12 Re-imagining community participation at the district level: Lessons from the DIALHS collaboration

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In South Africa, the value of community participation as one of the central components of a primary health care approach is highlighted in legislation, policy documents and strategic plans. There is widespread acceptance that community participation strengthens community empowerment, disease prevention and access to services.

Since 2010, the District Innovation and Action Learning for Health System Development collaboration has co-produced knowledge about how to strengthen district health systems. Nested within this collaboration is a series of engagements seeking to understand and strengthen community participation including a multi-stakeholder health risks and assets mapping activity; 'Local Action Group' initiatives; reflective meetings with service colleagues about community participation experiences; and a capacity-development initiative (community participation-related short courses and mentoring).

These engagements hold a number of lessons for those interested in enhancing the population orientation of primary health care and the district health system, the first of which is the clear benefit to those interested in community roles and engagement of convening spaces for dialogue. However, it is not easy to generate and sustain these spaces. Through the application of a framework of collective capacity, this chapter aims to shed light on why this is the case, and in so doing, to highlight a second lesson, which is the perhaps unrecognised capacities of certain cadres, particularly environmental health practitioners, in the implementation of community participation.

Ultimately, the chapter seeks to stimulate thinking and engagement about the ways in which dialogue and participation can enrich the South African health system.

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Introduction

In South Africa, the value of community participation in primary health care is highlighted in legislation,[1] policy[2,3] and strategic documents.[4,5] Community participation promotes community empowerment, health promotion and disease prevention, access to services and community accountability. However, health practitioners often acknowledge a desire to do things differently: to re-imagine community participation and breathe new life into implementation practice.

Participatory "behaviours and attitudes, methods, and practices of sharing"[6] grew in popularity during the late 1980s and early 1990s as a family of approaches for building relationships and empowering participants, through giving voice to and foregrounding the value of local and informal knowledge.[7-12] Community participation within health systems has been advocated since the 1978 Alma Ata Declaration, with the fourth clause stating that "the people have the right and duty to participate individually and collectively in the planning and implementation of their health care".[13]

In addition to the raft of documents[3,4,14,15] re-emphasising community participation as a cornerstone of the primary health care approach, legislation to this effect has also been enacted. In terms of legislation, promoting "community participation in the planning, provision and evaluation of health services"[1] is noted as one of the general functions of the Department of Health at a national, provincial and district levels, with clinic or health facility committees (HFCs) being identified as the principle organisational arrangement through which this occurs. Establishing the specific roles and functions of these committees and the accompanying legislation is a task that has been deferred to provincial government.[16]

Whilst a draft policy has been in existence for a number of years in the Western Cape, without its formalisation into legislation, HFCs have to date had to remain as informal entities assuming a quasi-official role for community participation in the health system.[16] However, it is understood that now that the District Health Council is in place,[17] a policy process has been set in motion to amend the current legislative framework so as to include HFCs as a formalised mechanism of engagement between primary-level services, community members and, importantly, other health stakeholders in the district health system (DHS).

The reported benefits of community participation have been well-described and synthesised[18] and include – from the perspective of participating community members – improving health knowledge and health-related behaviour and articulating local expectations and needs. From the perspective of the health system, community participation is viewed as beneficial in terms of expanding the coverage of health care; mobilising additional resources for health; making the health system more efficient, effective and equitable; improving the quality of health care; and strengthening the responsiveness and accountability of health service providers.

Tangible benefits notwithstanding, in a recent literature review Rifkin re-emphasises the importance of conceptualising community participation not so much as an intervention or end in itself, but as a process that is reflective of the context in which it takes place – and which cannot be considered without addressing issues of power and control.[19] Rifkin reminds us of the complexity of factors influencing community participation and how issues like leadership, capacity-building, resource mobilisation and management have a bearing on the nature of the community participation process.

Understanding the capacity of the system to participate

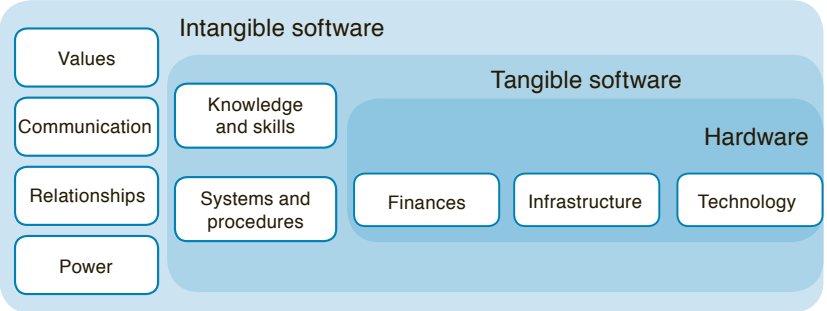
In a previous *South African Health Review* chapter, the importance of understanding collective capacity in district/sub-district functioning – where capacity is seen as the combination of attributes that enable a system to achieve its intentions with effectiveness and at a degree scale over time, has been highlighted.[20,21] In applying this framework of collective capacity to community participation, the system consists broadly of all actors involved in the web of community participation-related engagements/actions within a geographical locality, including those living in the area, and that these local engagements are framed and influenced by the actions of actors higher in the system (district and provincial managers, policymakers, legislators), as well as by actors outside the health services including the police and a range of local government actors such as ward councillors and solid waste service providers among others.

As summarised in Figure 1, the capacity of this system to enable participation among its actors rests on three interacting dimensions. The hardware of finances, infrastructure and technology points to the need for funding for salaries, stipends, transport and activities; physical spaces to plan, engage and conduct activities; and technology such as cell-phones and computers, to enable communication and to develop materials as necessary.

The tangible software, on the other hand, includes the dimensions of *knowledge and skills*, and *systems and procedures*. For example, local knowledge (a form of non-verbal knowing that evolves from seeing and interacting over time[22]) as well as participatory facilitation skills such as 'handing over the stick' (i.e. allowing others to speak, lead, facilitate, etc.), developing the capacity to listen, and actively valuing local knowledge[23] are key elements of participatory capacity, forming part of the tangible software in Figure 1. Systems and procedures include the mechanisms through which community participation is implemented, such as health facility committees, community-based outreach events, contracts with NPOs, job descriptions and key performance areas of providers, as well as the service delivery targets of the district or municipal health system.

The intangible features of communication, relationships and power, and the value that is given to participation, are particularly important in shaping the behaviours of those working towards community participation, underpinning their power to perform.[20]

Figure 1: Hardware/Software framework of system capacity



Source: Elloker et al., 2012;[20] Ortiz Aragón, 2010.[21]

Setting and approach

This chapter reflects on more than four years of experience in engagement and action around the implementation of community participation in primary health care services. Through collaborative action learning and reflective practice, the chapter draws on a combination of service partner tacit knowledge (values, mindsets and experiences) and scholarly understandings, brought together through a series of conversations, engagements and actions among the authors. Knowledge is therefore co-produced, which implies a broadening of the view of knowledge from data that are collected and analysed, to a view of knowledge that may also be built through layers of conversation.

Keeping track and making meaning of this knowledge was achieved through processes of reflective practice and through the documentation of conversations and engagements using a combination of verbatim recordings, minute-taking, compilation of activity reports and researcher diaries. Additional insights into our approach to knowledge co-production are available in Lehmann and Gilson.[24] The arguments and ideas presented in this chapter are therefore gained through a combination of intervention, engagement, participation and discussion, and are offered as a set of experiences from one urban sub-district as a stimulus for reflection elsewhere in the South African health system.

The setting of this work is the health sub-district of Mitchells Plain, a low-income community of approximately 500 000 people within Cape Town that includes 90 informal settlements. Health service delivery in Mitchells Plain is under the dual authority of the Metro District Health Service (MDHS) of the Western Cape Department of Health and the City of Cape Town's (CoCT) health department. The intention is that services should be co-ordinated between the two authorities through an Integrated Sub-District Management Team (ISDMT) and annually renewed Service Level Agreements.

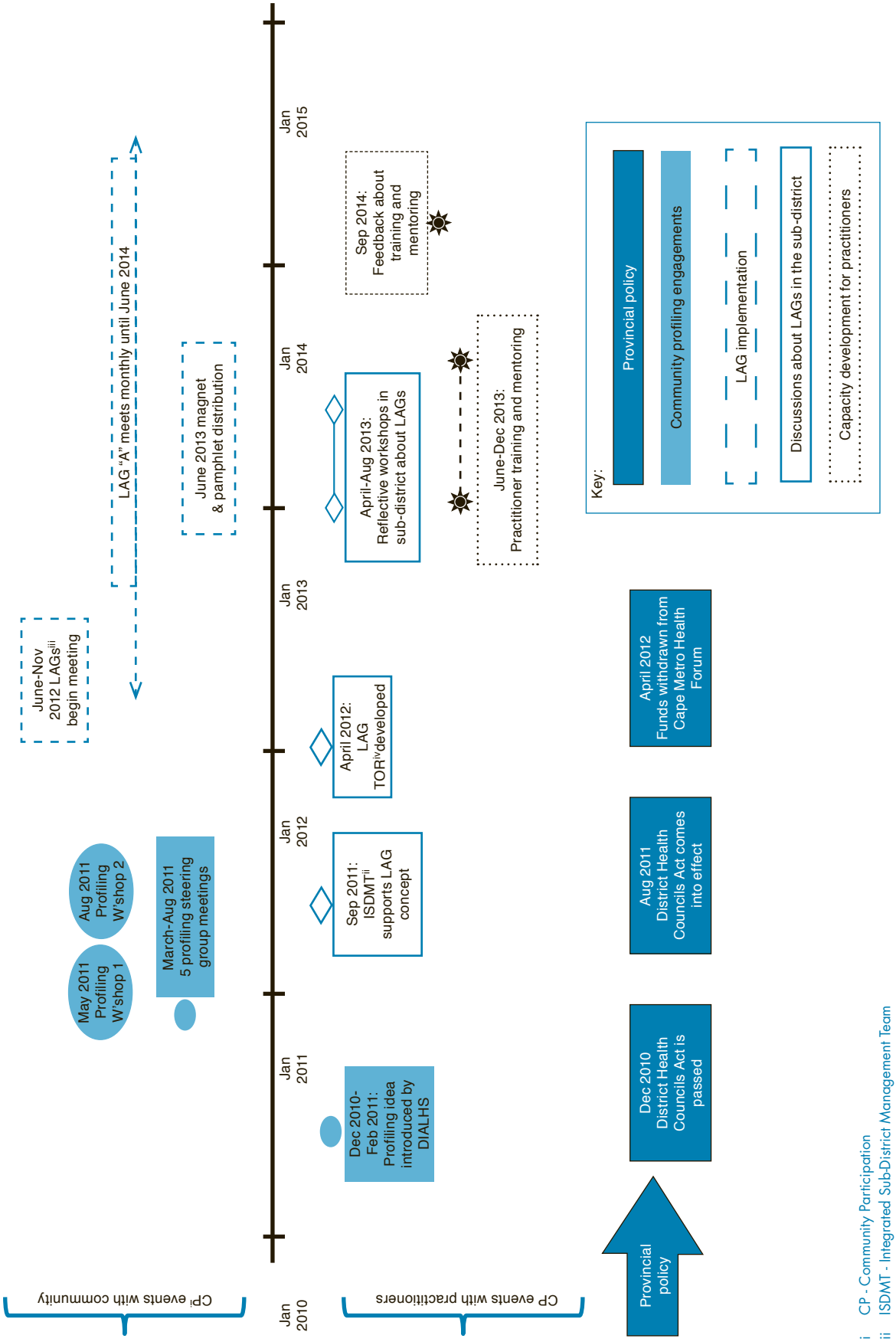
Government health services include nine City of Cape Town clinics, four Community Health Centres (three MDHS, one CoCT) and one level-1 hospital. Apart from the facility-based health services – and of particular relevance to community participation – 16 Environmental Health Practitioners, one Community Service Environmental Health Practitioner and three Environmental Health Assistants who support environmental health services within the area, and 10 Health Promoters facilitate a range of health education activities (although much of the work of the health promoters takes place within health facilities). The responsibility for Community-based Services (CBS) rests with MDHS and includes formalised partnerships with non-profit organisations (NPOs) to deliver various services, including TB and HIV adherence support, counselling services, home and community-based care, with sub-district CBS co-ordinators being responsible for monitoring and evaluating CBS and for supporting NPOs.[25] In October 2013, there were nine official health facility committees, of which four were active.

Description of events, interventions and engagements

The engagements that have informed this chapter are illustrated in Figure 2. In December 2010, the idea of conducting a community profiling exercise that would bring all Mitchells Plain stakeholders into conversation was first raised by the DIALHS project. Co-constructed by a range of service and community stakeholders, the idea of the profiling was supported through five steering group meetings where the two large community profiling workshops of May and August 2011 were planned and conceptualised. The energy and enthusiasm of these large meetings generated a commitment to continue engagement through decentralising activities into four smaller Local Action Groups (LAGs). While one of these (LAG A) met for two years between June 2012 and June 2014, the other LAGs struggled to get off the ground. To better understand this 'capacity to participate', DIALHS initiated a series of four reflective workshops with health service colleagues between April and August 2013 that revealed a number of benefits and challenges of participation. These discussions emphasised, inter alia, the particular skills needed to facilitate community participation, an insight that was deepened through a community participation capacity-development initiative for environmental health and health promotion practitioners during the period July to December 2013. While these engagements proceeded in Mitchells Plain, provincial processes relating to the enactment of the District Health Councils Act and associated changes in funding flows also impacted on the capacity of the sub-district system to participate.

As we shall argue, these engagements hold a number of lessons for those interested in enhancing the population orientation of primary health care services and the district health system. A first key lesson is the clear benefit to stakeholders of convening spaces for dialogue. It is, however, not easy to generate and sustain these spaces. Through the application of the Hardware/Software framework to community participation (Figure 1), we illustrate why

Figure 2: Timeline of events, interventions and engagements, 2010-2015



i CP - Community Participation
ii ISDMT - Integrated Sub-District Management Team
iii LAG - Local Action Group
iv TOR - Terms of Reference

this is the case, and in so doing highlight a second key lesson, which is the unrecognised capacities of certain cadres, particularly environmental health practitioners (EHPs), in the implementation of community participation approaches.

Creating a community profile with Mitchells Plain stakeholders

The first set of engagements that inform this chapter began in late 2010 when the DIALHS project introduced the idea of conducting a community profile to complement the formal 2011/12 strategic planning processes in Mitchells Plain. The initiative had multiple rationales: shifting the lens of service providers from patients to a stronger population orientation as advocated in national and provincial policy and strategy;[4,14] an acknowledgement by facility and sub-district managers of the importance of community participation and health facility committees, but uncertainty about how to improve these relationships; and a sense of unease among some facility managers about "not knowing the community they serve", of being unsure about what lies beyond the clinic door, and whether the services rendered respond effectively to local needs.[a]

As illustrated in Figure 2, engagements were co-constructed by health service providers and community representatives over a series of five steering group meetings between March and August 2011, and culminated in two large community profiling workshops of approximately 70 and 100 people respectively (see Box 1 for more details).

These engagements were considered a 'first of its kind' by health service providers (DIALHS Internal Report: Community Profiling Exercise, October 2011) where a team of service partners, NPOs, community members (including local health facility committee members) and others conceptualised and implemented a series of multi-stakeholder workshops which succeeded in bringing a diverse group of actors into conversation with each other. While the information generated allowed for a number of quick wins (for example, a series of interventions and engagements to improve sanitation practices within Early Childhood Development (ECD) centres – see Box 1) the workshops also demonstrated the importance of generating spaces for dialogue – confirming the value of both relationship-building approaches and of local and informal knowledge (key tangible and intangible software – as presented in Figure 1). These engagements also highlighted the particular skillsets of EHPs in enabling a population-based approach to primary health care: an important unanticipated outcome of the community profiling event.

Box 1: Mapping local health risks and resources

Two large community profiling workshops were convened in May and August 2011 involving approximately 70 and 100 people respectively. The workshops made use of a profiling exercise in which stakeholders (nurses, NPO staff, community representatives from local health facility committees and of police fora, environmental health practitioners, and others) were given maps of their neighbourhood/geographic area (provided by EHP colleagues) and asked to plot priority health risks and concerns, available resources, and potential opportunities to reduce risks.

In acknowledgement of the diversity of the local communities in Mitchells Plain and in order to make the task more manageable, the sub-district was divided into 'local area groups' for these discussions – each of which was linked to a Community Health Centre (CHC) and its feeder clinics.

Together stakeholders identified the issues and places which were of greatest concern (for example, substance abuse and the sites in which alcohol and drugs were sold, inter-personal violence and the crime 'hot spots', dangerous traffic intersections, sites of illegal dumping, and the vulnerability of the youth in relation to HIV, teenage pregnancy and substance abuse). A range of health resources were also plotted on the maps (from traditional healers to private practitioners and the local clinics) along with those that were considered to offer potential (such as a religious centre or a recreational centre for youth). The neighbourhoods which appeared to be under-resourced in terms of health assets and services were noted.

Discussions led to a number of practical actions, including negotiating with local taxi operators to change their routes to improve access to one facility, while the information that was collected was fed into sub-district planning processes that year. The process of plotting information on maps also revealed a considerable number of unregistered ECD centres in Mitchells Plain. This prompted the EHPs to reconsider the possible causes of the ongoing high levels of diarrhoeal disease in infants and young children, and with local government councillors in the area, funding was granted by the sub-council to allow EHPs to intervene through training ECD teachers in hygiene promotion, providing 'squeezy' bottles and soap for hand-washing, and providing new drinking water containers to identified ECD centres.

Decentralising the community engagement: the Local Action Groups

During the final phase of the community profiling, there was agreement from community representatives and the ISDMT that the process was valuable, prompting the idea of continued engagement within four Local Action Groups (LAGs). Through the drafting and discussion of a 'roles and responsibilities' document (in April 2012 – see Figure 2), the purpose of the LAG was conceptualised as a combination of building relationships and a sense of community among all stakeholders; supporting local-level input into sub-district and district health planning; ensuring that appropriate links were made with other health-related governance structures (health facility committees, the City's Multi-Sectoral Action Teams (MSATs) for HIV/AIDS, and others including the Community Policing Forum); and undertaking local-level action in relation to needs and priorities. Whilst conceptualised as complementing the work of these existing structures, the role and responsibilities of the LAGs were seen as extending beyond a set of specific health issues or a particular health facility. Building on the issues raised by participants in the community profiling workshops, considered these and the social determinants of ill health, were considered.

It was anticipated that the work of a LAG facilitator – the four being appointed from among the programme managers of the two health authorities – would be supported by the local clinic and CHC facility

a Sources: DIALHS Internal Report: Community Profiling Exercise, October 2011; Summary Report for Mitchell's Plain ISDMT: The DIAHLS Community Profiling Activity, September 2011; Writing Reflective Meeting II, March 2015.

managers and EHPs working in the same area, and that overall oversight of the LAG initiative would be provided by the ISDMT.

Despite this enthusiasm, uptake of the LAG was mixed: one group did not meet at all and two groups met once or twice. Some of the reasons for this uneven uptake are discussed in Box 3. The fourth group (LAG A), however, met on a monthly basis for another two years (mid-2012 to mid-2014), with support from DIALHS, during which period a name and vision was created for the group by local stakeholders:

> [LAG A] Cares for Health. Making [local area 'A'] a healthier community by promoting the health of its residents and community members, through working collectively together (as community representatives and service providers) and specifically focusing on environmental health issues and substance abuse.

As with the community profiling, key to this success was the way in which the local knowledge of the EHP (a tangible software skillset denoted in Figure 2) enabled community members to access a variety of needed services (e.g. how to report illegal dumping, leaking pipes, dog fighting, etc.; how to motivate for trees to be planted in recreational spaces) and the way in which this local knowledge was aligned to many of the social determinants of ill health that particularly occupied the minds of community members in the group.

The group was also instrumental in developing and undertaking the door-to-door distribution of 4 200 leaflets containing health and referral-related information – a proportion of which were magnetised so that they could be placed on the door of a household refrigerator (see Box 2). The information in the leaflets reflected the key health-related concerns and identified priorities of group members, including referral information for illegal dumping, leaking pipes, dog fighting (facilitated through environmental health colleagues), and substance misuse (facilitated through one of the NGOs partnering with the health services in Local Area A). While this activity was an excellent illustration of the type of local area action the LAGs could do, as Box 2 highlights, it also provided an experience of the importance of being aware of the role of power and the deeply political nature of community participation.

> *For me it is fundamentally important to always know that these processes are deeply political… I think particularly in communities where the resources are so stretched and people have so little opportunity to be valued and be somebody, these things simply become enormously important and so even very small resources… becomes an area that this plays out. (Writing Reflective Workshop I, March 2015).*

Box 2: Power and participation

The development and distribution of 4 200 fridge magnets and information pamphlets by LAG A provided a key experience of the importance of understanding relationships and power in participatory processes. The original idea of the fridge magnet came from a number of members in the group, and was partly in response to the apparent lack of health-related information in the community, and partly a way to galvanise energy around a local activity. Initially envisaged as an information pamphlet, when one group member suggested the creation of a fridge-magnet version of the pamphlet, the idea caught the group's imagination as a way of spreading health information into each household. The information to be contained in the pamphlet and on the magnet was discussed in detail over a number of months, and a local business was contracted to do the printing. Magnets were purchased separately, and the plan was to have an extended workshop where the magnets would be attached to some of the pamphlets.

However, the day of this workshop saw the arrival of a large group of new members. While it had been the intention to allocate the magnet and pamphlet proportionately to different areas based on household numbers, the newcomers argued that they should take half of the materials, because they represented the one (geographical) side of Local Area A while the longer-serving members of the group were from the other side. After animated discussion, and some raised voices, the materials were allocated equally between the two geographical areas with little consideration being given to household numbers in each area.

The development and distribution of the fridge magnet and pamphlet – which provided group members with something tangible to work with in the local community, and also attracted the new members to the group – was an excellent illustration of the type of local area action the LAGs could undertake. However, it also ultimately demonstrated that in a resource-poor community, deciding how a resource like the fridge magnet/pamphlet ought to be shared is a deeply political rather than rational process – and one which foregrounded pre-existing tensions and divisions between members of the local community around, for example, the geographical area in which one lived, or whether one was a member of the health facility committee or a supporter of political parties campaigning in the bi-election. Instead of being a space for engagement with all members, existing members complained that new members were coming into the space to "steal our group", and that they should not be welcome because they had not been involved from "the beginning".

Reflecting on the process of creating Local Action Groups with practitioners

The potential benefits and challenges of enabling participation through more formalised systems and procedures (tangible software in Figure 1) including LAGs and health facility committees have been well documented.[16,18,26-28] However, given the potential of the LAG concept, the perceived success in Local Area A and the varied uptake elsewhere, DIALHS academic partners facilitated four reflective workshops with MDHS and CoCT colleagues between April and August 2013 to further understand and build participatory capacity. The meetings reflected on the progress of the LAGs, highlighting some of the opportunities and challenges that had arisen, and considered the implications for the future of LAGs and similar community engagement initiatives. These workshops were complemented by a capacity-development initiative for a subset of these practitioners (including a team of Environmental Health Practitioners and the CoCT Health Promotion Officer) that commenced in June 2013. The initiative included attendance at community participation and health promotion-related short courses at the University of the Western Cape Winter School, complemented by five mentoring workshops that focused on enabling the development of tangible and intangible software (including listening skills, problem-solving, communication skills and relationship-building skills).

In the LAG workshops, the meeting participants recognised once again that a benefit of participation lay in bringing stakeholders into conversation, reducing the division where "they [the community] is sitting on one side and we are on the other" (LAG Reflective Workshop, May 2013). Other perceived benefits included improved access to information about a range of government services and improved responsiveness of services to community needs.

Despite these benefits, the engagements in these workshops highlighted the way in which key elements of organisational support for community participation (through budgets, systems and procedures) were felt to be inadequate to sustain participation, as highlighted in Box 3. The inadequacy of these more tangible markers of support also raised questions about the extent to which the system could be said to value (an element of intangible software in Figure 1) community participation relative to other service delivery priorities.

Box 3: Organisational support for participation

Reflective workshops about the implementation of Local Action Groups highlighted the importance of community participation being enabled by system hardware (e.g. budgets) as well as by the tangible software of systems and procedures (e.g. through functioning health facility committees). An understanding of why this is the case can be gained through the example of the Western Cape government's withdrawal of funding for the Cape Metro Health Forum (CMHF) – a long-standing but unlegislated governance body under which the Mitchells Plain Community Health Forum operated. The withdrawal of funding to the CMHF resulted from the formalisation of legislated governance structures, such as the Metro District Health Council, which was established in May 2012 in accordance with the District Health Councils Act.[17,29]

Without this funding – and in the absence of appropriate provincial legislation – the primary-level health facility committees were left to operate as volunteer bodies. This action had a particular impact on the functioning of one of the LAGs, given that many of the LAG members were local HFC members who were disappointed and angered by this change.

The LAG group facilitator felt that, given this context, her ability to engage with community members in a meaningful way was compromised and that the removal of the funding for the local HFC had a direct impact on the sustainability of the LAG. (Minutes of meeting, 11 April 2013)

Beyond this example, the lack of budget for community participation activities in generally very under-resourced communities (such as for the printing of information pamphlets and fridge magnets, but also basic refreshments for participants of meetings and activities) was one of the reasons why LAG A could not sustain its engagement.

> I think community participation needs to be a funded entity.... if [the health services] cannot provide a budget line item that says community participation then we are setting ourselves up for failure. (Writing Reflective Workshop 1, March 2015)

Understanding the 'relational' skillset

Many of the engagements outlined in this chapter have highlighted both the benefits of convening spaces for dialogue, and the particular relational skillset required to do so. Chambers,[7,23] an influential early practitioner and scholar of participatory approaches, similarly argues that the capacities of facilitators and the style of facilitation are crucial, and that this includes actively demonstrating respect, establishing rapport, abandoning preconceived ideas about one's own expertise on a topic (and so valuing local and informal knowledge), 'handing over the stick' (i.e. allowing others to speak, lead, facilitate, etc.), learning from mistakes, and cultivating self-awareness.

In the Mitchells Plain discussions, practitioners highlighted a number of related capacities, including:

Being flexible and open to learning from mistakes:

> *Pshew, that was a touch-and-go [decision] I must be honest... I did not know I was going to have to do that and you... think on your feet... and you don't always know if thinking on your feet and the decision you took was the right one. [Writing Reflective Workshop I, March 2015]*

Developing an awareness of power:

> *One needs to be fully aware of tensions and dynamics (whether political parties or religion or whatever)... [and] one has to continuously remind people what brings them together, [and ask that they] leave other dynamics behind... [one] cannot manage if one isn't fully aware of [this type of] situation, otherwise you are taken by surprise. [Writing Reflective Workshop I, March 2015]*

Valuing and demonstrating equality:

> *The situation becomes explosive if one voice seems to be heard more than another voice. [As the facilitator] you need to create equal opportunities for all voices – and to quieten down the loud voices and create an equal platform in which everyone can speak equally... but this does not mean that the equal platform will be maintained by members... you need to be vigilant. [Writing Reflective Workshop I, March 2015]*

Being reflective about one's own legitimacy, role and practice:

> *What made it work for [me] was having the support of and reflection with [DIALHS colleagues]... I had them on my side... That is what I liked about our relationship – is that we could reflect back and say 'what went wrong here? How could we do it differently?' That is what made me continue... because the reflection of it [the situation] was never about me – the person – but about how the situation was managed. And that is what made it work for me. [Writing Reflective Workshop I, March 2015]*

Re-imagining community participation

In this chapter, we have argued that there is a clear benefit to creating spaces for dialogue, and that the more formalised systems and procedures (such as LAGs and HFCs) provide one important mechanism for this engagement. Our work has also highlighted that the enablement of participation is partly about attitudes and values (a 'relational' skillset). While the possible interventions needed to enhance such a skillset are beyond the scope of this chapter, what became clear to the team over the four years of engagement was the extent to which this relational skillset was already apparent within many of the environmental health colleagues in Mitchells Plain. Their way of working requires EHPs to be 'embedded' in and knowledgeable about local communities. Not only are they familiar with the geography of the local landscape given their role in monitoring potential environmental health hazards in and around households, within formal and informal business premises (such as ECD centres) and in the natural environment, but in operating across sectors (with colleagues from Solid Waste, Water and Sanitation, Human Settlements, local government councillors and others), they accrue a wealth of information and contacts relating to a range of

local stakeholders living and working in a neighbourhood. This local knowledge was particularly valued by community members who participated in the various engagements, in that EHPs could facilitate access to a variety of local government services through providing information or support for issues ranging from illegal dumping, rodent infestations, burning of tyres, illegal dog fighting, leaking pipes and taps, sanitation concerns, and unregistered ECD centres, to name a few. This EHP terrain of work requires the ability to work as part of a team, to negotiate, to network and to think creatively in solving problems, and with two years of community development as one of the main subjects in the curriculum of the National Diploma in Environmental Health, EHPs are adept in the processes required for sustaining community participation in health. This terrain of work also draws attention to the possibilities of community participation within informal spaces and engagements (beyond HFCs and LAGs), suggesting that there are alternative opportunities to strengthen community involvement in health through highlighting and valuing such efforts. Box 4 gives one example of how this might play out.

Box 4: Opportunities for participation around a common cause: illegal dumping

The story of a 2012 pond clean-up campaign is one illustration of the opportunities for community participation beyond the more formalised systems and procedures (tangible software in Figure 1) such as health facility committees. The pond, located adjacent to an informal settlement in Mitchells Plain, had been the subject of a number of community complaints regarding illegal dumping. Concerned about the associated environmental health risks, the environmental health team conducted a door-to-door survey with approximately 500 local households to explore with residents the extent to which they felt the refuse removal services were meeting their needs. The survey revealed that a significant number of backyard dwellers were living in the area, which meant that the standard 240 litre refuse bin provided by the CoCT to each household was insufficient for the volume of refuse generated by each household (with its backyard tenants). Community members thus regularly emptied their over-loaded refuse bins alongside and into the pond in between the weekly refuse collection service. In addition, samples taken from the pond revealed the presence of E.coli in the water. As a result of this investigation, and concerned that young children were using the pond to swim in, an urgent health education intervention was conducted by the environmental health team in the primary schools that were located close to the pond.

Having assessed some of the underlying causes of the dumping, the EHPs in the area sat together and identified all the role-players that they felt could help them to find a solution – including the local community leader (who they already knew through their engagements) and all relevant government services.

Altogether I think we had about 15 different departments that we thought had a role to play in that scenario. (Writing Reflective Workshop I, March 2015).

Given that many of these role-players "might not have a clue what we are talking about", the meetings were purposefully held in a venue close to the pond, making use of the community leader's church as a meeting space. Shortly after the engagement commenced, community members reported that murdered bodies were being dumped in the pond – and when a body was discovered, that gave us more 'wheels' now to say… Council must really… find a sustainable solution to the environmental pollution challenges of this pond: either commit to cleaning it up (in the short term) or fence it off (in the long term)… as a way of deterring the community from dumping waste in the pond and the children from contracting water-borne diseases whilst swimming in the contaminated water… And (so) we brought everyone together and I tell you that pond was then cleaned – and around the pond trees were planted and the north and south side of the pond was converted into a play park for children from the surrounding area. (Writing Reflective Workshop I, March 2015).

In thinking more about the informal spaces for community participation, *Healthcare 2030*, the Western Cape Department of Health's Comprehensive Service Plan, recognises that mechanisms for participation include community-based health promotion campaigns and everyday interactions between health workers and patients, and between community care workers and households.[4] Similarly, outreach teams implementing the Primary Health Care Re-engineering Strategy are intended to create an enabling environment in which communities are empowered "to direct local resources and have a voice in what happens".[14]

However, while EHPs are acknowledged as a critical cadre in the health workforce at the district level,[30] the emphasis in policy documents tends to focus on their core practice of identifying, controlling, evaluating and preventing environmental hazards and harms that could negatively impact on the health and wellbeing of community members.[31] Thus, whilst the potential of EHPs to act as "catalysts for desired change"[31] has been highlighted,[32] the potential of their unique local knowledge and relational skillset presents an under-valued resource for community participation.

Discussion

In recounting a series of engagements in Mitchells Plain that evolved over a number of years, this chapter has sought to shed new light onto the question of what enables community participation in a sub-district health system. Key lessons learnt and recommendations are summarised later in the chapter. Using a framework of collective capacity, we have argued that the capacity to participate is enabled through a number of dimensions. For example, we have contended that community participation needs to be sustained through budgets and resources (hardware) and we have suggested that the removal of funding to the Cape Metro Health Forum and the lack of budget for community participation ultimately played a role in the closure of two Local Action Groups. In the absence of these more tangible markers of organisational support, questions are raised about the extent to which the system values community participation (intangible software) relative to other priorities. For tangible software, we have outlined the LAG experience as an example of a more formalised participatory mechanism focusing on the social determinants of health with relevance to the functioning of HFCs, and have demonstrated that the relational skillset and local knowledge of certain practitioners (notably, environmental health colleagues) is key (along with the hardware of resources, etc.) to enabling the establishment of dialogue among local stakeholders. This relational skillset includes more tangible components, such as the ability to facilitate participatory engagements and being open to learning from mistakes, and possibly less tangible components (intangible software) including the valuing of local and informal knowledge, being aware of power dynamics, and developing awareness of one's own legitimacy, role and practice. We have also reasoned that there is scope for community participation beyond the more formal structures, and have provided an example of how a participatory approach can powerfully enable change when stakeholders are brought into conversation around a common cause.

Our intention for this article is to stimulate thought – to reimagine community participation – through sharing in-depth implementation experience from one particular sub-district setting. While the specific events and activities that we have described are applicable only to

this particular time and place, we believe that the lessons we have learnt about the importance of dialogue, about the different types of capacities needed and about the importance of the role of EHPs in interfacing between services and communities, are of value and relevance to those seeking to improve the practice of community participation in other district and sub-district settings.

Lessons learnt about the practice of community participation

Drawing on the work of Ortiz Aragón[20,21] and his framework of system capacity (illustrated in Figure 1), we have suggested that the capacity of a district or a sub-district to facilitate community participation relies on both tangible and intangible resources and capacities. The tangible capacity includes both the 'hardware' (for example, a budget to support participatory activities, the infrastructure to hold meetings, and the technology to produce community participation-related resources and to facilitate communication between stakeholders), and the 'software' such as the organisational systems (e.g. legislation and regulations for HFCs), knowledge (including local knowledge), and skills – including the ability to facilitate participatory engagements. These latter skills, combined with the 'intangible software' of values, power and communication, form what we have termed a 'relational skillset'.

These relational skills – as a powerful combination of local knowledge, relationship-building and communication skills – are key enablers of community participation in combination with the more tangible markers of organisational support such as budgets, systems and procedures.

District and sub-district managers seeking to enable community participation could consider the extent to which both these hardware and software capacities are present; identify practitioners that have such relational skills and who would likely be suitable facilitators of participatory processes; and could begin to actively value such a skillset as a key capacity needed for community participation.

Training institutions seeking to support community participation implementation could highlight the value of local and informal knowledge, and could include listening, communication and problem-solving skills within their offerings. They could consider the value of on-the-job training, mentoring and coaching within their pedagogical approach.

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