Accountability and participation in Africa

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Introduction

Definitions

Community: a group of people living together in one place, especially one practicing common ownership ; a group of people having a religion, race, or profession in common ; the condition of having certain attitudes and interests in common ;
The community: the people of an area or country considered collectively (Pearsall 2001).

When the term community is used in this text, it is always assumed that within this community there will be differences in power and in access to and control over resources; that some individuals or groups within this community will be more likely than others to have a political voice and access to any mechanisms for holding health services accountable, whether because of their age, sex, political party allegiance, geographical location closer to sources of power or money, or lack of disability.

The term **community organizations** in this text does not include non-governmental organizations (NGOs) which play a service provision or an intermediary role between communities and government or donors.

Accountable: describes something which is required or expected to justify actions or decisions ;
Participate: to take part ;
Involve: cause to experience or participate in an activity or situation (Pearsall 2001).
The words involvement and participation are used interchangeably in this text.

Why the concern with accountability?

The brief for this chapter was to review current experience in Africa with health sector reforms (HSR) as they pertain to health service accountability to users. The chapter, in fact, focuses as much on participation as on accountability, on the argument that the way in which community members participate will determine whether or not health services are accountable to them.

The discourse around community participation in health that has shaped developing country policies and practice has had two sources:

- empowerment and the holistic and intersectoral conceptualisation of the primary health care (PHC) approach encapsulated in the Declaration of Alma Ata;
- the need articulated by the Washington Consensus for communities to provide resources in the context of increasing resource constraints in the 1980s and 1990s.

By 1991, 70% of the member states of the World Health Organisation (WHO) reported having mechanisms for community involvement (Shisana and Versfeld 1993).

As suggested by the two sources, there is not a single motivation for encouraging participation. The World Bank s John Garrison identified a distinction between the motivation of the World Bank (which sees participation from an operational perspective) and CSOs [civil society organisations] themselves (who tend to view participation from an ethical perspective) (Richmond 2000:8). 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 and Gaventa 2000). This position argues that it is only through community participation that services can meet the needs of the communities they serve, and that the process of participation can serve to empower individuals and strengthen the democratic process.

The degree of formal democracy in a society will directly influence the degree to which the voice of ordinary citizens is heard. In general, the greater the degree of decentralisation, the more input the public is likely to have regarding policy and services. Since decentralisation is a cornerstone of HSRs, it is here that the HSR agenda may coincide with the concerns of those promoting participation as a means of achieving justice and equity in health.

The other dimensions of HSR that pertains to community involvement are its efforts to address under-resourcing of government health services, through a shift in responsibility for health service financing to communities. This includes the introduction of user fees, as well as expectations that community groups will provide both funds and labour to support health services. This approach to community participation reflects the broader neo-liberal notion of the state as regulator and purchaser rather than provider of services.

As there is some potential synergy between these perspectives, one is seeing some agreement between the new left and new right regarding the development agenda, albeit with different agendas (Mohan and Stokke 2000). Community involvement is one of the meeting points between the neo-liberal and the empowerment discourses. Yet, because they have different agendas, its actual meaning differs depending on which institutions and individuals are promoting it. In addition, different initiatives lend themselves to different levels of participation, few of which relate to actual health service accountability to communities. The following table suggests this range.

Mode of participation	Involvement of local people	Who identifies problem?**
Collective action	Local people set their own agenda and mobilise to carry it out, in absence of outside initiation and facilitators	C
Delegated power	Local people hold a clear majority of seats on committees with delegated power to make decisions	C
Control but accompaniment	Organisation asks local people to identify the problem and make all key decisions on goals and means. Provides support to community to accomplish goals*	C
Partnership	Sharing of knowledge, planning and decision-making responsibilities to create new understanding	C/O
Cooperation	Local people work together with outsiders to determine priorities, responsibility remains with outsiders for directing	O/C

	process	
Advice	Organisation presents a plan and invites questions.* Prepared to modify plan up to a point.	O
Consultation	Soliciting of views, those with power analyse, decide on course of action and control inputs. Aims to facilitate acceptance or give sufficient sanction to the plan so that administrative compliance can be expected.*	O
Informing	Tasks are assigned, those in power decide agenda, direct process, no channel for feedback guaranteed	O
Co-option	Token representatives are chosen, but no real input or power	O
Manipulation	Distortion of participation into public relations vehicle	O
None*	Community told nothing	O

Key: Others : researchers/research institutions, NGO or government
C=local control and hence accountability; O = others decide on overall direction
Source: Gibbon, (2000:72), with author s changes marked ** and *.

Some might question why community members need to be involved. Many citizens, even in developing countries, are used to having basic services without having to give their time or resources to these. But given declining quality of services, and given that in many countries people are not and/or do not feel well represented through the formal election system, holding services accountable is a means of direct democracy that could ensure that limited resources are used to meet the needs of community members.

In addition, in the context of weak structures and mechanisms of democracy found in many African countries, public participation becomes even more important. Fredman (2002) notes, in particular, that the increasing recognition that formal systems of representation may not allow for the experience of marginalised groupings to be heard, has led to growing interest in developing other mechanisms for participation.

The African context

With few exceptions, the policies, structure and operational approaches of health services in Africa reflect the theory and practice of their colonisers. In addition, given the high degree of dependence of many African countries on donor funds, one sees a singularly similar approach to health systems and policy across countries.

In the 1970s and early 1980s the WHO was influential in shaping the discourse as well as ideas of best practice regarding health policy, through the Health for All agenda consolidated in the Declaration of Alma Ata. From the late 1980s, given the negative impact of debt, war, corruption and related factors on health systems, the health agenda has been much more substantively influenced by the macro-economic agendas of the international financial institutions, particularly the World Bank and International Monetary Fund (IMF). Policy, health systems and service delivery thus reflect the need of most African governments for some financial support and their dependence on multilateral, European and US donor support.

The past two decades have seen substantial service and managerial reorganisation, including the introduction of new mechanisms of health financing such as cost-recovery . It is in these processes that questions of community involvement have been put on the policy and programming agenda.

This chapter provides examples of the different types of community involvement that can be found across the continent. It focuses first on the diverse efforts of governments and civil society at establishing mechanisms for community members to influence policy and services. It then presents some of the efforts to promote health service accountability to communities, or responsiveness to users. Finally, it briefly describes the most common form of community involvement in health in Africa, which is through specific health programmes initiated by government or non-governmental organisations. By and large community participation within health sector reforms is not generated for particular health problems. The paper therefore considers it as a generic issue and only focuses on SRRH where relevant examples were available. The paper concludes by considering

- gaps in information;
- issues requiring further research which arise from this; and
- potential foci for advocacy.

Community input into policy

Institutionalised mechanisms for community involvement in policy development

Development of poverty reduction strategy papers

One of the common current processes across many African countries is the establishment of mechanisms for community input into the poverty reduction strategy papers (PRSPs) being developed by Heavily Indebted Poor Countries (HIPC) in anticipation of debt-relief. This is not a health-specific process. However, it impacts directly on health systems and services because it influences government allocation of resources.

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.

- In Ethiopia the government established a consultative process which began at district (woreda) level, with 115 meetings with about 50 participants in each. About 60% of participants were individual members of the public and the remaining 40% from among civil servants, civil society organisations and mass organisations. Thirty per cent of participants had to be women. In parallel to this process, the Christian Relief and Development Association initiated the establishment of an NGO PRSP Task Force which negotiated with government to get involved in the PRSP process. The Association also simultaneously initiated a process of consultation to gather the views of civil society in order to inform its own participation in the process (Christian Relief and Development Association 2001:4).
- In Rwanda the government conducted a national poverty assessment which reached communities and households at the second lowest organisational level of government and covered 10 000 people. However, there were few mechanisms for community involvement after this initial analysis. International and national NGOs, trade unions

and some churches gained some access to the process, but most religious organisation, rural NGOs, peasants associations and the informal sector had little access (Painter 2002).

- In Malawi the government did not try to establish any mechanisms outside of existing elected representatives. Whilst there were district level workshops, they were predominantly for elected local official, government employees and traditional authorities. Participation was on invitation of the district chief executive. The Malawi Economic Justice Network was formed to push for greater civil society involvement in response to this approach (Painter 2002).

As the three examples illustrate, by and large government mechanisms saw community involvement as providing information from communities, rather than gaining their input as to how to shape policy. This conclusion is supported by the perspectives of a range of different national groupings:

- The Ethiopian NGO PRSP Task Force fears that although it has been asked to participate, it is being asked to consult rather than participate (Christian Relief and Development Association 2001: 4);
- In Mali civil society organisations complained of being called to meetings with inadequate time for preparation, thus giving the appearance rather than the reality of the participatory process required by the World Bank (Richmond & Ladd 2001:11);
- The Mozambique Debt Group s assessment of the consultation process is that the restricted consultation process (has) created a climate of despondence toward further participation by civil society, which had no wish to expend time and resources with no guarantee that their contribution would affect a single line of the PRSP (Mozambique Debt Group cited in Richmond & Ladd 2001: 20);
- The Uganda Debt Network was concerned that (s)ubmissions made to government were used selectively, with key issues they raised ignored in the final document. This was in contrast to the government invitation (and) has led some to wonder whether Civil Society Organisations are invited to the table simply to legitimise what the government wants to write .(Nyamugasira cited in Richmond & Ladd 2001: 11).

Whilst the PRSP processes are not specific to health, they include assessments of what needs to be done in all the social sectors, including health. They therefore provide an opportunity for government to access ordinary people s understanding of their health problems, their views on health system functioning and their ideas as to how things could be improved. In addition, the initial mobilisation around PRSPs has led civil society groups in various countries to establish mechanisms for monitoring the use of funds in implementing the policy recommendations contained in the PRSPs. This provides an opportunity of creating direct accountability of government services for their use of funds. The initiative in Uganda described in the box is an example of collective action according to our earlier categorisation.

District-level monitoring of poverty fund, Uganda

The Uganda Debt Network (UDN) monitors the distribution and use of funds from the Poverty Action Fund (PAF) which holds money made available through the HIPC initiative as well as additional donor contributions for poverty reduction. Primary health care is one of the five sectors to which these funds are directed (Poverty Action Fund, no date).

A UDN study to ascertain local views on the PAF showed that few community members were aware of the PAF money or knew about or attended the district budget conferences . The research also identified diverse concerns of community members which could be addressed by the PAF, including, in relation to health, youth concerns about inadequate HIV prevention strategies, and women s concerns about lack of adequate maternity facilities. This research found that health units take a long time to submit their accountability statements yet receive further funding before the statements are in, thus undermining the purpose of monitoring (Poverty Action Fund, no date).

In response to these findings, the UDN embarked on a process of establishing district PAF monitoring committees. The role of these committees is to collect data, disseminate information to the public and work with government monitoring teams, sending the relevant information and other issues to the UDN to address at national level. The initial committees consisted predominantly of men (Shah & Youssef 2002; Lamptey, Zeitz & Larivee 2001).

National approaches to public participation in policy development

Spaces for public input in normal political decision-making
Countries without PRSPs have sometimes also experimented with different forms of public input into political decision-making. Post-apartheid South Africa provides an example of consultation/advice according to our categorisation.

Institutional mechanisms for public participation in policy making, South Africa
The process of anti-apartheid struggle included a discourse of participation. As a result of both this, and the fact that many of the first politicians and civil servants came out of a highly mobilised civil society (Klugman 2000), the process of policy development in the years immediately after the 1994 change of government strengthened expectations of consultation and also established some mechanisms for this.

The process began with a major media effort to gain public input on the new constitution. In addition, draft white papers were advertised as being available for public inputs, and sometimes consultative workshops were held to gain input from specific stakeholders. Some were initiated with the publication of green papers which raised questions about the overall policy directions as a prior consultative step before drafting white papers. By 2002, whether this approach was adopted had seemingly become dependent upon the interests of the particular politician or department concerned. However, once laws get to parliament, there is an established practice of public hearings at which any individual or group in civil society can ask to make a presentation. In some cases NGOs play an accompaniment role, identifying, encouraging and making it possible for ordinary citizens to give evidence. Parliament at times provides funds for such participation.

NGOs in the sexual and reproductive rights field have taken advantage of the opportunities. They have used their resources and links to politicians to have a substantial influence over a series of progressive policies including on abortion and on violence against women. By and large, however, this active effort at facilitating participation is declining. One constraint is that it is largely up to organisations to ensure that they know what is happening and organise

themselves to give evidence. As a result, some, such as the Congress of South African Trade Unions, have established a formal presence in the form of a parliamentary office.

The bureaucracy frequently draws members of civil society into advisory roles. In health this has included:

- an advisory committee on cancer control which shaped the national cancer policy, which includes a national cervical screening programme;
- a national termination of pregnancy advisory group which strategises how to improve implementation of the abortion law of 1997; and
- an AIDS Council which gives advice on implementation of strategies on addressing HIV/AIDS, but has not been the driving force to challenge the highly contested position of the country s President and Minister of Health on certain issues.

Sources: the author; http://www.ilo.org

The South African case suggests that even where there is a public discourse of popular consultation, it goes only as far as politicians want it to go. Beyond that, it is left to civil society to mobilise outside of institutionalised mechanisms, an issue discussed further below. The case study also indicates that institutionalising participation of NGOs and organised civil society, such as trade unions, is much easier than of the public at large.

WHO s Strategic Approach for participation in reproductive health policy making

WHO is promoting The Strategic Approach to Contraceptive Introduction . It has thus far supported its use for broader reproductive health assessments and policy development in Ethiopia, South Africa and Zambia. The approach has three principles: country ownership, participation of all stakeholders; and open, transparent processes (Simmons et al 1997). It involves bringing in diverse stakeholders to guide an assessment of services and to make policy and programming suggestions based on its findings. In addition to government and donors, the stakeholders include women s health advocates, influential leaders or community groups, and people or groups with needs currently not addressed by existing services (WHO 2002). The motivation for their involvement is to generate broad-based support for proposed actions, and to identify and address barriers experienced by users.

There are two mechanisms for community input. The first is that NGOs get invited to the initial planning meeting and the final dissemination workshop which shapes policy proposals. The second is through interviews with community opinion makers and community residents. The latter includes groups who are usually not consulted about policy. In Zambia, for example, workshop participants included representatives from the Young Women s Christian Association, the Makeni Ecumenical Centre, the Family Life Movement, the Planned Parenthood Association of Zambia, Women in Development, and the Society for Women and AIDS. The dissemination workshop added to this group some community-based providers (WHO 1995). In Ethiopia the Women s Affairs Bureau in each region was visited by the assessment team. As a result, the findings drew attention to limitations in women s participation in local government decision-making and made suggestions about how to improve this (WHO 2002).

The assessments thus far have shown that findings are indeed influenced by the participation of both NGOs and community members. That said, the WHO notes that the limited time

that both government officials and representatives of women s groups can give to the process can be a limitation (Simmons et al 1997).

Civil society advocacy for changes in policy and health systems

Where democracy does not respond to people s felt needs, they frequently engage in activities outside the formal political space. These may involve establishing organisations which provide a base from which to engage with and even negotiate with government, or they may involve contentious politics (Tarrow 1998). The latter involves the politics of opposition where organisations try to influence public opinion, shame government, and create new conditions which will make engagement and negotiation possible (Klugman and Hlatshwayo 2001).

In comparison to both Latin America and Asia, Africa does not have a strong record of this kind of grass-roots activism for health policy change. Most community-level and even NGO initiatives in health are externally motivated – whether by international NGOs or donors – and externally supported both financially and in terms of skills. There are, nevertheless, some initiatives to influence health policy and practice which provide useful lessons.

National coalitions to influence national health system policy and practice

Whilst government can facilitate hearing the voice of people at local level regarding international and national policy, this is not a common practice in relation to health policy. It is therefore mostly up to organisations of civil society to create mechanisms for local level concerns to be brought to the national level. National coalitions of organisations of civil society are a likely mechanism for this. The cases of the Community Working Group on Health in Zimbabwe and the Uganda Community-based Health Care Association (UCBHCA) provide good, if unusual, examples of what we can categorise as collective action.

Community Working Group on Health, Zimbabwe

The Community Working Group on Health (CWGH) was formed in 1998. It comprised 25 organisations, some of which were national with branches, and some local. Until it recently became a trust, it had a secretariat based in an NGO.

The CWGH has taken up a range of initiatives in an effort to promote health service accountability to civil society. These include:

- Since 1999 it has had a Civil Education Programme on Health at district level, having set up local CWGH committees in urban and rural areas. CWGH produced a facilitator s guide and trained facilitators and then set up an ongoing programme of workshops throughout the country;
- Discussions on the health budget held with members, parliamentarians, local government authorities and others, raising questions of inequity in distribution of health spending between hospitals and clinics, declines in per capita spending on health, and the role of debt and war in squeezing health . CWGH developed specific recommendations regarding both budget allocations and where to extract funds, and regarding community contributions to health;

- A regular presence in the deliberations of the parliamentary committee on health, including participating in the development of new policies and promoting specific concerns such as the role of village health workers (Rusike and Loewenson 2002); and
- Revitalising or setting up health centre committees to ensure that communities have a say in planning and management of their health services (Rusike and Loewenson 2002).

The secretariat s assessment of CWGH s impact is that it enables weaker groups and stronger to develop a combined voice on health policies, for solidarity to grown across groups, such as across rural and urban areas, in relation to people with disability or HIV/AIDS or across gender, and to use such networks to strengthen informed participation in local health planning (Loewenson 2000b:15).
Source: Community Working Group on Health 1999 except where specifically indicated.

The CWGH s degree of organisation and impact reflect the influence of its key initiators the trade union movement and a research and advocacy NGO. This talks to a more general finding of this research, namely that facilitation and resources – including conceptual and organisational skills – are critical components for enabling community participation.

The Uganda Community-based Health Care Association
The UCBHCA is an umbrella organisation of health-related NGOs which came together to find ways to impact on the development of the Government of Uganda/UNICEF health plan for 1995-2000. The Association did so through diverse strategies, including

- Drawing on its reputation for delivery to gain a central role in UNICEF s plan to form contractual relationships with organisations to support district-level capacity building;
- Using formal and informal meetings to engage with senior officials; and
- Attending and facilitating planning task forces, meetings and workshops.

Through these and other interventions, the UCGHCA had a direct influence on the health plan, including:

- Incorporation of a component on community capacity building and allocation of resources towards its implementation countrywide;
- Use of participatory learning approaches and participatory rural appraisal tools as key approaches for implementing the plan; and
- Signing of a memorandum of understanding between the Ministry of Health, UNICEF and the UCBHCA which spells out the roles and responsibilities of each in the community capacity building process. The UCBHCA s role is to facilitate the training and follow-up of government extension workers at national and district levels on contractual terms .

Source: Osuga 1998

Civil society activism to influence sexual and reproductive health and rights policy
It is more common in Africa to find processes for promoting policy change on specific issues rather than in relation to health policy or health systems as a whole. These processes generally push government to be responsive to community needs, rather than formally accountable to communities.

The South African case below shows the use of similar strategies to those described in relation to the UCBHCA above. It illustrates that when arguing for controversial policy changes, a community voice in the forms of both organisations with a mass constituency and individuals willing to provide personal testimony can be powerful if the government wishes to be seen to be listening to its constituency. The case involves elements of both accompaniment and collective action according to our categorisation.

The abortion policy process, South Africa

The process of advocacy for liberalisation of the abortion law in South Africa culminated in the implementation of the Choice on Termination of Pregnancy Act in 1997. The Act allows abortion on request in the first trimester; allows midwives to conduct abortions; and allows adolescents to access abortion without requiring parental consent. The campaign to change this law was not based on community mobilisation. However, the Reproductive Rights Alliance of NGOs was established to coordinate activity around the issue. Examples of influential activities include:

- An NGO identifying rural, poor and previously disenfranchised women who had been criminalised for having abortions, and facilitating their ability to talk in parliament about their experience;
- The Congress of South African Trade Unions and the African National Congress Women s League taking a public position in support of a liberalised law.

The voices of these groups were critical in challenging the argument that abortion was against African culture.

Another very influential factor was research undertaken by the Medical Research Council and presented to parliament, counting and costing the impact of unsafe abortions on the health system. This had no community component, but was important in winning a policy victory which makes a positive contribution to the quality of life of poor women.

Source: Klugman and Varkey 2001

The Auntie Stella initiative in Zimbabwe is an example of NGOs playing an advisory/consultation role in which they developed policy proposals based on research among the target groups within communities.

Involving young people in their reproductive health, Zimbabwe

The Training and Research Support Centre (TARSC) used open-ended interviews to identify students reproductive education needs. From this they developed an education pack which they called Auntie Stella . For two years, they field-tested the pack in collaboration with the Ministry of Education. They worked with students to develop indicators of change by which to measure the impact of Auntie Stella , and found that students did describe many positive changes. Nevertheless TARSC could not get the Ministry of Education to accept this initiative into its educational curriculum because material is often too explicit and poses a threat to decision-makers in the education field (Kaim 2002:7). The TARSC feel that they may have been more successful in influencing policy had they built alliances with key ministry officials earlier in the process.

Source: Kaim 2002

The Zimbabwe case serves as a reminder that research findings, however good they are, may not be used by policy makers (Stone, Maxwell and Keating 2001; Cornwall and Gaventa 2000).

Civil society activism to influence the policy environment

When the public and hence community need to be challenged
Creation of an enabling environment for policy change is a critical activity in countries with conservative cultural practices which undermine SRRH health. The first case study below is of collective action, while the second involves both NGO collective action and community accompaniment in this respect.

Creating alternative access to abortion services under a restrictive law, Kenya
In 1996, the Network of Private Health Providers of Western Kenya was established to train members to provide comprehensive, affordable post-abortion care (PAC). The network used government facilities to train private individuals, and both NGO and government providers. The project included advocacy activities designed to raise awareness and build support among providers for PAC. The initiative enthused other players to undertake other activities on this issue. For example a pilot project to expand PAC training for mid-level health professionals was created with legislative and administrative support from the Nursing Council and Ministry of Health. The National Nursing Association of Kenya subsequently included PAC as part of the nurse-midwife curriculum. The Kenya Medical Association, together with other stakeholders, established a project to expand legal policy and access to abortion services.
Source: Nzau-Ombaka (2001)

The Kenyan initiative and the Egyptian one described below were neither the result of community-identified problem definition nor of community mobilisation. On the contrary, they were undertaken in the face of community opposition to what they were advocating for. In both cases they were nationally initiated, but given some ~~d~~international support. The Egyptian case study illustrates how well-meaning efforts at international solidarity brought public attention to the issue of FGM in ways that polarised Egyptian society.

Coalitions to influence the public against the practice of FGM, Egypt
The International Conference on Population and Development in Cairo in 1994 gave impetus to the work of local groups who were trying to create public debate on the issue of female genital mutilation (FGM). That year, the Egyptian FGM Task Force was established under the Egyptian National NGO Commissions for Population and Development. It included human rights, health, education, women s rights, education and legal aid groups.

A turning point occurred when CNN broadcast a documentary on FGM in Egypt which prompted the Minister of Health to form a committee of physicians, clergy, medical and lawyers to provide an opinion on FGM in Egypt. The then Mufti issued a fatwa saying that female circumcision is not Islamic and could be left to physicians discretion, whilst other religious leaders disagreed. The task force recommended that FGM should be abolished. The Minister issued a decree saying that FGM should be performed only in hospitals at a minimal fee and that parents at these hospitals should be advised that the operation is

harmful. In response, several NGOs and a group of lawyers and human rights activists filed a law suit against the Minister for ignoring the committee s recommendations. The Minister then issued a decree prohibiting FGM, but did not announce it publicly in the light of forthcoming parliamentary elections. In July 1996, a new Minister announced the existence of this decree. In response, a gynaecologist filed a law suit against the new Minister, arguing against the prohibition of FGM. The argument was based both on constitutional/religious grounds and on the grounds that girls will continue to have the operation and hence from a health perspective it would be safer if done in hospitals. In December 1997 Egypt s Supreme Administrative Court upheld the Minister s decision.
Sources: Hussein and Assaad (2001); Warraq (no date); Legal Research and Resource Center for Human Rights (2001); Tadros (2000).

Promoting accountability through community involvement

Institutionalised mechanisms for community participation

Community participation through local governance structures
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. The Uganda example can be categorised as a mechanism for co-operation.

Community participation in the context of decentralisation, Uganda
In Uganda, there are local council structures at five levels, with each level feeding representatives to the next one. These structures allow community representatives to participate in decision-making processes. Women, youth and the disabled are allocated reserved seats on the councils through the constitution and the Local Government Statute of 1993.

A study of three districts found that the effectiveness of these institutionalised mechanisms depend on a range of factors:

- some councillors see their own participation as adequate, whereas others choose to hold regular meetings to report to and consult with their constituencies;
- where participatory rural appraisal methods have been used for project design and implementation, this has helped build ownership;
- the greater the opportunities for participation, the greater the extent of comfort of community members with the practice of participation, and the more likely they are to draw on available technical staff in the district;
- despite quotas for women s representation, husbands sometimes prevent their going to meetings. In addition, household chores and lack of education sometimes make it difficult to fill the women s special posts.

While community members can attend meetings at all levels, they can only vote at the lowest level. Actual planning takes place at the district level, without involvement of the health management committees and health workers at lower levels, let alone of community representatives. Nevertheless, the study found that people feel a greater sense of ownership,

and that the decentralisation process had increased participation of women.
Source: Makerere Institute of Social Research 1997

Community participation through government health structures
Where health services are not decentralised to local authorities, there may nevertheless be other mechanisms for community input. Probably the most common is community representation on hospital boards and clinic committees and/or the establishment of community-level health committees to interface between the health system and community, and sometimes to manage community health workers.

If run well, such committees can provide a framework of expectations of services, and indicators for monitoring (Clark 2000). The success of such committees may be influenced by whether or not community members are elected and hence are genuine representatives, or are chosen by clinic staff (Bennett, Msauli & Manjiya 2001). Their effectiveness also depends on whether they include a diversity of opinion and community members who have the confidence to speak.

The case of Senegal occurred in the context of the UNICEF/WHO Bamako Initiative of 1987, which focued on improving health for all through effective and efficient implementation of the primary health care approach at the community level (WHO/Africa Regional Office 1997) in the face of cuts in government funding for health. The case is an example of cooperation in terms of our categorisation.

Community input into health services, Senegal
From 1972 to 1984 Senegal slowly decentralised, one region every two years. A legal structure comprising several villages with elected representatives and budgetary autonomy formed the basis for community representation. This was matched by decentralisation of the health system to health centres and health posts responsible for preventive, promotive and curative services. Each facility at each level of the health infrastructure had an elected health committee with three sub-committees one for management, one for public health and hygiene, and one mothers. In addition to managing the money collected through user fees, the health committee could decide what activities should be carried out in the area.

A 1988 assessment found that while Senegal s health services provided for community participation, this was mainly limited to financial contributions , with community contributions financing 69% of the cost of drugs in the public health service and 46% of recurrent costs (Bichmann 1991:89). The other, secondary task of the committee was to mobilise the population, for example for immunisation or environmental health activities. The author notes that community members were not involved in decisions about health priorities, nor were they confident to express their views. Health services had neither the capacity nor management skills to support processes of community diagnosis. In addition, some committees did not communicate much with the communities they represent.

The launch of the Bamako Initiative in 1992 resulted in new regulations in respect of health committees. The financial contribution from communities for drugs and user tickets increased further. However, the organisation and functioning of services were still far from adequate in 1993 . One of the foci of the second phase of the Bamako Initiative was thus to

promote effective participation of communities in the process of health management (ibid 92).

Diop et al (2000) describe how in 1996 a restructuring was undertaken to rationalise the system and introduce tighter national planning, whilst increasing participation of local communities. However, although the restructuring provided that in theory, local councils will determine priorities and plan how health monies will be spent, with technical support form the district health officer , in practice the local councils had very limited financial powers. In addition, services were clearly not offering an acceptable level of primary care.

A 1998 study on local leaders knowledge of reproductive health and their roles in the decentralization process (Diop et al 2000) found that most leaders were men (80%) and older (55% over 50) with 47% unable to read or write French. Only 22% had received some training on the new process; only 31% knew the amount of the grant received from the central level and only 1% knew the approximate population size of their community. Whilst these leaders thought health a top priority, no council has developed a plan specifically for health, and few have any kind of development plan at all. The study found that whilst 80% of elected leaders were in favor of family planning to space births , 55% believed that youth should be excluded from such programmes and 45% were opposed to the use of contraception in order to limit births. When elected leaders were asked what they perceived the priorities in health to be, they tended to cite tangible investments, such as medications, qualified personnel, infrastructure and equipment (particularly ambulances).
Sources: Bichman 1991; Bichman & Diallo 1999; Diop et al 2000.

A 1994/5 review of the experiences of the Bamako Initiative in Benin, Kenya and Zambia found that all countries failed in protecting the most poor from the burden of payment, benefiting this group preferentially and ensuring that their views were heard in decision-making (Gilson et al 2001: 37) The authors note that community participation (was) seen as strategy of implementation (and) not (an) objective in its own right and there were no mechanisms to promote inclusion of poorest (ibid: 55). It was only in areas where NGOs provided support that the mechanisms for local decision-making which considered the voice of the poorest occurred.

The Nigerian case study provides another example of outside this time donor support for community input. The case study differs from those of Uganda and Senegal to the extent that Nigeria had had a military government, and participation was thus not built into the political system. The case study is an example of cooperation.

Participation in a context of military rule, Nigeria
In 1997 the Benue Health Fund Project was started as a partnership between the Hospitals Management Board, a specially established parastatal of Benue State, and the Department for International Development (DFID) of the UK government. The project aimed to improve the coverage, utilisation and quality of basic health services in seven local government areas. One of its five intended outputs was to empower communities to plan and manage improvements in their own health care . No representatives of community structures sat on the project advisory committee. Nevertheless, the project succeeded in building the capacity of health providers, managers and community members for

participating on management committees.

Staff capacity and resources were explicitly allocated to achieve this among other outcomes. Community visits, dramas, and participatory appraisal tools were used to build interest in the projects. Village development committees were established and had to include at least two women, and youth. Resource people in each village were trained to support participatory projects at that level, which required some contribution in cash and kind from villagers. Community members had to indicate their satisfaction before any contractors would be paid by the Benue Health Fund.

Despite these successes in building participation and a degree of accountability, Unom (2000) identified a number of difficulties. These included cases where exclusive caucuses of elderly men have selected women and youth representatives ; inadequate training and hence lack of confidence of community members to know what to ask and what they can reasonably expect and monitor; and hospital board members not being directly elected and hence not having to account to communities.
Source: Unom (2000)

Community participation in specific health programmes

Most of the literature on participation in Africa relates to community involvement in specific programmes. These are no known initiatives that aim to promote overall health service accountability to community members.

Research for information and/or action is a common phenomenon in the African SRHR context. Some of the research can be conceptualised as a form of participation or accountability to the extent that it identifies community needs and so involves a (usually weak) form of consultation . A limited number of research projects go further than this in terms of participation at the research or follow-up stage. The following examples illustrate some of the complexities and opportunities these create for identifying and addressing concerns of community members. The case studies include some examples that do not involve research.

Community involvement in research on sexual and reproductive health

The use of research to find out community perceptions of issues is fairly common in Africa. However, such initiatives usually do not attempt to assess priorities of different community groups, let alone to let go of any control over decision-making. This section looks at different levels of participation of different types of research interventions in the SRHR field. The first example, from Uganda, involves providing information.

Community-based HIV research and action in Musaka District, Uganda

In the early 1990s, the Medical Research Council and Uganda Virus Research Institute undertook a long-term HIV/AIDS study in a Ugandan sub-county. Initially, the primary role of community members was to be told about the study, and to support it by being willing to participate in an annual survey. In response to a request by community leaders to be more involved in discussions on the programme policy, a health advisory committee consisting of political, religious and traditional medical leaders was formed. The committee s discussions covered problems related to the implementation of

programme activities, such as counselling issues, community participation, AIDS control approaches, and improvement of health services. It had a purely advisory role but also helped create links with some sectors of the community.

As the study took shape, some of the community members employed as interviewers and mobilisers gave feedback on questionnaire design and the impact of the study. In the process some identified the need for specific interventions and helped design and implement social research projects of interest to them. Community requests which arose through this process have led the programme to support a range of initiatives beyond the scope of the actual study, such as a joint District/UNICEF spring protection project, provision of logistical support to government health services in the area, and implementation of a community-based health care programme.
Source: Seeley et al 1992

The Ethiopian case study is an example in which the lead agency more explicitly saw its research as influencing action. It involves advice and cooperation in terms of our categorisation.

Maternal and child health programmes, Ethiopia
USAID s Basic Support for Institutionalizing Chid Survival programme provided technical support to Ethiopia s Ministry of Health at national and regional level. It identified internationally recognised emphasis behaviours of caretakers which are seen as helpful for improving child health. The regional Ministry of Health staff selected from the emphasis behaviours they were given. The project then did a rapid community assessment to work out which of these behaviours are currently practised, which are not, and why. They then engaged with community members to work out how to overcome the why s .

In the intervention phase, both community members and the local health staff participated in identifying strategies to promote the emphasis behaviours. Responsibilities were allocated between community, Ministry of Health staff and project staff. For example, for the emphasis behaviour of exclusive breast feeding it was agreed to develop peer support groups; for lack of vaccinations it was agreed that health facilities would routinely vaccinate rather than only one day a week; for the low proportion of women attending ante-natal services, it was agreed to train community health workers because health facilities were too far away from many women. Project follow-up after a year showed improvements, among others, in exclusive breastfeeding.
Source: Bhattacharayya & Murray 2000

Interventions such as the Ethiopian one do not change power relations in a community. However, they do create an organised moment of communication between community members and health officials which can help staff learn from community members and so improve services. In the Tanzanian example, there was more emphasis on encouraging community members to shape and implement solutions. This example thus involves cooperation according to our categorisation.

Transportation for obstetric emergencies in Mwanza region, Tanzania
In a project initiated in 1996 by the international NGO, CARE, researchers conducted a

baseline study in 50 villages, none of which had any community plan for providing transportation during maternal health emergencies. Instead, this was considered the expectant mother s responsibility or that of her family. Based on the information they gathered, CARE developed a train-the-trainer curriculum on community empowerment. Ten master trainers from government, community members and CARE staff were trained. They then 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 transport systems available. Also, villages had started to provide social administrative and technical support for village health workers. Six villages were providing some financial support.
Source: Schmid et al 2001.

The Tanzanian example illustrates the increasingly common use of processes to empower communities in problem identification and solution development. The advantage of these participatory methods is that the process not only helps members identify possible actions, but also builds their confidence to take further steps.

Community involvement in NGO programmes
By far the most common mechanism for community involvement in health in Africa is through NGO projects such as REACH in Uganda, described above. Such projects can be found on malaria, immunisation, tuberculosis and aspects of SRHR. The projects are not a specific response to HSR, nor are they attempting to use the HSR restructuring process to address the SRHR issue through community involvement. The case study of the Christian Health Association of Ghana below involves elements of both cooperation and partnership.

Christian Health Association of Ghana Community Response to HIV/AIDS, Ghana
CHAG comprises 16 church groups and 128 health institutions (49 hospitals and 79 clinics) and provides 40% of western health services in Ghana.

In an attempt to develop an appropriate response to HIV/AIDS, CHAG established 11 pilot districts in four regions. PRA processes were used to sensitise communities about the issues and to document knowledge, attitudes, beliefs and practices of community members. These processes then provided the basis for planning and implementation of joint action. Activities in the community included:

- Information dissemination and training;
- Medical care and counselling;
- Income generation programmes and support groups; and
- Home-based care.

Community members volunteered to participate in the identified actions, and health committees were selected to support the process of work.

Impact assessments have shown that volunteers are knowledgeable and skillful mobilisers and that communities have a sense of ownership over the programme. There has been an improvement in community attitudes towards people living with AIDS (PLWAs), although

they remain highly stigmatised. The programme has also enabled PLWAs to form support groups and undertake income-generating activities together.
Source: CHAG no date

The story of Jijenge! is another example in which an NGO attempted to work with a community, and encourage them to take ownership of an initiative. This case study involves elements of control, accompaniment and collective action.

Community mobilisation to end violence against women in Mwanza, Tanzania
A Tanzanian rights-based organisation, Kuleana, formed a partnership with the African Medical Research Foundation, a health service delivery organisation, to address root causes of sexual health problems in Mwanza. They called the initiative Jijenge! Within six months of starting, the initiative focused in on ending violence against women . This included a pilot project which attempted to create lasting change in the community of Igogo.

Jijenge! staff identified 19 community leaders, including three women, met each individually, and then ran a three-day workshop with them on the issue. After the workshop the group endorsed the anti-violence intervention and established a volunteer community interest group (CIG) of seven women and three men. With CIG s support, Jijenge! staff conducted a needs assessment using in-depth interviews and focus group discussions to get to understand community attitudes to violence. Drawing on these findings, a range of actions were undertaken:

- CIG facilitators held impromptu discussions in busy public paces with questions like Do women experience violence in this marketplace? Do you think this is acceptable behaviour? ;
- Jijenge! collaborated with the Mahagama Theatre group to present dramas 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 established in 18 streets in Igogo with around 50 women and men in each. The groups met regularly with a CIG facilitator to guide discussion;
- Posters were distributed through NGOs, health centres, businesses, schools, religious groups and government agencies;
- Radio programmes were broadcast; and
- Murals were put up on eight store-fronts and walls in Igogo, for example saying I don t hit my partner, we talk about our problems instead.

The CIG recruited 10 women and six men volunteers to develop a watch group to provide support and intervention services. They tried to document domestic violence on each Igogo street, and to end the silence. They tried to get community members to intervene while violence was happening, and alerted the police where necessary. Some men requested to get involved so Jijenge! ran three-day workshops for men. As part of the attempt to win men s support, the discourse shifted from women s rights to family harmony .

The initiative also worked to change perspectives of service institutions. As part of this, it offered trainer-training to the police, social welfare and health providers, Catholic women s

groups, AIDS NGOs and others. After the initial trainer-training, the Jijenge! training coordinator provided on-site assistance to the new trainers in carrying out their plans in their own organisations. Jijenge! also offered an intern programme for clinicians in the public health service to work in the Jijenge! clinic.

Over time, the initiative led to an observable shift in people s willingness to intervene against violence.
Source: Michau et al 2002

Self-initiated community action
There is also a history in Africa of community-initiated action unrelated to HSR. While these are initiated by communities, if they look for external resources they will often work through an NGO or religious institution. In recent years communities doing it for themselves can be seen most notably in relation to the organisations of PLWAs in many African countries, as illustrated by the Malawi case of collective action.

Malawi Network of People Living with AIDS
In Malawi, as in many African countries, PLWAs have been at the forefront of organising to raise awareness about the problem. Catherine Phiri was one of the first people in Malawi to go public about being HIV-positive. She did so in 1990, resigning from her job as a hospital nurse in the face of stigmatisation, and establishing the Salima HIV/AIDS Support Organisation (SASO) in a remote lakeshore district, 60 miles east of the capital Lilongwe. SASO aimed to help give a human face and voice to those who suffered from the effects of HIV/AIDS under the veil of silence . Over time, SASO has developed programmes within communities, primary and secondary schools. It distributes condoms and mobilises voluntary support and home-based care. Volunteers also care for more than 1,500 HIV/AIDS orphans.

This community-initiated process gained such momentum that Catherine Phiri and others brought together similar groups to establish an NGO, the Malawi Network of People Living with HIV/AIDS.

Early in 2000 the United Nations Development Fund (UNDP) helped government organise a resource mobilisation roundtable, which aimed to raise funds to support districts and local communities to take action around HIV/AIDS. The Network played a central role, thus ensuring that new resources will strengthen existing community-based initiatives.
Sources: UNDP 2000; Kanjaye 2001

There are also forms of collective organisation which are traditional, yet respond to new challenges and opportunities as they arise. The case of the Dimba in Senegal is another example of collective action.

The Dimba of Senegal: a support group for women
The Dimba is a support group for women who have not borne children because of infertility or repeat miscarriages, women whose children died young, mothers of twins, and women who have adopted orphans. It is organised through neighbourhood-based groups, crossing ethnic lines, throughout southern Senegal and in Guinea Bissau, Guinea and Mali.

The Dimba regards itself as responsible for matters relating to pregnancy and childbirth, fertility, sexually transmitted infections (STIs) and the health of mothers and children in the community. Members provide antenatal care. This extends to removing a pregnant women from her home if her husband makes her work too hard. The rituals Dimba uses can be traced back to the Mali Empires of the 11th to 16th centuries. Each group is headed by an older woman traditional doctor who is also the group s spiritual leader. Next in rank is a mother who organises the group and delegates administrative tasks between members. The mother has three to six senior members who advise her and participate in decision-making. Yet despite this hierarchy, the style of decision-making is democratic, encouraging participation of all members. There are also men attached to each group with specific responsibilities. They include a father who usually treats couples with STIs.

In addition to playing the role of a therapeutic and support group, the Dimba is an activist political force. It organises protest marches and finds means of embarrassing the leadership so that it will take note of its concerns. It has also taken on the task of disseminating more contemporary health information and education in the context of HIV/AIDS.
Source: Niang 1994

Whilst such collective action may seem far away from the world of HSR, organisations such as the Dimba provide an entry point for health services to share information with community members. They could also provide an organisational form for community members to hold health services accountable.

Conclusion

Most community involvement in Africa is around health activities, rather than around ensuring health system accountability. There are many examples of specific groups within communities organising themselves around health issues. There are also many examples of NGOs mobilising around policy or services. The extent of community involvement in problem definition through to service implementation differs from case to case, as shown in the many examples above.

The case studies presented above include both top-down, government-initiated efforts to facilitate community input into policy, and bottom-up, NGO-initiated efforts to influence policy. Whilst some of the government processes related directly to public sector reforms, the reproductive health initiatives of NGOs tend not to take on board challenges raised by HSR such as the declining government inclination to spend funds on the social sector or weak management capacity to implement specific policy changes in the context of major restructuring.

Community involvement activities preceded HSR, and will no doubt continue as new reforms are instituted over time. They are, of course, affected by changes in donor strategies and in the opportunities created by new forms of organisation of the public health system. This conclusion draws on the case studies from this chapter as well as a range of reviews of experience to identify key lessons and challenges for institutionalising meaningful community participation (Conference on community-based health care (CBHC) 1997; Kahssay 1991; Loewenson 2000a; McGee and Norton 2000).

Participation only becomes partnership when communities decide on priorities
The degree of power envisaged for structures which include community representatives is a key factor in determining to what extent their participation can foster health service accountability. Overall, a lack of power appears to be the norm in community involvement in health governance, with some decision-making over drugs being the most common degree of decision-making.

Abdication of state responsibility
Behind the rhetoric, community participation is often conceptualised as a means for government to abdicate some of its responsibility for health services looking to community members to provide the time and financial resources to make services possible (Botchway 2001). Meanwhile, lack of success due to failure to provide equipment, support and training to the initiative are then blamed on communities (Conference on CBHC 1997). To be successful, community participation requires facilitation. Facilitation, in turn, requires resources of time, skill and funds (Botchway 2001; Shisana & Versfeld 1993; Taket 1998). Community participation is often presented as a means of communities supporting services in a context of resource shortages, within a broader ideological notion that the state should play a lesser role in health service provision. However, community participation requires strengthening of the state if it is to work effectively.

Need for institutionalised governance mechanisms
Across different countries, case studies illustrate the problem of structures for community input not having agreed systems that ensure accountability. Brinkerhoff (2000) notes that one cannot assume that civil society groups are naturally democratic or that consensus and cooperation are natural outcomes. One also cannot assume that, once elected, representatives will elicit the views of their constituencies or report back to them.

Reorientation of the health system and staff
As Loewenson (2000c) notes, while communities want more authority, health workers want communities to take more responsibility for health and to contribute more resources. Underlying these conflicting motives, are powerful social norms. Firstly, there is the medical model of top-down we-know-best service provision. Secondly, there are generations of experience of government from above. For policy makers, participation can create unwanted demands and complications (Brinkerhoff 2000:609) This cannot be overcome simply by creating space for representatives on a clinic committee or by consulting communities, in the absence of long-term efforts to address the systematic disempowerment of people in communities. For participation to succeed, health managers and professionals also need to see the value of listening to community voices.

Who is the community?
The case studies illustrate the problem of assuming that the community is homogeneous. It is likely that only the loudest voices within communities will be heard (Brinkerhoff 2000) and that the community participation process may benefit local elites who thereby obtain additional, institutionalised, and officially-supported power, patronage and subsidy (Mills 1990:31). Mechanisms for community involvement need to take account of existing power relations within communities. They need to make active provision both for identifying usually marginalised community members and for building their capacity for participation.

The question of who represents the community is of particular significance in relation to SRHR. There may well be arguments for decisions about an essential package of services to be made at higher levels, where public health concerns, if not human rights concerns, are more likely to be articulated. Likewise, given high levels of taboo around acknowledging sexual health issues, a community s health and wellbeing may be jeopardised if community representatives give priority to maintaining current norms rather than acknowledging and addressing threats such as STIs or sexual violence.

Gaps in information

The research for this chapter revealed that there is very little information for Africa available about:

- 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; content of health services; 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. (Taket 1998).

Issues requiring further research

The following are areas where there is some information available, but more is needed:

- 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.

Potential advocacy foci

The information contained in this chapter could inform the following avenues of advocacy:

- To politicians, donors and senior bureaucrats: on participation in policy making and monitoring generally. People concerned with SRHR need to link up with existing monitoring, evaluation and advocacy efforts such as those connected to PRSPs;
- To politicians and senior health bureaucrats: in relation to health budgets and monitoring of spending service provision on health, including SRHR, at different levels of government;
- To donors: to invest in health governance rather than only in vertical programming (Kickbush 2000: 988);
- To politicians: sharing examples of the benefits of community participation in policy development and monitoring;
- To health service managers: sharing examples of the benefits of positive experiences of health service accountability to communities; and

- To community groups: about their health rights and possible vehicles for promoting these in relation to both influencing policy and playing roles in health service governance.

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Abbreviations used in the text

AFRO	Africa Regional Office (of the World Health Organisation)
CBHC	Community-based health care
CHAG	Christian Health Association of Ghana
CIG	Community interest group
CWGH	Community Working Group on Health
DFID	Department for International Development
FGM	Female genital mutilation
HIPC	Heavly Indebted Poor Country
HSR	Health sector reforms
IMF	International Monetary Fund
NEDLAC	National Economic Development and Labour Council
NGO	Non-governmental organisation
PAC	Post-abortion care
PAF	Poverty Action Fund
PHC	Primary health care
PLWA	Person/people living with AIDS
PRSP	Poverty reduction strategy paper
REACH	Reproductive, Education and Community Health Programme
SASO	Salima HIV/AIDS Support Organisation
SRHR	Sexual and reproductive health and rights

STI	Sexually transmitted infection
TARSC	Training and Research Support Centre
UCBHCA	Uganda Community-based Health Care Association
UDN	Uganda Debt Network
UNDP	United Nations Development Programme
WHO	World Health Organisation

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