical support project (MCSP, 2014).

For nearly a century, the language of civil society was absent from intellectual and political life, and as recently as two decades ago, the term itself was little used outside of professional circles (Keane, 2009). Since then, around the world, the term civil society has become an important category in social sciences and is a concept known to all (if not fully understood). Contrasted with government, civil society is viewed as a realm of social life—a complex and dynamic ensemble of legally protected nongovernmental institutions that are nonviolent and self-organizing (Keane, 2009). Recent comparative studies show the vital role played by civil society in the transition toward democracy. A robust civil society starts transitions, helps block reversals, generates political alternatives and keeps post-authoritarian governments responsive to public sentiment. Civil society organizations (CSOs) may also represent populations that are marginalized and vulnerable due to stigma and discrimination. Unlike the private sector with its basic power base of financial capital, civil society exercises its power through social capital and trust (Edwards, 2014). As Ingrid Srinath, Former Secretary General of CIVICUS, concisely put it, "Civil society is consistently trusted far more than government, business and the media at a time when trust is by far the most valuable currency," (WEF, 2013). However, governments may not always welcome or agree with CSOs' recommendations or actions. Some governments seek to actively control civil society to minimize internal dissent and consolidate political power (Keane, 2009; Mendelson, 2015).

This stands in contrast to the current United States government (USG) position. Former Secretary of State Clinton described legitimate "country ownership":

> *"To us, country ownership in health is the end state where a nation's efforts are led, implemented, and eventually paid for by its government, communities, civil society, and private sector…and those plans must be carried out primarily by the country's own institutions, and then these groups must be able to hold each other accountable…" (Clinton, 2011).*

More recently, President Obama released a memorandum in response to a High Level Event on Civil Society at the United Nations General Assembly (September 2014) that was directed to USG agencies engaged in development programs and projects abroad (The White House, 2014). In it, he called on USG personnel "to take actions that elevate and strengthen the role of civil society; challenge undue restrictions on civil society; and foster constructive engagement between governments and civil society." In President Obama's latest memorandum (September 2015), he continues to call for an advancement of the *Stand with Civil Society Agenda*, a global

call to action to support civil society organizations against increasing restrictions. Since 2010, the USG has invested more than $3.2 billion in efforts to strengthen civil society and plans to commit additional resources to partnering with others to support the *Agenda* (The White House, 2015).

The interest in civil society as a driving force of global health change started about 40 years ago and was articulated in the Declaration of Alma-Ata (WHO, 1978). Articles IV and VI state, in part,

> *"The people have the right and duty to participate individually and collectively in the planning and implementation of their health care...Primary health care [should be] made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford...It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process" (WHO, 1978).*

More recently, a series of international meetings were held, beginning in the early 2000s, to address ways to improve international aid effectiveness. To date, four High Level Forums on Aid Effectiveness have taken place in Rome, Italy (2003), Paris, France (2005), Accra, Ghana (2008), and Busan, Republic of Korea (2011). At first, discussions on aid effectiveness were mostly led by donors and partner governments. But, at the third meeting, civil society achieved recognition as an independent development sector, as well as established the importance of a healthy "enabling environment" (that is, without undue legal or political restrictions). Open Forum was created in June 2008 with the aim of building a global civil society consensus on the role and effectiveness of CSOs in development. During a Global Assembly of the Open Forum in Istanbul, Turkey (September 2010), eight Principles for CSO Development Effectiveness were articulated as guiding values for the development of CSOs (Open Forum for CSO Development Effectiveness, 2010). This was immediately followed by an Open Forum consultation that resulted in an International Framework for CSO Development Effectiveness in June 2011 (Open Forum for CSO Development Effectiveness, 2011).

Despite this recent headway, the role of civil society in national health system strengthening (HSS) remains ill-defined, as disagreements continue to exist concerning the roles and responsibilities of donors, governments and civil society itself. To address this lack in clarity, the current paper reviews extant literature on efforts to engage civil society in strengthening national health systems to end preventable child and maternal deaths (EPCMD). In doing so, this paper aims to showcase the potential of civil society engagement to strengthen national health systems.

Methodology

Search Process

Using an iterative approach, the authors searched for public health articles between the years 2000 and 2015, including public access databases such as Google Scholar, Popline, World Bank's Knowledge Repository and e-library, the USAID Development Experience Clearinghouse and PubMed. Other documents were identified through article bibliographies and suggestions of colleagues. We chose this timeframe to ensure that the content is relevant and fairly current, and the location databases to ensure a wide range of possible results that are readily available. Although it was not an exhaustive search, the authors believe that most of the recent public health articles that featured civil society engagement, both peer reviewed as well as not, have been captured.

Starting with broader keywords (e.g., “civil society” and "civil society health systems") to understand the civil society landscape and available literature, we then began to narrow our search terms by specific outcomes or technical areas. In particular, we were keen to uncover civil society’s contributions to the MCSP technical areas, and in turn, that impact on national health systems strengthening. As such, our search terms included, but were not limited to, “health system strengthening civil society accountability,” “civil society maternal and child health,” “civil society HIV/AIDS” and “civil society social capital.” Each search yielded a different number of results, with the most results coming from broader terms, such as “civil society” and “civil society health systems.”

Inclusion Criteria

We chose literature based on their publication date (between 2000 and 2015), credibility of source (e.g., reputable journal) and potential relevance to our review aims. The relevance was influenced by what we deemed to be their purpose through our initial literature scans. In the end, more than 160 documents fit these criteria. These were composed mostly of journal articles, briefs, meeting reports and guides and occasionally books. There were several compilations of results taken from multiple sources. After the referenced materials were collected, the authors conducted full reviews of selected documents, as determined by their degree of relevance. We also scanned longer texts for relevant sections to review and noted additional references to seek out. Other shorter texts also were scanned for content. We noted key findings and credibility of the sources and made comments on the texts’ content, strengths and shortcomings. For all the articles chosen for use in this document, we classified them into four categories, by their purpose: information, guidance, evidence and advocacy (Exhibit 1). In all, we referenced 108 sources for this review.

Exhibit 1. Number of referenced public health articles, by category

Purpose	Description	# Articles Reviewed
Evidence	Provides data and/or case studies of civil society engagement	49
Guidance	Provides guidance and frameworks around civil society engagement	30
Information	Provides general information, e.g., historical contexts and definitions	28
Advocacy	Provides general support of civil society engagement, without the detail of guidance or evidence	1

TOTAL	108

Below is a summary of this review beginning with two key definitions. Examples taken from the review are provided in the results section, and a full bibliography of the references follows this text.

Key Definitions

MCSP has developed and posted on its internal SharePoint key definitions for a set of terms commonly applied to global health in the context of the program (MCSP SharePoint, 2016). These include three related to civil society:

Civil Society is a wide array of formal and informal associations and organizations that advance public interests and ideas and are independent of the public and for-profit private sectors. This definition differentiates civil society from the for-profit private sector. However, the private sector may include both civil society organizations and for-profit service providers.

Social Capital is the connections among individuals in social networks, and the norms of reciprocity and trustworthiness that result from them. It is the degree and quality of these networks, norms and trustworthiness that bond similar individuals together or bridge diverse people together.

CSOs are diverse groups that express the interests and values of their members or others, and exist in the public space between the state, the market and ordinary households. CSOs can lead and organize social action, advocate on priority issues, participate actively in public service monitoring and oversight, and deliver services to members and the larger population. They may be community groups, nongovernmental organizations (NGOs), labor unions, indigenous groups, charitable organizations, faith-based organizations (FBOs), professional associations, foundations and providers.

Although other definitions have been developed during the past decade, we feel that these definitions build upon previous efforts, and are clear, simple and understandable to readers (Open Forum for CSO Development Effectiveness, 2011; LeBan, 2011; UNICEF, 2003; The World Bank, 2013).

Further distinctions are often made among CSOs which, in turn, reflect their roles in global health: international NGOs (INGOs); global health initiatives or partnerships; national or local NGOs and CSOs; FBOs; and networks of CSOs/NGOs/FBOs. Although these groups vary widely, there are also overlaps in their purposes and roles, reflecting values commonly shared: equity, reaching marginalized populations, promoting the strength of diversity and social capital.

Results

Based on our literature review, we determined that results fell into three recurring themes: (1) roles of civil society and civil society organizations; (2) key elements of successful civil society engagement; and (3) reported benefits of civil society engagement. Each theme and selected sub-themes are presented below.

Roles of Civil Society and CSOs

There are eight basic roles of civil society within the realm of national health care systems: 1. Public information, advocacy and policy development; 2. Public oversight; 3. Participatory governance; 4. Direct service provision; 5. Capacity development; 6. Resource mobilization; 7. Research and innovation; and 8. Networking.

Public information, advocacy and policy development

Public information, advocacy and policy development refers to all activities to raise public awareness, advocate for policy and program reforms and engage in visible activities to bring public attention to an issue, policy and/or program. Such information-sharing and advocacy generally occur at the national or global level.

Health-oriented CSOs classically engage in advocacy to transform public understanding and attitudes on health, represent public and community interests in policy discussions, and promote pro-poor and equity concerns for better resource allocation. The USAID-funded Kenya Civil Society Strengthening Program, for example, assisted numerous CSOs in Kenya to advocate for reforms, leading to such bills as the Truth, Justice and Reconciliation Bill, National Land Policy, Political Parties Bill, Elections Bill, Forest Act and Wildlife Policy Bill (USAID, 2013a). This program also led to SAFE-COAST, a partnership with the Kenya Community Support Centre to create a mechanism, Safe Coast Early Warning and Response, to warn users of the potential of human conflicts and threats (USAID, 2014b).

Frequently, policy and program advocacy go hand-in-hand with efforts to raise public awareness. The White Ribbon Alliance for Safe Motherhood Tanzania, for instance, launched a national advocacy campaign in 2006 to present data to government officials on its survey findings, which highlighted the need for skilled medical personnel to serve facilities in the Sumbawanga and Monduli districts (Futures Group, 2010). *For velferdsstaten* (For the Welfare State) in Norway also rallied the public behind social welfare and public services (Blas et al., 2008). In another example, groups in India advocated for a redrafting of the 2002 "Protection of Women from Domestic Violence Act" that they felt had neglected to fully protect survivors (Blas et al., 2008). Passing in 2005, the revised act added measures to protect survivors, including allowing women to bypass police to file a complaint directly with judges, as well as expanding protection to all females, not only wives or partners.

One of the most well-known global examples of effective public information, advocacy and policy development is the case of HIV/AIDs. In 2000, HIV/AIDS, tuberculosis and malaria, combined, contributed to more than 6 million annual deaths (The Global Fund, 2015). Since that time, HIV/AIDS has catapulted to be one of the most highly funded communicable diseases for prevention and control. A direct result of this awareness was the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria. In Brazil during the 1980s, the initial response to the epidemic took shape through social actions linked to the progressive Catholic Church, the sanitary reform movement in public health and the emerging gay rights movement (Parker, 2009). A broad-based civil society coalition took shape over the course of the 1990s, and

political alliances were built up during 1996 to pass legislation guaranteeing the right to antiretroviral treatment access. Brazilian CSOs are reported to continue to exert pressure to guarantee the sustainability of treatment access, as well as more broadly strengthening public health infrastructures and providing a model for health-related social mobilization.

Public oversight

Public oversight, or playing a "watchdog" role, refers to the act of holding governments accountable to their commitments. In this role, civil society acts as an independent agent.

Over the years, civil society has increasingly adopted this oversight capacity. In 2011, for example, the Centre for Health, Human Rights and Development, a Ugandan NGO, challenged the government in a landmark lawsuit over two women who bled to death, unattended, during childbirth in local hospitals (Ray et al., 2012; Webb, 2011). The case claimed that these deaths were preventable and that the government had violated these patients' rights to maternal health care and life. Leveraging the support of activist coalitions, the case received national attention and uncovered thousands of similar cases, highlighting the grave state of maternal health care in the country. Although years of dismissals and appeals ensued, on May 7, 2015, the High Court of Uganda finally ruled in favor of the Centre for Health, Human Rights and Development (Rudrum, 2015).

Because CSOs often work within communities, they can represent public and community interests in policy. In the past, many have systematically tracked policy implementation to ensure that policies fairly include community interests (Futures Group, 2010). One such example is Guatemala's Reproductive Health Observatories Network (OSAR). Since its inception in 2012, the Reproductive Health Observatories Network has systematically monitored and measured the impact of Guatemala's Universal Law for Family Planning and Sexual Education through the development of indicators, policy oversight and data collection on barriers to policy implementation (Green and West Slevin, 2013; Merino, 2012). All the while, the Reproductive Health Observatories Network has proactively worked with key stakeholders to devise solutions to barriers and engaged communities in the policy process. Another example is the White Ribbon Alliance for Safe Motherhood India, a coalition dedicated to making pregnancy and childbirth safer for women and newborns. In an effort to track policy implementation, this group rolled out checklists in several districts to monitor policies that sought to improve health care access for women and children (Futures Group, 2010).

On a global scale, international groups track trends to monitor governmental activity. Global Health Watch, for instance, periodically publishes an alternative world health report to highlight key health-related issues (Global Health Watch, 2014). The Partnership for Maternal Newborn and Child Health recently released the report, *2015 Strengthening Accountability: Achievements and Perspectives for Women's, Children's and Adolescents' Health* (PMNCH, 2015). The Partnership for Maternal Newborn and Child Health also has released a new report, *Engendering Accountability: Upholding Commitments to Maternal and Newborn Health* (Sneeringer et al., 2015). The report, commissioned by the Bill & Melinda Gates Foundation and the Children's Investment Fund Foundation, is an in-depth review of accountability processes at the regional, national, and sub-national levels, with a particular focus on those involving civil society.

When enabled, civil society has the potential to record policymakers' promises, track corresponding fund allocations and examine discrepancies in resource availability (Green and West Slevin, 2013). One example is Zimbabwean civil society and its 2012 success in calling for financial transparency from the National AIDS Council. In the previous decade, Zimbabwe's government had begun collecting an AIDS tax to care for those affected by HIV/AIDS, which in

turn resulted in drastic declines in HIV prevalence (Mhofu, 2012; Green and West Slevin, 2013). During one period, rates dropped from 27% to almost 14% (Green and West Slevin, 2013; Merino, 2012). Yet, in light of these promising results, pharmacies and clinics still reported supply shortages of antiretrovirals. In response to allegations of financial mismanagement, Zimbabwe activists took to the streets to demand information on how the AIDS tax was being managed, and more importantly, to improve patients' access to antiretrovirals (Mhofu, 2012; Green and West Slevin, 2013). The Zimbabwe Lawyers for Human Rights furthered activists' demands by petitioning the National AIDS Council to release information on tax allocation.

In addition to demanding financial information, civil society can monitor available financial information to improve resource allocation (Kanthor et al., 2014). The Institute of Policy Analysis and Research, a Kenyan NGO, did just that in 2009. At the time, the Kenyan government had increased public spending on health care. Yet, unlike previous surges in health care spending, this surge was not accompanied by any improvements in health outcomes. Knowing that at least half of health expenditures went to salaries, the Institute of Policy Analysis and Research sought to examine the extent and causes of health care provider absenteeism. In surprise visits to 40 facilities in the Machakos district, the Institute estimated an average staff absenteeism rate of 25%, or a monthly loss to the district of about $6 million in Kenyan schillings.

Participatory governance

CSOs have also joined forces with government (public) health staff at the local and national levels to provide greater scrutiny of programs and budgets.[1] There are different degrees of participation in governance, ranging from jointly monitoring program data to the direct management of health programs, remotely supervised by government officials. Also described more broadly in the literature as "social accountability," common themes included: preparation and planning, involvement of marginalized populations and the poorest of the poor, identification of barriers for effective participation by civil society and the governmental/public sectors, interface meetings between civil society and governmental/public sector, a focus on accountability and health outcomes measurement, strong facilitation and use of guides and rigorous evaluations of interventions (CORE Group, 2014). The recently released USAID'S Vision for Health Systems Strengthening, 2015–2019, calls for shared health governance by building "civil society/private sector capacity for stronger voice, [and] better advocacy to increase government transparency and accountability" (USAID, 2015a). In an online video series, the World Bank offers a broad overview of participatory governance through brief presentations (four to 15 minutes each) on Engaging Citizens: A Game Changer for Development (World Bank Group's Open Learning Campus, 2015).

A simple and effective joint monitoring example was recently reported by Jain et al. (2015), in which the ''My Village Is My Home'' tool was used by volunteers and health workers to record the births and vaccination dates of every infant in a community. This poster-sized material was tested in India and Timor Leste, and assessments in both countries produced evidence suggesting improved vaccination timeliness and coverage. The authors concluded that this is a

[1] It is useful to note the difference between public oversight and participatory governance, as the authors view them. Public oversight occurs when civil society independently assesses and reports on governments' accountability to their commitments, whereas, participatory governance occurs when civil society actively holds a stake in governance. In the latter case, the government may formally engage civil society in managing programs at certain levels, while under public oversight, civil society serves as an independent watchdog of government management. A third level of community participation, more passive, is 'community mobilization' (as defined by these authors) by public health workers, and through government led health communication activities. Since participation is passive and does not represent engagement by civil society actors, this topic is not discussed in this document. This narrow definition of community mobilization should not be confused with active engagement strategies described in community development, community empowerment and community transformation literature.

promising tool that has the potential to broaden program coverage by marshaling both community residents and health workers to track individual children's vaccinations.
In Ramnathpur, Bangladesh, the NGO DCPUK worked with the community to use scorecards to evaluate local health and family welfare services. Leveraging its political and social capital, DCPUK engaged community members, district health and government officials in focus groups and discussions on identifying performance indicators (Kanthor et al., 2014). In doing so, they were able to clearly identify the main health issues: high absenteeism of medical professionals and lack of access to free medicines. Other scorecard experiences recently have been reported for Kenya, Madigascar, Malawi, Tanzania, Liberia, Senegal and Ethiopia (UNICEF, 2014).

An additional recent tool describes community engagement for community-based management of acute malnutrition, which has been used widely to treat childhood malnutrition (Dessie et al., 2015; Dessie, 2015). This process engages communities and CSOs in actively participating in a full project management cycle (inputs, process, output and outcomes) and could be applied to a wide variety of health specific activities managed jointly.

Direct service provision, usually at the local level

As the name implies, direct service provision refers to civil society's role in delivering health services directly to patients, usually at the local level. Beyond simply delivering services, CSOs have the unique advantage of reaching marginalized populations with services where they live, integrating cultural preferences into service delivery, and successfully testing unconventional approaches to service provision (WHO, 2001). In countries where multiple CSOs may be offering direct health services, CSOs or CSO networks can facilitate the "harmonization" of health messages and strategies across programs, based on government standards (Estifanos, 2015).

In areas in East and Southern Africa, CSOs involved in HIV/AIDS are mostly tasked with directly providing HIV-prevention services (Kelly and Birdsall, 2010). In other cases, CSOs may be tasked with enabling communities to provide care for themselves. The Kakamega project in Kenya, for instance, enables women in communities to identify their health issues, collect data on these issues and choose the appropriate community health workers to assist them (Rosato et al., 2008).

CSOs also are created to provide services to chronically underserved populations. Prosalud is one such network and is made up of primary care and secondary care clinics located across Bolivia that provide low-cost health services to the poor in their neighborhoods. Prosalud engages in extensive community outreach and covers such priority issues as diabetes, TB and sexual and reproductive health (Center for Health Market Innovations, 2015).

NGOs and CSOs have sometimes been criticized for duplicating public services or competing for scarce resources, depriving a national or local government of the human, material and financial resources needed to strengthen the public health sector. Many such distortions have been documented over the past century of international development, with privately raised philanthropic funds targeting selected groups based on religion, ethnicity, gender or disease (and excluding many others with unmet health needs), or willfully ignoring public services for many other reasons, such as declared public fraud, waste, corruption or due to cultural hegemony (Easterly, 2007). Two reviews noted that Global Health Initiatives (or Global Health Partnerships) may distort health strategies by overwhelming existing national systems with external resources targeting donor priorities, such as HIV/AIDS (Bill & Melinda Gates Foundation and McKinsey Company, 2005; Biesma et al., 2009). On the other hand, contemporary global health actions usually attempt to explicitly include governments and their programs, as well as civil society actors (UN, 2015b).

Capacity development

Capacity development commonly refers to civil society's role in training and developing human capital, as well as building organizational capacity in both the civil society and public sectors. For example in Uganda, CSOs supported a shift to misoprostol use to treat postpartum hemorrhage by training public health care providers (Atukunda et al., 2015). Ugandan health centers traditionally lacked clinical guidelines and training on misoprostol use, and thus weren't prepared for the national policy change. Venture Strategies Innovations, Programme for Accessible Health Communication and Education and Ipas, among other CSOs, subsequently hosted trainings on the correct use of misoprostol to private practitioners and other trainers (Atukunda et al., 2015). An Indonesian CSO, DKT Indonesia, also contributed to developing human capital, by training local midwives to own and operate Andalan-franchised clinics to increase the use of contraception (Center for Health Market Innovations, 2015). In 2012, these clinics achieved $1 billion USD in condom sales.

Over the past 20 years, multiple organization capacity assessment tools have been published and used by the NGO/CSO community, as have training curriculae to respond to gaps identified during such analyses. Recently, the Health Policy Project has published the Organizational Capacity Assessment Suite of Tools that assist CSOs in areas of policy, advocacy, governance and finance, including a step-by-step facilitator guide, with supporting resources and user-friendly spreadsheets and templates to help participants learn about and discuss key topics, rate their organization's capacities, analyze the results, and plan for improvements where needed (HPP, 2015). Likewise, the CORE Group recently released The Consortium Management and Leadership Training Facilitator's Guide (Friedman and LeBan, 2014). It offers a reflective process to strengthen the consortium management and leadership skills of the senior leadership team of a consortium, technical team leaders within partner organizations and the senior management of local partner organizations.

Unfortunately, many CSOs, especially in sub-Saharan Africa, continue to struggle to build their organizational capacity. In a recent review of local CSOs in Kenya, more than half ranked as having poor managerial and operational capacity (Ekirapa et al., 2012). At the same time, in the Democratic Republic of Congo, community relationships typically last until the end of specific projects (USAID, 2013d). Likewise, in Sudan, only 25% of CSOs have strategic plans, but less than 10% follow through with these plans (USAID, 2013d). Although not entirely surprising, the trend of poor organizational capacity largely reflects the unreliability of funding. With long-term funding, CSOs are able to plan strategies and maintain relationships beyond a single project's duration. However, international and national donors have been accused of using CSOs to get externally designed programs closer to target populations quickly, without a commitment or appreciation for strengthening community assets to address ongoing health needs (Swanson et al., 2015; Kelly and Birdsall, 2010; Cohn et al., 2011).

Resource mobilization

Civil society also has the ability to attract and/or mobilize resources for a given task or goal at all levels of society: locally, nationally and globally. In rural areas of South Sudan, finding and paying for transportation to health facilities often prohibits many mothers from accessing health services (International HIV/AIDS Alliance, 2011). As part of a 12-month project in 2011, Action for Rights Relief and Development addressed this barrier by providing women in labor with transportation to local health facilities, which led to an increase in safe deliveries, reduction in the number of maternal deaths and better-informed communities (International HIV/AIDS Alliance, 2011). In Honduras, ChildFund International led a USAID-funded project in which 28 local communities built and continued to maintain community health huts staffed by local part-time health volunteers to provide basic health services, education and referral, in coordination with local

public health facilities (USAID et al., 2015). These activities contributed to increased local demand for services, lowered costs to patients, improved health outcomes, and suggestive reductions in child mortality rates.

In 2010, following the Gujarat earthquake, CARE India partnered with the Federation of Indian Chambers of Commerce and Industries to assist with relief efforts, resulting in the immediate provision of much-needed resources and investments in the rebuilding and rehabilitation of villages (Levenger and McLeod, 2002). CARE India also partnered with Tata Steel Rural Development Society and Parivar Kalyan Sansthan to both mobilize funding for the sustainability of child survival programs, and other industries in prioritizing health.

In Africa, measles and malaria are leading causes of childhood mortality. In an effort to counter this trend, the Ghana Red Cross, Ghana Ministry of Health (MOH), American Red Cross, Rotarians Against Malaria, Centers for Disease Control and Prevention, UNICEF, ExxonMobil, Satellife, Inc., BASF Corporation and the World Bank partnered in a pilot project to distribute insecticide-treated bed nets under the Measles Partnership Campaign to a remote northern district of Lawra (Kanne et al., 2004). The mass measles campaign encouraged caregivers to bring children to campaign sites for vaccinations. While at the campaign site, caregivers then received free insecticide-treated nets. By the end of the month, Lawra district went from only 4.4% of households to a majority of 80% of households using the nets. Based on the success of this pilot, the Zambian Red Cross collaborated with similar agencies and scaled this model in Zambia.

Similarly, on an international level, global health initiatives serve as “a blueprint for financing, resourcing, coordinating and/or implementing disease control across at least several countries in more than one region of the world” (Biesma et al., 2009). True to their description, three such global health initiatives, the Global Fund, the World Bank Multi-Country AIDS Program and the US President's Emergency Plan for AIDS Relief have jointly contributed to almost two-thirds of external funding for HIV/AIDS control in resource-poor nations (Biesma et al., 2009). Global health initiatives have diversified stakeholder engagement to include NGOs and FBOs as direct funding recipients, and in turn, program implementers, albeit with challenges as mentioned previously (Biesma et al., 2009). Overall, funding support through CSOs in developing countries steadily increased in the past decade, with official development assistance increasing from 12.7% ($14.5 billion USD, 2008) to 15.2% ($19.3 billion, 2011) (Coventry, 2013). Most of this growth was earmarked for service delivery in health, education, water and sanitation. Donor countries assign different levels of importance to the support of civil society, and current research indicates a growing donor interest in providing more direct support to CSOs in developing countries through multi-donor funds in-country.

Research and innovation

CSOs have the unique advantage and flexibility to experiment and test innovative methods and tools to improve service delivery. Aga Khan Health Services, Pakistan, for example, has successfully tested a “pay for performance” method for improving outcomes (Thacker et al., 2013). Instead of receiving a set salary, community health workers received bonuses based on the completion of different pre-defined activities related to vaccination coverage, maternal malnourishment and skilled labor and delivery (Thacker et al., 2013). What resulted was a shift in thinking, in which community health workers were encouraged to focus on outcomes (Thacker et al., 2013). Likewise, between 2008 and 2013, Concern Worldwide tested a different service model in Burundi, in which it compared the outcomes of volunteer management by an NGO versus the Burundi MOH (USAID, 2014c). Previously, Concern Worldwide had trained local NGOs to implement care groups, each made up of 10-15 volunteer mothers of children under five years of age, to then disseminate information on maternal and child health and

nutrition practices within their communities. Under the test, Concern Worldwide instead trained the District Health Teams and health facility staff to share the same information with community health workers, who then trained and supervised care groups. In the end, the MOH-led model improved maternal and child health and nutrition outcomes just as well as did the NGO-led model, hence, making the case for MOH-integration (USAID, 2014c; Perry et al., 2015a).

Similarly, in Nepal, PATH, Save the Children US, USAID, UNICEF and the United Nations Population Fund jointly developed the clean home delivery kit to address high numbers of newborn deaths due to unassisted and unhygienic home births. Launched in 1994, the kits consist of "a bar of soap, a plastic sheet, razor blade, plastic disk on which to cut the umbilical cord, and string to tie the cord along with pictorial instructions to guide birthing attendants with limited literacy skills through the delivery" (Levenger and McLeod, 2002). This comprehensive package resulted from 18 months of intensive research that included a needs assessment to determine the appropriate configurations, price and priority messages; prototype trials of 131 births in the field; and test marketing in two districts (Levenger and McLeod, 2002; Tsu, 2000). Since launching, the product has successfully been sold to individuals and larger entities, such as the MOH and nursing campuses.

USAID's Child Survival and Health Grants Program greatly encouraged the formation of partnerships among NGOs, academia and ministries of health to accelerate reductions in maternal, newborn and child mortality for the past 30 years. As an example, one recent project funded by the program found that the use of cell phones by community health workers to share health information with pregnant and postpartum women in rural Afghanistan led to improved care-seeking behavior and service utilization (USAID and World Vision, 2014).

Networking

CSOs contribute considerable social capital; that is, they build and maintain a range of trusting relationships to achieve shared goals. These relationships can traverse industries and sectors and occur between governments, NGOs, CSOs, religious faiths, private corporations and/or community members. Such relationships may be developed from the local level to the global, and may interact across these levels, as the examples below demonstrate.

In India, the Uttarakhand Cluster links small community health programs together to build NGO capacity, increase visibility and better link to the formal health care system (Grills, Robinson and Phillip, 2012). Research was conducted between 1998 and 2011 to examine barriers and facilitators to networking, or clustering, and the effectiveness of this approach. Results indicated that key brokers and network players were important in bridging between organizations. The ties that held the cluster together included shared common faith, common friendships and geographical location and common mission. Self-interest, whereby members sought funds, visibility, credibility, increased capacity and access to trainings was also a commonly identified motivating factor for networking. Barriers to networking included lack of funding, poor communication, limited time and lack of human resources. Risk aversion and mistrust remained significant barriers to overcome for the cluster.

An excellent local example of CSO networking that then scaled up to a national level is the Senegal health hut system. With support from USAID, and implemented by a consortium of seven NGOs, current program efforts cover 72 districts in all 14 regions of the country, with the intention of being fully national in scope (Digne and Shanklin, 2012). Programme Sante/Sante Communitaire fosters ownership of community health services by the Senegal MOH and other sectors by harmonizing relationships with national policy and improving the quality and availability of information, products and services at the health hut and outreach sites. This

includes using standardized strategies, tools and training across partners and with a strong community engagement strategy for eventual local management and support of program sites, linked to district/MOH programs and policies. Between 2012 and 2015, 20% of health huts have been transferred successfully to local management.

Another national example of a successful civil society network is the Kenya NGOs Alliance Against Malaria (KeNAAM, 2015; KeNAAM, 2010). Formed in 2001, the network addressed the country's need for a central, coordinating entity for all civil society resources, skills and programs, with an initial emphasis on malaria programming. Among other activities, the Alliance translated government policies into actionable interventions for local community-based organizations, enabling civil society to participate directly in the national fight against malaria by mobilizing for additional resources. Seed funding for the network's secretariat was provided through a USAID grant and supported by the CORE Group.

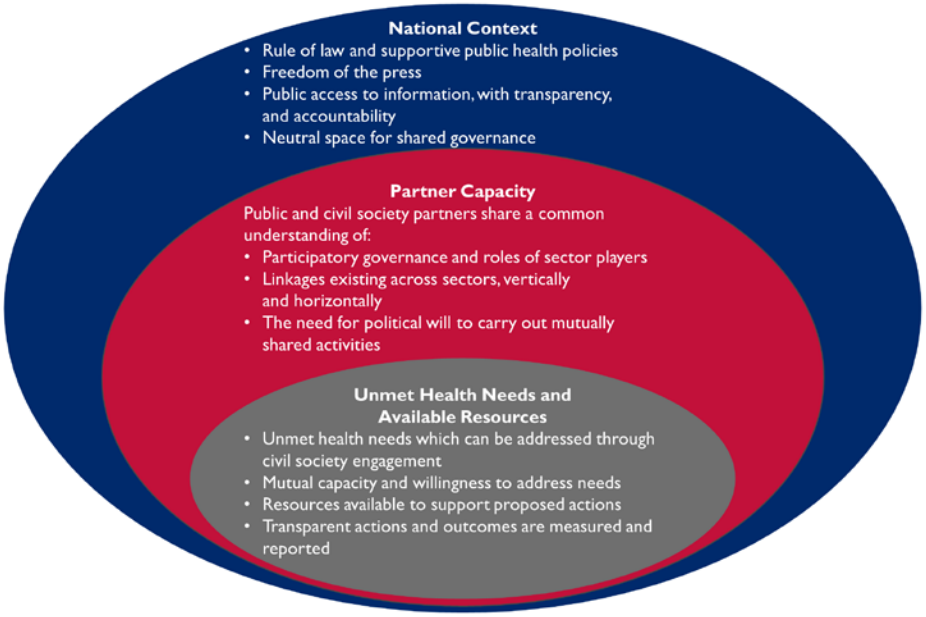
Similarly, A Promise Renewed demonstrates that national and global networks can be linked. In 2012, following the Child Survival Call to Action, 178 governments, hundreds of civil society, private sector and faith-based organizations made a promise to prevent easily avoidable maternal and child deaths. This commitment, called A Promise Renewed, has since led to dramatic declines in under-five mortality due to preventable causes and has even inspired the formation of country-specific alliances (Garin et al., 2015; Maseko, 2015). In response to A Promise Renewed, a coalition of CSOs has recently launched an alliance to reduce maternal, neonatal and child deaths in Zambia. In a country where one of 22 children die before the age of one and one in every 13 does not live to age five, networking and collaboration between sectors are desperately needed to lower the mortality rates (Maseko, 2015).

This new alliance could learn from veteran, international networks, like CORE Group. Since its incorporation in 2001, CORE Group has enabled the sharing of financial and technical resources among its 70+ members and associates for the improvement of child survival/child health programs (Levenger and McLeod, 2002). In fact, past studies have found as many as 91% of members had obtained technical information from the network (Levenger and McLeod, 2002). CORE Group has also been actively involved in establishing multiple national CSO networks, called CORE Group secretariats (CORE Group (a); CORE Group, 2015). Initially developed to help eradicate polio, the secretariat model seeks to establish in-country infrastructures to respond to pressing, unmet health needs. Accumulating success over the years, the model encourages government and civil society to come together in a neutral space to facilitate communication, brainstorm solutions for unmet needs and coordinate health concerns (CORE Group (b); CORE Group, 2015).

Key Elements of a Framework for National Civil Society Engagement

The three domains of a framework for civil society engagement in national health programming (Exhibit 2) include: 1) the national context, or the "enabling environment"; 2) partner capacity, with a shared common understanding of roles and responsibilities; and 3) clear health need and available resources.

Exhibit 2: Framework for Civil Society Engagement within a National Health System



The national context

In the previous section, we saw how diverse civil society's roles can be. Civil society has the capacity to provide oversight, monitor policies, track budgets, raise public awareness and deliver services. However, the effectiveness and extent of civil society engagement also depends upon the enabling environment (i.e., the rule of law, freedom of press and public voice).

Rule of law

As mentioned in the Istanbul CSO Development Effective Principles, CSOs are effective "development actors" when they support democratic principles, basic human rights, policies that encourage public participation in governance and stable governance (Open Forum for CSO Development Effectiveness, 2010; Open Forum for CSO Development Effectiveness, 2011). As may be expected, CSOs function best in contexts that also support these principles. According to USAID, promoting democracy, human rights and governance is essential to supporting USAID's development agenda and the United States national interest (USAID, 2013b; USAID, 2013c). Core to civil society is the freedom of association; that every individual fundamentally has the right to join together in pursuit of common aspirations and goals (Ademi and Evans, 2013). However, in the past few years, governments around the world have increasingly proposed or enacted laws (more than 90 in 2012) to restrict civil society's freedom of association or assembly (Mendelson, 2015). Ethiopia is just one example. In 2009, the Ethiopian government enacted the Proclamation to Provide for the Registration and Regulation of Charities and Societies to regulate and require NGO registration, in the name of national security (Hodel, 2013). Since this law passed, the government has restricted multiple NGO activities, including the support of human and democratic rights (Hodel, 2013). Similarly, some countries in Central Asia require potential associations to have a minimum of 500 members to form, which may not be achievable for many groups (ICNL, 2013). Global organizations and their guiding rules may influence civil society relations. The charters of the United Nations and World Trade Organization, for example, explicitly approve relations with civil society. However, the Organisation for Economic

Co-operation and Development and International Monetary Fund do not make any such mention. The latter case risks limiting civil society's political space (Scholte, 2004).

The International Center for Non-Profit Law recently called for more explicit inclusion of CSOs to meaningfully contribute to the sustainable development goals (ICNL, 2015). Specifically, they called for the following actions: 1) the post-2015 development agenda should include a target and indicator(s) to promote an enabling environment for civil society; 2) the target and indicator(s) should be linked to an analogue to Millennium Development Goal 8 focusing on partnerships for development or to a new goal, such as good governance, human rights or the enabling environment for development writ large; and 3) a core group of countries and other stakeholders should assume leadership for ensuring that the enabling environment for civil society is a priority in the post-2015 development agenda.

In a recent blog by the NGO, Oxfam, the organization laments the closing space for CSOs globally (Green, 2015). "As states become less dependent on western aid, they become less open to influence by western governments. Developing country governments are less tolerant of CSOs challenging 'political capture'. In some contexts CSOs doing this are perceived as acting for the political opposition. Weak regulatory and accountability frameworks for civil society make CSOs vulnerable to this charge. Several governments exploit this vulnerability and use new regulations to restrict the space of civil society to debate or challenge their economic and political development agenda. Patterns are emerging where neighboring states apply very similar legislation and tactics, learning from one another about how to control civil society space."

USAID's CSO Sustainability Index highlights advances and setbacks in CSO sector sustainability, and allows for comparisons across countries and sub-regions over time in seven key components: legal environment, organizational capacity, financial viability, advocacy, service provision, infrastructure, and public image (USAID, 2014a). The scores for each dimension are averaged to produce an overall sustainability score for the CSO sector in a given country. The 2013 CSO Sustainability Index for sub-Saharan Africa evaluates the strength and viability of the CSO sectors in 25 countries in East Africa, West Africa, and Southern Africa. As in 2012, 10 of the 25 countries were in the Sustainability Impeded category, the weakest level of CSO sustainability. The other 15 countries remained in Sustainability Evolving, the middle range of CSO sustainability. No country transitioned to a different category of sustainability in 2013, and no country reached Sustainability Enhanced, the strongest level of CSO sustainability, in any dimension.

Contrary to the trend of closing public space for civil society engagement in selected countries, there are activities that governments and their citizens can do to widen that space. To be sustainable, per the CSO Sustainability Index, the CSO sector needs to operate in a legal and regulatory environment that is supportive of its needs (USAID, 2014a). Examples of these include the public commitment to health as a basic human right and the implementation of health policies, programs and practices that explicitly include civil society participation. The recently announced sustainable development goals at the United Nations General Assembly further expands on this right to include health for all as a human right (UN, 2015a). But, discussions need to continue on ensuring an enabling environment for civil society in the post-2015 development agenda (ICNL, 2013).

An example of national commitment to civil society participation can be found in Senegal, where in 2014, the MOH released a formal national policy incorporating community-based structures (health huts) as integral elements of the national health system with significant input and management control exercised by communities themselves.

Freedom of press

Reporting free of reprisal is not only fundamental to democracies, but also critical to enabling civil society's work. We see this, especially, in the comparison between Ethiopia's relatively low freedom of press and South Africa's relatively high freedom of press for CSOs (Thinkwell, 2014). Not surprisingly, CSOs in Ethiopia encounter more barriers, such as bottlenecks to accessing and disseminating information (Thinkwell, 2014). Meanwhile, CSOs in South Africa have relatively open dialogue with their government. As a result, compared to Ethiopia, South Africa has a more vibrant, active civil society, in which CSOs contribute in multiple ways to governance.

Public access to information, with transparency and accountability

Complementing freedom of the press, public access to information regarding public health policies, budgets/expenditures, and program results is essential, yet is frequently difficult to obtain, even in the most open of societies. The price of such access usually is paid through the routine vigilance of a free press and civil society.

Transparency

Public transparency, or disclosure of key information, is critical for establishing effective democratic accountability, maintaining public trust and eliminating corruption (OECD, 2008; Scholte, 2004).

Nationally, governments must "effectively" share information; that is, they must not only share key information with the public, but also ensure the public's comprehension of the information. For example, some time ago, the Brazil Network on Multilateral Financial Institutions (Rede Brasil) had been receiving significant public pressure to share the World Bank's Country Assistance Strategy for Brazil (Scholte, 2004). However, the Strategy was only available in English, and Rede Brasil's customers mostly read only Portuguese. In the end, Rede Brasil disclosed the strategy to the public, as well as translated the original English version into Portuguese for a wider reach (Scholte, 2004).

Although national transparency is critical, local transparency must also occur. Argentinian CSO, Fundacion El Otro ("El Otro"), for instance, generated transparency at the local level through active citizen engagement. Operating for eight months between 2004 and 2005, El Otro involved citizens and CSOs in collecting information on the operations of key social programs and then reporting this information to government officials (Reames and Lynott, Involving Citizens in Public Budgets: Mechanisms for Transparent and Participatory Budgeting, n.d.). These social programs included an income transfer program for households with unemployed heads of families, a low-income household assistance program, a financing program for soup kitchens, a free medicine program and a student grant program. The citizens and CSOs created a series of reports delineating the problems of selected social programs, and in doing so, opened channels for communication and service improvement.

Accountability besides

Improving transparency, civil society plays a key role in eliciting government accountability, or responsibility, to their commitments. Civil society has enhanced accountability through activism, oversight and participation in service provision, among other roles. The recent launch of the sustainable development goals is another opportunity for civil society to improve accountability. Multiple organizations have joined together in the global action/2015 campaign to demand that their country representatives be more explicit in the measurement of the sustainable development goals (action/2015, 2015).

In this case, national governments are being held accountable to their citizens. However, accountability occurs at multiple levels and in different directions, beyond just the relationship between nation states and their citizens (Glennie et al., 2013). Governments also are accountable to foreign donor agencies; foreign donors are accountable to the governments' citizens; and the foreign donors are accountable to their own governments' citizens. To ensure optimal accountability, all parties should be aware of the interplay of these dynamic relationships, and be able to work within an enabling environment of a free press and public access to information.

Partner capacity

Public, private and civil society partners should share a common understanding of participatory governance, and the roles, responsibilities and capacities that are needed for sector organizations to function effectively. Linkages should exist across sectors, both vertically as well as horizontally. Most importantly, political will is essential to carry out mutually shared activities.

Shared common understanding of participatory governance, and the roles, responsibilities and capacities that are needed

Substantial capacity strengthening may be required for both CSOs and the public sector to effectively partner in program planning, implementation and evaluation. This will ensure that partners have the skills to understand development mechanisms and processes (including country budgeting and fiscal reporting) and performance indicators; advocate on behalf of constituents and clients; monitor implementation and establish accountability mechanisms; develop and maintain strong internal management structures and form alliances and partnerships (Hodel, 2013).

Brazil's child rights councils exemplify a strong, shared common understanding of participatory governance. Created by national law, Brazil's child rights councils operate at the policymaking and judicial levels to implement the nation's statute for legally protecting adolescent and child rights (Hoffman, 1994). At the same time, these councils are required to have equal representation of civil society and public sector actors. In contrast, Brazil's guardianship councils operate within communities to monitor their compliance with the statute, are made up of various members and intervene on behalf of vulnerable children. Through the clear understanding of responsibilities at different levels, these councils have been able to jointly enforce the statute across the nation.

National governments, however, may not always support CSOs' involvement in governance. Some CSOs and public agencies may then opt for alternative legal remedies, such as contracting. Contracts are beneficial in that they clearly and formally specify terms for sharing information and responsibility between CSOs and their partners. Medicus Mundi International, for example, advocates for the use of contracting to integrate CSO health services into district health systems around the world (Loewenson, 2003b). Similarly, UNICEF's formal partnerships with CSOs are governed by a memorandum of understanding that clearly outlines the partners' joint objectives and the use of resources to achieve those objectives (UNICEF, 2015b). Not to mention, all UNICEF partnerships with CSOs are mandated to follow the UNICEF Principles of Partnerships, which clearly call for mutual commitment to protecting the rights of children and maintaining mutual accountability (UNICEF, 2015b).

Linkages exist across sectors, vertically as well as horizontally

A recent contribution to identifying entry points for community engagement in health system strengthening is the release of USAID's Community Health Framework (USAID, 2015c). In it, health specific and health enabling components are identified within the continuum of district/national, local community and home-based care. Using this approach, readers are encouraged to explore what is needed, and how to take action on community health "ecosystems." Another useful tool, entry point mapping provides a methodology for systemic review and identification of mechanisms, forums and public platforms by which CSOs can participate in health sector policy formulation, program implementation, and oversight (Paraskeva and Kanthor, 2014).

Political will to carry out mutually shared activities

Broad-based political will clearly advances the possibility of responses to shared problems. Look at the global movement to control HIV/AIDS. Following the United Nations Declaration of Commitment on HIV/AIDS, governments and agencies around the world jointly invested in the rapid scale-up of services to treat and prevent HIV/AIDS in their countries, often allocating funds to CSOs for service delivery (Biesma et al., 2009). For example, between 2002 and 2006, donor funding for the AIDS response increased six-fold, largely due to political backing (Rodriguez-García et. al, 2013). Similarly, in 2011, the United Nations High-Level Meeting on Non-Communicable Diseases declared a global commitment to reduce mortality from these diseases. Since this announcement, non-communicable diseases have been added as a priority to national health and development plans. To this end, the Tanzania Diabetes Association and Tanzanian government collaborated recently to develop and implement a diabetes program (The East Africa NCD Alliance Initiative, 2014).

Clear health need and available resources to support ongoing partner capacity development

Clear health need

A clearly defined unmet health need serves to unify CSOs and other development actors around a shared goal. As we saw previously, Zambian CSOs came together to form the Zambia Alliance for Maternal Neonatal and Child Health in response to both the Call of Action by A Promised Renewed and the nation's high newborn mortality rates. Likewise, the Government of Kenya has recently launched a "Beyond Zero" campaign to garner additional resources for reducing their high maternal and child mortality rates (USAID, 2015b).

Available resources to support ongoing partner capacity development

Resources for prioritized health needs are essential to support direct service delivery, improve management capacity and the capacity to engagement in positive and effective ways. One important recent example of the impact of donor funding policies is found in the global effort to address HIV/AIDS in Africa.

Over the years, in East and Southern Africa, large-scale funding programs increasingly focused on HIV/AIDS as an investment area, and service provision (75%) as the channel for investment (Kelly and Birdsall, 2010). As such, most CSO activity in the region moved toward the delivery of HIV-preventive services. In Kenya, CSOs focused heavily on HIV/AIDS, while relatively few attempted to address child health, juvenile delinquency and gender issues (Ekirapa et al., 2012). Despite these shifts in funding toward HIV/AIDS programs, large-scale programs frequently neglected to invest in the strengthening of community HIV/AIDS services (Kelly and Birdsall, 2010). Too often, donors did not support the overhead of CSOs, leaving CSOs struggling to

enhance their own capacity (Glennie et al., 2013). At the same time, funding was often short-term and financed by international donors, further weakening CSOs' long-term capacity (Ademi and Evans, 2013; USAID, 2013d). In fact, according to a study of CSO sustainability in sub-Saharan Africa, CSOs consistently exhibited weak financial viability (USAID, 2013d).

There is an obvious link between the availability of needed resources, the quality and effectiveness of interventions and the impact of services upon clients. Multiple authors reported the need for donors to support CSOs' ongoing institutional development, including building management and governance systems and the skills to form and sustain alliances and partnerships. In contrast, CSOs could achieve greater financial viability and sustainability by calling on national governments for more domestic investment in civil society to reduce dependence on foreign aid. Additionally, CSOs could call upon all health program donors to diversify their investments to expand CSO roles, capacity and longevity.

Reported Benefits of Civil Society Engagement

The reported benefits of civil society engagement parallel the roles that CSOs play in national health systems: 1) Increased public awareness of unmet health priorities and the importance of health service quality; 2) Increased funding for high priority public health topics; 3) Participatory governance introduced, supported and capacity developed; 4) Demand and use of high quality health care increased and improvements made to service quality; and 5) Outcomes improved, including increased health service equity among marginalized populations. These benefits are most often achieved in an enabling context, and depending upon the degree to which these enabling conditions are not met, benefits may be reduced, not realized, and/or not sustained over time. The evidence presented in one review indicated that CSOs can and do reach impoverished communities and can and do make improvements in their health (Loewenson, 2003a; 2003b; 2003c). However, CSOs and the systems they work within often have weaknesses that impede effectiveness. The challenges between positive CSO pro-poor health actions and the wider enabling environment is an area that merits much greater attention and study.

Increased public awareness of unmet health priorities and of health service quality

Civil society engagement has led to heightened public awareness of unmet health needs and the importance of service quality to positive outcomes. For instance, through its lawsuit, Centre for Health, Human Rights and Development brought Uganda's dire maternal health care situation to the attention of the nation and government, prompting responses. Similarly, Kenya's Institute of Policy Analysis and Research revealed poor service quality as a result of high staff absenteeism rates. Another example is the Global Vaccine Action Plan, which strives to extend immunization coverage to all people. In Pakistan, civil society has advanced the Plan's mission by organizing vaccine campaigns, setting up local vaccine camps and offering training sessions to raise public awareness of the importance of immunization (Thacker et al., 2013). Among their accomplishments is the successful hosting of more than 4,000 health meetings for marginalized, neglected and hard-to-reach populations.

A majority of CSO activities are focused on the local or program level. CSOs also tend to focus on the immediate effects of their activities, and some evidence points to a shortfall in CSO capacity to monitor results at outcome and impact level (OECD, 2013). Thus, although there is considerable evidence of CSO activities delivering results at local or regional levels, there is less systematic evidence on the contribution of CSOs to long-term development outcomes or their wider impact through national policy or practice change.

Increased funding is made for high priority public health topics

Besides public recognition of key issues, civil society engagement may spur greater investment in priority health services. Although current global funding includes significant outlays for HIV/AIDS services, this was not always the case. In fact, civil society engagement in some countries actually predated (and eventually stimulated) global HIV funding (Coutinho et al., 2012). In Uganda, The AIDS Support Organization emerged in the 1980s to destigmatize HIV and ensure quality care for people living with HIV. Likewise, in Brazil, civil society and people living with HIV heavily promoted condom use (and HIV prevention), especially among sex workers and men who have sex with men. As these efforts grew, so did global attention to the HIV/AIDS epidemic. Eventually, governments around the world began engaging civil society in HIV prevention messages (e.g., "AIDS kills"). Finally, following the United Nations' Declaration of Commitment on HIV/AIDS in 2001, multiple international funding sources arose to tackle HIV, including the Global Fund to Fight AIDS, Malaria and Tuberculosis and the President's Emergency Program for AIDS Relief. Since the advent of these funds, The AIDS Support Organization has expanded its services from advocacy and education to direct care and treatment.

Participatory governance is introduced, supported and capacity developed

Civil society engagement also has a track record of leading to improved participatory governance, as shown previously by the examples of Fundacion El Otro ("El Otro") and White Ribbon Alliance for Safe Motherhood India. El Otro, a local Argentinian CSO, improved transparency and monitoring of key social programs through citizen engagement. Likewise, White Ribbon Alliance for Safe Motherhood India implemented checklists in several districts to monitor policies to improve health outcomes. Engagement between government and civil society requires openly and readily available data at various levels, as well as mechanisms to induce regular discussions on findings (MA4Health, 2015). Therefore, by improving transparency and accountability, civil society engagement can lead to strengthened relationships between government and civil society and improvements in outcomes.

As CSOs experience shared governance, capacity needs will also emerge. Such needs commonly include: governance skills, measurement (monitoring and evaluation), advocacy capacity, and resource mobilization, among others. As part of this literature scan, we have identified multiple resources documenting shared capacity building tools and guides. These resources range from reports on social accountability approaches to country-specific guides for civil society on engaging in health budget advocacy.

At the national/regional level, Governance, Accountability, Participation and Performance provides a useful guide for achieving more equitable, efficient and effective service delivery (USAID, 2012a). Proposed in response to issues in Uganda, Governance, Accountability, Participation and Performance strengthens local governments and supports NGO led efforts to enhance accountability and democratic governance (USAID, 2012a). Sample activities include reviewing policies that affect service delivery, improving local tax systems to be more transparent and supporting CSOs' participation in national/local planning and budgeting processes.

In addition, the Entry Point Mapping Tool supports CSOs by systematically identifying legal "entry points" into national policy formulation, program implementation and oversight (Paraskeva and Kanthor, 2014). In doing so, the tool also helps CSOs to pinpoint and assess variances in civic engagement strength across the different entry points. Bangladesh's case study highlights the potential benefits of this tool. By using the tool, CSOs were able to identify health service entry points in their districts, which then generated public circulars requiring civil society

engagement (Paraskeva and Kanthor, 2014). Although this is a district example, the capacity building tool can be implemented successfully at all levels, including the national/regional level. The last example is the Community Score Card of Malawi. This process starts with a planning meeting with key community stakeholders, who identify sites and groups to implement the Score Card (UNC-Chapel Hill School of Journalism and Mass Communication et al., 2012). Subsequently, the chosen groups using the score card identify issues or barriers to accessing services, organize issues into themes, develop and score measurable indicators for each theme and make suggestions for improvements. For instance, one community group could identify "mean service providers" and "ridicule from providers" as barriers to accessing health care services and the corresponding theme as "provider service." This same group then scores the theme, provides reasons for the score and brainstorms solutions to the theme. At an Interface Meeting, community members, health providers and government officials come together to discuss their score cards, issues and priorities and to then jointly devise and implement a community action plan. This process repeats every 6 months to ensure accountability, and has, to date, led to significant improvements in maternal health in Malawi.

Demand for high quality health care is increased and improvements are made to service quality

The literature indicates that effective civil society engagement has led to increases in service demand and improvements in health service quality. This may happen in three ways. First, CSOs may play the role of shared monitoring and oversight, providing valuable input to public service improvements. Second, CSOs often provide high quality direct services in conjunction with national health programming. Third CSOs may mobilize the public to seek timely health services and/or inform communities of improvements made to the local health system. For example, CSO-led care groups have documented significant improvements in healthy behaviors, demand and health outcomes, with under-five mortality in care group areas decreasing by about 32% (Perry et al., 2015b).

Regarding service demand, Ghanaian-based CSO, Future Generations International demonstrated positive outcomes in vaccination demand, access and use in a disadvantaged district of Ghana (Thacker et al., 2013). A few years ago, Ghana's diphtheria, tetanus and pertussis vaccine coverage of children was more than 80%. Yet, many districts at the time, especially hard-to-reach communities, fell below this level. Allocating funds to address this gap, GAVI the Vaccine Alliance subsequently engaged Future Generations International to improve access to these hard-to-reach communities for these vaccines. Through its analyses, Future Generations International identified physical, economic, cultural, family and transportation barriers to the community's awareness, access and use of vaccines. Since then, Future Generations International has set up community oversight committees to support community health workers and volunteers and ultimately to overcome identified barriers.

Civil society also helps to improve service quality through program monitoring and oversight. In Bangladesh, through strong community participation, a Bangladeshi NGO identified that one village's lack of access to free medicines came from those same medicines being sold on the market (Kanthor et al., 2014). To find this out, the NGO conducted multiple focus groups and hosted numerous community meetings, all the while using community scorecards. As a result of this finding, clinic staff began counting medicine wrappers to monitor distribution.

Improved program outcomes

Civil society engagement can lead to multiple positive program outcomes. Rodriquez-Garcia highlights how community responses can lead directly to increased awareness of HIV/AIDS, increased service utilization and decreased HIV incidence (Rodriguez-Garcia et al., 2012;

Rodriguez-García et al., 2013). Community engagement is also particularly helpful in serving hard-to-reach, at-risk and marginalized populations. The author noted:

> *"The evaluation found evidence (varying from causal to associative, to suggestive) that, depending on the country context and the service delivery mechanisms, the response of communities can achieve the following: help mobilize substantial local resources; improve knowledge and behavior; increase the use of services; affect outcomes of social processes; and impact HIV incidence and other health outcomes."*

It's important to note that community responses are not a replacement for weak national plans. Rather, communities can assist national health programs, but must also operate under realistic objectives and with financial and technical support. As one example, the Indian Academy of Pediatrics publicly advocates for the importance of vaccines to enhancing child survival in India. Thus far, it has spread campaigns to counteract misinformation; launched an SMS-based national immunization reminder program for all parents; trained health professionals in vaccinology; and run an internal, polio eradication committee for almost a decade (Thacker et al., 2013).

Another case study of improved outcomes is the My Village Is My Home tool in India (also known as Uma Imunizasaun in Timor-Leste) (Jain et al., 2015). The tool documents births and vaccination dates of every infant in a community on a poster-sized material. By consolidating information on one poster, community leaders and health workers can then reference one poster to check on levels of vaccination coverage in their communities. To date, assessments have suggested that the tool improves vaccination coverage and timeliness. In India, communities using My Village Is My Home reported an 80% higher coverage of children for vaccines (Jain et al., 2015). Similarly, in Timor-Leste, villages using the tool saw a substantial increase in the number of infants identified and immunized, as compared to the previous year before the tool had been introduced.

Mansuri et al. found that on balance, greater community involvement seems to improve resource sustainability and infrastructure quality. But, the evidence also suggests that people who benefit tend to be the most literate, the least geographically isolated, and the most connected to wealthy and powerful people. Studies that are able to assess the impact of participation typically find that although inducing community engagement alone has little impact on outcomes, community engagement can substantially amplify the impact of investments in public health or inputs. In the case of health service delivery, for example, the formation of community health groups appears to have virtually no effect on any health-related outcome when done in isolation but is effective when combined with inputs such as trained health personnel or the upgrading of health facilities. Community engagement leads to significantly larger reductions in maternal and child mortality, larger improvements in health-related behaviors, and greater use of health facilities than investments in health inputs alone can deliver. Interestingly, successful programs are often located within larger government health delivery systems. This finding is encouraging, because government participation is usually central for scaling up health initiatives. The evidence also suggests that the most successful programs tend to be implemented by local governments that have some management autonomy and are downwardly accountable. Most important, there needs to room for honest feedback to facilitate learning instead of a tendency to rush to judgment coupled with a pervasive fear of failure. The complexity of participatory development requires a high tolerance for failure and clear incentives for project managers to report evidence of it. Failure is sometimes the best way to learn about what works. Only in an environment in which failure is tolerated can innovation take place and evidence-based policy decisions be made (Mansuri, 2013).

Jonathan Fox (2014) drew similar conclusions in his review of civil society engagement in health programming. Tracking program data alone results in mixed results across studies (Fox, 2014). However, when civil society is engaged in multiple ways (using mutually-reinforcing tools, such as social accountability through shared governance, public advocacy, and governmental reforms) the evidence is much stronger of positive impacts.

Discussion

Many theories of change in relation to civil society are based on an assumption of a nation state that is capable and willing to respond to the demand of its citizens (Coventry, 2013). However, several evaluations have challenged how applicable this type of logic is in all contexts, for example, where the state is weak or highly authoritarian. The links between support to civil society, democracy, good governance and pro-poor development should be objectively assessed to enable both donors and CSOs to clarify what changes they might be able to influence, what changes are beyond their scope of influence and whether their assumptions are valid. USAID has published analysis reports on CSO sustainability in developing nations to better inform this discussion. As described earlier in this text, their 2014 report summarized the status of 25 countries in sub-Saharan Africa, and no country reached the strongest level of CSO sustainability, in any dimension (USAID, 2014a). That is to say, most countries' scores either impeded CSO engagement or were mixed in CSO supportive mechanisms.

Nevertheless, through community health, CSOs often represent at-risk communities and populations, no matter the extent of the 'enabling environment', and have created health programs that effectively reach dispersed families in hard-to-reach areas. CSOs also mobilize communities for actions to improve determinants of health, such as water, sanitation, health service demand, and emergency transportation, among others. However, CSOs often work independently of one another, and while their work may be similar, the means by which they accomplish their tasks often vary, and may not be fully integrated into public facility services.

On the other hand, the national health model being implemented in most countries favors a facility-based, professionalized approach to health care provision. This probably results in reaching more urban, geographically assessable, and relatively more affluent populations, although not necessarily reaching socially marginalized groups in these same areas. Further, the "medical culture" of in-country health professionals has frequently been reported to be associated with poor quality, poor patient treatment and lack of access and demand.

The perceived high costs of reaching high risk, marginalized populations often lowers their priority for health services among national health policymakers and donors because such populations are viewed as "expensive" to reach through the traditional facility-based model. In response to this context, health planners often turn to "community outreach" offered through established facilities to increase population coverage of services and at a perceived minimum marginal cost per client. Gwatkins and Ergo argue that equitable health coverage requires that people who are poor should gain at least as much in terms of improved health care coverage as those who are better off at every step of the way toward universal coverage, rather than having to wait and catch up as that goal is eventually approached (Gwatkins and Ergo, 2011). Otherwise, those in greatest need are likely to wait longest for the "trickle down" approach of gradual expansion.

For the most part, national health system strengthening models and platforms do not explicitly include a structured role for civil society in health system strengthening. This represents an important lost opportunity to further reduce mother and child mortality through such programming. Often, international donors face challenges supporting civil society engagement within national health systems. These may include working in countries with a limited or hostile context for civil society engagement, supporting existing bilateral agreements that do not include participatory governance and limited resources to dedicate to health system strengthening. Nevertheless, in almost all contexts, there are activities that donors and civil society can undertake to promote and expand civil society's contribution to improved national health and to respond to President Obama's Call to Action (The White House, 2015).

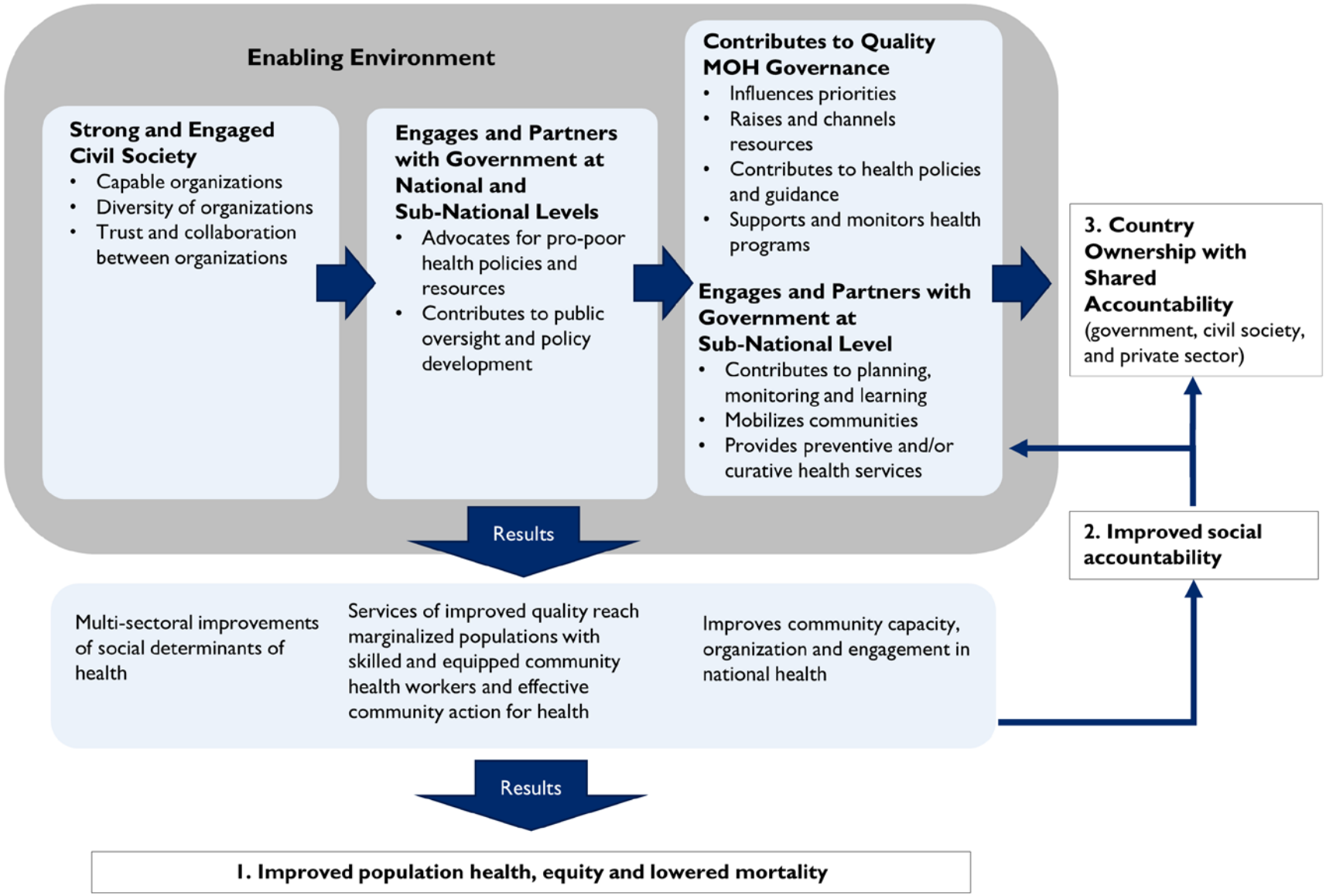
A Proposed Model for Civil Society Engagement

Exhibit 3 (below) presents a model for the role of civil society in strengthening national health efforts, based on information synthesized in this literature review. It provides a basis for MCSP program design in selected countries and for a concurrently developed MCSP Civil Society Engagement Strategy.

The model shows how civil society engagement fits within a system of social influences operating at multiple levels of the national health system to advance three main outcomes:

1. Improve population health, demand and outcomes, including lowered maternal, newborn and child mortality rates, with increased health equity.
2. Develop and support social accountability processes to inform both local and national processes.
3. Build country ownership for health with shared accountability through improved governance of health involving government, civil society, and the private sector.

Exhibit 3. A Model for the Role of Civil Society to Strengthen National Health Systems to End Preventable Child and Maternal Deaths



Death

The model describes how a strong and engaged civil society at national and sub-national level engages and partners with governments at the national and sub-national levels to improve MOH governance and ultimately country ownership with shared accountability. The model assumes that civil society needs to be composed of capable and diverse organizations that trust and collaborate with each other. These organizations demonstrate leadership by carrying out public education, advocacy and social mobilization, and strengthening local implementation capacity. They use their capacities and representation with government to advocate for pro-poor health policies and resources, contribute to public oversight and policy development and mobilize communities to become engaged in local governance. Ultimately, they work with government to improve MOH health priorities, mobilization and use of resources, policy guidance and accountability to commitments.

These efforts are mirrored, or sometimes initiated at the local level, so that national policy is informed by local efforts through improved bottom up signaling, learning, adaptation and use of information for decisions. Policies at the national level with local participatory action, if implemented properly, should result in higher quality of health services, reach into poor communities and mobilization of neighborhoods and communities for health prevention and promotion.

Direct effects accrue in terms of community capacity and structures, mobilized frontline health workers and health competency. Population health is also indirectly improved through multi-sectoral improvements in the social determinants of health and improved community capacity and participation in social accountability processes.

The model is influenced by the global and country environment that directly influences the ability of civil society to organize, collaborate, express themselves and have representation in global health initiatives and country coordinating mechanisms and/or in financing mechanisms.

Conclusion

Based on the results of this literature review, we conclude that community engagement can substantially amplify the impact of investments in public health. Community engagement leads to significantly larger reductions in maternal and child mortality, larger improvements in health-related behaviors and greater use of health facilities than investments in health inputs alone can deliver. Interestingly, successful programs are often located within larger government health delivery systems. This finding is encouraging because government participation is usually central for scaling up health initiatives. The evidence also suggests that the most successful programs tend to be implemented by sub-national governments that have some management autonomy and are downwardly accountable. When civil society is engaged in multiple ways (e.g., using mutually-reinforcing tools, such as social accountability through shared governance, public advocacy and governmental reforms), in the context of a safe and enabling environment (even if nascent), the evidence is strong for positive health impacts.

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