A systematic review of the literature for evidence on health facility committees in low- and middle-income countries

David C McCoy,1* Jennifer A Hall1 and Melanie Ridge2

1Centre for International Health and Development, University College London, UK and 2NHS Public Health Trainee, London, UK

*Corresponding author. Centre for International Health and Development, University College London, 30 Guilford Street, London, WC1N 1EH, UK. Tel: +44 0 20 7905 2122. Fax: +44 0 20 7404 2062. E-mail: d.mccoy@ucl.ac.uk

Accepted 23 September 2011

Community participation in health (CPH) has been advocated as a health-improving strategy for many decades. However, CPH comes in many different forms, one of which is the use of health facility committees (HFCs) on which there is community representation. This paper presents the findings of a systematic literature review of: (a) the evidence of HFCs’ effectiveness, and (b) the factors that influence the performance and effectiveness of HFCs.

Four electronic databases and the websites of eight key organizations were searched. Out of 341 potentially relevant publications, only four provided reasonable evidence of the effectiveness of HFCs. A further 37 papers were selected and used to draw out data on the factors that influence the functioning of HFCs. A conceptual model was developed to describe the key factors. It consists of, firstly, the features of the HFC, community and facility, and their interactions; secondly, process factors relating to the way HFCs are established and supported; and finally, a set of contextual factors.

The review found some evidence that HFCs can be effective in terms of improving the quality and coverage of health care, as well as impacting on health outcomes. However, the external validity of these studies is inevitably limited. Given the different potential roles/functions of HFCs and the complex and multiple set of factors influencing their functioning, there is no ‘one size fits all’ approach to CPH via HFCs, nor to the evaluation of HFCs. However, there are plenty of experiences and lessons in the literature which decision makers and managers can use to optimize HFCs.

Keywords Community, participation, involvement, health facility committee, systematic review

KEY MESSAGES

- Community participation in health (CPH) has been advocated for more than 30 years, but there have been few systematic reviews of its functioning and effectiveness.

- A commonly promoted mechanism for CPH is the health facility committee. A systematic review of the peer-reviewed and grey literature found four studies citing empirical evidence of effectiveness.
Introduction

Community participation in health (CPH) was first articulated within international health policy circles as a strategy for health improvement in developing countries in the late 1970s (WHO 1978). This followed the successes of a number of community-orientated projects, such as those managed by Sidney and Emily Kark in South Africa as well as community-based and community-led health interventions in countries such as China, Indonesia and India (WHO 1975). Running in parallel was a growing appreciation for a more ‘people-centred’ and ‘participatory’ form of development (Chambers 1983; Kahsay and Oakley 1999).

In 1998, Zakus and Lysack noted: ‘the health literature is seriously lacking in empirical studies that demonstrate [the] benefits of CPH’. Since then, there has been a greater accumulation of evidence of the effectiveness and cost-effectiveness of CPH (Rosato et al. 2008; Preston et al. 2010). However, the evidence base remains relatively thin (Crawford and Rutter 2002; NICE 2008; Kilpatrick 2009; Draper et al. 2010), especially given the fact that CPH covers a wide range of forms and interventions.

One form of CPH is the health facility committee (HFC), a structure that is promoted as a strategy for health systems strengthening and health improvement. There has been little written specifically about HFCs. We therefore undertook a systematic review of the literature on the effectiveness of HFCs and the factors that determine their effectiveness. However, we first discuss the broader literature on CPH from which we draw out four themes that are relevant to HFCs.

Background

The nature of participation is a prominent theme in the literature on CPH. Arnstein (1969) described different forms of CPH by means of a ‘ladder of participation’. At the lowest rung of the ladder, participation can mean communities being manipulated and coerced into co-operation. Further up are ‘tokenistic’ forms of participation where people are merely informed about externally-determined activities and interventions. This graduates to ‘consultation’ which may give communities a voice but not the power to ensure that their views will be acted upon. Finally, at the top of the ladder, delegated power and decision-making clout are in the hands of community members.

Pretty’s (1995) ‘typology of participation’ is similar and consists of seven forms: (1) manipulative participation; (2) passive participation; (3) participation by consultation; (4) participation for material incentives; (5) functional participation; (6) interactive participation; and (7) self-mobilization. Similarly, Oakley (1991) describes how participation can be active or passive; and contributive, collaborative or transformative.

Another distinction is between ‘formal’ and ‘informal’ forms of CPH (Rodriguez-García et al. 2011). Formal forms include those that are officially sanctioned and operate through structures within the health system, or which act through non-government organizations (NGOs) or community-based organizations (CBOs) that receive funding from governments or donors. Informal modes of CPH tend to emerge spontaneously out of the community (e.g. self-help groups or self-organizing protest groups).

The second theme concerns the purpose of CPH. A frequent consideration in the literature is the distinction between CPH as a ‘means’ and CPH as an ‘end’ (Annett and Nickson 1991; Rifkin 1996; Zakus 1998; Mosquera et al. 2001). With the former, participation is subservient to the achievement of pre-determined targets and objectives, and is often associated with planners/professionals defining the objectives of a health programme and then convincing the community to accept and act on them.

By contrast, when CPH is valued as an ‘end’ in itself, it is more likely to be ‘dynamic, unquantifiable and even unpredictable’ (Oakley 1989) and to emphasize less tangible outcomes such as greater self-reliance, ownership and empowerment (Annett and Nickson 1991; WHO 1991; Stone 1992; Sepheri and Pettigrew 1996; Zakus 1998; WHO 1999). According to Zakus and Lysack (1998), the most important benefit of CPH is ‘the heightened sense of responsibility and conscientiousness regarding health and the concomitant gain in power achieved through the acquisition of new skills and control over resources’.

Through empowerment, CPH also has the potential to be emancipatory. In apartheid South Africa, for example, community mobilization around health was also a vehicle that helped black communities develop a sense of control, pride and agency, which were ingredients in the broader struggle for democracy and freedom (Van Rensburg and Harrison 1995). Similarly, Rifkin (1996) reported on health programmes in Peru and Indonesia that were expected to empower local populations to participate in political and social change.

Another example of different purposes is the distinction between interventions or programmes that are based in communities but which focus on achieving change in individuals, and interventions or programmes that seek to achieve change in a community as a whole.

The purpose of CPH may also be shaped by prevailing ideas about the role of the state and markets, and their relationship to individuals. The World Health Organization’s declaration from 1978 that ‘people have the right and duty to participate individually and collectively in the planning and implementation of their health care’ (WHO 1978) is rights-based and implies a sense of entitlement for citizens and a duty upon the state. On the other hand, liberal political philosophy may advocate CPH from the perspective of individual consumers operating...
within a market with minimal state involvement. Citizens with an entitlement to public services, clients of personal insurance firms and consumers who purchase care with out-of-pocket payments will each invoke different starting points for CPH.

Most of the literature assumes that CPH is beneficial, either to participating community members, the community more generally, or the health system itself. CPH is said to be able to improve health knowledge and change health behaviour (MacCormack 1983; Rifkin 1996; Zakus 1998); involve local people in needs assessments; and express local expectations (Annett and Nickson 1991; Zakus 1998; Mubyazi and Hutton 2003). From the perspective of the health system, benefits include expanding the coverage of health care; mobilizing 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 (MacCormack 1983; Annett and Nickson 1991; Rifkin 1996; Sepheri and Pettigrew 1996; Zakus and Lysack 1998; WHO 1999; Mosquera et al. 2001; Bishai et al. 2002; Mubyazi and Hutton 2003).

Emphasis on CPH as a means of improving public sector accountability has grown in recent years, and is of particular relevance to HFCs. The 2004 World Development Report (World Bank, 2003) proposed a framework of accountability relationships consisting of three elements: stronger accountability of politicians and policy makers towards citizens/clients; a ‘compact’ between policy makers and service providers; and citizens/clients exercising some power over service providers (e.g. by co-producing and/or monitoring health services).

CPH may also be used for less beneficent reasons. Governments may, for example, use and manipulate CPH to diffuse public criticism and delay action (Rifkin 1983; Collins 1989; Wallerstein 1992; Zakus 1998); legitimate an existing poor quality service (Ugalde 1985); or divert itself of certain responsibilities by passing them onto communities. Rather than empowering people, ‘participatory’ approaches have also been criticized as a device that ‘serve[s] to represent external interests as local needs, dominant interests as community concerns’ (Mosse 2001, p. 22), prevents any challenge to prevailing hierarchies and inequalities in society (Kothari 2001, p. 143), or reinforces perceptions that external experts or professional staff are more knowledgeable (Mosse 2001, pp. 23–24).

The third theme relates to the multiple meanings of ‘community’ (Oakley 1989; Mubyazi and Hutton 2003). In the case of HFCs, the word ‘community’ is typically framed in terms of the catchment population of a facility. However, geographic communities are not homogeneous but contain divisions along the lines of class, gender, political, professional status and religion (Jewkes and Murcott 1996). Oakley (1989) argued against treating the community as a ‘constant, static and uncomplicated unit’, while Gryboski et al. (2006) warned that participatory processes can in themselves create or aggravate tensions and conflicts within communities such that facilitators of CPH must be able and prepared to resolve conflicts and, in particular, protect vulnerable groups from any backlash.

The fourth theme is that CPH does not exist in a vacuum. Social, political and cultural factors all impact on the purpose, form, type and effectiveness of CPH (La Forgia 1985; WHO 1991; Zakus and Lysack 1998; Mosquera et al. 2001; Mubyazi and Hutton 2003). Not only are cases or examples of CPH heterogeneous in their own right, they operate within particular contexts and through complex and multiple socially mediated pathways. Evaluating CPH and measuring the effectiveness of CPH needs therefore to take this into account.

Aims
We set out to review the literature and evidence base concerning the effectiveness of health facility committees in low- or middle-income countries. HFCs were defined as any formally constituted structure with community representation that has an explicit link to a health facility and whose primary purpose is to enable CPH with the aims of improving health service provision and health outcomes. A second aim of the literature review was to develop an understanding of the factors that determine and influence the functioning and effectiveness of HFCs.

Methods
A literature search was conducted in April 2011 to identify studies describing the experience, impact or effectiveness of HFCs. Four electronic databases were searched—Medline, Cinahl, Cochrane Library and ELDIS—as were the websites of six key organizations—Management Sciences for Health, World Bank, United States Agency for International Development (USAID), Department for International Development (DFID), World Health Organization (WHO) and United Nations Children’s Fund (UNICEF). Later, we also searched the websites of the Regional Network on Equity in Health in Southern Africa (Equinat) and Equity in Asia-Pacific Health Systems (Equitap). The search was mainly confined to literature related to low- or middle-income countries according to the World Bank classification and to English language papers published after 1970.

Where possible, Medical Subject Headings (MeSH) terms were used when searching databases, for example ‘community health planning’, ‘health services administration’ or ‘consumer participation’. However, the available MeSH terms were insufficient, so in addition key words such as ‘health facility committee’, ‘clinic committee’, ‘hospital board’ and ‘community participation’ were used.

For the first aim of the review, inclusion criteria consisted of experimental or case-control studies concerning HFCs, or observational case studies in which there was a structured evaluation and rigorous analysis linking HFCs to relevant output or outcome measures. Studies that evaluated primary health care projects that consisted of HFCs and other interventions, such as training primary health care staff, strengthening medicine supply systems or supervising clinic staff, but which could not disentangle the specific effects of HFCs were not included.

For the second aim of the review, we selected papers that may not have qualified as rigorous studies of the effectiveness of HFCs but which nonetheless described and studied the functioning of HFCs or which discussed the factors influencing
their performance and effectiveness. We also identified and reviewed a few additional papers and reports about CPH more broadly that we felt were pertinent to an understanding of the factors that might influence the functioning and effectiveness of HFCs. The selection of these additional papers was unstructured and not derived from a comprehensive search and review of the CPH literature.

Full text copies of papers meeting both sets of criteria were obtained and reviewed. The references of included studies were also searched to identify any further potentially relevant studies. Data were extracted using a semi-structured form designed for this review.

The initial search identified 341 potentially relevant studies. On the basis of the title and abstract, 274 studies were discounted as not relevant or as duplicates. These were mostly short editorials, project proposals, short case reports, or papers that were not linked to HFCs. This left 67 papers for which the full text was obtained and reviewed. Of these, only four met the inclusion criteria for the primary review. An additional 21 papers were retained for the secondary review. Forty-one studies were excluded as shown in the flowchart. Reviewing the references of the 25 retained studies, we identified an additional 26 relevant articles. None of these met the criteria for the primary review, although 16 were retained for the secondary review.

Figure 1  Flowchart of study selection process
Table 1 Description of the key characteristics of included studies

<table>
<thead>
<tr>
<th>Study description</th>
<th>Source</th>
<th>Purpose/mandate of health facility committee</th>
<th>Membership of health facility committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retrospective study of the impact of Local Committees for Health Administration (CLAS). No control group but some comparisons made with non-CLAS run facilities.</td>
<td>Journal of Public Health Medicine</td>
<td>CLAS managed finances, were responsible for local health needs assessments and made some operational decisions.</td>
<td>Seven members: physician, 3 community reps selected by physician and 3 elected by community.</td>
</tr>
<tr>
<td>Ecological case-control study in 3 rural districts comparing 4 wards / facilities with Health Centre Committees (HCCs) and 4 wards / facilities without. The study also set out to describe the functioning of HCCs and the factors influencing their performance and impact.</td>
<td>Equinet website</td>
<td>HCCs identified community needs, mobilized community action and support for primary health care programmes. Their role in decision-making and holding service providers to account was contested.</td>
<td>A mixture of health service professionals, local government officials, local politicians, traditional leaders and other community members.</td>
</tr>
<tr>
<td>Before-and-after intervention study of a model of community participation in health involving 10 Dispensary Health Committees (DHCs) in 2 rural districts. No control dispensaries. Parallel study of the process of the intervention.</td>
<td>UK Department for International Development (DFID) website</td>
<td>DHCs were mandated to oversee the general running of the health facility, the use of local revenue, and to represent community interests. They were also expected to advise the community on health issues and mobilize community action and resources.</td>
<td>Elected democratically following village level discussions. Ten members elected for 3-year terms. Special provisions made to encourage women’s representation.</td>
</tr>
<tr>
<td>Randomized case-control study of an intervention to strengthen the community monitoring of rural primary health care facilities. The study also set out to assess how the community viewed the health system and how their views contrasted with those of health workers.</td>
<td>Quarterly Journal of Economics</td>
<td>Health Unit Management Committees (HUMCs) were used as a link between the community and the facility, and as a means to monitor the day-to-day running of the facility. But the HUMC had no authority to sanction workers.</td>
<td>Both health workers and non-political representatives from the community.</td>
</tr>
</tbody>
</table>

Findings on the effectiveness of HFCs

Only four studies met the inclusion criteria (see Table 1). In spite of the search extending back to 1970, all four papers were published after 2000. Two were in peer-reviewed journals; three were from sub-Saharan Africa and one from Latin America. Two studies had a control group: one was a case-control study and the other was a randomized controlled trial. A third paper was a retrospective analysis with a small element of comparison to a control, while the fourth paper was a before-and-after study with no control group. All four studies presented evidence on the beneficial effect of HFCs on various indicators of performance, as well as data and discussion about the factors influencing the functioning of HFCs.

The paper by Iwami and Petchey (2002) reported on an evaluation of local committees for health administration (known as CLAS in Spanish) in Peru. CLAS were established to provide some direct management over health facilities, operating under a formal 3-year contract with the Ministry of Health. They had a significant mandate, receiving funding on a weighted capitation basis and having responsibility for, amongst other things, carrying out health needs assessments and making decisions about personnel recruitment and user fee schedules. However, they operated within nationally set guidelines and policies. Each CLAS consisted of three representatives elected by the community, three representatives appointed by the head physician of the health centre, and the physician.

CLAS-run facilities began to be established in 1993 and grew in number to eventually cover about 25% of all government primary care facilities. Most of them were established in areas designated as poor and/or rural. Iwami and Petchey conducted a retrospective study of these facilities, using a variety of secondary data. They concluded that CLAS facilities did better than non-CLAS facilities on a number of measures including better user satisfaction and access for the poorest, partly through better outreach and more effective exemption of user fees for poor individuals and families. However, a significant weakness of the paper was a lack of description and discussion about their methodology and the limitations of their study. The paper also noted that CLAS were unevenly implemented and characterized by varying degrees and types of community participation. In some instances, CLAS were ‘under-resourced, inadequately supported and poorly integrated with the national health system’, and even characterized by ‘the absence of effective community participation’ (Iwami and Petchey 2002).

Loewenson et al.’s paper reported on a study of Health Centre Committees (HCCs) in rural Zimbabwe (Loewenson et al. 2004).
HCCs had previously received support from an NGO which had aimed to shift the role of HCCs from being limited to community mobilization around centrally defined programmes towards enabling communities to influence the health system and make services more responsive to their interests, and their study was designed partly as a follow-up.

In addition to studying the effect of HCCs, they studied the factors influencing HCC performance, the relationship between HCCs and specific health systems processes such as health planning and budget allocations, the attitude of community members and health service decision-makers towards HCCs, and the extent to which different sections of the community were aware of the role and functions of HCCs.

A case-control study was designed in which four wards with functioning HCCs were compared to four wards without HCCs. Control sites were selected from the same districts but far away enough to avoid spill-over effects. The study also included an element of participatory research whereby actors from the study sites were invited to discuss and interpret initial findings from the research.

Data collection consisted of a cross-sectional community survey, of both HCC and non-HCC wards; key informant interviews of health workers, local government officers and elected traditional and civic leaders; focus group discussions with community members; analysis of routine health systems and finance data; and nested case studies of specific issues. As well as case-control comparisons, the study analysed differences amongst the four HCC cases providing ‘thick’ descriptions of how HCCs worked and were perceived; and what they actually did. The rich mix of data allowed for some internal validation of the data and for generating an understanding of the process by which HCCs work within their given context.

HCC members were supposed to be nominated and chosen democratically at community meetings, although key informants in all areas stated that many members were chosen because of their status and role in health services. As such, HCCs consisted of a mix of health personnel, officials, councillors, traditional leaders and other community representatives.

The study found that facilities/wards with HCCs had a significantly higher likelihood of health service use for the last illnesses and a significantly greater use of antenatal care compared with those without HCCs. Wards with HCCs also had fewer cases of diarrhoea and greater use of ORS; more staff; better community health indicators (health knowledge, health practices, knowledge and use of health services); and stronger links between communities and health workers. In addition, clinics with HCCs tended to be better staffed and better funded which was thought to result in a virtuous cycle whereby improved capacity helped to draw in further resources. These findings were corroborated by reports of HCCs assessing community needs; building waiting mothers’ shelters, water tanks and toilets; supporting clinic security; mobilizing action for health promotion and follow-up care in the community; and raising resources for health from the community.

However, HCCs were found to have had little or no direct influence over core health budgets or over how clinics were managed and run. The relative failure of HCCs in making service providers more accountable was said to be due to a lack of knowledge about health resources, staffing levels or budget processes, as well as officials and health professionals not seeing such roles as being within the remit of community members.

Although the study showed a positive association between HCCs and broader CPH, it also found that many people in the community were unaware of HCCs or their work, and that while HCCs appeared to relate well to some sections of the community, vulnerable and poor groups had difficulty attending HCC meetings and were often overlooked.

Sohani’s paper described a before-and-after intervention study in two districts of the Coast province of Kenya (Sohani 2005). The intervention consisted of organizing local communities to form representative Dispensary Health Committees (DHCs) that would allow people ‘to govern the health and development activities at the dispensary level’. It was implemented jointly by the Ministry of Health and the Aga Khan Health Service (AKHS).

Members of the DHCs were democratically elected following a process of community mobilization and facilitated discussions. Special provisions were made to encourage women’s representation and avoid capture by local elites. The nurse in charge of the facility served as secretary to the committee. The DHC and dispensary staff then took part in ‘participatory trainings on planning, managing and governing health care at the dispensary level’ and were also equipped with ‘skills on consensus building and conflict resolution’ (Sohani 2005).

DHCs were registered as legal entities and helped to develop a ‘constitution’ that set out their aims, mandate (e.g. clarifying the roles and responsibilities of committee members and nursing staff) and working arrangements (including how often they would report back to the broader community). The constitution was based on a standard template but allowed for local adaptation. While DHCs did not have the authority to hire or fire nurses, they could exert pressure on the District Health Management Team if, for example, nurses did not act in a professional or reasonable manner. Critically, the DHCs were given authority to manage revenue generated from user fees, to establish fee levels and to shape the local policy for user fee exemptions and waivers. Other functions included identifying and supporting village health workers; facilitating outreach health care and health education; and helping to improve the supply of essential drugs.

Throughout, AKHS played an important role in capacity building, facilitating continuous dialogue and joint reviews, as well as developing health information, accounting and financial monitoring systems. The project also facilitated sessions for DHC members to review and interpret health and financial information.

The intervention was found to have had a number of positive impacts. Health care utilization and revenue generation increased in all clinics; weekend outreach services for the most distant villages were initiated; medicines became more readily available; and village health workers were revitalized. Improved financial systems reduced the leakage of funds and financial mismanagement, whilst at the same time cost barriers for the poorest were reduced through the more effective implementation of fee exemptions and deferrals. The study concluded that ‘a pro-poor health system can be developed if the true representatives of the poorest are enabled to participate in health care
delivery and good governance and proper systems are established’, and that semi-literate community members can be trained to collect, aggregate and use health and financial information for decision making and taking corrective action against the misuse and appropriation of scarce resources (Sohani 2005).

Although the study lacked control clinics, it was able to describe a number of plausible causal pathways linking the intervention to the improvements described above. In similar fashion to Loewenson et al.’s paper from Zimbabwe (Loewenson et al. 2004), there was a convincing description of processes and outputs that lends plausibility to the conclusion that the intervention had had a positive impact on community health.

The final paper was a randomized controlled study to measure and describe the impact of community monitoring of public primary health care providers in nine rural districts of Uganda (Björkman and Svensson 2009). Covering a population of about 55,000 households, data were collected through two before-and-after surveys: one of households and one of health services. In addition, qualitative data were collected on how the intervention worked; how communities became involved in monitoring health workers; the behaviour of health workers; and the factors that influenced the intervention.

The intervention itself was very structured. It first consisted of local NGOs facilitating village and staff meetings in which community members discussed the status of health service delivery. Some data from the pre-intervention survey of health services had been assembled into report cards for each treatment facility and were used to facilitate discussions. Community members were encouraged to identify the key problems and develop an action plan for themselves and providers to improve service provision.

The community meeting was spread over two afternoons and was designed expressly to avoid capture by local elites. Participants from different strata of society were invited and small group discussions were used to ensure that more marginalized groups such as women and youth could raise their voices and participate. Information on patients’ rights and entitlements was also disseminated and discussed. The issues raised in the action plans differed across communities, but a common set of concerns included high rates of staff absenteeism, long waiting times, poor care and differential treatment.

Next, a dedicated meeting was held for staff from each facility. Here, data from the pre-intervention surveys were discussed together with the outcomes from the community meeting. This was then followed by an ‘interface meeting’ at which community representatives and health workers met together to discuss proposed plans for improvement, as well as their respective rights and responsibilities. The outcome was a shared action plan and a ‘community contract’ which described how the community would monitor the agreements. Finally, after a period of 6 months, the local NGOs facilitated a second community meeting followed by a second interface meeting after which the post-intervention surveys took place 6 months later.

A key element of the intervention was the Health Unit Management Committee (HUMC), a structure that was supposed to link the community to the facility and which consisted of both health workers and non-political representatives from the community. Prior to the intervention, HUMCs had often been viewed as being ineffective. Consequently, a third of HUMCs were dissolved and new members elected or incorporated in the treatment communities, a phenomenon that did not occur in the control communities. The community monitoring process that was established was a joint effort of the local councils, the HUMC and ordinary community members.

The study results were impressive. Immunization and vitamin A supplementation coverage significantly improved in the intervention communities compared with the control communities. Utilization for general outpatient services was about 20% higher in the intervention facilities for deliveries, antenatal care and family planning. Differences in under-5 mortality suggested a substantial treatment effect: the point estimate for the youngest cohort implied a 35% reduction in the likelihood of death of a child born in 2005 in the intervention group compared with the control group. There were also differences in weight-for-age between the intervention and control groups.

The effects on health outcomes compare favourably to some of the more successful community-based intervention trials reported in the medical literature. A back-of-the-envelope calculation estimated the cost of averting the death of a child under 5 to be around US$300, which compares favourably to the estimated average cost per child life achieved through the integrated delivery of 23 mainly clinical interventions against the major causes of death in young children (Bryce et al. 2005).

The study also demonstrated improved process and output indicators in the intervention facilities compared with the control facilities. For example, patients in the intervention community were significantly more likely to report the availability and use of clinic equipment as well as shorter average waiting times. Staff absenteeism was less in intervention facilities which were also found to be cleaner and in better condition.

The differences in outcome, output and process indicators between control and intervention facilities were mirrored by differences in the way communities monitored their facilities. For example, the performance of health staff was more often discussed in local council meetings in the intervention communities, and community members in the intervention group were, on average, better informed about the HUMC’s roles and responsibilities. Both the quantity and the specificity of discussions were found to have improved in response to the intervention. Monitoring tools such as suggestion boxes, numbered waiting cards, and duty rosters were also significantly more common at intervention sites.

Using variation in treatment intensity across districts, the study also showed a significant relationship between the intensity of community monitoring and health utilization and health outcome indicators, providing further evidence of the effectiveness of community monitoring. (The study excluded other possible explanations such as differences in health worker knowledge and differences in the behaviour of district or subdistrict management teams.)

The fact that all four studies had positive results suggests publication bias with negative studies being less likely to be published or reported. Certainly it is not hard to imagine HFCs having no or little impact on service delivery or health outcomes. Only one of the four studies evaluated HFCs as a
‘normal’ aspect of the health system and at scale (Iwami and Petchey 2002). The other three were small-scale projects involving NGOs and/or research institutions with external support and resources. Nonetheless, taken together, the four studies provide some strong evidence that HFCs can impact positively on the quality of care provided and on health outcomes.

Factors influencing HFC effectiveness

Of the 37 additional papers included in the second part of the review, 26 were published in peer-reviewed journals, seven of which were in Health Policy and Planning and five in Social Science and Medicine. Of these 26, nine were studies of specific community involvement but without an evaluative component. Six were descriptive in that they were either case studies or opinion pieces, two were reviews and three were theoretical treatises on the concept of CPH. The 11 included papers that were not published in peer-reviewed journals were: Equinet papers \((n = 4)\); WHO documents \((n = 3)\); or reports published by other agencies \((n = 4)\). These papers covered countries in Sub-Saharan Africa, Central and South Eastern Asia and Central and South America. Appendix 1 gives a brief description of these 37 studies.

Following a preliminary reading of the literature, a framework to organize the extraction of data was used and consisted of three levels of factors: the level of the HFC; the level of the health system; and the level of society. During the course of the review and analysis of the literature, this framework was revised to the one shown in Figure 2. One set of factors concerns features related to the HFC itself, and the interaction between two other sets of local factors: those related to the health facility and its staff, and those related to the local catchment population (or ‘community’). There is then a set of ‘process factors’ relating to how the participation is achieved, followed by a set of contextual factors, sub-divided into those related to the health system and those related to society more generally.

Features of the HFC

Many studies of HFCs describe clarity and consensus on the role(s) and function(s) as important factors influencing their effectiveness (La Forgia 1985; Zakus 1998; Ramiro et al. 2001; Loewenson et al. 2004; Uzochukwu et al. 2004; Sohani 2005; Israr and Ilam 2006; World Bank 2008). This includes clarity and consensus on their mandate and authority, where HFCs are expected to play a public monitoring and accountability role, and clarity on accountability arrangements between community representatives and facility staff.

For example, Sohani (2005) described how dispensary health committees were hampered by conflicts between staff and community representatives, especially over the control of dispensary funds, because of a lack of agreement over relative roles. Similarly, Björkman and Svensson (2009) noted how a lack of information and a failure to agree on what is reasonable to expect or demand from service providers inhibited community members from effectively monitoring health facilities. In Mongolia, O’Rourke’s descriptive study of hospital boards revealed how they were initially given too much power and ended up interfering in the day-to-day running of hospitals (O’Rourke et al. 2003).

In their study of the determinants of health worker performance in Rwanda, Serneels and Lievens (2008) found that Community Health Committees were only effective in improving the quality of care through performance monitoring if they had some discretionary power to reward well-performing health workers and discipline poor performers, but that in general, the capabilities and arrangements for such monitoring and accountability were absent or ineffectual. Other papers similarly described a lack of power or authority over health facility staff and budgets as a reason why HFCs were unable
to exert effective influence over the provision of services (Tumwine 1993; Loewenson 2000; Kapiriri et al. 2003; Mubyazi and Hutton 2003; Loewenson et al. 2004).

There were also descriptions of HFCs being frustrated and constrained by having to comply with policy directives ‘from above’ (Mosquera et al. 2001; Mubyazi et al. 2007a; Ndunguru 2008), or having large portions of their delegated budget already earmarked (Kapiriri et al. 2003). In particular, committees that were expected to focus only on mobilizing additional resources for the health system were susceptible to feeling disenchanted (Zakus 1998; Uzochukwu et al. 2004) or exploited (Kapiriri et al. 2003). These descriptions suggest a tendency for HFCs to operate on the lower rungs of Arnstein’s ‘participation ladder’.

Various papers described the capabilities and resources of HFC members as significant factors (Oakley 1989; WHO 1991; Zakus 1998; Loewenson 2000; Mosquera et al. 2001; Iwami and Petchey 2002; Sohani 2005). These include health knowledge and management skills, as well as attributes such as confidence. Björkman and Svensson (2009) highlighted the importance of data and comparative information about the quality of health care for enabling community members to hold staff and officials accountable, as well as for determining and then addressing the causes of poor quality care.

Other capabilities and resources identified as being important were effective leadership, material resources and funds (La Forgia 1985; WHO 1991; Tumwine 1993; Zakus and Lysack 1998; Mosquera et al. 2001; Ngulube et al. 2004; Israr and Ilam 2006). Most of the literature indicates that community members are expected to participate on HFCs on an unpaid basis. However, there was surprisingly little discussion about the relative pros and cons of remunerated vs voluntary participation.

In the literature, features relating to HFC composition were frequently cited. Although the HFCs considered were a mixture of staff and community members, there was little discussion about the appropriate size of committees or the balance in numbers between community members and staff. The benefits and challenges of having the involvement of women (Tumwine 1993; Sato 2006) and representatives of marginalized groups (Loewenson 2000; Bishai et al. 2002) were common discussion points in the literature, and raise the possibility of the use of quotas to ensure adequate representation of different segments of the community.

Another important dimension of a HFC is its relationship to the catchment population of its health facility. The extent to which HFCs are able to facilitate CPH or improve the responsiveness of health care providers is considerably determined by the representativeness and legitimacy of HFC members (Selph and Pettigrew 1996; Ramiro et al. 2001; Mubyazi and Hutton 2003; O’Rourke et al. 2003; Loewenson et al. 2004; Sohani 2005). Zakus and Lysack (1998) went as far as to say that ‘the methods used to select organisation members and the degree to which they represent local issues are . . . crucial in determining the perceived legitimacy of the representatives in the eyes of the population served’. However, several papers described poor or absent linkages between HFCs and the community (La Forgia 1985; Zakus 1998; Mosquera et al. 2001; Ramiro et al. 2001; O’Rourke et al. 2003; Israr and Ilam 2006) and a low recognition within the community of HFCs (Loewenson et al. 2004; Mubyazi et al. 2007).

**Features of the health facility and its staff**

Poorly functioning and resourced health facilities appear to be associated with poorly functioning HFCs. As observed by Loewenson et al. (2004), health facilities and HFCs operate synergistically with each other. For example, staff attitudes, skills and perceptions on CPH can influence the functioning of HFCs (Kasaje et al. 1987; Loewenson 2000; Ramiro et al. 2001; Bishai et al. 2002). Some papers described how negative attitudes amongst health care workers and government employees about the competency and capacity of community members could prevent effective CPH (La Forgia 1985; Oakley 1989; WHO 1991; Mubyazi and Hutton 2003; Mubyazi et al. 2007a). In their evaluation of user participation reforms in Colombia, Mosquera et al. (2001) found that scepticism amongst health managers towards lay people resulted in CPH being limited to complaints about specific grievances rather than anything to do with policy, planning or organizational change.

Sohani (2005) noted that nurses had to be helped and encouraged to recognize that even if community members were illiterate or semi-literate and lacked clinical expertise, they had other useful attributes as well as a right to call for more accountability. In Sohani’s experience, dispensary health committees were more effective ‘in places with younger nurses who were less likely to have inflated egos, and more keen to learn by listening to different views’ (Sohani 2005).

Loewenson et al. (2004) also found more effective community participation when health staff were responsive, co-operative and willing and able to make outreach visits. Gryboski et al. (2006) make the point that CPH programmes ask as much of health professionals as they do of citizens, by requiring them to learn new skills (such as adult learning approaches, conflict resolution, facilitation and participatory research) and to view health in a more holistic way, not solely from a disease-oriented perspective.

**Features of the community**

Several papers highlighted the influence of social hierarchies and economic or political divisions on CPH, and the degree of participation by those who occupy lower positions in society, and not infrequently HFCs reflected these hierarchies and patterns of power and patronage (La Forgia 1985; Kasaje et al. 1987; Madan 1987; Oakley 1989; Sepheri and Pettigrew 1996; Iwami and Petchey 2002; Kapiriri et al. 2003; Israr and Ilam 2006). According to Sepheri and Pettigrew (1996), economic and cultural hierarchies, including male domination, helped prevent health committees from adequately representing the interests of the entire community and hindered full community participation in the delivery of primary health care.

Economic barriers to participation in HFCs have also been noted. The direct and indirect costs of participation can be substantial (Kasaje et al. 1987), and it has even been suggested that poor and disadvantaged people might prefer the professional handling of community health matters by paid workers for this reason. Where economic circumstances are such that communities struggle to survive day to day, health care services are often not seen as a priority; addressing poverty may be more important (Loewenson 2000). Social and economic barriers to participation may be aggravated by physical barriers.
associated with topographical features, travel distance and the availability of transport.

In an intervention study of a participatory project directed at adolescent health in Nepal, it was noted that youth participation did not mean the same thing in rural and urban settings, and that achieving and maintaining participation was more difficult in urban areas because the boundaries of ‘community’ were more ambiguous. In addition urban residents were generally better off financially and less in need of the benefits offered by the project, as well as having less time to invest in participatory processes (Gryboski et al. 2006).

HFCs were also influenced by local political dynamics. Uzochukwu et al. (2004) found some community members refusing to participate in health activities due to ‘opposition to the leadership of the committee, polarisation into different political parties and religious differences’. Mubyazi et al. (2007b) found that the poor functioning of village health committees in Tanzania was significantly explained by political divides between local community health committee members and ruling party leaders at the ward and district level.

Several papers gave other examples of local politics affecting the functioning of HFCs, especially in relation to local politicians or elites asserting control over committees for their own gain (La Forgia 1985; Ramiro et al. 2001; Sohani 2005), dominating priority setting (Kapiriri et al. 2003), preventing the committee from performing some of their actions (La Forgia 1985) and attempting to appoint relatives onto the committee (Tumwine 1993). Ramiro et al. (2001) found when health care devolution took place in the Philippines, it ended up concentrating power amongst local elites and accentuating a system of political patronage.

Sohani (2005) described a well-performing HFC which was forced by a local councillor to re-elect its members who then installed his own supporters and transferred the nurse out of the clinic, the result of which was deterioration in the utilization of the clinic. Thus while earlier it was noted that CPH can be undermined by health professionals and officials resisting community involvement, there are equally examples of professional staff being undermined by forms of community participation that enable unhelpful political interference.

On the other hand, participatory budgeting facilitated by local government in Latin America enabled community involvement in local development planning with positive benefits for health (De Sousa Santos 1998). In other instances, local political support was reported as a positive influence that helped empower HFCs (Loewenson et al. 2004).

Process factors
Papers describing successful case studies tended to emphasize the importance of process in the establishment and development of effective HFCs. One conclusion is that there needs to be wider community mobilization. This was the experience in the Uganda case study in which the improved functioning of HFCs was preceded by community mobilization efforts at the village level (Björkman and Svensson 2009). This was also the experience in Kenya where the weight and influence of civil society needed to be strengthened first before it could counterbalance the negative influence of local politicians (Sohani 2005).

Sato described how the effective involvement of women in HFCs in Afghanistan had to be preceded by the active lobbying of men in order to overcome strong traditions of patriarchy. Only then were women allowed to participate, in some places together with men (sometimes with a curtain dividing them), in other places through separate committees for men and women (Sato 2006).

In Gryboski et al.’s review of a project in northern Peru that improved primary health care coverage and outcomes (partly by changing the system from being primarily clinical and focused on individuals to being more holistic, preventive and family-oriented), HFCs were not a mechanism for change (Gryboski et al. 2006). Instead, the approach taken was to mobilize and strengthen the capabilities of the community as a whole (partly through a process that included participatory research, critical feedback and policy impact analyses). This suggests the importance of community mobilization but also that facility-based primary health care services can be improved through forms of CPH that do not involve HFCs.

Boule et al. (2008) described the use of participatory research and ‘community mapping’ to establish links between HFCs and three types of community groups: those that could help support health improvement such as church groups, local CBOs, soup kitchens, community policing forums and patient groups; those that were contributing to health problems such as gang members and tavern owners; and those with the poorest health who needed targeted mobilization and empowerment. By bringing HFC members and other community groups together, HFCs were given greater legitimacy while simultaneously identifying a number of unanticipated health problems, such as those related to alcohol, gangs, domestic violence and the illegal dumping of rubbish, and thereby encouraging a more comprehensive and multi-sectoral approach to health improvement.

The value of external facilitation and support in enabling staff and community members to arrive at effective working arrangements is another lesson drawn from successful case studies. Sohani, for example, described a ‘cycle of reflection sessions’ with case studies and role-play for nurses, community members and district management staff that was facilitated by an external and neutral intermediary (Sohani 2005). The results documented in Uganda by Björkman and Svensson (2009) followed an intervention that included structured and facilitated interactions between communities, HFCs and health facility staff, and external technical support, to develop an effective monitoring and health information system.

The participatory research and community mapping process described earlier in South Africa (Boule et al. 2008) also helped clarify the role, mandate and authority of HFCs and enabled consensus building. This was facilitated by a university department that helped clinical staff and community members overcome difficulties and tensions as they arose.

In Paxman et al.’s study of a reproductive and child health programme in India, three professional local NGOs were an important source of support for 620 village health committees that helped to improve health care coverage and outcomes
The NGOs provided training and support to the committees (e.g. on project management and use of data), but also, through their own local activities and knowledge of the area, they helped mobilize the community around health and adapt the activities of village health committees to the needs and capacities of the local population and health system. The support of a US-based technocratic public health agency was an additional and important ingredient of the programme.

Finally, as described by Iwami and Petchey (2002), Loewenson et al. (2004), Sohani (2005), Gryboski et al. (2006), Boullé et al. (2008) and Björkman and Svensson (2009), external actors and NGOs are often instrumental in carrying out the proactive measures required to ensure the inclusion and involvement of poor and marginalized communities in HFCs and other forms of CPH.

Thus, time and commitment appear to be important factors, especially for the development of the trust and skills required for communities and health professionals to work together, and for the empowerment of those most in need of access to good quality health care (Nathan et al. 2006). The establishment of effective HFCs is not a simple task, as illustrated by Sohani’s description of plans to sustain and replicate the successful case study in Kenya. This included more than just one-off training for staff and community members, but also the on-going commitment of district level authorities as well as sustained on-site assistance and follow up (Sohani 2005). According to Preston et al.’s literature review of community participation in rural health care, health improvements are not gained without an extended timeframe, sound methodology, adequate and sustained resources, and strong relationships (Preston et al. 2010).

**Contextual factors**

Many of the factors described above are clearly influenced by contextual factors that envelop local communities and clinics. Most obviously is the influence of the wider health system, including the legislative, regulatory and policy framework which shapes the approach towards CPH as well as the role, functions, mandate and authority of HFCs. Health policy-makers may also be important in influencing the approaches of government more generally towards CPH. Israr and Islam (2006), for example, described how the central Finance Department in Pakistan prevented the investment required to operationalize village health committees because it was unconvinced of their value, even though this was the policy. According to Ramiro et al. (2001), health systems with a management culture that encourages transparency and openness are more likely to support effective HFCs.

Furthermore, for successful small-scale projects to be scaled-up, the health system as a whole would need to be capable of replicating the ingredients of success including the provision of training and resources to community members and staff and the facilitation required for HFCs to work effectively. According to Iwami and Petchey (2002), ‘creating and sustaining community capacity implies an important developmental role for the state’ (as well as institutions such as universities and NGOs). By implication, for HFCs to be effective they need to be supported and nurtured by the health system.

Only a few papers examined the role and effectiveness of HFCs (or other types of health committee) at a national or large scale, so there is little hard evidence on the impact of health systems factors on the effectiveness of HFCs. However, the functioning of HFCs is clearly bound to the functioning of the primary health care system as a whole. Mubyazi and Hutton (2003), for example, found that weak district and primary health care systems undermined participation as staff lacked the resources to respond to demands from the community, while poor quality care inhibited community support for participation.

Loewenson et al. (2004) noted how the performance of HFCs was influenced by the attitude and responsiveness of district-level health authorities, while in Peru, CLAS were most successful where the local and regional ministries of health were committed to CPH and supported it (Iwami and Petchey 2002). In Panama, La Forgia attributed the general decline in village health committees partly to deterioration in communication from the central ministry about the purpose and function of the committees, and partly to a reduction in its commitment to CPH and preventive and community-orientated services (La Forgia 1985).

The case study from South Africa included a description of the role of community liaison officers, a cadre of health worker whose role is to facilitate more effective linkages between the formal health care system and the community (Boullé et al. 2008). Such a role may also be performed by community health workers. Through the financing of such cadres of health worker, health systems policy can influence the functionality of HFCs. Boullé et al. (2008) also suggested that a more nurturing environment for HFCs could be created by including key performance indicators related to HFCs in the job descriptions of relevant health workers and managers and by conducting periodic structured audits of HFCs.

Where a nurturing environment is not forthcoming La Forgia (1985) described how local health committees worked together to exert pressure on the health system to access funds and effect change, illustrating how ‘bottom-up’ pressure and advocacy can also influence the health system to enable HFCs to carry out their functions.

There are also contextual factors beyond the health system which can influence HFCs, either through the health system or ‘communities’. The political, social and cultural features of society can influence, for example, local community dynamics and attitudes towards CPH (Oakley 1989; WHO 1991; Stone 1992; Ramiro et al. 2001; Mubyazi and Hutton 2003; Israr and Ilam 2006). And policies on CPH will take on a different form in repressive regimes than in more open and democratic societies. Zakus and Lysack (1998) even argue that where the political situation is oppressive, it is ‘incumbent upon the proponents of community participation to examine how relevant, or even possible, collective action is’.

As summarized by Mosquera et al., CPH is not just a matter of policies and structures, but incorporates a complex process involving belief, customs, way of life and power relations (Mosquera et al. 2001). La Forgia (1985) also emphasized the political economy of national development planning, while other papers made reference to the bureaucratic nature and
structure of the state and the willingness of the centre to relinquish power (Oakley 1989; Zakus 1998; Zakus and Lysack 1998; Mosquera et al. 2001; Israr and Ilam 2006). And as mentioned earlier, health care markets and neoliberal approaches to development will create a different environment compared with more socialized systems of organization and state or community-led approaches to development.

Historical and cultural traditions may also lead to differences in the way policies and plans for CPH are translated into practice. For example, in Peru, CLAS was built ‘on a tradition of local self-help’ and women’s grassroots self-help circles that emerged during ‘guerrilla attacks and economic crises of the 1980s’ (Iwami and Petchey 2002). In rural Nepal, Sepheri and Pettigrew (1996) described how Nepali social norms and kinship relationships influenced community participation, while cultural beliefs and practices about illness and healing influenced the nature of engagement between community members and health service providers.

Finally, it is necessary to note that while communities and clinics are shaped and influenced by broader social, cultural and political forces, CPH is also potentially a mechanism for citizens and local actors to shape societal values and attitudes.

**Discussion**

This literature review found only four rigorous studies or evaluations of the effectiveness of HFCs in low- and middle-income country settings. This small number is surprising given the ubiquity of HFCs. All four studies described a positive impact, suggesting the possibility of publication bias. Only one of the studies involved a randomized controlled study design, but two other studies involved reasonable study designs that provide convincing evidence of benefit.

However, the external validity of any of these studies is extremely limited. HFCs are not a standardized intervention and, furthermore, they take place in the context of different health systems and a unique social, cultural and political context. What can be concluded from these studies is not that HFCs are effective but that they can be effective. Furthermore, they can be very effective. In the case of the study from Kenya, the impact was sizeable and impressive.

These findings are compatible with studies of other forms of CPH. Preston et al.’s review of various forms of community participation in rural primary health care found evidence that community participation can result in beneficial health outcomes and increased uptake of services (Preston et al. 2010). They identified 14 studies which reported improved health outcomes associated with community participation with evidence level 4 or above (Australian National Health and Medical Research Council levels of evidence).

Among these studies were a cluster randomized trial of an empowerment and developmental approach using ‘women’s groups’ that showed a significant and positive impact on newborn mortality in Nepal (Manandhar et al. 2004). However, while a replication trial of participatory women’s groups in India showed evidence of similar positive impact (Tripathy et al. 2010), a trial in Bangladesh showed no impact on neonatal mortality, nor a variety of process indicators (Azad et al. 2010). Part of the explanation for this variation lies in the interaction between the intervention and unique contextual factors, as well as inevitable differences in the quality and nature of the intervention itself.

It is important that both HFCs and ‘women’s groups’ have evidence showing that they can be effective or that they have been effective. But seeking replication of both intervention and impact may be a futile strategy. Community participation is a complex social process that is situation specific. What works in one community should not be expected to work in the same way or with the same effect elsewhere.

What is important is to understand the process by which such interventions were successful, the context in which these processes took place, and the interaction between intervention and context. This knowledge can be transferred elsewhere, but not in a formulaic or mechanistic way. Rather, the knowledge will need to be reinterpreted to fit in with the particularities and peculiarities of alternative and different contexts. This is somewhat at odds with the current paradigm of science that tends to seek absolute truths and a singular interpretation of events and causality, and which sees CPH as ‘an intervention and analyses it as linear [and] causally’ or target oriented (Rifkin 1996).

While randomized controlled trials are the gold standard for demonstrating that CPH interventions can be effective, descriptive and analytical case studies are a more appropriate methodology for studying and understanding the implementation process, and working out how and why HFCs work. It should be noted that it is as relevant and important to learn from cases that are unsuccessful. In particular, there is a need for more research on HFCs in the form of longitudinal comparative case studies (with or without a control study design) that would allow for the description and measurement of both process and outcomes; contain qualitative and quantitative data; and be capable of reflecting and analysing the complex web of interactions between all the factors outlined earlier.

A second concluding point drawn from the literature is that because HFCs are in themselves a heterogeneous set of entities, it would be useful to design a framework for categorizing the different roles and functions of HFCs. Drawing from the literature, we elicited seven such categories as follows:

- Governance—to strengthen the accountability of the health facility to the community and public
- Co-management—of health facility resources and services
- Resource generator—in the form of material resources, labour and funds for health facility
- Community outreach—to help the health facility reach into the community for the purpose of health promotion and improving health-seeking behaviour
- Advocacy—to act as a community voice to advocate (e.g. to local politicians and health managers higher up the health system) on behalf of the health facility
- Intelligence—to provide a means of transmitting information about the views and needs of the community to the health facility
- Social leveller—to help mitigate social stratification by empowering marginalized sections of the community/public.

This framework shows that HFCs can perform activities which face ‘inwardly’ into the health facility, as well as those that face ‘outwardly’ towards the community or towards authorities.
higher up the health system. The framework also brings out the tension that can exist between certain roles and functions. For example, the role of ‘governance’ could potentially conflict with that of ‘co-management’. Interestingly, none of the papers we reviewed described problems arising from HFCs having conflicting roles and functions, nor role overload.

When it comes to the determinants of the effectiveness of HFCs, the literature reveals a complex system of multiple and interacting factors, operating at a variety of levels. Purely at the level of the individual community representatives of a HFC, performance and functionality can be influenced by the number of community representatives, their skills and training, whether they are paid or not, and how representative of the community they are. Other factors include the attitude of health care workers towards community members, the clarity of mandate and authority of the HFC, and whether or not the health system as a whole values and enables CPH. Social, political, cultural and economic factors also play a role in creating an environment that is either facilitative or inhibitive.

Many of the case studies of successful HFCs also suggest the importance of external support and facilitation. Sometimes communities appear to need ‘a push from the outside’ for them to take charge of their own health care. At other times, communities and professional staff need external facilitation to overcome tensions and misunderstandings. Support may also be provided by local NGOs in mobilizing the broader community and supporting the interaction between HFCs and the wider community.

These findings may to some extent reflect the bias in the literature towards small-scale and externally facilitated projects. However, many studies provide compelling arguments that for HFCs to have real and sustained impact on care quality and performance and functionality can be influenced by the number of community representatives, their skills and training, whether they are paid or not, and how representative of the community they are. Other factors include the attitude of health care workers towards community members, the clarity of mandate and authority of the HFC, and whether or not the health system as a whole values and enables CPH. Social, political, cultural and economic factors also play a role in creating an environment that is either facilitative or inhibitive.

Many of the case studies of successful HFCs also suggest the importance of external support and facilitation. Sometimes communities appear to need ‘a push from the outside’ for them to take charge of their own health care. At other times, communities and professional staff need external facilitation to overcome tensions and misunderstandings. Support may also be provided by local NGOs in mobilizing the broader community and supporting the interaction between HFCs and the wider community.

These findings may to some extent reflect the bias in the literature towards small-scale and externally facilitated projects. However, many studies provide compelling arguments that for HFCs to have real and sustained impact on care quality and health improvement, facilitation, material support, time and commitment are required.

However, it should be noted that HFCs operate synergistically with other interventions. For example, the literature suggests the importance of accompanying efforts at wider community mobilization and the need to address local political dynamics. According to Rifkin (1986), ‘there appears to be a prevalent myth among planners and agencies that, because the delivery of health services is seen to be relatively void of political implications, community participation in health programmes is also void of these implications’; however, ‘any programme which chooses to address the issue of community participation must realize that it is also addressing the issue of power’.

In addition, efforts to improve health care through HFCs will operate synergistically with other ingredients for motivating and improving the performance of health care workers, such as financial incentives and non-financial motivational factors associated with ethical norms and professionalism. HFCs are therefore not a simple and ready-made solution to the problems of poor health services. But they can have a positive impact provided they are designed and implemented with care and thought.

Acknowledgements
Antonia Smithies, from the Options Consultancy firm, helped with some of the initial literature search.

Funding
None received.

Conflict of interest
None declared.

References


Appendix 1

Papers used for background

<table>
<thead>
<tr>
<th>Study</th>
<th>Brief description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preston R, Waugh H, Larkins S, Taylor J. 2010. Community participation in rural primary health care: intervention or approach? Australian Journal of Primary Health 16: 4–16.</td>
<td>A literature review following a search which generated 689 empirical studies linking rural community participation and health outcomes. 37 papers were finally selected, grouped and analysed according to: contextual factors; the conceptual approach to community participation; community participation process; level of evidence; and outcomes.</td>
</tr>
</tbody>
</table>
## Papers used in the secondary review

<table>
<thead>
<tr>
<th>Study</th>
<th>Brief description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bishai D, Niessen L, Shrestha M. 2002. Local governance and community financing of primary care: evidence from Nepal. <em>Health Policy and Planning</em> <strong>12</strong>: 202–6.</td>
<td>Cross-sectional study of the relationship between the socio-economic composition of village development committees (VDCs) in Nepal with the amount of local financing given for the local health facility. The main finding was that VDCs with more lower caste members were significantly associated with higher amounts of local financing for the health clinic.</td>
</tr>
<tr>
<td>La Forgia G. 1985. Fifteen years of community organization for health in Panama: an assessment of current progress and problems. <em>Social Science &amp; Medicine</em> <strong>20</strong>: 53–65.</td>
<td>Mostly qualitative and retrospective study of Panama’s Community Health Programme designed to explain why in some communities, health promoting activities were numerous and effective, while in others, activities were few and deficient. This included the specific study of village health committees.</td>
</tr>
<tr>
<td>Loewenson R. 2000. Public Participation in Health Systems. In Report of the EQUINET / TARSC Regional Meeting. Harare.</td>
<td>This report documents a meeting on public participation in health systems that sought to better understand the principles and key features of effective community participation in health.</td>
</tr>
<tr>
<td>Mosquera M, Zapata Y, Lee K, Arango C, Varela A. 2001. Strengthening user participation through health sector reform in Colombia: a study of institutional change and social representation. <em>Health Policy and Planning</em> <strong>16</strong>: 52–60.</td>
<td>Mixed methods case study of user associations (intended to represent user interests through monitoring health service quality and mediating between insurers, providers and users when user entitlements have been undermined) and customer service offices (a complaints mechanism which should protect and promote user rights) in one district of Columbia. It focuses on the political, economic and legislative frameworks that may help or hinder community participation.</td>
</tr>
<tr>
<td>Mubyazi G, Mushi A, Shayo E et al. 2007. Local primary health care committees and community-based health workers in Mkuranga District, Tanzania: does the public recognise and appreciate them? <em>Ethnomedicine</em> <strong>1</strong>: 27–35.</td>
<td>Investigates the views of communities in Tanzania and found low levels of recognition of the existence and function of VDCs. Reasons given by the communities for the lack of participation included political differences and dissatisfaction with services.</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Study</th>
<th>Brief description</th>
</tr>
</thead>
</table>

Before and after study set in Australia to examine staff attitudes towards community involvement on key health-service decision-making committees. A key finding was that developing constructive relationships between health services and communities takes time and iterative learning. |

Retrospective descriptive case study to ascertain the presence of activities that contributed to CPH and verify whether community participation was taking place. The study sought to correlate levels of community participation (including through Health Facility Governing Committees) with various health service indicators. Paper claimed improvements associated with CPH, but study design was too weak to include in primary review. |

A commentary highlighting the importance of differentiating between the community as a client to whom services are provided and the community as a participant in planning its own health and development. |

A descriptive study of well and poorly performing HFCs in Zambia aimed at describing the reasons for the differences. The paper found some examples of CPH enhanced by HFCs, but this was limited CPH. No evidence of any differences in the quality and impact of health care. |

A book which provides a general overview of CPH and the factors that need to be considered when implementing it. Some case studies presented, but no presentation of any research. |

Not a study but a descriptive paper of the set up of 32 hospital boards in Mongolia in 1998, the initial problems experienced and subsequent changes made in 2000. Before and after descriptive study of a successful community-based programme to improve reproductive and child health in three different parts of India. One of the key interventions was the establishment of 620 village-based health committees. |

A study assessing the role and impact of Local Health Boards (LHBs) (constituted at the level of the municipality) in promoting CPH and improving certain health systems outputs in the Philippines. A cross-sectional study of 4 purposively selected LHBs using a mix of quantitative and qualitative data was carried out to examine the experience of LHBs and the factors determining their impact on CPH. Commentary based on a review of about 200 case studies. It includes a discussion about the meaning of CPH and why CPH that focuses on health care services tends to fail. |

A review of reviews on CPH, mainly drawing on the author's own previous reviews and other papers published since 2004. A descriptive qualitative study of the experience of a USAID-funded project to involve women in Afghanistan’s community-based health care strategy, partly through local community health committees. Descriptive comparative case study of CPH in two villages in Nepal—one with a state run and financed health post and one with a community run and financed health post. Differences in level and quality of CPH noted, but unable to determine any relationship with quality of care or health status. Qualitative study of the determinants of health worker motivation which concludes that four institutional factors explain health worker performance and career choice: incentives, monitoring arrangements, professional norms and intrinsic motivation. The paper suggests that community health committees can act as a mechanism for effective monitoring. A paper that traces the perceived role of culture in CPH over time. A description of ward health teams made up of health facility staff, other development workers and community representatives in Zimbabwe. Cross-sectional study of district and village health committees in one area of Enugu state, Nigeria. Its aim was to assess awareness of the (continued)
<table>
<thead>
<tr>
<th>Study</th>
<th>Brief description</th>
</tr>
</thead>
</table>