

Demand side approaches to policy and service delivery are currently high on the pro-poor agendas of international agencies. These approaches reflect concerns of human rights and social justice organisations and also the recognition that supply side health sector reform has had limited success in improving the delivery of health services.

This paper reviews the six main approaches to demand side projects and programmes, including the need to change user behaviour to improve health outcomes.

The paper concludes with comment on the implications that the demand side approach has for development agencies, arguing that this approach poses major challenges to governments and others as to how aid instruments are deployed.



# Understanding the 'demand side' in service delivery

definitions, frameworks and tools  
from the health sector

Hilary Standing

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The DFID Health Systems Resource Centre (HSRC) provides technical assistance and information to the British Government's Department for International Development (DFID) and its partners in support of pro-poor health policies, financing and services. The HSRC is based at IHSD Ltd's London offices and managed by an international consortium of seven organisations: Aga Khan Health Services Community Health Department, Kenya; CREDES-International, France; Curatio International Foundation, Georgia; IDS (Institute of Development Studies, University of Sussex, UK); IHSD Ltd (Institute of Health Sector Development Limited, UK); IHSG (International Health Systems Group, Harvard School of Public Health, USA); and the Institute of Policy Studies, Sri Lanka.

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Title: Understanding the 'demand side' in service delivery: definitions, frameworks and tools from the health sector

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# Summary

Demand side approaches are currently high on the pro-poor agenda. This paper examines the different understandings of 'demand side' in various literatures, in operational and policy perspectives and in international agencies. It maps out the different ways in which demand side issues have been defined in the health sector context in low and middle-income countries, together with various frameworks and tools that have been employed in developing demand side initiatives.

The term 'demand side' appears with increasing frequency in health planning and policy literature. The main drivers behind this interest are located in the economic and institutional crises and transformations of national health sectors in the last decade, including increasing marketisation and provider pluralism, the collapse (in some settings) of public sector services, and governance and regulatory failures. This has gone alongside the limited success of supply side health sector reforms in improving health service delivery.

This has led to two main demand side concerns. One is understanding health seeking behaviours and patterns of utilisation with a view to either changing them or catering better to them. The other is to find ways of harnessing the demand side in pressing for change and improving the responsiveness of the supply side.

The most recent *World Development Report* (2004) on improving service delivery to poor people particularly captures the emerging demand side language of empowerment, voice and accountability. However, this emerging language is not necessarily being used in the same way by different actors and stakeholders. Although an emerging consensus in international health policy debates is detected, there is clear ideological water on the demand side between some of the human rights/social justice language of empowerment, and some of the consumer voice/choice language of empowerment.

Six main approaches to understanding and working on the demand side are reviewed in terms of the themes, actors and tools that they are associated with, and the key challenges which they present for the health sector. These approaches are: changing user behaviour to improve health outcomes; rights-based approaches; improving accountability through the demand side; participatory approaches; multi-sectoral/multiple stakeholder approaches; and demand side financing.

The paper concludes by drawing out some general implications of demand side approaches for development agency thinking and practice. It also highlights areas where there is scope for cross-sectoral learning. It argues that demand side approaches pose major challenges not only to governments but also to the way agencies work and how aid



instruments are deployed. One of the principle challenges is the need to come to terms with the changing institutional landscape and configurations of actors that make it up. These include not just the users but organisations and coalitions that represent or advocate for user interests or that cut across the demand–supply divide. Agencies may find themselves in a more active engagement with these. This raises issues about the modes by which agencies work and the actors with which they work. It suggests the need for a potentially different and even more challenging politics of aid.

Although demand side issues are high on the pro-poor agenda, it is clear that there are different understandings of what they mean. This often stems from different disciplinary and institutional perspectives. For instance, in health, public health personnel tend to focus on demand side interventions for creating better health outcomes, while people concerned with governance issues tend to focus on improved accountability. Rights-based approaches to health are also seen as demand led as they stress citizenship and the entitlements that flow from it. The paper maps out the different ways in which demand side issues have been discussed and defined in the context of the health sector in low and middle-income countries, together with the various frameworks and tools that have been employed in developing demand side initiatives. It stresses the importance of contextualising frameworks, tools and financing mechanisms in demand side approaches in terms of the different experiences in low and middle-income countries.

Material comes mainly from secondary sources, but also from discussions with DFID and other agency personnel concerned with developing their understanding of the demand side. As well as the development literature, documents have been sourced from bilateral and multilateral organisations, and from country-level experiences.



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# 1 What does 'demand side' mean?

Within the health sector, an implicit or explicit distinction has always been drawn between demand and supply side mechanisms. Crudely, 'supply side' refers to service delivery inputs such as human resources and supplies provided on the basis of formal sectoral planning by technical planners and managers. 'Demand side' refers to the behaviour and inputs of the recipients or intended recipients of these efforts: individuals, households and communities.

However, a review of the ways in which the term 'demand side' has been used in the health sector reveals at least five distinct meanings:

## **Leveraging inputs (e.g. labour and resources) from communities**

There is a long history of this in the health sector. Indeed, it is so embedded that it is hard to point to any single source of authority on this. Communities have frequently been called upon to donate land for facilities, and labour to construct and maintain them. More recently, this has taken the form of 'time' donation through local health committees and other mechanisms of management and accountability involving local representation. Another development of the last decade has been the shift in the locus of many public health interventions to household and individually based action. Malaria control is a major example of this, as management has switched from large-scale interventions such as spraying to the 'demand side' ones of purchasing and maintaining insecticide-treated nets.

## **Understanding and changing demand side behaviours**

Here again, there is a very long history, particularly in public health, of behaviour change interventions aimed at modifying individual, household, community and peer group behaviours.<sup>1</sup> Alongside this, has been a counterpoint view – most evident in the medical anthropology literature – that health beliefs and practices have their own integrity and should be understood in their own right. Their truth or falsity is in some ways besides the point, as they fulfil other, potentially health promoting sociological, psychological and emotional needs. More recently, there has also been a practical concern with understanding how and why users, particularly the poor, make health-seeking behaviour decisions in situations of medical pluralism.<sup>2</sup>



## **Stimulating the demand side to provoke changes in provider/supplier behaviour**

Concerns over the quality and responsiveness of health care have led to increasing interest in how to use demand side interventions to improve them. These range from consultative processes through to major involvement in the planning, designing, management and monitoring of health service delivery.

## **Channelling resources directly to the demand side to obtain health goods and services**

This has a recent and limited history in the health sector, particularly as compared to other sectors. Health financing modalities generally operate by transferring resources to authorised facilities and providers. What is termed 'demand side financing' operates through giving vouchers, coupons or cards directly to users, often in conjunction with a choice between providers. They are then reimbursed either by the user or by encashment of the voucher etc. Interest in these financing models is also linked to their potential for improving the quality and responsiveness of health care delivery.

## **Mobilising multiple stakeholders in pursuit of health objectives**

Users are increasingly seen as important stakeholders in attempts to widen the constituencies involved in producing health gain. This is taking the form of partnerships across users and public, private and voluntary sectors, where users again may play different roles on a spectrum of participation.

### **1.1 Demand side approaches in bilateral and multilateral agencies**

Recent policy documents and approaches from a selection of bilateral and multilateral agencies were examined from the point of view of current thinking about demand side approaches in the health sector, using the categories above. The results are shown in Figure 1 in the annex. First, it may be noted that the first three categories are most strongly represented in the matrix. These are the ones most concerned with behaviour change and individual and community responsibility, and also with the oldest history. demand side financing is the least represented, while multiple stakeholder partnerships are an emergent category.

Second, there is a very strong emphasis on governance and accountability underlying efforts to stimulate users to provoke changes in provider behaviour. Third, there is a strong focus on HIV/AIDS across the categories in relation to behaviour change, community-based action and partnerships across stakeholder groups. Fourth, the role of the private sector appears quite prominently but is configured differently, particularly as between some of the European agencies and the multilaterals. The USAID model is most





closely linked to market and consumer models of accountability. Other agencies stress the important role of non-governmental organisations (NGOs) in advocacy and governance.



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## 2 Why the current interest in the demand side?

The term 'demand side' now appears with increasing frequency in health planning and policy literature. Two major drivers for this interest are apparent. The first is the perhaps belated acknowledgement of the major role played by the non-government sector in health care.<sup>3</sup> The second is the associated sense of the growing failure of many governments to provide adequate, competent public sector services as a result particularly of economic and governance crises. Estimates of the amount of household health expenditure (largely out of pocket) going to the 'private sector' range from 40 to 50 per cent in parts of sub-Saharan Africa to up to 80 per cent in India. A significant share of this expenditure comes from the pockets of the poor, much of it to pay for substandard treatment and for drugs purchased for self-treatment or as a result of their unavailability in public facilities.

This has led to considerable debate and some experimentation on ways to reduce the out-of-pocket spend, particularly among the poor, and to improve the quality and responsiveness of service delivery in both public and private sectors. The argument has been that understanding and working with the demand side is key to both of these objectives. This has led to two main demand side concerns. One is understanding health-seeking behaviours and patterns of utilisation with a view either to changing them or to catering better to them. The other is to find ways of harnessing the demand side as an active agent in pressing for change and improving the responsiveness of the supply side.

Associated with this argument has been a critique of the health sector reforms of the last decade as 'supply driven'. Criticisms have focused on their top-down nature and emphasis on technocratic and managerial solutions to sectoral failures. Increasingly, these failures are becoming seen as endemic institutional and governance failures that require action on a broad front, but particularly involving users (or consumers, in the more market-oriented reassessments of health sector reform).

A recent evaluation of DFID's health sector reform financing during the 1990s commented that:

*“an organisation concerned with health sector reform must take into account all the elements of the system and all the relationships involved. A review of the DFID portfolio, however, shows that much of the work supported to date has focused on the supply side, particularly service providers. Very little attention has been paid to*

*demand – in particular the relationship between households and communities, purchasers and providers.” (Cassels and Watson 2001)*

## **2.1 Other key contextual factors in the focus on demand side**

A number of contextual factors are relevant to this refocusing from supply to demand side influences on health sector performance.

### **Pluralism and how to manage it**

The prominence of unorganised markets in health care in many low and some middle-income countries, and the associated provider pluralism, pose major challenges to reforming or rehabilitating health systems. Individuals and households face an unregulated environment in which the boundaries between public and private sectors have become increasingly blurred. But they also face a market from a position of informational inequality. This calls for approaches that can address the needs of users in making decisions about health care.

### **The shift from a 'poor country' to an 'inequalities within' approach**

There is increasing recognition of the way national and sub-national inequalities affect health outcomes and of the very different experiences of the poor that contribute to this. Poor people tend to under-utilise health services. The demand side determinants of this are often complex, and encompass not only cost factors but also indifferent treatment and rude behaviour from providers, gender-related barriers within the household and a host of other cultural and social constraints.

### **Changing trends in aid instruments**

Making macro-economic environments more poverty focused through Poverty Reduction Strategies and related aid instruments has brought about a focus on 'Voices of the Poor'. This has brought out the extent of powerlessness of the poor in relation to the quality and responsiveness of service delivery.

## **2.2 Transforming health sectors: an emerging consensus?**

Health care, its policy and practice, has always been an arena of robust debate. Suggesting an emerging consensus is therefore a risky business. Nevertheless, it may be argued that there is a widening zone of convergence that has contributed to a greater focus on the demand side. The main elements of this are as follows:



## **Old institutional certainties have gone**

These include the clear division between public and private sectors in an increasingly pluralistic environment, together with faith in a 'command and control' mode of planning and service delivery. Hybrid forms of provision that cross institutional boundaries between public, private, voluntary and civil society organisations have become increasingly prevalent. Some aspects of this are captured in the concept of 'co-production', where groups of citizens come forward as partners of government to fill specific needs or gaps in service provision. Co-production suggests a blurred distinction between producers and users, as users increasingly make substantial resource contributions and become involved in institutionalised, long-term relationships with state agencies in the management of service delivery (Joshi and Moore 2002).

## **There is no grand narrative for change, so 'let a 1000 flowers bloom'**

The assumption that all health systems are heading at different speeds in the same direction has given way to a greater pragmatism about the nature and direction of change and a lot of experimentation with different approaches involving different stakeholders.

## **There is no inherent incompatibility between social justice and economics approaches to health 'public goods'**

There has always been tension between these in international health debates. This has coalesced particularly around a view that equity and efficiency are frequently opposed objectives. Recent initiatives, such as the United Nations 'Right to Development', have begun to tackle this tension. Analysing rights-based and economic approaches to health care and education in developing countries, Gauri (2003) argues that the policy consequences of rights concur with economic approaches in some critical ways. In particular, they both regard the state and the market as insufficiently accountable for providing effective and equitable provision of services, and see the need for governance and accountability reforms to strengthen the role of users.

## **Health improvements need to focus on outcomes rather than inputs**

Health policy and planning has traditionally been inputs based, with an implicit assumption that health gain will result. Mixed experience of health sector reform over the last decade has led to greater concern with how to assess the outcomes of reforms for users, broken down by socio-economic, gender and other markers of disadvantage, and how to provide incentives to planners and implementers to focus on outcomes.

## **Difficulties of reform of public sector bureaucracies means the need for multiple, context-specific approaches to sectoral change**

Both the 'one size fits all' approach to health sector reform and the broader agenda of

public sector reform have proved far more difficult to implement in the political realities of many low- and middle-income countries. This has led to a greater understanding of the need to identify political constraints and opportunities, and to contextualise interventions accordingly.

### **Mismatch between health needs and expectations on the one hand, and available resources on the other, means inevitably a more active role for citizens/consumers in financing and stewardship**

This is increasingly evident in different models of cost sharing and cost recovery, and also in the stress on civil society involvement in planning and management of health services.

#### **More contentiously**

The critical relationship between citizen/consumer and services is *how* services are delivered, not *who* delivers them. This has led to the recent stress on the role of governments as stewards and regulators of services, rather than their role as deliverers of services. Improvements in access and quality to users require increasing choice and introducing or encouraging competition between providers. This approach stems from a critique of the quality and responsiveness of both public and private service providers. It sees the solution in terms of introducing some element of competition into health provision through a model of the 'informed user'. Conceptually and practically, this means giving users a 'voice' as well as 'exit' options.

## **2.3 An emerging language?**

Much of this thinking – and the strong link with demand side approaches – is encapsulated in the draft of, and associated background papers written for, the forthcoming *World Development Report 2004 'Improving Service Delivery for Poor People'* (WDR2004). WDR2004 particularly captures the emerging demand side language of empowerment, voice and accountability through its model of the three central service provision relationships of user–provider–planner. In this model, *empowered* citizens/consumers use *voice* to hold providers/policy-makers to *account* for fulfilling their contract to deliver competent, responsive services. This takes place through two routes: the 'short route' to accountability between service providers and users (for example, through involvement of the poor in monitoring and providing services, consumer power to complain, making the income of service providers dependent on accountability to users), and the 'long route' to accountability between governments and citizens, which involves broader social and political change.

It argues that the underlying mechanism by which greater accountability is secured is through changing the incentives to behaviour. These may be material or non-material incentives, and include broader political incentives to reform unaccountable public bureaucracies.



It should be noted, however, that this emerging language is not necessarily being used in the same way. In particular, there is clear ideological water between some of the human rights/social justice language of empowerment, and some of the consumer voice/choice language of empowerment.





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## 3 Types of demand side approaches

A review of approaches to the demand side in development agencies and other literature reveals six main approaches to working on the demand side. In the following sections, these are reviewed in terms of the *themes*, *actors* and *tools* that they are associated with and the *key challenges* that they present for the health sector.

### 3.1 Behaviour change to influence health outcomes

As noted, behaviour change interventions have a long history and are perhaps the paradigmatic demand side intervention in the health sector. For this reason, they will not be considered in any detail here. Underlying themes and assumptions are:

- education (formal or informal) influences people towards healthier lifestyles;
- the behaviour of individuals, households and communities is the key to many health improvements;
- some kinds of improvements can only be brought about through changes in behaviour (e.g. hand washing, management of tuberculosis through directly observed treatment, short course (DOTS), timely treatment seeking, reduction of HIV infection).

While behaviour change interventions have been around a long time, the language of behaviour change has itself changed. The early term 'health education' was replaced by 'health promotion', perhaps signifying a less didactic approach. More recently, the terms 'information, education and communication' (IEC), and 'behaviour change and communication' (BCC) have become more common. Behind this shift seems to be a greater emphasis on the content and mode of communicating messages.

#### Key challenges and implications

Perhaps because of their long history, behaviour change strategies are often rather traditional and didactic, and frequently function as poorly funded sections of public sector bureaucracies.

The challenge of pluralistic health systems is yet to penetrate much of this field. BCC is still geared more to giving people the 'correct' messages. An increasingly pressing need



is for more public information to enable people to navigate highly marketised systems with many types of providers and little regulation. People need information on very basic issues, such as how to determine if over-the-counter drugs are genuine and within their sell-by date, simple protocols on common disease treatments, etc.

This is linked to the need to find more innovative ways of putting over information and education to poor people, using both mass media and culturally relevant forms of conveying messages.

### 3.2 Rights-based approaches

Rights-based approaches are currently receiving a lot of emphasis in international health. There are several discourses of health and rights. Human rights and health is grounded in fundamental rights that inhere in the person as a human being and citizen, such as freedom from torture, slavery, gender discrimination, etc. These are a prerequisite to a healthy life, they are independent of governments and they cannot be abrogated by governments legitimately. 'Rights to health' are rights that entail claims to specific forms of care or treatment. As such, they are arguably context dependent and subject to the capacity of states to underwrite them. Rights to health are more controversial and contested.<sup>4</sup>

Debates and approaches to health and rights at the macro level are generally cast in terms of rights formally given by constitutions or international law. From a demand side point of view, there is an equally important discourse of rights as situated in experience and gained and maintained through empowerment and struggle: that is, rights from below. In terms of health, examples of this kind of empowerment from below are to be found in the women's health movement (often focused on reproductive health and rights such as abortion), and in HIV/AIDS and disability rights advocacy. Such struggles are usually aimed at both access issues (interpreting access in its widest sense) and at broader citizenship claims, such as anti-discrimination. For these reasons, rights-based approaches are important. They frame health as a social justice/aspirational issue and provide a way of situating health in the context of the claims and entitlements of citizens to equal consideration and treatment on the basis of need.

Other demand side elements of a rights-based approach include:

- an empowering strategy for health that includes vulnerable and marginalised groups engaged as meaningful and active participants;
- a powerful authoritative basis for advocacy and cooperation with governments, international organisations, international financial institutions, and in building partnerships with relevant actors of civil society;

- a recognition that universal conceptions of needs, met through uniform social policies, fail to recognise the diversity of the poor. New approaches to social citizenship seek to link concepts of universal rights with recognition of diversity of needs in the delivery of social services.

In terms of actualising rights-based approaches in the health sector, there is practical convergence with agendas on accountability and participation, particularly those concerned with the voice and empowerment of users and advocacy groups (Goetz and Gaventa 2000). These are discussed further in the relevant sections.

### Key challenges and implications

Some discussions of rights and health distinguish strongly between citizen-based rights and consumer-focused discourses. The basis for this distinction lies in a view of health as an entitlement rather than a set of market-based services and commodities. While citizenship entitlements unify, markets differentiate users according to their purchasing power. The implication of this is that consumer rights are a less supportable form of right as they do not have relevance to poor populations. The reality in many low and middle-income countries is of rampant marketisation that greatly affects poor people. This suggests the need to revise this purist view of rights and see consumer-based movements as potential allies in the struggle for rights.

It is important to be aware of other discourses in health that have a bearing on rights but use different entry points. Equity is a key one, as in health it poses an interesting challenge to some formulations of rights. Given high levels of health inequalities and their well-attested link to poverty and social exclusion, health equity requires *unequal treatment on the basis of need*. An equity discourse is not averse to rights, but it does require rights to be specified in a way that does not elevate demand-based rights above needs. And needs require some objectively or collectively agreed standard by which they are to be judged. They cannot depend solely on pressure from below. A useful illustration of this is a study of priority setting in Ghana (Reichenbach 2002). This found that strong pressure from middle class women (initiated by the President's wife) had resulted in the introduction of a breast cancer screening programme in urban areas. However, clinically, the far greater need was for screening and treatment services for cervical cancer, which was a disease primarily of poor rural women. But these women lacked advocates for their needs.

Rights-based approaches can be very contentious and external agencies have to consider how to position themselves. In some contexts, rights language is not necessarily the best entry point. Concepts such as 'participation', 'accountability' and 'responsiveness' can be less contentious ways of talking about the key elements of a rights-based approach.

Finally, working with rights does not mean actions only on the demand side. There are legitimate concerns about raising expectations that then cannot be met because of real resource constraints. Responsiveness requires equal attention to the supply side.

### 3.3 Improving accountability through the demand side

As noted above, governance and accountability have risen very high on the development agenda. Poor service delivery has increasingly been seen as an example of poor governance, with corruption, clientelism and rent seeking as pervasive, unpunished and sometimes overtly sanctioned by higher authorities. This in turn produces unresponsive provision – particularly in the public sector – with low quality, indifferent and discriminatory treatment of the poor and vulnerable. Again, as noted, WDR2004 uses a governance/accountability framework for examining service delivery. In the health sector, interest in accountability has focused on the potential role of civil society and intermediate organisations in providing pressure from below and oversight functions through alternative accountability structures.

In definitional terms,<sup>5</sup> 'governance' is generally used as an overarching term that encompasses accountability as a key element. For example, under DFID's predecessor, the Overseas Development Administration, four main elements were seen to underpin good governance: the legitimacy of governance; the accountability of governance; the competence of governance; and respect for human rights and the rule of law (Turner and Hulme 1997). The World Bank considers public sector management, accountability, the legal framework for development, and information and transparency as the components of governance.

There are now numerous definitions of accountability in relation to service delivery (see, for example, Brinkerhoff 2003, Cornwall *et al.* 2000, Moncrieffe 2001, Schedler 1999). In the health sector, Karim and Zaidi (1999) see the elements of good governance as efficiency, effectiveness, quality, availability and equity of health care, community participation, and accountability with respect to decision-making and delivery of health care.

For the World Bank,<sup>6</sup> accountability in service delivery refers to the ability to call public officials, private employers or service providers to account, requiring that they be answerable for their policies, actions and use of funds. Widespread corruption, defined as the abuse of public office for private gain, hurts poor people the most because they are the least likely to have direct access to officials and the least able to use connections to get services. They also have the fewest options to use private services as an alternative.

Despite the many different definitions, most concepts of accountability encompass the following elements:

- 'The essence of accountability is answerability; being accountable means having the obligation to answer questions regarding decisions and/or actions' (Brinkerhoff 2003);
- accountability is defined positionally in terms of answerability *to whom* and *for what*;
- accountability requires sanctions of enforcement, which can include negative to positive sanctions and internalised ethics such as codes of conduct;
- there are three main types of accountability mechanisms – political, administrative (bureaucratic) and public;
- accountability has a directional dimension (vertical versus horizontal and downward versus upward), a content dimension (e.g. financial, managerial, meeting of performance targets), and a temporal dimension (maintenance of feedback loops between citizens and authorities).

The role of the demand side in improving accountability in service delivery is strongly put in WDR2004. Strengthening 'client power' can improve services for the poor by substituting for or correcting weaknesses in the 'long route' of accountability between citizens and the state. This can be through mechanisms such as making the income of health service providers depend more on demand from poor clients (see Section 3.6 on demand side financing), making providers accountable to local bodies for their performance, and fostering the involvement of poor people in the monitoring and provision of services.

The concepts of 'voice' ('demand') and 'responsiveness' ('supply'), as defined by Goetz and Gaventa (2000), provide a helpful way of operationalising accountability in service delivery. Voice refers to the range of measures – such as complaints, organised protest, lobbying and participation in decision making and product delivery – used by civil society actors to put pressure on service providers to demand better service outcomes.

Responsiveness refers to the extent to which a service agency demonstrates receptivity to the views, complaints and suggestions of service users by implementing changes to its own structures, culture and service delivery pattern in order to deliver a more appropriate service. At the level of the state, this may require quite far-reaching reforms to public administration and a shift from an input to an output/outcome based model of performance.

A strongly emerging theme is the failure of political mechanisms to address needs and to be responsive in countries where there are severe accountability deficits. In recent years, multiple initiatives in service sectors that have an accountability element have therefore emerged to fill this gap through different forms of direct action by citizens towards

bureaucracies through a variety of civil society organisations and *ad hoc* fora (Goetz and Gaventa 2000; Rakodi 2002).

The debate about accountability in the context of improving governance is a complex one that has to recognise the many different agendas and channels by which accountability can be considered. Answering the question 'Accountability by whom, to whom, for what and how?' is by no means easy. There are not, as yet, clear answers on what works and how transportable experiences are across different political, developmental and service delivery contexts.

### Key challenges and implications

The political science literature on governance and accountability is derived overwhelmingly from a Western historical perspective on representative democracy. Less attention has been paid to other political traditions that may also have value in improving accountability (e.g. African jurisprudence). This has also resulted in a tendency to favour simplistic representational solutions, such as counting the numbers of women and poor people on committees. Development agencies trying to engage with accountability issues in service delivery need to encourage more in-depth macro-political and contextual analysis, and recognise the existence of other cultural and political approaches to accountability. For instance, in China, the term 'accountability' is almost untranslatable.

Fiscal crisis has raised questions about the capacity of the state to continue providing public services on the scale to which earlier generations in many societies had grown accustomed. Civil society organisations have increasingly become 'co-producers' of what were once largely state functions. This has resulted in the emergence of a wide range of new institutional arrangements in the form of intermediate organisations and hybrid public–private structures. These raise interesting new questions about accountabilities and how they are managed in these complex institutional environments.

While encouraging the existing engagement by the health sector with civil society and intermediate organisations, it is important also to be aware of accountability deficits in these – who is speaking for whom and with what degree of legitimacy – and develop an informed view of which organisations can command both downwards and upwards legitimacy.

Agencies should also consider their own accountability to citizens in ensuring that civil society groups have access to key documents and strategies, and have structured opportunities to participate in debate about how external assistance is used.

More mapping is needed of what works in different contexts and what is transportable from one service delivery setting to another.



### 3.4 Participatory approaches

There are important links between accountability and participation in respect of demand side approaches to service delivery. Greater participation is frequently linked to improving accountability (Cornwall *et al.* 2000; Loewenson 1999). However, participation has multiple meanings. There is a history in the health sector of endorsing 'community participation' as an essential feature of primary health care, going back at least the Alma Ata Declaration in 1979. This was reaffirmed and updated in the 1987 WHO Harare Declaration, which endorsed direct public involvement in the design and management of health systems and called for a reorientation of politics and service delivery to support participation (Loewenson 2002). As Loewenson notes, despite the serious rhetorical commitment, the concept of participation is often hard to pin down.

This is partly because in the health sector it has three rather different historical provenances. One is a long behavioural tradition – people are seen as partners in responsibility for their health and the health of others. Another is the link to resources noted above. In contexts of resource scarcity and failing service provision, people are increasingly being required to participate through contributing their own labour and resources. The most recent is the link to accountability and the argument that engaged and involved users who participate through, for example, user forums or local management committees, will increase the responsiveness of services and providers. In respect of these different meanings, an important distinction should be kept in mind between participation and participatory. The latter refers to methodologies and tools for enabling engagement and expression of voice. Participation, particularly in the first two senses, does not necessarily entail a 'participatory' approach.

In operational terms, participation covers a spectrum of approaches:

- consultations with users on, for example, preferences, satisfaction, resource allocation;
- involvement in priority and standard setting;
- mobilisation of resources – for example, human labour for building and maintaining facilities, involvement in direct management of facilities;
- oversight and monitoring of services and providers;
- civil society-based initiatives to increase answerability of providers and bureaucracies and markets.

Each of these entails different degrees of involvement and different types of organisational arrangements.



## Key challenges and implications

Health sector reforms have been very supply side driven, and this extends to the way in which participation and participatory approaches have often been used in the health sector as instrumental means to compel users to take over responsibilities previously undertaken by the state. While this is probably inevitable given resource constraints, and not necessarily to be decried, it is important to be aware of the limits to participation in terms of the capacity, desirability and wish of users to 'participate'.

First, not all services and issues are amenable to direct citizen engagement and participation. Although citizen participation in service design, delivery and monitoring can deliver improved information flows about client needs, greater transparency and, in the end, better accountability, there are some contexts where direct citizen engagement is either not desirable or possible – for instance, the management of major public health emergencies or where there are concerns with privacy and confidentiality.

Second, there are limits to participation. This means treading the line between inclusiveness and consultation, and overloading the poor, especially women. Well-meaning efforts to ensure membership of committees by poor women do not always recognise the women's own needs and time constraints. For instance, improving the logistics of drug supply may be more 'rights and accountability friendly' to the poor than enforced democracy.

There are equally contexts where public participation should be regarded as mandatory. The contrasting experiences of Poverty Reduction Strategy (PRS) processes and Sector Wide Approaches (SWAs) hold some lessons. Though of variable quality and influence, all PRS processes are required to incorporate a Participatory Poverty Assessment with poor people. To date, sectoral aid instruments have not done so, and the experience of most SWAs has been disappointing in respect of the participation of non-official stakeholders, particularly the poor (Foster 1999). As agencies such as DFID move towards Direct Budgetary Support, the distance between poor people and aid modalities is in danger of widening even further.

## 3.5 Multi-sectoral/multiple stakeholder approaches

In health, there has always been a rhetorical concern with multi-sectoral approaches as part of the appreciation that health is much broader than health care and health services. What is more recent is the development of certain types of institutional arrangements to facilitate a more multi-sectoral approach, whether to service delivery or to broader health gain goals. From a demand side perspective, factors contributing to this include the emphasis on governance and accountability issues in social sectors, and the increasing recognition of the roles of multiple stakeholders in rapidly transforming health sectors. This includes many actors from civil society as well as users themselves.

One outcome of this has been the emergence of a 'partnership' language to describe organisational arrangements involving stakeholders across governments, bureaucracies, commerce, the professions and civil society. These partnerships coalesce around an issue that may be condition specific (e.g. 'Roll Back Malaria'), or more broadly defined, and often locational (e.g. 'Healthy Cities').<sup>7</sup> Many are international either in scope or in being spearheaded by United Nations organisations but operating at a regional or national level.

A recent example is the Alliance of Mayors Initiative for Community Action on AIDS at the Local Level, which incorporates a Partnership Programme, launched in April 2001, with the support of UNAIDS.<sup>8</sup> Its aim has been to broaden out action on HIV/AIDS to take into consideration its political, development, gender, social, economic, cultural and human rights dimensions. It attempts to facilitate stakeholders working together at several levels to coordinate service delivery, avoid duplication and identify gaps. These include municipal teams interfacing with communities, policy roundtables for sector-level ministries, and national committees.

Experience of these kinds of initiatives is relatively new, and evaluations are limited and tentative. An evaluation of the World Health Organization Healthy Cities initiative found that stakeholder involvement, particularly from women and the poor, was variable and influenced by the location and management structure of the project (Harpham *et al.* 2001). There was no strong political commitment by city leaders, possibly because cities did not initially request the projects. While WHO support enabled project coordinators to network at national and international levels, capacity building of individuals did not scale up to institutional level. In relation to the demand side, it recommended increasing stakeholder involvement by raising public awareness and ensuring that the organisational arrangements are visible to local communities, encouraging women in particular to become involved and state their views, and initiating new projects only at the behest of local partners.

### Key challenges and implications

This evaluation points to issues that are likely to affect all initiatives that attempt to draw in stakeholders from different structural positions and harness them to quite ambitious objectives. Two major challenges have to be confronted:

**The management of power imbalances between different actors.** Most of these partnership initiatives have been set up from the top down. This is not necessarily a bad thing. But it does raise questions about the extent of buy-in and ownership from those coming from 'below'. This points to the need for careful groundwork and extensive consultation over needs and interests.

**New learning on institutional and political implications and consequences.** Multi-sector, multiple partner arrangements are complex to manage. They raise major logistical

questions about how finances are managed and accounted for, who has power of veto, and where overall political and institutional responsibility rests. More systematic lesson learning is needed.

### 3.6 Demand side financing

'Demand side financing' (DSF) is a relatively new term. It seems to have been first used by the World Bank in relation to experience with vouchers in the education sector (Patrinos and Ariasingham 1997). The main working assumptions behind the use of DSF are:

- promoting competition and choice (changing provider behaviour);
- targeting social sector resources to specific populations, particularly the poor and disadvantaged groups (linking demand to supply);
- improving propensity to consume social sector goods by earmarked transfers (changing demand side behaviour).

A working definition of DSF for the health sector is: 'A means of transferring purchasing power to specified groups for the purchase of defined goods or services' (Pearson 2001). What distinguishes DSF from other kinds of transfer, such as the more usual third party payment, is that it goes directly to the service user, not the provider.

Most interest in DSF is focused on vouchers, and the greatest experience is in the education sector. There has only been one systematically evaluated trial of vouchers in the health sector. There is, however, a range of instruments that would broadly qualify as demand side tools. Ensor (2003) makes a distinction between pure supply side, third party purchaser and what he terms consumer-led demand side mechanisms, where individuals are given purchasing power to obtain a particular service from an accredited supplier. But there are many grey areas, as he acknowledges. One important grey area from the point of view of possible DSF models is community-based purchasing of health services, either through pre-payment or micro-insurance mechanisms.

DSF should therefore be seen as part of a spectrum of transfers to individuals, groups and communities that have essentially demand side characteristics. Typically, DSF has been associated with the individual/household or epidemiological target group levels of transfer, but as Table 1 indicates, vouchers are just one modality of DSF.

**Table 1: The demand side transfer spectrum in health**

<b>Individual/household (general or limited to designated poor)</b>	<b>Vulnerable/special needs groups</b>	<b>Community</b>
Micro-nutrient supplementation	Group specific transfers, e.g. pregnant/nursing mothers, sex workers	Joint purchasing schemes through pre-payment or insurance
Social marketing/subsidies, e.g. insecticide-treated nets	Treatment entitlements, e.g. for people with disabilities, elderly care packages	Social funds – health facilities, services
Payments for major illness/hospital treatment Coverage of indirect costs, e.g. transport		
Community funds, e.g. services for obstetric emergencies		

The following situations and issues are generally identified as having potential to be addressed by DSF in the health sector:

- poor supply side performance and failure of supply side mechanisms to address this – for example, staff supervision and sanctions not implemented;
- under-utilisation of formal public sector services due to quality and cost considerations, high usage of the unregulated sector and levels of out-of-pocket expenditure;
- driving up standards by introducing greater competition and choice between providers, including the private sector;
- empowerment of users by increasing their choice;
- influencing of household determinants of health-seeking behaviour;
- failure of existing supply side targeting/exemption mechanisms for the poor – few effective systems in operation anywhere.

However, most of the detailed examples of DSF come from developed countries. As Ensor (2003) demonstrates, there is generic value in exploring them (for instance, in developing a template for institutional and risk analyses). Their substantive value is more limited. This is because they are embedded in contexts where the major political,

institutional and informational requirements are already met. These include population registration, functioning bureaucracies, strong regulatory frameworks and fairly robust mechanisms for accountability. In contexts where these are lacking, the same political, bureaucratic, regulatory and accountability deficits that undermine supply side interventions will also affect demand side ones. DSF should not, therefore, be seen as a substitute for supply side interventions. *Rather, it should be regarded as a different entry point to the same set of problems, which may have potential for addressing them from a fresh standpoint.*

The most detailed literature on DSFs comes from the education sector, where there is now significant experience in direct payment/voucher-type interventions for schooling and related goods.<sup>9</sup> There are, however, important differences between health and education that temper the direct transfer of lessons. Foremost among these are differences in the nature and complexity of the product or service and its delivery mechanisms; differences in the degree of information asymmetry and in the extent of competition and choice (most education voucher schemes in low-income countries work with public provision, not a choice of schools).

International experience suggests that voucher-type schemes have been most successful in increasing coverage to poorer and vulnerable groups. They have been less successful in raising the quality of service provision (Ensor 2003). Areas where voucher-type transfer mechanisms are likely to work best in low-income countries are where there are relatively easily identified target groups, such as pregnant women, and the services offered are standard and predictable. This still requires capacity in administering the financing schemes and in accrediting providers.

### Key challenges and implications

There are three parameters to any DSF intervention: the nature of the intervention itself; the nature of the population to be targeted; and the extent of the institutional capacity to manage different arrangements. Experience is most limited on the third of these, particularly capability in developing and managing accreditation schemes for providers. DSF is not a quick fix in an institutional sense, and issues of corruption, leakage and mismanagement will still have to be addressed.

It is important to know which objective(s) is primary from the point of view of evaluating DSF interventions. For instance, is DSF aimed primarily at improving service utilisation or service quality?

There are interventions that appear to be most suitable for DSF to target poor populations and vulnerable groups. Any DSF intervention must be accompanied by a study of other barriers to demand, as cost may be only a part of the reason for low utilisation of services.

Factors such as intra-household resource allocation decisions and cultural constraints



can be powerful determinants of this.

As was noted, the main comparator for health DSF has been education (and nutrition, to some extent). DSF has thus been seen largely as a sectoral subsidy. However, there is also highly (and possibly more) relevant learning from a) social funds, and b) social transfers and social protection in extending services to underserved populations.



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## 4 Concluding comments

This paper has explored the wide range of ways in which the concept of the 'demand side' has been understood in service provision, taking the health sector as the example. What seems at first sight a rather specific term turns out, in practice, to carry multiple meanings and agendas, with considerable implications for the different sets of actors involved in health service provision.

Moreover, while concern with the demand side can be shown to have a long history, it is not accidental that there is currently renewed interest. The last decade has seen major changes in the economic, political and institutional environments within which service sectors operate. The crisis in funding and governance in the public sector, the rise of pluralism and the increasing failure of bureaucratic and professional management and regulation to provide high quality, accessible services have all contributed to new agendas emphasising the centrality of the user to improving service provision. The essential features that cross-cut all the various ways in which demand side is defined are the voice and active engagement – or agency – of primary stakeholders.

The implications of these new agendas are beginning to be mapped out, both from the point of view of the different sets of actors and from a relational perspective. In the following, the focus is on some of the likely implications for development agencies that provide sector specific or general support through different aid instruments.

### 4.1 Implications of demand side approaches for development agencies

What does working with the demand side imply for development agency thinking and practice? One of the most important implications is the need to come to terms with the changing institutional landscape, the configurations of actors and the various relationships between these – all of which combine to make up this landscape. This includes not just the users but also organisations and coalitions that represent or advocate for user interests or that cut across the demand–supply divide.

Development agencies may find themselves in a more active engagement with these. This raises issues about the modes by which agencies work and the actors with whom they work. It does *not* mean that agencies therefore switch from working with official stakeholders, although there may be contexts, such as failing states, where this is appropriate. It does mean the need for a potentially different and even more challenging politics of aid.

Decisions on modes of working, and which actors to work with, therefore requires the following in any given context:

- an institutional and macro/micro political analysis to understand the context within which service delivery is taking place. This includes an examination of the degree of pluralism, and of old and new institutional forms and their impact on utilisation;
- an associated analysis of the politics of balancing working with governments and bureaucracies, and with 'civil society' and local communities.

Attention to the demand side must also not lead to the neglect of supply side failure. Raising expectations on the demand side that cannot be met is a recipe for further cynicism and despair among both providers and users. It is simplistic, for instance, to see DSF instruments as an alternative to health system reforms rather than as an approach that entails significant supply side interventions. There are real resource and institutional constraints on the supply side that must continue to be addressed.

For development agencies, working more actively with the demand side may mean:

### **Support to civil society organisations, e.g. citizen's groups, NGOs, consumer organisations**

This generally takes the form of small grants to or arms-length 'challenge fund'-type arrangements to encourage civil society involvement in a wide range of activities – grassroots action on quality and malpractice, improving information flows, public education, monitoring of services, etc.

This can be a very important way of catalysing actions on the demand side, both in contexts where civil society organisations are already established and where there is a need to encourage new initiatives. Agencies also need to be aware of some of the pitfalls. First, it is important not to over-resource grassroots organisations in particular, and pre-empt local capacity to sustain autonomous initiatives. Second, there may be accountability deficits. Agencies need to take an informed view of which organisations command legitimacy, especially where they purport to speak for others such as the poor.

### **Working with governments, professional bodies and intermediate organisations to support demand side interventions**

Taking the demand side seriously is a major challenge to governments and professional bodies, especially in the health sector, where command-and-control bureaucracies have been the norm and professional bodies rarely, if ever, engage with service users. Major changes in the way health services are financed and delivered provide the wider context for the concern with demand side approaches. These raise questions about the management and monitoring of new institutional arrangements that have increasingly

emerged. Greater use of demand side approaches will require development agencies to look at, and address, accountability issues differently.

The most immediate impact of this is the large and diverse range of organisations and stakeholders concerned with service delivery. The institutional environment is not only new but also more complex. Agencies therefore have to address not only how accountabilities should be negotiated and according to what standards, but also which stakeholders have legitimacy and how stakeholder politics can be navigated so as not to simply reinforce dominant interests such as the most powerful groups of providers and users.

Again, there is a need to catalogue and share experience not only in the health sector but also across social and other sectors where there are traditions of demand side involvement (e.g. the water sector), and where co-production arrangements are already established.

Strengthening the demand side also needs to be backed by an informed view of how these approaches will feed into longer-term institutional and service delivery capacity-strengthening and institutional-relationship building at national and local levels. Shifts to more demand-led approaches to service delivery, such as DSF and contracting out of services and monitoring arrangements to NGOs and civil society organisations, raise much larger questions about the impact on public sector capacity. Should the primary focus be on enhancing the market management and regulatory roles of government? Or should this be accompanied by continuing effort to strengthen government's capacity to act as a main service provider in a pluralistic environment?

The same question applies to impact on political institutions. How does the strengthening of civil society organisations affect the developmental capacity of local democratic structures? The increasing development of social funds, a strongly demand side intervention that channels resources directly to local communities, raises this question in a particularly challenging way. In what circumstances might such transfers weaken or revitalise existing structures or provoke the development of new ones?

### **Building capacity for monitoring service delivery using demand-sensitive indicators on quality, accountability and outcomes**

Inclusion of the demand side requires much more attention to the capacity needs of individuals, groups and organisations involved in any aspect of service delivery. New roles in designing, managing and monitoring service delivery require complex skills that cannot be assumed to be present. Agencies can play an important role in enabling capacity development by funding technical assessments, programme development and continuous learning. This is particularly needed where new institutions are being set up for these purposes, and at below-district level where there may be 'volunteer' capacity to take on these new roles but lack of skills and experience.

## Negotiating greater demand side engagement and voice into aid instruments and macro-economic policy

Agencies should also consider their own accountability to citizens in ensuring that civil society groups have access to key documents and strategies, and have structured opportunities to participate in debate about how external assistance is used.

This is particularly critical in the context of emerging aid instruments and their relation to demand side approaches. There may be a paradox here. As agencies move further and further from project aid and discretionary funding of specific initiatives in service delivery through SWAPs to direct budget support, the formal distance from the user gets greater and greater. Agencies need to consider how to negotiate to bridge this distance. For instance, this could entail specific attention to agreements with governments on monitoring processes incorporating demand-focused outcome indicators and to ways of changing the incentive structures for providers to deliver more responsive, quality services. There is urgent need for further analysis and tracking of the implications of these broader aid instruments for their positive or negative impact on citizen/client empowerment.

### 4.2 Cross-sectoral learning

The arguments above are generic to demand side interventions across service sectors. There is other learning which applies more generally in three areas:

- **Co-production and client voice initiatives on delivery of public services.** A number of tools and methodologies can be adapted across service delivery contexts, such as citizen's committees, user forums, media advocacy;
- **Modes of accountability.** Many of the accountability problems in service delivery are generic in that they concern weak, over-politicised or clientelistic bureaucracies and disempowered users due to failures in citizenship exacerbated by poverty, gender and other markers of disadvantage;
- **New modes of communication and information campaigns.** Tools such as social marketing and use of radio and television have shown the potential for getting basic messages to people on behaviour, practices and entitlements.

There are also limits to learning across sectors that should not be disregarded. In health, these are due to differences in the nature of the goods and services being transacted, the informational asymmetries in knowledge and the nature of the demand for services (often unpredictable and specialist). Health is an extremely heterogeneous sector as compared, for instance, to education and water and sanitation. It requires a nuanced approach to the respective roles of states, markets and civil society.



Rather than a wholesale shift to the demand side, what is needed is a more detailed breakdown of the potential roles of these in relation to health service delivery. This would look, for instance, at which part of the health market/delivery system can consumer or other citizens' action inform. This may include actions in relation to better, more accountable management of technical knowledge and 'expertise'. It cannot, however, supplant it.



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# Annex

## Approaches to working with the demand side among selected bilateral and multilateral agencies

	Use of demand side inputs	Changing demand side behaviour	Stimulating demand side to provoke changes in supplier behaviour	Channelling resources directly to demand side	Partnerships across stakeholders in pursuit of health objectives
<b>CIDA</b>	<p>Encouragement of integrated, community-based treatment and prevention programmes for communicable diseases within the context of sustainable primary health care programmes.</p> <p>Under safe motherhood, priority to programmes that 'support capacity building for community-based care and referral'.</p>		<p>Efforts to strengthen health systems must encourage civil society participation. Empowered civil society can promote and advocate good health sector governance and stronger national health systems.</p>		<p>Support for 'partnerships with civil society, academic, and research organisations and institutions, and between the public and private sector, including the development of new technologies (drugs and vaccines) for treatment and prevention of priority diseases'.</p>
<b>DANIDA</b>	<p>Providing technical assistance related to strengthening the community and family capacity to cater for their own health, if necessary.</p> <p>Establishing or strengthening community-based service delivery systems, comprising curative, preventive, and promotive aspects, e.g. village health volunteers and traditional birth attendants.</p>	<p>Health education for health promoting practices, reduction of health damaging behaviour, use of preventive services, use of medications and recognition of early symptoms of disease.</p> <p>Education on water and sanitation issues.</p> <p>Education for gender: IEC activities emphasising the active involvement of men and empowerment of women with regard to status, rights and decision-making in relation to sexuality and reproduction.</p>	<p>Helping the community to participate in identifying priority health problems and in planning appropriate services, through, for example, existing local democratic government institutions, or by the establishment of village health or development committees, or by strengthening local NGOs.</p> <p>Improve the capacity of civil society institutions as watchdogs and to promote health interests of poor.</p> <p>Support to NGOs to empower consumers, e.g. consumer groups and watchdog functions.</p>		<p>Support development and implementation of integrated inter-sectoral HIV/AIDS programmes involving, for instance, health, labour, planning, education, defence, and private and religious sectors at national and district levels.</p>

	Use of demand side inputs	Changing demand side behaviour	Stimulating demand side to provoke changes in supplier behaviour	Channelling resources directly to demand side	Partnerships across stakeholders in pursuit of health objectives
<b>USAID</b>	<p>Accountability of USAID is to end user. Programmes must aim to meet individual needs of clients and patients not specified targets, and be responsive to needs and problems as locally defined. Activities must be 'customer driven', with clear need and demand.</p> <p>Need for increased local resources for appropriate disease interventions. Includes involvement of private sector in providing goods, services and information, and increased use of communities' and families' resources to support interventions. Increased cost recovery is important to sustainability.</p>	<p>USAID prevention effort focuses on communication strategies that will change high-risk behaviours, combine mass media and interpersonal communications, social marketing, e.g. billboards, peer counselling. Encourage changes in behaviour and reduce fear and stigma.</p> <p>BCC to improve effectiveness of care and support interventions by encouraging people to use available services.</p>	<p>Need for local participation in design and implementation for sustainability. (Brings ownership and commitment from community).</p> <p>Important to involve women in design and management of family planning and reproductive health programmes.</p> <p>Participation of high-risk groups in planning and implementing HIV programmes.</p>		<p>Lessons learned include need for programmes to use variety of implementation channels for sustainability, including public sector, NGOs, and for-profit private sector. Reliance on a single channel makes programmes vulnerable to destruction.</p>
<b>UNFPA</b>	<p>Lack of government financing forces cost-sharing, fees and other charges to raise revenue. User fees have been adopted but create problems of access for the poor.</p>	<p>IEC important for success of population programmes. Better information enables communities and families to discuss and act on reproductive health issues.</p> <p>Community action to promote behavioural change necessitated by HIV/AIDS.</p> <p>Social marketing as one strategy for changing behaviour.</p> <p>Social marketing of condoms employs advertising and marketing techniques to create demand and take the stigma out of condom use.</p>	<p>A basic principle for reaching the poor is to give the poor a voice in design, implementation and monitoring of programmes.</p> <p>Effective reproductive health programmes for the poor depend on listening to their opinions and involving them in programme design and delivery.</p> <p>Where NGOs are strong advocates for reproductive health and clients' rights to quality services within health sector reform 'the involvement and empowerment of clients, through</p>	<p>Governments should change their role from provider to financier, providing subsidies and letting the poor choose among providers in the private and NGO sectors.</p> <p>Meeting the International Conference On Population and Development consensus goal of universal access to reproductive health care by 2015 requires safety net systems –free services, subsidised care, insurance schemes and sliding-scale fees – to ensure that the poor clients receive reproductive health care. The ICPD agenda helps frame the issue of</p>	<p>Governments, communities, the private sector and the international community must cooperate to make best use of their comparative advantages and reduce duplication, waste and inefficiency.</p> <p>Public-private partnerships can improve access to services.</p>

	Use of demand side inputs	Changing demand side behaviour	Stimulating demand side to provoke changes in supplier behaviour	Channelling resources directly to demand side	Partnerships across stakeholders in pursuit of health objectives
<b>UNFPA (continued)</b>		demystify sexuality, increase consumer confidence and make it possible to discuss HIV/AIDS.	civil, societal and actual consumer inputs in health service design, delivery and evaluation, is helping to make clients more aware and more demanding of the services they receive.'	health financing in terms of client needs and empowerment. The question that needs to be asked by any policy initiative is, will it hurt the poor and will it discriminate against women?	
<b>UNDP</b>	Involvement of and capacity building for local community leaders in providing services for HIV/AIDS strategies.	Activities for HIV/AIDS include information/prevention campaigns targeting vulnerable groups, and mass awareness campaigns and media strategies to shift national and community perceptions and responses to HIV/AIDS.  Changing behaviour to decrease the spread of infection requires significant investment in information services. UNDP seeks to deploy well-designed communications strategies, using commercial, traditional and interpersonal channels, to mobilise leadership at different levels and to address people's needs.	UNDP interest in collaboration with CSOs partly due to their watchdog function:  CSOs have vital roles to play as participants, legitimisers and endorsers of government policy and action, as watchdogs on the behaviour of regimes and public agencies, and as collaborators in the national development effort.  HIV Advocacy and Policy Dialogue activities include: targeting decision makers and opinion leaders (e.g. heads of state, ministers, parliamentarians, religious figures, CSO leaders, media leaders, etc.) to advocate for change and build results-oriented coalitions.  Channelling outrage of people at lack of access to affordable treatment in developing countries.		'Our partnerships with civil society organizations are going to be as important as our partnerships with governments in shaping the future of development.' Governments in developing countries cannot on their own fulfil all the tasks required for sustainable human development. This goal requires the active participation and partnership of citizens and their organisations.  UNDP helps place HIV/AIDS at the centre of national development. It works with governments, civil society and the private sector to utilise effectively international financial support and address the underlying causes of the epidemic.
<b>WHO</b>	Roll Back Malaria: lack of resources for a quick expansion of services, so communities will have to undertake this. Community as an active participant in malaria programmes – individual and collective action to prevent and control it.		Shift in measuring to focus on outcomes not inputs. Need for key stakeholders (including community) to be involved in setting goals, managing and monitoring.		

	Use of demand side inputs	Changing demand side behaviour	Stimulating demand side to provoke changes in supplier behaviour	Channelling resources directly to demand side	Partnerships across stakeholders in pursuit of health objectives
<b>DFID</b>	<p>Health policies need to acknowledge and build on community resources and resourcefulness by empowering individuals and communities, reinforcing social networks, understanding livelihoods, and responding sensitively to needs.</p> <p>Civil society and the private sector must be enabled to take on a more effective role in service provision. In situations of weak governance, the role of civil society in service delivery is important, but only successful if tackled on an ambitious scale.</p> <p>Social networks, local institutions and community action substitute for, supplement and interact with formal service provision.</p> <p>HIV/AIDS care: promote linkages among the array of care providers, particularly home-based care linked to health systems.</p>	<p>Educated citizens are more likely to have healthier lifestyles and smaller families, and to demand quality health services.</p> <p>Local action supported by education can play a major role in influencing individual and collective health behaviour.</p> <p>HIV/AIDS: use an intersectoral approach to focus on the needs of young people not yet affected by the epidemic, where preventive behaviour has proven effective in reducing HIV incidence. Support interventions to reduce stigma and discrimination against people with HIV/AIDS. Work on harm reduction with intravenous drug users.</p> <p>Traditional IEC aspects still important. Hygiene promotion helps people adopt hygiene practices that are safer for the household and the wider community.</p> <p>A better understanding of the illnesses caused by unclean water and unsafe faecal disposal contributes to the demand for water and sanitation services. Support for school programmes involving children.</p>	<p>NGOs have an important role in advocacy and governance.</p> <p>Mechanisms to ensure transparency and accountability on spending and services are necessary to enable citizens and civil society to determine which services they need and whether governments are using resources effectively to ensure people can enact their economic and social rights.</p> <p>Need to realise people's rights to adequate basic health services and accountable service providers as rationale for supporting broad-based participation in the development and delivery of health and related services—specifically through public consultation processes for national and regional needs assessment; policy formulation and standard setting; the development of local-level governance structures that help to strengthen accountability; and the establishment of benchmarks for service quality.</p> <p>The poor themselves are key actors in securing better health outcomes. Empowerment and community participation are key components of the strategy for the future.</p>	<p>Targeted food and employment-based safety nets are particularly important to protect the most vulnerable households in the context of unstable situations and structural adjustment.</p> <p>Support and extend work on innovative mechanisms for increasing access to health by the poor, such as franchising, social marketing and voucher schemes.</p>	<p>Work with academia, NGOs, civil society and the private sector.</p> <p>Must look at private sector due to limited state resources and private choice.</p> <p>Private sector tools include public-private-partnership, franchising, contracting, social marketing or targeted subsidies.</p>

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<b>Dutch Ministry of Foreign Affairs</b>	Support for 'active deployment of local organisations and people living with HIV/AIDS' needed. Zambia: home care for HIV/AIDS patients.	Publicity campaigns and training programmes, distribution of condoms to men and women, timely treatment of sexually transmitted infections and voluntary counselling and testing.	Support for active involvement of local organisations and people living with HIV/AIDS.	Support for NGOs and private company initiatives.	Encouragement of innovative partnerships between NGOs, government institutions, the private sector and civil society organisations (CSOs).
<b>GTZ</b>	Community-based services for reproductive health through local volunteers who know their situations; e.g. peer counselling in Burkina Faso. Providing resources is a means of empowerment and a step towards community participation in a watchdog role. For example, in Nepal communities contributed to renovation of hospital building as start of process to develop community ownership and interest in making authorities accountable. Devolution offers local representation and increased accountability; e.g. community participation in hospital reform in Senegal.	Use of IEC in reproductive health and malaria.	Participation in management, co-financing and decision-making enables communities to monitor and demand accountability. Value of media, consumer groups and legal framework for patient rights. Examples: Senegal – survey on patient satisfaction published and discussed at local level. Eastern Indonesia – support for CSOs to monitor public health services through involvement in quality assessments, consumer satisfaction surveys, audits.	Contracting and franchising with private sector, vouchers. Support for social insurance schemes. Health insurances may be a tool for donors to channel their funds through, and policy development in the recipient countries can be stimulated and steered by its financial mechanism.	Increasing promotion of public-private partnerships is a response to public sector inefficiencies. Need for integration of private sector. Ways of working with private sector include regulation, franchising, enabling, vouchers, contracting and partnerships.

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<b>Norad</b>	The public sector cannot assume sole responsibility for providing basic services. Many countries enable NGOs and the private sector to participate in developing and operating social services. This means fostering cooperation with the local community so that the efforts made by users, as well as any user fees, help to ensure the quality and use of these services.	HIV/AIDS and development: protecting youth through efforts aimed at reducing vulnerability, changing risk behaviour and providing access to contraception and counselling.	Civil society (NGOs, political parties, religious movements, academic communities, the media, cultural communities, trade unions, etc.) plays an important role in supplementing the public sector with a view to both increasing access to basic social benefits and strengthening and developing democracy. NGOs often serve as an important corrective to the authorities.	Funding to civil society groups and private sector as well as government.	Increasing attention to cooperation between NGOs, private sector and government institutions, cultural communities, commercial enterprises and research communities.  HIV/AIDS and development: need for public-private cooperation and involvement of civil society. Combating HIV/AIDS requires joint efforts and broad partnerships at the local, national, regional and global levels, with active public-private collaboration and involvement of civil society, such as the International Partnership against AIDS in Africa.
<b>SIDA</b>	Need for mechanisms for community participation in planning.	Lifestyle factors and individual behaviour important and can be influenced through health promotion and education.  Information on alcohol abuse, tobacco and illicit drugs needed as part of information to young.  Strong relationship between health and education in bringing confidence and changed attitudes, especially for women.	Development of health sector as a tool in the democratic process, with increased participation and reinforcement of civil society bringing development of social capital.  Decentralisation important to increase local participation in decision-making and make health services more responsive, transparent, cost-effective.		Private sector and NGOs as important partners.



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<b>World Bank</b>	<p>Community involvement in co-production through self-care: e.g. women's groups encouraging breastfeeding. Self-care can empower poor communities. Communities have co-produced professional services to compensate for deficient providers; e.g. construct facilities, take over service provision and management.</p> <p>Civil society and community organisations should contribute financial resources to increase client power.</p>	<p>Demand side obstacles often related to insufficient information, weak household decision-making capacity and intra-household resource allocation; i.e. personal behaviour. Value of literacy and mothers' knowledge.</p> <p>Better informed and educated citizens make better decisions.</p> <p>AIDS has challenged policy-makers to look more at behaviour and societal values.</p> <p>Social marketing – many examples show some success. But a focus on cost recovery excludes the poorest. Market segmentation, tier pricing and product differentiation can help.</p>	<p>Short route of accountability through client control of frontline providers' incentives is needed. Mechanisms to strengthen client power over health services are re-emerging as response to weaknesses of state-run model.</p> <p>Strategies: make income of service providers depend more on demand from poor clients; increase purchasing power of the poor; foster involvement of poor in monitoring and providing services; expand consumer power to access complaint and redress mechanisms. Clients can pool financial resources and use new purchasing power to influence providers' behaviour. Micro-insurance schemes, traditional mutuality associations, and community-based revolving drug funds as means for strengthening client power.</p> <p>CSOs important to bridge gaps between communities, researchers, providers and policy-makers. Bring community participation to research to ensure perspectives of poor influence policy advocacy. Strengthen people's voice to influence priorities of public spending and make policy-makers accountable. CSOs can monitor services and serve an important role as watchdog. Draw attention to health hazards.</p>	<p>Demand side subsidies. Direct transfers to client households to boost client power and increase purchasing power. Vouchers have a good record for well defined services; e.g. PROGRESA in Mexico and Nicaragua sex worker cases.</p> <p>Subsidies also successful for less well-defined services; e.g. Thailand's low-income insurance scheme. However problems of targeting – need careful design.</p> <p>Demand side subsidies must be accompanied by other strategies, especially healthy behaviour promotion and support to services.</p> <p>Outcome-based contracting – difficult to implement. Output-based contracting is easier.</p>	<p>Need for partnerships with NGOs, private sector, academic institutions, other agencies.</p>



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# Notes

- 1 Arguably, behaviour modification is one of the oldest tasks of medicine. See, for example, Porter's (1997) description of Moses Maimonides' twelfth century *Regimen of Health* and other medieval systems and practices.
- 2 This is used to refer to the burgeoning range of providers in situations where health care has become increasingly marketised (Bloom and Standing 2001).
- 3 This is often referred to as the private sector. However, this is confusing for audiences used to thinking of the private sector as the 'for profit' sector. Where necessary, this distinction will be indicated.
- 4 For further discussion of various discourses on rights-based approaches to health, see Daniels (1985), Roberts and Reich (2002) and WHO (2002).
- 5 The following discussion owes much to a literature review of governance and accountability by my doctoral student, Fang Jing, who is currently working on this issue in the health sector in China.
- 6 See their website: Four Elements of Empowerment: Accountability, [www.worldbank.org/poverty/empowerment/whatis/acct.htm](http://www.worldbank.org/poverty/empowerment/whatis/acct.htm)
- 7 See Muhe (2002) on Roll Back Malaria, and Pan-American Health Organization Healthy Cities website [www.paho.org](http://www.paho.org)
- 8 See their website: The Alliance of Mayors [www.amicaall.org/](http://www.amicaall.org/)
- 9 See particularly World Bank Education Section on Demand Side Financing [www.worldbank.org/education/economicssed/finance/demand/demand\\_index.htm](http://www.worldbank.org/education/economicssed/finance/demand/demand_index.htm)