

Understanding mechanisms for integrating community priorities in health planning, resource allocation and service delivery

Results of a literature review

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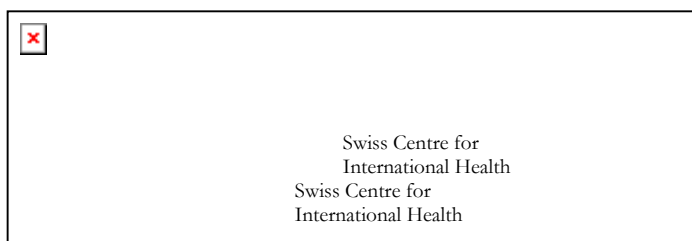
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Summary

The aim of this study was to review the evidence for community participation in health, in terms of community contribution to health planning, resource allocation, and service delivery. The review was seen more as an ‘exploratory’ than ‘systematic’ review, although in the end close to 100 studies were reviewed, mainly from the developing world. In selecting literature for inclusion in the review, the focus was on articles published in peer reviewed journals or technical research reports that in one way or another could provide information about equity and governance in health both in theory and practice as experienced in different countries and as discussed under the study sub-themes mentioned above. The reference information cited in this report was mainly taken from original research work and/or review papers that have been published in peer reviewed academic journals as well as specific chapters published in academic books, in addition to selected technical research reports. A framework developed by EQUINET was applied to evaluate a selection of successful case studies – evaluating community participation in terms of underlying factors, proximal factors, and outcomes. Topics that received special attention include: what is understood by community participation; the link between community participation, governance and equity in health; and factors explaining poor community participation, despite increasing emphasis on decentralisation and community involvement.

Community participation is widely agreed to contribute to good governance, and is most advocated for providing a mechanism for potential beneficiaries of health services to be involved in the design, implementation and evaluation of activities, with the overall aim of increasing the responsiveness, sustainability and efficiency of health services or programmes. Early reviews on the subject found that community participation is widely accepted as a fundamental right of the population and is also a principal factor in the success of development programmes. Furthermore, when the community is involved in health planning and service delivery, it makes more explicit who currently benefits from services, and therefore starts the process of considering who *should* be targeted.

The review of the literature shows that studies have some difficulty in proving the success or failures of community participation schemes due to the different perspectives about community participation and different approaches in implementing public participation. Based on their own experience or from review of schemes tried out in different countries, many authors have observed that public participation in health can be analysed and have been realized at different stages in the project ‘cycle’ (planning-management-implementation-evaluation). While this is not surprising, and is not in itself a bad thing, it does raise questions about whether those working in the field of community participation are talking about the same thing when ‘community’ is mentioned. Furthermore, the outcomes reported by studies are very varied in terms of the success of community participation schemes, with some reporting remarkable results in terms of increasing resources for health, empowerment and ownership, health service use, and eventually improving health outcomes.

In terms of resource allocation, it has been observed that communities in Africa and other developing countries have mostly been mobilised to participate in cost recovery programs such as payment of user fees or community-based health care prepayment schemes, as stipulated under the Bamako Initiative of 1988 and as supported by the World Bank through its World Development Report of 1993 ‘*Investing In Health*’. Public participation in resource allocation has also been interpreted in terms of people’s

contributions of efforts such as labour or money to construct or renovate health facilities or other services such as water projects and schools, with substantial assistance from their governments or external donors. Nevertheless, a number of publications on community health financing mechanisms have identified that the decision of what and how much of the resources have to be set aside for what specific services, has been done by either the democratically elected public representatives/leaders who attend various health committees or health boards at village/health facility, ward, division, district or provincial levels. In some areas, there has been little public trust in the ability of local leaders or community representatives to participate in, or to influence decisions for the actual allocation of resources for social services including health. This mistrust has partly rooted from the observed gap between the expected/promised performance and the actual performance as indicated by the inadequate services delivered. Experience from high-income countries like UK and Australia has shown that even with attempt to consult patients and the general public, there has been a tendency of the public not being committed to express their feelings of how things should be or sometimes expressing their general thought that critical decisions about what types of health resources should be allocated for which population groups is a responsibility of medical professionals or the state.

The evidence shows that in terms of public mobilisation and the contribution of labour or monetary resources to run various health activities, some of the most successful community-based health initiatives were those that received financial support from external agencies within limited pilot timeframes, which does not give much hope for scaling successful projects up to national level. There are also many examples of community participation schemes that did not live up to expectations. The many factors limiting success have received quite some attention in the literature, and include definitional problems, barriers to empowerment (e.g. reluctance of professionals to involve the community), mistrust or inadequate representation and communication, 'projectization' and resource scarcity. Where the public or citizens have been given an opportunity as important stakeholders in priority setting processes related to resource allocation, more rational decisions have been experienced, and this is mainly where health committees or health boards appeared to function well, some of which were supported by participatory action research.

One key conclusion of the review is that, while this study gives an overview of important elements for community participation, it is crucial to understand that these elements must be put into practice through the appropriate channels. Community participation mechanisms only work under certain circumstances. For example, there must be a strong political will and legal or constitutional framework providing guidelines as to where and how the public should be made to participate. There must also be adequate information or education to the public who are to be involved, and in some circumstances such as community-based health care prepayment or cost sharing schemes, external support at the beginning or sometimes in the process of project implementation becomes essential in stimulating or topping up community initiatives. In other words, more often than not it becomes inevitable to have in place other pre-existing factors such as political support, laws supporting governing bodies, or community interest, and additional support from external agencies. However, as noted by one author 'choosing the appropriate combination of public, elected officials, experts and stakeholders to make these decisions, can be complicated and determining what and how public views will be

obtained and incorporated in the decision making process is even more challenging'¹. Knowing which mechanisms are appropriate requires an in-depth knowledge of the country as well as the local (community) setting. Thus, many authors cite the failure to operationalize concepts as a major problem, and more evaluative studies under ordinary (non-project) conditions are demanded.

The diversity of the meaning or interpretations of the concept 'community participation' poses a challenge both in theory and practice on how to analyze and draw conclusion on the concept. This challenge exposes the need to have a framework for undertaking a sound analysis such as the one developed recently by EQUINET. This means that one must be clear on the terminology as well as the levels at which community participation can be analyzed. Meanwhile, it is important to understand that the classification of factors as 'underlying', 'proximal' or 'outcome/impact' measures will depend on the setting and the perspective of the analysis. There is also need to look at how different factors classified as underlying, proximal and outcome will influence or are linked to each other, and further work is needed to further develop the framework.

¹ Abelson (2001 p 778)

1. Introduction

1.1 Increasing attention to community participation

Community participation (CP) in health is most advocated for providing a mechanism for potential beneficiaries of health services to get involved in the design, implementation and evaluation of activities, with the overall aim of increasing the responsiveness, sustainability and efficiency of health services or health initiatives/programmes. In 1989 a review was published by the World Health Organization (WHO) which summarised studies to date and reported a problem analysis of community participation in health (Oakley 1989). Oakley argued even then that community participation is widely accepted as a fundamental right of the population and that it is a principal factor in the success of development programmes, as it allows individuals to choose what they like or don't like. Now, fourteen years later, a considerable body of literature reveals an increasing recognition, at least in theory, of the WHO's statement that *'people have the right and duty to participate individually and collectively in the planning and implementation of their health care'*, as stated through its Alma Ata Declaration of 1978 (Wiseman et al 2003 p 1003). The literature testifies that the last two decades have witnessed a growing enthusiasm to implement social welfare policies through the participation of the 'community'. Nevertheless, as this document reveals, the concept of community participation is far from being clear in many of the contexts in which it is advocated and applied, and partly for this reason the goal of *'Better Health for All by the year 2000'* under the Alma Ata Declaration has yet to be achieved.

1.2 Prioritisation as an explicit process

A general problem of human society is that of resource scarcity, a problem that is especially acute in economically poor countries where budgets for health are extremely low compared to economically developed countries, and where a significant proportion of the population is often living in poverty and exposed to higher risks². However, despite resource scarcity, people still wish to satisfy their health needs. It is recognised that the mismatch between supply and demand requires some kind of prioritisation and selection process, whether it is done explicitly or implicitly. For example, Kinnunen *et al* (1998) argue that the gap between health care expectations and the delivery of health care will increase if greater emphasis is not given to the process of making reasoned choices. But making explicit choices is harder, as it then becomes evident who gains and who loses from a given resource allocation. This was recognised by Ubel, who states *"setting health care priorities often means making hard choices. And when these choices involve the denial of health care to specific groups of people, many will look for a way to avoid making such choices"* (Ubel 1999, page 276). Therefore, while there may be forces working against a move towards more explicit recognition of priorities and the eventual resource allocation **decisions** they give rise to, the participation of the community necessitates that such processes are made explicit.

Purdley et al (1994 p 329) observed, 'community-based development empowers villagers to develop community cohesion and confidence, increase their ability to identify, analyze, and prioritise their needs, and organize the resources to meet these needs'. By

² For example, environmental degradation, pollution, inadequate shelter, famine, poor sanitation & water supply, low literacy levels, (re)emergence of infectious diseases, drug resistance, high morbidity and mortality levels.

empowerment, these authors refer to a situation in which people increase their capacity to act individually and with others to affect change.

In many countries, the need for community involvement is acknowledged as the core for the successful implementation of voluntary cost recovery and health insurance schemes, and is valued by all policies on decentralization. While the retention of cost recovery revenues for use by local health management bodies has an advantage of empowering the local populations to prioritise resources to the most desired public health needs and making the scheme responsive to local community preferences and demands, it also widens the chances for cost recovery schemes to gain a large community acceptance potential for the financing scheme in place to be sustainable (Shaw and Ainsworth 1996; Atim 1999). Also, the importance of community participation in health planning and actual service delivery has increasingly been recognized in disease control programs. The ability of the community to influence the planning and/or allocation of resources has been noted to depend on, among other things, where the authority is centred within the health system and the willingness of other stakeholders (health workers, managers, political leaders, etc) to include other social groups in the priority setting process. Furthermore, 'reaching agreed and acceptable levels of shared control over resources between clients and providers is important for sustaining the health system and for other forms community involvement in health' (Loewenson 2000, unpublished Technical Report for EQUINET/TARSC).

1.3 The increasing focus on 'governance'

The question of the efficient allocation of scarce resources is important, but equity in their allocation and the question of whether outcomes desired by communities are met, are issues that have come to the fore in recent health sector reforms. A sizeable literature has noted an increasing recognition by many authors and agencies that resources will be more equitably allocated and utilised if all stakeholders with mutual interests in the system are involved in the processes of planning, prioritisation, implementation, management, monitoring and evaluation. Stakeholder involvement leads to greater transparency (explicit and informed decisions) and defining the roles that can be played by each stakeholder that eventually might enable monitoring for accountability, which are essential elements of 'good governance'. As a number of authors have pointed out (e.g. Wiseman et al 2003), the growing impetus for public involvement in health care decisions stems from the desire to make providers more accountable to the community they serve. However, Atim (1999) observes that, while democratic operation and accountability are crucial elements in analyzing social movement dynamics, in practice many so-called social movements in the form of health insurance schemes have had little or no participation of members in running them. Improved governance (defined as the *nature and exercise of authority within a given socioeconomic and/or political system or structure*) is now seen by the international community as of central importance in meeting international development targets such as the Millennium Development Goals (MDG), and a large number of recent reports are devoted to this subject. An increasing number of donors as well as global funding agencies (e.g. Global Fund for AIDS, Tuberculosis and Malaria - GFATM) are linking aid budgets and disbursements to the quality of governance in recipient countries. Therefore, advocates of community participation as well as the wider development community consider the full involvement of community as a key means of improving governance including the equitable allocation and utilization of resources in the health sector.

1.4 The research agenda

Recently, since the WHO review of community participation in health (Oakley 1989), there has been limited review or research synthesis work, where experiences reported since 1990 have been brought together to understand ‘where we are at’ in community participation in health, and to propose a future research and implementation agenda. This review in part responds to a call made by Tenbensen (2002), who argued that the most important clues for best practice could be from an analysis of *existing practice* instead of simply trying to devise *best practice* from first principles. Therefore, this review brings together a synthesis of many (but not all) of the debates found in the literature as well as experience in community participation in health. This allows the identification of a research agenda.

2. Terms of reference for this review

2.1 Background to the current study

This review was undertaken under the auspices of EQUINET Steering Committee (January 2002) on Equity and Governance in Health Network (GovERN), coordinated by TARSC Zimbabwe and CHESSORE Zambia, and following on from a previous meeting held in Zambia where priority areas for research were encouraged that address the following aspects of participatory structures:

- representing the interests of the communities (and sections thereof)
- have any role to play in health system performance and resource allocation
- include community preferences in health planning and resource allocation
- improve the health system performance, especially in relation to equity

It was also agreed and recommended that all research studies should aim to include context-specific issues in their background, particularly focusing on: policies of participation, the legal framework, identified key issues in health systems, resource allocation through participatory mechanisms, and structures that improve the equity within operation of the health system. Furthermore, it was agreed that all studies undertaken under EQUINET/GovERN should aim to give clarity to the definition of the term ‘community’; the role of information and how it flows between individuals, agencies and health system levels; areas of authority of community structures; and indicators of ‘success’ in participation – process or outcome. These conform to the three part framework in evaluating community participation, which is picked up later:

1. Underlying factors that determine community participation,
2. Proximal factors (e.g. functioning) that determine community participation, and
3. Outcomes of community participation.

As one of the identified collaborators of EQUINET, the National Institute for Medical Research (NIMR), Tanzania submitted a concept paper early in August 2002 that was discussed by GovERN Steering Committee, and deliberations made for further development of the concept paper to a fuller proposal for Tanzania that would contribute to a multi-country case studies under EQUINET. At this point, the need for undertaking a systematic review of international literature was raised, in order to summarise current understandings and evidence with regard to community participation. The application was accepted, and sponsorship provided by EQUINET.

2.2 Purpose, objectives and scope of work

This review report is a precursor to a study to be conducted in Tanzania as part of a multi-country study on equity and governance in health systems. The results of this review are expected to feed into the design and evaluation of the proposed study.

The **overall objective** is to undertake a literature review on mechanisms for inclusion of community preferences, responsiveness and inputs in health planning, resource allocation and service delivery.

In line with terms of reference from EQUINET the task of the authors of this report was to:

- a. Review the literature to extract information available regarding the international experience with mechanisms for inclusion of community preferences in health planning, resource allocation and service delivery.
- b. Develop a research proposal for Tanzania based on experience and recommendations obtained from the literature review and the current priority research agenda and research approach of EQUINET. The completed version of the research proposal will be submitted to EQUINET and other organizations for further funding.

The main output of this study is a review of the international literature on issues related to equity and governance in health, with specific focus on identifying the role of communities in setting priorities that lead to improvements in local health planning, actual resource allocation and provision of health services. After identifying relevant studies and reports, and presenting the current situation as reflected by the literature, the review was expected to highlight the existing gaps and contribute to the design of a research study to be conducted in Tanzania examining the inclusion of community preferences and priorities in health in decentralized settings.

3. Methodology

3.1 Sources of literature and limits of the review

From the beginning, it was intended to cover as much literature as possible. The main sources of studies were the following:

1. Search of MEDLINE (PubMed) using key word searches. For the most relevant articles, the 'related articles' on the PubMed website were searched, revealing other articles not contained within the original search.
2. Previously collected articles by the authors.
3. Contacts of the two authors working in the field of community participation, including colleagues from NIMR and STI, TEHIP, IHRDC, Ministry of Health Tanzania, EQUINET and CRESSORE (see acknowledgements). These contacts in particular provided 'grey' literature of either unpublished studies, or studies that are incomplete.
4. An internet search was undertaken to identify organizations working in the field of governance and equity in health and subsequently relevant literature extracted from their home pages.
5. The bibliographies or reference list of all the above publications were scanned, and relevant articles identified and copied.

The MEDLINE search was conducted using combination of search terms (see Table 1), contained in either the title, abstract or key words of the article. The search was configured so that articles were identified that have the word 'health', and one of the terms describing participants, and one of the terms describing input type, and one of the terms describing the processes. Note that (community) health care financing was not included as a search term (e.g. user fees, community health insurance), as this was not a focus of the review, although the issue surfaces frequently in the presentation of results.

The search was further refined by requiring one of the following geographic areas to be contained within the title, abstract or key words: 'africa', 'asia', 'latin america' or 'south america'. This gave 546 articles. The titles and abstracts of these articles were reviewed separately by the two authors, and 49 articles were agreed as being relevant for the review. These articles, as well as articles identified from following up related articles and the reference lists, were gathered either from the internet (from the websites of the journals with the access of the University of Basel), from the STI library, or requested for inter-library search and copy of articles. A total of 85 articles were obtained in hard or electronic copy that were included in the review. Articles were entered in Endnote © for cataloguing and bibliography purposes.

Table 1: Search terms used to find relevant documents in MEDLINE

Sector	Participants	Input type	Process involved in
Health	Communit* Public Civic	Responsive* Participat* Prefer* Input Involve*	Plan* Service deliv* Service prov* Resource allocat* Priorit*

* was used so that different endings of words would be captured

As literature about public involvement in priority-setting and in development projects or programmes is potentially enormous, this review by itself could by no means exhaust all the ranges of approaches that have been adopted all over the world nor all the studies that have been published. As commented by Tenbenschel (2002), doing this kind of task sounds ambitious but would be too complex and of dubious value. This review was therefore intended to be indicative of trends in community participation, and reveal findings from evaluations of such community participation. While the geographical focus was on the 'developing' world, interesting and relevant articles that were identified from developed countries were included in the review.

3.2 Framework for the presentation of findings

Due to the sheer breadth of the review and the huge number of interesting findings, the literature review is first presented in terms of:

- a. Number of studies looking at key areas of community participation, and using a variety of scientific or reporting approaches. The most relevant of the 85 studies are presented in tables in the Annex, detailing the country and locality of study, participation study theme, mechanisms tested, and study details.
- b. Description of understanding of definitions and terms, to demonstrate the various ways in which community participation is understood, and importantly to ensure that the later reporting of findings is clear to the reader.
- c. Presentation of six selected key case studies in terms of the framework developed in September 2002 by EQUINET/TARSC/CHESSORE/CWGH/INESOR/IDRC:

- **Underlying factors** in community participation. These have been broken into formal sources (e.g. legal), political sources (e.g. mandates), and technical sources (e.g. recognition by health management).
- **Proximal factors** in community participation. These include capacities and attitudes of stakeholders, communication and information flow, mechanisms for community involvement, and incentives for effective functioning.
- **Impact/outcome variables** from community participation, which include allocation of resources, responsiveness of care, and community knowledge of health.

In this case, we attempted to report the successes and failures as documented in the literature by tracing the link between the theoretical proposition (ideological, political, economic and policy expectations) and the practical experience.

The later sections detail the findings relating to the following important themes:

- d. How community participation contributes to equity and good governance
- e. Viewpoints on the inadequacy and limited practice of community participation
- f. Suggestions for future studies and areas of focus for community participation

4. Findings

4.1 Classification and overview of reviewed articles

In this review, published articles were categorised according to the type of information presented in order to identify the areas in which community participation has been most evaluated (see Table 2). This categorisation concentrated on 85 of the most relevant articles out of more than 90 articles reviewed. The categorisation was made on the basis of whether the article addressed community participation in terms of:

- Health planning (H-Plann).
- Resource allocation (Res-All.).
- Governance (GovERN).
- Service delivery (S-Deliv.).
- All the above mentioned (All).

Furthermore, the area(s) of focus of each study were cross-tabulated with the information source, whether an experimental study, an observational/exploratory study, a review and discussion paper, or an author's commentary. Note that due to the multiple foci and multiple methods of many studies, the columns and rows of Table 2 sum to over 100%.

Table 2: Classification of articles reviewed by type of evidence/information presented

No.	Method/Type of Study	Number of papers	Papers by type of participation and as % of the 85 papers				
			H-Plann.	Res-All.	GovERN	S-Deliv.	All
1	Experimental	32 (38%)	31 (37%)	23 (27%)	22 (26%)	29 (34%)	17 (20%)
2	Observation, exploratory	47 (55%)	38 (45%)	25 (29%)	31 (37%)	40 (47%)	23 (27%)
3	Review/Discussion	36 (42%)	20 (24%)	27 (32%)	18 (21%)	20 (24%)	15 (18%)
4	Commentary	10 (12%)	10 (12%)	10 (12%)	9 (11%)	10 (12%)	9 (11%)
5	Both methods 1 & 2	12 (14%)	12 (14%)	7 (8%)	9 (11%)	11 (13%)	7 (8%)
6	Both methods 1& 3	3 (4%)	3 (4%)	2 (2%)	1 (1%)	2 (2%)	1 (1%)
7	Both methods 2 & 3	6 (7%)	5 (6%)	3 (4%)	3 (4%)	5 (6%)	3 (4%)

From Table 2, it is possible to analyse the areas in which authors have most concentrated. Looking at the information presented by type of method/study, it can be seen that most of the papers discussed evidence from exploratory surveys (55%), followed by review/discussions (42%) and experimental studies (38%). Table 2 also shows that the greatest focus on community participation by primary studies (1 & 2) is on health planning processes and service delivery, although resource allocation and governance are not far behind. Nine out of ten of the commentary articles focussed on all the participation processes. The element of governance or leadership in health was given more weight by articles based on observational studies (31 out of 47) than the rest of the methods. Exploratory studies also focused on community participation in health planning and service delivery proportionately more than other types of the articles in the presentation of evidence.

Annex Table 1 presents in more detail 28 different studies reported from around the world, including the intervention objectives, the types of participation and approaches used for community mobilisation, and the mechanisms used by the researchers to test the outcome of participatory approaches. These studies, while not exhaustive of the literature, show the range of approaches and understanding of community participation, as well as a range of evaluative frameworks (as also presented in Table 2 above). The following are some of the foci of studies identified in this review:

- Specific disease control (Addmore et al 2003, Briger et al 2002, Katarbarwa et al 2002, Ghebreyesus et al 1996, Brieger 1996, Cline and Hewlet 1996, Greene 1991, Beeker et al 1998, Bresline and Sawyer 1999, Chitambo et al 2002, Kironde and Kahirimanyi 2002, Cairncross et al 1996, Richards et al 1996, Gubler & Clark 1996, Okanurak and Ruebush 1996, Krogstad and Ruebush 1996) or disease surveillance (Hoffman et al 1988).
- Primary health care or health promotion (Perry et al 1999, Greene 2003, Jewkes and Murcott 1998, Schuftan 2003).
- Womens' involvement (Brieger et al 2002, Katarbarwa et al 2002, Greene 2003).
- Vulnerable groups (Flower and Wirz 2000).
- Empowerment and preference elicitation (Souza (undated), McIntyre and Gilson 2002, Litva et al 2002, Browning et al 2001).
- Planning and budgeting (Green et al 2000, Ramiro et al 2001, Kapiriri et al 2003, Knippenberg et al 1997).

4.2 How has 'Community Participation' been defined and understood?

It is already clear from the initial presentation of the range of studies above that there is not necessarily a common understanding of what community participation actually is, or could be. As pointed out by Madan some 16 years ago, until that time insufficient attention has been given to understanding what community participation is.

“Obviously, community involvement is generally believed to be important in all schemes of community welfare, but conceptual and operational problems have received inadequate attention at the hands of social scientists as well as public administrators” (Madan 1987, page 616).

Since then there has been a considerable literature on community participation dealing both with conceptual issues as well as reporting experiences from the ‘field’. Quotations below show how different authors have expressed their understanding of community participation.

In general, it is clear that participation means actively giving ideas, influencing decisions, and sometimes playing a role in implementation, as shown by the following quotes:

“Ideally, community involvement should mean that the initiatives come from the people, and the government and other agencies provide assistance” (Madan 1987, page 615).

“Communities are deliverers of policy and creators of solutions as well as the context in which problems have to be understood” (Greene 2003, page 110).

“Broadly, public participation means ‘taking part in the process of formulation, passage, and implementation of public policies [through] action by citizens, aimed at influencing decisions which are, in most cases, ultimately taken by public representatives and officials’ ” (Parry et al 1992, page 16).

This is supported by EQUINET, who agrees with the egalitarians’ claim that health care cannot rest on individual achievements (i.e. libertarians’ claim), and instead should be approached by society as a whole if equitable access has to be achieved to all populations (EQUINET 1998).

Other authors emphasize the shifting of power, greater social equality, and collective action:

“It (community participation) can mean the voice of people, but it can also mean empowering the poor to become aware of inequalities and to reform the political and social system through collective action” (Souza, undated reference).

“Community empowerment denotes shifts towards greater equality in the social relations of power (who has resources, authority, legitimacy or influence)” (Laverack & Labonte 2000, page 255).

Yet others see community participation as taking control of their destiny, suggesting that they act alone.

“The process whereby communities take responsibility for their own destiny by understanding the problems they face and how to properly address them in a participatory way” (Atim et al 1996 as cited in Desmet et al 1999, page 926).

Rifkins’ “Empowerment Framework” sees community participation as *“a way of giving people power over their health choices... a process whereby communities are strengthened in their capacity to control their own lives and make decisions outside the direction of professionals and authorities” (Rifkin 1996, page 87).*

A large number of authors see community participation, more pragmatically, as a way to mobilise community resources to supplement health services (Oakley 1989, Annett & Nickson 1991, Epp 1987, Bracht and Tsouros 1990, UNICEF 1992) and this is clearly one of the main driving forces for the popularisation of community health funds and community insurance schemes (or 'mutuelles de santé' in francophone Africa) (Atim et al 1998). User fees and community-based prepayment schemes for health care (in some countries referred to as 'community health fund'), for example, have been devised and implemented in a number of developing countries and have been key components within the decentralisation policy frameworks that have a focus on community participation (Moens 1990, Shaw and Ainsworth 1996, Noterman et al 1995, Gilson 1997, Wiseman et al 2003). Atim (1999) reports, citing Carrin (1987) and Kutzin and Barnum (1992), that one of the advantages of community financing schemes such as voluntary health insurance or user fees planned with inputs from the local population, is their potential (if well-implemented) for being responsive to the preferences of the local populations, which consequently has a positive effect on the acceptability of the cost-recovery program. However, emphasis needs to be placed on if well implemented. In some countries, for example, community health financing schemes have been introduced with limited community consultation and without putting in place some instruments to enable the local people to have control of the schemes, such as in Chile (Celedon 2000).

With reference to other authors, Atim (1999) depicts that despite their achievement in resource mobilization through community participation, voluntary community-based health insurance schemes have not always been successful in reducing inequity in access to health services and have failed to show their potential for protecting the poorest groups in the society. For example, evidence from the Bamwanda health insurance scheme in the Democratic Republic of Congo, and similar schemes in Ghana and Cameroon, shows that low cost recovery rates, adverse selection and moral hazard have dominated the financing schemes, lowering the financial resource base and coverage to wider populations and thus reducing the sustainability of the scheme. Atim agrees with other authors who argue that these failures are often attributable to poor design of such schemes, and concludes that with better design and wider dissemination many of the drawbacks could be overcome. Meanwhile, a recent review of user fee experience in sub-Saharan Africa has reported the tendency of most of the financing schemes to be dominated by efficiency motives with little or no mechanisms in place for reducing inequities in access to health care between the richer and the poorer groups (Gilson 1997).

Therefore, what are the main elements of community participation? Are differences between the understanding of authors' differences of emphasis or perspective? Or are understandings of community participation fundamentally different? Rather than to try and answer this question, the aim of this section is instead to synthesise the different elements of community participation, being inclusive rather than exclusive. Community participation is commonly regarded as a way of generating additional resources to support health sector activities. Some of the arguments for community participation are summarised below under three main sub-headings: resource allocation, resource mobilisation, and resource management.

Resource prioritisation and allocation

- Community participation could lead to cost-effective health care (Stone 1992, MacCormack 1983). The cardinal approach to cost-effectiveness analysis has

been challenged for its inability to reveal how people really want to set health priorities (Hardon 1991, as cited by Ubel 1999 p 267).

- Help to solve problems emanating from diseases whose origins lie outside the health sector, promotes self-reliance i.e. freedom of dependency on professionals (Annett & Nickson 1991); and as an important means of changing people's attitudes towards the causes of ill-health (Rifkin 1986)
- Under-use or misuse of health service could be avoided if those who use it were involved in planning (Rifkin 1986).
- When discussing resource allocation, it is also important to be aware of the levels at which rationing decisions are made in many countries as the eventual effectiveness of community participation will be determined by its eventual influence on resource allocation decisions at each level (Klein 1993, Hunter 1993, Litva et al 2002), which include (a) the national level - e.g. between health and education; (b) at the level of commissioners deciding about priorities between services (e.g. disease focus) and between primary, secondary and tertiary care; and (c) at the micro levels of deciding about priorities within services, including allocating resources between different types of treatments and between different patients.

According to Green (2000), the resource allocation and budgetary system is a critical component of any decentralization policy, albeit often neglected. Even Kinnunen et al (1998 p 218) had noted that, 'although prioritisation has been a much discussed topic both nationally and internationally, there is a general lack of studies based on empirical evidence'. These points are supported by this review where few studies were found that examined the link between health budgeting and resource allocation processes and its equity implications. Possibly this is due to either the limits of studies or the low policy priority given to this issue by government and health authorities of country examples explored in this review. In many countries, the traditional policy goal for attaining equity in resource allocation for health especially since the Alma Ata Declaration has been to ensure universal coverage of health services through what is termed as 'equal access for all' to a uniform set of services. This policy ambition is, however, challenged for it runs a risk of maintaining the existing levels of relative disadvantage by ignoring the differences in the current levels of service availability and differential levels of need between geographical localities and population groups especially in large, multiethnic and multiracial countries like South Africa and Brazil (McIntyre and Gilson 2002). With reference to experience from Brazil on decentralization, participation and public empowerment, Souza (undated reference) reveals that, 'however well-meaning, structural and even constitutional changes intended to distribute fiscal resources can be ineffective and/or by-passed when inequalities are very high'.

For community groups to influence resource allocation decisions to achieve equity, it depends on whether the public is informed of the available health resource budget in a defined period and health problems that are perceived to be a priority to them. For instance, a study of doctors, nurses, politicians involved in social and health care administration and the general public in Finland found that priorities for what types of care should be allocated how much of the resources, were not stable, as opinions differed between the respondents (even between doctors and nurses) and were context-dependent, particularly on the available budget. The difference in opinion about priority health problems for resource allocation seems to have partly been attributed to the difference in respondents' knowledge of the available municipal health budget and their commitments or legislative limitations and differences in respondents' comparative value

of short-term benefits versus long-term risks of whatever decision they made. In case of the latter, it was noted that preventive services were not prioritised under declining resource budget context, and generally it was observed that when the budget increased, the inclusion, exclusion and ranking of health problems in terms of priority changes (Kinnunen et al 1998).

Resource mobilisation

- Need to generate additional resources for health (Mahler 1981, Mahler 1987).
- Mobilising resources available from the community to complement those of the public sector (Oakley 1989, Annett & Nickson 1991)
- Generating ‘untapped’ resources in the community – i.e. voluntary contributions of labour and finance (Epp 1987, Bracht and Tsouros 1990).
- Increased community financing (UNICEF 1992 in light of the Bamako Initiative launched in 1988).
- Communities are expected to participate to mobilise human resources and to draw upon the scarce resource materials and financial resources available for disease control at village level (Krogstad and Ruebush 1996).

Resource management

- Increased control of the health centre (UNICEF 1992 in light of the Bamako Initiative launched in 1988).
- ‘Virtuous necessity’ towards improvement of the quality and reliability of health services’ (World Bank 1993).
- Enables unbureaucratic employment of local or community staff and allows greater flexibility in executing activities outside normal working hours (World Bank 1994).
- Field experiences have demonstrated that development projects in which local people are actively involved prove to be more successful (Stone 1992, Annett & Nickson 1991).
- Participation would lead to the development of local skills and competencies which could be used for future community development (Bracht & Tsouros 1990), and could be extended to other aspects of people’s lives (Liffman 1978).

Further rationale is provided by Krogstad and Ruebush (1996), who, citing an example from the guinea worm eradication campaign, claim that community participation helps make public health strategies a success *if there is active involvement of the local communities*. While disease control programmes must be based on solid biological foundation, it must be recognised that not every biologically effective strategy will be effective as a community-based intervention. For this reason, community participation and education are justified because of their facilitation to biologically based interventions, and ultimately their impact on effectiveness of these interventions (Krogstad and Ruebush 1996, page 78). Similarly, Rifkin (1996) reports that health programmes in Peru and Indonesia were expected to act as a catalyst for social change by empowering local populations to participate in the political process. And according to Souza (undated reference), sustainable development demands greater participation at all levels in the policy and less ‘top-down’ management, and empowerment that can lead to a more equitable distribution of economic resources to all local participating governments and movements. These case studies are supported at the conceptual level by Wiseman et al who note that “attempts have been made to value both processes and outcome attributes of interventions, thus moving beyond the traditional consequentialist view of health care” (Wiseman et al 2003 p 1003, citing Mooney & Lange 1993).

These views from the literature are incorporated below in Table 3 using the EQUINET framework, thus providing more content as well as focus for this framework. This exposition gives a clearer understanding of the case studies described in section 4.3.

Table 3: Further elaboration of the EQUINET framework taking into account the findings of the literature review

Underlying factors	Proximal factors	Outcomes/Impacts
<ul style="list-style-type: none"> ▪ Legal recognition and powers for formal control over health resources and finances ▪ Political support (mandates, elections, delegated power) ▪ Policy frameworks, including links to other sectors related to health ▪ Technical sources (recognition of community input by health management) ▪ Traditional and socioeconomic environment and their influence on community participation 	<ul style="list-style-type: none"> ▪ Capacities and attitudes of stakeholders, and their relationships with structures ▪ Communication and information flow, not only between health actors but also with other sectors related to health ▪ Procedures, mechanisms and evidence used for transparency of decision making, and uptake of community inputs, including inter-sectoral collaboration ▪ Formation of community decision-making organs such as health committees, health boards, general public meetings, suggestion boxes ▪ Trust in those implementing programmes ▪ Incentives and resources for effective functioning of these mechanisms ▪ Geographical, socioeconomic, demographic and gender dimensions 	<ul style="list-style-type: none"> ▪ Allocation of resources by level, especially to the poor and vulnerable groups ▪ Responsiveness of care and services to local population's needs, especially to vulnerable groups ▪ Cost-effectiveness of care ▪ Community knowledge of health and health service issues ▪ Actual community involvement and inclusion of their priorities in health planning ▪ Community input into management, and benefits observed ▪ Actual collaboration with other sectors related to health ▪ Level of use of health services by the population, especially vulnerable groups ▪ Generation of additional funds for health by the community ▪ Community input in terms of human or material contributions

Source: Report of research meeting EQUINET/TARSC/CHESSORE/CWGH/INESOR/IDRC 2002.

4.3 Presentation of case studies using EQUINET framework

This section presented six selected case studies (Tables 4-7) to illustrate not only some community participation experiences that are generally positive, but also from a range of settings and with a variety of objectives and approaches. The examples cover specific disease control initiatives (Ghebreyesus et al 1996, Katarbarwa et al 2002), primary health care development (Perry et al 2003), health promotion (Greene 2003), water and sanitation improvement (Breslin 1998, Mukungu 1998, Musabayane 1998), involvement of women (Katarbarwa et al 2002), and district health development (de Savigny et al 2002), and these in a range of countries (Cuba, Ethiopia, Bolivia, Uganda, South Africa, Zimbabwe, and Tanzania).

Case Study 1: Community participation in health promotion in Cuba (Table 4)

This case study from Cuba (Greene 2003) reports the experiences of implementing community participation schemes at national level. This initiative received support from highest levels, with strong ties to communist principles of community self-reliance, solidarity, fraternity and equality. While the level of community participation was claimed to be high, the communist principles are likely to have influenced this, as well as the approaches to implementation and the monitoring of the programme. The country's priority on health promotion is disease prevention, and there is a widely acceptable policy throughout the country that allows community participation initiatives, and the devotion of the president himself to such health initiatives including his appearances at various public and media presentations especially in case of HIV/AIDS is a demonstration of the presence of a *strong political will* of the federal government that is a stimulus to other political leaders and the general public to participate in public health issues. Community participation basically consisted of information giving and education in health promotion and a situation analysis of the health of the local population. To ensure that community participation is effective, the federal government through its health ministry has adopted various methods including the use of local opinion leaders, formation of health committees, women's associations, training programmes of professionals and the general public and targeting neglected groups. There has been a strategy for motivating those performing well by actively engaging themselves in health promotion campaigns and infant day care or in adult education teaching programs, by awarding certificates. A number of youth centres were established, and youths participated in singing and dancing which was not only envisioned to maintain their youthful outlook on life but also as a source of income generation for their centre. Community participation is also high in the case of health care administration and the community themselves recognize their pivotal opportunities given to them as stakeholders in their own health care system while the government remains a leader in providing framework for regulatory purpose of weaker areas. This has also created a sense of ownership of the system rather than everyone thinking that health promotion is a responsibility of the state.

Case Study 2: Community participation in malaria control in Ethiopia (Table 5)

Designed during the civil war, a community-based malaria control program was anchored on grass-root participation as a community health initiative in Tigray region, Ethiopia that received support from a key body – the Social Affairs Committee. Unpaid community health workers (CHW) who volunteer to work for the programme were democratically elected by the general public (which is an important stimulus to public participation), preceded by meetings with personnel from the National Malaria Control Program or Health Bureau. The latter shortlist the volunteers and define the responsibilities and criteria for their selection (which is important element for identifying good community representatives), and a high level of commitment was expected (such as weekly report writing). Such a malaria control program increased activities in malaria control, sensitized successfully the local populations on the mosquito bite prevention and avoidance of potential mosquito breeding sites, early detection of symptoms and signs, standard dosage of chloroquine for malaria episodes or as a prophylaxis in pregnant women, and increased the sense of ownership of what of the community. Also, the involvement of the community meant cost savings to the government as labour charges because of the use of unpaid (volunteer) CHWs. Organized through community health workers and health committees, the public were mobilized to participate in the prevention of malaria in pregnant women and in morbidity and mortality control activities. Through focus group discussions, community members and CHWs were asked to express their opinion as to why the malaria problems were so experienced, after which

changes were made to improve coverage of the vulnerable groups. There was also an element of cost sharing to establish a village revolving fund scheme to finance specific program activities to augment budget support from the regional government and the WHO (Ghebreyesus et al 1996).

Case Study 3: Census-Based Impact-Oriented (CBIO) approach to PHC in Bolivia (Table 5)

Community and NGO (Andean Rural Health Care and its sister organizations) input was seen as essential to the delivery of a more comprehensive (as opposed to selective) model of PHC, and have been in operation in some parts in Bolivia since early 1980s. Through a CBIO approach recently adopted in Bolivia (and whose model is tried in other countries of south and north America (including the U.S.A), a great deal of responsibilities were given to paid community health workers, such as who were selected instead of being elected. One of the reasons for the success of this approach is that, at least some of the program staff are long-time members of the same communities they serve and the program has been built on principle of trust based on open and open communication between program staff and local communities. The new approach was stated to be much more responsive to local needs, and through the regular discussions between the CHWs and the community, community health knowledge increased. High service coverage of about 75,000 people in three district ecological-cultural regions in the country has been facilitated by involving CHWs in the disease-epidemiologic surveillance system and services provided through home delivery (through routine systematic home visitation), when needed, and based on local health priorities, and with community members being strong partners in the planning, implementation and evaluation of the program activities. Identification of new services to provide to populations in need or the identification of the need for improving the existing types of services including the actual allocation of resources are based on information collected from community-oriented demographic and epidemiologic surveillance. As a ground for ensuring that program activities are performed successfully, various activities have been designed, including among others, the employment and training of field staff, establishing working relationship with local communities, designing, piloting and refining methods for obtaining opinions from community members on their health priorities through open individual or group dialogues and methods for better delivery of health services to prioritised health needs. Due to its relevance and viability, the CBIO model has attracted attention from other countries, in the academic, NGO and government programme departments who are interested in undergoing community participation strategies in health (Perry et al 1999).

Case Study 4: Involvement of women in Community-Directed Treatment with Ivermectine (CDTI) in Rekungiri district, Uganda (Table 6)

CDTI is one of a multi-country strategy of mass chemotherapy towards eradicating onchocerciasis and other vector-borne diseases, where the role of the community is recognized as essential. Community participation is encouraged through giving the public an opportunity to select their health workers, deciding on the best distribution channels and practice, where and how the drugs should be stored and the number of CHWs should be involved in the program and participatory evaluation meetings on the performance of health staff and the success or failures of the program in general. One of the distinctive strengths of this program is that communities were given the opportunity to select their CHWs from outside the communities, as other studies reveal that communities may accept outsiders more than 'insiders'. After the involvement of women as CHWs was promoted, it was found that they generally performed better in terms of

service coverage than their counterpart men and in some areas they were more knowledgeable of the groups of people that deserved to be served than their counterpart men. Intersectoral linkage between the MoH, local district health services, the Carter Centre, Global 2000 and the Church improved considerably, and the schemes were found to be self-sustaining, to do what with no external funds provided (Katabarwa et al 2002).

Case Study 5: Participatory Hygiene and Sanitation Transformation (PHAST) in South Africa, Uganda, and Zimbabwe (Table 6)

The PHAST initiative has been implanted widely, with community participation a central feature, offering an approach 'learner-centered awareness creation', under which local communities were let to the attention of the need for environment sanitation, hygiene and conservation as an important factor for better health and sustainable development. Under support from government ministries of health, agriculture, natural resources and work, communities in beneficiary countries as mentioned have obtained an opportunity for appraising environmental health projects in areas such as water and reforestation, including their involvement in planning, management, evaluation and cost sharing programs in the projects agreed commonly to be initiated. All these initiatives could be possible given the supportive policy framework that emphasize on devolution of decision-making power from central level to local populations through their local government authorities. For example, in all the countries where the PHAST Project was implemented, consultations were made by the project management staff with the local populations to see what could be done, e.g. where to dig wells and their willingness to share the costs of running the projects, including provision of volunteer labour power or payment out of pockets. Through health committees, local populations were made aware of their ownership of - and their responsibility towards making the projects initiatives succeed. This is evident by their actual participation in the cost sharing and voluntary labour initiatives, and owing to this, PHAST has demonstrated increasing coverage of water and sanitation facilities (Breslin, 1998; Mukungu, 1998; Musabayane 1998- all in I.C. et al., (*edit*). 2000).

Case Study 6: Tanzania Essential Health Intervention Project (TEHIP) (Table 7)

TEHIP was a donor-supported multi-faceted project with the aim of strengthening district health planning and management, with community participation as a central theme throughout many key activities. The project was implemented alongside government decentralization (both general as well as health sector) and other reforms in the health sector, including donor coordination. Simple but constructive tools were developed by the TEHIP research team that could be used by communities, through the district and health facility health management teams and Boards, for such activities as evidence-based planning, drug management, and health service evaluation. Participatory Action Research (PAR) with involvement of TEHIP research staff, health workers and local populations' representatives in the collection of morbidity and mortality data to supplement the health facility-based one, have been adopted, and feedback is usually provided to local communities through scheduled official meetings organised by TEHIP in liaison with the local government and health authorities. Health workers became more accountable to the local community, and they were assisted in planning methods. The financial resources as well as technical input from the donor side were crucial factors in the success of this project. To translate the national political ideology of self-reliance into practice, TEHIP has collaborated with the office of the district council's executive directors (DED) of Rufiji and Morogoro Rural districts to initiate community-based health facility buildings. In this regard, communities have been sensitised to, and actually

participated in, cost sharing programmes, including their contribution of labour time and efforts in the construction of health facility buildings. This has reduced construction costs by 40-60%. Also, by *promoting ownership of health facilities by local communities, TEHIP has used facility rehabilitation as an entry point to engage the 'community voice' in the whole process of planning and implementation in the district* (de Savigny et al 2002; TEHIP News 2000-2002).

Table 4: Case study from Cuba to illustrate community participation in health

Case Study	Underlying Factors	Proximal Factors	Outcome
<p>Community Participation in Health Promotion in CUBA</p> <p><i>Greene, R (2003)</i></p>	<p>Political support from the Government. Cuba is one of the countries to implement health promotion policy that reaches all the population in the country. Senior political leaders including the President are in the frontline to support community-oriented programmes. This is a key incentive to communities to support the system</p> <p>Recognition of Community Input. Government belief that a strong health system cannot be build without community participation and building a society with the culture of self-reliance</p> <p>Strengthening public health through health promotion with community participation, to enable the country to meet the contemporary challenges of resource scarcity for health and burden of disease</p>	<p>Semi-autonomous, time-efficient and transparent health directorates legally formed at all levels (Ministerial, provincial, municipal) for implementation and monitoring of policy programmes, including fund raising based on community mobilisation</p> <p>Committee for the Defence of the Revolution (CDR), a community group led by one resident family member in a defined community who are trained first in order take responsibility for giving information and education to about 30 families</p> <p>Health situation analysis conducted by the family doctor team at the end of each year, to identify local health problems, define priorities and means for intervention. This is facilitated by the doctors meeting 30-40 persons representing various community representatives and various organisations</p> <p>Federation of Cuban Women (FMC) involved in <i>Pap smear campaigns</i> for cervical cancer screening in women</p> <p>Health Education Initiatives under the Health Education Directorate provides training programmes about public health issues for political leaders, journalists, and community in general special groups like children, adolescents, and sex workers</p>	<p>Community Voice. Opinion leaders consulted about community health problems – through appropriate use of CDR and FMC</p> <p>Trust: Community trust in the existing political directorate</p> <p>Motivation: State political directorates awarding certificates and other kinds of recognition to specialist multidisciplinary teams who are committed to work on community based interventions e.g. on infant day care and serving the elderly</p> <p>Relatively higher state allocation of resources for the use of mass media and training of journalists and special groups on community health promotion aspects</p> <p>Thus, all the above have contributed to rising community sensitiveness and sense of ownership of the health delivery system and their willingness to continue participating in health promotion campaigns</p>

Table 5: Case study from Ethiopia and Bolivia to illustrate community participation in health

Case Study	Underlying Factors	Proximal Factors	Outcome
<p>Community Participation in Malaria Control in ETHIOPIA</p> <p><i>Ghebreyesus et al (1996)</i></p>	<p>Political support: Presence of Social Affairs Committee of the local government supporting community health initiatives such as environmental management for malaria vector control</p> <p>Recognition of Community Input: Communities recognised as a focal point for needs identification for vector control</p>	<p>Community based focus group discussion: facilitates the democratic election of volunteer CHWs; identification of priority needs and suggestion of possible solutions</p> <p>Training: Unpaid community health workers totalling 681 trained in malaria to serve the population. Also responsible for the general health of the population.</p> <p>External resource inputs: Government and donor (WHO) covering the cost of reporting materials and drugs. Supervision of CHWs supported by personnel of Malaria Control Programme</p> <p>Information flow: Weekly reports submitted by CHWs to the MCP offices. Feedback for the compiled data sent from Zonal Health Departments, Social Affairs Committee and MCP offices</p>	<p>Services Delivered: A significant proportion of the rural communities at risk of malaria now receiving treatment at village level</p> <p>Knowledge enhanced: Voluntary CHWs have helped to educate local people on appropriate detection of signs and symptoms of malaria and treatment</p> <p>Sense of Ownership: Many community volunteer groups elected by community members themselves</p> <p>Cost saving: Involvement of voluntary CHWs indicates some savings on the total cost of the malaria control programme and widens the prospects for the sustainability of the scheme</p>
<p>Census-Based, Impact-Oriented (CBIO) Approach to PHC in BOLIVIA</p> <p><i>Perry et al (2003)</i></p>	<p>Political Support and policy framework: Presence of political environment that allows participation of NGO's in health development affairs</p> <p>Recognition of Community Input: Understanding that a selective PHC approach alone would not succeed, therefore need for looking at elements of a comprehensive PHC that emphasises community participation</p>	<p>Trust: CHWs selected from the same community, having lived there for a long time, and their frank and open communication with community members</p> <p>Routine systematic home visits: To record fertility rates, illnesses, disability and mortality, to update population census, and to discuss with local populations about health problems</p> <p>Information flow: Regular staff meeting with communities for discussion of topical issues</p>	<p>Needs based service delivery: Health services are planned and provided based on local health priorities determined by locally acquired epidemiologic information and through discussion with local people</p> <p>Knowledge enhanced: Interaction between CHWs and local population during disease surveillance and discussions offers opportunity for local population to be educated on various health problems before they identify the priority ones</p> <p>Coverage: 75,000 people served</p>

Table 6: Case studies from Uganda, South Africa and Zimbabwe to illustrate community participation in health

Case Study	Underlying Factors	Proximal Factors	Outcome
<p>Involvement of Women in Community-Directed Treatment with ivermectine (CDTI) in Rukungiri, UGANDA</p> <p><i>Katabarwa et al (2002)</i></p>	<p>Political support: CDTI officially launched by the Government in 1997 as part of multi-country strategy</p> <p>Recognition of Community's role: community sensitisation and involvement in programme design was viewed as a key factor for success</p> <p>Mandates: decision-making and managerial powers devolved to local government authorities</p> <p>Socio-cultural considerations: exploratory studies in the country and in neighbouring countries of Tanzania and Zambia have revealed that it is traditionally believed that a healer or person from far away is better than that one close to your homestead. This was considered when giving communities a chance to select their CDHWs</p>	<p>Selecting of Community-Directed Health Workers (CDHWs) from the community; how many should be and which community area they should work</p> <p>Ensuring the CDHW are properly accountable; organising their own distribution exercises</p> <p>Information sharing: regular meeting between implementers, community leaders and mass or selected community members through <i>participatory evaluation meetings</i></p> <p>Gender sensitivity: recognition of the fact that women play an important role as CDHWs</p> <p>Health education: Was an important package to raising public awareness and change their beliefs and attitudes to ivermectine</p>	<p>Service Delivery: The successful CDHW was judged only if they cover 90% of the planned target population</p> <p>Intersectoral linkages: NGO's work with communities, mission agencies, CDHWs and public organs to make the process a success</p> <p>Empowerment and Confidence building: Involvement of women in the programme activities have increased the general public's and women's confidence of the ability of women if given an opportunity, as in some areas women were more accepted and proved to work the same or better than men</p> <p>Incentives: As it was made open from the start of the programme, no demands for external incentives have been experienced from communities. This implies a degree of self-reliance</p>
<p>Participatory Hygiene and Sanitation Transformation (PHAST) - water, sanitation, environment, and community health (South Africa, Uganda, Zimbabwe)</p> <p><i>Breslin (1998); Mukungu (1998); Musabayane (1998)</i></p>	<p>Political support: Strong commitment by governments to fight poverty and poor health among populations through support of all initiatives aimed at improving community health conditions</p> <p>Legal frameworks set to enforce action</p> <p>Recognition of Community Input: Attention has been to the fact that <i>long-term sustainability</i> of projects can only be ensured if there is <i>community involvement</i> in the planning and management of such projects</p>	<p>Learner-centered awareness creation (health-education) and local-action planning (South Africa)</p> <p>Voluntary community cost-sharing system: e.g. for the operation and maintenance of facilities (Uganda)</p> <p>Participatory management and evaluation with local community leaders and sharing information with the general public (all the three countries)</p>	<p>INGO's adoption of the PHAST method in the rest of the country after successes in Uganda and Zimbabwe</p> <p>Empowerment: communities feeling empowered for being involved in defining priority needs and interventions. Central government powers devolved to Local government</p> <p>Service Delivery: Self-identified needs and projects has improved the accessibility to many populations in need of water, latrines and other sanitation facilities (all countries)</p>

Table 7: Case study from Tanzania to illustrate community participation in health

Case Study	Underlying Factors	Proximal Factors	Outcome
<p>Tanzania Essential Health Intervention Project (TEHIP)</p> <p><i>(TEHIP News 2001/2002; de Savigny et al., 2002)</i></p>	<p>Political support: decentralisation of planning and managerial functions backed with private-public mix and intersectoral collaboration in health is explicitly recognised by the government as an essential step towards effective health interventions.</p> <p>Recognition of Community Input: Both TEHIP and the MoH understand, as they explicitly state in their policy missions, that without needs-based planning, interventions are at risk of failing to achieve the predetermined objectives.</p> <p>Need for working through Local Health Authorities: To ensure that plans are compatible with the existing local political framework and socioeconomic conditions, a policy framework for working through the established local health committees and leadership has been set by the government</p>	<p>Participatory action research (PAR) whereby TEHIP researchers involve local communities not only in responding to exploratory questions but also in collecting demographic data that facilitate in needs-based planning using the burden of disease approach</p> <p>Strengthening local health management capacity: through awareness raising by TEHIP team and explicit criteria for assessing performance of the planned activities within the given budgets, local communities have been given a challenge to identify the poorly performing health workers and making them accountable through appropriate channels such as public meetings or health committees</p> <p>Financial support: TEHIP has been providing matching funds for community-initiated health projects as it understands that external support at least in the initial stage is often required as a stimulus of community participation. To enable them reach the remote areas, the CHMT in both districts where TEHIP operates have been equipped with radios in their respective offices, mobile radios in their motor vehicles, and each of the co-ordinating health centres was given a motorcycle while dispensaries were offered bicycles to facilitate the day-to-day community oriented health activities</p>	<p>Health facility rehabilitation whereby communities have been sensitised and contribute their resources in material terms or in-kind.</p> <p>Empowerment and self-reliance: communities have increasingly been aware that maintaining health facilities and ensuring that limited health resources are properly allocated is their own responsibility. Their continued cooperation with community health workers shows considerable success</p> <p>Capacity-building in health planning has been the most important mission of TEHIP. District planning authorities have gained much from TEHIP lectures and field testing and in the use of user-friendly software package for data handling and analysis for planning-designed by TEHIP</p> <p>Discussions and Dialogues: Open discussions and dialogues have been used as an important consultation instrument for eliciting community preferences and priorities in health</p>

4.4 Community participation as an impetus for equity and good governance in health

Community participation is reported to foster efficiency, self-reliance, *good governance* and democracy through building capacity for decision-making and control at local level (GTZ & ULB 2002). Similarly, Krogstad and Ruebush II (1996) argue that community participation is one of the most practical and effective forms of democracy and can be effective only when the interests or the concerns of all members of the community are considered and valued. At a W.H.O. European Region meeting towards the end of the 1990s, a concern was expressed for the recent market-driven cost containment policies in Europe, leading to a call to give greater focus back to human dignity, *equity*, *solidarity* and professional ethics (Southon and Braithwaite 1998).

While in practice some sub-Saharan African countries' health policies have considered the need for reviewing current strategies with a focus on equity and equality (McIntyre and Gilson 2002), Schuftan (2003) observes a 'top-down' approach in the renewed global interest in poverty alleviation and international equity. He diagnoses that such an approach ignores the contributions the poor themselves have to make to the debate, and implies that failing to include the contributions of the poor will lead to a failure of policy. This echoes examples given earlier where public health strategies are generally more successful when there is active participation of the local community.

At the same time, Schuftan (2003) comments that the definition of 'poor' has been weighted towards professionally-determined definitions instead of locally defined definitions, arguing that the communities themselves are best qualified to identifying the poor amongst themselves. However, with the increasing inclusion of community views in poverty diagnosis and designing poverty reduction strategies, as evidenced by a review of selected PRSP Progress Reports (e.g. Tanzania, Uganda), it may be time for a comprehensive evidence-based review of this important issue.

It is also widely documented that encouraging community participation would help to reduce inequities and inequalities in health through building local capacities and empowerment and as *an important element of good governance* in decentralised settings (Wolman 1990 as cited in Subrahmanian 1999 p 69). Schuftan (2003 p 2) claims 'the battle against poverty, ill-health and malnutrition calls for liberation, empowerment, self-reliance and partnership', and this mission has come to the fore of agenda in the current strategies for globalisation. However, examples show that this is more difficult to achieve in practice. For example, with reference to the empowerment of local governments and local communities in decentralised regions of Brazil, Souza (undated) reports that despite some notable degree of involvement of local governments and communities in policy formulation, experience shows that so far it has been difficult to achieve equitable and sustainable participation in a country with high levels of regional and social inequality.

Some authors warn that, in allocating resources, the equal treatment of unequals would perpetuate inequalities (McIntyre & Gilson 2000). This suggests that, unless a public health system is made considerably more progressive (i.e. favouring the disadvantaged or poor), an acceptable final outcome will not be obtained. For this reason, Schuftan (2003) argues that focusing on equity is a step *towards* social justice, and does not necessarily guarantee social

justice. It is critical therefore, that improving equity is *explicitly* prioritised as a means for addressing problems of poor and disadvantaged groups.

So can there be an internationally accepted approach towards ‘equity’? A recent review by EQUINET found that, as is the case of the term ‘community participation’, *equity* has been viewed and defined differently within and across various countries, and for this reason, the approaches used to address problems relating to inequity in health have also varied. Considering the many dimensions and perspectives of health as documented by various authors, EQUINET proposes the following definition as the commonest denominator based on which strategies to address *equity* should be directed: “*it is a condition in which unnecessary, avoidable and unfair differences – be it in health or other social dimensions of living, should not be experienced*” (EQUINET, 1998). In this case, the concern is that placing an emphasis on individuals’ responsibility for their own health is a narrow focus that is contrary to the emerging challenges in public health today and undermines the role of collective strategies towards addressing community health problems. Also, EQUINET’s definition explicitly includes power relations in defining equity: ‘Equity in health includes the extent to which different groups of people have the opportunity for participation and the power to direct resources towards their health needs, and the policies that influence this’.

Good governance, it is argued, is a means of improving equity. But what, in practice, does good governance consist of? As recognised by the EQUINET framework presented earlier, there are underlying as well as proximal factors. That is, not only do you need the right environment, legal backing or political mandates, but you also need the mechanisms to work well. As for mechanisms adopted by countries to increase community participation, most of the articles identify the formation of health boards and health committees at various levels where community preferences in health can be represented – at (a) village, health facility, division and ward levels (that can be commonly called grass-root level); (b) municipal level (e.g. municipal health boards) and (c) provincial level (e.g. in federal state governments like Nigeria, Cuba and the Philippines). At all these levels, it has been made evident that communities participate in the election or selection of their representatives and voluntary health workers (e.g. village health workers) as well as in the formation of sub-committees or unions to represent the voice of some interest (mostly disadvantaged) groups. Voluntary work, such as construction of health facilities and cost sharing through community insurance funds, are taken as key indicators of community participation in health service delivery.

Many articles and technical reports mention other instruments through which community members can express their views and participate to set priorities for health, and these include suggestion boxes at health facilities and other complaint mechanisms, patient committees in local health centres, public meetings, and informal and formal surveys. Annex Tables 1 and 2 highlight approaches used in a number of countries in their attempt to go about community participation in health.

4.5 Why is community participation inadequate?

This review has until now demonstrated quite a variety of approaches to community participation, as well as a variety of evidence showing the success of community projects in health. It is useful at this point to reflect on why in many circumstances, the actual participation of the community is inadequate, or has not lived up to expectations. This section covers problems of definition, barriers to community ‘empowerment’, inadequate

representation and communication, and resource scarcity. A summary of selected findings related to evidence of inadequate participation is shown in Table 8.

Definitional problems

As was pointed out earlier in the findings of this paper, community participation is understood in a variety of ways. As noted by Flower and Wirz (2000 p 177) *'the notion of participation is often cited, but seldom defined'*. Participation in health can range dramatically from relatively passive involvement in predetermined activities to full control of organisations and health related affairs. For example, Madan (1987 p 617) views that the word 'involvement' is ambiguous, as it might mean letting someone on in the system on voluntary basis through persuasion or education, or rather, through pressure or coercion. While on the one hand this reflects the complexity of the concept of community participation, and the diversity of cultures in which it is applied (Zakus *et al* 1998), such lack of common understanding brings confusion in application of the concepts in practical terms, as well as in comparing and evaluating community participation projects (Madan 1987, Zakus *et al* 1998, Litva *et al* 2002).

Barriers to community 'empowerment'

Empowerment means having the power to influence outcomes, not as a theoretical notion but as a real possibility. As Brownlea (1987) argued *'participation is supposed to make a difference, and not simply to become a process'*. Also, empowerment should not mean simply accepting a decision *'participation may be seen not so much as influencing the decision, but rather more achieving a platform for the acceptance of a decision already made elsewhere in the system'* Brownlea (1987 p 605). This argument is supported by evidence from a recent study on cost sharing system in Zambia whereby some community respondents were heard complaining that, 'we only come to know of a health project when they want free labour. How can one become involved in health services when the services are planned and brought to us?'. Meanwhile, health workers were sceptical of community involvement even when voluntary labour was concerned (van der Geest *et al.* 2000 p 60). 'Even where *preferences* are picked-up through participatory processes, they would not necessarily have an impact on the way services are managed. Upward feedback must be strong, and control over decision-making sufficiently devolved to translate *preferences* into systematic change' (Subrahmanian 1999 p 74). Even unintentionally, therefore, the ultimate end of community participation has often been the consolidation of power rather than achieving the ideal of broad-based local involvement.

The literature has reported an increasing advocacy for, but to date few achievements in, community empowerment, including their participation in setting priorities, financing, implementation and management of development projects. In this regard, it has been observed that most development projects, including those in the health sector, have been designed by professionals based in government ministries or regional capitals, while communities have remained as spectators or reserves watching the game or acting as mere implementers of the predetermined activities under the auspices of professional management teams.

Also, there are other factors in the health system that may restrict the priorities of the community from being adopted if they do not accord with priorities as reflected in the current system. These can be factors that are explicitly recognised as being important for determining health priorities (e.g. burden of disease and cost-effectiveness analyses) or factors that are implicit within a government system that changes only very slowly (e.g.

budget incrementalism). The explicit factors do not necessarily work against community interests, as evidence such as disease burden or cost-effectiveness can be fed into the community participation mechanisms to improve responsiveness and impact of health services.

Inadequate representation and communication

Initiatives for community involvement have also failed or reported poor performance due to lack of trust between the community and those representing the community. For example, in the UK community health workers have been criticised by their own constituency for appearing to too be closely allied with the health service managers (Zakus et al 1998). In Uganda, the public in one district expressed their dissatisfaction with their democratically elected local leaders, and instead preferred to set priorities themselves (Kapiriri *et al.* 2003).

A related but different problem has been the lack of representation of the community at key decision making fora. This relates to not only the community in general (van de Geest et al 2000), but also segments of it, such as women (Kaseje et al 1987, Brieger et al 2002). For example, a study of decentralisation under the cost sharing system in the Western Province of Zambia found a significant proportion of people claimed they were not involved in the planning and evaluation of health services. Such community members expressed their lack of faith in the existing health care system and felt that it was not ‘theirs’, although policy-makers assumed that local people were involved (van de Geest et al 2000). Similarly, Tenbensel (2002) claims that mediating bodies, such as health committees or health commissions, whose task it is to interpret information about public values, end up (whether intentionally or unintentionally) distorting the information or interpreting it in an ambiguous manner. Abelson (2001) reports from Canada difficulties in choosing the right mix of people to represent the community, a finding which supports previous authors that the difficulty in creating health care policies that reflect community values rises from the fact (among others) that no single society is made up of single ‘community’, and therefore the process of sorting out which community values are incorporated into health care policy becomes inevitable (Emmanuel 1991 as cited by Ubel 1999 p 264). Also, while the wish may exist on the part of the health system representatives to involve the community, there may be a lack of knowledge on how to involve the community (Flower and Wirz 2000).

These issues are also relevant at the clinical level, where ‘shared decision-making’ (SDM) between clinicians and patients is a means by which communities, via individuals, have more say over health care options. However, Sculpher et al (2002) warn that there is risk of conflicting preferences to rise (a) between different categories of patients and (b) between patients and clinicians in collectively funded health systems, unless clear distinction is made between clinical guidelines (focusing on effectiveness of alternative forms of management) and the ‘system’ guidelines indicating which interventions will the system fund from collective resources (in a cost-effective manner). In other words, the authors argue that SDM is desirable to guide medical practice, but there is need for defining the limits or level at which clinicians can involve their clients (patients) in deciding on which kind of medical practice they deserve under ‘what’ context or condition.

‘Projectization’ of community participation

Much of the evidence on community participation originates from projects, pilot studies and/or experimental studies (see Table 2). Sometimes, but not always, these are heavily influenced by researchers or others external to the communities where the project takes

place. This can be both at the design and the implementation phase. From a generalisability point-of-view, such influences can be seen as having negative consequences, as it reduces the extent to which the results can be extrapolated to other settings ('scaling up'), where the same external actors will not be present. The negative aspects of 'projectization' of community participation include such factors as inadequate time frame to show benefits, unrealistic a priori expectations of what community participation can achieve, unsustainable levels of funds available for projects, and the distorting effect of including research in building community participation. What has been particularly damaging, according to Rifkin (1996), is the perception of community participation as a magic bullet to solve all problems arising from health and political power. Together these factors may cause community participation to be shown as being more successful than it really is (due to outside intervention such as technical assistance and funding) or less successful than it really is (due to not being truly community-led, but instead researcher-led). In particular, authors have observed that most of the so-called community based initiatives especially in developing countries have been designed and piloted in an experimental fashion, and most of them have failed to demonstrate beyond reasonable doubts how the approaches they used could be effectively and sustainably replicated or adopted on a large scale. Possibly it is because of understanding of this limitation that some authors (e.g. Addmore *et al.* 2003) have attempted to point out that 'community participation' is a concept that needs to be adopted through systematic approaches and as a learning process in a process rather than being conceptualised as a short-time achievable activity.

Resource scarcity

Even with community participation, the actual resources available for health care will not change enormously, although the potential importance of raising additional resources from the community should not be underestimated. Lack of resources does not mean simply shortage of money, but motivation and skills should also be seen as resources. For example, Nyandindi *et al.* (1994) found that teachers were not effective in promoting dental health among school children due to lack of knowledge in oral health matters including skills in tooth-brushing, lack of training of teachers to carry out the task, low priority given to health lessons, shortage of time and teaching materials and heavy workload for teachers at school.

Table 8: Reasons for the poor or inadequate performance in public participation in health

Reason(s) for poor performance of participation	Country Area & Author
Lack of knowledge among officers (e.g. planners, managers) of mechanisms or models for ensuring effective participation	International NGOs (Flower & Wirz 2000)
Difficulty in choosing appropriate mix of representatives to ensure public views are incorporated in decision making	Canada experience (Abelson, 2001)
Decisions-being led by medical professionals and other elite groups	All authors cited in this document
Bureaucrats and medical professionals not being in favour of translating the concept of community participation into practice	India (Madan 1987), Rwanda (Freyens et al 1993), Rifkin (1986)
Gender imbalance and neglect of women and other minority groups	Kenya (Kaseje at al., 1987); Nigeria (Brieger et al. 2002)
Overemphasis on cost-effectiveness and efficiency as selective approach to planning, resource allocation and delivery of PHC	Bolivia, South America (Perry et al. 1999),
"Politicians and professionals feeling vulnerable when their muddled thinking and inadequate evidence-base are exposed to	New Zealand (Klein 2000) as cited by Tenbensen (2002 p 176)

Reason(s) for poor performance of participation	Country Area & Author
external scrutiny”	
Sometimes community capacity to contribute to public health decisions is low or absent even if they wished to	Zakus et al. 1998 p 8, Beeker et al 1998 p 834
Personal time expenditures, information compilation and dissemination limit involvement of community members	Zakus et al. 1998 p 7
Health budget allocations are based on historical incrementalism that are neither efficient nor equitable	Pakistan (Green, A et al. 2000 p 1025)
Complexities resulting from communities being heterogeneous both in terms of demographics and interests	Brazil (Souza, C), Zakus et al. 1998 p 6
Community representatives such as community health workers may not be capable to serve the community in the right way	Zakus et al. 1998 p 3
Lack of common agreement about how to best develop community participatory approaches for health improvement	Rifkin 1996 p 80

A study to assess community participation in health priority setting in four districts in Tanzania (Mubyazi et al 2003) found the majority of village residents dissatisfied with district local government health authorities who have neglected their demands for qualified health workers and laboratory facilities at dispensaries, and complaints about shortage of drugs for some diseases which are not government priorities. There was a common report in all districts that local health committees were mostly weakened by district-level managers who undermined the ability of community leaders to represent their people at district council meetings. This evidence is supported by a recent literature review and meetings by EQUINET GoVERN group that indicate that weak district and primary health care systems undermine participation - they cannot respond to demands from communities, the staff do not have the resources or time for it, the management skills are weak to integrate it, and so on. This seems to imply a vicious cycle: inadequate resource allocation to the clinic level undermines services, which undermines the support for participation, weakens the community links and inputs needed to exert pressure for more resources or to build the capacity to benefit from new resource flows. Also, this finding is supported by Meuwissen (2002) who observed that, many health workers do not master the techniques of participatory approaches, and themselves being part of the health system, have their own interests that do not always coincide with the idea of sharing responsibility with the community.

4.6 Suggestions for improving community participation, and future research agenda

In the reasons for inadequate participation (section 4.5) lie many of the solutions. This section identifies what commentators from the literature have to say about the solutions they see for improving community participation, either in terms of further research or specific actions in implementing programmes. For example, Zakus et al (1998), citing other authors, identify the following conditions for improving community participation:

- Goals and expectations from participation must be mutually identified and agreed upon by all involved.
- Understanding community’s needs, resources, social structure and values in the first place in order to create collaborative partnerships with communities.
- The existence of suitable formal organisation e.g. health- committee, board, coalition or network, established and sustained with adequate input from communities.

- Organs implementing activities in a sensitive, open and coordinated way.
- Basic skills and competence in five domain areas for those [intending to-] implementing participatory activities: community mobilisation; problem solving; priority setting; health information collection and analysis; health intervention planning and delivery; and programme evaluation. For this reason, there must be an investment in training new members of community organisations.

Similarly, Laverack and Labonte (2000) stress that any planning or programme that is intended to achieve community empowerment should support the community in the identification of issues that are important to their lives and enable them to design strategies for resolving them. For this reason, health programmers or promoters have to perform the following duties: (i) improving community participation; (ii) enhance problem assessment capacities; (iii) strengthen/develop local leadership; (iv) build empowering organisational structures; (v) improve resource mobilisation; (vi) increase stakeholder control over programme management; and (vii) create an equitable environment with outside agents.

The suggestions of both these authors for improvements in community participation in health can easily be fitted to the EQUINET conceptual framework (presented in Table 3), where underlying factors, proximal factors, and impacts achieved are distinguished. Therefore, this framework, once fitted with all the factors and elements involved in community participation, can act as a framework for proposing solutions.

In terms of furthering understanding in community participation, Chabalala (1995) emphasises that improving the operationalisation of the concepts are paramount: “the issue of CP in health and development problems will always remain meaningless if it is not translated into the methodology that is going to make the whole concept a reality”. And, as quoted earlier, Tenbensel considers it important that ‘best’ practice for community participation is devised based on successful and generalisable experiences already reported, as opposed to putting together best practice based on first principles (i.e. ideological reasoning). In this vein, Zakus et al. (1998) underline the need for more research and information “...more experimental evidence is needed on both small and large scale, and increased sharing of experience, both negative and positive, are needed to maximise the potential of community participation in pursuit of Health for All”.

Table 9 summarises the main areas identified for further research and reporting. These include:

- How to include all stakeholders, especially vulnerable groups (e.g. disabled, women)
- Reporting of experiences of health service development under ordinary conditions
- How priority setting works in decentralised settings, and the role of mediating bodies.
- The importance of developing community capacity for participation
- Balancing diverse community views on controversial issues for spending public money (e.g. fertility regulation, organ transplantation)
- The importance of contextual factors in community participation, to aid the development of a flexible framework to guide community participation initiatives

Table 9: Areas identified as requiring further research based global experience

Area(s) needing further study	Author(s)
Disabled people's participation in planning processes of organisations that run programmes for them at either an NGO or statutory level	Flower & Wirz (2000)
How health services can be delivered effectively in ordinary, typical field situations rather than the traditional tendency of more closely-supervised studies/field trials assessing the effectiveness of specific interventions	Perry et al. (1999)
How members of the general public choose to prioritise health services and treatments	Bowling 1996, Dixon 1991; Richardson et al. 1992; Stronks et al. 1997
How better can health resources be allocated within decentralised settings	Green, A et al. (2000 p 1024), EQUINET (1998)
How the involvement of women in community directed service delivery would help to improve coverage of services delivered (e.g. mass drug distribution)	Brieger et al. 2002
Role and relevance of mediating bodies in interpreting and digesting information about public values and preferences	Tenbenschel (2002)
Public opinions and preferences for being involved in particular types of rationing decisions, and the degree of the 'involvement' desired by them	Litva et al. (2002)
How municipalities are implementing sustainable development policies with a component of community participation, and how individuals are selected to have access to them	Souza C (Undated), Wyss K et al (2001)
How to operationalize new concepts, such as the testing of relationships between community participation and increased community capacity	Beeker et al. (1998 p 839)
Public values in resource allocation for organ transplantation	Ubel et al. 1996; Ubel & Loewenstein 1995, 1996a,b
Interaction between individual (local) opinion leaders and the collective process of negotiating a change by re-orienting professional norms	Locock, et al. (2001)
The role of various contextual factors in influencing both the methods employed and the outcomes of community decision-making process	Abelson, J (2001)

5. Discussion, conclusions and recommendations

In the findings section of this report, there has already been quite some discussion about concepts, experiences and conclusions, as reported by the authors of the reviewed publications. The purpose of this section is to pick up some of these discussions and take them further, incorporating the views and experiences of the report authors (GM & GH). The discussion covers four topics: how the concept of community participation has been applied in health; the arguments for community participation, and links with governance and equity; the usefulness of the EQUINET framework. Recommendations on the future research and implementation agenda are contained within each section.

5.1 The application of 'community participation' in the health sector

This review has presented considerable evidence showing the variety of ways in which community participation has been understood and applied, and concludes that there is no clear-cut way or a universal approach to community participation. Community is a word

much used in the health literature, whether community health, community responsiveness, community preferences, community participation, community outreach, etc. It is clear, however, that these terms can describe *actual* community involvement, ranging dramatically from relatively passive involvement in predetermined activities to full control of organisations and health related affairs. In some cases, it is a passive term, where the community is waiting to be intervened, such as ‘community outreach’. However, in most cases, the term ‘community participation’ is used in the recognition that some input is required from the community if any public-oriented project has to achieve its objective. While it is far from perfect, after considering all issues pertaining to the definition of community participation as contained in this review, *we would like to use the term ‘community participation’ to denote the active involvement or input of the community, and by the word ‘community’ we refer to all members of the society* (irrespective of gender, education, ethnic group, etc.). By ‘involvement’ or ‘participation’ we refer to a situation whereby individual or group members of the general public (society) are consulted to contribute their ideas, efforts or material resources in support of an initiative oriented to yield benefits to the public as a whole or to specific members of the public (such as disease vulnerable groups, the disabled, the poor, the elderly, immigrants, and other disadvantaged).

The above definition has been suggested based on our finding from the literature that ‘community participation’ has been understood and interpreted differently, and sometimes ambiguously, between different authors. This may be explained by specific influences on authors, such as their academic discipline, political context or the influence of specific studies on their thinking. Alternatively, it could be explained by the fact that the term is so broad, that it can mean different things to different people. Alternatively, it may be that people have misunderstood the term, or applied it in a very narrow sense. Therefore, the key point is that, when using such a broad term, it should be clear what the authors understand by it, and how they intend to apply it. With the year-by-year increase in the application of community participation, this is an urgent point to address.

Furthermore, from the brief review of the literature presented in this report, it is clear that there have been many good as well as many poor examples of actual community participation. The trend of most authors analysing community participation in health was to focus on one or selected dimensions of participation, thus signifying the difficulty in carrying out a comprehensive analysis on a multi-dimension concept. Papers reviewed were of two main types. Many studies concentrated on a discussion of the mechanisms available for incorporating expressed public preferences and priorities in health programmes, with reference to the literature for examples. Other studies, on the other hand, evaluate real community participation schemes that are either pilot tests or schemes that are part of a national governments policy. While this current study has attempted to present and synthesise findings of these studies, it has not identified a universally correct understanding or approach to community participation. However, as Ubel (1999) suggests, perhaps it is not desirable to find a universal approach, and that the existence of different approaches allows the strengths and weaknesses of each approach to complement each other.

One conclusion of the review is that, while such an overview gives one a good understanding of what are important elements for good community participation - for example, as presented by Zakus et al (1998) and Laverack and Labonte (2000) in section 4.6 – it is crucial to understand that, if these elements are not put into practice through the appropriate channels, it will all be for nothing. Using the wrong approach could even have

counter-productive effects, such as reducing feelings of solidarity, reducing access to the poor, or reducing the resources available for health. While from the literature it is clear how many possible mechanisms exist for community participation, it must be recognized that these only work under certain circumstances or with other pre-existing factors (such as political support, laws supporting governing bodies, or community interest). Knowing which mechanisms are appropriate requires an in-depth knowledge of the country as well as the local (community) setting, even down to the very individuals that make up the community and their positions within it. The most relevant new mechanisms for a particular community will depend crucially on the capacities of that community, the current mechanisms operating in the health and other sectors, and the traditional roles of the State and the community. Communities may not be able to suddenly ‘participate’ over night, and it may take years for them to get used to the mechanisms (e.g. elections) and build the necessary capacities. Also, a careful balance of power is needed between the health representatives (providers and managers) and the community members or beneficiaries, especially as the community may be expert in knowing their true needs, but may not have the technical expertise for understanding how to meet that need. For example, if communities prioritize services that are *not affordable* or *not cost-effective* to them or to the health system, some expert guidance and over-ruling is necessary. In this situation, professional *know-how* becomes crucial to show the way forward.

In conclusion, we support the call made by several authors that more work is needed to further operationalise the notion of community participation, but at the same time to recognize the limitations of the findings of schemes implemented by outsiders and with external funds. It is also necessary to identify and counteract the forces working against community participation. For example, while decentralization is in process or has happened in many health sectors, the new global initiatives, with many decisions made in Washington or Geneva, have the effect of undermining the progress that has been made to date. While the solutions are not easy, it is crucial to start the discussion about how to incorporate these new instruments into the new approaches to decision-making and implementation evident in many countries. Certainly, strong upward feedback is essential.

5.2 Arguments for community participation, and links with governance and equity

It is clear that community participation has many potential benefits, both direct and indirect, as well as health-related benefits and benefits outside the health domain. If it works well, community participation can:

- Increase the resources available for health
- Sensitize communities to health problems and possible solutions
- Increase the uptake and effectiveness of interventions, as demonstrated by various disease control programs mentioned earlier (also see Annex Table 1).
- Improve specific quality elements of health care (e.g. drug availability) – as demonstrated by several cost sharing schemes where the modest charges are introduced with public acceptance there has been a general deterioration of quality of health care including the shortage of drug
- Increase the quality of management, through introducing accountability and performance measurement
- Improve governance and the responsiveness of services to the population. It is argued that lack of community participation in the supervision and control of

- financial administration hinders the sustainability of any community-oriented financing scheme
- Direct resources towards vulnerable groups
 - Increase the feeling of solidarity in a community
 - Increase self-reliance and local skill base

The combination of these improvements, both on the demand and supply sides, should rapidly have a positive impact on health indicators that are most amenable to change. There are sufficient case studies to support these hypotheses. However, as it seems in most publications and research reports on community health financing, there is no single cost recovery project that has ever successfully demonstrated all the above mentioned elements in practice, and that is why despite some reported achievements, notably there have been some failures here and there in such projects as well.

However, the link between community participation, governance and equity is not necessarily clear. Is community participation a precondition for good governance and equity, or is it simply an assisting factor? This question, in a sense, goes to the heart of political theory – can a democratically elected government (at national level) serve the interests of the population at the community level, without their direct day-to-day input at that level? In other words, is decentralization a necessary political objective of a democratic government, if true democracy is the ultimate aim? These questions are discussed below under the distinction between ‘*top-down*’ and ‘*bottom-up*’ political systems.

In the health sector, examples of the top-down approach are the national programs, such as immunization (EPI) or nutrition programs (vitamin A supplementation) in which communities are sensitized to participate either as service recipients or as volunteer health workers. Some authors have expressed their concerns that these programs, even though the benefits are intended for the local population, the latter are not consulted but rather are mobilized to participate in and legitimize the activities already planned from higher national and international health authorities. The Cuba case study could be seen as a top-down approach in the way that the rules of involvement are set by the central authorities, and community members given pre-defined roles (Greene 2003). Another example of the top-down approach is the Bamako Initiative on user fees (the most prominent form of community involvement and most conspicuous element in government’s health reforms in some countries), which commentators in the literature are very ready to criticize, especially for the observation that implementation has not been truly community-based (McPake et al 1992, Meuwissen 2002). Considering the inequity and poor acceptability of the Bamako Initiative, the authors argue that such a situation is likely to persist until central importance is given to community participation. A natural conclusion regarding these top-down approaches to governance is that, while national authorities may be democratically elected, they are not experts in understanding true community needs and providing health services efficiently and to the right people, as demanded by the community themselves.

In the health sector, the bottom-up approach has also been widely applied, and many examples have been cited and discussed in this review. With a growing body of literature and evidence from pilot projects or programs, proponents of the “bottom-up” approach claim that when local communities are consulted to decide on the best mechanisms for health service delivery, the performance of the planned activities is found to improve. Furthermore,

it is recommended that, if the aim of community participation is to ensure ownership, the community should be involved in decisions regarding the design and planning of the cost-recovery system, while donors, health planners and the Ministry of Health should continue supporting the system after it has started (Meuwissen 2002). With these viewpoints, it is clear that community participation is a necessary pre-condition for good governance and improved equity in the health system. Nevertheless, the ultimate consequences of cost-recovery schemes are not always predictable. Experience from some schemes such as in Niger (Gilson 1997, Meuwissen 2002) have initially demonstrated some potential success in terms of revenue collection that helped to improve the availability of drugs and attracted more patients, but in the longer term utilization rates have dropped (Meuwissen 2002, van der Geest et al 2000). This raises the question about whether cost recovery encourages collective participation or instead individual consumerism, and the overall attitude of patients and providers towards their health system.

However, because the idea of looking at governance and equity together in the domain of health is still relatively novel, we support other authors who have recommended further experimental and evaluation studies in this area, and that information generated from such studies is shared across countries so that good practice can be replicated.

5.3 Usefulness of the EQUINET framework

The EQUINET conceptual framework has been presented and further detailed in this review, with six case studies of community participation in health presented using the framework. Certainly it is felt that this review has benefited from the distinction between the different levels that determine whether community participation is successful or not. Having applied the framework to these case studies, this review raises two main points for improving the framework and making it more useful and applicable.

The first point is that there exists considerable overlap between the three levels, as contributing factors can be interpreted or expected in various ways that leads them to belong to more than one level. Clearly the main terms describing the levels need to be further defined and clarified, with examples given to illustrate the definitions. What do ‘underlying’, ‘proximal’ and ‘outcome’ really mean? The possible explanation of this is that, while agreeing that different interpretations exist, the context in which an assessment is done may determine whether a particular item is classified as either underlying, proximal or outcome. Thus the meaning of underlying, proximal or outcome will depend on the angle of perception coupled with the context in which the assessment is made.

The second point is related to the first point, and concerns the further clarification of the framework. As was shown in the case studies, the range of factors that potentially appear at each of the three levels is so great that further description is needed of ‘sub-levels’ that exist at each level (see Table 10 for a proposed expansion of the framework). The different sub-levels presented in Table 10 only reflect the results of brainstorming following this review, but these need to be further clarified and distinguished in group discussions among experts. Also, further links need to be developed between the levels (i.e. how underlying factors affect proximal factors, and how proximal factors affect outcomes), and between the different sub-levels, as well as the hypothesised links with, or effects on, community participation. While the importance of various factors may vary between settings where

community participation mechanisms are applied, it would be useful to qualify the expected effects in given settings.

Table 1. Expanded EQUINET framework for understanding community participation

OUTCOMES – REAL & PERCEIVED IMPACT	Health
	Knowledge
	Responsiveness
	Resource allocation
	Participation
PROXIMAL FACTORS	Trust
	Incentives
	Stakeholder capacity
	Community organs
	Functioning of mechanisms & health system*
UNDERLYING FACTORS	Community voice
	Policy documents
	Political mandates
	Legal framework
	Ideological and political frameworks

* For example, mechanisms and processes for adjudicating claims, communication systems, resources for outreach, social networks, etc.

ANNEX TABLES

Annex Table 1: Inventory of the reviewed published studies from different countries about community participation

Country	Participation Study Theme	Published details about Participation	Mechanisms Tested	Locality	Author(s)
1. Zimbabwe	-Schistomiasis control project	-level of participation, involvement rates, plot care, socio-cultural factors motivating people to participate in development project	-Performance of Ward Development Committees (WARDCO's) and Village Development Committees (VIDCO's)	Guruve district	Addmore N, et al (2003)
2. Kenya	-Health Development Programme	-who was involved, how, in what activities, and when. For example, Village residents supporting village health helpers (VHH's), fund raising, leadership positions and roles, influence of traditional clans and sub-clans on project operation, relationship between traditional leaders with government and project leaders	- Village Health Committees (VHC's), Programme Development Committees, the Executive Board, attendance	Saradidi rural area, western Kenya	Kaseje <i>et al.</i> (1987) <i>Annals of Tropical Med Parasitology</i> (1987) 81(1): pp 46-55
3. Bolivia	-Census-based impact-oriented (CBIO) approach to PHC	-local populations involved in the diagnosis of their health needs/problems, implementation and evaluation of CBIO performance	-performance of CBIO approach -application of CBIO approach on a large scale	Altiplano rural area (NE Bolivia); Texas-Mexican border; Haiti	Perry, H et al., 1999 <i>Soc. Sci. Med.</i> 48(8): 1053-1067
4. Nigeria	-Community-directed treatment with ivermectine (CDTI)	-acceptance rate to take the drug -women involvement in the distribution of drug -opinion-giving regarding the manner in which the drug was/is supposed to be distributed -reasons for community acceptance or non-acceptance to participate in the drug programme	-performance of community-directed drug distributors (CDD's) who were selected by the programme staff -impact of CDTI on ownership, empowerment of the community, and sustainability of health systems	Oyo State	Brieger, W <i>et al.</i> , (2002) <i>Trop. Med. Int. Health</i> 7(1): 11-18
5. Guinea 6. Benin	-Implementation of the Bamako Initiative (BI)	-community empowerment in financing, management and delivery of health services -regular contacts between health service providers and communities	-cost-recovery/sharing initiatives -effectiveness of village health committees and workers	Countrywide	Knippenberg et al., (1997); <i>Int. J. Health Plann. Mgmt</i> 12(Suppl. 1): S29-S47
7. South Africa 8. Zambia	-Implementing health financing policy reform	-how non-elite community actors are excluded from the policy-making process	-centralisation of decision-making in policy formulation and planning by national	Countrywide	Gilson, L et al., (2003) <i>Health Policy and</i>

Country	Participation Study Theme	Published details about Participation	Mechanisms Tested	Locality	Author(s)
			bureaucrats		<i>Planning 18(1): 31-46</i>
9. Pakistan	-Budgeting and resource allocation in a decentralised setting/system	-resource allocation being centrally based on historical incrementalism but not needs-oriented -limitedness of decentralisation in planning and resource allocation contrary to policy advocacy for community needs-based allocation	-How effective was the policy of bottom-up approach -Flow of information between levels -information base: whose views were valued?....	Balochistan State	Green A et al (2000) <i>Bull WHO vol. 78(8): 1024-1035</i>
10. Brazil	-Empowerment of local governments and communities in a decentralised and unequal policy	-Contradictory results of decentralisation: from policy perspective, local governments and communities are more involved in the delivery of policies, but the practical experience shows that it is difficult to achieve equitable and sustainable participation in a country with high levels of regional and social inequalities. -Variations in levels and results of 'participation' and decentralisation across the country	-How the national constitution, political democratisation process and decentralisation policies influence public participation and empowerment	Countrywide analysis	Souza, C University of Brazil (Undated: manuscript)
11. South Africa	-Equity in health as a social policy agenda -Need for increasing community empowerment-initiating participatory processes to lead local level health action e.g needs assessment and evaluations)	-constitutional reforms to address social inequalities since 1994 in a multiethnic and multiracial state -impact of macroeconomic policies on equity-oriented initiatives seeming to be undermining despite the policy rhetoric	-critical analysis of the past, recent and current situation: social differences in access to health services, community voice in needs assessment and priority setting programmes, resource allocation, etc.	Countrywide analysis	McIntyre, D & Gilson, L (2002) <i>Soc. Sci. Med. 54(2003): 1637-1656</i>
12. Uganda	-Involvement and performance of women in community directed treatment with ivermectine (CDTI)	-level of women involvement -how community-directed female HWs differed from men HWs -health education as a means for enhancing CP, especially among women	-performance of community directed HWs -CDTI decision-making process and power relations	Rukungiri district	Katarbarwa, M <i>et al</i> (2002) <i>Health and Soc. Sci in the community 10(5): 382-393</i>
13. South Africa	-The Mamre Community Health Project – rationale & methods	-Community-based disease surveillance data collection	-CP in questionnaire design -CP in data collection	Mamre Village (Cape Town)	Hoffman, M et al <i>S.A.M.J 74(1988) 323-327</i>
14. Australia	-Conditions or situations in which the general public can be involved in priority setting	-different levels of priority setting - whether the preferences of general public should lead priority setting - public opinion on 'who else' preferences should be	-priority setting preferences across: healthcare programmes, medical procedures, and at global level	Central Sydney	Wiseman, V et al (2002) <i>Soc. Sci. Med. 56(2003): 1001-</i>

Country	Participation Study Theme	Published details about Participation	Mechanisms Tested	Locality	Author(s)
		used to inform priority setting at each level -Overwhelming view of the respondents that the public preferences should be the central in priority.. -Preferences of politicians lowly valued			1012
15. Cuba	-Strategies for CP in health promotion	-the concept of direct involvement by political directorate in health promotion	-the political nature of health promotion -the Committee for the Defence Revolution (CDR) -Neighbourhood empowerment -health situation analysis conducted by the family doctor -Federal Cuban woman -Training community trainers	Countrywide analysis	Greene, R (2003) <i>Int. J. Health Plann. Mgmt.</i> 18 : 105-116
16. England	-Priority setting through group discussions among patients users of health services	-how patients viewed of their own legitimacy and that of healthcare managers in health priority setting -views about 'who' have the right to influence priority setting decisions seemed to change as the focus group discussions were going on and on	-the extent to which people change their views about priority setting as a result of discussions and deliberations	North Yorkshire	Dolan, P et al (1999) <i>British Med. Journal</i> 318 pp 916-919
17. Finland	-Healthcare priorities as a problem of resource allocation	-attitudes to prioritisation of healthcare among the general public, politicians, doctors and nurses	-analysis of 'Prioritisation of Health Care Project' -how attitudes towards priorities were context-dependent	Countrywide	Kinnunen, J et al (1998) <i>Int. J. Health Plann. Mgmt. Vol. 13</i> : pp 216-229
18. England	-Public preferences in being involved in particular types of services	-how the 'publics' think to deserve being involved in, and at what level, and -who else should be involved and for what level?	-willingness of various public bodies to participate in particular decisions, including (either) by: individually or pre-existing health related interest organisations	One National Health Service Authority	Litva, A et al (2002) <i>Soc. Sci. Med.</i> 54 (2002): pp 1824-1837
19. Global	-Participation of Disabled people in NGO planning	-limitedness of studies about participation of disabled people in planning programmes for their... -Stepwise framework for involving disabled people	-How INGOs dealt with disabled peoples by: (1) providing information (2) consultation (3) inclusion in decision-making (4) supporting actions initiated by them	Worldwide (cross-country)	Flower J & Wirz S (2000). <i>Health Policy & Plann.</i> 15 (2): 177-185

Country	Participation Study Theme	Published details about Participation	Mechanisms Tested	Locality	Author(s)
20. England and many other countries	-Shared decision-making (SDM) between patients and clinicians in medical practice	<i>With reference to Charles et al. (1997), the authors look at participation in a situation whereby:</i> -both the patients and the doctor take part in decision-making -there is a two-way flow of information between the clinician and patient -a treatment decision is made when both the clinician and patient agree about the right treatment	- How SDM can rise conflicts of interests in the medical practice, among patients and between patients and clinicians, in collectively funded health-care system	Global overview, with greater focus on UK	Sculpher, M. et al. (2002) <i>Soc. Sci. Med.</i> 54 (2002): pp 1369-1377
21. Philippines	-Community participation in local health boards (LHBs) in a decentralised setting	- Municipal health officers generally disliking devolution mainly due to local government units failing to salary increases and benefits as per law -Also, Dept. of Health representatives also opposed devolution, partly as their own positions were not devolved.... (p 64) -Only in one LGU (Talahib) that NGO representatives appreciated devolution because of good leadership of local mayor and increased resource allocation for health and their involvement -Variations in perceptions/appreciation of a new decentralised set up and functions with some local government units (LGU) perceiving positively of ... -No democratic selection of NGO representatives -Inadequate attendance to LHB meetings by NGO representatives, partly this caused by personal or professional commitments elsewhere...	-Functioning of LHBs -Interaction between LHBs and local government leaders -Community appreciation of LHBs -Democratic selection of community representatives -degree of devolution of power: involvement in 'high' decision-making for health -Attendance of members in LHB meetings -Presence of regular community consultation and information-dissemination...	One Region	Ramiro, L. et al (2001) <i>Health Policy & Planning</i> 16 (Suppl 2) pp 61-69
22. Uganda	-Public participation in health planning and priority setting at the district level	-Formal structures for participatory planning exist -Weakness in the existing planning approaches -Variations in types and levels of participation -Economic, social and cultural barriers to participation	-Public (community) and their local leaders' perception of the manner and degree to which public participation policy is translated into practice	Mukono District	Kapiriri L. et al (2003) <i>Health Policy & Planning</i> 18 (2) pp 205-213
23. England	-Community participation in health promotion in developed countries, specifically UK	-Variations in the meaning of 'community' -Community has constructed meanings, depending on when, in what circumstances, by and for whom	-How ideas of 'community' were put into operation in order to identify 'community representatives' -the consequences of the	Southern England	Jewkes & Murcott (1998) <i>Soc. Sci. Med.</i> 46 (7): 843-858

Country	Participation Study Theme	Published details about Participation	Mechanisms Tested	Locality	Author(s)
			existing mechanisms for participation on ultimate achievement of the projects		
24. Ethiopia	- Community participation in malaria control	-Community-based malaria control program formed and the steps taken to strengthen/sustain it -Community having had an opportunity for village volunteers who would work as CHWs	-Formation of health committees and CHWs -Community revolving fund (through cost-sharing)	Tigray region	Ghebreyesus <i>et al.</i> (1996) <i>Acta Tropica</i> 61 (1996): 145-156
25. Australia	- Community values and preferences in transplantation organ allocation decision	- How lay people incorporate various criteria in the organ allocation process -The importance of understanding the values of a broad range of stakeholders in issues concerned with rationing of medical resources	-what criteria does the community believe must be applied in organ transplantation decisions? -How does the community weight those criteria in organ allocation decisions? -How far does the community agree with each other as relative to the priorities of transplant patients with specific attributes?	Melbourne	Browning <i>et al.</i> (2001) <i>Soc. Sci. Med.</i> 52 (2001): 853-861
26. Canada	-The role of contextual influences on local health-care decision-making	-Framework for analysing participation and its influences	-identification of contextual influences on public decision-making and -how the presence or absence of contextual factors shape participation -influence of independent and combined factors on participation	Ontario	Abelson, J (2001) <i>Soc. Sci. Med.</i> 53 (2001): 777-793
27. Nigeria	-Community involvement in the control of Guinea worms	-How health education given through use of community health workers has facilitated a dramatic control of guinea worms at community level	-Training of local community health educators: the voluntary VHWs	Idere State	Brieger, W.R 1996 <i>Acta Tropica</i> 61 : 93-106
28. Cameroon	-Community-based approach to Schistosomiasis control	-health education used as a means to enhance participation and create local capacity to diagnose...	-Training of Comm-HWs -Cost-recovery participation -Functions of the Social Affairs Committees of the Local Government.	Kaele sub-division, North Province	Cline & Hewlet 1996 <i>Acta Tropica</i> 61 : pp 107-119

Annex Table 2: Some country-specific and international evidence on tested mechanisms for community participation

Success of the Mechanisms Used	Gaps/Failure in Approaches Used	Key conclusions and recommendations	Authors and Literature Source
Group discussions are a useful tool for collecting shared opinions from the general public, as people have a chance to criticise each other or themselves and develop a better vision on the issue	-If considered opinions are required, the value of surveys that do not allow time or opportunity for reflection may be doubted about.	-Public's views about setting priorities in health care are systematically different when they are given an adequate opportunity to discuss the issue -Different techniques used to obtain the public's views about participation may give different results	Dolan et al. (1999). <i>British Med. Journal Vol. 3 April (1999): pp 916-919</i>
Implementation of the Bamako Initiative (BI) marked an improved community empowerment in micro-planning, financing (through cost sharing) and management of PHC services in Benin and Guinea. Involvement empowered the community to own PHC services; giving more access to adequate and quality services for which they share the cost. Through their local leaders, communities decide on how to protect the indigents	-The paper is one-sided for it has not disclosed the operational failures of the BI scheme and any community dissatisfaction. It is only biased to legitimatise the BI by demonstrating only the positive outcomes. No wonder there were some failures as well, and we all know that the BI was a top-down policy injected by WHO & UNICEF	-Involvement of the community in the implementation of the BI is vital to create a sense of ownership, empowerment and control of the health-care service system	Knippenberg et al. (1997) <i>Int. J. Health Plann. Mgmt. Vol. 12(Suppl. 1), S29-S47</i>
Governments of South Africa and Zambia (SAZA) have at least realised the need for analysing/evaluating the process of policy reform in their countries towards more informed basis for action	-Limited attention has been directed to communicating policy to, or consulting with, front-line health-workers, middle-level managers, and the public, although these groups had important influence on policy implementation, and their neglect potentially result into unanticipated and unintended impacts. -In relation to reforms, health economists & policy analysts have tended to prescribe 'what should be done', meanwhile they have given on explanation as to 'why things are wrong' and 'how to do it'.	-Failure to communicate policy changes to all key stakeholders including (among others) front-line healthcare providers and the public can undermine policy implementation -The trend of overemphasis on policy strategies directed by professional health economists and medical professionals needs to be looked at cautiously	Gilson et al., (2003). <i>Health Policy and Planning 18(1): 31-46</i>
Political constitutional framework and democratisation process within federal states indicate prospects towards increased and	-Individual states and large cities within the Federal Republic of Brazil struggle for their own ways to mobilise revenue for funding social	-Equal and sustained participation will remain a critical problem in the Brazilian case (and other countries sharing the same	Souza, C (Undated reference)

Success of the Mechanisms Used	Gaps/Failure in Approaches Used	Key conclusions and recommendations	Authors and Literature Source
sustained local government and community participation in Brazil	services in their localities (boundaries). Consequently this intensifies regional imbalances. Also, the capacity of local governments to implement participation, either as a voice or as empowerment, varies greatly	characteristics) if regional disparities in terms of income, human resource and institutional capacities are not addressed, despite the current strategies to democratise and decentralise decisions.	
Despite having had inherited huge socio-economic and health inequalities from the apartheid regime, the new South African Government, among other achievements, has since 1994 explicitly stated its intent for reaching the vulnerable groups through health policy action and to foster the empowerment of all citizens. In line with this, The National Progressive Primary Health Care Network (NPPHCN) has been formed, including health-related NGO's and community-based organisations that embarked on 'Health Rights Charter' campaign.	-Targeting equity oriented medical-related policies to people who are in <i>real</i> need is hindered by lack of clear policy clarity of who are the <i>most vulnerable</i> -Vertical equity promoting policies seem to conflict with those for horizontal equity (such as universal access to all populations), and this ultimately undermines intentions to ensure the "fairest" form of resource allocation and empowerment in health -Lags towards implementations of equity-oriented policy strategies at provincial levels still exist	-The apparent constraints should be seen as an opportunity for innovative and visionary policy action rather than an excuse for any possible action -Governments should encourage and enable other stakeholders to take action in favour of equity. Good examples can be learned from action groups outside governments (e.g. NGO's) that bring the voice of the poorest to decision-making	McIntyre, D & Gilson, L (2002) <i>Soc. Sci. Med.</i> 54(2003): 1637-1656
Increased awareness at national, district and health programme levels of the benefits of women involvement in community-oriented health service affairs, as demonstrated by the CDTI Programme in Rukungiri distr., Uganda	-Differences were observed in the enthusiasm and levels of involvement of women in health service delivery initiatives from one locality to another. This observed difference was partly related to the role of kinship and traditional beliefs regarding "who should be selected to provide service to them" p 391	-Recruiting more female CDHWs and supervisors has a positive impact on the performance of health service delivery systems, and help to reduce the predominance of the patriarchal system	Katabarwa, M <i>et al</i> (2002) <i>Health and Soc. Sci in the community</i> 10(5): 382-393
British-supported INGOs have involved 'disabled people' as equally important in health care initiatives	-Some INGOs failing to involve them by sharing information with them right from the beginning of formulation of agenda for problem solving	-The participation of disabled people in the planning process of INGOs is a growing reality, but there is a lot of rhetoric about participation worldwide	Flower J & Wirz S (2000). <i>Health Policy & Plann.</i> 15(2): 177-185
Ugandan Government is politically determined to ensure public participation in decision-making in the health sector, and formal structures such as health committees, health boards, and local councils have been established for this aim.	-Public participation has not been addressed clearly. Participation is more in terms of health benefits and programme activities than decision-making, monitoring and evaluation that are dominated by locally elected leaders	-Mechanisms for motivating the public to participate should be devised. These include, finding out solutions to social, cultural and economic barriers that discourage them: Example, educating them, raising their awareness, involvement in information gathering and poverty	Kapiriri <i>et al</i> (2003) <i>Health Policy & Planning</i> 18(2): 205-213 Bossert, T <i>et al</i> (2002) <i>Health Policy & Planning</i> 17(1): 14-31

Success of the Mechanisms Used	Gaps/Failure in Approaches Used	Key conclusions and recommendations	Authors and Literature Source
		alleviation strategies	
Organizational forms of community participation through the user fee system exist in Honduras: community <i>health boards</i> , municipal <i>health committee</i> and <i>patronato</i> health committee	-There are conflicts of understanding between different implementers of decentralisation policy: lack of trust in the representation by one organ of another or the community exists. User fee implementation has not functioned in a situation most desirable to ensure effective participation	-The system, and mostly the community, has to be made clear to understand the goals, the operating rules and procedures with regard to user fees so as to achieve harmonious participation and integrity of local health facilities' operations.	Fiedler & Sauzo (2002) <i>Health Policy & Planning</i> 17 (4): 362-377
Women empowerment through increased (free partner-choice, education, and wealth of the family) contributed significantly to the decline in fertility	-Empowerment in the areas mentioned, especially that of education, has increased confidence in women and their opportunities to do things including decision-making that have positive impact on downing fertility...	-Relatively high parity women still exist due to social cultural ties: e.g. asking husbands' permission even for smallest purchase -Women in low parity calss with partners in cash earning occupations are fairly more comfortable than.....	<i>Soc. Sci. Med.</i> 56 (2003): 1001-1012
Judgement and decision analysis procedures can be used to elicit community values and preferences about complex allocation decisions as it was evident in Australia	-High national health policy bodies have recognised the rights of the community in expressing views concerning health resource allocation -Clear preferences among the community about allocation criteria were successfully elicited from survey	-Poor argument that those in-charge of the allocation protocols should act as 'trustees' for the community in transplantation organs allocations	Larsen & Hollos (2003) <i>Soc. Sci. Med.</i> 57 (2003): 1099-1115

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Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CBHI	Community-based Health Initiative
CBHW	Community-based Health Worker
CDTI	Community-directed treatment with ivermectine
CHMT (Tanzania)	Council Health Management Team (previously DHMT)
DED	District Executive Director
DHB	District Health Board
EQUINET	Regional Network on Equity in Health
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HIV	Human Immune-deficiency Virus
IDRC	International Research and Development Centre (Canada)
IHRDC	Ifakara Health Research and Development Centre (Tanzania)
INGO	International NGO
MoH	Ministry of Health
NGO	Non-Governmental Organisation
NIMR	National Institute for Medical Research (Tanzania)
PHC	Primary Health Care
SCIH	Swiss Centre for International Health (in the STI), Basel
STI	Swiss Tropical Institute, Basel
TARSC	Training and Research Support Centre
TEHIP	Tanzania Essential Health Interventions Project
TDR	UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases
UNICEF	United Nations Children Fund
VHW	Village Health Worker
VHC	Village Health Committee
W.H.O	World Health Organization