A literature review of district health systems in east and southern Africa: Facilitators and barriers to participation in health

Lisa Lopez Levers, F Innocent Magweva, Elias Mpofu
Duquesne University, Counselling for Health International (CHI) Trust and Pennsylvania State University

for the
Regional Network for Equity in Health
in east and southern Africa (EQUINET)

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Executive summary

This review was commissioned by the Regional Network for Equity in Health in East and Southern Africa (EQUINET), with support from IDRC Research Matters, CHESSORE and TARSC, to review and analyse evidence on community voice, roles and participation at district level. We reviewed the available published and grey literature, with a focus on primary health care and the district health systems in sub-Saharan Africa, in order to explore the facilitators and barriers to community participation. We selected six African countries for deeper review and analysis: Botswana, Lesotho, Namibia, Rwanda, Swaziland and Tanzania.

The literature that was reviewed noted the following:

- It is not enough for governmental Ministries to author policy documents that outline and promote participation by the citizenry; they must also construct mechanisms for participation and citizen-friendly avenues for participation.
- Governmental policies need to establish mechanisms for leading participation-based reforms; probably, at minimum, this includes base-line training for district health personnel on how to empower citizens' participation and how to establish clear and open channels of communication.
- Without strategic implementation and deliberate training, policies that are *intended* as user friendly do not always translate as such; a *socially constructed* sense of participation often obscures an authentic process for establishing community voice and for delineating roles at the district health level.
- Both national and international efforts to implement public health strategies often ignore local input. The delivery of 'decentralised' health care has often lost touch with local communities.
- Local consultation is essential, and power relations among communities, health workers, bureaucrats and politicians need further analysis.
- The scientific literature does not adequately capture the cultural, ethnographic and social dimensions of the mechanisms and processes that facilitate or hinder participation.
- Qualitative strategies, such as hermeneutic translational research, participatory rural appraisal, responsive evaluation and community-based participatory research methods can serve to illuminate culturally relevant trends, gaps and any other specific issues that require further investigation.
- Local cultures and indigenous systems of knowledge must be considered within the scope of any translational medical practices; biomedical health-care practices cannot be simply extracted from one context and *insinuated* into another.

The work signals a need for more culturally informed interventions that draw from indigenous knowledge bases, with evidence-based data that is culturally relevant, and that contextualises poverty, health risks and systems in sub-Saharan Africa. This requires further deconstruction of current definitions of 'district health system', analysing social constructions of health systems, and finding out how they have been affected by global trends, market reforms and policy shifts, like decentralisation.

A number of challenges remain, not the least of which is the prevailing perspective of the citizen as an *object* of health care or *object* of research, rather than the required perspective of citizen as *participant* and *knower.* So, this perspective needs to change. In research and training, this change of perspective can help to promote health literacy, greater intentionality and a better understanding of local–central power relations, which will inform cross-disciplinary designs for future research.

1. Introduction

Health care in Africa is a complex and multi-faceted issue. The HIV/AIDS pandemic continues to devastate sub-Saharan Africa, particularly in the southern region (Loewenson and Whiteside, 1997), as well as in parts of the eastern and central regions. A recent report from the Joint United Nations Programme on HIV/AIDS and the World Health Organisation (WHO) (UNAIDS/WHO, 2005) has indicated that about 38 million adults and 2.3 million children under the age of 15 were living with HIV at the end of 2005. Of these 40.3 million people living with HIV, it is estimated that 25.8 million live in sub-Saharan Africa, affecting Africa far more seriously than any other continent.

The AIDS pandemic has strained the historically fragile health care systems throughout sub-Saharan Africa, adding to existing challenges of equitable distribution of essential health interventions (Casper, 2004; Lewis, 2003; Tanser, Gijsbertsen and Herbst , 2006). Even in better-resourced urban settings, severe health-care disparities exist, so that people from a lower (or working) socioeconomic status (SES) do not always receive adequate health care services from either the central or the regional governments (Casper, 2004; Promtussananon and Peltzer, 2003; Hilhorst, van Liere, Ode and de Koning, 2006).

Although there are resources available to respond to the AIDS crisis, they are woefully inadequate, and other health concerns, such as malaria, tuberculosis and malnutrition, are also severely under-resourced. Ante-natal and post-natal health care for children in some parts of sub-Saharan Africa has regressed to pre-1970 levels, and some preventable diseases that were once presumed rare (for example polio and scabies) have re-emerged (Barreto, Sacramento, Robertson, Langa, de Gourville, Wolfson and Schoub, 2006; Houweling, Kunst, Moser and Mackenbach, 2006). Many of the health-related resources that at one time were distributed to rural and remote communities seem to have ‘migrated’ back to urban areas to be used for the hospital-related costs associated with AIDS (Fotso, 2006; Wilson, Kahn and Blower, 2006).

District health systems have the potential to address the limitations of current healthcare systems, which remain relatively centralised in some respects and urban-oriented. This review explores the role of community participation by citizens in their own healthcare in district health systems. Their participation has the potential to enhance the availability and relevance of healthcare services to citizens in African countries. The activities surrounding meaningful participation can have relevance to systems and powerful impacts on people’s lives, yet we know very little about how these processes function or what they *mean* in people’s lives.

The historic 1978 Alma-Ata International Conference on Primary Health Care offered a framework for understanding health in terms of equity and its related socioeconomic and health system issues. The primary health care (PHC) approach to health-service provision was adopted by WHO as it appeared in the Alma-Ata declaration (WHO, 1987). The PHC model equates health with freedom, endorsing a definition of health that is not merely the absence of disease (WHO, 1988). The overarching framework for the PHC model included promotion, protection, prevention, care and support, and rehabilitation. Most countries in sub-Saharan Africa adopted the PHC model as a model for health delivery. For example, in 1987, the Harare Declaration was 'signed by representatives of 22 African countries' (Görgen and Schmidt-Ehry, 2004: 28). While Poverty Reduction and Millennium Development Goals have been prioritised in more recent years, Görgen and Schmidt-Ehry (2004) maintain that they are 'fully in line with the concepts and principles of PHC, [although] to some extent they are adjusted to current expectations and perspectives' (ibid: 29-30).

Görgen and Schmidt-Ehry (2004) presented six guiding principles for PHC:

- maximum accessibility
- utilisation of local resources
- involvement of the target population in planning and implementation
- integration of preventive and curative services
- rationalisation of the health services (appropriate technology, financing and management)
- inter-sectoral co-operation.

They emphasise that PHC is *not* limited to simple measures (for example rehydration and preventive measures), the promotion of village health workers and community development, and activities at the lowest level of health care (for example dispensaries). It also affects the referral system and the way in which scarce health care resources (for example complex medical procedures) can be used optimally in facilities with the requisite expertise. This, in turn allows the system to minimise any unnecessary duplication of services.

District health systems, as formulated by WHO in 1983, supported PHC with "coherent health services closer to the people" (Korte, 2004: 22). The WHO Study Group on the Functions of Hospitals pointed out that, "in the context of the 'health for all' movement, the term 'district health system' has taken on a specific meaning, as defined in 1986 by the WHO Global Programme Committee" (1992: 5). This definition has informed the delivery of health services in many African countries:

> *A district health system based on primary health care is a more or less self-contained segment of the national health system. It consists of, first and foremost, a well-defined population, living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private or traditional. A district health system therefore consists of a large variety of interrelated elements that contribute to health in homes, schools, work places and communities, through health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level and the appropriate laboratory, diagnostic and logistic support services. Its component elements need to be well coordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities.*

Source: WHO, 1988: 9; WHO, 1992: 5-6.

The implementation of this vision of a district health system has been influenced by national health care priorities (for example child immunisation and HIV/STD prevention), rather than unique or exclusive interpretations by national governments. The above-cited definition has been encoded in numerous government policies throughout southern, eastern and central Africa (Görgen, Kirsch-Woik and Schmidt-Ehry, 2004; Mankesso and Lambo, 1993; Paine and Tjam, 1988; WHO, 1987, 1988). Additionally, making this district health-system vision accessible to historically neglected areas (for example rural areas), or social groups has been important in the fulfilment of 'health-care-for-all.'

PHC and the District Health System (DHS) have remained relevant to the delivery of health care in Africa. (Görgen et al, 2004). Decentralisation policies have placed greater emphasis on the roles and authorities of districts.

Korte (2004) notes the following:

> *During the colonial period some countries in Africa had already developed some degree of decentralisation, for example by charging district councils with the management of ambulatory care. With independence, decentralisation was, however, often reversed for the sake of national unity in the emerging nation states. Today the centralised management of a health system for tens of millions of people is an impossible task. But there are other reasons to promote decentralisation* [related to taking] *services closer to the people* (ibid: 22)

Decentralisation has had structural (i.e. infrastructure), resource (i.e. personnel and finance), and service (i.e. programmes) dimensions (Mpofu, 2004). In Zimbabwe, for example, the comprehensive decentralisation of health services required infrastructure development and incentives to tempt health personnel to work in the rural areas. District health systems have provided most of the core health services, along with referral facilities to provincial health centres for the more resource-demanding cases (ibid). This set-up calls for levels of financial autonomy, responsibility for staff recruitment and development, and adequate infrastructure and technical skills (Korte, 2004), which are not always present (Macwan'gi and Ngwengwe, 2004). When conceptualising the DHS, an emphasis on structures, rather than on delivery mechanisms built on naturally occurring local participatory models, reduces local ownership and utilisation of the health care system, thereby reducing its capacity to meet their needs.

In addition, PHC models that consider users of health-care services only as benefactors to be 'provided' with health care, rather than *active participants* with choices about the health outcomes to which they aspire, also negatively affect locally informed participation. District health systems have much to gain from recognising health promotion and maintenance practices embedded in local cultures. For example they would gain greater credibility with users. But there is a need for further research into how such participatory models of health care are framed and implemented in sub-Saharan Africa.

The *Health-for-all Policy for the 21st Century in the African Region: Agenda 2020* (WHO, 2002) identifies equity as an essential principle and a core value for health development policies focused on a vision of health for all. It states that equity is 'based on the principle of, availability of and universal access to essential health care' (ibid: 11). The issues of equity in health care and the impact of poverty on the possibilities for health, are huge concerns in sub-Saharan Africa (WHO, 2006; Commission for Africa, 2005). While equity implies addressing differences in access to health care and health status that are unnecessary, avoidable, and unfair (Gwatkin, Bhuiya and Victora, 2004) these decisions are socially defined. Loewenson (cited in Johnson, 2004: 4-5), for example, defines EQUINET work on health equity from a social justice perspective as:

> *… a socially defined parameter that involves social values. We consider that strengthening people's power to direct resources to their health needs is part of the equity framework and that you can have inequitable distributions of power and access to decision-making that are as important as inequitable distributions of health workers or of drugs and so on. So our work is also looking at that area. And we consider all of that to be part of an equity agenda.*

If health care systems are to be more equitable, they need to embrace the basic principle of ensuring the 'empowerment of poor clients to have a more central role in health system design and operation' (Gwatkin et al, 2004: 1273). We propose that equitable health care services are possible when citizens have equal opportunity to access the services they need, and with the expectancies to achieve to their desired health outcomes, along with an equal objective health status (Mpofu, 2005). However, a health service may function differently across groups not only because of provision, but also because of different meanings of health and health services in different groups affecting how services are accessed and used. Thus, equity in health systems is premised on both technical adequacy (e.g. the objective comparability of needs and services) and socio-moral perspectives (e.g. the opportunity to access services and the consequences for consumers of the services). This explains why people-centred health systems are important from an equity and public health perspective, and not merely as a matter of social justice. Unfortunately, the African literature does not reflect the applied importance of PHC-based approaches to addressing inequality, especially in reaching out to and improving access for poor communities. Ngulube, Mdhluli, Gondwe and Njobvu (2004: 6) point to the need for stakeholders to assume a more active role in making choices about their own health care agendas, which requires 'a clearer analysis of the social dimensions of health and their roles in health equity'. Others have also pointed to the importance of this social dimension:

> *The absence of strong community engagement with health care providers in the planning and monitoring of health services has been a limiting factor in strengthening access to and quality of care, especially in disadvantaged areas of the country. The South African Equity Gauge has started working with communities and doing work on empowering communities to become involved in their health care system*

Source: Health Systems Trust, undated: 9.

Health equity in Africa is a complex issue, so it cannot be viewed as separate from other salient socio-cultural and political issues. In addition, a distinction must be made between the theoretical DHS model, as it exists in policy documents, and the application of such a model to the functional operation of the DHS. Brandrup-Lukanow (2004) proposes that strengthening district health systems is an essential step in making health services accessible and affordable for those population groups who would otherwise be unable to reap the benefits of health promotion, good quality health care and access to essential drugs. According to Görgen and Schmidt-Ehry (2004), some questions remain unanswered:

- How far does this strengthening adopt and maintain patterns codified within highly centralised systems, without losing touch with the communities being served?
- How far does the DHS operate as a horizontal, rather than vertical, structure?
- How far have selective vertical approaches focusing on one specific disease resulted in short-term successes, but weakened the long-term development of an integrated health care system?

2. Purpose and methods

In the past, the Regional Network for Equity in Health in east and southern Africa (EQUINET), through CHESSORE Zambia and TARSC Zimbabwe, has examined participatory mechanisms at primary care and district level, as well as the role of these mechanisms in equitable resource allocation and service delivery (Ngulube et al 2004; Loewenson et al, 2004; Macwan'gi and Ngwengwe, 2004). The studies revealed that governance structures in health care can have a positive impact on health equity, such as improving interactions between the health system and the community with regard to:

- health service outreach (as well as access to and use of health services);
- the uptake of primary health care; and
- the responsiveness of health services to community issues.

Some successes were achieved in a difficult environment, and many challenges still remain. The sometimes ambivalent political will, as well as hostility, of health workers towards other community stakeholders compromised participation and accountability in these studies, especially in relation to their roles in decision-making. Other problems included:

- lack of information
- poor knowledge of the legal framework
- lack of adequate funding

- lack of motivation
- lack of skills among community constituents.

District health boards were often not even functioning, and some beneficiaries were ignorant of the existence of their boards. The findings from these studies reinforce the importance of continuing to investigate the cultural and contextual factors associated with health care.

The researchers included two university professors and a community-based rehabilitation expert, who were all well versed in health-related issues affecting Africa. They had experience in developing programmes and systems, as well as in analytical and interpretive research procedures.

We reviewed and analysed literature on participatory health mechanisms, associated barriers and facilitators, and the inclusion of community and public views and preferences in planning and implementing health systems in east and southern Africa. Six countries were selected for deeper analysis: the central African nation of Rwanda, the eastern African nation of Tanzania, and the southern African countries of Botswana, Lesotho, Namibia and Swaziland. Two of the countries – Botswana and Rwanda – were visited in order to retrieve documents, attend public events and attempt to understand health-related matters in person. (The selection of these two countries was largely based on convenience.) For the remaining four countries, as well as for the two visited, we relied on internet retrieval and collected documents from Ministries, NGOs and international donor organisations. We were able to retrieve written information effectively, and already-established contacts have made person-to-person telephone and electronic access easier.

This procedure went well beyond the standard literature review and can be framed as a type of hermeneutic translational research. Hermeneutics is a type of qualitative research that illuminates a concern through careful understanding and interpretation of text (Byrne, 2001; van Manen, 1990). The practice of hermeneutic translational research is a relatively recent inclusion in the medical and health-related literatures (Stanford University School of Medicine, 2002) and has been promoted by institutions like the American Psychological Association and the National Institutes of Health. 'The goal is to bridge the gap between bench and bedside, and to facilitate the flow of scientific discovery to practical application' (Dingfelder, 2005: 22).

The review draws on detailed case study evidence from the six countries to explore questions regarding facilitators and barriers in the *systemic functioning* of the DHS. Systemic functioning has been associated with the degree to which the various district health systems identify and address health-related risks and protective factors that exist in the environments of participants at multiple systemic levels. This mode of analysis relies on Bronfenbrenner’s (1979; 2004) bio-ecological model of human development. His model views the individual as nested in (and reciprocally interacting with) multiple systems of influence, from the proximal (the closest, e.g. personal and familial values) to the distal (the furthest, e.g. cultural values). The model’s emphasis on risks and protective factors or resiliencies provides a good fit with the facilitator and barrier model of this review. It has also demonstrated a high level of cultural elasticity and has been used effectively in developing contexts (Levers, 2002; 2003; 2006a). In addition, an ecological perspective makes sense in this context, because district health services (a more distal influence) have been informed by local health demands (more proximal influences), as per citizens' perceptions of their own needs. Districts serve as the linchpins of care; however, the delivery of services is not the same between any two communities. According to the bio-ecological model, such variations can be considered positive when PHC systems are grounded in local needs, as perceived by users of services.

The following keywords were used to search for reference purposes for this review: DHS, PHC, health care/service, Africa, sub-Saharan and equity. The searches were conducted using broad-based search facilities with multi-site search engines, as well as archival materials from networked agencies with which EQUINET has ongoing or historical collaboration. The searches included the relevant Ministry documents, white papers, available research-based studies, grey papers and theory-based papers. The following issues were focused on:

- the presence of community voice and the delineation of roles at the district level;
- how district planning, decision-making, financing and budgeting, resource allocation, and programme implementation enable or block community participation;
- how districts articulate and represent community interests at the national level;
- positive case studies or examples of community representation and district influence at the national level;
- gaps in knowledge and gaps in the collection of relevant evidence; and
- research implications, especially regarding the need for future research and how such an agenda might be prioritised.

Unfortunately, there is currently a serious lack of information in the empirical health literature about participatory health mechanisms and the citizen/community voice. Indeed, these constructs have typically not been captured in the results of positivist (i.e. quantitative, statistical and biomedical) research endeavours. We gathered an enormous quantity of literature, either in person or retrieved from electronic sources. While most researchers proposed equity and participation in health systems, there was little evidence that these constructs were translated from policy into practice. There was little mention of the above-mentioned constructs in mainstream health literature and we had to extrapolate data and anecdotal descriptions of illustrative practices as best we could. Consequently, we also generate further questions, which will need to be addressed empirically through continued research.

3. Findings

In this section, the findings will be discussed under the following headings:

- community-based health structures in the selected countries;
- community voice and roles in district level health systems;
- how the organisation of district health systems affects community participation;
- district representation of community interests at the national level; and
- gaps in the literature review.

3.1. Community-based health structures in the selected countries

As stated earlier, most countries in sub-Saharan Africa have adopted the WHO definition of DHS, as well as the PHC model upon which it is based. It appears that the political will exists at the national level, in terms of participatory approaches to health care. Yet, when reviewing both governmental documents and the professional health literatures, there is little documentary evidence of actual participation by communities. In a discussion of community participation through local governance structures, Klugman (2004: 12) asserts:

> *Primary health care policy in many countries provides mechanisms for community participation. The mechanisms differ from country to country, and are influenced by each country's broader political and governance framework as well as the nature of the health service prior to the introduction of HSR* [Health Service Reform].

Structures for participation at village level typically include the chieftaincy, the Village Development Committee (VDC) and the village health committee. The VDC's function is to identify and prioritise village needs, providing a forum for contact between the villagers and the politicians and local authorities. In Botswana, for example, the VDC reports all development issues at traditional meetings, called *kgotla*. According to Serema (2002), consultation takes place between the Development Officer, who works under the District Commissioner and the District Council Planning Officer, and those participating in the *kgotla*. Serema (2002:5) describes the *kgotla* as a forum for community discussions:

> *People attend the* kgotla *meeting without fear or favour and they express their ideas freely.* Kgotla *presents a good institution for policy making. Information takes centre stage at the* kgotla *as communities voice their concerns and proposals and ministries, and civil servants present and, at times, defend government policies. There is two-way communications at the* kgotla*.*

Government documents from all six countries offer varying levels of detail about structures, but little operational information, especially regarding channels of communication. Some of the documents appear to be constructed with little or no consideration of potential contextual influences that might impede the ability of health-service users to participate in authentic and meaningful ways.

One notable exception is Lesotho. The Lesotho Ministry of Health and Social Welfare was quite transparent about this issue in its *National Health and Social Welfare Policy* (undated), in which it clearly states that communities are actively encouraged and supported to participate in decision-making and planning for health, and that they are the beneficiaries of sustainable PHC programmes. However, the policy goes on to say:

> *While efforts have been made to transfer functions such as planning to lower levels of administration and communities, there are no effective methods for genuine community participation in health services management. The challenge therefore is for the local authorities and Ministry of Health and Social Welfare to ensure that mechanisms for community participation in health services are developed* (ibid: 7).

Typical government bureaucratic structures do not allow for a bottom-up approach. The governments of most countries still have a head office in the capital city, responsible for the policy-development framework, while the regional or district office is given the responsibility for preparing budgets and implementing Ministry policies. We found no documented evidence that communities are involved in budget preparation, for example. Instead, the Ministry official, from the region or the district, is charged with the operational and financial decision-making of the health facility.

While participatory rural approaches are used in a number of countries for research and evaluation purposes, they tend to be used by NGOs and international donor organisations, and funds are typically limited to a few villages and a few demonstration projects. Unfortunately, these programmes are often not constructed with sustainability in mind and when the funding ends, the programmes often disappear, along with any participatory practices that may have been inaugurated (WHO, 2005).

While participation is provided for, this often only takes place when free labour is needed, such as to construct a health facility. Consultation on community needs and plans is absent. Even where consultation with and participation of the general population through the village health committees *does* exist, such as in VDCs, and village-based meetings, the consultation may not really be accessible. Serema (2002: 4) reports: 'A VDC chairman told me that sometimes they are given major reports like the village development plan written in English to read and verify certain things and comment. He admitted that sometimes it is not always easy for them to understand these reports.'

3.2. Community voice and roles in district level health systems

During the literature review, the presence of the community voice and how roles are delineated at the district level was also assessed. Various questions were raised:

- Who has a voice and whose voice is heard?
- Who are the major actors in communicating community needs?
- How are community mandates received by the health delivery system?
- What are the roles of the various participants?
- How are these roles structured?
- Through what mechanisms do district health systems operate?
- What are the processes involved in decision-making?
- To what extent do these processes include stakeholders in service-planning?
- To what extent do these processes include stakeholders in service delivery?
- To what extent are these participatory processes integrated into future systemic planning efforts?

While the review could not answer all these questions, they served as initial probes for reviewing the related literature and are also useful for subsequent research on this issue.

The health-care delivery systems of all six countries are their government health institutions, which have been the main providers of biomedical health care. However, due to a variety of factors, governmental health delivery is more or less augmented by the services provided by donor, international aid and faith-based organisations. Traditional healers are a major, but ignored, resource. Government institutions function under the auspices of the Ministries of Health. Health care systems, while based on PHC principles, are organised hierarchically, and are at various levels of decentralisation. Government health care strategies are spelled out in a variety of national documents that emphasise accessibility, equity and community participation. Yet, in spite of this emphasis, none of the government planning or policy documents reviewed here described or mentioned structural mechanisms for ensuring participatory procedures, with the notable exception of the Lesotho *National Health and Social Welfare Policy*, quoted above.

A perusal of governmental and other public domain documents indicated, in general, a formal or theoretical inclusion of community-based roles, particularly as outlined in Ministry of Health documents. Community participation was implied and community voice was assumed, but how this input was actually made was unclear. For example, the Botswana Ministry of Health website (2006: paragraph 5) stated: 'the objective of the Primary Health Care department is to ensure, through community sensitisation, involvement and participation, that the majority of Batswana have access to preventive, promotive, curative and rehabilitative services.' Other broad, sweeping statements like this one were found in many Ministry documents across countries, legitimising notions of community involvement and participation. However the issue of how channels for community involvement were actually accessed and promoted was poorly addressed.

In practice, there may be contradictions between the aspirations of participatory mechanisms and those of formalised bureaucracies. For example Botswana's *National Policy on Mental Health* (Botswana Ministry of Health, 2003: 2) takes an enlightened approach to mental health concerns, with a focus on ensuring the human rights and dignity of those with severe psychiatric disorders:

> *The separatist or vertical model of mental health care has often led to discrimination whereby the various needs of those with mental health problems and mental disorders were seen as the responsibility of mental health services and trained mental health professionals only.*

The document identifies a number of challenges and, in response to these challenges, claims that 'Botswana has made significant strides in laying the necessary foundation for developing a comprehensive Mental Health Service in the context of Primary Health Care, through a community-based mental health programme' (ibid: 3). It recognises the need for well-trained health personnel and strong support from caregivers, and notes that 'the community should positively contribute to the treatment and rehabilitation of the patients in order to minimise this harm' (ibid: 4). This goal can be reached by:

- the decentralisation and integration of mental health services into general health services within primary care facilities and the rest of the referral system;
- defining the roles and responsibilities of service users and providers in the prevention, promotion and treatment of mental illness and substance abuse; and
- promoting the development of community-based rehabilitation services in mental health 'so as to take mental health services closer to individuals, their families, communities and socio-cultural networks' (ibid: 5-6).

This is backed by involvement of all stakeholders and strengthened co-ordination mechanisms in the health sector, with the formation of support groups for discharged patients. Roles are given to service users, their families and the community so they can identify the symptoms of mental illness early to ensure referral and aftercare. The local government’s role is to ensure that mental health services are integrated into PHC and all the activities of the District Health Teams and other relevant council departments.

As can be seen above, the policy intends to promote user-friendly policies that incorporate human rights and a community-based perspective. However, it is what is *not* found in the text that is important to the discussion here. For example, enlightened policies for participatory health care (for example the early identification of symptoms by patients or significant others) presume a level of health literacy (and also inter-cultural consensus about the meaning of symptoms) that *cannot* be assumed in the general African population without further study (Mpofu and Harley, 2002). Furthermore, providers of health services (mostly Ministries of Health) are presumed capable of operationally translating policy into practice without specific personnel training or preparation. A shift in responsibility from the Ministry of Health to the Ministry of Local Government to ensure that mental health services are integrated creates further challenges. How do the health ministries deal with obligations and health systems approaches through other ministries? The formal mechanisms and significant investments are *implied*, but often lacking.

3.3. How the organisation of district health systems affects community participation

The literature review continued by exploring how organisation at the district health level enables or blocks community participation, particularly through processes for planning, decision-making, financing and budgeting, resource allocation, and programme implementation. We asked:

- What is the structure for these processes? Is it a vertical hierarchy or a more horizontal structure?
- To what extent do these processes *enable* or *facilitate* community participation?
- To what extent do these processes *block* or *restrict* community participation?
- What access does an ordinary citizen have to inform these processes?
- What quality control mechanisms are in place?
- What feedback loops exist for community input?
- What informal evaluation and assessment opportunities exist?
- What formal evaluation and assessment mechanisms exist?

Some barriers, such those relating to geographical access, may be difficult to overcome (Görgen and Schmidt-Ehry, 2004). Others, like attitudinal and systemic barriers may be enormous, and have greater potential to be more readily diminished, or even, in some instances, eliminated. The literature found evidence that barriers included the attitudes of professionals, the lack of a perspective that sees health-care practices as a part of a larger service-delivery system, and the inability to operate systemically (CDC, 2006). These barriers mean that we need urgently to create links across programmes in the health care system and to care and conditions in communities. Children involved in the prevention of mother-to-child transmission (PMTCT) programme in Botswana, which included formula distribution and infant growth programmes, were found in one assessment to have died due to malnutrition. They had severe diarrhoea because mothers could not access formula or use it correctly. In a situation where living standards were relatively good, such systemic problems make one wonder how often mothers' voices are really *heard* by health personnel. It also raises questions about issues that are more under the control of the mothers, like breastfeeding exclusively vs. using breastmilk substitutes (CDC, 2006; Ashworth, Chopra, McCoy, Sanders, Jackson, Karaolis, Sogula and Schofield, 2004). It reinforces the point raised by Owolabi and Shaibu (2001:10): 'The involvement of communities in health care delivery is a major key to the identification of cultural attitudes and practices that may hinder the success of the health promotion programme.'

This dialogue with communities in policy and programme design is not often found in health systems. In her discussion of institutionalised mechanisms for community involvement in policy development, Klugman (2004:4) notes: 'By and large, government mechanisms saw community involvement as providing information from communities, rather than gaining their input as to how to shape policy.' In other words, the government only sees the role of the community as providing them with information for demographics and statistics, rather than as real participants who can help shape policy through meaningful input. It seems that a large barrier to greater participation revolves around the inability of some parts of the formal health system to recognise opportunities for authentic engagement.

The issue of traditional healing is also relevant here. Many people use the services of local traditional healers, so it makes sense for the health system to work with the healers and engage them in areas where natural collaboration is possible (Levers, 2006b, 2006c; Levers and Maki, 1994, 1995). However, there are still limited instances of co-operation between them and the other parts of the DHS as a result of widely divergent views on the causes of diseases and how best to treat them (Görgen and Schmidt-Ehry, 2004). Some research suggested a willingness on the part of legitimate traditional healers to collaborate with biomedical programming. There was a trend for traditional healers to be rejected by their biomedical colleagues, rather than the reverse (Levers, 2006b).

A further example is the talent of youth. Wilson Ngoni is a brilliant young artist in Botswana. While he has received international attention for a profoundly evocative and captivating series of paintings on HIV/AIDS, very few have taken note within Botswana. Even the health system officials who have been approached by both Batswana and expatriat professionals about his work remain uninterested. Also musically talented, Ngoni (2006) recently produced a CD called *Mankind Arrival*. Ngoni wrote all the songs, arranged the music, made traditional instruments, played the instruments and sang all the song tracks. Some of the songs deal powerfully with significant psychosocial and health-related issues, such as domestic violence, HIV/AIDS and the death of his mother (Ngoni gave up a university scholarship to remain at home to care for six younger siblings). He also addresses the 'passion killings' currently plaguing Botswana ('crimes of passion' that usually involve a young man killing his girlfriend and then often himself). Young people love his album, and many pestered radio stations to play his songs before the CD was even released. While formal health institutions are not using this work, we found in our own experience that youth resonate with the message of this young reggae musician regarding health issues pertinent to them. One might consider Ngoni's art as community participation, but this level of effort may get blocked or go unrecognised by health personnel who do not recognise this 'form' of participatory role.

Community health workers (CHWs) play a role in this ‘dialogue’ between communities and other elements of health systems. They may be seen as system transformers, central to the reshaping of the health system into a more people-centred system. Alternatively, they may be viewed as utilitarian extensions of the medical practitioners, who attempt to improve coverage and outreach. It could be argued that the role played by CHWs in the early transformation of PHC-based systems is not necessarily the same as the role they would play by simply adding them to an essentially vertical programme (for example, HIV/AIDS programme) in order to provide the support that the health system cannot provide.

This review proposes that negative health experiences with village health workers may stem from an outsider-looking-in perspective – one that may lack the benefit of local perspectives. The true value of CHWs can be appreciated by taking into account the health consultation needs of local communities, as well as the role of supplemental health care from community members who may not formally be designated health workers, such as informal women fellowships revolving around communal facilities, like the local water well. Certain issues would need to be further explored, e.g. they may not be:

- educated about the expectations for health providers by the central government nor compensated, or adequately compensated, for the time they invest in communal health care; and
- prepared to make, or know how to make, the requisite life-style adjustments in the face of competing subsistence needs for their families.

All these variables need to be considered in any discussion about the effects of auxiliary health care providers on the health delivery system.

3.4. District representation of community interests at the national level

Further research explored how districts articulate and represent community interests at the national level. There was very little discussion in the literature regarding the bottom-up representation of district or community concerns at the national level. Mechanisms are in place, to varying degrees, for *political* representation, but there was little evidence of the existence of participatory health mechanisms for voicing local concerns at the national level.

An indication of a formal mechanism was provided in government documents from Tanzania (e.g. Ministry of Health [MoH] Tanzania, 2003a, 2003b). The MoH’s *National Norms, Guidelines, and Standards (NGS) in Crossing-cutting Issues for Health Care Practice in Tanzania* (MoH Tanzania, 2003b:3) stipulates that recipients of health services should have their voices heard about their levels of satisfaction and needs in relation to health services: 'Health care providers should therefore consult the opinions of clients during the implementing of these norms, guidelines and standards.' Tanzania’s communities are now working together to repair or rebuild dilapidated dispensaries. District Commissioners have transferred ownership of health facilities to the communities, giving people more of a stake in the health system. In addition, the *National Health Policy* (MoH, 2003) indicates that there should be community involvement and ownership through active participation in identifying problem areas, and in planning, implementing, monitoring and evaluating health services. The policy speaks of the empowerment of the community by means of the decentralisation of health services to regions, districts and communities in order to ensure effective coordination, implementation and supervision, and the provision of quality health care.

This policy is a potential asset but one needs to examine what the term ‘consultation’ means in practice. Klugman (2004:4) points out that, in general, 'the mechanisms for consultation differ from country to country. The degree of consultation appears to be shaped predominantly by the degree of political will that governments have regarding community involvement.' The nature of consultation may be affected by power relations among communities, health workers, bureaucrats and politicians. While an analysis of these dimensions is needed, the research-based literature we found does not deal well with this issue. Some examples of ‘participation’ at national level are shown below.

3.4.1. Namibia

In Namibia, a notable example of ‘single-issue’ (rather than district-level) representation at the national level is people living with disabilities (Levers and Magweva, 2005). An evaluation found particularly politicised groups of persons with disabilities in Namibia, who not only demanded a voice, but asserted their right to have direct representation in the President’s office. A special post was created, and the person in this post was able to take concerns directly to the top, bypassing the relevant Ministry.

3.4.2 Rwanda

Diop and Butera (2005) report that community-based health insurance (CBHI), implemented in some districts in Rwanda, serves to provide mutual aid and maintain community solidarity value systems. CBHI is meant to assist communities in accessing health care. Diop and Butera (2005: paragraph 4) state: 'CBHI schemes in Rwanda are health insurance organisations based on a partnership between the community and health care providers.' Contributions to CBHI scheme funds are yearly and cost about US$7.60 per family per year. A member referred to the hospital has direct access to the hospital package without any co-payment. Greater access to the CBHI by the poor is being promoted by building on partnerships among CBHI schemes, grassroots associations and micro-finance schemes, so that grassroots associations enrol as a group and that NGO and administrative districts finance the enrolment of the poorest and most vulnerable groups (Republic of Rwanda National AIDS Control Commission, 2002). The extent to which CBHI really reduces out-of-pocket payments – a major barrier to real participation in and access to health systems – is however not clear from the evidence provided and remains a thorny issue.

3.4.3 Tanzania: CARE

Klugman (2004) provides an interesting example of community involvement in transportation for obstetric emergencies in the Mwanza region. An international NGO, CARE, began the project in 1996. They conducted a baseline study in 50 villages, where there were no opportunities available for transportation during maternal health emergencies; instead, it was considered the responsibility of the expectant mother or of her family. Based on their data collection, CARE had sufficient information to design and offer a 'train-the-trainer' opportunity relating to community development around this issue. Klugman (2004:17) reports that, after the training…

> *… [CARE] convened meetings with leaders from 50 communities to discuss the development of emergency transport plans. They also developed community assessment tools to monitor progress. An assessment in April 2001 found that 19 villages had made some progress with their plans, and one had a transport system available. Also, villages had started to provide social administrative and technical support for village health workers. Six villages were providing some financial support*.

Klugman (2004: 17) also points out that this example illustrates the 'increasingly common use of processes to empower communities in problem identification' and solving, building their confidence to move forward.

3.4.4. Tanzania: Jijenge!

According to Klugman (2004), a project was launched in Tanzania, called Jijenge!, which means ‘build yourself’ or ‘re-building’ (Haberland and Measham, 2002), and was aimed at mobilising community involvement in ending violence against women in Mwanza, Tanzania. A pilot project was run by a Tanzanian organisation, *Kuleana*, in partnership with the African

Medical Research Foundation, in an attempt to empower authentic change in the community of Igogo. The project engaged community leaders, and together they conducted a three-day workshop regarding project-relevant issues. As a result, a concerned group coalesced; they endorsed anti-violence interventions and a “community interest group” (CIG) emerged (Klugman, 2004). The Jijenge! staff, with the support of the local group, conducted a needs assessment, which included using in-depth interviews and focus group discussions, in an attempt to understand the community’s attitudes about violence. Based on the findings of the assessment, Klugman (2004:18) reports that the following actions were taken:

- *CIG facilitators held impromptu discussions in busy public paces with questions like, “Do women experience violence in this marketplace?” and “Do you think this is acceptable behaviour?”*
- *Jijenge! collaborated with the Mahagama Theatre Group to present plays on violence, which engaged the audience in discussions.*
- *Public days like World AIDS Day were used for ‘fun’ activities, which focused on violence against women.*
- *Story booklets were produced and ‘booklet clubs’ were established in 18 streets in Igogo with around 50 women and men in each. The groups met regularly with a CIG facilitator to guide their discussions.*
- *Posters were distributed via NGOs, health centres, businesses, schools, religious groups and government agencies.*
- *Radio programmes were broadcast.*
- *Murals were put up on eight storefronts and walls in Igogo. An example is one stating the following: “I don’t hit my partner – we talk about our problems instead*.

Klugman (2004) reveals that the CIG recruited additional volunteers and developed a ‘watch group’ to offer support and interventions. They began to document local instances of domestic violence in an effort to sensitise the public. Eventually they were able to solicit increased community support, including the involvement of men running workshops for other men. 'As part of the attempt to win men’s support, the discourse shifted from "women’s rights" to "family harmony"' (ibid: 18). This initiative also aimed to alter the perceptions of service institutions by offering training to social welfare and health providers, the police, faith-based groups, NGOs, and others. 'Over time, the initiative led to an observable shift in people’s willingness to intervene against violence' (ibid: 18).

3.4.5. Social marketing

Social marketing has recently been used as an effective intervention strategy throughout Africa (Harris, 2006; Kikumbih, Hanson, Mills, Mponda and Schellenberg, 2005). It is a utilitarian model for developing programmes because it begins by understanding the needs and desires of the constituent group(s), rather than relying on more traditional top-down methods used by experts or professionals who ‘dictate’ programmes to the community. Social marketing has been used in Botswana to ‘market’ reproductive health services to the youth (Harris, 2006). Likewise, the strategy has been used in the social marketing of mosquito nets in Tanzania (Kikumbih, Hanson, Mills, Mponda and Schellenberg, 2005). However, this last example also has raised a number of questions regarding its dynamic relationship with various PHC models: How does the role of this approach position communities and what does it imply about participation? It may enhance participation but it also could have a negative impact, depending on the context, type of PHC and how it developed. For example, one might argue that a particular social marketing technique, like marketing bed nets, may unintentionally commodify an important health concern by ‘verticalising’ the understanding of essential health concerns into simplistic interventions. This is counter to the philosophy of the PHC approach, which espouses a philosophy aimed at dealing proactively with the *social determinants* of health and illness. This particular type of example would position communities as consumers of commodities, rather than as primary actors in the response to local health concerns.

3.5. Gaps in the literature review

A number of gaps were found during the literature review:

- gaps in knowledge;
- gaps in evidence and data collection; and
- gaps in research.

Let's now examine these gaps individually.

3.5.1. Gaps in knowledge

We know very little about health-related interactions between government Ministries and traditional healing activities, despite the wide use of these traditional systems. We observed that despite their local cultural importance, traditional healers have often been ignored, almost completely by the biomedical community of Western-trained medical professionals. The extent to which African medical professionals have interjected Euro-American cultural biases around this issue is worthy of further investigation.

In a perusal of the numerous Ministry documents from all the countries reviewed here, we saw an emphasis on *writing* policy, with very little attention paid to how policies are *translated* and *implemented*. The issue of poor policy-translation/implementation practices seems to be intricately interconnected with an absence of systemic intentionality. We found nothing in the literature about translating or implementing policy that pertains to community participation; we also found nothing linking policy translation or implementation with fair practices, production or systems thinking:

- What have we learned from years of initiating policy that goes unimplemented?
- What can be learned from cases where strong policy was actually translated and implemented?
- What can be learned from policy-related errors?

Although a robust literature exists regarding modern leadership skills and how to train leaders, we found nothing that is relative to community-based leadership in terms of participatory health mechanisms. Yet many important questions surround this emergent issue:

- What are the leadership skills necessary to facilitate participatory health mechanisms in developing communities?
- Who are the naturally occurring leaders?
- What can we learn from traditional or indigenous leadership processes?
- How can we encourage new actors to step into traditional leadership roles in meaningful and contemporary ways?

Klugman (2004:22) asserts that very little information is available about Africa and identifies the following gaps that need to be addressed:

- *the detailed workings of health committees;*
- *the impact of such committees on community representatives' ability to play their designated roles;*
- *community awareness and sense of ownership of health services;*
- *the content and quality of health services;*
- *what sorts of facilitation are empowering of communities engaged in health service governance structures; and*
- *the impact of participation on health inequalities*.

3.5.2. Gaps in evidence and data collection

The types of data collected and the processes for collecting them are significant to outcomes. Since the trend is for decisions to rely upon evidence-based data, the process is, by definition, driven almost exclusively by positivistic perspectives. Leonard, Mliga and Mariam (2002) suggest that health-care systems in poor countries modify current objectives, thereby developing plans and monitoring progress in ways that are more relevant to the conditions of the poor. The strategy of *responsive evaluation* (Abma, 2005) offers a vision for assessing health promotion in a way that takes context into account. Community-based participatory research methods have recently been promoted as a way to address partnerships in health care matters (US Department of Health and Human Services, 2003):

- What level of data collection can current health structures facilitate in the six countries examined here?
- How well do currently used measurement objectives address the most relevant needs of the majority of the citizens?
- How might community-based participatory methods contribute to existing databases?

Government documents encourage community participation with few indicators for translating ideas about community participation into reality. There is some indication that top-down communication is equated with consultation. Especially in vertical structures of service provision, for example HIV/AIDS, assumptions have been made by service providers about mechanisms of participation, without adequate evidence to support their assumptions and without sufficient consultation with citizens.

A huge gap exists between policy ideals and what actually exists in practice. Government documents encourage community participation with few indicators for translating or operationalising the ideals associated with community participation. It seems that governments consider one-way/top-down communication as qualifying as community participation. Even in the more vertical structures of service provision, for example the HIV/AIDS arena, assumptions have been made about the relevance of the VDCs to community participation. Yet no data have been collected to support this, and we are aware of situations in which the VDCs have hampered authentic community involvement in determining relevant local HIV/AIDS interventions.

We found very little evidence in the formal literature of positive participatory health mechanisms. Many of the examples that we found were in the literature on disability and HIV/AIDS. Interestingly, these examples would largely be considered vertical interventions, while the literature conceptualising district health strategies, particularly those relative to participation, emphasises the relevance of *horizontal interventions*. These are areas worthy of further investigation.

3.5.3. Gaps in research

The implications for research are enormous in light of the findings of this review. Klugman (2004:22) identifies the following issues as needing further research:

- *different forms of facilitation of empowerment both of health managers and providers and of communities, and the factors that make them effective*;
- *a comparison of impact of efforts at improving services through traditional quality assurance, a right-based approach within the health services, and community participation;*
- *where pilot interventions of building health service accountability to communities have been successfully scaled up to regional/provincial or national levels; and*
- *development of measures of participation that could be incorporated into assessments of health systems and services*.

Any further research into health systems needs to be done in the context of the connections between poverty, health, equity and participation. McCoy, Sanders, Baum, Narayan and Legge (2004:1630) point to the unfulfilled role of research 'in improving the health of poor people, not only through the distribution of knowledge, but also by answering questions, such as why health and health-care inequities continue to grow despite greatly increased global wealth, enhanced knowledge and more effective technologies.'

Research needs to interrogate whether participation can be genuinely embedded in practices that, in practice, increase household burdens. The CBHI schemes described earlier are recent in some African communities, with mixed reports of outcomes on household burdens:

- What are the effects of these schemes in a wider context of market-oriented economic policies?
- What might ethnographic research reveal about the lived health experiences of those using CBHIs?
- How are concepts like co-determination realised in a context of dependence on donor financing and market reforms?

One study noted that 'the impression is that external donor organisations in particular attach a great deal of importance to co-determination bodies, expecting their operations to be in line with Western concepts of democracy, which often, however, run counter to local cultural and political circumstances' (Kirsch-Woik and Oepen, 2004:216). These expectations also raise questions about the extent to which the values of corporate globalisation influence the details of decentralised health care, the interests of international donors and the general ‘tone’ and approach of local health policies.

4. Conclusions and recommendations

The literature reviewed showed that governments drew up policies for dealing with community participation in local health care, but that there was little, if any, implementation of the policies. Our analysis raised numerous concerns about the complexities of putting policies into practice, and we realised that this is best understood as a multi-layered discourse. The contextual issues surrounding healthcare and the cultural and knowledge frameworks affecting participatory mechanisms generated additional difficult questions, in turn, begging further examination. Because this is a multi-layered discourse, we discovered that we need to know much more about how contextual issues affect participatory mechanisms so we can understand how to frame relevant research in this area. We found a number of areas that highlighted these issues of complexity and context, e.g. differing cultural understandings of health and illness, issues related to globalisation and the commodification of health, the paradoxical nature of decentralisation of health services and, of course, poverty.

The reality of poverty in Africa has incredible significance for health issues. The inter-relationship of poverty with equity issues and the meaningful participation in health and health-care services seems obvious, but is not well explored. We have little understanding of how participatory mechanisms interact with social networks and self-perception among poor communities, and how this affects health delivery.

Pointing to how the health system is *supposed* to operate draws on social constructions of concepts such as health, illness and healing that are socially determined and vary among cultures. We suggest that culturally informed understandings of differing perspectives on health, illness, healing, medicine and so forth could be instrumental in getting at the heart of some of the very complex problems being unravelled here (Berger and Luckmann, 1967).

The debates and understanding of how the health system and its bureaucracy balance and distribute powers, resources and roles are still in process. For example, unresolved issues around the use and abuse of power affect the degree to which the system remains operationally centralised, in spite of strategic efforts to decentralise.

Current trends in globalisation have a profound but unanalysed impact on the delivery of healthcare services in the region. International donors bring global perspectives into local and national cultures, and health is commodified in ways that fundamentally redefine participation.

4.1. What lessons were learned?

The literature reviewed suggests that community-oriented healthcare systems that are responsive to the needs of citizens are likely to be more successful in PHC than those systems that have externally imposed mandates or are serving the needs of a distant provider. Health systems need to be designed in a way that protects social protection and universal coverage, as well as management and stewardship capacities in the health sector (Doherty and Gilson, 2006). Investments and measures are needed to specifically fund, exchange knowledge on, assess performance in, provide social leadership for and strengthen community capacities for participatory processes and mechanisms (Klugman, 2004).

A distinction must be made between DHSs based on theoretical models and their day-to-day functional operations. The main lesson learnt from this literature review is that it is not enough for governments to state in their policies that they intend to seek the participation of ordinary citizens. They must take it one step further and *construct and invest in reality-based mechanisms and processes for participation, citizen-friendly avenues for participation.* Governments need to establish mechanisms for supporting participatory reform, at minimum, perhaps, through training DHS personnel on how to empower citizens' participation and how to establish clear and open channels of communication. They also need to consider viable forms of collaboration with the traditional health systems.

Many documents make the claim for a formal or theoretical inclusion of community-based roles, but presume a certain level of health literacy, and the means for achieving these roles is not clear. The notion of community involvement and participation is legitimised, but the channels for actualising such mechanisms are lacking. Talk of participation should not obscure an authentic process for establishing community voice and for delineating roles at the district health level, backed by health literacy and other capabilities. Without strategic implementation and deliberate training, policies *intended* to be user friendly do not always translate as such. Attitudinal and systemic barriers can be important, especially those relating to the attitudes of professionals and their professional ideologies. Such attitudes ignore the important role of indigenous knowledge, and by extension, the role of traditional healers

Experiences of decentralisation highlight features of systems that were codified within centralised arrangements, which have often been maintained, even under policies of decentralisation. These affect participation. For example bureaucracies replicate existing, top-down hierarchies, and 'decentralised' health systems may still have little connection with local communities. There is scant discussion in the literature regarding bottom-up representation of district/community concerns at the national level. Although some mechanisms exist for political representation, very little evidence was found of participatory mechanisms for voicing local health concerns at the national level.

The type of evidence to support review of these processes, or more realistic design, is largely absent in the literature. We do not typically capture such human dynamic constructs and need qualitative research strategies that can serve to point to contextually and culturally relevant trends and gaps.

The issue of community voice, role and participation at the district health level is a complex one. An extensive review of the literature left us with many questions. We would suggest that future work on participation and health at district level:

- deconstruct current definitions of *district health system*;
- analyse social constructions of *health system*;
- probe the impacts of global and market influences in health and ensure they are not unwittingly being reinforced through participatory mechanisms;
- understand the power relations and balance that informs decentralisation; and
- examine the contextual influence of poverty and the role that participation has in addressing dimensions of poverty.

This calls for a clearer conceptualisation of what is commonly meant by PHC and DHS, so mechanisms and policies can be located within these conceptualisations. Most important, there is a challenge in the prevailing perspective of the citizen as *object* of health care or *object* of research, rather than the needed perspective of citizen as *participant* and *knower* (Mpofu, 2003); this perspective needs to change.

4.2. Recommendations for further research

Further research into facilitators and barriers to participating in health care needs to be done. It can contribute significantly to the multi-layered discourse on community-based participatory health mechanisms. We recommend further investigation in the following areas:

- **Health literacy:** Little use has been made of local health education committees or the trained expertise of village health workers or their supervisors. Raising the levels of health literacy among local health providers and in health systems is essential to developing the health-care participation skills of the general population. There have been many missed opportunities for enhancing health literacy skills in Africa. Identifying and taking advantage of these opportunities has the potential for increasing the participation of community members in their own health-care processes. For example, including health-literacy content in reading and writing literacy programmes could be an effective tool to encourage health-care participation in local communities. Other significant aspects of community well-being, such as subsistence farming, could also be addressed, using relevant information that relates to their health care needs. However, there is still much that remains to be discovered about health literacy in a cultural context.
- **Intentionality:** The providers of health services, especially at ministerial level, are presumed capable of operationally translating policy into practice without deliberate personnel training or preparation. The issue of intentionality in policy-making is raised in the literature, but not addressed in any significant manner. We suspect that this is due to the lack of any research base. Because it is such a poorly explored area, we really do not yet know how to frame the questions. Intentionality is closely related to systemic perspectives of health service delivery and desperately needs further investigation.
- **The paradox of decentralisation:** We have pointed to the tensions in decentralisation over the delegation of power, capabilities and resources and how these issues are resolved, using the lens of participatory health systems, based on PHC:
  - How do systems avoid socially reproducing, at least operationally, centralisation patterns that are intended to be corrected?
  - What is it about systems that lead to this reproduction of roles and power, when it conflicts with goals of equity and participation?

This paper has examined equity and participatory mechanisms in the health delivery systems of six African countries. While specific issues and knowledge gaps are identified, we also suggest that research on participatory healthcare in sub-Saharan Africa is not simply about the accumulation of knowledge, but needs to work with local citizens as *knowers* rather than as *objects of study* in order to close the gap between knowledge and action (Mpofu, 2003). There is a need to work closely with local communities in ways that they can connect to their real-life health needs. Otherwise they may continue to perceive research into their health care as something meant primarily to benefit an external agent, and not themselves (Mpofu, 1994). Certainly this goes beyond traditional quantitative methods to qualitative, participatory approaches that bring in wider disciplines.

Health services need to be delivered in systematic ways, but also in ways that *systemically include the perspectives of those who receive services*. Achieving this goal depends upon appropriate multi-disciplinary approaches, an informed knowledge of sectoral priorities, and practical measures for empowering all people, including the poorest. In this paper we have highlighted possibilities for developing more effective models of participation, in order to strengthen the holistic, participatory and equitable nature of district health systems in Africa.

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***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

For further information on EQUINET please contact the secretariat:
Training and Research Support Centre (TARSC)
Box CY2720, Causeway, Harare, Zimbabwe
Tel + 263 4 705108/708835 Fax + 737220
Email: admin@equinetafrica.org
Website: www.equinetafrica.org

Series Editor: Rene Loewenson
Issue Editors: Pierre Norden, Rene Loewenson, Rebecca Pointer