

Knowledge Brief



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Improving Voice, Participation and Accountability for Basic Health Services in Cambodia

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KEY MESSAGES:

This note explains how users of health services engage in the delivery of local basic health services. The note discusses voice and accountability in the health sector. It sets out the relevant policy framework and compares this with the reality on the ground, focusing particularly on the nature, scope and role of local agents established to implement formal sector policies for participation, and the formal and informal processes that play out. The note then summarizes the findings and recommendations.

Background

The Royal Government of Cambodia (RGC) intends to develop an accountability framework to increase user participation in local governance. The legal and policy framework for decentralization articulates a transformation of accountability in governance through sub-national democratic development. It defines vertical, horizontal and downward accountability relationships within sub-national councils. It sets out the relationships between elected officials and the administrations responsible for public services, and defines the legal, administrative and fiscal instruments to ensure sub-national administrations (SNA) function autonomously. In practice, however, the boundaries of the accountability framework envisaged for SNAs are narrow, and mainly apply to the structures of government under the control of the Ministry of Interior. The health sector does not normally operate within the same accountability framework, as it is still the responsibility of its line ministry. While theoretically deconcentrated, representatives placed in provinces and districts mostly operate as centralized, vertical silos, and few decisions are made at the local level.

Voice, Participation and Accountability in Health: Findings

The forms of participation by citizens, their ability and willingness to articulate their voice, and the nature and scope of accountability by service providers, is shaped by obscure relations between actors in health. Many actors have both state and non-state identities and roles. The 2003 community participation policy for health envisages a Village Health Support Group (VHSG) and a Health Center Management Committee (HCMC). The VHSG and HCMC are defined as the primary vehicles for engaging local representatives in outreach and awareness building, and in the management of the primary health care facility: the health centers. The policy prescribes the membership and roles of these groups and committees at village and commune level.

'Community participation' to health practitioners and officials is synonymous with 'communities cooperating in outreach, campaigns and awareness building', i.e. getting villagers to join health campaigns that might, for instance,

promote nutrition or maternal health care. The VHSG—through which the health sector reaches the grass roots in villages—is a supply-side vehicle for this mobilization, providing an important outreach and awareness-raising role. Village health volunteers deliver messages to households, perform basic primary care services and, through semi-structured monitoring, obtain information (including community feedback) to pass back to higher levels of government.

As a grassroots agent of change, the VHSG is not performing a role that mobilizes voice and engagement for enhanced health service delivery. The VHSG is neither mandated to mobilize voice, nor to hold health service providers to account; nor is it the right organization to do so. Acting as an intermediary, the VHSG tends to establish a filter on community voice regarding health matters, and the village volunteers are bearers and custodians of information. This arrangement does not empower households or communities as users with rights to health care. Given that village volunteers channel feedback, and simultaneously provide outreach services, their role is ambiguous: it is both intermediary and provider. Currently, no other direct mechanism for communities to provide feedback on health services exists.

The HCMC is a multi-stakeholder group of government actors and service providers that plays neither a management role nor an oversight role, but functions as a support committee. In practice, the chief of the health center plays a key role in the HCMC. Moreover, the intertwined membership of the committee (mixing service providers and community leaders) promotes a consensus-driven approach. The HCMC is not managing or overseeing, but generally supporting the HC chief. The HCMC and the VHSG are also constrained by low incentives and limited capacities, challenges that have only been overcome where external, typically NGO, support is present.

The HCMC policy envisages a key role for commune councilors to help manage health centers (including planning, setting user fees, and managing budgets). In practice, however, commune councilors nominated to the HCMC limit their involvement due to a lack of time and an unclear mandate. Currently, their mandate comes from the policy that they chair the HCMC, but it is also established through their poverty reduction mandate. An overriding unwillingness to create discord locally limits any action that might hold to account health workers, and

councilors will step in only if complaints reach unacceptable levels.

There are functioning upward accountabilities in primary health care that help to keep services flowing and improving, and problems are often resolved locally. Although few vehicles have been established for voice, the health sector has established internal accountabilities. Service providers are upwardly accountable to the next level, from the village/commune level facilities to the operational district offices, to the province, and to the national level. Villagers who are unhappy with the performance of health staff do bring their concerns forward informally, and concerns are then managed locally wherever possible. With few directives to improve, downward accountability is not a priority for health workers.

In the absence of a clear mechanism for voice, and as incomes increase, households often adopt a choice and exit strategy, rather than a voice and accountability strategy, to obtain better services. The reality is that the public health system only served 25 percent of those seeking treatment for illness in 2010 (Martinez, 2011). Rather than negotiating informal and mediated voice mechanisms, households who can afford to, opt out of services provided by government and seek primary health care from alternative providers. This has implications for the regulation of private health (e.g. dual practices, unlicensed drug sellers) and the inclusion of these providers in governmental oversight arrangements, as well as opportunities for a shift to demand-side financing mechanisms (CCTs, scholarships, vouchers etc.).

Voice and accountability mechanisms in relation to primary health services have proven successful when stimulated through external agents, such as NGOs, who create space for voice. Fieldwork confirms that NGOs make a difference in the levels of voice and accountability, through monitoring efforts and providing space for citizens to give feedback. These initiatives stimulate the direct participation of users, and mobilize the commune council as convener and driver of change.

Partly because it is focused on mobilizing communities to participate in campaigns, the policy for community participation in health does not empower users to participate, or empower them with information. A number

of attributes constrain the way the community participation policy functions. It currently does not provide space for users to voice feedback independently and safely. It sets up roles for local leaders, the local elite and quasi-officials, and reinforces existing balance of powers. This fails to empower the poor. Little information flows within the communities about health services (standards, policies, budgets, targets and/or performance). The nature of these groups/committees reinforces the consensus-driven approach adopted at the local level to decision-making and conflict resolution. In practice, a primary interest is that relations are harmonious. Organizational structures are created, not for the purpose of enhancing voice or accountability, but for the purpose of building accord among stakeholders through compromise. There are some fundamental gaps in knowledge and awareness of the role of users in a participatory process that is distinct from leaders and service providers. Health policies have not been coordinated, and only weak linkages exist between the participatory processes for commune planning and annual decision-making for health centers. The District Integration Workshop (DIW) provides an opportunity for coordinating local level activities, but does not include coordination or discussion about the engagement of citizens in development processes.

A lack of demand for participation, even where opportunities exist, is common in Cambodia and relevant to the discussion on voice in basic services. Users often do not desire a platform for voice. Moreover, both officials and citizens lack any belief that inclusive arrangements will make a difference. Villagers make rational decisions on where they should focus effort to improve their lives and it is unlikely they would try to influence policy or the small budgets for deconcentrated services. These historically and culturally sustained social structures are nevertheless subject to change under specific circumstances. This lack of demand is generally exacerbated by a lack of access to information. Communities do not know what standards of service to expect or what the budgets are for services. At the local level, users are reluctant to articulate their voice, but if they do, they do so through two types of intermediaries:

- (i) **Small, invited groups/committees** are comprised of a few active individuals, mostly elite members of the community, who usually serve in a multitude of similar bodies. Actors are benevolent and informed, but non-elected and non-representative, many in quasi-state roles. They hear about issues informally, and then carry, and filter, the voice of ordinary

citizens to meetings.

- (ii) **Multi-stakeholder groups/committees with confused mandates** include both service providers and community leaders/elite together, (e.g. village health volunteers, school directors sit beside village chiefs, elders (*archas*), commune councilors on these committees at village, commune and district levels) playing various service provider and supporting roles.

Participation in planning is constrained by the minor nature of decisions made at the local level, and there is almost no participation in monitoring. Decision-making at the commune level for local basic services can be extremely limited in scope, as health is deconcentrated, not decentralized. Even if participatory mechanisms were well-designed, there is a limit to how much input users can provide at the planning stage. A critical gap for user engagement is the scope for engaging in other (non-planning) processes, e.g. monitoring of service provision that enable users to engage directly on matters that affect them.

Users do articulate their voice occasionally in events with clearly defined rules and facilitation (e.g., formal workshops arranged by external parties). These situations provide alternative vehicles for communication that have been endorsed by the normal players. Typically users are unaware of what to expect in terms of their rights or agreed standards of service (e.g. hours of opening of health centers, drugs that should be available). They make judgments on what is unacceptable, and voice their opinions only rarely, when they perceive mismanagement to have gone too far. In these bottom-line cases, protests are loud and caution is cast aside.

Increasing incomes and levels of awareness are enabling households to decide to go to a different health center or an alternative provider. This could change the structures of primary health services, and have significant implications for regulation, financing and voice. This 'opting out' could affect those left (normally the poorest households), weakening the collective voice, and slowing improvements in public services.

Recommendations

- **Processes for voice and engagement need clarification in health policies and as they are revised policies should be coordinated as much as possible.** Participation policies should make a clear distinction between community participation for the purposes of outreach campaigns and the forms of citizen engagement that promote voice and accountability. The operationalization of the SNDD social accountability framework provides a potential platform to develop this clarity and ensure local level policy and practices are aligned, and reinforce each other.
- **The structure, membership and functions of groups/committees at the local level is currently limiting the space for voice and blurring the lines of accountability.** At the grassroots level, the separation between those that provide a service, and the users of the service, is critical. A distinction between management and oversight functions is also urgently needed. Local level committees (HCMC and VHSG) require review and clarification of their roles, responsibilities and functions, especially with a view to enhancing empowerment and engagement of ordinary citizens and establishing local accountabilities.
- **Participatory spaces that encourage voice and engagement must be pro-actively developed and sensitively implemented.** Given that citizens generally avoid engaging with the state, and that the benevolent attitudes of the elite members of the community dominate local dynamics, it is essential that safe spaces for voice and engagement are found at village level. Mechanisms for sensitive and independent facilitation will be critical.
- **The mandate of the Commune Council in supporting, monitoring and overseeing local basic services needs to be clearly and consistently defined in both council and Ministry of Health procedures.** In practice, commune councilors play vastly different roles. While some councils hold health providers to account for the quality of the services they provide in a commune, other councilors rubber-stamp decisions by Health Center management

significantly affecting local accountabilities. Policy dialogue is needed to clarify relationships between line ministry staff and elected commune councilors (given their poverty reduction mandate).

- **Health center workers require significant attitudinal change and capacity development to improve downward accountability.** As providers of health services they need to develop a conceptual understanding and practical knowledge of downward accountability.
- **Functional assignment offers an opportunity to change accountabilities in service delivery.** The current process of functional mapping and the proposed delegation of functions to communes and districts offer an opportunity to develop demand-side processes involving users and elected councilors, as well as lowering the level of decision-making around aspects of service delivery.
- **Monitoring and evaluation (M&E) should include monitoring voice and accountability.** M&E systems should include simple indicators on the degree of meaningful user engagement. These can be measured through perception surveys, community scorecards or through third party monitoring.
- **The role of non-state actors as outside facilitators of voice and accountability is emerging, but a strategy for scaling up needs to be formulated.** The role of external facilitators is key to ensuring that processes are inclusive (women, youth, or vulnerable groups) and empowering users. Impact evaluations need to be carried out to see what works, when, where and why. Moving forward, sustainable funding approaches are needed to facilitate participation and empowerment processes.
- **Policy needs to respond to the growing trend for users of health services to exercise “choice” and obtain services from alternative providers.** While users can vote with their feet, the burgeoning market of private providers needs appropriate regulation (e.g. dual providers).

The Health, Nutrition and Population Knowledge Briefs of the World Bank are quick reference on the essentials of specific HNP-related topics summarizing new findings and information. These may highlight an issue and key interventions proven to be effective in improving health, or disseminate new findings and lessons learned from the regions.

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