Participatory Governance

Sharing best practices for the participation of marginalised groups in health sector governance

HEALTH POVERTY ACTION

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Report by Health Poverty Action, May 2016

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Commonwealth Foundation

Supported by the Commonwealth Foundation

Cover image: In Mandera County, North Eastern Kenya, Community Conversation is used to engage diverse groups in critical dialogue around FGM and associated practices, which are linked to high maternal death rates.

Design: www.revangeldesigns.co.uk

Health Poverty Action works to strengthen poor and marginalised people in their struggle for health.

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HEALTH POVERTY ACTION

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In 1978 community participation was enshrined as a necessary part of health provision in the *Alma Ata Declaration*. The Alma Ata was unequivocal in its emphasis on the role that communities should play in health provision:

> Essential health care, based on practical, scientifically sound and socially accepted methods and technology made universally accessible to individuals and families in their community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO 1978:45)

The statement and the establishment of Alma Ata represented a watershed movement in the global definition of health. Health was no longer understood as something provisioned through health services alone. Health strategies needed to also "address the underlying social, economic and political causes of poor health" (Werner and Sanders, 1997:18) People and communities, especially those adversely affected by social, economic and political causes of poor health, were now expected to play a critical role in "planning and evaluating their own health services" within a broader understanding and awareness of the "socio-political and development issues" that affected their lives.

Health Poverty Action's Commonwealth Foundation funded project, **Sharing best practices for the participation of marginalised groups in health sector governance**, initiated in October 2014, is in part located in and emerges out of this foundational framing of health. The project aimed to *increase the participation of marginalised communities in the governance of health policies* and encourage *policy makers to replicate the best practices* that arose out of this project. The project focused on strengthening Civil Society Organisations' (CSO) knowledge of participatory governance and their ability to advocate for more participatory forms of health governance. **Health Poverty Action (HPA)** focuses on engaging the poorest and most marginalised people, excluded from access to health services and information, to realise their right to health and to improve their health and wellbeing through training aimed at building local capacity to deliver sustainable health services and information. Central to Health Poverty Action's mandate is an **emphasis on the need for justice rather than charity**. The project's focus on participatory health governance recognizes that health equity can only truly be achieved if citizens, especially those on the margins of society, play an active role, and have a voice in the creation and review of policies that shape their life outcomes. Health Poverty Action's focus on **prioritising those missed by others** acknowledges that gaps in health can often reflect gaps in a governance structure's relationship with historically overlooked communities. With this in mind HPA aims to offer and promote **holistic approaches** to health, which includes a prioritisation of participatory methodologies that have the potential to bring lasting improvements by tackling numerous factors together. The participatory models profiled in this process and their combined potential reflect HPA's desire to explore modes of community engagement that have the greatest holistic potential.

Sharing best practices: Participatory models in Kenya, Rwanda, and Namibia

The *Sharing Best Practices* project reflects HPA's commitment to increase the participation of communities in decision-making processes that impact their health. Rather than identifying and imposing new methodologies HPA decided to focus on the rich work already being done by identifying existing participatory models utilised in the projects that Health Poverty Action and its partners implement across Sub-Saharan Africa. Approaches that already demonstrated promise at the community level but could also, through creative linkages and innovations, make substantial contributions to participatory health governance at the local, national and even international level.

Rwanda, Kenya, and Namibia were identified as sites utilising participatory models that could potentially make distinct contributions to health governance. In Rwanda, Health Poverty Action and local organisation PAJER use an adapted form of '**Ubudehe', a traditional Rwandan co-operative practice, to engage communities in the planning and production of public services. In Namibia, Clinic Health Committees (CHC) have been used to establish and enhance the involvement of marginalised community members in health service delivery and provision. In Kenya, the 'Community Conversation' (CC) method has been used as a transformational participatory dialogue and consensus-building methodology to address a number of social determinants impacting on communal health.**

Health Poverty Action wanted to explore the potential synergies and contributions that each of these participatory models could offer to one another and the broader aim of promoting participatory health governance. **This effort was in part facilitated through a best practices meeting that brought Health Poverty Action and partner staff from Rwanda, Namibia, and Kenya, together in Nairobi to explore these synergies over a 5 day training and experience sharing encounter**. The encounter focused on exploring the Community Conversations approach in depth and its potential contributions to the CHC and Ubudehe community participation models. Overall the encounter enabled participants not only to think about the ways their work could be enriched by each other's models, but also how the combination of models could ultimately enhance the participation of the communities they work with in health governance processes and decision making.

The following report offers key insights into the methodologies and their contextual application, and provides experiential insights into attempts by Health Poverty Action and our partners to promote participatory health governance using these models. As a best practices document this report aims to help a diverse set of practitioners and stakeholders think more critically about the ways in which participatory health governance can be enhanced in their respective contexts. A focus on these models reflects HPA's understanding of community "participation" as a combination of supportive systems, processes and group science that encourage open, honest, and safe dialogue. While some community participation approaches refer to open public forums and large to small scale consultations as participatory, this report highlights how important it is for local stakeholders and policy makers to think critically about the models, processes, and tools used to encourage and cultivate participatory spaces.

This report documents the project's lessons and learnings in the following ways. Section (2.0) provides a conceptual rationale for participatory health governance by discussing why addressing the political determinants matters most today and how participation fits into this. Section (3.0) provides a conceptual overview of the **Community Conversations (CC), Clinic Health Committee (CHC), and Ubudehe** models. Section (4.0) offers in depth case studies of the models in context, highlighting key insights and experiences from the projects themselves. Section (5.0), "Methodological cross roads/synergies" spotlights important points of learning that arose from the project's attempts to enhance participatory health governance by exploring the combination of models and approaches. Finally Section (6.0) lifts shared lessons and learnings from the *case studies* and *methodological cross roads* in order to provide policy and practitioner focused advice for organisations, institutions and or governing bodies interested in participatory health governance.

2. Political determinants of health and participatory health governance

The People's Health Charter was developed and endorsed by the First Peoples Health Assembly held in Dhaka, Bangladesh in December 2000. The People's Health Charter was, and continues to be, one of the most widely endorsed health documents since the Alma Ata. It arose out of the acknowledgement that the Alma Ata declaration, "Health for All" by 2000 had not been realised. According to the Charter, responsibility for this failure lies with "governments and the international community" that have routinely fallen short of addressing the systemic barriers to health. The People's Health Movement evolved out of the need to carry forward the People's Health Charter across a broad network of Civil Society Organisations and Movements. Health Poverty Action is one of the only international NGOs formally affiliated with the People's Health Movement.

The People's Health Charter formed the foundation for creation of a concerted international effort to put the goal of "Health for All" in its rightful place on the development agenda. Genuine, people-centred initiatives had to be strengthened to increase pressure on decision makers, governments and the private sector to ensure that the vision of Alma-Ata became a reality. This ultimately meant cultivating people-centred and people-led movements to address the political determinants of health.

In 2014, The Lancet/University of Oslo Commission on Global Governance for Health published *The Political Origins of Health Inequity: Prospects for Change* (Ottersen et al 2014). The piece proposed a renewed focus on the role that the political determinants of health played in shaping health inequities. While the focus was on global political forces, the article directed our attention to the way policy making and governmental strategic actions incidentally "harm health". Ottersen et al was not alone in directing our attention to the role that governance plays in enabling and/or disabling the health of poor and marginalised communities. Years before, Kickbusch (2005) and Bambra (2005) wrote about the way political determinants of health set norms that guided societal interactions and shaped how problems or issues were addressed through governance channels. That wasn't all. Political determinants also explicitly and implicitly dictated what solutions were considered reasonable and rational. Ottersen et al said the following: "Political determinants such as rules of representation, voting, transparency, and accountability relate to who participates in … decision making processes, and how these processes are shaped by actors with different values, interests, and powers" (Ibid 2014). The picture that arose from their work was one in which the health of communities, especially the marginal and poor, was deeply affected and shaped by asymmetries in power and by extension the inability to influence decision-making spaces. What the Lancet Commission highlighted is this: *enhancing marginal groups' participation in health sector governance* required directly engaging the political determinants of health in creative and considerate ways. These ways needed to focus in part on shifting the power divide between everyday marginal citizens and authorities, decision makers, and power brokers. While standard interpretations of participation may have sufficed, learnings from the Commission called for something more than this. Community-based participatory approaches to health intervention have often been criticised for doing little to disturb the larger social and political determinants of health inequity. Participation and its conceptualisation within this project had to be emboldened. *Participatory Health Governance*, both as a practice and concept, offered an alternative framework to consider the role that participation in health governance could play in attempts to engage the political determinants of health and the promotion of health justice.

What is participatory health governance?

According to Walper and McNulty (2011) participatory governance looks like the following:

> Participatory governance consists of state-sanctioned institutional processes that allow citizens to exercise voice and vote, which then results in the implementation of public policies that produce some sort of changes in citizens' lives. Citizens are engaged in public venues at a variety of times throughout the year, thus allowing them to be involved in policy formation, selection, and oversight. The inclusion of citizens in state-sanctioned venues means that they are now in constant contact with government officials. These institutions generate new forms of interactions among citizens as well as between citizens and government officials.

Participatory Health Governance (PHG) as a model focuses on giving citizens on the margins of society, those typically left out of health policy formation and processes, the opportunity to shape not only policies, but the sorts of health systems set up to serve the public. According to Jillian Clare Kohler and Martha Gabriela Martinez (Kohler & Martinez 2015), participation in health governance fosters the following:

i) PHG enhances citizenship inclusion in governance processes that shape health. The inclusion of citizens helps increase transparency and accountability in political decision-making with regard to healthcare.

ii) PHG can promote civil society's ability to access information on the health system and health policies that can be used to monitor government practices.

iii) PHG can create opportunities for civil society supporters to raise concerns or challenge their local government and health authorities.

Why participatory health governance?

According to Wampler and McNulty (2011) the emphasis on participatory governance arose out of a recognition that representative democracy has limits. While representative democracy reflects a fundamental belief in the power of the vote and efficacy of representative governance, participatory governance as a practice and approach acknowledges that the 'democratisation' of health and the promotion of health equity requires a great deal more than representative politics. A number of academics suggest that representative democracy is unable to improve the performance of the state, politically educate and empower citizens, and guide the state's use of scarce public resources so they work in favour of citizens that have little access to resources and influence (Wampler & Mcnulty 2011). There is mounting global evidence that demonstrates the effectiveness of participatory governance models and their contribution to realising hard-to-achieve outcomes (Goldfrank 2011; Wampler & McNulty 2011).

This evidence demonstrates that these approaches can have distinct but overlapping progressive outcomes for citizens and their respective governments. Creating the civic space for public deliberation and collaboration offers citizens unparalleled opportunities to better understand and learn about the political processes that shape their lives. This can prove to be particularly empowering for citizens that feel alienated by larger democratic processes and political structures. In short, participatory health governance can be a form of citizen building. Citizen building that helps everyday people learn how to engage and 'leverage' authorities, systems, and services in the interest of their broader health needs. For governments willing to embrace participatory health governance approaches, the potential is huge. Democratic stability and sustainability can be continually cultivated when citizens have a regular say in the allocation of "public health resources" (Wampler & Mcnulty 2011). Democratic tools and methodologies that consistently encourage transparency at the governance and policy making level can be especially beneficial for states actively engaged in narrowing the gap between health outcomes of the historically dispossessed and socio-economically privileged groups in society.

For civil society organisations and in particular local community based organisations (CBOs) supporting communities on the margins, *participatory health governance* presents a unique opportunity. A great deal of activity in support of health equity focuses on supporting communities through the direct provision of services and/or advocacy for particular health services, levels of access, and systems improvements. While necessary, as Ottersen et al point out, the accessibility and efficacy of health services and systems, and the allocation of health resources, are all shaped by larger political processes that make up representative democracies. Supporting communities by providing missing services and systems is necessary but *Participatory Health Governance* as a programmatic focus and approach offers an important complementary approach to the promotion of health equity and justice. Participatory Health Governance acknowledges that health

justice can only truly be ensured in national and/or communal contexts that have attempted to create "health enabling democracies" (Rolston 2016). Democracies that embody political processes and systems of citizen and government collaboration and contestation are those that consistently push a nation's "health barometer" towards justice and equity (Ibid 2016). Establishing and advocating for Participatory Health Governance is one way of attempting to shift the existing power dynamics – that so often shape political processes and citizen/government engagement – in the interest of groups historically left out of or forgotten by policy making processes, service delivery decisions, health spending, and resource allocation decision-making circles. Health outcomes and health equity can be greatly influenced by citizens' ability to engage and influence whether or not the democracies they are a part of work in the interest of their health and well-being. Participatory Health Governance is one way to increasingly align health justice with broader global movements towards genuine democracy and health for all.

What does promoting the participation of marginalised groups in health sector governance look like in this project?

Within this project participatory health governance has meant supporting marginalised citizens to establish collaborative civic spaces and venues so they could increasingly exercise more influence over health systems, resources, facilities, practice, policy and decision-making. This meant exploring and identifying new ways of engaging health governance systems and service providers. It also meant more clearly defining what governance looked like across the diverse contexts.

Throughout this project it became clear that governance was a term that needed to be understood in more complex ways. By extension the concept of participatory health governance needed to be expanded to encompass the diverse array of governance systems encountered throughout this process. Governance within the context of this project embodied both existing *political governance systems* and long standing *indigenous governance systems*.

Exploring the potential for Participatory Health Governance had to take into account the two often overlapping systems of decision making that exist throughout Kenya, Namibia, and Rwanda. While Participatory Health Governance in one context may be expanding citizens' voices and participation in the local health service delivery or district health spending discussions; in other contexts it meant doing this while also engaging existing indigenous governance structures and authorities. This meant that citizens were often *dual citizens* with relationships and responsibilities to two sorts of governance and accountability structures. Citizen participation and voice needed to be thought of and conceptualized with these complexities in mind.

Of equal importance to this project were the different *participatory approaches or methodologies* employed by Health Poverty Action and our partners. Engaging the political determinants of health and promoting participation involved exploring a series of existing participatory approaches already being utilised by HPA. Participation in health governance would not happen by accident or incident. Exploring methodologies and their combinative potential could help produce new models for participatory health governance and collaboration. **Community Conversations (CC), Ubudehe, and Clinic Health Committees (CHC)** each offered a unique approach to the conceptualization process. The limitations of representative democracy that gave way to a new focus on Participatory Health Governance was not merely about political personalities and the performance of political representatives. The limitations were in part a reflection of how limited *representative technologies* like voting can be in the face of large inequities. Focusing on the aforementioned best practices and participatory approaches provided an opportunity to consider how these approaches do or do not serve as small steps towards the democratization of health and well-being.

3. Participatory methodologies and participatory health governance

HPA identified participatory best practices at the local implementation level. Each of the methodologies had a unique and contextually appropriate approach to encouraging the participation of marginal groups in the promotion of health justice. **HPA and our partner EPAG[i] in Mandera, Kenya used Community Conversations as a communal dialogue and change process that created space for collective reflection and action to address Female Genital Mutilation and gender dynamics. In Rwanda, HPA and our partner PAJER[ii] used Ubudehe – an indigenous community engagement method – to enhance communal cooperation and collaboration in the provision of local health and sanitation services. In Tsumkwe, Namibia, HPA employed Clinic Health Committees (CHC) as a way to enhance marginal groups' influence on local health provision services.** The project process focused first on developing an in depth understanding of each participatory best practice with a focus on identifying how they each offered a unique framing of participation. Secondly a focus was placed on exploring how these approaches could be potentially combined and merged to create contextually appropriate approaches to participatory health governance. There was particular interest in understanding and exploring whether or not these combinations could **produce new models for citizen engagement and citizen/health sector governance collaboration**. This section provides a brief outline of each methodology.

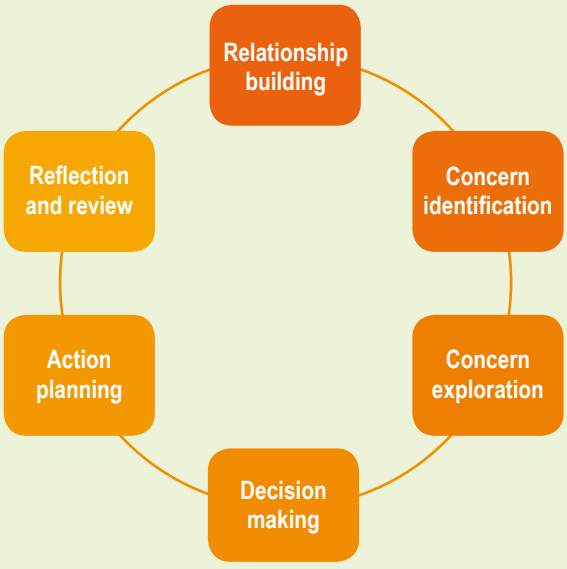
Kenya: Community Conversations (CC)

The Community Conversations approach employed by HPA is based on the **UNDP Community Capacity Enhancement – Community Conversations (CCE-CC)** tool for health promotion and communal engagement. The CCE-CC process was developed by civil society organisations during the early stages of AIDS pandemic (UNDP 2005).

The methodology reflects the amalgamation of two distinct approaches to AIDS prevention developed in Zambia and Senegal. In Senegal *ENDA Santé* established the Community Capacity Reinforcement (CCR) approach to AIDS prevention; an approach that focused on using community storytelling and story creation to unearth hidden beliefs, practices, and their historical foundations. In Zambia the Salvation Army developed the *Community Counselling* approach to AIDS prevention that focused on exploring the emotional side of AIDS prevalence through a facilitated accompaniment process that opted out of dominant approaches to AIDS prevention that focused on "teaching and preaching" safe sex.

The merging of these two methodologies resulted in the CCE-CC approach; a facilitated dialogical process with set methodical steps and accompanying tools. The Community Conversations process steps include *a) Relationship Building b) Concern Identification c) Concern Exploration d) Decision Making e) Action Planning f) Reflection and Review*. The Community Conversations approach's original aim was to enhance affected communities ability to identify and address the root causes of HIV/AIDS.

Figure 1: CCE–CC methodological steps



i. Emergency Pastoralist Assistance Group (Kenya)
ii. Parlement des Jeunes Rwandais (Rwandan Youth Parliament)

The UNDP Community Conversations approach was originally developed as a larger part of a **Leadership for Results (LR)** programme**.** The LR programme focused on enhancing a community's ability to engage local leaders, political representatives, and influential stakeholders alongside improving political representatives' ability to engage with citizens and civil society. As a part of the LR programme Community Conversations were intended to be the grassroots segment of a larger effort to align citizen-led organising with governmental decision-making. As the Community Conversations element moved out and beyond the boundaries of the UNDP, through adaptation efforts, the LR portion of the programme which focused on political representatives was lost.

Research exploring the use of Community Conversations in Zimbabwe (Campbell et al 2013) emphasises its ability to create "social spaces for dialogue, which can engage marginalised peoples… to engage in critical thinking". Campbell et al also highlight how Community Conversations (CC) help communities identify locally generated change strategies. Community Conversations have been increasingly adapted to different circumstances and used to address a variety of social issues including FGM, gender inequity, xenophobia and more. As a methodology it has the potential to make very specific contributions to the participation of marginal groups in health sector governance. CC can serve as a civic space for local influential leaders, political representatives, and citizens to collectively reflect on shared health concerns and issues with an aim to develop collaborative actions and strategies. Its contribution to participatory health governance is in its ability to support and cultivate egalitarian consciousness raising democratic dialogue in contexts where divides between marginal groups and governance structures adversely affect health.

Rwanda: Ubudehe

Ubudehe is a historically practised form of communal collaboration and collective action (Ezeanya 2015). Historically Ubudehe was a socio-cultural practice in which communities collectively got together to prepare farmlands for planting and the coming rains. Ubudehe ensured that all contributing family lands were prepared and ploughed regardless of a family size and capacity. This process ensured that vulnerable community members were taken care of during this process (RGB 2013). In 2009 the Rwandan federal government revived Ubudehe as a decentralization strategy that attempted to make decision making around local services more accessible to everyday citizens (Ezeanya 2015). The Ubudehe approach attempted to merge cooperative traditions and culture with participatory approaches to community engagement (MINALOC 2009). As a participatory approach Ubudehe is located at the village level. Under this new decentralization effort the Rwandan federal government constructed 14,837 distinct, politically constructed villages. Ubudehe became a village level political mechanism for "bottom up planning and policy-making". (Ibid 2015)

As with the Community Conversations approach, the present manifestation of Ubudehe involves a series of clear methodological steps. Ezeanya outlines the 11 methodological steps in the table opposite. (Fig. 2)

Ubudehe is a facilitated process led by the Rwandan Ministry of Local Government (MINALOC 2009). Ubudehe to date has been used to assess and profile inequality as an ongoing contribution to policy based action and national health insurance administration. Ubudehe offers unique learnings on participatory health governance because of its history and relation to the state. Its historical embeddedness offers insights into broader questions about the need for indigenous approaches to participatory citizen engagement. As a government driven participatory process it also offers insights into the opportunities and challenges associated with participatory approaches overseen and administered by the state. Because Ubudehe is meant to both decentralize decision making around service provision and promote a form of "grassroots policy making," it can provide important learnings around how governmental health sectors can be reshaped in the interest of greater participation and the engagement of marginal groups.

Namibia: Clinic Health Committees (CHC)

Clinic Health Committees (CHC) are meant to serve as a bridge between marginal communities and local health services. They provide a means through which local communal health needs and concerns can reach, and hopefully influence, various local, district, provincial and national level decision-making processes and spaces. While Ubudehe and CC have methodological steps aimed at guiding the process of citizen/government interaction and engagement, CHC operate in a distinctly different way.

Figure 2: Home grown and grassroots-based strategies for determining inequality towards policy action – Ubudehe approach in perspective

1. The **determination of poverty among members**, according to community perception
2. Identification of the **causes and consequences of poverty** by community members.
3. Placement of all **community residents on a social and economic categorisation** set, provided by the **Ministry of Local Government (MINALOC**).
4. Construction of a **social map of the village**.
5. Identification of all **common challenges facing the village**, followed by prioritisation.
6. Formulation of a **collective action plan** for tackling the most pressing of community challenges.
7. Election of **committee members tasked with implementation**, monitoring, and evaluation.
8. Testing of the **relevance of identified challenges and analysis of selected strategies** for tackling challenges.
9. Signing-off of the **community strategy by community members and request for funds from the closest government administrative unit**.
10. Opening of **bank account and funds transfer**.
11. Repetition **of cycles and learning from mistakes.**

CHC exist as a part of a distinctly "tiered system in which the voices of ordinary community members eventually make their way from the local to the provincial level" (Padarath & Freidman 2008). CHC act as a platform to contribute "social knowledge, experience, and perspectives" to health challenges and struggles while also providing an opportunity for citizens to jointly plan, design and implement the plan and budgets for existing health systems at the "primary care level" (Loewenseon *et al* 2014).

In the Namibian context specifically, CHC aim to enhance community ownership of the services at the health centres/ clinics. They create a link between the community and the Regional Health Office/Ministry of Health and Social Services (MOHSS) as the representatives of the community; provide feedback on health services at the health centres; advocate to MOHSS for the community's health needs; educate and mobilise communities for positive behaviour; support the Community Based Resource Persons (who are community health education volunteers) to perform their roles; support community level referrals; and resolve conflicts and misunderstandings between service providers and the community.

A reported core strength of CHC is their emphasis on the participation of diverse sets of community members – while research also shows that diversity comes with its own complexities (Loewenseon et al 2014). The difference between being a community-elected committee member and a government-appointed committee member has dramatically shaped the outcome of CHC committee efforts in South Africa (Ibid 2014). The relative influence of committee members and their position in the community often shaped the committee's ability to influence and shape health systems. Influential committee members, according to the research, often had a great ability to influence the power imbalances that existed between marginal groups and health representatives and systems. Marginal group representatives with less power offered important experience and knowledge. These findings highlight the complexities of CHC as a participatory health governance approach and mechanism. While the integration of the CHC into health systems process bodes well for their potential, the ability for CHC to actively contribute to effective PHG is often mediated by a number of internal committee and external dynamics.

4. Case Studies: Namibia, Rwanda, Kenya

The following case studies offer key insights, lessons, learnings, and outcomes from HPA and our partners' programmatic experience. Central to the case studies is context. Each case study aims to situate the conversation around participatory processes and approaches within the broader socio-political context of each country. Exploring the contextual potential for Participatory Health Governance is enriched by an in depth account of the particular lessons and outcomes.

NAMIBIA
Clinic Health Committees: Best practices and lessons learnt

HPA's DFID-funded **Health Education, Awareness and Rights for the San (HEARTS**) project on HIV, Tuberculosis (TB) and Malaria in Tsumkwe, Namibia, in partnership with local NGO CoHeNa ran from April 2011 to March 2014. The project's goal was improved health for San communities and their neighbours in the Tsumkwe constituency. The project aimed to contribute to Millennium Development Goal 6 by reversing the local trend on HIV, TB and malaria. That was to be accomplished by "empowering San communities and their neighbours to realise their right to access health services in Tsumkwe constituency." The support of CHC and plans for their sustainability through income generation activities was crucial to this project. This case study provides key insights into this programme.

Namibia and San community health

It is important to acknowledge that the HEARTS programme, like all health programming, was implemented within very specific socio-political contexts. As a country the Republic of Namibia, on a rhetorical policy level, recognizes health and social well-being as a fundamental human right. The Presidential health commission enquiry report on the Namibian health sector states the following: "The goal of government is the attainment of a level of health and social well-being by all Namibians". Namibian national spending on the health sector, standing at 11% of overall governmental spending, exceeds the average 9.6% health sector funding of South African Development Communities (SADC) countries. Despite this, historically rooted forms of disparity continue to shape the health outcomes of particular ethnic groups.

While Namibia's German-speaking population has a life expectancy of 79 years, the San, Namibia indigenous population has an average life expectancy of 52 years (UNDP, 2007). This disparity is further reflected in health services and systems. Individuals from the larger ethnic/ language groups predominantly populate health services and systems. A 2014 assessment by HPA found that the San and other ethnic groups consistently reported ill treatment from local health workers (Health Poverty Action 2014). The survey further revealed that San respondents had low levels of confidence and comfort when attempting to access health care services. While ambitious national policies proclaim that no citizens will be turned away from health services for financial reasons, the HPA 2014 assessment found that San peoples were often refused health service and support. Beyond disparities these findings suggest that under the clear inequities, lie pronounced climates of discrimination and systemic prejudice. Having signed the United Nations (UN) Covenants and Conventions that protect indigenous rights including right to equal access, the Republic of Namibia has assumed a clear duty to protect San communities and other minoritised communities from all forms of racial discrimination. These policy proclamations are not being realised in the lives of San populations today. While governmental mechanisms for the inclusion of San perspectives and experiences in governmental decision-making exist, their influence is limited by an intersecting array of internal and external dynamics. Overall San communities generally did not feel properly consulted by the health sector and service and felt politically marginalised and discriminated against. It was within this broader socio-political context that this HEARTS programme was located.

Health Poverty Action works with the San Community to realise their right to health in Tsumkwe, Namibia.

Clinic Health Committees (CHC) in Tsumkwe: Lessons and learnings

The early stages of the HEARTS programme attempted to construct communal/civic spaces for communities to directly engage in constructive conversation with health service providers about crucial deficits or challenges experienced when accessing health services. The CHC were to serve as the primary mechanism for this sort of process. The ultimate aim was to improve the responsiveness and accessibility of local services by making them more culturally appropriate, sensitive and specific to the needs of San communities. The CHC were also intended to serve as a space to officially lodge health service complaints. The CHC feedback and input process was a layered one in which feedback, complaints, and/or concerns were to be transferred up through the layered system, through the necessary channels to the appropriate health sector authorities and or governmental representatives. While well planned out, this process proved challenging. **The following are key lessons and learnings that provide insight into the potential for participatory approaches like CHC to contribute to participatory health governance:**

i) **Speaking truth to power and criticising authorities** CHC participants often found the process challenging because critiques of the health care system and services could often be read as a "critiques of the Government". **These fears and concerns demonstrated how central power dynamics and perceived levels of vulnerability were to the overall efficacy of the project**. Often overlooked was the relative level of power participants had and by extension the distinct levels of vulnerability they felt when engaging in critical discussion about the quality of local health care services. One of the most telling signs of power imbalance were the low levels of response from governance structures and health sector authorities when feedback was sent up through the layers. Lessons gleaned from the project highlighted how important closer mentorship and support was to improving feedback and participation. **Through feedback innovations like anonymous "suggestion boxes" and closer HPA support and mentorship, feedback and overall participation in the CHC improved by the end of the project. HPA staff's active involvement ensured that CHC feedback was recorded and passed through to the necessary governance channels, whether it was to key local stakeholders or national Ministry of Health and Social Services (MOHSS) staff.**

Leon Tsamkgao, Cohena, talks to a group of villagers near Tsumkwe, Namibia delivering an HIV & TB awareness session to educate locals about how to either avoid, or treat the diseases.

ii) Maintaining CHC momentum and sustainability

When HPA staff returned to assess the progress of the CHC after project completion it was clear that the CHCs had lost a great deal of momentum and as a result were inactive. Without close mentorship support and funding, committee members moved on, utilising their CHC experience to secure formal forms of employment. While remaining members and communities were more than willing to resume the CHC process there was clear need to rethink and redesign the CHC approach to ensure sustainability.

iii) Health rights and governance knowledge

CHC committee members were trained before beginning their work on the committees. While the trainings proved helpful in terms of enhancing committee members' biomedical understanding of HIV, TB, and Malaria it became clear that the lack of focus on health rights in the original training limited the active potential of committees and committee members. A lack of information about patients' rights and patient responsibilities made clear how essential an understanding of not only rights but health sector systems and authority structures are to committee member's work. More importantly it became clear that committee members needed to be knowledgeable about not just health rights but their own broader human rights. The end of project evaluation/review highlighted how essential the impartation of health and human rights was to the process. After a health rights focused training held at the beginning of project's second half, HPA staff noted a noticeable increase in community feedback and engagement. This demonstrated how important practical governance and politically oriented knowledge is to the participatory governance process. Often overlooked are the ways in which knowledge of rights and political systems tracks along the lines of inequity, with marginal groups often falling on the losing side of the knowledge divide.

iv) CHC committee make-up and societal profile

The initial approach to identifying CHC committee members focused on selecting "highly respected persons" that would have the confidence and the communal stature needed to effectively represent community perspectives when engaging health workers and officials. This category of potential community members would include traditional headmen, school headmasters, elders etc. Literacy levels were also a concern. However, across project sites young people were often selected because of their high degrees of literacy and availability to volunteer their time. As one Tsumkwe CHC member remarked "We were chosen by the community because we are unemployed and have nothing to do". The picture that this member's remarks and the broader committee selection experience paints is a complex one. While identifying influential community members can be an important strategy it can also result in a missed opportunity to develop the political and public experience and potential of the most marginal community members. At the same time younger less experienced committee members without support and mentorship may have found contextual protocols around age, class, and station difficult to surmount when engaging health service workers.

HEARTS Project: Final outcomes and insights

The Clinic Health Committees (CHC) offered an important contribution to nurturing the potential for more participatory forms of health sector governance in the project sites. In supporting San communities to realise their rights to access health services, the project constructed a system through which communities could engage in dialogue with health services. Ultimately the feedback system that was created had multiple layers. Feedback and experiences generated at the CHC level were fed up through the layers of governance. When an issue could not be resolved at one layer it was supposed to be fed further up the system. The participatory model and feedback system consolidated under this project was as follows:

Stage 1: Collecting community perspectives

At the lowest level, Community Based Resources Persons (CBRP) collected the views of the community, and shared them with CHCs.

Stage 2: CHC dialogue and reflection

CHC members discussed the views of the community amongst themselves, and the project also organised quarterly CHC meetings where all CHC discussed common issues amongst all four CHCs. A district level Ministry of Health representative and local traditional leaders were invited to participate.

Stage 3: Health sector stakeholder meetings

Quarterly meetings were convened with all of the relevant stakeholders involved in the Tsumkwe health sector. These stakeholders included traditional leaders, various government departments and local NGOs. The Ministry of Health chaired the meeting. District, regional, and national representatives attended the meetings. The HEARTS programme manager sat on this committee and brought attention to issues that could not be addressed at the CHC level.

While this method offered some important improvements to the participation of San communities in health services decision making, there were definite challenges. Despite being invited to attend and participate in CHC meetings, traditional leadership and Ministry of Health representatives rarely attended. There was at times limited governmental response to the feedback received meaning that very little feedback made it through to the necessary authorities. This was in part due to the fears spoken of earlier; the fear of being seen as critical of the existing government. This fear produced serious bottlenecks and at times stalled the flow of information moving upwards.

While the layers of feedback proved effective, the project outcomes demonstrated a definite need to ensure that all actors had a strong working knowledge of their roles and personal responsibilities to this process. This also included building CHC members' knowledge of health issues and health rights.

Traditional Governance and Leadership proved to be an important level of governance that needed to be intentionally and constructively engaged throughout the process. Traditional leaders and governance systems often stood as an equally important local governance system and local leaders needed to be effectively briefed and included in the project process. HPA took steps to more intentionally engage traditional leaders and governance structures in the project's second half. Towards the end of the project traditional leadership presented community issues and concerns to the Ministry of Health alongside the HEARTS programme manager and staff. This innovation demonstrated how important consolidating groups and individuals with influence is to the participatory health governance process.

The CHC process and the overall HEARTS project did realise important gains in the San community's ability to feed into the health sector and local health systems. Community feedback was routinely elevated to the district level stakeholder meetings. As a result of this feedback the national government has recognised the need for greater interventions in curbing Multi-drug resistant TB in Tsumkwe and is considering how to respond. In the meantime it has put in place temporary housing where patients from remote villages can stay while receiving treatment. While this is representative of one of the many important advocacy wins achieved throughout the project's life, the final evaluation of the project brought to the fore the ongoing challenges associated with this project and its work. CHC committee members continued to be unaware of the decisions taken at various layers of the feedback chain and on return the CHC were found to be dormant and inactive. The momentum and engagement subsided without ongoing support structures and mentorship.

Citizens in Rwanda developed a sense of ownership of water and sanitation health issues through the Ubudehe participatory process.

RWANDA
Ubudehe: Best practices and lessons learnt

Health Poverty Action's European Commission funded Saving Lives through Water, Sanitation and Hygiene (SALTWASH) project in the Nyaruguru District in Southern Province Rwanda ran from July 2011 to January 2016. In order to improve health, its aim was to increase the proportion of people with sustainable access to safe drinking water and basic sanitation in support of the Millennium Development Goals (MDG) number 4 to *reduce child mortality*, MDG 5 to *reduce maternal mortality* and MDG 6 to *prevent malaria and other diseases* in Rwanda.

Rwanda (Nyaruguru) and WASH

In 2000 the Government of Rwanda presented VISION 2020 committing itself to reaching the very ambitious target of 100% in water supply and sanitation coverage by the year 2020.[iii] Despite making formidable strides to achieve this goal the attainment rate demonstrated varied success. According to the 2012 district statistics it was estimated that only 65% of residents in the Nyaruguru District had access to a clean and safe water source. This is compared to the national average of 75%. The district also struggled with limited accessibility of safe and clean water. Women and girls – primarily responsible for securing water for household and communal use – were most affected by the long distances that must be travelled to secure clean water. The long hours spent increased their vulnerability and negatively affected women's and girls' educational outcomes.[iv]

The statistical outlook of sanitation and latrine coverage in the Nyaruguru district when considered against the national average painted a similar picture. Sanitation and latrine coverage in the Nyaruguru district stood at an estimated 90% compared to the

iii. Republic of Rwanda, Ministry of Finance and Economic Planning: Rwanda Vision 2020. Kigali, July 2000 Accessed from http://www.sida.se/globalassets/global/countries-and-regions/africa/rwanda/d40233 1a.pdf
iv. Republic of Rwanda; National Institute of Statistics of Rwanda: EICV3 District Profile, Nyaruguru.

national average of 96%; and with only half of these latrines meeting acceptable standards (considered as 'improved sanitation facility' which is either a flush toilet or a pit latrine with a floor slab).[v] Sanitation and latrine coverage had a direct relationship with early childhood education and children's health. Increases in children's enrolment in schools while positive highlighted the need for safe sanitation services and facilities. School sanitation facilities were insufficient with many schools still using traditional pit latrines. Pit latrines can be unhygienic and increase the risk of transmission of waterborne diseases such as diarrhoea and cholera among the school children and the wider communities. Health reports have indicated that unsafe water, poor sanitation and lack of hygiene are a precursor to various diarrheal diseases with diarrhoea being among the top three killers of children within Rwanda.[vi] The SALTWASH programme was established to address this disparity.

Ubudehe in the Nyaruguru District: Lessons learnt

The SALTWASH project adapted *Ubudehe* as the leading participatory approach for this project. This adaptation in part employed the addition of other contextually appropriate participatory engagement approaches central to the *Ubudehe* process including *Haute Intensité de Main d'Oeuvre* (HIMO) and *Umaganda.* Each of the processes were utilised at different points in the project cycle. *Ubudehe* was utilised during the project design period to help communities collaboratively identify community problems within the water hygiene and sanitation sector. Central to this process was the identification of collaborative communal actions that could assist in the construction of water and sanitation facilities. *Haute Intensité de Main d'oeuvre (HIMO)* – traditionally a facet of *Ubudehe* – is an aspect of Ubudehe that refers to labour intensive public works practised in Rwanda's rural poverty reduction efforts. It is a preferred methodology because it releases the productive capacity of the very poor to participate in public works. *Umaganda* – which means, "coming together for a common purpose to achieve a desired income" – was utilised as a community outreach strategy. Traditionally *Umaganda* served as culturally rooted form of collaborative work. Communities would call upon family, friends, and neighbours to help them complete a difficult task. The combination of these historically rooted and culturally relevant community engagement practices provided important insights into Participatory Health Governance and its application. **The following are key lessons and learnings that provide insight into the potential for participatory approaches like Ubudehe to contribute to participatory health governance.**

i) **Horizontal citizenship and community collaboration** A central focus of the SALTWASH process was the mobilisation of community resources, energies, and labour to power projects that improve hygiene, sanitation, and local facilities. Everyday citizens reported an appreciation for the process, and the learning and skills building this process afforded. Often overlooked in Participatory Health Governance is the increased need for the strengthening of horizontal citizenship (Kabeer 2014). While community engagement initiatives prompted by projects often emphasise the relationship between participants and project outcomes, project participants are simultaneously acting as citizens within the context of the broader state. Horizontal Citizenship, which stresses relationships between citizens, is an equally important part of promoting participatory health governance. The forms of collective action and communal participation cultivated through the SALTWASH project can help prepare the civic ground for more vertical forms of engagement with municipal level or district level stakeholders. In this project's case, Community Hygiene Clubs (CHC) and Water User Committees (WUC) created ongoing communal sanitation and hygiene structures that embody in depth knowledge of local water and sanitation issues along with the applicable skills. In future, clubs and committees of this sort can better enable the targeted communities in the Nyaruguru District to engage with municipal and district bodies on issues of water and sanitation. The sense of ownership that involved citizens developed through the *Ubudehe* process can in the future enhance everyday citizens' ability to engage in substantive conversation on water and sanitation health-related issues with influential stakeholders, leaders, and political representatives.

v. http://www.wssinfo.org/definitions-methods/watsan-categories/
vi. http://www.unicef.org/rwanda/hiv_aids.html

ii) Historically and culturally rooted methodology

The application of *Ubudehe, Haute Intensité de Main d'Oeuvre* and *Umaganda* are all historically and culturally rooted approaches that aim to mobilise the energies and efforts of communities. Both *Ubudehe* and *Umaganda* are widely known and are currently utilised as citizen engagement strategies by the Rwandan government. Despite their importance and potential success many participatory communal engagement approaches arrive as externally driven technical interventions. Throughout the project various district level stakeholders remarked on the level of ownership communities displayed throughout the process. While this can be attributed to a number of contextual realities and project features it is important not to overlook how the cultural rootedness of the participatory methodologies shaped and influenced the participants' participation and engagement in the process. Drawing on these approaches enabled the project to align its efforts and work with monthly *Umaganda* days promoted by the Rwandan government. It may be that community participants were much more ready to identify with, participate in, and take ownership of this process because of its historical and cultural rootedness.

iii) Promoting citizens' involvement in local service upkeep and provision

Central to this project was engaging community members in need in the building and construction of ECOSAN toilets, drinking water systems and the overall improvement of water and sanitation facilities. The project in essence focused on supporting citizens' collective ability to fill the national gaps in water and sanitation provision. Additionally, community members identified to participate in construction were paid for their "labour power" contributions ensuring that the financial benefits of the facilities' enhancement process remained in the community and went to families in need. While the project demonstrated definite successes, there are deeper complexities that must be considered. Supporting citizens' efforts to fill gaps can be an essential contribution to the broader MDG/SDGs and nationally set goals, but efforts such as these can also circumvent the necessary forms of service provision municipal, district, and federal level governmental bodies are responsible for. There is a complex balance between mobilising communities to improve local water and sanitation facilities, and efforts to effectively advocate for improvements in water and sanitation services as a fundamental right accorded to all citizens. While not a central concern in this SALTWASH project, this remains an important point to consider when translating into new contexts.

iv) Competing for time and attention

While there was a great deal of participation in the SALTWASH Project, HPA staff noted that community members were often torn between participating in project activities and initiatives and their everyday tasks. In many cases community members had to choose between SALTWASH activities and other activities like working on their family gardens, attending to social commitments like funerals or participating in other communal activities. These contextual realities highlighted how important it was to consider the ways that participatory approaches add work and responsibility to individuals and community members whose time is already consumed with livelihood and communal responsibilities that predate the project. SALTWASH staff had to demonstrate that the project would in the end improve the community by ensuring that a working spring was available on days when there was little to no water to pump. This lesson highlighted the need to consider the ways in which participatory processes such as these fit into existing communal fabric and life.

SALTWASH Project: Final outcomes and insights

The SALTWASH *Ubudehe* process contributed to the creation of horizontally focused citizens' engagement efforts to improve the quality of, and access to water and sanitation facilities. The process utilised culturally relevant methods of collaborative action that encouraged local citizens in the Nyaruguru District to donate their personal time and energy to rehabilitating and improving local water and sanitation. **As a methodology *Ubudehe* highlighted the important role of horizontal citizen organising in longer-term efforts to promote participatory health governance work**. While the project focused less on consistently engaging district and or municipal stakeholders, this approach offers important insights. **The project established culturally appropriate citizen-owned health promotion mechanisms that could, with greater technical and financial support, become longer-term or even permanent citizen engagement/ mobilisation structures**. The *Ubudehe* process

highlighted how important it is to consider how methodologies of this sort can or cannot be naturally interwoven into the societal fabrics of the communities, districts, and nations they operate within and how this interwovenness shapes the longevity of the methodology in context. The participatory approach consolidated through this project was as follows:

Stage 1: Identifying community problems/ challenges

During this stage *Ubudehe* helped create space for communities to surface shared or common problems/challenges around water, hygiene, and sanitation issues. The process also helped identify what activities and or actions need to be taken to address identified problems or challenges.

Stage 2: Mobilising community "labour power" and taking action

The project utilised *Haut Intensité de la Main d'Oeuvre* to identify and coordinate people power in the form of community labour. Unique to this process was enlisting able-bodied community members in greatest need (as defined by *Community Hygiene Clubs*) in the rehabilitation of springs and the creation of ECOSAN toilets.

Stage 3: Cultivating knowledge and building skills

The project utilised *Umaganda* as a means to reach out and convene space to raise community members' knowledge and awareness of water, sanitation, and hygiene related issues.

The *Ubudehe* process and accompanying community engagement approaches, *Umaganda* and *HIMO,* demonstrated important successes. The local communal ownership of the process and its noted cultural embeddedness contributed greatly to participants' willingness to dedicate their time and energies to the project. Of equal importance was the project emphasis on compensating community members for their participation.

The engagement methodology also demonstrated how necessary it is to consider the ways in which context and focus can either conspire to help or hinder the early stages of participatory health governance processes. In this instance a culturally embedded participatory approach was utilised to engage, mobilise, and compensate communities for their direct participation in the rehabilitation of necessary everyday facilities. Overlooking the central importance of water, hygiene, and sanitation to communal health, this project, and the project's outcomes would be a mistake. The project's proposed improvements to water, hygiene, and sanitation may have also contributed to communal participation and district level approval. Applying processes such as these to more complex social dimensions of society in new contexts may prove to be more complex.

While there was a high degree of ownership and communal involvement it was also made clear throughout the process that *Ubudehe, HIMO, and Umaganda* require a dedication of time that non-participatory approaches may not require. The project took a great deal of time to ensure communal buy-in and that communities had a strong understanding of the projects' outcomes and goals. Processes of these sorts often entailed a great deal of 'consensus building'. Building consensus often required repeated meetings and communal dialogues.

Finally it is important to note that in enlivening and creating opportunities to strengthen horizontal citizens' work, the *Ubudehe* process may have done so at the risk of limiting very necessary forms of *vertical citizen engagement* with municipal and district level authorities. The issues of access to water, hygiene, and sanitation could have been approached as governmental provision issues, as the state is often deemed responsible for the provision of these services, and indeed they are enshrined as rights in international law which governments have to duty to fulfil.[vii] The lower rates of access and provision in the Nyaruguru district could equally be approached from a vertical citizenship, rights-based standpoint in which *Ubudehe* is utilised to convene space between communities in need and representative bodies responsible for water and sanitation services and service provision.

vii. For example water is regarded as an integral component of the rights to life, to adequate standard of living, to health, to housing and to food which are enshrined In the 1948 Universal Declaration of Human Rights and the 1966 International Covenants on, Economic, Social and Cultural Rights (ICESCR) and Civil and Political Rights (ICCPR). Access to water enjoys explicit protection under the 1979 Convention on the Elimination of all Forms of Discrimination against Women and the 1989 Convention on the Rights of the Child.

In Mandera County, North Eastern Kenya, Community Conversation is used to engage diverse groups in critical dialogue around FGM and associated practices, which are linked to high maternal death rates.

KENYA
Community Conversations: Best practices and lessons learnt

Health Poverty Action (HPA)'s Maternal and Child Health (MNCH) programme began in 2012. The aim was to expand community-based MNCH services and address the socio-cultural barriers to the uptake of services by promoting **participation in community health governance**. The project placed an emphasis on engaging community leadership structures including community elders, religious leaders and traditional authorities. Through participatory problem analysis with beneficiaries, Health Poverty Action staff and communities identified Harmful Traditional Practices such as Female Genital Mutilation (FGM) as the main cultural practice affecting women's and girls' health. Despite being outlawed under the Prohibition of Female Genital Mutilation Act, 2011, enforcing this law has been challenging. An advocacy strategy was developed targeting key decision makers at the community and Mandera County Government level, particularly religious leaders. The MNCH programme was developed to address FGM and other Harmful Traditional Practices (HTP).

Mandera and Harmful Traditional Practices

Kenya has one of the highest maternal mortality rates in the world. 44% of Kenyan women give birth with the support of medically trained health personnel skilled enough to respond to complications (UNFPA 2014). 15 of Kenya's counties account for 98.7% of maternal deaths in the country. According the UNPFA (2016) "nearly all of the counties have faced high levels of poverty, insecurity, infrastructural challenges and inequity/marginalization leading to poor maternal and new-born health statics". Mandera is one of these counties.

Mandera County is located in the Arid and Semi-Arid Lands Region (ASAL) of the North Eastern part of Kenya. The ASAL region borders Ethiopia and Somalia. Relatively high numbers of maternal and neonatal deaths disproportionately affect populations living in the area. The maternal mortality rate in Mandera is estimated to be 3,795 deaths for every 100,000 deliveries according to the *2013 Kenya Population Situation Analysis Report*. Mandera's rates are seven times the national average which stands at 376 deaths for every 100,000 deliveries. A recent UNFPA (2016) report identified Mandera as having the highest maternal mortality out of the 15 counties that contributed to 98.7% of Kenya's overall maternal death rate. While this disparity in maternal mortality can be attributed to a relative lack of Emergency Obstetric Care Facilities (EMOC) there are definite social factors that contribute. Female Genital Mutilation (FGM) has been identified as one of the social factors.

FGM is a deeply rooted practice and social factor that directly contributes to increased maternal deaths. Perceived religious obligation, family honour, and virginity as a prerequisite for marriage are societal factors that sustain the practice. FGM is often deeply woven in the societal fabric and belief systems of communities within which it is practiced. There are numerous negative health consequences associated with FGM including haemorrhage, cervical infection, urethral damage, urinary tract infections, and difficult child births; all conditions that if untreated can result in maternal death or chronic ill health. FGM often has marked psychological and social impacts. A historical focus on health initiatives that addressed the bio-medical side of FGM eventually exposed the need to address the psycho-social societal drivers of the practice. The HPA Mandera project was established to address these drivers through a participatory communal engagement process.

Community Conversations in Mandera: Lessons learnt:

The Community Conversations (CC) approach was utilised to engage diverse groups of community members in critical dialogue around FGM and associated Harmful Traditional Practices (HTP). The approach involved key influential leaders, elders, and other community gatekeepers. This included religious leaders, circumcisers, youth groups, Imams and traditional leadership. The engagement of influential community members increased communal ownership and set up support networks that would ensure that the gains in behaviour change and practice would be sustained beyond the project cycle. The Community Conversations enabled communities to identify shared concerns and develop strategic actions to change behaviours, beliefs, and societal practice. As a method it created space for community members to engage in deep and honest conversations with influential leaders, elders, and gatekeepers. As a result Community Conversations participants were then able to act with the support and understanding of some individuals in position of power. **The following are key lessons and learnings that provide insight into the potential for participatory approaches like Community Conversations to contribute to participatory health governance:**

i) Civic dialogue and collective reflection

The Community Conversations created inclusive civic space to discuss complex cultural issues. In this project's case the topic under discussion was a very sensitive issue with deep historical roots. **The Community Conversations process highlighted how important it is to give attention and thought to *conversational process*. Engaging in dialogue across gender, ethnicity, and class with members and stakeholders with different levels of power requires facilitated processes that take all of these differences into account.** The Community Conversations process stood in distinct contrast to traditional community meetings in which decisions on who attends, who gets heard and the topics of discussion are under the purview of religious leaders and community elders. **The Community Conversation's focus on building trust, unpacking power differentials, and cultivating equity raises important questions around civic dialogue and democratic forms that don't take these dynamics and differences into account in conversational design and approach**. The CC approach demonstrated that democratic dialogue often requires democratic design and an attention to communal power dynamics and cultural sensitivity.

ii) Sharing knowledge and creating knowledge

An important element in the process was the careful balance that needed to be achieved between sharing knowledge and creating the space for communities and participants to create and come into their own knowledge and new understandings of the root causes of FGM. The CC process demonstrated how important it is to create space for opinion leaders to share important facts and dispel popular myths while also creating room for disagreement, questioning, and productive conflict and debate. **The social change process is a cycle that must give attention to this balance. When we view the Community Conversations as form of civic dialogue the lesson that most clearly emerges is that participants need to be given the space and support to create shared understandings**. This involves everyday citizens and influential stakeholders sharing their knowledge and then engaging in dialogue that uses that knowledge to build a new, shared and holistic understanding of the issues and context.

iii) "Change is Slow Dance"

The project demonstrated that issues like FGM take a long and concerted period of engagement to change. The deep-rooted cultures and beliefs that underpin FGM along with existing gender

inequities meant that issues such as these could not be addressed through awareness raising or short conversation cycles. While Community Conversations made important contributions to change and beliefs and perceptions, **Community Conversations implemented as a project serve as one moment in a community member's and community's long and complex life. As a result it is important to consider how Community Conversations need to be implemented in terms of scope and time in order for them to be effective**. It may be that Community Conversations need to become an integral part of communal life over longer periods of time with set communities; reweaving new pathways for collaboration between citizens and institutions with influence and power.

iv) Getting political leadership involved

While the project was able to engage a number of influential leaders there were many local traditional and political leaders that did not participate in or express a commitment to the change process. This was in part a reflection of their own beliefs in and support of FGM and other Harmful Traditional Practices (HTP). In some instances leaders believed that FGM and other HTPs were in fact positive practices that needed to be preserved and protected. **This outcome demonstrated how essential it is to intensively engage local traditional and political leadership and suggests the need for an accompanying process that specifically focuses on promoting change amongst influential stakeholders alongside the Community Dialogues process**. When the CC process was originally conceptualized by the UNDP it was accompanied by a Leadership for Results programme that took local political leaders and representatives through their own personal and institutional change process. **The psychologies, practices, and beliefs of influential stakeholders and leaders need to be intentionally worked on and worked with throughout the change cycle.**

Community Conversations project: Final outcomes and insights

The Community Conversations (CC) process ultimately made important contributions to FGM and HTM related local perceptions, beliefs and practices. Before the Community Conversations began, facilitators participated in trainings focused on gender roles and identity within local culture, and women's and children's health and wellness. Facilitators also participated in trainings that enhanced their community mobilising and education skills. After the trainings the Health Poverty Action teams convened a series of public forums with key opinion leaders, youth groups, circumcisers, and adult men and women (including elders). This careful and incremental approach was developed out of a recognition of the prevailing silence around gender inequality issues in the community. **Breaking the silence, particularly around sensitive issues like FGM as well as other gender related issues that pose barriers to women's health, required careful and culturally respectful forms of engagement**. The Community Conversations methodology embodied this sensitivity through its series of tools and steps that helped surface feelings, thoughts, beliefs, and practices rarely talked about in open gender and age mixed forums. The following are the 6 steps that CC used to engage a transformative change in the community.

Stage 1: Building trust and relationships

During this stage facilitators convened groups of concerned community members willing to participate in conversations on FGM and HTP. The facilitator took some time to collaboratively identify norms and rules for the conversation to ensure safety and comfort for all those involved. Facilitators' utilised various dialogical tools and approaches to build trust between facilitators and participants. Facilitators spent a good deal of time building trust to enhance the group's capacity to openly speak about troubling truths, historically rooted concerns and taboo subjects.

Stage 2: Identifying community concerns related to FGM and HTP

Facilitators utilised CC tools and process to help communities identify and map community concerns. Beginning with "concerns" rather than ideas and/or complaints ensured that space was created for participants to identify issues causing the greatest emotional, physical, and psychological turmoil. Examples of community concerns that arose included challenges associated with fistulas, painful intercourse, complicated child births, and excruciating pain that comes with cutting.

Stage 3: Exploring community concerns

Once concerns were raised facilitators worked with community members to look more deeply into the raised concerns. The exploration focused on measuring the magnitude of the concerns and

surfacing their underlying factors. The exploration also aimed to bring out the interconnectedness and the factors underlying them. For example, rape associated with early marriages may be connected to herding of livestock by young girls in the community as well as poor law enforcement regarding rape.

Stage 4: Decision-making and commitment to action Facilitators supported communities to select and prioritise the concerns that they would eventually take action upon. This involved a facilitated collaborative decision making process that ensured that all voices and perspectives were heard. A simple plan of how the action points will unfold was drawn out by clearly listing who is going to take action on what issue, where the action will take place and by when. Resources, including social capital, are also listed against specific action points. The design of planned community actions involved as many community members as present. The facilitator assisted the community in reflecting on the implications of the proposed actions on individual and collective life.

Stage 5: Acting and implementing
Facilitators supported community members to implement actions to address the prioritised concerns. In some cases this involved requesting the support from various institutional bodies and influential leaders. The facilitator acted as a link to other systems, keeping the community informed of available resources that may be helpful.

Stage 6: Reflection and review
Reflection and review was a way of looking back at what had transpired – shifts in practices that achieved the objectives of the decision-making process. The community answered critical questions about what has changed in its values, attitudes and practices as they related to FGM and HTP. In addition, the community provided experiences and stories to illustrate the changes, and the change that was yet to happen.

The Community Conversations process in Mandera served as an important tool that helped promote citizen-led reflection, dialogue, and action. The focus on FGM and HTP highlighted the various levels of influential stakeholders and authorities that often have equal influence on communal beliefs, practices, and behaviours. Between citizens, governmental representatives, and policy makers are a host of gatekeepers, leaders, and authorities that have equal influence on health outcomes and the efficacy and success of participatory health governance initiatives. The Kenyan government in 2011 legislatively prohibited Female Genital Mutilation (FGM) but it continues to be a supported practiced at the community level.

Although small in scope, the project succeeded in bringing together Sheikhs, circumcisers, youth and adults (men and women) into a dialogue focused on FGM. This was in itself significant. The project demonstrated how necessary it is for participatory health governance initiatives to build collaborative bridges between everyday citizens and individuals with power. This effort in part involves working to sensitise and educate opinion leaders and religious leaders. In this case small groups of opinion and religious leaders engaged were very receptive and supportive. Aside from support they offered great insights into the religious and cultural community context. Religious leaders approached the practice of FGM from a Quranic perspective dispelling myths that rooted the practice in religious text and tradition. Project staff as a part of the Community Conversations process also engaged law enforcement authorities in order to lobby for more active enforcement of the anti-FGM law locally.

While tangible gains were made, the project demonstrated how central facilitators are to the Community Conversations process. The knowledge, skill, and self-awareness of facilitators emerged as a key element in the CC process. Identifying, training and follow-up of skill building was critical for successful implementation of CC. Facilitators must be guided by a value system that includes sensitivity to local community experiences, gender sensitivity, respect, commitment to reduction of vulnerabilities, improvement of sexual and reproductive health and upholding human rights. Facilitators are the architects of trust in the process and must model behaviours, beliefs, and practices that express openness to being personally transformed alongside participating community member and leaders. The role of the facilitators brought home how essential critically conscious instigators/facilitators are to participatory health governance processes. When citizens offer their time to participatory spaces, the process and method that guides the dialogue and reflection become extremely important. In everyday forums predating the CC process, certain groups, including women and youths, found themselves at times silenced and unheard. The public deliberation that often takes place during participatory health governance processes requires skilled, thoughtful, and value rooted individuals that are able to guide difficult and sensitive conversations towards greater openness and transparency with little bias.

5. Methodological synergies

A central focus of *sharing best practices for the participation of marginalised groups in health sector governance* project was to explore the synergies between the participatory approaches utilised throughout the project. This section highlights the synergies and/or pedagogical crossroads that unite *Community Conversations, Ubudehe, and Community Health Committees.* Part of exploring these synergies will involve highlighting the potential contributions that each methodology offers to the other. The lessons that emerged out of this project offer important insights into the way different facets of each methodology enhance the potential for participatory health governance to thrive in complex and layered contexts.

What became clear through the project was the important role that *socio-political technologies* play in Participatory Health Governance. The methodologies profiled in this project are socio-political technologies that embody their own sorts of community organising and democracy enhancing science. Socio-political technologies contribute process and methodology to the practice of public forums, meetings, participatory planning, and civic discourse. Each of the methodologies used steps, tools, and practices to create collaborative spaces between everyday citizens and institutional, communal, and political leadership. They can be considered technologies because they each have their own psycho-social science that they apply to the process of collaboration, dialogue, and political engagement.

To explore the synergies between these technologies, the sections that follow profile each methodology (Community Conversations; Ubudehe; Clinic Health Committees) and considers how the methodology in focus can be enriched and/or benefit from the approach, pedagogy and practice of the other approaches profiled in this project.

Clinic Health Committees: Learning from Ubudehe and Community Conversations

The Clinic Health Committees (CHC) approach's strength is its ability to create a sustained structure for community representatives and health representatives to discuss service, resource and health facility concerns with health facilities management. More importantly the CHC exists as part of much larger upwardly focused feedback chain through which communal concerns and feedback pass. Where CHC may lack is in its ability to cultivate open space to genuinely explore and prioritize communal concerns. **Health Poverty Action staff identified three distinct ways in which the Community Conversations method could enhance the CHC process**:

i. **Community Conversations identifies, explores, and prioritises communal concerns** The Community Conversations process can enrich the process used to identify community concerns that are brought to CHC meetings. While CHC convened space to discuss community service and health concerns, the approach does not embody a set of tools that ensures that the concerns that have been shared have emerged out of fair, open, and in depth communal dialogue. Public meetings and consultations often overlook the various levels of power dynamics, history, and broader communal dynamics that influence who speaks and who is present during public forums. Who speaks and who is present influences how certain concerns come to be seen as shared community concerns. The CC process offers to CHC a set of tools and methodologies that can enrich the concern raising process.

ii. **Community Conversations can enrich CHC deliberations** Participating in CHC meetings are actors with varying histories, personal dispositions, professional experiences, and power. While the consultative CHC process has significant strengths it is important to consider how group dynamics at the CHC level may limit the meeting outcomes and sense of

accountability amongst CHC members. The Community Conversations approach emphasises relationship and trust building through a series of tools. These tools could strengthen relationships amongst CHC members and enrich the depth of dialogue that takes place in those settings.

iii. **Community Conversations helps clarify what is an organising vs advocacy issue** Health services and broader health concerns may have both institutional and socio-behavioural dimensions. Health and health service concerns may in some instances require a combination of horizontally focused citizen-led action as well as vertically focused forms of advocacy for improved access, support, and or treatment. Identifying how and where communities can organise to address the socio-behavioural dimensions of concerns while entrusting CHC members with the advocacy portion of organising efforts can be achieved through the use of Community Conversations tools. More importantly Community Conversations can create an ongoing civic space that ensures that community-led actions to improve health remain in line and connected to advocacy efforts taking place at the CHC level.

Like Community Conversations, Ubudehe can also make its own contribution to the CHC approach. An important strength that the Ubudehe approach has is its historical and cultural rootedness. Conceptually Ubudehe as an approach helped generate important questions about how CHC fits into the broader cultural lexicon of the communities it serves. In the Tsumkwe case it raises important questions about how indigenous San beliefs and practice stands in relation to the CHC process. Questions such as these are particularly important when exploring participatory health governance approaches that engage historically dispossessed indigenous peoples. There is often an emphasis on changing and/or influencing local beliefs and practices. Ubudehe as an approach makes clear the need to consider how participatory mechanisms are or are not being influenced, shaped, and embodied by communities they target.

Ubudehe: Learning from Community Conversations and Clinic Health Committees

The Ubudehe approach to participatory engagement offers important insights into participatory health governance efforts that focus on cultivating forms of horizontal citizenship for collaborative community aims. Ubudehe, HIMO, Umaganda approach to water and sanitation demonstrated the importance of culturally respectable and historically situated approaches to communal engagement and participatory work. **Health Poverty Action staff identified two distinct ways in which the CHC method could enhance the Ubudehe process:**

i. **Clinic Health Committees (CHC) creates structures for ongoing collaboration and regular meeting** Ubudehe was able to mobilise community members to support and participate in the improvement and building of local water and sanitation facilities. While a significant gain, the methodology stopped short of creating ongoing spaces for citizens to engage with local political representatives or water and sanitation service representatives. The provision and maintenance of health and sanitation services undoubtedly requires ongoing forms of collaboration between citizens and responsible authorities. The CHC, as participatory structures, proposes the creation of ongoing structures that serves as a regular forum for the airing of concerns. SALTWASH committees could follow a similar model and provide an opportunity for ongoing feedback and collaboration.

ii. **Clinic Health Committees (CHC) are part of a layered governance feedback model** The CHC process was situated in a layered accountability structure that was intended to ensure that community concerns and feedback could be escalated to the appropriate governing bodies. While this arrangement had its challenges it did represent a potential structure that could prove useful to Ubudehe process. The Ubudehe emphasis on citizen mobilisation overlooks the need for clear and accessible vertical forms of democratic collaboration that ensure that governance structures are accountable to the collective voices of citizens engaged in communal improvement initiatives.

Aside from existing structures that enhance vertical accountability between citizens and governing bodies, Ubudehe as a process can also benefit from the Community Conversations approach. While the Community Conversations approach is a defined process it is one that embodies a number of tools that focus on bringing to light typically overlooked features of community context and shared psychology. The Community Conversations tools can be additional supports for Ubudehe facilitators that may find themselves in the midst of difficult and complex contexts. One example of such a tool is *Storytelling*. The Storytelling tool is one that encourages communities to explore issues through the telling, exploring, and unpacking of commonly shared stories. By adopting the tools Ubudehe facilitators can enhance their ability to promote more egalitarian and democratic collaborative decision-making.

Community Conversations: Learning from CHC and Ubudehe

The Community Conversations process demonstrated that participatory health governance often requires intentionally cultivated civic spaces that engage a host of local opinion, religious, and traditional leaders. The Community Conversations approach, through process and method, creates the space for communities to engage in in depth conversations across difference. As a methodology it emphasises a facilitated approach that utilises tools to promote deep reflection and strategic communal organising and action. **Health Poverty Action staff identified two distinct ways in which the CHC method could enhance the Community Conversations process:**

i. **Clinic Health Committees (CHC) and Sustainable Structures** While the Community Conversations process did produce strategic actions to address FGM and HTP, the actions produced often fell short of creating sustainable structures for deliberation and information sharing. The Clinic Health Committee approach can provide an ongoing linkage between communities in conversation and local or regional health facilities. This pairing can ensure that the many insights and perspectives that emerge from dialogue have set pathways into institutional and governing bodies.

ii. **Clinic Health Committees (CHC) and Health Services Feedback** Strengthening the downward accountability of governance structures and facilities can pose a challenge. Throughout Community Conversations, local leadership and governance representatives at times missed or did not participate in parts of the process. This can affect flows of information and feedback that need to flow from governing bodies and health facilities into community deliberations. While not a complete solution, an ongoing CHC structure can be one way to establish ongoing points of contact and pathways for knowledge exchange. Communities and or advocates can devise ways for the Community Conversations/ CHC process to be supported and resourced as an essential part of local/ municipal governance practice.

One of the more significant features of Ubudehe is its standing as a government- supported and funded federal community engagement approach. While the HPA project employed an adaptation of this process the methodology's place in the political landscape of Rwanda suggests some further possibilities. The Community Conversations approach has traditionally been employed as a participatory community mobilising/engagement method owned and led by civil society. One possible consideration is to approach Community Conversations as a democracy enhancing methodology that, with legislative support, could form the foundation for citizen assemblies that foster citizen and government collaboration on issues of health and health service provision. Ubudehe and its position in the socio-political imagination of Rwandan society suggest similar possibilities for Community Conversations; especially in contexts where the tradition of governance through dialogue is still a prominent feature at the grassroots level.

6. Participatory health governance and best practices: Policy and practice implications and the everyday work of communities

The *Sharing best practices for the participation of marginalised groups in health sector governance* project produced important findings and perspectives relevant for policy makers and civil society organisations that endeavour to implement, promote and advocate for the use of participatory methodologies as a form of participatory health governance intervention. Each of the methodologies central to this report offers important insights into the ways that socio-political technologies can be used to cultivate *health-enabling democracies* (Rolston 2016). If participatory health governance is a democratic model then *socio-political technologies* (Ibid 2016) like the Community Conversations, Clinic Health Committees (CHC), and Ubudehe are processes and tools that can assist in making this model of governance possible. The case studies provided above demonstrate that doing so entails contextual and pedagogical complexities that need to be considered if these technologies are to have a formative impact on governance systems and the health outcomes of marginalised citizens. These technologies are in essence citizen-led *technologies* that can contribute to the cultivation of health-enabling democracies from the grassroots up. At the same time they can assist municipalities, districts, and policymakers that aim to expand the voice and influence of citizens on policy, health service provision decision-making, and accessibility issues.

To better support the work of activists, civil society organisations, policy makers and political bodies engaged in supporting and or implementing similar approaches, Health Poverty Action has developed a series of recommendations. These recommendations are meant to guide interested institutions, collectives, and individuals that aim to promote participatory health governance in complex context through the introduction of the sorts of socio-political technologies explored in this report. More broadly the following recommendations are particularly focused on guiding work that focuses on expanding the voice of marginalised communities and peoples in health decision-making processes.

Recommendations: Civil society organisations

Supporting long term in-depth programming Participatory processes like the ones profiled in this project often aim to address health issues that are deeply imbedded in historical and present day forms of intersecting inequality. **Marginalised communities often exist at the centre of multiple forms of intersecting injustices that adversely affect their outcomes. Projects and programmes that aim to ally with marginalised communities to address these issues have to reconsider short-term intervention models**. This project demonstrated that there are a host of external political factors that limit the potential of participatory health governance initiatives. One of the most prominent being the lack of political participation in and/or commitment to said processes, demonstrated in both the Namibian and Kenyan case study. The project also pointed out how deeply rooted health issues can be in complex cultural and communal histories. Transforming the socio-political landscape that shapes health outcomes is a long-term effort that requires intensive longer term and focused programmatic support.

Balancing horizontal citizenship and vertical citizenship organising Each of the case studies featured in this report highlight the need for participatory health governance initiatives to give concerted attention to fostering mutually reinforcing and coordinated forms of horizontal and vertical citizenship organising and action (Kabeer 2005). **This means employing approaches and *technologies* that build solidarity and equality amongst citizens horizontally with a focus on promoting health justice, while at the same time enhancing the same citizen's ability to engage local stakeholders and political representatives in effective and strategic ways.** Civil society organisations supporting such initiatives should ensure a programmatic focus that sufficiently supports both forms of citizenship organising, taking into account the different tools, methods, and processes needed for each.

Maintaining momentum and continuity

Throughout the project it became clear that consistent and uninterrupted support was a necessary part of process and progress. **Communities engaged in the difficult work of transformational change and advocacy often lose momentum, communal support, and miss opportunities when projects are interrupted for significant periods of time. Building and maintaining momentum is an essential part of citizen-led participatory health governance initiatives.** Frontline staffs often invest a great deal of effort in mobilising community members whose time is already limited. An important part of this process involves building relationships and instilling trust in the project and its proposed outcomes. Interruptions can disturb the trust and relationships built in the early stages.

Supporting contextually and culturally appropriate methods

Communities and peoples often have long histories of communal collaboration and organising interwoven into local culture beliefs and practice. Health justice initiatives do a disservice to existing community knowledge systems and wealth when these histories and practices are overlooked or misunderstood. **Introducing new methodologies and tools to communities should entail a collaborative reflection on histories of organising, action, and communal dialogue with a focus on exploring ways of promoting and contributing to endogenous forms of participatory health governance**. This may mean offering socio-political technologies like the ones profiled in this project as accompanying and/or supporting processes or methodologies that exist within already contextually rooted and culturally appropriate practices and/or institutions.

Supporting the combinative potentials of socio-political technologies

As this report demonstrates the socio-political technologies profiled in this process had significant strengths along with notable gaps. These gaps represented opportunities for more combinative approaches to participatory health governance. **Civil society organisations supporting and/or implementing the technologies profiled in this report should give attention to the combinative potential of technologies and emphasise a health justice approach that utilises the strengths of different approaches to cultivate more holistic change initiatives**.

Recommendations: Activists and organisers

Building people; building movements

Community organisers and activists employing *socio-political technologies* to promote participatory health governance must give attention to the personal capacities, skills, and knowledge of facilitators, project staff, and community members engaged in the community organisation/consultation processes. **Building on and enhancing the skills, capacities and knowledge of facilitators guiding communities through transformative processes enhances and builds on the potential for movement and change**. Organising collectives should advocate for and self-organise relevant trainings, skills enhancement encounters, and mentoring for individuals involved in leading, participating in, and guiding participatory health governance processes. This may entail advocating for additional training and capacity building resources and support from civil society and/or government representatives.

Enhancing citizens' knowledge and access to information

Participatory Health Governance initiatives depend on a critically conscious and critically informed citizenry. **While socio-political technologies embody tools and methods that promote Participatory Health Governance, they require informed participants and facilitators that have an increasingly complex understanding of political processes, institutional decision-making spaces, and local traditional governance structures for example**. This knowledge in part reflects an understanding of the way power and authority is structured and works in the interest of, or in opposition to, health justice organising and action. The sorts of knowledge and information that potentially have the greatest impact on process are understandings of how power and authority works to limit the ability of marginalised communities to realise greater health outcomes.

Addressing horizontal power and intragroup dynamics

Enhancing and supporting marginalised communities' ability to advocate for and engage in participatory health governance is strengthened by efforts to address protracted power imbalances amongst citizens. Gender disparities, ethnic divisions, and class imbalances are some of the challenges that can limit a community's capacity to collaboratively develop effective health justice strategies and actions.

Understanding how horizontal power imbalances limit the organising potential of communities engaged in efforts to promote and/or advocate for participatory health governance is essential. Socio-political technologies employed by organisers and activists can assist with this process. When using socio-political technologies like the ones profiled in this report, organisers and activists should give particular attention to the ways in which they do and don't support critical conversations that unpack local power dynamics.

Recommendations: Governance structures and policy makers

Promoting responsive governance systems

Responsive and accountable governance systems enhance the potential impact of participatory health governance systems. **Governing bodies and/or institutions that aim to actively support and cultivate participatory health governance initiatives should explore organisational ways of regularly integrating feedback, concerns, and/or advocacy efforts into influential deliberations, policy making, and budgeting at the municipal and district leve**l. The project routinely demonstrated the ways in which a lack of political engagement limited citizen's ability to positively shape their own health outcomes. Increased responsiveness and accountability could involve integrating support to participatory health governance processes into the remit of appropriate municipal and or district level agencies.

Promoting active governmental participation in participatory health governance structures and processes

A number of the socio-political technologies central to this project provided opportunities for governmental representatives to be directly involved in the processes and or proceedings. **While creating feedback mechanisms can be beneficial, governmental participation in participatory health governance could in some cases reshape governmental agencies' understanding of predominant health issues.** The relative distance between marginalised citizens and the state is often vast leaving little room for regular and meaningful engagement. Governments that participate in, but do not capture, participatory processes can create new opportunities for meaningful civic engagement.

Introducing socio-political technologies into policymaking and decision-making processes

Governance structures exploring new methods and means to engage citizens in decision-making and policy making processes can look to socio-political technologies. Many governance structures interpret participatory processes as periodic consultative meetings that often overlook the complexities of participation. This project demonstrates that even with careful attention to process, constructing participatory processes is often fraught with complexities. The project's outcomes illustrate how essential tools, methods, and process are to cultivating new understandings and arrangements that promote health justice. At the municipal level governance structures can employ socio-political technologies as an on-going form of civic space for democratic deliberation.

References

Bambra C, Fox D, Scott-Samuel A (2005) *Towards a politics of health*. Health Promot Int; 20: 187–93.

Campbell, Catherine; Nhamo, Mercy; Scott,Kerry; Madanhire, Claudia; Nyamukapa, Constance; Skovdal, Morten; Gregson, Simon (2013), *The Role of Community Conversations in facilitator local HIV competence: case study from rural Zimbabwe*. BMC Public Health.

Ezeanya, C (2015) *Home-Grown and Grassroots-Based Strategies for Determining Inequality Towards Policy Action: Rwanda's Ubudehe Approach in Perspective*. UNU-WIDER, Helsinki, Finland

Goldfrank, B (2011) *Deepening Local Democracy in Latin America: Participation, Decentralization, and the Left*. University Park, PA: Pennsylvania State University Press.

Health Poverty Action (2014) *Tackling Inequality in Global Health: Why we must break down health data by ethnicity*

Kabeer, N., 2005. *The search for inclusive citizenship: meanings and expressions in an interconnected world*. In N. Kabeer, ed. Inclusive citizenship: meanings and expressions. London: Zed Books, 1–27.

Kenya Demographic and Health Survey (KDHS) 2014

Kickbusch I (2005) *Tackling the political determinants of global health*. BMJ; 331: 246–47.

Kohler, Jillian and Martinez, Martha (2015) *Participatory Health Councils and Good Governance: Healthy democracy in Brazil*. International Journal for Equity in Health; 14:21

Loewenson R, Machingura F, Kaim B, (2014) *Health Centre committee as a vehicle for social participation in health systems in east and southern Africa*, EQUINET discussion paper 101, TARSC with CWGH and Medico, EQUINET: Harare

MINALOC (2009). *Ubudehe mu Kurwanya Ubukene Concept Note*. Kigali: Rwanda Ministry of Local Government (MINALOC)

Ottersen, Ole et al (2014) *The Political Origins of Health Inequity: Prospects for Change*. *The Lancet/ University of Oslo Commission on Global Governance for Health*. Lancet 2014; 383: 630–67

Padarath, Ashnie & Freidman, Irwin (2008) *The Status of Clinic Committees in Primary Level Public Health Sector Facilities in South Africa.* Health Systems Trust.

Peoples Health Movement (2000) *The Peoples Health Charter*, http://www.phmovement.org/en/resources/charters/peopleshealth

Rolston, Imara (2016) *(Re)politicizing and (Re)positioning Prevention: Community Mobilization and AIDS Prevention in the new AIDS era. – Pending Publication*

UNDP (2005) Community Capacity Enhancement – Strategic Note

UNDP (2007) Trends in Human Development and Human Poverty in Namibia

UNFPA (2013) Kenya Populations Situational Analysis Report

UNFPA (2016) Summary Report of Assessment of UNFPA Advocacy Campaign to End Preventable Maternal and New-Born Mortality.

Wampler, Brian & McNulty, Stephanie (2011) *Does Participatory Governance Matter? : Exploring the Nature and Impact of Participatory Reforms*. Woodrow Wilson International Centre for Scholars.

https://www.wilsoncenter.org/sites/default/files/CUSP_110108_Participatory%20Gov.pdf

Werner, David & Sanders, David (1997) *Questioning the solution: The politics of Primary Health Care and Child Survival*. Palo Alto. HealthWrights. Pp 18

World Health Organisation (1978) *Declaration of Alma Ata*. International conference on primary health care, Alma-Ata, USSR, 6-12 September 1978 Geneva:. www.who.int/hpr/NPH/docs/declaration_almaata.pdf

Participatory Governance

Sharing best practices for the participation of marginalised groups in health sector governance

This report aims to explore different ways of increasing the participation of marginalised communities in the governance of health services and policies in three countries of Sub-Saharan Africa. It aims to explore synergies and encourage policy makers to replicate best practices.

HEALTH POVERTY ACTION

Health Poverty Action works to strengthen poor and marginalised people in their struggle for health.

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