Community voice and role in district health systems in east and southern Africa: A literature review

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Executive summary

Research has been conducted in a number of countries in eastern and southern Africa on mechanisms that promote community participation in health systems at primary care and district level. This work has been reported upon and used at national level to review participatory mechanisms, and at regional level to synthesise knowledge towards policy intervention and training for local government and health authorities. However, there are still gaps in knowledge about the contextual influences on the current situation with regard to community voice and roles at district level in particular.

This study is a review of the literature and secondary evidence on community participation in central, eastern and southern Africa. It focuses in particular on South Africa, Mozambique, Malawi, Zambia and Kenya, and presents and analyses evidence of the current situation with regard to the role of districts in promoting community participation and articulating community voice. This includes looking at how:

- community voice and roles at district level are structured and integrated into planning;
- the way districts carry out their functions enables or blocks participation;
- districts articulate and represent community interests at national level; and
- wider contexts and processes at national and district levels influence and explain these outcomes.

The purpose of the review is to identify examples of enabling and blocking mechanisms for community participation at district level and to provide pointers for further research.

The review took into account the socioeconomic and political context in which the health sector operates in Africa, and its impact on community participation. This context is characterised broadly by growing social inequalities that have emerged over the last two decades in African countries; deepening poverty in most African countries; economic crises and severe public sector resource constraints; wide ranging health reforms as part of, or influenced by economic structural adjustment programmes; and growing dominance of neoliberal, market-oriented approaches to the provision of basic social services. Evidence of the impact of this context on community participation was identified.

The methodology followed was firstly to identify and collate published and grey literature from a wide variety of sources, mostly through searches on the web pages of institutions related to the health care systems in the African region. Documentation was also acquired through direct contact with numerous key informants. Over 250 documents, including abstracts, lists of titles, articles in journals, project reports and research papers, were accessed in this way. Further information was obtained through email, telephone and direct communication with key informants. One of the limitations of this methodology was that very little experience or information that had not been formally documented could be reviewed. Another limitation was the fact that the authors' knowledge of the situation in each of the countries studied was very uneven. In relation to some countries, this knowledge came only from what was learned during this review. This limited the comprehensiveness and analytical sharpness of the review.

Most of the documentation identified was produced by external institutions, such as northern universities, multilateral donor agencies or international non-governmental organisations (NGOs). It was difficult to find locally written research reports, project reports or evaluations produced by Africans at local or district level. These might have provided more insight into the possible bias of evidence presented by the external support agencies.

This potential bias relates to, amongst other issues, different ways of looking at community participation that are based on divergent philosophical or ideological viewpoints. Broadly, these are on the one hand the market-driven approach, which sees decentralisation as a support for commodification of social services and a way of breaking up large public sector bureaucracies, and on the other, a social development approach that sees decentralisation as a vital principle of a primary health care (PHC) approach, particularly in the development of intersectoral co-

ordination and community participation. However, the review found that the available documentation represents a reasonable balance between the two approaches, with the World Bank producing the bulk of the former, and EQUINET the bulk of the latter.

A rich diversity of examples of community participation in different countries, at community and district levels, is presented. Numerous lessons are drawn from the evidence, the most important of which are summarised in the conclusions. In relation to what was learnt about the role of districts in enabling or blocking community participation, the key lesson seemed to be that participation can have most impact when supported by functional local governance structures that promote participation in decision-making in addition to carrying out administrative tasks. When these structures are composed of elites, whether from the bureaucracy or from the community, that are not accountable to any defined constituency, broad community participation is constrained. Where systems have remained faithful to the democratising and empowering rationale of the PHC approach, rather than focusing solely on managerial aspects, outcomes have been better, but such systems are a small minority.

Effective functioning of district structures includes such aspects as local-level control and management of funds; proactive building of the capacity of community representatives, including elected councillors, and of officials; participatory planning and partnerships; and incorporating health programmes into broader, holistic development programmes that improve livelihoods as well. Inclusive democratic practice, which involves vulnerable groups, has also been shown to be essential for sustainable outcomes.

In cases where district structures do not function effectively, often owing to confusing decentralisation policies, community participation can still be achieved through supporting local initiatives, which underscores the validity of the PHC approach.

The available evidence suggests that mechanisms to articulate community concerns at national level are still very poorly developed. Community voice at national level is mostly articulated through civil society activism. There may be a role for politicians at different levels to play this role to some extent, if better informed of issues relating to health. One structure that does seem to function well and includes community and other civil society representatives is the AIDS Councils. However, the evidence is not clear as to how well they function, particularly in terms of acting as democratic forums. It would be useful to have such information, in order possibly to include actions to strengthen such forums.

The areas in which more information is needed to better understand the enabling and inhibiting factors for participation include, in the first instance, the broad question of health reform policy development and implementation. More insight is needed into the processes of development and evolution of systems, rather than just descriptions of how they work. In addition, few programmes have documented in any detail the less obvious factors that influence the form and content of community participation, such as the role of power relations between different stakeholders. More work on this would be useful to corroborate, or not, the few examples that tend to show that when participation includes all strata of society and the power of vested interests is counterbalanced, more sustainable outcomes that enjoy more community support are achieved.

At the level of national governments and regional inter-governmental networks, the promotion of genuine community participation and the democratising and empowering rationale for the PHC approach, would be strengthened if successes throughout the region could be described in a single advocacy document. This would expand substantially on this review and would include an analysis of the sustainability of the policies and approaches to community participation and district development in the region. A research framework should be developed by EQUINET and research commissioned from different local researchers in different countries, who have more in-depth understanding and access to unpublished work and even to documentation that is incomplete or was intended only for internal organisational consumption. This could fill some of the gaps in this review.

1. Introduction

EQUINET, through the Centre for Health and Social Science (CHESSORE) and the Training and Research Support Centre (TARSC), has been carrying out work in a number of countries in eastern, southern and central Africa on participatory mechanisms at primary care and district level, and the role of such mechanisms in equitable resource allocation and service provision. Three field studies and a substantive literature review have been implemented, and the work reported back and used at national level to review participatory mechanisms and at regional level to extract from knowledge lessons to inform policy intervention and training on participatory mechanisms for local government and health authorities.

A regional meeting on participation and health hosted by EQUINET, CHESSORE and TARSC found that at district level there is a need for good quality, accessible health facilities that orient services to decentralise their main focus to community level services and that are able to articulate the needs at this level and influence national policies. It was also found that there are gaps in knowledge about the contextual influences on community voice and roles at district level, and the current situation in this regard.

EQUINET has therefore commission a review of literature and secondary evidence to present and analyse evidence of the current situation with regard to:

- community voice and roles at district level (how is this structured, through what mechanisms within and beyond the formal system, through what alliances and relationships, and how integrated into planning);
- how district planning, decision-making, financing and budgeting, resource allocation and programme implementation enables or blocks such participation;
- how districts articulate and represent community interests at national level; and
- how wider contexts and processes at national and district levels influence and explain these outcomes (the political, cultural and institutional contexts and social processes and relations that enable or disable engagement).

This review is one of two on this theme commissioned by EQUINET. It focuses particularly on evidence from published and grey literature and key informant interviews from South Africa, Mozambique, Malawi, Zambia and Kenya and provides a greater depth of evidence from these countries. This includes positive case studies or examples of community voice, representation and district influence at national level, making clear the context for such case studies and factors leading to positive outcomes.

2. The wider context and processes

Over the past 20 years and more, the distribution of wealth and other resources in almost all African countries has become markedly more unequal and inequitable, with the result that the poorest segments of the population, who constitute the overwhelming majority, have little or no access to formal health care. Already in the 1980s, the question of inequality in the health systems was brought to the fore of public debate. In response, most African governments adopted the PHC strategy, encapsulated in the Alma Ata Declaration of 1978, which was based on making basic health services accessible to all by using community participation, both to reach people more effectively and to stimulate a sense of individual and community responsibility for preserving and improving health.

The adoption of the PHC strategy was part of radical health sector reforms that all governments in Africa were forced to implement because of the economic crises that began in the early 1980s and crippled their ability to provide cost-effective and efficient services to their people. All the countries of central, eastern and southern Africa revised their health legislation in the last decade or two of the last century in order to create an enabling legislative framework within which to implement health reforms. The legislative reforms are quite well documented and

relatively easy to access. Most of them are based on the early models developed by the United Nations (UN) and other agencies at the beginning of the reform era, influenced by economic models developed as part of structural adjustment programmes. Most attempt to retain elements of country specific approaches and policies, but the impression that remains after browsing through them is that, although they have been adapted to the different situations and backgrounds, the language, the tone and the message are the same.

Decentralisation was at the heart of the health reforms, and with it the establishment of decentralised governance structures as legal entities by acts of parliament. Decentralisation policies aim to transfer the authority to define policies, make decisions, implement managerial functions and make use of resources from national to district and local levels. Different processes and models exist within decentralisation such as de-concentration, delegation, devolution, federalism and autonomy in service delivery units (Kolehmainen-Aitken,1999; Ugalde et al, 2002).

The main difference among these different models and processes is the level of responsibility, authority and autonomy transferred from the central level to the peripheral level. This involves, amongst other elements, the establishment of governance structures to assume some of these roles and functions and by doing that representing and articulating community voice, from the bottom to the top, and vice versa, through the implementation of a district health system (DHS). While some potentially good experiences have been identified, a new phenomenon of 'structuralism' occurred (Báez, 2001) reflected in the establishment, in many countries, of non-representative and therefore (more often than not) non-functional health governance structures.

The DHS must first be thought of as a means to an end, rather than an end in itself. In this instance, the DHS is the 'means' to achieve the 'end' of an equitable, efficient and effective health system based on the principles of the PHC approach. The features, elements and conceptual framework of the PHC approach should therefore be reflected in the nature and design of the DHS. This means that the DHS is more than just a structure or form of organisation. It is also the manifestation of a set of activities such as community involvement, integrated and comprehensive health care delivery, intersectoral collaboration and a strong 'bottom-up' approach to planning, policy development and management (Barron et al, 2001).

While countries were encountering problems in trying to implement the too often vague and imperfectly understood concept of community participation, particularly within large-scale national health programmes, the immediate context for this was the economic crisis. The austerity measures introduced by African governments as part of the adopted structural adjustment programmes contained commitments to cost recovery and the introduction of user charges as part of the strategy to reduce the social expenditure of government. As the economic crises and structural adjustment policies took their toll on public services, the public health system was itself increasingly exposed to an internal commercial logic which, for the average patient, meant payment for virtually every service rendered. Also, the 'social safety net' programmes put in place by most governments to alleviate the social consequences of the various reform policies introduced, failed to make the anticipated positive impact, for different reasons.

The state of health in Africa is inextricably linked to the state of poverty and socioeconomic development. Poverty impacts on African population health status at the individual, household and health systems levels in a number of ways. In a study to analyse the reasons why the maternal mortality ratio in Malawi doubled over the course of the 1990s to one of the highest rates of the world, McCoy et al (2004) noted that the impact of poverty on health is at the household level, where poverty constrains access to health facilities and the consumption of health care. They further explain, at the health systems level, how health expenditure falls far short of that required to finance a minimum essential package of health services and to adequately remunerate health personnel. At the country level, the system is vulnerable to the loss of its few skilled health workers to richer countries and is unable to adequately fund its education sector.

One of the main reasons for this level of poverty in Africa is the unfair debts that most African countries still have to repay, at the expense of the well being of their people. Support from the International Monetary Fund and WB for countries with crippling debt has been contingent on governments adopting painful structural adjustment programmes (Sanders et al, 2005). For example, Kenya's external debt has continued to swell over the years, in spite of the country meeting its debt commitment through regular servicing. This debt servicing has been done at the expense of key social services such as health, education, water and sanitation. Although good health is a prerequisite to socioeconomic development, public budget allocation to the health sector has been dwindling over the years in per capita terms (Kimalu, 2001).

At current rates of progress, sub-Saharan Africa will not achieve any of the millennium development goals. In health, the situation is especially bleak, with little or no substantive progress since 1990. All key health indicators are at much worse levels than those in any other of the world's developing regions (Sanders et al, 2005).

This dramatic situation is not a new challenge for Africa's leaders. The initial programme of action of the health strategy of the New Partnership for Africa's Development (NEPAD) adopted at the first African Union Conference of Health Ministers held in Tripoli in April 2003, and by the African Union (AU) in Maputo in July 2003, is a medium-term one based on the recognition of what is required to sustainably tackle the huge burden of avoidable disease, death and disability in Africa. The health strategy recognises the broader socioeconomic and political factors that are at the root of much ill health on the continent and emphasises the broad contribution of NEPAD to improving health. While the NEPAD document recognises the need for increasing local accountability and community participation and empowerment, there is an omission in terms of recognising the role and importance of governance structures in the strengthening of local health systems.

The growth of social inequalities that have emerged over the last two decades in African countries has not improved the environment for community participation. As the comprehensive PHC concept was pushed towards a selective PHC approach, the understanding of community participation elaborated in Alma Ata also suffered from the impact of such rethinking. The term 'participation' was subtly replaced by the proponents of these new strategies with the term 'community involvement in health (CIH)'. Beyond semantics, this envisaged a disempowering role of communities in health issues. As noted by Klugman (2000), the WB's John Garrison identified a distinction between the motivation of the WB – which sees participation from an operational perspective – and civil society organisations (CSOs) themselves, which tend to view participation from an ethical perspective (Richmond et al, 2001). It is the latter perspective that looks to participation as a means of extending social citizenship by allowing community representatives and members to hold health services accountable (Cornwall et al, 2000; Klugman, 2000).

However, it is widely agreed that participation of communities is essential for improving health outcomes and the performance of health systems. Participation takes different forms and reflects varying degrees of community control over decision-making systems. These different levels of community authority depend also on where authority is located within the health systems and how health workers and managers are willing to widen the inclusion of different social groups in decisions that have often been under their control (Loewenson, 2000).

3. Methods

3.1. Definitions and concepts

The terms community, community participation, district and national can be defined in widely varying ways. The following definitions are used in this review.

Community
A group of people living in the same geographic area with some degree of common interest.

Community participation
The definition developed at the 1978 International Conference on Primary Health Care held at Alma Ata, elaborates on what constitutes community participation:

> *The process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their and the community's development. They come to know their own situation better and are motivated to solve their common problems. These enable them to become agents of their own development instead of passive beneficiaries of development aid. They therefore need to realise that they are not obliged to accept conventional solutions that are unsuitable but can improvise and innovate to find solutions that are suitable. They have to acquire the capacity to appraise a situation, weight the various possibilities and estimate what their own contribution can be. While the community might be willing to learn, the health system is responsible for explaining and advising, and for providing clear information about the favourable and adverse consequences of the interventions being proposed, as well as their relative cost.*

Source: World Health Organisation (WHO), 1978.

Health system
All services, functions and resources in a geographic area whose primary purpose is to affect the state of health of the population (http://www.dph.state.ct.us/OPPE/sha99/glossary.htm).

Health district
The WHO definition of a health district is a well-defined population, living in a clearly delineated administrative and geographical area, where all relevant agencies that contribute to health in homes, schools, workplaces, communities and health facilities are included.

In this review, any reference to a health district also includes the management structures to the lowest levels of decision-making, including the governance structures and the technical lines of control.

Health management structures
The health management structures are denominated in different ways as follows:

Level	Governance	Technical/professional
Community	Village, neighbourhood committees	Community health workers
Facility	Clinic, dispensary or community health centre committee	Sister or doctor in charge of facility
	Hospital boards	Hospital management teams
District	District health board (DHB) or council or assembly	District management teams
National	Central Board of Health (CBoH)	Directors of health

3.2. Methodology and limitations

3.2.1. Scope
The scope of this review, as defined in the terms of reference, is limited, in the first instance to countries in the central, eastern and southern African regions. Particular emphasis has been placed on five of these countries, namely Kenya, Malawi, Mozambique, South Africa and Zambia, because the reviewers knew more potential key informants there. Further attention was paid to Mozambique and South Africa, where the reviewers have extensive personal work experience.

In terms of the time period studied, every effort was made to identify examples and case studies that were as recent as possible in order to avoid drawing erroneous conclusions from out-of-date information. However, some of the information obtained could not be dated very precisely.

3.2.2. Sources of information

Firstly, the EQUINET literature was consulted, followed by published and grey literature from a wide variety of other sources. Most of this was identified via searches on the web pages of institutions related to the health care systems in the African region. Over 250 documents, including abstracts, lists of titles, articles in journals, project reports and research papers, were downloaded. The issues that were searched included:

- health system background of each targeted country;
- health reform, DHS and decentralisation policy documents for each country;
- legislation and governance structures in health;
- national policies on community participation or related issues;
- community participation in health programmes;
- project descriptions and reports, mainly on NGO web sites; and
- similar experiences in other continents for comparative purposes (e.g. Score Card method in India).

In parallel with this exercise, emails were sent to over 50 people identified as potential key informants, either through personal knowledge or through identification during the internet search. Although the response from these contacts was not as quick and helpful as hoped, useful information, including emailed documentation and verbal communication by phone, was received from twenty people. As information gaps became clearer during the course of the work, specific informants were targeted for follow-up, and information obtained either verbally or via email.

Challenges with key informants

Much of the information received from key informants was received some 10 to 15 days after first contacting them, which placed considerable pressure on the writing-up process as the deadline approached. One of the reasons was specific to Mozambique, where key informants required official authorisation from senior officials in the MoH before making information available. The only key informants who were interviewed personally were an MP from Malawi and a representative of the African Population and Health Research Centre in Kenya, who attended a Global Equity Gauge Alliance (GEGA) meeting in Johannesburg. The latter subsequently also provided contact details for others who could assist with information.

With regard to the ease or otherwise of obtaining information from key informants, it should be noted that this task required an enormous amount of effort in terms of following up and insisting on responses. It was clear that many informants were not prepared to give their time for free, and this reflects the changed circumstances of many organisations that now operate on the basis of selling their time. One informant specifically enquired about payment for collaborating. In addition, numerous articles found on the internet were not accessed because payment was required.

Requesting information from strangers is made more difficult by the impersonal nature of electronic communication. Although it might be unfair to categorise respondents according to the degree of familiarity they have with the authors of this review, or the person that recommended them, this was certainly a factor. It is also important to acknowledge that the most generous and tireless sources were mainly from community-level organisations.

Possible bias

Of significance also was the fact that a large amount of documentation identified was produced by external institutions, such as northern universities, World Bank agencies or international NGOs. It was difficult to find locally written research reports, project reports and evaluations produced by Africans at local or district level. These might have provided more insight into the

possible bias of evidence presented by the external support agencies. Attempts were made through the key informants to get more grey literature and to validate some of the results claimed in some documents, but with limited success.

The potential bias referred to above has to do, amongst other issues, with the two different ways of looking at community participation, and of assessing content of community participation and its impact on health outcomes, referred to in Section 2. These divergent philosophical or ideological viewpoints translate in practice to different approaches to health reforms and decentralisation in general. At the risk of oversimplifying – there are many shades of opinion along the continuum between the extremes – on the one hand the market-driven approach sees decentralisation as a support for privatisation and a way of breaking up large public sector bureaucracies, while on the other, a social development approach sees decentralisation as a vital principle of a PHC approach, particularly in the development of intersectoral co-ordination and community participation.

This review found that the available documentation represents a reasonable balance between the two approaches, with the World Bank producing the bulk of the former and EQUINET the bulk of the latter. The authors have sought to analyse all the information with a full awareness of the potential bias inherent in the sources.

Thus, in spite of the potential biases, the authors believe that this review will contribute positively to existing knowledge, since not a single paper was found that has analysed the dimensions of community participation and representation at the different levels of the health system in Africa in quite as comprehensive a way as has been done here. The data collection method used in this study, which combined pure literature review results with information from relevant accessible people who were willing to contribute, has been the main factor in producing the substantial content of the review.

Other limitations of the methodology

It should be borne in mind that the comprehensiveness and analytical sharpness of this review is constrained by the fact that the authors' knowledge of the situation in each of the countries studied is very uneven. In relation to some situations, this knowledge comes only from what was learned during this review. It was also not possible in all cases to verify whether information, for example on web sites, was up to date.

In some cases it was also not clear whether examples of good practice cited were only locally relevant. The available evidence in these cases did not enable conclusions to be drawn as to whether and how they would be replicable in other settings and on a larger scale.

In spite of the relative comprehensiveness of this review, in the view of the authors the results still do not reflect the reality at district and even national level, in most of the countries sampled. Some of the causes include the fact that much locally produced research is still fragmented, unpublished and inaccessible; the absence of a commonly accepted, systematic way for stakeholders to document process issues; and a sense of elitism and selfishness generated in these neoliberal times, which prevents many people from sharing information generously for developmental purposes.

To better understand the nature, full scope and content of community participation in the region, further research is needed, and it might be advisable to use complementary (more qualitative) methodologies and local researchers with a common framework to reach projects and people more effectively. Lessons can be drawn out better from such comparative analysis to provide a basis on which countries can expand their efforts to promote more democratic forms of governance for community voices to be heard.

4. Findings

This section describes the evidence this study was able to source, from published literature and from secondary sources, on community voice and participation in the health sector, with emphasis on how this is manifested, facilitated and hindered at district level.

Community participation and the expression of community voice take different forms and reflect varying degrees of community control over decision-making processes. These different levels of community authority depend also on where they are located within the health systems (over planning, resource allocation, etc) and how health workers and managers are willing to widen the inclusion of different social groups in decisions that have often been under their control. The different aspects of community participation and the areas where it is manifested and facilitated or hindered by district structures are described below under the following headings:

- Community participation at community level
- Community participation at district level
- Analysis of enabling and inhibiting factors at community and district levels
- Representing community interests at national level.

4.1. Community participation at community level

4.1.1. Community participation in health programmes and PHC delivery

Community participation in health programmes and in PHC delivery happens to varying degrees in all the countries surveyed. However, the following examples are best documented and seem to offer the most useful lessons for the purposes of this review.

In Zimbabwe the government decentralised the health system soon after independence in 1980, and adopted the PHC approach. One health centre was established for up to six villages and these provided preventive, promotional, rehabilitative and curative health care. PHC efforts ranged from immunisation to family planning (FP) and malaria control. District health teams worked with development committees and organised ward health teams, composed of health centre staff, local village health workers, other development workers and community members.

In 1985 ward health teams began participating in annual planning and evaluation sessions and quarterly follow-ups. These involved identification of health problems and discussion of possible efforts to solve the problems. The ward health teams helped guide the focus of district health education programmes. However, insufficient organisation and funding hampered the efforts of some ward health teams. Further, the rural elite worked against community involvement. Nevertheless, community participation and health centres contributed to the considerable success of the health sector in Zimbabwe in the 1980s (Tumwine, 1993). In the 1980s, the relationships between the health sector and other stakeholders were based on trust and idealism, oriented towards the needs of the community, but this changed as corruption was fed by the poorly defined roles, functions and systems that regulated these relationships.

Approximately twenty years later, a study in Zimbabwe suggested an association between empowered health centre committees (HCCs) and improved health outcomes, even in highly under-resourced poor communities and clinics. HCCs have acted on and improved PHC services. Community, HCC and health authority sources all reported that HCCs have taken up environmental health and service quality issues. Their primary mode of action seems to be more of an additional service outreach and link. They find out community needs and organise service inputs such as purchasing drugs and building shelters for waiting mothers, water tanks and toilets. They also provide health information (Loewenson et al, 2005).

The PHC approach has been the basis of the health system in Zimbabwe since the 1980s. In both phases of development of the system, mentioned above, despite the number of years that

elapsed in-between, the strategies employed were based on PHC principles. However, although the latter phase shows a higher level and scope of organisation at community level, where local resource mobilisation and responsiveness to community priorities helped to produce satisfactory results, the HCCs seem to be vulnerable to a number of factors limiting their effectiveness. These factors include weak formal recognition by health authorities, lack of own area of authority, and unclear reporting structures and role definition. This suggests a weakening of district structures over the years, including their ability to support community participation. It may also suggest an unwillingness of district structures to empower the HCCs (although they agreed that their performance needed to be improved), as they have no direct influence over core health budgets and have little influence over how their clinics are managed and run. Health authorities show some ambivalence and lack of consensus on HCC roles (Loewenson et al, 2005).

The case of Zimbabwe shows that a system based on PHC principles can function in spite of severe resource constraints, but that optimal community participation is compromised by the weaknesses at district level mentioned above.

In South Africa the PHC approach was introduced in 1994 by the new democratic government. Previously, the system was mainly curative and no community participation was promoted. Such participation was thus a new paradigm both for health workers and communities. In the Monyakeng Location, in the Free State province, the clinic committee was initiated and nourished by the HIV and AIDS youth group, which was the main linkage with communities and other key actors. The clinic committee meets regularly and has a number of very keen members: sometimes even the ward councillor attends meetings. Although they are a dynamic group of people, they feel ignored by the authorities.

The local health area manager represents them at the District Health Authority (DHA) and the councillor at the District Health Council (DHC) but there is no systematic communication with these representatives to ask about their problems or successes. They reported that they work on their own with practically no resources, with the exception of abundant training that is not planned on the basis of locally specific needs (key informant, 2006). As in the Zimbabwean example described by Loewenson et al (2005), they have achieved notable successes in their work, such as improvements in the indicators of the TB control programme (increased cure rate and decrease in defaulter rate to practically zero) and an extensive outreach programme for prevention of HIV and STIs in rural schools. This demonstrates the potential for community involvement to enhance the performance of the formal health system.

Although the implementation of the DHS is still in its initial stages compared to other African countries, it is clear that community participation is taking place at community level. However, the voice of these communities has not been allowed to echo beyond the limits of their own area and clinics, while the district and provincial meetings take place regularly, deciding about these communities and their needs. As in the case of Zimbabwe, the potential to significantly increase community participation and enhance its content is being compromised by a combination of weak district structures and unclear role definition. If this situation of lack of recognition and support persists, there is a risk of momentum being lost and communities being demoralised.

A very different example from those described above, showing how well-supported community structures flourish and community participation produces optimal results, is that of the neighbourhood health committees (NHCs) in Zambia. The Zambian Integrated Health Programme included the creation and empowerment of NHCs, which have been formed in 12 districts. The key informant interviewed reported that this mammoth task was a participatory process that allowed all stakeholders to gain an appreciation of the need to work together. Training of trainers was conducted, helping NHC members to mobilise their communities, identify and prioritise their problems and work towards solutions.

In addition, she mentioned the Distance Education Radio Programme for NHC members, as the glue of the whole NHC. Entitled 'Our Neighbourhood', it is a six-month, 30-minute per week, repeatable course. The programme provided technical updates on both health interventions and community mobilisation techniques and provided ongoing support and encouragement, filling some of the gaps in supportive supervision. The Central Board of Health (CBoH) endorses the programme as an official distance learning program, certifying graduates as qualified in community mobilisation.

The action plans formulated by the NHC were elevated to form part of the health centre and district action plans. Preliminary findings from supervisory/field visits show that positive changes have taken place. Additional NHCs have been formed, more community members are willing to join, neighbourhoods are cleaner and the demand for CLORIN (a water purification product promoted by NHCs) has increased. People are seeking information on the benefits of living more healthily.

The challenge for these structures has been highlighted in an article written by John Malimo, in which he recognises that NHCs are already carrying out some important 'partnership' functions in most districts of the country. Malimo recommends that they be developed further to enable them to articulate community concerns on health and other related social issues to the other, often more powerful and better organised stakeholders. In collaboration with these stakeholders, the NHCs can ensure equitable access to quality health services and create a sense of ownership over health facilities (Malimo, 2005).

The key lesson here, with regard to the role of districts, is that they are clear about their respective roles and functions and provide the necessary political and material support to the NHCs. Table 1 below summarises some of the experience with community participation in health programmes in three countries where, whether supported by district authorities or not, it is well organised and structured at local level and as a result achieves good results.

Table 1: Community participation in health programmes at community level in three countries

Country	Year	Type/scope	Programme	Structure	Impact	Sustainable	Support from district authorities
Zimbabwe	1980	Outreach Developmental	Extended programme of immunisation (EPI), FP, Malaria	Yes	Yes	No	No support Unclear roles
Zimbabwe	2000	Outreach Quality services	Drug purchase Mothers' shelters, water tanks and toilets	Yes	Yes	?	Uneven support Unclear roles
South Africa	1999	Outreach Quality services	HIV and AIDS, STI, TB, child health	Yes	Yes	?	No recognised by authorities
Zambia	1996	Outreach Developmental	HIV, TB	Yes	Yes	?	Support from district Supported by national authorities External support

4.1.2. Community participation in planning and managing health facilities

Two studies at district level in Zambia show that decisions regarding user fees and development of action plans did involve the governance bodies of local participation (Bossert et al, 2004). It was also mentioned that planned activities were, in most cases, presented by the health centre staff to the HCCs and decisions were made at that level.

A considerable amount has been written about the HCCs in Zambia. An assessment of their impact, through systematic monitoring, found a high level of satisfaction with their performance amongst all stakeholders. All key stakeholders at district level, whether from HCCs, frontline health workers or from the district health management team (DHMT), were unanimous in affirming that the HCCs had made an impact on the functioning of clinics, and their value to the health system was acknowledged. However, this impact was limited in terms of the desired equity goals and coverage. There was also consensus that HCCs had little or no impact among vulnerable groups and in important decision-making roles at the health centre, especially in relation to clinical care services. Channels of communication have been developed between the health system and HCCs in health promotion and provision of preventive services (Ngulube et al, 2004).

In Malawi, life expectancy is less than 50 years, slightly more than half of that of people living in wealthy countries. With health care being such a major issue, the village health centre is critically important to Malawians. Unfortunately, there has been growing dissatisfaction with the service provided. In 2001 the Community Score Card concept was introduced in some areas of the country on a trial basis. It is a system that involves local people in the running of their health centres. Services are scored by users and the results are compiled and presented to health centre staff by a village health committee (VHC). The committee is elected at consultative village meetings and is the bridge between health staff and the community.

All aspects of health care are analysed – everything from how staff listen to patients to how they care for undernourished children. Staff also score their own performance. All feedback is used to improve the way things work, ensuring that local needs are met. Not only has service improved, but community confidence has risen as well. Death rates among mothers related to childbirth have reduced because more women are now going to the health centre. And the effects of an improved health centre filter throughout the community.

Similarly to decision-making, these planning and policy formulation processes can be assessed for their inclusiveness, transparency and openness to citizen and community input. Participation in setting agendas, generating proposals and discussing their merits links people to the institutions of governance that are meant to act on their behalf by making and implementing decisions that provide services and by promoting local development (Helling et al, 2005). It is not clear from the evidence how widely the Score Card system is being used in Malawi.

Besides this example of community-level planning, little other information could be found on community participation in planning at district level in Malawi. The findings of one study revealed that at local level communities generally consider programme planning to be the responsibility of service providers, particularly government, or at the very least the responsibility of the project management committees (PMCs) or the implementing NGOs (Dulani, 2000). This was confirmed by the key informant from this country who noted with regret that health plans are developed by technocrats at all levels. This aspect of the health system reflects the status of community participation in general in Malawi, which is weak, owing to the authoritarian political climate, inherited from the Banda era. Until there is a more general democratisation and there are supportive district structures, community participation will remain localised.

In 1997 in the Coast Province of Kenya, the Aga Khan Health Services (AKHS), working in close collaboration with the Kenya MoH, began the Kwale Health Systems Strengthening Project (KHSSP), which aims to improve the quality of health care at the dispensary (clinic) level. Constrained by a lack of manpower and financial resources, as is the case in most if not all developing countries, the Kenya MoH was unable to maintain a consistent supply of drugs in its health facilities, and it was prevented from providing adequate supervision of the staff who worked in them. The solution envisaged by the KHSSP was to make the ministry's dispensaries more self-sufficient.

Unlike many previous initiatives in different parts of the world, in which community participation has been stimulated outside the government health facilities through such activities as establishing community pharmacies along the Bamako Initiative lines, or supporting volunteers in community-based health education programmes, the KHSSP sought to promote public participation inside the dispensaries. The key objective was to strengthen the capacities of the dispensary health committees (DHCs), comprising representatives drawn from the VHCs of the catchment areas, so that they could more effectively raise and monitor funds and oversee the services provided in both the facilities and in any outreach activities. To do these things effectively, the DHCs needed a practical health management information system.

The Mtaa Dispensary was one of the six chosen for the initial phase of the KHSSP. It had been established in the 1970s as a community-based facility. Eventually, the MoH took it over, posted a nurse-in-charge, and began to supply kits of essential drugs. When the KHSSP started, the community was not very involved in the running of the dispensary. What happened there, supported by the project, illustrates how an ordinary but determined small community can collaborate with the ministry's health staff in successfully managing a local health facility (Sohani et al, 2004) (KHSSP, 2005).

Case study 1: Mtaa dispensary health information system, Kwale, Kenya

The key figure in developing and operating the health management information system at Mtaa was a volunteer and a DHC member. She is Zabibu Chizi Mwero. She had been trained as a nurse-aid and then attended the training course for the DHC members provided by the KHSSP. She became particularly interested in what was said about health management information systems. She started collecting data for the Mtaa Dispensary and writing it up on a blackboard and on charts. All this information is taken from the registers completed by the nurse-in-charge, since he is the one who actually attends to the patients. At the end of each month, Zabibu notes how many patients have been treated for malaria, for respiratory problems and for bilharzia. She writes up on the board the figures for the top five diseases. She also gets the figures for growth monitoring and immunisation from both the dispensary and from the villages. Almost every month the DHC organises health action days. So both growth monitoring and immunisation are carried out in every village.

For all the main activities, the Mtaa DHC sets targets and the board shows whether the dispensary was achieving this target every month. All this information is used in the DHC meetings. Also, the board is for public use. When people come to the dispensary, they can see what the DHC is doing about the problems. As Zabibu says, "The people know how many patients have been seen and the amount of money collected, and what we did with it."
After two years, there were encouraging indications that, not only at Mtaa but across all the six dispensaries, KHSSP was having a positive impact: the average monthly income of dispensaries rose by 110%, utilisation of preventive care increased 54% and utilisation of curative care increased by 15%. None of the dispensaries was without drugs for a single day.

Source: Sohani et al, 2004; KHSSP, 2005.

This is another example of the effect of supportive health structures, from national to district levels, on promoting and enhancing community participation, in this case by reinforcing community-created structures for participation.

It seems, based on the evidence gathered, that the Kenyan MoH supports the development of facility- and community-based information systems (Odhiambo-Otieno, 2005). It was, however, not possible to find out to what degree all these projects are co-ordinated and whether they are having any impact at higher levels of decision-making.

Table 2 summarises the experience of community participation in planning and decision-making in three countries, and shows that there are better outcomes when the approach is more participatory.

Table 2: Examples of community participation in planning and decision-making

Country	Year	Level	Structure	Approach	Impact	Decision-making
Zambia	2003	Health centre	HCC	Unclear	Yes	Poor
Malawi	2001	Clinic	VHC	Participatory	Yes	Good (locally)
Kenya	1997	Dispensary	DHC	Participatory	Yes	Good (locally)

4.1.3. Community participation in local action-oriented assessments and research

Community participation is easier to achieve and more sustainable when programme design and operational planning are carried out in such a way that community participation is sufficiently influential that it results in programmes being contextually and culturally sensitive, and thus fully aligned to local priorities and ways of doing things. One way to achieve culturally sensitive programme design is to involve communities in needs and solutions identification and baseline research.

In Tzaneen, Mopani District, South Africa, the Community Responsiveness Programme (CRP), a community-based organisation (CBO), carried out community research to identify the perceptions of communities regarding violence against women, children and men. The results of this study have been used to help design multisectoral initiatives that will address some of the problems identified. According to the key informant from the community research group, they are considering promoting small business development to create jobs and tackle in this way the underlying cause of all sorts of violence, besides helping to improve the services and management of these cases at community level (Ramalepe, 2004). In a country like South Africa, this serious public health problem needs a collective response that emanates from the community itself such as in this case.

Another important outcome of the project was that the district health officials and clinic committee members were part of the survey and now own the results (ibid). By involving the district in the research, they were able to appreciate the value of community involvement, and will support this and other forms of community participation in the future.

Community participation in the design of an HIV and AIDS prevention project in Chiure, Mozambique, was essential for the success of the project. The inclusion of the local people in the design enabled the project to find culturally acceptable and locally owned solutions (Ruedin, 2006). The DHAs played a significant facilitating role in this project, as discussed in section 4.2.

The Tanzania Essential Health Intervention Project (TEHIP) study in Tanzania analysed the experience of the decentralisation of the EPI from national to district levels. Community support for EPI, measured by willingness to pay for kerosene (to keep vaccines cool), was low. Participatory research carried out in the community showed that community support was significantly associated with whether providers in the nearest health facility properly attended the target population and whether the providers in the facility were available when needed. Community support was found to be not high. This was possibly due to the perceived non-

availability of the service providers and their lack of awareness of the population they serve. It was proposed that reforms should give priority to the involvement of communities and peripheral health facility providers in the process (Semali et al, 2005).

Case study 2: SolidarMed HIV and AIDS prevention project, Chiure, Mozambique

SolidarMed facilitated a joint analysis of high-risk practices between health care providers and community members, which identified possible source of public health problems that may increase risk for HIV infection. These are the multiple use of material without sterilisation by informal (illegal) care providers for injections and by traditional healers for circumcision and scarification. Local explanatory models were shared and exchanged (for example, blood contact is not perceived as bearing any risk of contamination). Common risk behaviours (for example, informal exchange of sexual services against material and financial benefits are not considered 'prostitution') and the social situations where they frequently take place (for example, meetings at taxi and bus stations or women selling beer in local markets, were jointly identified and analysed. This stage of analysis then leads to a dialogue with the aim of finding adapted, culturally acceptable and locally owned solutions.

As most young people in deep rural areas still undergo ritual initiation, this particular moment is considered an ideal opportunity to integrate sexual and reproductive education as well as education about gender relations. Following exchange with and training of the persons in charge of the rites, adapted messages – including HIV prevention – have been integrated into traditional communication forms, such as chants, dance and drama.

In a similar approach, other local leaders such as male and female village chiefs have been actively involved in the health promotion campaigns. For a society as traumatised by longstanding civil war as the one in Mozambique, these discussion platforms are a crucial help in redefining a commonly shared definition of social roles and culturally accepted values.

Source: Ruedin, 2006.

In the Morogoro region in Tanzania, TEHIP has operated for 12 years and has developed approaches and tools to systematically identify the barriers to community participation for the improvement of programmes and social development. For example, they have developed a community voice tool that uses a participatory action research approach to give communities the opportunity to reflect on their development preferences and to be involved in identifying and solving their own problems, as in the case described above.

4.1.4. Community participation in Social Funds

One of the increasingly popular anti-poverty instruments to emerge in recent years, designed to embrace the virtues of community participation, has been Social Funds (SFs).

In Malawi, SFs, as in many other countries, are increasingly being introduced in major development programmes. In a recent review of a major programme in Malawi, which is considered the most successful in addressing people's needs, community participation is singled out as a major factor explaining the success of SFs, and refutes the doubts about their ability to reach the poor, both at the geographical and household levels (Rawlings et al, 2001).

In analysing this programme in his country, Dulani (2000) notes that the majority of the evaluations looking at community participation in SFs have tended to generalise about the nature of community participation. As a result, there does not appear to be an adequate analysis of the participatory process itself to assess the depth and scope of community participation and whether such participation can generate the benefits associated with the new approach (ibid).

In Uganda, given the limited success in influencing SFs, CSOs have at times taken the monitoring route to ensure accountability and effective implementation of the positive elements

of the Poverty Reduction Strategy Papers (PRSPs). The Uganda Debt Network, a national NGO, is one of the organisations that engage in monitoring the distribution and use of funds from the Poverty Action Fund (PAF) set up as part of the PRSPs. The Uganda Debt Network carried out a survey in which they found that few community members were aware of the PAF money or knew about or attended the district budget conference The Uganda Debt Network then created a reporting model by means of which sectoral departments, including the health department, are supposed to submit accountability statements showing how they have utilised the funds given and whether the expenditure has met local needs, before receiving more funds (Murthy et al, 2003).

This review has focused considerable attention on investigating the extent of use of SFs, and has found that they exist in almost all countries in the region, being considered by most as the epitome of good practice in promoting community participation. Some experts, such as Van Donge (2000), argue that they can serve as a viable mechanism for ensuring the sustainability of development programmes targeting the poor. This would be done by 'grafting' decentralisation measures onto existing institutions – for example, through SF procedures – instead of embarking on comprehensive decentralisation programmes. Almost all SF programmes include a significant health component. This linking of health and livelihoods initiatives and its impact on community participation are described further in the next section.

4.1.5. Community participation in income generating projects targeted at addressing public health problems

Contemporary ideas about participation and development have the potential to liberate the powerless and thus ensure genuine participatory development by all people (Espino et al, 2004). This is why the multisectoral approach to understanding the underlying causes of ill health and to designing strategies for addressing these causes in an integrated way, is an opportunity in itself for participation at community level.

An evaluation carried out in 1998 by the International Planned Parenthood Federation of three integrated programmes (IPs) established by the national Planned Parenthood Associations in Zambia, Tanzania and Ghana, and funded by the United States Agency for International Development (USAID), found that while FP and maternal and child health (MCH) continue to be the major goals of the project, a variety of innovative approaches are being implemented to improve the general health and wellbeing of communities. For example, men's clubs have sprung up alongside women's clubs and have been working together to promote the activities of the IP in Fimwale, Zambia. The clubs are also involved in a variety of community development/ income generation projects, such as poultry farming and food preparation.

In Tanzania, IPs have overcome resistance from the Catholic Church and gained acceptance of the people living in the predominantly Catholic area of Mgeta, Morogoro Region. The contraceptive prevalence rate has since been on the increase. Community-based distribution services have also been established within villages to ease access to FP/MCH services (International Planned Parenthood Foundation (IPPF), 1998). Community members participate actively when it is their own decision and not imposed. For maximum use of the health services, the community perception and expectation about that programme have to be considered and addressed (Hossain et al, 2002).

Effectively reducing vulnerability at community level can only be addressed through community-led, community-based interventions that are multi-pronged. An excellent example of this is the Widow Support Groups in Lusaka, Zambia, who address health issues holistically as part of a broad approach to enhancing sustainable livelihoods (Family Health Trust, 2006).

Case study 3: From loneliness and hopelessness to community support and self reliance: The Widow Support Groups, Zambia

The Widow Support Groups (WSGs) are community-initiated and community-led groups of widows who have come together to improve their livelihoods (and those of their households) and give each other psychosocial (spiritual, social, physical and emotional) support. They include many households affected by HIV and AIDS. They receive outside assistance, for example from the Family Health Trust through the Children in Distress (CINDI) programme There are 13 affiliated groups in Lusaka with an average of 160 members each.

The major income generating activities which most of the WSG are engaged in include handicrafts and preparing and selling food. Income goes into a revolving fund. The money for the start up of the revolving fund was raised from within the groups (some groups have a micro credit facility, locally known as 'icilimba' where they take turns in giving each other credit from the group's savings) or from grants obtained. The group determines whether or not interest will be charged.

Part of the funds raised are used for educational support to orphans and vulnerable children (including a feeding programme at the community school) and helping other members in times of need, such as during bereavement. Another part is used to pay for medical schemes of the very poor and the elderly guardians of the orphans and vulnerable children.

The role of CINDI is capacity building, mentoring and linking to funding organisations. In 2005, five groups were linked to Zambia National AIDS Network and accessed global funds.

Source: Family Health Trust (FHT), 2006.

A programme run by Africare in Chimoio, Mozambique is addressing the needs of a particular community that was recovering from drought and war which had lead to high levels of malnutrition, in particular chronic malnutrition in children. The proposal for a multisectoral programme emanated from community meetings where lack of food was identified as a health problem. People wanted to learn how to set up agricultural projects and also receive training and start-up funding. The key informant from this project emphasised that the success and sustainability of the project is due not only to the participatory methodology adopted but fundamentally to the fact that the members of this Mozambican community started to understand the links between good nutrition and health. The main objective of the project is to improve the effectiveness of subsistence farming activities, community food security and nutrition of the target households as a direct and indirect way to alleviate suffering and poverty, and to improve health (Key informant, 2006).

The Zambian Integrated Health Programme (ZIHP) included the creation and empowerment of NHCs, mentioned above. Many of the NHCs have embarked on development programmes that seek to integrate health concerns with other community development initiatives. In Kapata, the NHCs applied to national government for Community Health Innovation Funds (CHIFs) and used them to initiate income generating activities to fund home-based care for AIDS sufferers (ZIHP, 2005).

Case study 4: Neighbourhood Health Committees in Kapata, Zambia

The 10 NHCs in the Kapata Health Centre Catchment Area, in Chipata District, identified HIV and AIDS as a priority area during their Participatory Learning in Action (PLA) exercise, implemented with assistance from the Chipata DHMT and the ZIHP. They recognised that HIV and AIDS was the root of the problems certain households were experiencing (households with widows, orphans and chronically ill patients).

These NHCs decided to work together to help solve the problem. They applied to the CBoH for CHIFs. They were awarded the funds that they then used to purchase an oil press. They have joined with the farmers who are producing sunflowers and they are working together to produce sunflower oil. These communities are using the proceeds from the oil sales to provide home-based care for the HIV-affected families.

They are also providing care through home visits. During the visit, they provide food, bring appropriate medicines from the clinic, and provide health information using the materials provided by ZIHP.

These NHCs have also partnered with a local CBO called Families in Distress. Working together with the CBO, they are providing health education and behaviour change communication throughout the 10 communities. They are using the resources provided by ZIHP and the National AIDS Council.

Mr Munene, the Health Centre Chairperson in Kapata, has said, "These communities have realised the need for a collective responsibility in mobilisation of resources and implementation of activities for HIV and AIDS." These communities are showing their care and support for those affected by HIV and AIDS and are trying to prevent the infection from spreading by working collaboratively.

Source: ZHIP website, 2005.

In South Africa the HIV and AIDS pandemic and the patchy government response to it have acted as powerful incentives for communities to organise themselves into self-help groups. Local government has subsequently taken the lead, in many areas, in supporting these groups, usually incorporating HIV and AIDS programmes into broader local development programmes. A good example of this is the Umkhanyakude District Municipality's support for the Sibambiseni HIV and AIDS initiative.

Less well known are the hundreds of multisectoral approaches initiated, developed and implemented from within communities and by communities. The fact that most of the case studies are not part of published literature is a challenge for community organisations and structures, who should be documenting their processes as a means of disseminating their experiences to shape and influence policies at district and national level.

Case study 5: Community participation in combating AIDS in Umkhanyakude District, KwaZulu-Natal, South Africa

Sibambisene is registered as a Section 21 company and has the recognition of the local Umkhanyakude District Municipality. It provides a strong leadership and intersectoral district-wide HIV and AIDS co-ordination role and can be seen as one of the most imaginative local initiatives anywhere in the country. Sibambisene is derived from the verb bambisana, which means 'to co-operate', literally, 'we co-operate together.' Sibambisene is at one level a forum where everyone in the district meets to strategise on how to win the war against HIV and AIDS. But it is more than a talk shop: it is also an action-oriented collaboration with well-formulated plans on how to work together to defeat the disease. There are five programmatic elements, the most important of which are home-based care, a strong education/prevention programme, and care and support for children in need of special attention. Income-generating activities are also promoted.

The Lebombo Spatial Development Initiative, which participates in Sibambisene, is a powerful government-driven, multi-disciplinary thrust to stimulate economic development in the area, particularly through ecotourism. Several corporate donors have rallied together to support the initiatives of the district and to work collaboratively with them. In addition, an advocacy and marketing campaign is the last element of a powerful strategy to mobilise community structures, tribal authorities, local government and other government departments to join in the struggle against HIV and AIDS and overcome stigma and a dereliction of health rights.
Sibambisene also participates actively in the development of the Integrated Development Plans of the municipality, which include the health sector, as a genuine voice from the community.

Source: van Rensburg, 2002.

4.2. Community participation at district level

This section looks at the district level more closely, and presents evidence of how the way in which district authorities carry out their key functions – resource mobilisation, health service provision, planning and decision-making – either enables or blocks community participation.

Community participation at district level in different countries is strongly affected by the form and degree of decentralisation of the health system in each. The levels of decentralisation define, in principle, the levels of authority. To assist in understanding the situation across the region, a model developed by Mills (1994) and Gilson et al (1997) was adapted for the five countries selected in order to summarise the form and level of decentralisation reported in the literature (Table 3).

Table 3: Forms of decentralisation in selected countries in Africa

Form	Description	In practice
Deconcentration	• administrative responsibilities transferred to locally based office/s of central government ministry within the health system • accountable to higher levels of government	*Zambia, Malawi:* deconcentration to district health management teams *Mozambique:* deconcentration to provincial offices (Harbeson, 2001)
Devolution	• political authority transferred to statutory agency or local government municipality; health functions decentralised of the whole public systems to local government • able to generate revenue owing to statutory status • accountable to electorate	*South Africa:* some health functions devolved to local government; in practice not fully independent *Malawi:* waiting for constitutional amendments (UNCDF, 2001) *Mozambique:* some functions like environment and cemeteries decentralised (Libombo, 2003)
Delegation	• managerial responsibilities transferred to a semi-autonomous organisation e.g. parastatal or board • aim to free central government from day-to-day management function • accountable to central government	*Zambia:* creation of hospital boards to manage hospitals and district boards to oversee districts on behalf of government Kenya and Malawi: bad experiences because of lack of resources and skills (Oyaya et al, 2003; UNCDF, 2001)
Privatisation	• transfer government functions to a private (profit or non-profit) entity • accountable to government and consumers services	*Kenya:* transferred provision of curative care to private sector, but functioning poorly owing to lack of regulations and weak oversight (Oyaya et al, 2003) Limited in Africa; has mainly been voluntary organisations and missions providing services on behalf of government

As can be appreciated from the table above, health sector devolution is diverse:

- it takes on a different strategic context according to how it fits into broader programmes of health sector reform; and
- it has different organisational forms.

It appears in the literature that these systems are not always clear-cut in practice, and any one system might well combine different aspects of these systems. Countries tend to mix a number of different forms of decentralisation in their government system (Collins, 2001).

For the purpose of this review it was important to have an idea of the degree of decentralisation and its diverse forms in order to understand the link between district management structures and the decentralisation strategy, specifically with regard to the transfer of authority.

4.2.1. Community participation in governance structures at district level

The district level is the focal point of a primary health care system where strategic planning and decision-making takes place to improve the health of the community as a whole. Through the decentralisation process, district management teams (DMTs) were established and governance structures – such as DHBs – were created to facilitate effective partnership between stakeholders and to foster community involvement.

Roles and accountability

Several studies have investigated district management and governance structures; however, there is still a scarcity of literature. What seems to emerge is that, in general, the role of DMTs and DHBs is still not clear. It seems that national level health planners' and policy-makers' interpretation of decentralisation and community participation is reflected in the way that authority is granted in practice to the lower levels. This lack of clarity often acts as a barrier to community participation.

A study in Kenya showed that although, in general, people at local level are satisfied with the introduction of decentralised governance structures, one stakeholder at district level felt that at district level people in key decision-making positions are not clear on many issues regarding the reform process. An example given was the lack of a clear definition of the role of various district-level health officials, non-governmental health care providers and communities within the newly defined DHS, particularly with regard to lines of responsibility and accountability. Another example was the lack of clarity concerning the tasks of the DHMTs in relation to the requirement that they work closely with the communities in planning and provision of health care. While the DHMTs are expected to initiate the development of local policies and plans, they have been given neither specific instructions nor resources to undertake this task (Oyaya and Rifkin, 2003).

The problem of lack of clarity concerning roles was also reported in Zambia. Owing to the lack of clear guidelines about the roles and functions of DHBs, which are legal entities created by an Act of Parliament, they were dissolved after completing their first term in office because it was not clear how they should be replaced or continue in their mandate. But a number continued to function, as they were playing an important role, until clear guidelines were developed and all DHBs were reconstituted (Macwan'gi and Ngwengwe, 2004).

Scope of authority

In South Africa no study was found, with any degree of detail and analysis, on the level of knowledge, understanding and development of the DHAs and the DHCs, which are struggling to get going. In 2005 a new Health Act came into operation. This provides for the mandatory establishment of DHCs, with formal representation from local government politicians who are democratically elected. Some Health Systems Trust (HST) experiences in some districts in the Eastern Cape province confirmed that they are still in the early stages of dealing with the very initial steps, dealing with the legal aspects of defining the scope of their authority and the separation of power between local authorities and provincial departments, which are separate spheres of government, not different levels.

Composition and criteria for forming part of governance structures

Problems have also arisen in the implementation of the decentralisation policies, owing to problems in their conceptualisation. Bossert et al (2000) describe the Zambian process, in which

the general rules of governance are fairly narrowly defined by the central authorities in the National Health Services Act of 1995 and in the guidelines set out by the CBoH. The central decision-maker in the district is the DHMT, but the DHMT should involve the local community in the decision-making process. The DHMT is supposed to first form the DHB, usually made up of between four and 10 local community members. The boards were to be proposed by the districts and approved by the MoH.

Macwan'gi and Ngwengwe describe this process in more detail, noting that the guidelines specify that using a democratic process, the DMT shall, through the office of the District Council Secretary, nominate and submit the names of the board members to the Minister of Health for appointment (Macwan'gi and Ngwengwe, 2004). Thus, a system that was intended to be decentralised is in practice still largely controlled from the centre.

Communication

However, communication between the DHBs and the communities they represent seems to be poor. In some of the districts studied, although knowledge about the roles and functions of DHBs is high among DHB members and DHMT staff, it was very low among the ordinary community members.

In Malawi the District Assemblies are currently dissolved and, according to our informant, decisions are taken by technocrats. The input of communities to the districts is happening in an informal way. It may be interesting to investigate more about the impact of this less-structured relationship between communities and councillors and evaluate its effectiveness in voicing communities' inputs.

Performance

In terms of performance, it seems that DHBs in some districts in Zambia were considered to operate effectively and to be a necessary entity in both planning and delivery of health services (Ngulube, Mdhluli, Gondwe and Njobvu, 2004).

In an evaluation of the effectiveness of DHBs in interceding for the community, DHBs were reported to be playing a pivotal role in policy guidance and advisory services to the DHMT (Macwan'gi and Ngwengwe, 2004). However, the same study reported limited knowledge at community level of the existence of the DHBs, with many blaming non-functioning NHCs for not informing their constituencies as they should.

Relevance

Governance structures at district level were formed to enable community participation, but even with the limited documentation available, one can conclude that while on the one hand they enjoy legitimacy and are recognised as playing an important role when they are functional, there are problems. Right from the stage of conceptualisation it appears there were problems in the interpretation of their composition, roles, functions and authority to intercede for the community they are supposed to represent.

More research needs to be done in each country to understand the intrinsic organisational issues and processes and to come up with recommendations to strengthen the district heath governance structures as a key element of improved community participation and democratisation of the provision of basic services.

Table 4 below summarises evidence of poorly functioning governance structures in three countries, reflecting that the essential elements that make governance structures functional are lacking or undeveloped.

Table 4: Functioning elements of district governance structures in Zambia, Malawi and South Africa

Country	Appointment of members	Roles	Accountability	Performance	Communication
Zambia	DHMT select and submit to higher levels	Relatively clear; it varies	Poor to communities	Perceived to be uneven	Poor; usually one way
Malawi	District Assemblies (past) None (currently)	Relatively clear (past)	Unknown	Unknown	Informal
South Africa	DHMT currently since they are not formalised	Unclear	None (currently)	None	Informal

4.2.2. Relationship between district management teams and district governance structures

The desired relationship between DMTs and district community structures is generally described in most countries in guidelines issued in terms of enabling legislation. These guidelines are the tools for operationalising the new institutional arrangements at different levels, and specify roles and functions. However, several years later in the implementation of decentralisation policies, there is still confusion in a number of countries, and in many instances the recommendations contained in the guidelines are not implementable (Bossert et al, 2000). An important constraint in developing the desired relationships, and thus achieving full and genuine community participation, is the lack of definition around the composition of district health structures.

In Zambia, understanding of the roles, responsibilities and selection criteria of boards and committees varied from district to district and between boards and DHMTs. This occurred in all the districts. However, the central authorities did not clearly define who should be selected; nor did they determine whether selection should involve any voting procedures. Members were usually drawn from the local urban elite, which included teachers, farmers and businessmen. However, board composition often included some residents of rural areas. Most of the boards did not appear to include representatives of the local government, but the boards appeared to have been formed prior to the distribution of guidelines that contained this criterion (ibid).

A similar situation was reported in Kenya where the Minister of Health appoints the members of the board which are recommended by the District Medical Officer (on behalf of the DMT) and other authorities. Board members selected are supposed to be highly respected people of integrity, with professional and technical know-how in their respective fields. Very often they are selected on the basis of political allegiance and patronage. Consequently, they are not accountable to any defined constituency except the appointing authority (Oyaya et al, 2003).

These practices reflect the lack of clarity in guidelines that results in a lack of transparency, which unfortunately seems to be the pattern in many countries. In Mozambique an organisation called Organização Suica de Entreajuda Operaria (OSEO) has warned the stakeholders in the sector of the threats that this type of top-down autocratic approach represents (Querol, 2005). This organisation is facilitating the decentralisation process in the Manica province and has detected the tendencies that the Zambian and Kenyans have identified.

This issue emerged as a key risk area during this review, in terms of progress towards achieving the desired relationships between stakeholders, and requires further investigation. While stakeholders are satisfied with the new decentralised systems, it seems that there is a fairly general concern that the process is not sufficiently democratic.

The gap between policy-makers and implementers at district level has been described in Zambia where, within the decentralisation process, the districts did not gain much control over personnel, although it had been anticipated that staff would be 'de-linked' from the Ministry and then the districts would have assumed responsibility for hiring and firing, and for paying salaries. This de-linkage occurred in 1998 for the non-professional staff only. For the period 1995 to 1998, there was little change observed for the professional staff of doctors, nurses and other health professionals. This situation has created low motivation amongst health workers, owing to uncertainties regarding future conditions of employment, and they were dissatisfied with their present conditions as salaries did not reflect actual responsibilities. However, they believed that health workers who continued to provide the best possible services did so because of professional ethics and increased control over decisions by the governance structures. In one district, the board was said to have provided moral support to the DHMT (Bossert et al, 2000). The same study highlighted that the quality of the services has not dropped, owing to the good relationship between the governance structure and health workers.

Furthermore, in this learning process of developing new relationships, there have been situations where the community has questioned the performance of governance structures. However, there are factors that constrain community structures from disciplining health workers, such as those related to the socioeconomic differences between health workers and the community they serve. In a study in Zambia, health workers were considered to be more educated about health matters than the health clinic committee members, and ordinary people were perceived not to be knowledgeable and competent on health issues (Macwan'gi et al, 2004). In the same study, some of those interviewed during focus group discussions said that the DHB had failed to act and that was why there were no improvements in terms of medication and the quality of care patients received.

Ngulube et al also looked at reasons for poor performance in Zambia and noted that, while reasons given for poor outcomes, measured against district plans and budgets, looked logical and understandable, they did not tell the full story. Reasons given included incorrect census population figures used to calculate funds to be allocated to the districts, and human resources crises resulting in overworked, under-skilled and low-performing personnel. However, the authors eventually concluded that the real underlying cause of the poor outcomes was mainly the reluctance to share power on the part of health workers at each level, stuck in outmoded, bureaucratic and hierarchical ways of working (Ngulube et al, 2005).

The same study concluded that health managers, in cascading decisions from national to lower levels, generally do so in an authoritarian way, using governance structures only to rubber stamp decisions. This top-down approach, without discussion and debate on policy issues, does not consider local priorities. It was even reported, in some instances, that community inputs were unwelcome and representatives were threatened with some form of punishment for their initiative. It would seem that this attitude derives from the power of health managers, which has not changed fundamentally with decentralisation and continues to undermine genuine community participation (Ngulube et al, 2005).

From some of the cases reviewed, it seems that the previously unchallenged power and authority of health workers can be contested with the establishment of governance structures on which communities are represented directly. However, there is evidence that perceptions that only those who are knowledgeable on health issues can take decisions might influence relationships and can act as a barrier to the effective performance of community structures. The power and influence wielded by health workers because of their socioeconomic status also affords them a disproportionate level of influence in such structures.

In this section the issue of governance structures that in practice do not achieve their democratic objectives emerged quite strongly. On the one hand, genuine democratic representation requires that clear selection criteria, that take into account representation of all sectors of society, in particular the most disadvantaged, be established and adhered to. This element is essential when analysing the facilitating role and impact of district governance

structures in voicing community concerns and inputs. On the other hand, there is a need to challenge the balance of power, which generally favours the technocrats, and to learn from examples where this has been achieved. It would seem that these aspects need further research, so that ways of ensuring broad representation and effective participation of all sectors and classes in society can be identified and practised.

4.2.3. Community participation in district planning and decision-making

Effective participatory local planning requires inclusive processes of consultation and links among the planning, decision-making and accountability elements of local governance. Many local planning processes, although internally well organised, are marginalised by weak connections to the organisations that are authorised to make decisions and manage resources. They tend to be led by individuals rather than institutions. Where, for example, in the Zambia districts, the District Medical Officer of Health is both a leader and a manager, the implementation of the policy seems to be working and where there is no leadership capacity, little progress is made (Bossert et al, 2000).

In a study carried out in rural and urban districts in Zambia 2004, it was reported that the DMTs develop plans and submit them to the DHBs for approval. Although the current national procedures allow for community input in health care planning and resources allocation they found that this is not the case since plans, even when submitted by the lowest levels (NHCs), are still 'finalised' (i.e. so as to exclude some of the activities planned by the NHC) at the district office (Macwan'gi et al, 2004).

Further analysis of this attitude amongst district managers, in the context of a study of power relations at district level, showed that health managers were driven by the need to be seen to support government policy with the available resources and political climate. Policy and implementation were interpreted to suit this understanding, not necessarily whether the desired goals were attained or attainable. This led to a situation where supervisory roles and responsibilities were not adhered to, and were selectively implemented to suit the desired policy context. This resulted in available resources being used to serve the needs and interests held by the most powerful rather than the needs and interests of the partnership at each level in the health system; the higher the level in the health systems, the more power was wielded (Ngulube et al, 2005).

Key functions related to planning and decision-making, such as approval of annual plans and budgets as well as district health development plans and monitoring and evaluation of the process of all health activities in the districts, were less frequently reported as roles of the DHB (Macwan'gi et al, 2004). In the same study it was suggested that their limited or lack of knowledge of medical aspects and/or lack of the appropriate managerial skills, might be barriers to full participation by the DHBs.

In South Africa a new health system has been developed since 1994. The main challenge has been to overcome the fragmentation of services inherited from the Apartheid era. Districts still fall under multiple, different health authorities and therefore have multiple, different plans for the same catchment population. Functional integration initiatives have been introduced to overcome this backlog from the fragmented Apartheid systems, but the devolution process has been slow. Officials from each authority sit and develop district plans jointly, but each submits their own plans to their own authority, with their own budget allocation. This leads to poor distribution of resources, which should be sufficient, compared to other countries in Africa.

The Initiative for Sub-District Support (ISDS), the district development programme of the HST in South Africa, has been working at district level since 1997. Its main aim is to facilitate the implementation of the DHS, developing health systems and capacitating health workers, governance structures and all stakeholders at district level. At the beginning most district teams had no formally appointed members and they were even employed by different health

authorities. The planning process used to be an innocuous exercise of adapting the provincial plans by just changing the name of the province and replacing it with the district name (ISDS, unpublished). This does not appear to be an isolated case: Ngulube describes the perception of planning in Zambia as an annual 'business-as-usual' routine exercise (Ngulube et al, 2005).

In the Lejweleputswa district (one of the ISDS sites), after four years of systematic work including the building of the district health information system (DHIS) from a zero base, the results were promising, although the participation of councillors for health was at that time not regulated as it is now by legislation. Even today, their participation is patchy and community participation in district health activities cannot be considered to be significant.

The Lejweleputswa DMT described the lessons it learned in the process as follows (Báez, 2001):

- The process of planning helps in team-building and overcoming fragmentation.
- When the district itself sets its own targets, this creates confidence in the understanding of the information and ownership of the process, and enables the district to communicate and engage with communities effectively.
- The process of planning also contributes to the individual monitoring and evaluation skills of all managers, as well as to their ability to produce timely and insightful reports, based on reliable information.
- Appropriate planning, linked to reliable information, shows a high degree of development of a district, and strengthens district resource demands at provincial level.
- The ownership of plans by the different stakeholders will ensure that the plans become living documents used as tools for monitoring and evaluation.

In 2000 the new district boundaries were defined and new local councillors elected. One of the instruments that municipalities are developing is the Integrated Development Plans (IDPs) in each municipality/district, but there is little participation of health workers, NGOs and communities. Case study 6 shows the difficulties in implementation of decentralisation policies where health is not seen as a priority.

Case study 6: Planning by District Municipalities in South Africa

In a study commissioned by the HST in South Africa, to evaluate the IDPs of municipalities, it was found, predictably, that amounts budgeted for health-related development projects as a percentage of the total IDP budget, varied considerably (from 47% to below 1%) in eight sites which provided suitable information. This could be a reflection of the varying importance assigned to health issues by the municipality, but could also reflect historic need or other more pressing needs in the municipal area. Lack of information precluded a reliable assessment of the health officials' participation in the IDP processes. Generally, indications point towards inadequate participation, although many IDPs nevertheless appeared to have good health information. Community participation in IDP development, a legal requirement, is increasing, although few municipalities have effective strategies.
The nature of health projects undertaken by different municipalities varied greatly. Categorisation into infrastructural, curative and preventative type projects suggests that most projects fall into the first two categories. HIV and AIDS related projects, the main component of the third category, were given high priority, presumably as a result of corresponding emphasis in the Department of Provincial and Local Government (DPLG) IDP guidelines, but these projects are frequently presented in isolation and do not link holistically with other health activities.

Source: Moodaley, 2001.

The evidence showed that, in general, community representatives and communities are poorly engaged in participating in health planning and decision-making processes at district level. Lack of knowledge of medical topics and of managerial skills might be a reason. However, in all countries, regardless of the level of decentralisation, the professional elitism of health workers and bureaucrats remains a significant barrier to community participation. There persists a

reluctance to trust in communities' capabilities of identifying their own needs and deciding on their own health.

4.2.4. Participation in and utilisation of district health information systems

The DHIS is the cornerstone of the DHS, because planning information at district level should be the aggregation of the information from the lower levels. Information enables DMTs, DHCs and councillors to take informed decisions as well as to plan according to local needs in a realistic way. The impact of setting their own targets and achieving them has shown positive results in team-building at district level (HST, 2001, unpublished).

It might sound overly technocratic to assert that "Nothing exists until it is measured" (AbouZahr et al, 2005), but it is indeed essential to have available reliable information to make well-informed decisions at district level. The Alma Ata Declaration on PHC refers to "scientifically sound" actions and programmes, and the DHIS is, in practice, one of the most powerful tools for enabling programmes to remain faithful to one of the principles of the PHC approach.

To convert the DHIS into an instrument used by all stakeholders, there are two fundamental issues to be demystified: firstly, that the DHIS is not a software package that requires high-level computer skills; and secondly that information is produced at community level, and therefore belongs to the communities (not to the higher levels). This was the case in the implementation of the DHIS in South Africa – district programme managers had to use the information regardless of their computer skills. The IT departments, the data capturer and the information officer at district level should provide the information to the management meetings, in graphs or spreadsheets. It was a discovery for the HIV and AIDS councils' members to know whether the numbers of people coming for HIV counselling were increasing or not.

The role of DMTs and DHBs should be to analyse the information provided and act accordingly. On the other hand, the other aspect that needs to change is the bad institutional culture of one-way reporting. In particular, the district administration has a responsibility to feed back to the providers of the district information (lower levels) after the analysis has taken place. This can happen through different mechanisms that each district has to define. In South Africa, the PHC supervisors' job description is based in the utilisation and discussion of information at clinic and sub-district level, including feedback as part of the supervisory system to improve services and programmes. Later, an additional task was added – to attend clinic committee meetings in order to share the information and the progress with its members and enhance community participation through empowerment with information.

This review confirmed that DHISs are in different stages of development and implementation in different countries in Africa. For example, a paper on Mozambique's information systems identified problems with the software development agencies involved, including lack of co-ordination, poor understanding of user requirements and inflexible systems designs (Kimaro and Nhampossa, 2005). On the other hand, the district information systems in Zambia (CBoH, 2003) and South Africa (WHO, 2004) were classified as being standardised and functional. However, none of these evaluations talk about the utilisation of information by health workers and governance structures for decision-making at all levels of the health system.

The literature only offers guidelines from the ministries of health on how to implement the DHISs. It was difficult to find documentation on the utilisation of the information at community and district levels. The Kenyan example, given earlier in this paper, does not reflect the upward flow of information to the district and how the district structures use this information to take well-informed and fair decisions. DMTs and DHBs should be using the information from the clinics and systematically analysing the trends and performance of the PHC programmes.

The universal use of information remains a challenge for health workers, governance structures and other stakeholders. Planning at all levels needs to be done based on locally generated data and this data needs to be accessible and familiar to all decision-makers at district level.

Research conducted by the TEHIP project in Tanzania, for example, showed that planning was not being conducted as a response to the burden of disease (as described in Case study 7). This example brings another dimension to planning at district level: there is a need to take into account multiple information sources, not only the routine data collected by health facilities (e.g. a high proportion of deaths occur in places other than formal health facilities). The evidence from this case study was that planning done in response to the burden of disease became more effective in ensuring the more equitable distribution of resources and health outcomes.

The results of the whole intervention showed marked improvements in health outcomes. For example, in the Morogoro and Rufiji districts, the under-five child mortality rate fell dramatically by over 40% in the five years following the introduction of evidence-based planning (Savigny et al, 2004).

Case study 7: The Tanzania Essential Health Interventions Project (TEHIP)

Research by the TEHIP into three distinct areas – health systems, health behaviour and health impacts – provided critical insights that aided health care reforms in Rufiji and Morogoro. One of the most striking findings of the inquiries into health-seeking behaviours, for example, was that most deaths (close to 80%) occurred at home rather than at a health facility. This statistic underscored earlier doubts about the use of attendance and cause-of-death statistics – compiled by the government on the basis of health facility data only – as an aid for planning health budgets. Surely this form of planning could not be reliable since it was based on only 20% of deaths. Since Demographic Surveillance System (DSS) information, by contrast, captures all deaths – those that occur in health facilities, in households and elsewhere – it can be counted upon to give a more accurate and complete portrait of the burden of disease as experienced by the community.

Another surprising revelation arising from research into health-seeking behaviour was that the people who had sought modern health care prior to their deaths greatly outnumbered those who had not. For malaria, 78.7% used modern care, only 9.4% used traditional care and 11.9% used no care at all. These figures prove that the death rates in Rufiji and Morogoro were not primarily an outgrowth of a preference for traditional healers over modern health care (as some observers had speculated), but are more reasonably seen as related to problems of access, delay or the apparent inability of modern health facilities to prevent these patients from dying. Formative research into the health systems' planning process confirmed that planning was not being conducted as a response to the burden of disease, but instead was driven by a wide range of factors including donor agencies' agendas, bureaucratic inertia and simple guesswork.

Source: TEHIP, 2004.

4.2.5 Participation in resource allocation and management

Decentralisation allows districts to make decisions regarding the allocation of resources, user fee levels and expenditure. However, this review was not able to find information from many countries on the role that communities and governance structures at district and local level play in resource allocation.

User fees

A key element of the health reforms and of the demand-responsive approach in general is the requirement that users contribute financially to the services that governments provide. This is intended to ensure demand and participation, and thus enhance the chances of sustainability, as well as to co-fund services and thus improve them. However, no clear evidence was found that links the payment of fees to greater community participation in decision-making. An evaluation undertaken in Bamako confirms that where money generated at the local level was

kept at the local level and not returned in any part to the central government, it resulted in improvements in the quality of care and immunisation coverage. This mechanism ensured that at least resources were available at the point of need (Hutton, 2002; Oyaya et al, 2003).

However, ensuring equity was a big problem. Interviews showed that the very poor were never asked by officials about their concerns, reflecting a continued top-down planning process in which professionals decide what is best for those without access to power and resources. In addition, the poor had little chance to join bodies that were involved in decision-making for collection and use of funds at the local level. As the study stated, ''community decision-making bodies created to strengthen accountability by giving a 'voice' to the community often did not appear to serve the interests of the poorest'' (Oyaya et al, 2003).

In Mozambique the situation is similar where user fees are only a small fraction of total budget – an average of 2% of total spending. Almost all of the recorded user fees are spent at the district level and virtually nothing is retained by or returned to the facilities. Charging regimes are highly diverse and users face inequitable, arbitrary differences in charging practices. Users pay an average of 1,700 MT (about US$ 0.06) per consultation. Nearly half of those paying said it was difficult to find the money. Illegal overcharging appears common and results suggest that only around 68% of the value of consultation fees paid by users is recorded at the facilities and remitted. Communities in Mozambique have not benefited at all at local level from this strategy for improving services (Oxford Policy Management, notes, 2004).

In Kenya (see below) the user fee system was also failure and has been abandoned.

Allocation of resources

Loewenson analyses the factors that influence resource allocation and mobilisation at local level. She notes that it is important for sustaining health systems, and for other forms of CIH, to reach agreed and acceptable levels of shared control over resources between clients and providers. While communities are willing to contribute towards health systems, negative lessons from the history of user fees indicates that community contributions need to be locally organised, to address local priorities, with value placed on cash and in-kind contributions. There must be visible impact on quality and relevance of services, locally applied and collective measures for ensuring equity and they must be organised and managed through representative structures such as HCCs (Loewenson, 2000).

The high willingness of communities in Zambia to support the resource allocation process was identified as a strength of the role of the DHBs in resource allocation. The same study recognises other strengths that DHBs have in this regard, such as approving/ disapproving the district health plans and budgets and being a potential source of funding. However, DHB members felt they had a limited understanding of budgetary processes and technical (medical) aspects, which prevented them from having a meaningful input into resource allocation (Macwan'gi et al, 2004).

District- and sector-wide funds do present an important opportunity for more innovative approaches towards linking community planning and inputs with accessible resources. Analysis of the performance of the first two years of these funds in Zimbabwe indicated problems of slow uptake owing to uncertainty about procedures for their use; variable levels of fee collection; weak application of allocative guidelines, particularly in terms of community-based interventions; strong demand from large hospitals; and weak community knowledge of the funds (Loewenson 2000).

In Zambia at present districts can spend only 2–5% of their budget on the Essential Health Package for the community level. It is very likely that an effective health package for this level requires a much higher input. Districts, like Kalabo, are now dependent on other sources of funding to implement successful approaches in community health development, to fully reflect the health reforms (Masuka et al, 1997).

Case study 8: Community contracts in the Kalabo district, Zambia

The Kalabo district in Western Province in Zambia introduced the practice of community contracts in 1990 to mobilise communities to actively participate in controlling the factors affecting their health. The gradual introduction and development of community contracts was an effort of the district to enhance active community participation in sustainable health development. The principle of loan-barter is that the district provides certain inputs valued at a certain price (purchase and transport) and gets this refunded in produce at a fixed value and a fixed period in time (e.g. time of delivery of inputs or after harvest). The price of delivery of the implements is converted into a quantity of agricultural produce, equating to the actual market prices. The produce is then marketed by the district and income put in a special account to be used for engagement in new contracts (not necessarily with the same community).

Community contract guidelines were developed as well as a standard contract format. Health staff and VHCs were prepared for engaging in such ventures. A well-established and active VHC can request HC staff to enter into a community contract if certain inputs are needed by the community in their activities to develop their health and well-being and if these are otherwise not available. A community/VHC proposal is discussed and assessed by HC staff and then forwarded to the district level which administers and co-ordinates the contract activity.

Good health outcomes were reported by the Kalabo district and the approach has enhanced a more equitable resource distribution in the district as all health centres had a share and all communities with a VHC signed one or more contracts. It also addresses issues of community-based health services, maternal health and environmental health, since the access to safe water points within walking distance has risen from 4% to 20% over four years.

Some of the lessons learnt recognise the need for proper community preparation, support by all key staff at district and health-centre level, setting of targets and indicators, with information from routine and survey data, development of tools for monitoring and evaluation, and capacity building as part of the programme. Successful community participation was facilitated by an enabling institutional framework, decentralised decision-making authority and effective, proactive district health structure.

Source: Masuka,, Mukelabai, Pannemans and Koot, 1997.

Poor financial management skills

Decentralisation of responsibility for resource allocation, and the potential it has for enhancing real community participation in decision-making, is often undermined by the relative lack of financial management skills and experience at district level. A study in Kenya showed that the main cause of the high levels of corruption and mismanagement in the health system was the lack of resources for the training of the DMTs and DHBs. This produced organised (e.g. through consumer organisations) and unorganised community complaints (Oyaya et al, 2003). Apparently this gap was not identified by the authorities and in January 2004 the Kenyan MoH, unable to resolve the problems that arose from the bad implementation of the user fees system, where the problems were most acute, had to abolish it (personal communication, 2006). It was not possible to find documentary evidence to corroborate this information, nor to ascertain whether the system was done away with in some areas or for some services, or in its entirety.

In South Africa the district health expenditure reviews (DHER) integrate financial, service and population data essential for general health service planning, monitoring and evaluation. It is a critical component of health systems planning and management, since districts cannot plan and manage without it. Although there is a long-term plan to have functional DHER teams, the HST, which promoted this tool, identified some lessons in its implementation. Amongst them was that the fact that the DHS and the DHMT were in their early structuring and development phase, limited their ability to use the information generated; that finance was always something that somebody else did and controlled; that sometimes people had the knowledge but not the authority regarding financial resources; and that management is often in a comfort zone of half knowing and managing chaos (Engelbrecht, 2001).

Like information and the use of information, it appears that financial matters in health systems are a new area where both health workers and community members feel uneasy owing to, according to the literature, lack of capacity in this field. Capacity building in financial management is urgently needed. Corruption might decrease if systems were in place and if they responded to the realities of the district and had closer community control.

Guidelines
A recent study in Zambia concluded that failure to adhere to set guidelines and the lack of participatory skills of health workers open the process of planning and budgeting to abuse and to the use of informal mechanisms to exclude views and interests of less-powerful stakeholders, especially those at community level (Ngulube et al, 2005).

Finally, another important element that was also highlighted in the literature are guidelines that are not adequate and do not follow the pace of developments. Community structures should be engaging and pressurising authorities to review policies and guidelines periodically, based on the experience of districts.

4.2.6. Participation of councillors as part of governance structures
Councillors' roles in health vary from country to country but their potential power and influence must not be underestimated. They are elected community members who, from the moment they are allocated the health portfolio, are accountable to their constituents and in some countries, such as South Africa and Malawi, by law. Therefore, it is important for communities to know about their obligations to be actively involved in governance structures.

Councillors need to make well-informed decisions based on local reality and trends. A survey done by the HST in the Chris Hani district in South Africa showed the lack of knowledge of councillors about health policies, programmes and indicators (Báez, 2002). A similar situation in Malawi was reported by a key informant from Malawi, an MP. He reported that parliamentarians are not well informed about how to use information systems and indicators, excepting those most commonly needed in the political arena, like STI or HIV incidence rates. He emphasised that there is also a need to develop these skills not only within parliamentarians but also members of the District Assemblies (personal communication, 2006).

The Aga Khan Health Service in Kenya also identified the need to encourage the widest possible representation on DHCs, including local administrative bodies and councils. However, there should be a mechanism for instituting accountability so that the stronger members remain accountable to the larger community. DHC powers need to be clear, especially in defining the general, as opposed to the technical powers of the committee. Local politicians should be involved from the start, with the understanding that their role is to resolve conflict rather than daily management. They must also remain accountable to those who elected them through some kind of village-wide forum. Finally, there is a need to build the capacity of councillors by including them in training programmes already provided for DHCs (Sohani et al, 2004).

4.2.7 Participation of other stakeholders at district level
The definition of the DHS is inclusive of other stakeholders in health who are operating within the boundaries of the district and whose actions might influence the health of the community.

Two examples were found, one from the Valley Trust, a long-established NGO in the KwaZulu-Natal province of South Africa, which works very closely with rural communities, facilitating participatory approaches in integrated health and agricultural programmes. The informant at this organisation reported that although the DMT knows about them and their positive impact on children's nutritional status in the communities in which they work, their relationship with the DMT is very poor and sometimes hostile. Health NGOs are supposed to be part of the DHC and DHA but in this case this has not happened (personal communication, 2006).

In the north of Mozambique a Swiss Development Centre (SDC)-funded project called Wiwanana works together with Solidar-Med (a Swiss NGO). A report on an external evaluation of this project conducted by the national government recognised the important positive impact of the participation of the NGO in provincial management and planning meetings. However this practice was not supported by a senior director and it was discontinued (Cumbi et al, 2004).

This could have been the result of a personal viewpoint or might be part of the antipathy towards insensitive externally driven aid programmes and agendas created over the past few decades. The DMTs and governance structures should develop mechanisms to protect the interests of the districts and at the same time include stakeholders, if not in decision-making then at least in having a say. Often these NGOs are from the community or are national organisations like Valley Trust or even external agencies with honest and respectful attitudes, as in the case of Wiwanana (ibid).

4.3. Analysis of enabling and inhibiting factors at community and district levels

Having presented and contextualised in the preceding two sections the information gathered on community participation at community and district levels, this section analyses the evidence in more detail, with particular reference to the role of districts, and under different broad thematic headings.

4.3.1. District-level governance structures

It is abundantly clear from the evidence from all of the countries reviewed that the extent, content and outcomes of community participation are fundamentally influenced by the extent to which district governance and management structures function as intended, interpret and implement policies correctly and support community participation at both community/facility and district/governance levels.

Undefined roles and functions and poor or complete lack of communication mechanisms at district level, and between district and community levels, are demotivating factors. The literature shows that many years down the line of health reforms, decentralisation policies lack political recognition and clarity of roles and functions of local governance structures. In some instances these gaps can constitute potential risk factors for the sustainability of such structures. Most frequently, however, these weaknesses seriously compromise effective community participation.

However, where district governance and management structures function as intended, and there are several examples of this, they act as enabling factors. This suggests that health programmes aimed at improving health outcomes through better community participation, should focus as much attention on district governance structures, and their relationship with both the management structures at this level and community-level structures, as on participation at community level.

An important factor in the functioning of district structures, which affects whether they facilitate or inhibit community participation, is the effectiveness of the two-way communication between them and the people they represent. A district is composed of all the stakeholders in its area of jurisdiction, so communication strategies need to be developed, implemented, reviewed and respected. District boards should have some measure of accountability to community committees, or at least they should be required to communicate with them. Where this does not happen, it reduces the potential effectiveness of these committees in the priority setting process and in other roles.

In addition, poor communication and feedback can also lead to poorer performance and low confidence, which can contribute to poor co-ordination and conflict. The quantity and quality of vertical communication are determinants of whether decentralised or centralised organisational

structures are likely to be effective and efficient. In Zambia NHCs are blamed for not informing communities about the existence and roles of the DHBs, whereas this is the role of the DHBs.

Besides these functional aspects of district governance structures, even more important for ensuring the genuine democratic content of community participation is their composition, in terms of representativeness and how members are chosen. Often governance structures are composed of elites that are not accountable to any defined constituency except the appointing authority. This can be the result of bias and prejudice amongst planners and professionals in relation to the potential of community participation, particularly of the poor and those without formal education, to planning, resource allocation and other functions. Querol (2005) in Mozambique warns:

> *Selected members represent a certain social class, and they might use the power legally given to them as a weapon of perpetuation of manipulation and dependency, not particularly genuine participation. These undemocratic practices have also been identified in the Mozambican process of multisectoral decentralisation as risk factors that might lead to deviations or distortions in the development of social consciousness in communities through the 'atomisation' of its structures, and the breakdown of its social relations, producing alienation of stakeholders and bureaucratisation of the process. This could obscure its objectives, diminishing its results and producing ultimately social exclusion.*

In practice, local institutions, community leadership structures and the availability of the necessary resources – knowledge, time and contributions in kind – determine who participates and how. Most members of communities only participate in some of the processes, owing to these constraints (Espino et al, 2004; Bermejo et al, 1993).

The only way to avoid this situation would be to design specific interventions and mechanisms to increase the participation and representation of the more disadvantaged.

The new responsibility given to community members in decentralised systems introduces new accountability demands and an enhanced status within the system. Facility committees have to report to district authorities on plans, revenues collected and progress, to motivate for more resources. The existence and recognition of these communities is inherent in the decentralisation policies and guidelines. However, the limited amount of evidence gathered on the subject seems to suggest that their role is seen by higher levels as a more administrative and bureaucratic one, rather than a source of information and inputs from the bottom to shape programmes, policies and systems. Such attitudes are fairly widespread and constitute a barrier to more effective community participation. Participation only to carry out administrative tasks cannot be sustained, especially if it is expected to be voluntary and unpaid: there has to be a significant element of participation in decision-making as well.

4.3.2. District-level management structures

Often district-level management structures are even more important than their governance counterparts in ensuring effective community participation and improved health outcomes. Dysfunctional, authoritarian or overly bureaucratic and inflexible district structures can severely hamper the development of community participation structures and initiatives, while effective and supportive structures can make the difference between success and failure of community initiatives.

A shift away from the bureaucratic and authoritarian culture of the public sector, which is heavily dependent on formal rules and procedures that defend the interests of those who developed them, is needed. While all systems need to have clear and standard rules and procedures to govern, they need to be flexible in order to adapt to the realities of the districts and communities and be updated according to developments and lessons learnt in the process of decentralisation.

District-level management structures can play a vital role in supporting the functioning of community-based governance and management structures, such as Community Health Centres (CHCs). The role that the CHCs' members played in Zimbabwe contributed to an improved level of organisation of the outreach programmes and of more efficient drug supplies to the clinics. In the case of the Mtaa dispensary (clinic) in Kenya as well, where stakeholders discovered a different and more adequate way to run the clinics with the use of locally generated health and financial information and indicators, the support of the district and higher structures was fundamental.

Evidence showed that functional local governance structures (clinic, health centre, dispensary committees, etc), working in harmony with health staff at both local and district levels and with their constituents, can be the most effective instrument for the better organisation and functioning of health services and the provision of quality care.

4.3.3. Strategy choices in implementing policy

As noted in Section 2, the health reforms have been fairly similar in most developing countries, and are backed by national-level legislation, so that at district level it is a matter of interpretation, rather than deciding on policy. District health structures' main potential area of flexibility is in designing strategies to implement policy, although in many countries even this flexibility does not exist. It is dependent on the degree and nature of decentralisation in each country.

Whatever the case in each country, to the extent that districts have any say in the matter, the interpretation of policy requires important choices to be made concerning approach. As discussed in Section 2 above, there are broadly two different interpretations of what health sector reform is: a social development approach, which sees decentralisation as a vital principle of a PHC approach, particularly in the development of community participation; and a market-oriented approach, which sees decentralisation as a support for commodification of health services.

The tendency to focus on the operational aspects of decentralised management of health services sometimes leads to the main purpose of the PHC approach being missed. Providing legal authority to committees to manage user fees or to raise funds by running a tuck shop at a hospital, as part of decentralised, community-based management, may be important, but it is irrelevant to one of the fundamental tasks that the community should assume, namely the promotion and prevention activities for improving the health of its members. It can be argued that both aspects are essential components of a PHC system. However, the former tends to be prioritised, owing to the change in approach brought about by the health reforms that promised to improve services through the implementation of a 'resource–based' (demand-driven) instead of a 'needs-based' planning approach (Oyaya et al, 2003).

Here it is important to understand how we relate decentralisation to broader policies of health sector reform and how this is translated at district level. Policy confusion around the approach to decentralisation can adversely affect the formulation and implementation of decentralisation policies.

One of the issues that emerge from the review is that the reforms that have been implemented in health have often been approached from a rather technical perspective, placing technically oriented managers in charge of strategies, plans and budgets, while leaving the facilitation of community participation to others. Donors have played a role in reinforcing this unintentional separation. The WB, for example, has placed great emphasis on the development of the technical skills of managers, often at the expense of their understanding of the importance of community participation in enhancing the sustainability of programmes.

The introduction of local-level governance structures was envisaged as part of an operational strategy within the health reforms, to handle the new locally generated resources in a relatively more autonomous way, to achieve what government could not, namely to provide more cost-effective and efficient services. However, the original rationale of the PHC approach of

promoting community participation in order to empower individuals and communities, and strengthen the democratic process, has not appeared to be a priority.

Even the introduction of user fees has not had universally positive results. Little evidence could be found of direct links between user fees and services becoming more demand responsive and increasing community participation. On the contrary, there is considerable evidence that worsening poverty has led to marginalisation in some instances. Poverty is a fundamental obstacle for the implementation of democratic governance (Espíndola, 2000).

In the past, community participation was mainly limited to participation in specific, stand-alone health programmes. Nowadays if people don't see an opportunity to meet their socioeconomic needs they are not interested in volunteering or being involved in campaigns or any other health-related activity. However, there is evidence that an important aspect of community contributions, namely local-level control and management of funds, functions far better than payment of fees to anonymous government officials who do not report back on the use of the funds.

Demand-driven mechanisms like SFs, which rely on communities to define investment priorities and implement them, have also had mixed results. Generally they seem to have worked well and have succeeded in involving communities quite extensively. However, they have been questioned in terms of their ability to represent the views of and to reach the poor, particularly the poorest of the poor. As such, despite their community participation rhetoric, SFs, like other similar demand-driven programmes, might not work well in environments with disparities in power and may possibly be detrimental to poor communities. Further questions have also been asked about how demand-driven SFs are in reality, both in terms of the participatory aspects and outcomes of community consultations (Devereux, 2002).

The relevance of this evidence for district structures is that the application of health reform policies, including decentralisation and community contributions, needs to be done in a flexible way, with due regard for local conditions and dynamics. Districts have a key role to play in this and they need to involve communities in developing strategies and plans. Without adequate community participation, reforms are unlikely to be successful.

4.3.4. Technical empowerment of both community representatives and health managers

A number of studies mention the fact that community representatives on district health bodies feel intimidated by technically qualified health managers and professionals, owing to their own lack of technical knowledge and formal technical education. They are required to set priorities and to mobilise, allocate and oversee the use of resources, but too often find themselves out of their depth.

However, it may be unrealistic in many instances to assume that stakeholders have the technical skills to implement these policies, even if they are from the educated elite. For example, Oyaya identified in her evaluation of district planning in Kenya that even the supposedly technical people at district level (the DHMT members) lack the required skills and knowledge to implement the policies (Oyaya et al, 2003).

The extent to which district structures are sensitive to these concerns and proactively build the capacity of community representatives determines whether they act as promoters or inhibitors of their genuine participation. This applies equally to local government councillors. This points to the need to factor into health programmes the capacitation of community representatives.

4.3.5 Linking health issues to broader community concerns

There are a number of examples of districts committed to supporting and increasing community participation that have successfully mobilised around AIDS programmes, using what is one of the primary concerns of their communities. There is sufficient evidence that confirms that the

HIV and AIDS problem has itself mobilised infected and affected communities in Africa. In South Africa, where the response to AIDS took some time to be developed, the pressure from the bottom from thousands of community initiatives, like the Monyakeng HIV and AIDS youth group, has shaped policies on HIV over a period of five years. Combating the AIDS epidemic is a golden opportunity to revitalise the PHC approach, and with it community participation, because only through active participation of all stakeholders at district level and through locally developed strategies and plans, can it be controlled.

However, the epidemic has also had serious negative impact on the health systems in many countries. In 1999 Báez wrote:

> *The new-born district health system is facing an enormous challenge: while DMTs and governance structures are battling to define their roles and functions and to develop new systems to improve the quality of health care, the greatest epidemic of the century is proving to be an additional obstacle to our transformational agenda.*

In poorer countries in the region, the impact has been even more severe.

In relation to other ways in which districts have increased community participation in health by linking it to other concerns of communities, successes have been documented in the use of participatory planning approaches that engage communities in a culturally sensitive way, so that outcomes are fully aligned to local priorities and ways of doing things. Community participation in this way is also more sustainable. Examples include a Solidar-Med project in Mozambique, the case of the WSGs in Zambia and the Community Responsiveness Programme in South Africa.

The literature also suggests that the scope of community participation in health is broadened when the developmental challenges produced by poverty and its consequences are addressed. Local networks have been created to facilitate resource mobilisation to ensure the consolidation and continuation of the projects, like the WSGs in Lusaka. Community groups are learning by doing, acquiring the skills to manage their projects and also to express popular creativity to respond adequately to the needs. The willingness of self reliance, demonstrated in all these case studies, has a subtle message of overcoming the donor dependency that still occurs. This is why a holistic approach to tackling the underlying causes of ill health is an opportunity in itself. This can only be done at district level and is a powerful incentive for heath authorities to promote multisectoral approaches to district development programmes.

4.4. Representing community interests at national level

The health reform policies promoted the establishment of governance structures from the community level to national level. The guidelines of each country specify how districts should be represented at national level, and how their voice communicates to national structures. Owing to the limited documentation available on this issue, it was not possible to analyse the effectiveness of these structures (where they exist) in terms of mechanisms and processes to express community voice. What follows is, therefore, in the main, descriptive rather than analytical.

4.4.1. National Health Boards

A possible exception is the case of South Africa, which can be reported through the experience of the HST in its endeavours and vast experience in district development in the country. The Health Act made provision for the establishment of the National Health Council, chaired by the Minister of Health, and comprised of high-level representatives of local, provincial and national government health authorities. The function of the National Health Council is to advise the minister on policy concerning any matter that will protect, promote, improve and maintain the health of the population (MoH, 2004).

The governance structures at district level are the DHC and the District Health Advisory Council (DHAC). The first is the governance wing of the system, while the other is the technical one.

The DHCs are still being established and because their roles and functions are not clear the composition varies from district to district. The chairperson of the DHC is, in general, the district councillor for health (local authority), who represents the district on the Provincial Health Council. The chairperson of the Provincial Health Council is the Provincial Minister of Health, with the secretariat formed by officials of the Provincial Department of Health (PDoH), who are the members of the Provincial Health Advisory Committee (PHAC). Meetings of the PHC in most provinces do take place but the representation is irregular, the same people do not always attend and, in general, members attend without a specific mandate from their constituency because the councillors for health are politicians and not well informed on the health needs and plans of the districts (key informant HST/ISDS, 2006).

This Provincial Health Council is a new structure, still being set up in most provinces, and thus it still faces many challenges. Until it is fully implemented there will be a gap and the voice of the community will not be heard at national level through this channel.

Zambia, as mentioned earlier in the review, has a very ambitious plan of decentralisation. Since 1995 the National Health Service Act has called for a significant change in the role and structure of the MoH and provides for the establishment of an autonomous health services delivery system. This led to the creation of the CBoH, whose mandate was to monitor the Health Management Boards (Bossert et al, 2000). The structure at district level is the DHB, as previously mentioned, with local health boards that are the lowest level of the popular structures. This governance structure was designed to ensure, by act of law, that the voice and concerns of the community reach higher levels.

It seems from the literature gathered that the Zambian CBoH has gained a certain profile and experience compared to other similar initiatives in other countries like the Kenyan CBoH that has not come across as a player in health. However, according to Chibuye, who studied Provincial Health Council services at district level, the strong control of the CBoH hinders community participation and ignores community initiatives and developments (Chibuye, 1992). This authoritarian attitude and position have been reported in several papers (Bossert et al, 2000; Macwan'gi et al, 2004; Ngulube et al, 2004). Further, the main difficulty with the functioning of the Zambian CBoH was reportedly the problem of disparities with the MoH in the recruitment of nurses and other medical personnel, leading to the abolition of the Board.

In Kenya, the CBoH has little authority and decision-making power and seems to be merely a window-dressing body attached to the Department of Health (DoH). The composition of the health system suggests that having the voluntary sector as part of the system might be a bridge to voice in some way the concerns of communities. This idea was supported by a piece of information gathered, to the effect that there is talk in Kenya of forming Health Forums at national level to present experiences from some of the stakeholders that work at district level, as an attempt to influence policy (personal communication, 2006).

In Malawi in 2004 the National Assembly, the maximum organ of popular representation, was dissolved by the newly elected president. Since then, according to an informant, decisions are made by officials and there is no formal means of channelling community voice from the district to national level. No more information was available to describe how communities used to channel their concerns to national level before this political crisis that affects all democratic processes.

According to an informal communication, in Mozambique the community does not have a formal structure at national level as it has in other countries. Communities channel their voice to national level through NGOs, forums, the AIDS Council and associations such as the Mozambican Association of Public Health (AMOSAPU).

4.4.2. National AIDS Councils

From the literature consulted in this review it was evident that in virtually all countries in the region, AIDS Councils have been established as structures with community representation at

national level. They seem to be, despite all the problems they might have, more representative. This is largely due to the fact that representatives active in the field of HIV and AIDS are from the different sectors of society.

In Mozambique, the National AIDS Council is the only recognised national governance structure that represents the voice of communities through representatives from CSOs. The HIV and AIDS Councils are well established at provincial level but they have not been able to establish District HIV and AIDS Councils in all districts (key informant, 2006).

In Zambia, at national level, overall co-ordination and execution rests with the Ministry of Finance and National Planning (MoFNP) with participation of line ministries, other Government institutions, CSOs and co-operating partners. The Minister of Health chairs a steering committee of cabinet ministers, which serves the purpose of a National Development Co-ordination Committee. The Minister of Health reports to the President of the Republic and the Partnership Forum (ambassadors, heads of mission, civic leaders, etc). Provincial AIDS Task Forces represent all sectors, inclusive of private, public and civil society, including people living with AIDS (PLWA), traditional leaders and healers and faith-based organisations (FBOs).

At district level there are district AIDS task forces (DATFs), which are sub-committees of the district development co-ordinating committees (DDCCs). The role of the DATFs is to co-ordinate, supervise and monitor the implementation of HIV and AIDS policies and programmes in the district and at village level. HIV and AIDS programme co-ordination, supervision, monitoring and implementation can be undertaken by various structures, such as NHCs, area/resident development committees (ADC/RDCs) and other CBOs. The allegiance of these CBOs would be to different funding partners but co-ordinated at district level through the DATFs (key informant from United Nations Development Programme (UNDP, 2004).

4.4.3. Other mechanisms for representing community interests at national level

As noted in the previous section, governance structures have been established in the five sampled countries with exception of Mozambique, but they do not play a very significant role in representing community voice at national level.

However, there are many other ways by which community interests and concerns reach national level, either directly (less frequently) or through human rights and other lobby groups. The latter include organisations linked to the People's Health Movement, and others, which seek to influence national policies by engaging with stakeholders on particular or general health policy issues, and to establish a civil society presence through press releases, positions papers, petitions, campaigns and debates.

Some of the most frequently reported ways in which community voices are projected at national level, besides through formal district structures, are described in the following sections.

Parliamentary hearings

In many countries in the region, national parliaments provide opportunities through public hearings for CBOs and NGOs to contribute to policy and law-making processes. In a regional meeting of the Initiative of Parliamentary Committees on Health of Southern Africa (2004), it was stated that Parliamentary Portfolio Committees on Health need to act as watchdogs of equity in health. It was noted that before the parliamentary reforms that were implemented as part of the general governance reform process in many countries, relationships between CSOs, parliaments and the state were often marked by suspicion and misunderstanding as parliaments could not effectively make the executive accountable for its activities (mainly budget and policy implementation). Parliamentary portfolio committee meetings were held in camera and there was neither consultation nor civic participation in the legislative and budgetary processes.

However, the reforms have ushered in a new era, which presents challenges to parliaments to become much more responsive as they strive to make and amend laws, supervise government expenditure, represent the people and debate issues. Parliamentary committees play a vital role in the monitoring of government policy, programmes and expenditure. In southern Africa several countries have effectively functioning parliamentary committee systems, with public participation, and the health committees of South Africa and Zimbabwe have been cited as examples of good practice (Mataure, 2003; MPAPST, 2003).

It is clear that public participation in hearings arranged by parliamentary portfolio committees is a mechanism for community voice to be expressed at national level that needs to be used more often and effectively.

NGOs and pressure/lobbying/human rights groups

Owing to the relatively underdeveloped state of extra-parliamentary mechanisms for democratic expression in most countries in the region, the most prevalent mechanism for expressing community concerns and demands at national level in most countries is through civil society, NGOs and other organisations working on poverty and related issues. A number of examples were found in the literature:

In Zimbabwe the *Community Monitoring Programme* has carried out quarterly community assessments of the socioeconomic situation in Zimbabwe, including of health and education (SARPN, 2004; CMP, 2004). This sentinel site surveillance approach to community-based monitoring is carried out in a majority of districts from all provinces of Zimbabwe, with an average of 1.5 reports per district. The monitoring aims to provide direct information on community experience for local planning. According to the literature, this type of survey conducted by an organ of African civil society is extremely rare. However, it could not be established to what extent such reviews are taken seriously by the national DoH in Zimbabwe.

In South Africa the HST has, since 1998, carried out an annual review of national health policies and their implementation, culminating in a report, the *South African Health Review (SAHR)*, which contains constructive criticism and recommendations. Although it does not involve a participatory approach with communities, it is informed mostly by research into field experience at community and district levels and attempts to articulate the interests of poor communities in the first instance. The national DoH has generally accepted critical comment without counter attacking, and it is often clear that the reports influence some programmes and policies in subtle ways.

A recent example is the latest SAHR 2005, which was linked largely to health reform issues. There was a chapter on the training of nurses. One of the most striking examples of problems in health reform was the fact that the training of new nurses (professional) had declined over the period 1995–2004. This was during a time when increasing numbers of nurses were leaving because of ill health, death (especially linked to HIV) and retirement to the private sector and the overseas market.

A new DoH health reform strategy and plan was launched in April 2006 and many of the policies and recommendations were very similar to those spelt out in the SAHR, including the fact that special attention needs to be given to the increased production of nurses.

Another example is that related to mid-level workers. The DoH health reform plan picks up on the recommendation made in the SAHR that mid-level health workers need to have very clear role definitions so that there will not be confusion between scope of practice of existing professionals and any new category of mid-level worker, such as a mid-level rehabilitation worker or clinical assistant.

The SAHR has a chapter on indicators which are widely quoted in SA DoH documents. The carrying out of District Health Expenditure Reviews, initiated by the HST, and described in the SAHR has been institutionalised throughout the DHS in South Africa.

In Mozambique, the government made a commitment to investing in youth and adopted a National Youth Policy that aims to increase youth participation in policy development and to improve their sexual and reproductive health. The *Geração Biz project* was designed and developed by youth, who named it to reflect their 'busy generation'. The project promotes behaviour change among students and out-of-school youth. This community initiative now involves the Ministry of Youth and Sports, MoH and the Ministry of Education, which share co-ordination and execution, involving their respective provincial directorates, NGOs and CBOs, including youth associations.

The project has managed to take youth concerns to national government and influence national policy decisively. Government agencies will assume full responsibility for the programme, although they need to be strengthened and their commitment, sense of ownership and partnering skills increased (UNFPA, 2002; UNDP, 2004).

In South Africa the *Women's Budget Initiative groups*, led by CSOs, have been set up at the national, provincial and local levels. At the national level, they analyse public expenditure patterns in terms of their likely impact on the economic and social condition of women, and of poor women in particular, and track spending on gender-sensitive policy measures, as well as general spending patterns throughout the public sector. The groups also analyse fiscal transfers between different tiers of government to identify whether local spending reflects policy commitments to gender equity. In addition, they work with senior finance officials in provincial governments to make key indicators for planning and budgeting more gender sensitive (Gender and Health Equity Network, 2004; Budgets Watch, 2004).

The organisational practices and strategies of the *Treatment Action Campaign (TAC*), an AIDS activist social movement in South Africa, draws on grassroots, bottom-up, network-based modes of organisation that operate simultaneously in diverse local, national and global spaces. The TAC provides examples of organisational practices that cut across institutional and non-institutional spaces, and that are capable of generating multiple relations to the state. In doing so, it has provided its members with opportunities to engage simultaneously in a variety of participatory spaces that allow for the articulation of new forms of citizenship from below (Robins et al, 2004).

The *Treatment Advocacy Literacy Campaign (TALC)* is a group of member organisations formed to lobby for equitable and sustainable access to affordable, quality HIV treatment, support and care in Zambia. Having identified the need for treatment literacy and advocacy programmes in various communities in Zambia, especially in rural areas, TALC was formed in June 2004 and registered as an NGO in August 2005. The mandate of TALC is to ensure that PLHA are empowered to advocate for access to comprehensive treatment, support, care and respect for their rights. It advocates for the greater involvement of PLWA (GIPA) and meaningful involvement of PLWA (MIPA) principles. Since its inception, TALC has been working hard to advance treatment advocacy and literacy in Zambia. The organisation has made remarkable progress. It embarked on mass HIV and AIDS actions during the last election campaign to engage politicians. "We want them to know how they are going to look at us living positively. They should not neglect us because our vote counts," a member said (Lombe, 2006).

The work of TALC could have played a key role in the recent government's back-pedalling on user fees for ARV treatment. It can be argued that community inputs (through media, influencing of co-operating partners, etc) played a key role in the change of policy.

Table 5 summarises the different vehicles through which civil society and community voice is articulated at national level in order to influence policy and decision-making, with an assessment of their level of effectiveness.

Table 5: Impact of different mechanisms at national level for influencing policy

Country	Group	Mechanism	Purpose	Participation (by whom, at what levels)	Policy influence
South Africa and Zimbabwe	Parliamentary Health Committees	Parliamentary hearings	Monitor government policy, programmes and expenditure	Parliamentarians, lobby and interest groups, community	Doubtful
Zimbabwe	Community Monitoring Programme	Quarterly assessment	Monitor socioeconomic indicators	Civil society monitors in 57 districts	Some
South Africa	HST	Annual health review (SAHR)	Monitor policy implementation and make recommendations	Research community, policy implementers at all levels	Strong
Mozambique	Geração Biz	Youth friendly services and schools	Increase youth participation in sexual and reproductive health	Youth, government departments , NGOs, others	Strong
South Africa	Women's Budget Initiative	Advocacy campaigns, monitoring if budget gender sensitive, etc	Address gender inequities in policy development and implementation	CSOs at national, provincial and district levels	Yes
South Africa	TAC	Campaigns and programmes	Monitor HIV and AIDS policy implementation	Civic organisations at all levels	Strong
Zambia	TALC	Campaigns and programmes	Monitor HIV and AIDS policy implementation	Civic organisations at all levels	Still new

4.4.4. The importance of political commitment

Sections 4.4.1 and 4.4.2 present what case studies exist on formal health sector structures and mechanisms for expressing community voice at national level. Section 4.4.3 describes the role of other stakeholders, mainly in civil society, to represent communities. What emerges is a picture of poorly developed translation of policy into practice in this regard.

One of the reasons for this seems to be the lack of a concerted political effort to create the right enabling environment for policy to be accepted and translated into action. In this review it was noticed that governments played a central role in establishing the institutional framework for the health sectors. However, it is important to bear in mind that, legal frameworks for participation are not the only aspect in the relationship between communities and governments, since the frameworks per se cannot ensure that participation takes place. Often what is more important than the introduction of legal frameworks is the readiness (fertile soil) of the institutions and organisations for which they are intended (Mc Gee, 2003). This, together with each country's own history, the evolution of its health system, the political context and successive governments' commitment, might explain the diverse situations and expressions of the process of decentralisation and democratisation of health systems.

The readiness of the institutions refers not only to their maturity and capability but also to the attitudes of the actors involved in the transformation of health systems. The implementation of these policies required a serious process of transformation of values, practices and approaches by all stakeholders, from the most disadvantaged in the community to the health ministers and presidents. It appears, from the information found, that while communities have always been

willing to take on the task of doing something about health, the attitude and readiness of the health policy-makers, health managers and workers seems to be more conservative.

This is a common phenomenon in all sectors. The concept of participatory democracy is still relatively new, and politicians tend to consider formal representation of community voice through elected parliamentarians and councillors as sufficient. Forms of expression of community voice not directly under their control are regarded by most with suspicion. Since politicians' attitudes are products of their environment, this also reflects a general political culture, which CSOs are trying to change, as noted in section 4.3.

5. General conclusions

5.1. More and better documentation of the process of reforms would provide valuable lessons

In reviewing the literature, clear differences were noted in the way health reforms have been implemented in Africa, in terms of the main components, namely decentralisation, user fees (commodification) and democratisation. As noted (Table 1) even the approach to decentralisation has been very diverse, and the level of development of local government is one of the main determining factors. Countries tend to mix a number of different forms of decentralisation. Democratisation depends strongly on the general state of democratic development in each country, and policies on user fees depend on a wide range of factors, including political principles.

However, what was noteworthy was the apparent scarcity of documentation published on the process of implementation of the reforms. One key informant was of the opinion that this was caused by the fact that the people from whom the reviewer was requesting information do not have the time to write – they are busy doing things. Although this is a comment from a single source, it might be a clue to the reason for there being so little written and published material on the probably very rich and abundant experiences of health reform implementation and community participation at community and district levels.

With the exception of the bulk of solid and important research produced by EQUINET, the availability of information on the policy implementation process does not represent or reflect the reality at district and community levels in the region. In addition, even when information is available, there is little evaluation and analysis of lessons learnt that can serve as a guide for other programmes to improve their sustainability and impact.

5.2. Local initiative and motivation often overcome lack of clear guidance

Major organisational change requires a change in attitude of all stakeholders. The implementation of the decentralisation policies created confusion at district level in many instances, often as a result of incomplete and inappropriate guidelines and procedures. In many cases this was because of intentional ambiguity and questionable willingness to transfer power on the part of those in charge at district level. However, community members of district structures and district teams demonstrated through their ability to resolve difficulties produced by these policy gaps, that there are other ways to implement the changes required. Community members are not involved in governance structures to take over government responsibilities but to improve the health of the community.

5.3. Inclusive democratic practice can improve health outcomes

Genuine community participation in programme planning and execution, which includes normally marginalised sections or classes in communities and successfully counterbalances the power of entrenched vested interests, ensures more effective programmes. However, the relatively weak level of democratic practice in most decentralised structures and processes has been questioned in almost all countries and is a stumbling block to genuine participation at district level. Zambia, Kenya, Malawi, Mozambique and South Africa, without exception, have not been able to facilitate the representation of the community at large in the new context. Mechanisms of selection of governance structure members have not allowed the most disadvantaged to be represented and their voices heard. The reason for this could be the generally elitist spirit of health managers who opt for electing people of a certain class, instead of lower classes, and their reluctance to shift power to lay people who have a limited understanding of the technical aspects of health issues. Political patronage has also been reported.

5.4. Effectively functioning district structures can improve services, even without support

The DHS is the vehicle for implementing the PHC approach. The opportunities identified in the review have shown that districts with functional management and governance structures, working in a harmonious and complementary way, can improve the quality of services and even strengthen preventive and promotive programmes, adapted to the realities of the district. The role of higher levels of the system was found to be limited to control instead of support. A more self-critical assessment of the implementation of the DHSs by health governance structures and authorities is needed.

5.5. Capacity building for the new approach

Institutions and organisations need to develop the capacity to ensure the functioning of fundamentally differently oriented health systems, and some have done so, but despite enormous efforts and investment, most still lack this capacity. The required capacity includes adequately developed human resources, particularly health workers and community members involved in health issues. The review confirmed that a major constraint is the availability and appropriateness of the necessary skills required for the implementation of a more outcome-resource-oriented system. More appropriate and needs-oriented capacity building has to be explored, taking into consideration the participatory method proven to be effective in areas such as use of information for planning.

5.6. Participatory planning and partnerships improve quality and accessibility of services

Resource mobilisation at community level has not been well documented, and the sustainability of the positive cases known and published needs follow-up research. Nevertheless, many case studies and examples were identified where communities and health authorities entered into shared commitments and jointly found solutions to better the health of their communities.

Several good and bad experiences were reported on the role of governance structures in the management of local resources and the level of community satisfaction with how these resources have impacted on the quality and accessibility of the services.

However, it seems that, in general, districts are not adopting systematic and participatory district planning approaches to enable them to take local decisions based on the available resources.

The TEHIP experiences showed that more capacity needs to be developed and more appropriate planning and management tools used for the development of the districts with the involvement of local researchers.

5.7. Community voice at national level through civil society activism

In terms of formal structures at national level, little documentation seems to have been produced on community participation and it is difficult to find evaluations except for those carried out by donors (when they have not been prevented from publishing them). Only three of the five focus countries reviewed had Central Health Boards in place and the only one that was relatively functional (in Zambia) was recently abolished.

The AIDS Councils appear to be the governance structures at national level that are the most representative and functional, with different degrees of civil society participation, mainly through NGOs. The impact of these bodies has not been documented according to the findings of this review.

Although governments will not recognise that they have changed or reviewed policies owing to civil society pressure, the role of specialised or lobbying groups has shown tangible results in the cases reported. In the context of weak or non-existent governance structures at national level, lobby groups can be considered as the maximum expression of community voice at national level.

However, it would seem that Health Boards might have the potential to formalise civil society representation. It might be worthwhile undertaking a study of their potential and include an analysis of the reasons for the abolition of the CBoH in Zambia.

5.8. Well-informed and equipped parliamentarians can articulate community voice

In relation to the role of parliamentarians in health, very little is documented, and it appears that parliamentarians need to be targeted and prioritised by health systems, to be used as important interlocutors for influencing and promoting policy for the communities they represent. However, for this to happen, based on the evidence of this review, there is a need to develop the necessary skills amongst them.

6. Knowledge gaps and proposals for research to support activities

As noted throughout sections 3, 4 and 5, in many areas of the focus of this review, the available documented evidence is limited. In order to fill these gaps, to better understand the factors that enable or inhibit community participation, and to use this knowledge to improve the effectiveness and outcomes of health systems and programmes, further research is needed. This section contains recommendations regarding this research, as well as identifying some of the lessons of good practice from the review that can be used to strengthen programmes in terms of community participation.

6.1. Understanding and improving the form and content of community voice and roles at district level

Although there is a reasonable amount of information available on community participation, it is mainly descriptive, providing general insights but not explaining or analysing the processes and

underlying reasons for the success or failure of community participation in the implementation of the DHS. In particular, few programmes have documented in any detail the less obvious factors that influence the form and content of community participation, such as the role of power relations between different stakeholders.

More work on this would be useful, to corroborate or not the few examples that tend to show that when participation includes all strata of society, and the power of vested interests is counterbalanced, more sustainable outcomes, which enjoy more community support, are achieved.

While the evidence shows that effective local-level structures can ensure community participation and improved health outcomes, even without significant support from district or higher-level authorities, there is also evidence that such support can make an important difference. The lesson would seem to be that health systems should invest effort into developing the capacity of district structures to support community participation, through measures such as capacity building of staff (emphasising on participatory managerial skills), developing clear policies and guidelines, and ensuring effective communication with communities.

Some of the areas in which more information is needed in order to develop clearer strategies for strengthening community participation and programmes in general, include the following:

- description and analysis of capacity of DMT members to run the districts and facilitate community participation;
- community role in planning, budgeting and resource allocation at district level;
- analyse from the perspective of organisational development, rather than health programmes, the weaknesses of the different DHSs in Southern Africa;
- investigate the validity of claims of success and the sustainability of donor-led 'community participation' approaches; and
- investigate the impact of SFs on the health of Southern Africans.

6.2. Supporting districts to change the way they work so as to enable community participation

As noted above, effectively functioning district structures can play a key role in promoting community participation and ensuring improved health outcomes. A number of examples of good practice exist, the key elements of which include:

- inclusive democratic practice that involves vulnerable groups;
- participatory planning and partnerships with communities;
- successful capacity development of health workers and community members; and
- attitudinal change of health workers and community members.

Further work is needed to identify more examples of good practice and to draw out the lessons for wider dissemination. Specifically, the review identified the following areas for further research:

- extent to which policies, guidelines, procedures and rules have been implemented as intended at district level, and the quality of outcomes;
- influence and determinants of appropriate successful capacity development strategies in health management in southern Africa;
- further research on processes and mechanisms to improve representation in governance structures of the most vulnerable groups in communities; and
- investigate policy-makers' and health authorities' perceptions of the role and relevance of the community in the implementation of the DHS, in order to design strategies to change attitudes and behaviour.

6.3. Supporting districts and civil society to articulate and represent community interests at national level

Few formal mechanisms that function as intended appear to exist for districts to articulate community concerns at national level, or for communities to be heard directly. One of the structures that does seem to function well and which includes community and other civil society representatives, is the AIDS Councils. However, the evidence is not clear as to how well they function, particularly in terms of acting as democratic forums. It would be useful to have such information, in order to possibly include actions to strengthen such forums.

For the same reasons, a clearer understanding of the role of civil society human rights and health lobby groups in expressing community voice could help inform strategies.

Although there is not much evidence of politicians at different levels playing a positive role in directly articulating community health-related issues, it would seem to the reviewers that they have the potential to do so, if well informed. It is therefore recommended that research be carried out on this topic, and should this potential be confirmed, guidelines provided for empowering all elected representatives linked directly to health matters.

One specific case would appear to merit closer attention, namely that of the recent abolition of the CBoH in Zambia. All the documentary evidence reviewed indicated that the Board, with all its problems, was the most firmly established governance structure at national level of all the countries sampled. Its presence was tangible since it was mentioned in several documents and reports, and even had a functional and informative website. However, its very recent abolition by the government raises a series of questions. It would seem that a serious and in-depth analysis is required to understand the processes and challenges of its existence and the reasons for its abolition.

6.4. Empowering governments and regional organisations to promote community participation

The fragmented nature of the information available points to the need for a systematic comparative analysis of African countries in terms of the policy processes in each and their impact on policy outcomes. This would include an analysis of the sustainability of the policies and approaches to community participation and district development in the region. As proposed in the methodology section, a research framework should be developed by EQUINET, and research commissioned from different local researchers in different countries, who have more in-depth understanding and access to unpublished work and even to documentation that is incomplete or was intended only for internal organisational consumption. This could fill some of the gaps in this review.

The product would be a document similar to the Pan American Health Organisation (PAHO) document ‘Community participation in health and development in the Americas’ produced in 1984, that provides a comprehensive analysis of the different variables in community participation in Latin America and the Caribbean. Considering the pivotal role that PAHO plays in co-ordinating research-based interventions on the continent, it is assumed that such a document was a positive contribution for addressing gaps both in knowledge of good practice and policy development.

According to the reviewers there is a need for such a document that could be used not only by governments to inform and improve their own practice, but also by, for example, the Southern African Development Community (SADC) and NEPAD authorities as an advocacy tool to encourage governments to expand their efforts in delivering health care at community level and in promoting greater community responsibility in health care decisions.

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Afriafya	http://www.afriafya.org
African Journals Online	http://www.ajol.info/browse-journals.php?tran=0
Afronet	http://www.afronet.com
Aga Khan Development Network	http://www.akdn.org/
British Journal of Medicine	http://bmj.bmjjournals.com
Bulletin of the World Health Organisation	http://www.who.int/bulletin/en/
Central Board of Health	http://www.cboh.gov.za/
Central Board of Health – Zambia	http://www.cboh.gov.zm/
Centre for Health and Population Research	http://www.icddrb.org/pub/
Communication Initiative	http://www.comminit.com/index.html
Community Development Foundation	http://www.fdc.org.mz/engl/home.html
Development Gateway	http://home.developmentgateway.org/
Eldis Gateway to Development Information	http://www.eldis.org/
Entrez – The Life Science Search Engine	http://www.ncbi.nlm.nih.gov/Entrez/index.html
Gender and Health Equity Network	http:// www.ids.ac.uk/ghen
Government of Kenya	http://www.kenya.go.ke/
Government of Malawi	http://www.malawi.gov.mw/
Government of Mozambique	http://www.mozambique.mz/
Government of South Africa	http://www.gov.za/
Government of Zambia	http://www.statehouse.gov.zm/
Health Policy and Planning – Oxford Journals	http://heapol.oxfordjournals.org/
Health Systems Trust	http://www.hst.org.za
High-level Forum on the Health MDGs	http://www.hlfhealthmdgs.org/index.asp
HIV in Site	http://hivinsite.ucsf.edu/InSite
Ifakara Health Research and Development Centre	http://www.ihrdc.org/
International Budget Project	http://www.internationalbudget.org/
International Development Research Centre	http://www.idrc.org/en/ev-1-201-1-DO_TOPIC.html
International Journal for Equity in Health	http://www.equityhealthj.com/
International Journal for Health Planning and Management	http://www3.interscience.winley.com
Irish Forum for Global Health	http://www.globalhealth.ie/
Journal of Sustainable Development in Africa	http://www.jsd-africa.com/
Kenya Institute of Social Work & Community Development	http://www.kiswcd.com/
Ministry of Health and Population of Malawi	http://www.sdnp.org.mw/~caphill/health/health.htm
Ministry of Health Malawi	http://www.sdnp.org.mw/~caphill/health/mohpstart.htm
Ministry of Health Mozambique	http://www.misau.gov.mz/
Ministry of Health of Zambia	http://www.moh.gov.zm/
Moi University – School of Public Health	http://www.mu.ac.ke/academic/schools/sph/index.html
Partnerships for Health Reform (PHR) Project	http://www.phrproject.com
POLICY Project	http://www.policyproject.com
PubMed Central (PMC)	http://www.pubmedcentral.nih.gov/
Regional Network on Equity in Health in Southern Africa	http://www.equinetafrica.org/
Scielo Public Health	http://www.scielosp.org/
Sociological Research Online	http://www.socresonline.org.uk
Swiss Agency for Development and Co-operation (SDC)	http://www.swisscooperation.org.mz
Synergos Institute	http://www.synergos.org/
Tanzania Essential Health Intervention Project	http://www.idrc.ca/tehip
Treatment Action Campaign – South Africa	http://www.tac.org.za/
United Nations Fund for Population	http://www.unfpa.org/
United States Agency for International Development	http://www.usaid.gov/
University of Zambia Medical Library	http://www.medguide.org.zm/zamresh/resh1.htm
World Bank	http://www.worldbank.org/
Zambian Integrated Health Project	http://www.zhip.org.zm

List of key informants

Name	Country	Gov, NGO, Univ	Telephonic interview	Electronic interview
Dr Nhavoto	Mozambique	Gov	X	X
Dr Djedje	Mozambique	Gov	X	
Dra Manjate	Mozambique	Fundaçao para o Desenvolvimento da Comunidade	X	
Dra Aly	Mozambique	SDC		X
Dra Zilhao	Mozambique	Generation Biz	X	
Ms Lima	Mozambique	SDC	X	
Mrs Leonor	Mozambique	Africare	X	X
Mr Paulino	Mozambique	Gesellschaft für Technische Zusammenarbeit (GTZ)		X
Prof Querol	Mozambique	OSEO	X	X
Dr Mugisha	Kenya	African Population Health Research Center APHRC	X	X
Dr Sohani	Kenya	AKHS, Kenya	X	X
Mr Ntukula	Malawi	MP	X	
Dr Rhudi Thetard	Malawi	Management Sciences for Health (MSH)	X	X
Mr John Njunwa	Malawi	Equity Network	X	X(no response)
Dr Dulani	Malawi	Academic	X	X
Mrs Sandy Dove	South Africa	The Valley Trust	X	X
Mr hai	South Africa	The Valley Trust		
Dr Irwin Friedman	South Africa	HST	X	X
Mrs Ramatsoele	South Africa	Lejweleputwa District – Local Authority	X	X
Mrs Tsidi	South Africa	Lejweleputswa District – Provincial Authority	X	
Mr Makhabela	South Africa	Sabambisene	X	X(no response)
Mr Sydney	South Africa	COSATU Parliament	X	X(no response)
Prof van Resburg	South Africa	Center for Health Systems research & Development (CHSR&D)	X	X
Mr Heunis	South Africa	CHSR&D	X	X
Mrs Ramalepe	South Africa	Community Responsiveness Programme(CRP)	X	X
Dr Urgoiti	South Africa	NGO		X
Dr Collins	Zambia			X
Mrs Vink	Zambia	TALC	X	X
Mrs Serlemitsos	Zambia	ZHIP	X	X
Mr Sibulowa	Zambia	Gov	X	X
Mrs Mataka	Zambia	National AIDS Council	X	
Mr John	Zambia	FHT	X	X
Dr Isler	Tanzania	SDC		X
Dr Loewenson	Zimbabwe	TARSC		X
Dr Rusike	Zimbabwe	Community Working Work on Health (CWGH)		X

Appendix 1: Acronyms and abbreviations

AIDS	acquired immunodeficiency syndrome
ADC/RDC	area/resident development committee
AKHS	Aga Khan Health Services
AMOSAPU	Mozambican Association of Public Health
ARV	antiretroviral
AU	African Union
CBO	community-based organisation
CBoH	Central Board of Health
CHC	Community Health Centre
CHESSORE	Centre for Health and Social Science
CHIF	Community Health Innovation Funds
CIH	community involvement in health
CMP	Community Monitoring Programme
CRP	community responsiveness programme
CSO	civil society organisation
DATF	district AIDS task force
DDCC	district development co-ordinating committee
DHA	District Health Authority
DHAC	District Health Advisory Council
DHB	District Health Board
DHC	District Health Council
DHER	district health expenditure review
DHIS	district health information system
DHMT	district health management team
DHS	district health system
DMT	district management team
DoH	Department of Health
DSS	Demographic Surveillance System
EQUINET	Regional Network for Equity in Health in Southern Africa
EPI	expanded programme of immunisation
FBO	faith-based organisation
FP	family planning
FHT	Family Health Trust
GEGA	Global Equity Gauge Alliance
GIPA	greater involvement of PLWA
HCC	health centre committees
HIV	human immunodeficiency virus
HST	Health Systems Trust
IDP	Integrated Development Plans
IP	integrated programme
IPPF	International Planned Parenthood Federation
ISDS	Initiative for Sub-District Support
KHSSP	Kwale Health Systems Strengthening Project
MASAF	Malawi Social Action Fund
MCH	maternal and child health
MIPA	meaningful involvement of PLWA
MoFNP	Ministry of Finance and National Planning
MoH	Ministry of Health
MP	Member Parliament
NEPAD	New Partnership for Africa's Development
NGO	non-governmental organisation
NHC	neighbourhood health committee
OSEO	Organizacao Suica de Entreajuda Operaria (Swiss Organisation of Mutual Workers Support)
PAHO	Pan American Health Organisation
PDoH	Provincial Department of Health
PHC	primary health care
PLA	Participatory Learning in Action
PLWA	people living with AIDS

PMC	project management committee
PRSP	Poverty Reduction Strategy Papers
SADC	Southern African Development Community
SAHR	South Africa Health Review
SARPN	Southern African Regional Poverty Network
SDC	Swiss Developmental Centre
SFs	Social Funds
STI	sexual transmitted infection
TAC	Treatment Action Campaign
TALC	Treatment Advocacy Literacy Campaign
TARSC	Training and Research Support Centre
TEHIP	Tanzania Essential Health Intervention Project
UN	United Nations
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VHC	village health committee
WB	World Bank
WHO	World Health Organisation
WSG	Widow Support Group
ZHIP	Zambian Health Integrated Programme

Equity in health *implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.*

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

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